Multidisciplinary Palliative Care Team Meeting



Mallee Division
2009-2010

DRAFT

Operational Manual

MDGP gratefully acknowledges the funding support from the Australian Government Department of Health and Ageing for this program.

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Introduction

The Mallee Division palliative care network is comprised of a number of vital components- one of these being the multidisciplinary team meeting (MDT). The MDT meeting is designed to reflect the profile and needs of the local stakeholders, ranging from patients to carers, volunteers and health care providers.

The MDT meeting design has been informed by existing models in other Divisions of General Practice that are promoting access for patients to quality, coordinated palliative care services.

Multidisciplinary care is promoted as the ideal by a number of sources including Palliative Care Australia (in their standards), the Commonwealth Department of Health and Aging and the State governments. The Victorian Government in particular highlighted the need for multidisciplinary care and outlined the manner in which to implement it via the policy document "Achieving Best Practice Cancer Care: A guide for implementing multidisciplinary care" (2007).

> "Multidisciplinary care aims to ensure that members of the treatment and care team can discuss all aspects of a cancer patient's physical, supportive care needs and other impacting factors. **A regular meeting of all health practitioners involved in the treatment and care of a cancer patient is an essential feature of multidisciplinary care.** This facilitates best-practice management and enables the most appropriate care plan to be developed. It also allows for an identified team member to convey the team recommendations to ensure the patient is able to effectively participate in forward planning. Through this process, each team member understands the plan, knows who to refer the patient to and the patient remains at the centre of all care provided by the team. It is important that both public and private sector cancer patients have access to multidisciplinary care and effective care coordination."

The principles contained within this document are applicable to all people with a palliative diagnosis (malignant and non malignant disease), particularly those related to the purpose and formation of multidisciplinary team meetings.

The Mallee Division multidisciplinary palliative care team meeting draws on components of established team meeting models and introduces specifically designed structures and processes to meet the needs of its unique population.

SECTION 1

Referral to the Meeting

Referral - Criteria and Forms

Criteria for referral to the MDT meeting are necessary to ensure referrals are appropriate and the meeting time is used effectively. The process of referral, discussion at the meeting and ongoing review is outlined in Diagram 1, page 10.

Referral Criteria

- Referrals to the MDT meeting can be made by GPs and any member of the MDT meeting team (see terms of reference for members- page 17)

- Patients or their carers must consent to being discussed at the meeting. The consent not only authorizes the discussion but facilitates the completion of Medicare forms enhancing the likelihood of GP participation.

- All new admissions are to be discussed ideally within four weeks of admission to the community palliative care service. Some cases will only require brief discussion while others will require a more detailed review

- All patients who have a change in their clinical status (physical, psychological, social or spiritual) and require the input and expertise of a multidisciplinary team

- Patients admitted to hospital will be discussed routinely

- Review discussions will occur routinely at 4 weeks to reassess effectiveness of the implementation of planned care. Review may be deferred if follow up information or relevant provider unavailable

Forms

a) A ***referral form*** must be completed and submitted to the MDT meeting Coordinator incorporating patient details, patient issues (physical, psychological, social or spiritual) and the patient's own goals. It is necessary to detail the specific reason for the referral.

b) An ***information brochure*** is an attachment to the referral form and is given to patients when the form is completed. The brochure informs them of the MDT meeting purpose and feedback process as well highlighting to them that the patient's goals are the drivers of any actions by the team.

c) A ***consent form*** will also be an attachment to the referral form. The consent form must be completed before the patient can be discussed at the meeting.

Mallee Division Rural Palliative Care Project

Palliative Care Multidisciplinary Team (MDT) Meeting

MEETING REFERRAL FORM

Patient's Name:	Date of Birth:

Contact Details:	Details of Patient's Carer (if applicable):

Details of Patient's Usual GP:	Name and role of person Referring patient:
Interpreter required: Yes /No **Cultural considerations:**	**Contact details of person referring patient :** **Fax:** **Telephone:**

Requires: ☐ Discussion ☐ Noting

Degree of urgency of the referral: Please circle

1. One week	2. Two weeks	3. Three Weeks	4. Four weeks
-Difficult physical/ psychosocial symptoms causing distress -Rapidly deteriorating condition -Resolution of issue required ASAP -High risk issue	-Difficult physical/ psychosocial symptoms -Complex issues	- New Patient	- New patient -Review

Referral Category:

☐ New patient ☐ Change in condition ☐ Requires multidisciplinary input ☐ Other……

Primary Diagnosis and Duration:

Other problems:

Current Medications:

Drug allergies:

Expected prognosis? **Is the patient aware of this?** ◯ Yes ☐ No

What are the problems you would like us to address that are likely to affect the patient's quality of life?

Does the patient have any goals related to their care? Long or short term e.g. Wedding to attend

FAX COMPLETED REFERRAL AND CONSENT FORM TO:……

Patient Information Brochure

Multidisciplinary Team Meetings

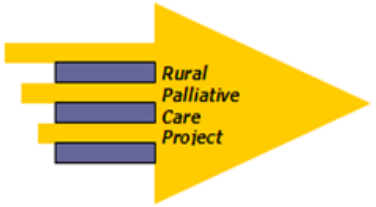
A team approach to care is one of the key elements of effective care delivery. A multidisciplinary approach to care helps to enhance quality of life for patients and families, and ensures decisions are made according to evidence based best practice.



Primary Business Address
Your Address Line 2
Your Address Line 3
Your Address Line 4

Phone: 555-555-5555
Fax: 555-555-5555
E-mail: someone@example.com

Palliative Care Multidisciplinary Team Meetings



Patient Information

mallee DGP
mallee division of general practice

What is a Multidisciplinary Team Meeting?

A Multidisciplinary Team Meeting is a team of health care providers coming together from across the region to discuss the most effective and suitable palliative care plan for you.

The team will suggest a care plan that strives to satisfy your individual desires and needs.

The team will consist of health care professionals including:

- Specialist Palliative Care Nurses
- Primary Care Nurse
- Breast Care Nurse
- Social worker
- Occupational Therapist
- Physiotherapist
- Dietician
- General Practitioners
- Pastoral Care Worker
- Coordinator of Volunteers

Why do I need a multidisciplinary team?

Evidence has shown that Multidisciplinary Care is a key aspect in providing best-practice treatment and care for patients with complex needs.

The benefits of being referred to a Multidisciplinary Team Meeting include; care coordination, recognition of emotional needs, improved treatment and care planning resulting in improved outcomes

What happens at the meeting?

The team members discuss your care and develop a plan that acknowledges your goals and issues and what is important to you. This plan is then communicated to you for your agreement.

All members of the team are bound by law and ethical practice to keep your information confidential.

Information is only disclosed for the direct purpose of planning the best care to meet your individual needs

What do I need to do?

- You will need a health care provider to make the referral to the Mallee Division Palliative Care Multidisciplinary Team Meeting.
- Your consent is required for your case to be referred to a Multidisciplinary Team meeting. Without your consent your case will not be referred.
- You will also be required to sign Medicare forms, which will be provided to you, so that your General Practitioner (doctor) can participate .

Rural Palliative Care Project



Patient Consent to Multidisciplinary Team Meeting Discussion

Patient Name_____

_____ has explained the purpose of the Multidisciplinary Team Meeting to me and
(Staff Name)

I*/ person responsible* give permission for the Multidisciplinary Team to discuss my diagnosis, medical history, health and care issues to formulate a care plan at the Multidisciplinary Team Meeting and convey this plan to my General Practitioner (doctor) and myself.
I understand that any final decisions about the recommendations developed by the Team will be made by me, in discussion with members of the Team.

Person Responsible Name _____ Signature _____

Staff Member Signature _____ Date: _____

I*/person responsible*, do*/do not* have any medical or other information I want withheld.

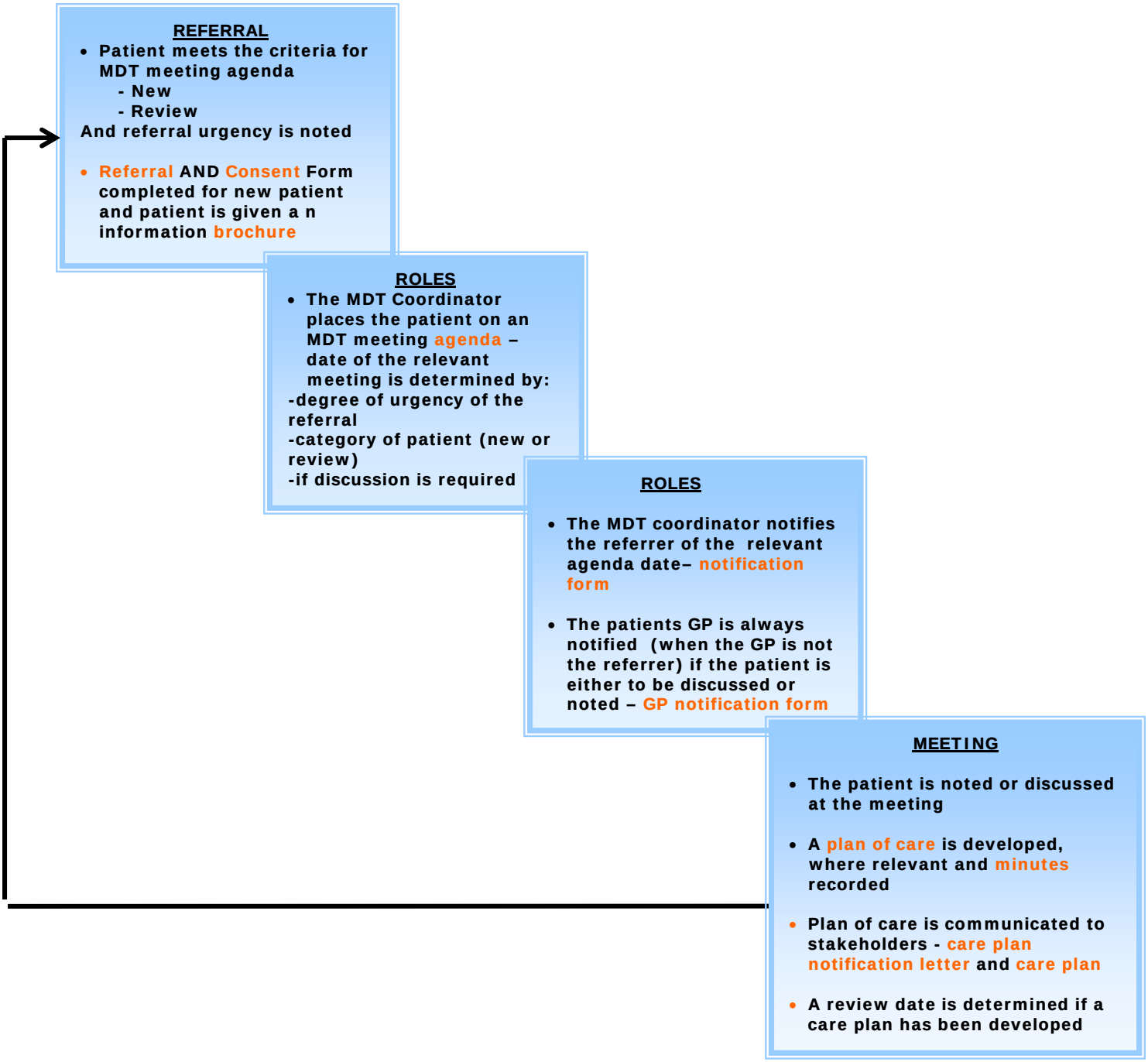
If medical or other information is to be withheld from the case conference the staff member is to be notified.

(*cross out whichever is not applicable).

Referral Process Flow Chart

The Multidisciplinary Team Meeting has a system and process in place for the management of referrals; ensuring plans of care, based on patient goals, are developed, reviewed and communicated to all relevant stakeholders.

Diagram1. Multidisciplinary Team Meeting Flow Chart



SECTION 2

Roles and Responsibilities

Roles and Responsibilities

Each member of the MDT has a role to play in ensuring the effectiveness of the meeting. Roles need to be clearly articulated to ensure that all members are aware of their responsibilities and that tasks are carried out in the manner endorsed by the meeting members.

Referrer

The health care provider making a referral to the MDT meeting will:

- Complete the MDT meeting ***referral form***
- Ensure the patient or carer completes the ***consent form***
- Ensure the patient receives the ***information brochure***
- Submit the referral and consent forms at least 3 business days in advance of the meeting at which they would like the patient to be noted or discussed
- If the patient is for discussion, respond to the ***notification form*** they will receive from the meeting coordinator detailing the date and time of the discussion regarding their patient
- Attend the scheduled meeting to address the referral (either in person or by teleconference)

Coordinator

The co-ordinator will:

Pre-Meeting

- Ensure received referral and consent forms are completed fully and correctly (Return form to sender if not completed)
- Place the referral on the ***agenda*** *(see section 3)* of the meeting of the MDT (as either new patient for discussion or noting or review patient) and notify the referrer (via the notification form) of the scheduled date, venue and the discussion time scheduled for their patient (if applicable). The urgency of the referral dictates which meeting date is set for discussing this referral. The referrer returns the notification form stating in which manner they will be attending the meeting e.g. teleconference or physical presence
- Send a ***GP letter of notification*** to the patients GP if the GP was not the referrer
- Maintain a schedule of review, ensuring ***care plans (see section 4)*** due for review are noted on the correct agenda date and copies of the care plan are available at the meeting
- Ensure the agenda reflects action items arising from previous meetings that are not directly related to an individual patient (Individual patient related actions already documented, via the patient care planning and review process, on the care plan at the meeting)
- Distribute the agenda to MDT members at least 2 business days prior to the meeting
- Liaise with the meeting chair to ensure appropriate numbers of referrals are listed for discussion

Meeting

- Ensure teleconference access available
- Ensure venue is ready
- Distribute copies of care plans being reviewed
- Take ***minutes****(see section 3)*
- Complete MDT care plans

Post Meeting

- Collate minutes of meeting, including action items and care plans completed at the meeting
- Collect copies of review care plans given out at the meeting and shred them
- Forward copy of care plans, with ***care plan notice letter,*** to relevant GP and health professionals indicated on the form as responsible for an action recorded on the plan, within 3 business days of the meeting
- Distribute minutes within 3 business days of the meeting

Chair

Roles of the Chair:

- Ensure all participants introduced
- Use of teleconference phone when indicated
- Keep meetings to the agenda and time schedule
- Commence discussions
- Promote 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
- Promote mutual professional respect among all team members

Team Members

Roles of the team member:

- Attend meetings (either physical attendance or teleconference)
- Contribute to discussions involving patients in your care
- Lead discussions on patients you have referred to the meeting
- Complete the feedback loop to the patient and others if you are noted on the care plan as the person responsible for doing so

Resources

Room to seat at least 10 people, Lap top computer, Teleconference capabilities

MDT Palliative Care Meeting Notification Form

To: (referrers name)

From: (meeting coordinator)

Re: (patients name)

A case conference / care planning discussion will be conducted to review the care of your patient as per your request.

The date and time scheduled for this discussion is:

Date:

Start Time: **Expected duration of case conference:** 15 mins

Venue:

Attending in person ☐

Attending via teleconference ☐ Telephone Number:_____

Unable to attend ☐

Please respond to this invitation by **insert date.**

Sincerely,

Insert Name, Multidisciplinary Team Meeting Coordinator,

Contact number

FAX your response to 50……

Notification to GP of Palliative Care Multidisciplinary Team Meeting

FAX MESSAGE

TO:	***Dr***	**Fax Number:**	
FROM:	**Insert name** **Case Conference Coordinator**	**No. of Pages:**	**1**
SUBJECT:	**Palliative Care Multidisciplinary Team Meeting**	**Date Sent:**	

Dear Dr **,**

Please circle

1. Insert patient's name**,** will have his/her case **noted** at the Palliative Care Multidisciplinary Team Meeting as a new referral to the Palliative Care Service

OR

2. Insert patient's name**,** will have his/her case **discussed** at the Palliative Care Multidisciplinary Team Meeting, in order to formulate or review a care plan. As a vital member of the care team we invite you to participate. Medicare items allow reimbursement for case conferences of at least 15 mins.

The reason for this case conference is:

- □ New admission to the palliative care service
- □ Recent admission to hospital
- □ Change in clinical status
- □ Requires multidisciplinary input
- □ Other _____

The date and time scheduled for this discussion is:

Date:

Start Time: **Expected duration of case conference:** 15 mins

Venue:

Attending in person □

Attending via teleconference □ Telephone Number:_____

Unable to attend □ (If you are unable to attend, you will still receive a copy of the care plan)

Please respond to this invitation by **insert date.**

Insert Name, Multidisciplinary Team Meeting Coordinator,

Contact number

FAX your response to 50……

SECTION 3

Meeting Structure

Meeting Structure

The MDT meeting has templates for agendas, minutes and terms of reference that indicate its purpose and objectives and detail performance indicators, facilitating review of the meetings success.

Terms of Reference

Mallee Division Rural Palliative Care Project

Multidisciplinary Team (MDT) Meeting

Terms Of Reference

PURPOSE

To provide a supportive, formal environment whereby a multidisciplinary team (MDT) can come together to improve the quality of life for patients with a life limiting illness through effective planning and coordination of the delivery of individualised evidence based palliative care.

OBJECTIVES

Objectives	KPIs (process and outcome)
To have representation from all relevant disciplines and organisations, ensuring a multidisciplinary meeting	• Core membership of the MDT meeting is composed of at least one representative from each relevant service • *Number and percentage of disciplines in attendance at meetings* • Improved awareness of roles of all the team members • Improved awareness regarding all aspects of the patients needs • Promotion of appropriate referrals to specialist services
To provide a supportive, formal environment	• Problem solving of complex cases is facilitated • Common issues are identified and actioned • Meeting process structured in a formal manner, facilitating the achievement of desired goals and using available time effectively • Stakeholders attending the meeting believe their input is valued and respected
To effectively plan and coordinate the delivery of evidence based palliative care	• *Number of patients discussed at the meetings* • Stakeholders are notified and invited in advance of any proposed presentation of a patient in their care • Cross organisational policy and procedure is developed where necessary- reflecting relevant standards • Assessments and visits are coordinated, reducing duplication of effort • Plans of care and recommendations formulated via the meeting are communicated to all relevant stakeholders • Education opportunities are explored
To ensure plans of care meet the individual needs of each patient	• Patient/carer consent is obtained prior to discussion at the meeting • Plans of care identify the patients stated goal/s of greatest importance to them • Patients/carers satisfaction with the service is greater than 90%
To evaluate the effectiveness of the meeting and address opportunities for improvement	• Stakeholders satisfaction with the meeting is greater than 90% • Performance indicators are measured and reported

MEMBERSHIP

Chair:

Core Team Members:

Role / Organisation	Name
Aboriginal Health Service Worker	Mary Baker or Mona
Breast Care Nurse	Kaye Matthews
Social Worker	
General Practitioners	Invited as relevant to the agenda
Hospice Staff (Mildura Base Hospital)	
Link Nurses	
Mildura Private Hospital	
Residential Aged Care Facility Staff	As relevant to the agenda
Specialist Palliative Care Nurse	Bertilla Campbell
	Catherine Kemp
	Joe Kervin
Community Nurse	
Coordinator of Volunteers	

Observers	
Medical Students	Monash University students
Nursing Students	La Trobe University students

Invited as required	
Other providers as relevant to the patient	

DURATION AND TIME OF MEETING: 90 minutes, 0930? 1230?

FREQUENCY OF MEETING: Weekly, Tuesdays????

QUORUM: Five

DURATION OF COMMITTEE / PROJECT TEAM:

REPORTING TO: Lead agency (?SCHS???PCP??)

REPORTING MECHANISM: Committee Review Report undertaken quarterly

APPROVED: ……..
(CEO Lead agency)

COMMENCEMENT DATE:

ANNUAL REVIEW DUE:

Agenda

The template for the meeting agenda is set out below:

Multidisciplinary Team (MDT) Meeting
Agenda

PURPOSE: To provide a supportive, formal environment whereby a multidisciplinary team (MDT) can come together to improve the quality of life for patients with a life limiting illness through effective planning and coordination of the delivery of individualised evidence based palliative care.

DATE / TIME: **Tuesday …….. 2009, 0930** **VENUE:** **…….**

TO BE PRESENT:

Role / Organisation	Name
Aboriginal Health Service Worker	Mary Baker or Mona
Breast Care Nurse	Kaye Matthews
Social Worker	
General Practitioners	Invited as relevant to the agenda
Hospice Staff (Mildura Base Hospital)	
Link Nurses	
Mildura Private Hospital	
Residential Aged Care Facility Staff	As relevant to the agenda
Specialist Palliative Care Nurse	Bertilla Campbell
	Catherine Kemp
	Joe Kervin
Community Nurse	
Coordinator of Volunteers	
Referrer/s	

1. BUSINESS ARISING

1.1 Action summary from previous meeting (Excludes care plans)

Date arising	Action Item	By Whom	By When	Action Completed

2. STANDING ITEMS

2.1 New Patients (Copy of referral will be displayed at the meeting)

Patient Name	Name of person referring patient	Patient to be Noted or Discussed? *N* *D*

2.2 Care plans due for review (Copy of current care plan will be displayed at the meeting)

Patient Name	Name of Palliative Care Service

3. NEW BUSINESS

4. CORRESPONDENCE

Minutes

The template for the minutes is set out below:

Multidisciplinary Team (MDT) Meeting
Minutes

Purpose: To provide a supportive, formal environment whereby a multidisciplinary team (MDT) can come together to improve the quality of life for patients with a life limiting illness through effective planning and coordination of the delivery of individualised evidence based palliative care.

Date / time: **Venue:**

1. Present or Apology

Role / Organisation	Name	Present or Apology
Aboriginal Health Service Worker	Mary Baker or Mona	
Breast Care Nurse	Kaye Matthews	
Social Worker		
General Practitioners	Invited as relevant to the agenda	
Hospice Staff (Mildura Base Hospital)		
Link Nurses		
Mildura Private Hospital		
Residential Aged Care Facility Staff	As relevant to the agenda	
Specialist Palliative Care Nurse	Bertilla Campbell	
	Catherine Kemp	
	Joe Kervin	
Community Nurse		
Coordinator of Volunteers		

2. Business arising - From action summary sheet

3. Standing Items

3.1 New Patients

Patient Name as listed on agenda for this meeting	Patient Discussed Noted Held over for next meeting or Case Conference required *D N H C*	Care Plan Created? *Y N*	Person responsible for communicating plan to the patient or arranging case conference

3.2 Review Patients

Patient Name as listed on agenda for this meeting	Care Plan Updated? *Y N*	Person responsible for communicating altered plan to the patient

4. New Business

5. Correspondence

ACTION SUMMARY

Date arising	Action Item	By Whom	By When	Action Completed

SECTION 4

Plan of Care

Plan of Care

The planning and coordination of care occurring at the MDT meeting is to be documented in a manner that facilitates ease of access to the plan of care, delineates roles and notes the health provider responsible for communicating the plan to the patient.

A set template is to be used for the plan of care as well as the care plan notice informing the General Practitioner of the team meeting and the action plan.

Palliative Care Multidisciplinary Team (MDT) Meeting

Multidisciplinary Case Conference Summary and Action Plan

To be completed by the MDT Meeting Coordinator

Patient's Name:	Diagnosis:	History:		
Consent for discussion completed?	**Date:**	**Time Commenced:**	**Time completed:**	**Minutes:**
Yes No				

The reason for this case conference is:

- □ New admission to the palliative care service
- □ Recent admission to hospital
- □ Change in clinical status
- □ Requires multidisciplinary input
- □ Other _____

Health Professional Participants

Name	Discipline/Position	Send copy of care plan?	Name	Discipline/Position	Send copy of care plan?

Health Professional Responsible for communicating plan of care to the patient

Name:

PLEASE TURN OVER FOR ACTION PLAN

ACTION PLAN

PATIENT GOALS OF CARE:

_____

_____

_____

Patient Issues	Goals	Action Plan	Team Member Responsible	Action Date	Review of Plan required?	Review date	Goals achieved?

Ensure patients GP receives a copy of this document

Mallee Division Rural Palliative Care Project

Palliative Care Multidisciplinary Team (MDT) Meeting

GP Care Plan Notice

FAX MESSAGE

TO:	***Dr***	**Fax Number:**	
FROM:	**Insert name** **Case Conference Coordinator**	**No. of Pages:**	
SUBJECT:	**Multidisciplinary Team Meeting** **Case Conference**	**Date Sent:**	

Dear Dr **,**

Please find following the documentation from the case conference/ team care plan for your patient, Insert patient name**,** held on Insert date.

Included:

- □ Case conference summary sheet
- □ Case conference action plan

A copy of the original documents will be posted to you.

Many thanks for your participation in this meeting. **Delete this section if GP did not participate**

Please do not hesitate to call if you have any queries or comments.

Sincerely,

Insert Name

Multidisciplinary Team Meeting Coordinator

	Multidisciplinary Team (MDT) Meeting

Care Plan Notice

FAX MESSAGE

TO:		**Fax Number:**	
FROM:	**Insert name** **Case Conference Coordinator**	**No. of Pages:**	
SUBJECT:	**Multidisciplinary Team Meeting** **Case Conference**	**Date Sent:**	

Dear **,**

Please find following the documentation from the case conference for your patient, Insert patient name**,** held on Insert date.

Included:

- □ Case conference summary sheet
- □ Case conference action plan

A copy of the original documents will be posted to you.

Many thanks for your participation in the meeting.

Please do not hesitate to call if you have any queries or comments.

Sincerely,

Insert Name

Multidisciplinary Team Meeting Coordinator

Meeting Review Process

The meeting will be initially reviewed at 3 months, and then every 6 months to ensure it is meeting the objectives desired by the stakeholders and is providing adequate benefits for the costs.
The review will be based on measurement of the performance indicators listed in the terms of reference

Information Management

The management, storage and confidentiality of data will be as detailed in policy and procedure by the lead agent. Health care providers participating in the meeting who are not employed by the lead agency will sign a confidentiality agreement that is kept on record.