



## **Rural Palliative Care Project & Aged Care GP Panel Initiative**

# **Creating a Multi- Disciplinary Team Approach to Care Planning In Residential Aged Care Facilities**

## **Tool kit**

## Table of Contents

Prelude .....	
Tool 1: Terms of Reference .....	
Tool 2: Memorandum of Understanding .....	
Tool 3: Monthly Report Form .....	
Tool 4: Multi-disciplinary Case Summary Sheet .....	
Tool 5: Multi-disciplinary Care Planning Checklist .....	
Tool 6: Multi-disciplinary Care - Checklist Resident Care Needs.....	
Tool 7: Letter Templates	
Tool 8: Implementation of Enhanced Primary Care in RACF Guidelines.....	
Reference List .....	

### Suggested citation

Phillips, J., Mandile, M., Dover, V., Dever, M., Nelson, C. and Pirie, H. 2006. ***Toolkit: Creating a Multi-Disciplinary Team Approach to Care Planning In Residential Aged Care Facilities***. Mid North Coast Division of General Practice, Coffs Harbour.

## Prelude

Managing the complex care needs of an ageing population is a global concern. In Australia, it is estimated that 6% of over 65 year olds live in residential aged care facilities (RACF) (Australian Institute of Health and Welfare 2004). Most recently, there has been a greater emphasis on community based care. Consequently older persons residing in RACF are more likely to be those with dementia (60%), individuals experiencing chronic pain (40-50%) and residents who are depressed (40%) (The Royal Australian College of General Practitioners 2006). RACF in Australia are increasingly becoming the place of death for many older persons with approximately 20% dying within 12 months of being admitted to permanent care (Australian Institute of Health and Welfare 2004).

This burden of disability and death in RACF has prompted the development of evidence-based guidelines that encourages Australian aged care providers to integrate the delivery of a palliative approach into their organisational practice (Australian Government Department of Health and Ageing 2004). In spite of this positive policy environment, previous research has identified numerous obstacles to the provision of palliative care in RACF, including: inadequate staffing levels; a regulatory focus on rehabilitation; a lack of palliative care competencies; failure to recognise treatment futility, lack of communication amongst decision makers, residents and families, no agreement on a course for end-of-life care and failure to implement a timely end-of-life care plan (Kayser-Jones 2002, Travis *et al.* 2002, Brazil *et al.* 2006, Phillips *et al.* 2006, Froggatt & Hault 2002, Avis *et al.* 1999, Hanson *et al.* 2002).

In an attempt to address these numerous barriers the establishment of in-house multi-disciplinary care planning meetings has been trialled as part of the Mid North Coast Rural Palliative Care Project (MNCRPCP) 2004-06 (inclusive). To ensure the sustainability of this initiative beyond the life of the MNCRPCP a strategic partnership has been established with the Aged Care Panels Initiative. This manual was developed in collaboration with aged care provider's and details how multi-disciplinary care meetings can operate within the aged care arena and promote the delivery of a palliative approach.



Ms Jane Phillips  
**Rural Palliative Care Program Coordinator**

Thursday, 7 December 2006



# **Tool 1:**

## **Terms of Reference**

### **Multi-disciplinary Team meetings**

## Terms of Reference

### BACKGROUND

The delivery of a palliative approach in Residential Aged Care Facilities is being endorsed by Australian government policy (Australian Government Department of Health and Ageing 2004). A palliative approach aims to improve the quality of life for older people with a life limiting illness and their families, by reducing their suffering through early identification, assessment and treatment of pain, physical, psychological, social and spiritual needs (Kristjanson et al. 2003). Adoption of a palliative approach focuses the intention of care on improving quality of life, including symptom control, dignity and comfort for the older person, acknowledges the needs of family and can be initiated well before the terminal stages of illness, making it the most appropriate approach for care for people in residential care (Kristjanson et al. 2005, Panke 2002).

Given the increasing complexity of the residents care needs combined with the call for a palliative approach to care delivery suggests that the adoption of a multi-disciplinary team approach to care planning and delivery is required. Multidisciplinary care is the vehicle for providing an integrated team approach to the provision of health care and this occurs when medical, nursing and allied health professionals consider all treatment options, including all of the potential benefits and disadvantages of treatment decisions, personal preferences of the resident and collaboratively develop an individual care plan that best meets the needs of each resident and their family (National Breast Cancer Centre 2005, Australian Government Department of Health and Ageing 2004). There is compelling evidence to suggest that a multi-disciplinary approach to care helps to enhance the residents quality of life by addressing the problems that are of most concern to the resident are addressed, reduces ambiguity around treatment and the goals of care, ensures that care decisions are based on best evidence based practice, and can enhance a clinicians mental well-being (National Breast Cancer Centre 2005).

The principles for multi-disciplinary care emphasis the need for:

- A team approach, involving core disciplines is integral to the provision of a palliative approach, including general practice, with input from all relevant disciplines, usually three or more people.
- Effective communication and teamwork are essential aspects of a palliative approach and critical to effective care planning and delivery
- Establishments of systems to ensure that all residents have access to all relevant services and that the goals of care are clearly defined
- Provision of care in accordance with nationally agreed standards
- Involvement of residents and their families in the decisions about their care (Australian Government Department of Health and Ageing 2004, National Breast Cancer Centre 2005).

A regular multi-disciplinary care meeting is a forum by which a palliative approach to care is facilitated. These terms of reference detail how the in-house multidisciplinary care planning forum will operate in local Residential Aged Care Facilities.

## **AIM**

To establish a multi-disciplinary team to facilitate collaborative care planning for all residents to ensure effective delivery of evidence based care in accordance with each individual resident's and their families needs.

## **OBJECTIVES**

- To establish a multi-disciplinary team comprising of core disciplines (usually three or more people) that meets on a regular basis to develop an individual care plan for each resident and their families in accordance with their identified needs
- To ensure that all residents and their family have access to a palliative approach
- To ensure that the resident's GP, aged care staff and other health care providers have an opportunity to be formally involved in the development of the resident's care plan
- To provide multidisciplinary team members with an opportunity for enhanced educational opportunities

## **POTENTIAL INHOUSE MULTI-DISCIPLINARY TEAM MEMBERS:**

- Aboriginal health workers
- Aged Care Assessment Team
- Care assistants
- Chaplains/pastoral care workers
- Dietician
- Discharge Planner
- Generalist nurses (RN and EN)
- General practitioners
- Link nurse
- Occupational therapist
- Palliative care physician
- Pharmacist
- Psychologists
- Psycho-geriatrician
- Physiotherapist or physio aid
- Podiatrist
- Speech Pathologist
- Specialist nurses (aged care, palliative care, wound care)

## **ATTENDANCE**

All health care providers actively involved in the provision of care to the resident will be invited to contribute to the planning of that residents care.

All attendees will be required to sign an attendance form, embedded in the Case Summary Sheet, which acknowledges that they agree to adhere to the NSW Health Records and Information Privacy Act (2003) and maintain resident confidentiality.

## **VENUE & TIME**

To be defined by each facility

## **RESIDENTS TO BE DISCUSSED**

- All new residents will have their care planned at a multi-disciplinary care planning meeting within four weeks of admission
- All residents will have their care needs reviewed at multi-disciplinary care planning meeting following:
  - Discharged from acute health care setting
  - a change in their clinical status (physical, psychological, social or spiritual) which requires additional nursing, medical or the input of external health care providers
  - more than two falls in a week
  - on an annual basis, in accordance with the Residential Aged Care Classification Scale

## **RESIDENT CONSENT**

All residents or their substitute decision maker will be asked to provide written consent, on the Case Summary Sheet giving permission to allow their care needs to be discussed at a multi-disciplinary team meeting.

## **NOTIFICATION OF TEAM MEMBERS**

It is responsibility of the health care provider scheduling the resident for discussion at the multidisciplinary care meeting to:

- Notify all relevant health care professionals whose input into the multidisciplinary care meeting would ensure that the resident and their family receive optimal care (GP, RN AIN, Oncology, ACAT, dietician, speech therapy, OT, physio etc.)
- Notify the family and or substitute decision maker
- Inform all relevant health care providers of the scheduled time for the residents care to be discussed. Encourage input either via phone or in person. If they plan to teleconference, ensure that you obtain the contact phone number of the relevant health care providers

## **MEETING COORDINATION**

The Multi-disciplinary Care Coordination Nurse, in the RACF will:

- Identify all residents whose meet the criteria for discussion at the multi-disciplinary care planning meeting

- Develop a care planning forum schedule for each multi-disciplinary meeting
- Ensure all relevant attendees are aware and invited to be at the relevant care planning meeting
- Chair the in-house multi-disciplinary care planning meeting
- Document the outcomes of each care planning case discussions, using the case conference template
- That a copy of the care planning case conference summary be placed into the resident's medical records and care plan updated to reflect the changes
- A copy of the care planning case conference will be sent to the resident's general practitioner, other health care provider and the residents and/or substitute decision maker, where appropriate.

## **ROLE OF THE CHAIR**

Effective teams are able to articulate common goals and work in a collaborative, non-hierarchical environment. Good leadership and facilitation are key factors in the success of multidisciplinary meetings.

“...The Chair's role is to facilitate participation by all members of the multidisciplinary team in clinical discussions and decision making and to ensure that the meeting is not dominated by a few clinicians (National Breast Cancer Centre 2005 p.26)

The meeting will be chaired by the in house Multi-disciplinary Care Coordination Nurse or the Director of Nursing

- Keeping meetings to the agenda
- Commencing discussions
- Promoting the full range of input into discussions if it is not forthcoming
- Summarise the discussion and invite any further input before moving to the next case
- Negotiate resolution of conflict if necessary
- Promoting mutual professional respect among all team members (National Breast Cancer Centre 2005 p. 26)

## **ROLE OF PARTICIPANTS**

- All core team members should attend the in-house multi-disciplinary care planning forum in person or via teleconference.
- To utilise the prompt checklist to guide the discussion, focusing on the issues relevant to planning effective care for the resident.

## **ROLE OF THE GP ADVOCATE**

The Mid North Coast Division of General Practice will endeavour to appoint a general practitioners liaison officer to attend the weekly in-house multi-disciplinary care planning forum. The function of this role will be to order to ensure that a general practitioner perspective is present at the forum, if indicated to provide feedback to other general practitioners and to assist the team to develop strategies to further engage general practitioners in this care planning process (National Breast Cancer Centre 2005).



## **MEASURABLE OUTCOMES**

The Multi-disciplinary Care Coordination Nurse will be required to maintain the following statistics and submit these on a monthly basis to the Rural Palliative Care Project Coordinator.

- Number of residents discussed
  - Number of new residents
  - Number following discharge from hospital
  - Number following falls
  - Number change in clinical status
  - Number of residents who die
  - Number of residents admitted to hospital
  - Number of residents with an advance care plan
    - Number of residents with clearly defined goals of care
    - Number of EPC Items/per item number
  - Number of CMA completed for residents
  - Number of Residential Medication Management Reviews
  - Number of phone calls to GPs after hours
  - Number of requests for GP attendance
- Number of attendees at in-house MDT Forum
- Composition of meeting attendances
- Health Care provider satisfaction survey



## **Tool 2:**

# **Memorandum of Understanding**

# **Multi-disciplinary Team meetings**



***Memorandum of Understanding***

***Between***

***Mid North Coast (NSW) Division of  
General Practice***

***and***

***RACF***

MNCDGP Contract Reference #  
MNCDGP Agreement Reference #

## MoU Table of Contents

Memorandum of Understanding Sample.....	12
Table of Contents .....	13
Table of Figures .....	14
Definitions and Acronyms .....	14
Memorandum of Understanding Defined .....	14
Purpose of the MoU .....	15
Standard Terms and Conditions .....	16
Responsibilities of the Provider.....	17
Responsibilities of the MNCDGP .....	17
MoU Contact Details .....	18
Memorandum of Understanding Signatories.....	19

## RACF Multi- disciplinary Team Meetings

### Table of Figures

- Table 1 - Service Level MoU Definitions and Acronyms
- Table 2 - Provider Details
- Table 3 - Key Performance Indicators
- Table 4 - MoU MNCDGP Responsible Officer(s)
- Table 5 - MNCDGP Responsible Officers
- Table 6 – Provider Responsible Officers
- Table 7 – MoU Relevant Contacts
- Table 8 - MNCDGP Recipient Signature
- Table 9 - Provider Signatory
- Table 10 - Provider Signatory (second signatory only as required)

### Definitions and Acronyms

#### Table 1 - Service Level MoU Definitions and Acronyms

Word / Acronym	Definition
MoU	Memorandum of Understanding
Provider	RACF - external organisation providing the goods and/or services
Confidential Information	Means information that by its nature is confidential, is designated by the MNCDGP as confidential, is confidential under the Privacy Act 1998 (Commonwealth) or by its nature the Vendor ought to know is confidential.
MNCDGP	Mid North Coast Division of General Practice (MNCDGP)

### Memorandum of Understanding Defined

Parties to the Memorandum of Understanding

This Memorandum of Understanding (hereinafter called the 'MoU') between:

Table 2 - Provider Details

Name:	RACF
Registered Address:	
Postal Address:	
ACN #	
ABN #	

The provider of the goods and/or services, as specified in Table 2, and hereinafter called the 'Provider' and:

The Mid North Coast Division of General Practice hereinafter called the MNCDGP.

## Purpose of the MoU

This MoU is to provide a secondment opportunity for a Registered Nurse, who has completed the palliative care link nurse education, who is a current employee of a local RACF. The employee will work with the Rural Palliative Care Project to trial the establishment of regular in-house multi-disciplinary team (MDT) meetings:-

- Use a systematic process to identify and plan the presentation of residents at the regular in house multi-disciplinary care planning meetings, including liaison with residents, their family, GPs, and other relevant health care providers;
- Facilitating the multidisciplinary care planning meeting meetings, including preparation of Enhanced Primary Care (EPC) items generated from the meeting.
- Determine the goals of care for all residents and develop strategies to communicate these to other health care providers
- Promote the use of advance care planning amongst residents with cognition and promote the use of substitute decision makers process for residents with cognitive impairment
- Assisting with obtaining consent from residents eligible for referral to the MNC Rural Palliative Care Project.
- Conduct in house palliative care education sessions for local Residential Aged Care Facility staff;
- Assist with the trial of the End-of-Life Care Pathway in the Residential aged care facility.

### Term of the MoU

This MoU is for the term starting on [add date] and ending on [add date], being a total of six (6) month duration.

## Standard Terms and Conditions

### Scope of this MoU

- This MoU outlines the procedures and responsibilities to be applied between the MNCDGP and the Provider.
- This MoU is to be interpreted as a written statement detailing the intention of the MNCDGP and the Provider with regard to how they will interact to achieve the purpose of the MoU.

### Communication

- All communication relating to this MoU shall be through the nominated MoU Responsible Officers.

### Code of Conduct

- MNCDGP employees are bound by the MNCDGP Code of Conduct that requires probity in all dealings including those conducted with the Provider.
- The MNCDGP has adopted this Code of Conduct to ensure that functions are undertaken efficiently, impartially and with integrity.
- Copies of the MNCDGP Code of conduct are available from the MNCDGP Office.

The Provider agrees to:

- Disclose any affiliation or association with the MNCDGP that could be deemed to constitute a material breach of interest.
- Report any reasonably held suspicion of fraudulent activity by any MNCDGP employee, arising out of or connected with this MoU, to the MNCDGP Chief Executive Officer.

The Provider conniving and/or inducing a breach of these Codes may constitute grounds for termination of this MoU.

### **Key Performance Indicators**

- At least annually and/or at the conclusion of the MoU the MNCDGP shall formally review the Provider's performance under this MoU.
- The standard key performance indicators for the Provider's performance evaluation shall at least include an evaluation of the following areas:

**Table 3 - Key Performance Indicators**

✓ Quality of good/service delivered
✓ Time Management
✓ Management and suitability of personnel
✓ Management of subcontractors, consultants and other service providers
✓ Contract administration and management
✓ Environmental management
✓ Management of employee and industrial relations
✓ Industry and workforce management
✓ Occupational health, safety and rehabilitation management

### **Confidential Information**

- The Provider shall not without the written consent of the MNCDGP disclose any Confidential Information in connection with this MoU.
- The Provider acknowledges that this obligation survives the expiry or termination of the MoU.

### **Dispute Resolution**

- Both parties understand that disputes that may arise in relation to this MoU need to be resolved by mutual consensus.
- In the event that the parties to the MoU cannot reach MoU then in the first instance the matter is to be referred to the MNCDGP Manager Responsible for the relevant department or facility and the manager for the Provider.
- In the event that a compromise cannot be reached then the matter is to be referred to an arbitrator as appointed by the Institute of Arbitrators Australia with the costs of, and incidental to, the arbitration being awarded as the discretion of the arbitrator.

## **Responsibilities of the Provider**

### **Responsibilities of the Provider**

- Provide a safe work environment while ever the Registered Nurse is performing Palliative Care duties on the Provider's premises.
- Continue to pay wages to the Registered Nurse at the employee's current rate of pay applicable to 8th year Registered Nurse under the Nursing Homes, Nurses (State) Award including on-costs for leave loading, superannuation, and workers compensation paid at 12%.
- Provide public liability coverage for the Registered Nurse as required.
- Invoice the MNCDGP at the end of each month during the term of the MoU at the rate of 8th year Registered Nurse under the Nursing Homes, Nurses (State) Award, including on costs for leave loading, superannuation, and workers compensation, for a total of 8 hours work per week.

## **Responsibilities of the MNCDGP**

### **Responsibilities of the MNCDGP**

- Provide clear directions for duties required.
- Provide supervision, encouragement, and support to the position.
- Include the Registered Nurse in staff development opportunities relative to the duties of the position and the project.
- Provide a safe work environment while ever the Registered Nurse is performing Palliative Care duties on MNCDGP premises.



**MoU Contact Details**

**Table 4 - MoU MNCDGP Responsible Officer(s)**

MoU MNCDGP Responsible Officer(s)	
Rural Palliative Care Program Coordinator [add name]	Mid North Coast (NSW) Division of General Practice PO Box 920 Coffs Harbour NSW 2450 Telephone: (02) 66515 774 Facsimile: (02) 6651 5781 [add e-mail]
Human Resources Officer [add name]	Mid North Coast (NSW) Division of General Practice PO Box 920 Coffs Harbour NSW 2450 Telephone: (02) 6651 5774 Facsimile: (02) 6651 5781 [add e-mail]

**Table 5 – Provider Responsible Officers**

Provider Responsible Officers	

**Table 5 – MoU Relevant Contacts**

MoU Relevant Contacts	
Human Resources Officer	Mid North Coast (NSW) Division of General Practice PO Box 920 Coffs Harbour NSW 2450 Telephone: (02) 6651 5774 Facsimile: (02) 6651 5781

**Memorandum of Understanding Signatories**

**Signatory for the MNCDGP Recipient**

Being an authorised agent of the MNCDGP Recipient with delegated authority and/or Woolgoolga & Districts Retirement Village approval to enter into contractual arrangements:

**Table 6 - MNCDGP Recipient Signature**

Chief Executive Officer, Mid North Coast Division of General Practice	[Add Name]
Signature	Name of Signatory
Position/Title Signatory	Date of Signature

**Signatory for the Provider**

Being an authorised representative(s) of the Provider with the authority to enter into contractual arrangements:

**Table 7 - Provider Signatory**

Signature	Name of Signatory
Position/Title Signatory	Date of Signature

**Table 8 - Provider Signatory (second signatory only as required)**

Signature	Name of Signatory
Position/Title Signatory	Date of Signature



# **Tool 3:**

# **Monthly Report Form**

# **Multi-disciplinary Team Meetings**

## Monthly Report Form

Monthly Report for (Month), (RACF Name)

### Education

Date	Audience	Topic	Number Attending

### Multi-Disciplinary Meetings

Date	Attendance No.			GP Input	EPC Item No.		No. of Residents Discussed	MMR	CMA
	Family	GP	Pall Care		ACAT	Other Nurses			
	Family	GP	Pall Care	ACAT	Other Nurses				
	Family	GP	Pall Care	ACAT	Other Nurses				
	Family	GP	Pall Care	ACAT	Other Nurses				
	Family	GP	Pall Care	ACAT	Other Nurses				
	Family	GP	Pall Care	ACAT	Other Nurses				
TOTAL	Family	GP	Pall Care	ACAT	Other Nurses				



# **Tool 4:**

## **Case Summary Sheet**

### **Multi-disciplinary Team meetings**

<h2 style="margin: 0;">Multi-disciplinary Case Summary Sheet</h2> <p style="margin: 5px 0;">Add RACF name:</p>
--

**PATIENT DETAILS:**

Attach Resident ID sticker

<b>DATE:</b>
--------------

Consent given by resident/prime carer     YES

<b>PRINCIPLE DIAGNOSES</b>	Current assessment, planned investigation, care and medication. Current medical, social and psychosocial needs

**CURRENT MEDICATIONS:** see attached list/chart

Health Professionals participants

NAME	Discipline/Position	CONTACT PHONE	FAX

Other participants (optional)

Resident

Relative/carer

Time Commenced \_\_\_\_:\_\_\_\_      Time Completed \_\_\_\_:\_\_\_\_

Place the original in the resident's clinical notes, offer copy to the participating health professionals and resident/carer. Send copy to GP. Update and review resident's care plan and assessments

General Practitioner name:

GP Organises & coordinates or participates in a case conference in a RACF  
 Item 734 (15 < 30 mins)     Item 736 (30 < 45 mins)     Item 738 (>45 mins)

My GP has explained the purpose of the case conference and I give/my carer gives permission to prepare a case conference and discuss my medical history and diagnosis with the providers listed.

I do / do not have any medical or other information I want withheld from other participants.

All participants are to retain confidentiality.

Resident's Signature/Agreement \_\_\_\_\_

Consent has been obtained and is kept at the facility.

Multi-disciplinary Team Meetings in Residential Aged Care Facilities

**PATIENT DETAILS:**

<b>MULTIDISCIPLINARY ISSUE</b> Reason for MDT care planning forum	<b>PLAN OF ACTION</b> <b>OUTCOME</b>	<b>TEAM MEMBER</b> <b>RESPONSIBLE</b>	<b>OUTCOME</b>

Attach Resident ID sticker



## **Tool 5:**

# **Planning Checklist**

# **Multi-disciplinary Team meetings**



## Planning Checklist

This checklist is to help you plan and conduct a multi-disciplinary team meeting.

### **PART A: PREPARATION: Four weeks prior to meeting**

1. **SCHEDULING:** Use the RCS Calender to identify and schedule when each resident will be presented in a 12 month period.
2. **MDT CRITERIA:** Incorporate into this Calender resident to be presented in accordance with the following criteria: 
  - All new residents will have their care planned at a multi-disciplinary care planning forum within four weeks of admission
  - All residents will have their care needs reviewed at multi-disciplinary care planning forum following: 
    - Discharged from acute health care setting
    - a change in their clinical status (physical, psychological, social or spiritual) which requires additional nursing, medical or the input of external health care providers
    - more than two falls in a week
    - On an annual basis, in accordance with the Residential Aged Care Classification Scale
3. **CONSENT:** All residents or their substitute decision maker will be asked to provide written consent, on the Case Summary Sheet giving permission to allow their care needs to be discussed at a multidisciplinary team meeting. Ensure that you inform them who will be present at the MDT.
4. **CREATING A TEAM:** Identify and list all of the relevant health care professionals whose input into the multidisciplinary care meeting would ensure that the resident and their family receive optimal care (GP, RN AIN, Oncology, ACAT, dietician, speech therapy, OT, physio etc.).
5. **LETTERS:** Complete and send out the letter inviting the GP and family to the MDT
6. **NOTIFY THE TEAM MEMBERS IN PERSON:** Notify all of the relevant team members and the family and or substitute decision maker of the MDT Meeting Date, Time and Place. Inform each member who else will be involved and ask if anyone is missing.
7. **TELECONFERENCE:** If the team members are participating via teleconference then ensure that you have their contact number, preferably their mobile as many surgery phone numbers are engaged or not manned.
8. **BOOKING:** Book the relevant meeting room
9. **PREPARING:** Inform the nursing team of the residents to be discussed at the next MDT. Encourage the nursing team to use the Residents Care Needs Checklist to help the team to identify the issues that they feel need to be raised at the MDT.
10. **ASSESSMENT:** Based on the findings from the Care Need Checklist, ensure that that all of the relevant assessments, including evaluation have been completed. Findings from the assessments documented in the resident's medical record.

**PART A: PREPARATION: One week prior to meeting**

11. **PRE-MEETING:** Ensure that you speak to all of the participants prior to the meeting, clarifying their role, the MDT process that they have clearly identified the issues that they want the team to address and identified the desired outcomes.

12. **CONFIRMING TEAM MEMBERS:** Contact all of the relevant team members and the family and or substitute decision maker reminding them of the MDT Meeting Date, Time and Place.

13. **GAME PLAN:** Make sure that you are clear about who is going to introduce the resident to the team and have an idea of what are the issues that the team want to be addressed, prior to the meeting.

**PART B: FACILITATION**

1. **PREPARATION:** Ensure that the meeting room is set up for the meeting. Make arrangements to ensure that the participants are able to locate the meeting room.

2. **START AND FINISH ON TIME:** Inform participants of the time allocated to discuss each residents care needs.

3. **WELCOME AND INTRODUCTIONS:**

4. **SIGN CASE SUMMARY SHEET:** All participants attending the MDT are required to sign the Case Summary Sheet acknowledging their attendance and input into the resident's care planning.

5. **GETTING STARTED:** Introduce the resident by providing an overview of their medical and social history. Ensure the issues that need to be discussed are promptly identified. Ensure that everyone gets to contribute to the discussion. As the facilitator, you may need to invite their input.

6. **PROMOTING A COLLABORATIVE APPROACH:** The MDT provides GP's and clinicians with an opportunity to work together to improve outcomes for their clients. It provides an opportunity for other team members to contribute any relevant information about residents or about management of identified issues.

7. **DEFINE THE GOALS OF CARE:**

8. **CONFIRM DECISIONS:** As you draw the MDT to a close, be sure to recap with the team the decisions that have been made, including: action to be taken, person responsible, and the process for reviewing the changes.

9. **DOCUMENTATION:** Complete the Case Summary Sheet. Ensure that you are clear and concise and use acceptable medical/nursing language, not abbreviations. Please check your spelling and grammar. Send a copy to the GP with the relevant Medicare Item Number entitlement. Offer a copy to other relevant health care providers. Please place the original in the designated area in the residents' medical records.

10. **UPDATE CARE PLAN:** Update care plan to reflect the decisions made at the MDT.

11. **ENTER NOTATION RESIDENTS PROGRESS NOTES:** Enter the following "MDT MEETING HELD. List the issues discussed and the outcomes".



## **Tool 6:**

# **Checklist Resident Care Needs**

# **Multi-disciplinary Team meetings**

## Resident's Care Needs Checklist

This checklist is to help identify the issues that need to be discussed at the resident's care planning forum. Ideally, it should be completed prior to the care planning meeting by the Nurse and Care Assistances responsible for the residents care provision:

- |  |                          |
|--|--------------------------|
| Communication  | <input type="checkbox"/> |
| <b>Mobility: Compulsory Review</b>                                 | <input type="checkbox"/> |
| Meals and drinks   | <input type="checkbox"/> |
| Personal hygiene   | <input type="checkbox"/> |
| Toileting  | <input type="checkbox"/> |
| Bladder Management   | <input type="checkbox"/> |
| Bowel Management   | <input type="checkbox"/> |
| Understanding and undertaking living activities                    | <input type="checkbox"/> |
| Problem wandering or intrusive behaviours                          | <input type="checkbox"/> |
| Verbally disruptive or noisy                                       | <input type="checkbox"/> |
| <b>Physically aggressive: Compulsory Review</b>                    | <input type="checkbox"/> |
| <b>Emotional dependence: Compulsory Review</b>                     | <input type="checkbox"/> |
| Depression   | <input type="checkbox"/> |
| Danger to self or others   | <input type="checkbox"/> |
| Other behaviour  | <input type="checkbox"/> |
| <b>Social and human needs – care recipient: Compulsory Review</b>  | <input type="checkbox"/> |
| Advance Care Planning  | <input type="checkbox"/> |
| Social and human needs – family and friends                        | <input type="checkbox"/> |
| Medication: Compulsory Review                                      | <input type="checkbox"/> |
| <b>Technical and complex nursing procedures: Compulsory Review</b> | <input type="checkbox"/> |
| Pain Management  | <input type="checkbox"/> |
| Palliative care plan   | <input type="checkbox"/> |
| Therapy  | <input type="checkbox"/> |
| Other services   | <input type="checkbox"/> |



## **Tool 7:**

# **Letter Templates**

# **Multi-disciplinary Team Meetings**

Insert RACF Letterhead

Date

Dear

### **GP input RACF multi-disciplinary care planning meeting**

Findings from the GP and RACF Nurses focus groups conducted last year revealed a desire to develop systematic process for assessing and managing the care of older people in Residential Aged Care Facilities (RACF). One of the strategies that emerged from the data was that the concept of developing in-house multi-disciplinary care planning forums. Based on these findings a decision has been made by the Rural Palliative Care Project Team to test the effectiveness of this intervention in four local Residential Aged Care Facilities with the aim of enhancing care delivery.

As the input of general practitioners is critical to the delivery of a palliative approach in Residential Aged Care Facilities, the Rural Palliative Care Project Team is calling for expressions of interest from GP's to act as a GP Advocate during the six month trial of this initiative at one of the four participating facilities: Mater Christi; Coffs Harbour Nursing Centre; Masonic Aged Care; and Woolgoolga Retirement Village.

If you are interested in participating in this six month trail then we ask that you:

- Nominate one of the four Residential Aged Care Facilities where you would like to act as the GP Advocate
- Be prepared to attend the weekly multi-disciplinary care planning meeting at the nominated RACF for 1 hour each week, for a minimum of four weeks during the period from mid April to mid September 2006
- Be paid \$130.00 per hour for your contribution (excluding GST)
- Be prepared to contribute to the development of systems and processes to streamline care planning in aged care, to provide a GP perspective and input into clinical decision making

If you require more information please contact add Jane Phillips or Marie Mandile at the Division. Should you be interested please complete the attached below and return it to Sarah at the Division.

We look forward to your input and guidance with this new initiative.

Yours sincerely,

Jane Phillips  
Palliative Care Service Coordinator

Marie Mandile  
Aged Care Program Officer

Insert RACF Letterhead

Insert Date

Add GPs  
Add Family name

Dear

### **RACF multi-disciplinary care planning meeting**

As you are aware (*add residents name*) has recently been admitted (*add facility name*).

Given the increasingly complexity of resident's care needs our aged care facility has decided to adopt and facilitate the delivery of a palliative approach to care (Australian Government Department of Health and Ageing 2004). A palliative approach aims to improve the quality of life for older people with a life limiting illness and their families, by reducing their suffering through early identification, assessment and treatment of pain, physical, psychological, social and spiritual needs (Kristjanson et al. 2003). In accordance with this approach we are conducting regular multi-disciplinary care meeting to ensure that the care needs of our resident's and their families are adequately addressed.

**Given our approach we invite you to participate in (*add residents name*) an in-house multi-disciplinary care planning forum to be held on (*add date, time*) at (*add location*). You may attend in person or we can arrange for you to join us via telephone link up.**

The following timeline has been provided to assist you in the preparatory work that you may feel is required to ensure that the residents care needs are effectively addresses at this multi-disciplinary care planning forum:

#### **General practitioner**

- Comprehensive medical assessment (CMA) – completed by add date;
- Residential Medication Management Review (RMMR) – completed by add date.

#### **Aged care nurses**

- Residential Classification Scale documentation requirements – completed by add date
- Contributing information to the comprehensive medical assessment, ordered by the general practitioner – completed by add date

#### **Family**

- Meet with the Diversional Therapist – completed by add date
- Identify the issues with care staff – completed by add date

We would value your presence as this enables us to discuss issues that may be of concern to us or to you. Please confirm your intention to participate by (*add date*). If you require further information please contact (*add name and number*)

We look forward to your input into this process.

Yours sincerely

Add Name  
Add Position

Insert RACF Letterhead  
Insert Date

Add GPs  
Add Family name

Dear

### **RACF multi-disciplinary care planning meeting**

As you are aware (*add residents name*) has recently been discharged from hospital; experienced a change in their clinical status; had a number of falls or is due for their annual care plan review. (Delete which ever is not applicable)

Given the increasingly complexity of resident's care needs our aged care facility has decided to adopt and facilitate the delivery of a palliative approach to care (Australian Government Department of Health and Ageing 2004). A palliative approach aims to improve the quality of life for older people with a life limiting illness and their families, by reducing their suffering through early identification, assessment and treatment of pain, physical, psychological, social and spiritual needs (Kristjanson et al. 2003). In accordance with this approach we are conducting regular multi-disciplinary care planning meeting to ensure that we are responsive to the changing care needs of our resident's and their families.

**Given our approach we invite you to participate in (*add residents name*) an in-house multi-disciplinary care planning forum to be held on (*add date, time*) at (*add location*). You may attend in person or we can arrange for you to join us via telephone link up.**

The following timeline has been provided to assist you in the preparatory work that you may feel is required to ensure that we are collectively able to identify the residents changing care needs and address them effectively at this multi-disciplinary care planning forum:

#### **General practitioner**

- Residential Medication Management Review (RMMR) – completed by add date

#### **Aged care nurses**

- Residential Classification Scale documentation requirements – completed by add date

#### **Family**

- Identify the issues with care staff – completed by add date

We would value your presence as this enables us to discuss issues that may be of concern to us or to you. Please confirm your intention to participate by (*add date*). If you require further information please contact (*add name and number*)

We look forward to your input into this process.

Yours sincerely

Add Name  
Add Position

CC: Practice Manager





## **Tool 8:**

# **Enhanced Primary Care Items**

# **Multi-disciplinary Team meetings**



## Implementation of Enhanced Primary Care In Residential Aged Care Facilities

### Guidelines

(Insert Facility name)

<b>Eligibility</b>	
Permanent residents in an aged care home with chronic/complex care needs	<b>RACF</b>
<b>Comprehensive Medical Assessment</b>	
<p>Within six weeks of admission, or as required, eg, post hospitalisation, complete CMA (Item 712)</p> <p>The CMA can be completed over one or more visits. Patient/carer consent required. Complete a biophysical assessment and identify patient/residents needs. Develop patient/resident diagnosis/problem list. Establish goals in relation to problems and needs. Develop a management plan to meet identified goals.</p> <p>Provide written summary of outcomes of CMA to resident/carer and RACF for inclusion in the resident's medical record.</p> <p>N.B. For new admission complete the CMA at 4 weeks following the initial consultation as the RACF will have undertaken a full assessment of the resident which can assist the GP with the completion of the CMA.</p>	<b>GP /RACF</b>
<b>Residential Medication Management Review</b>	
<p>Can link to CMA. New residents on admission. Existing residents where change eg. Change in condition, discharge from hospital, significant medication changes.</p> <p>GP assess resident need for review, gain consent. Refer to pharmacist.</p> <p>Review pharmacist report and discuss with pharmacist. (Exceptions where no changes, minor changes, agreement that changes discussed at case conference) Prepare medication management plan. Copy to residents RACF records.</p> <p>RMMR (Item 903)</p>	<b>GP/Pharmacist</b>
<b>Care Plan</b>	
At the request of the RACF, the GP contributes to a care plan prepared by the RACF ( Item 731)	<b>GP /RACF</b>
<b>In-house Multidisciplinary Care Planning Forum</b>	
<p>Either face to face or telephone (at least 15 mins), GP organises and coordinates, or participates in multi-disciplinary care planning forum. Requires at least 2 other contributing members each providing a different kind of service.</p> <p>Record of forum must be kept and copy offered to resident/carer.</p> <p>(Items 734,736,738,775,778 and 779)</p>	<b>GP/RACF +2 or more health professionals</b>
<b>Referral to Allied Professional and /or Dentist</b>	
<p>Identify provider(s) who best suits patients/residents specific needs. Ensure provider registration with HIC/Medicare Australia. Patients/residents eligible for up to 5 allied health services per year and 3 dental services per year, on referral from GP. Complete HIC/Medicare Australia referral form(s).</p>	<b>GP</b>
<p><i>Reference; Adapted from Sutherland Division of General Practice Aged Care Program and North West Melbourne Division of General Practice.</i></p>	

## Reference List

- Australian Government Department of Health and Ageing (2004) Australian Government Department of Health and Ageing, Canberra.
- Australian Institute of Health and Welfare, A. (2004) In *AIHW cat no. AGE 38* Australian Institute of Health and Welfare, Canberra.
- Avis, M., Greening Jackson, J., Cox, K. & Miskella, C. (1999) Evaluation of a project providing community palliative care support to nursing homes. *Health and Social Care in the community* **7**, 32-38.
- Brazil, K., Krueger, P., Bedard, M., Kelley, M., McAiney, C., Justice, C. & Taniguchi, A. (2006) Quality of care for residents dying in Ontario long-term care facilities: findings from a survey of directors of care. *Journal of Palliative Care* **22**, 18-25.
- Froggatt, K. & Hoult, L. (2002) Developing palliative care practice in nursing and residential care homes: the role of the clinical nurse specialist. *Journal of Clinical Nursing* **11**, 802-808.
- Hanson, L. C., Henderson, M. L. & Menon, M. (2002) As individual as death itself: a focus group study of terminal care in nursing homes. *Journal of Palliative Medicine* **5**, 117-125.
- Kayser-Jones, J. (2002) The experiences of dying: an ethnographic nursing home study. *The Gerontologist* **42**, 11-19.
- Kristjanson, L., Toye, C. T. & Dawson, S. (2003) New dimensions in palliative care: a palliative approach to neurodegenerative disease and final illness in older people. *Medical Journal of Australia* **179**, S42-44.
- Kristjanson, L., Walton, J. & Toye, C. T. (2005) End-of-life challenges in residential aged care facilities: a case for a palliative approach to care. *International Journal of Palliative Nursing* **11**, 127-129.
- National Breast Cancer Centre (2005) The National Breast Cancer Centre, Camperdown, New South Wales.
- Panke, J. A. (2002) Caring for persons with dementia: a palliative approach. *Journal of Hospice and Palliative Nursing* **4**, 143-149.
- Phillips, J., Davidson, P., Kristjanson, L., Jackson, D. & Daly, J. (2006) Residential aged care: the last frontier for palliative care. *Journal of Advanced Nursing* **55**, 416-424.
- The Royal Australian College of General Practitioners (2006) *Medical care of older persons in residential aged care facilities*, The Royal Australian College of General Practitioners,, Melbourne, Australia.
- Travis, S. S., Bernard, M., Dixon, S., McAuley, W. J., Loving, G. & McClanahan, L. (2002) Obstacles to palliation and end-of-life care in a long term care facility. *The Gerontologist* **42**, 342-349.