Department of Health and Human Services

Palliative Care Service

Multidisciplinary Team

(MDT)

Meeting Manual

Background

This manual has been developed by the Rural Palliative Care Project of General Practice South, and Palliative Care Services - South, Department of Health and Human Services, in conjunction with service providers.

It is designed as a guide for the operation of multidisciplinary team meetings in palliative care held in particular geographical locations where the meeting is held in the local community with local health professionals, with Hobart-based specialists participating either face to face, or via tele or video conference.

Acknowledgements

This manual has been adapted by General Practice South, and Palliative Care Services of the Department of Health and Human Services from manuals put together by the South Gippsland General Practice Alliance and the Mallee Division of General Practice, with permission, and with input from the local Governance Group of the Rural Palliative Care Project.

This manual fulfils the requirements of:

- The Information Privacy Act 2000
- Palliative Care Australia standards for Quality Palliative Care
- Principles of best practice—multidisciplinary team meetings published by the Cancer Coordination Unit, Victorian Department of Human Services where applicable
- Medical Benefits Schedule on all applicable claimable items suggested in this document

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* templates are available in MS Word format at www.gpsouth.com.au/pcp.html

Introduction

Palliative Care Multidisciplinary Team meetings are defined as "a deliberate, regular, face-to-face (or videoconference/teleconference) meeting involving a range of health professionals with expertise in the management of palliative care. The purpose of the meeting is to facilitate best practice management of all clients."[1]

Multidisciplinary Care (MDC) is an integrated team approach which sees the best interests, needs and wishes of the client, carers and families at the centre of care.

The Multidisciplinary Team (MDT) consists of Medical, Nursing and Allied Health care professionals who develop a collaborative treatment plan according to evidence based practice to enhance quality of life and provide optimal outcomes for the client.

The MDT then make recommendations to the client and/or carers and family to which they either accept or decline, whilst always remaining at the centre of care provided.

In order to provide Australians with quality 'holistic care', it is implicit that Multidisciplinary Care is utilised as the preferred care model as recognised by Palliative Care Australia's 'Standards for Providing Quality Palliative Care for all Australians' in which Standard 2 states:-

> "The holistic needs of the client, their caregiver/s and family, are acknowledged in the assessment and Care Planning processes---------"[2]

MDC has been promoted as best practice in Cancer and Palliative Care from several sources including the Tasmanian State Government through its Tasmania's Health Plan released in May 2007. In this document in relation to the Primary Health services Plan, key points included:

- Strengthening relationships with DHHS and general practice;
- Adopting and promoting a primary health approach which focuses on health and well being and not just illness;
- A population perspective on health not only for individuals;
- Multidisciplinary approach to care;
- A Partnership approach in which a range of groups and organisations need to work together to improve health;
- A focus on actual health needs, such as chronic disease, rather than service needs; and
- Fostering 'individuals' control over their health and participation in health decision making. (2007: 31) [3]

The Purpose and Aim of Multidisciplinary Care

The purpose of implementing multidisciplinary team meetings is to enhance the 'quality of life' for client's diagnosed with a life limiting illness, with the intent of improving their care outcome.

The aim of the MDT meeting, which is to facilitate 'best practice management' for all clients referred to the Palliative Care Services - South. This aim will be achieved by:-

- Developing a formal mechanism for multidisciplinary input into treatment planning and ongoing management and care of palliative care clients;
- Ensuring all new clients have their case discussed by all relevant disciplines and organisations, ensuring true multidisciplinary input;
- Determine, in the light of all available client information and evidence, the most appropriate 'evidence based' treatment and care plan for each individual client which meets their needs and goals of care;
- Encourage respectful, peer interaction in a supportive and inclusive atmosphere; and
- Provide education to all health professionals.

Benefits of Multidisciplinary Care

Evidence clearly shows that a Multidisciplinary care approach:-

- Improves symptom control and quality of life for the client;
- Increases the likelihood of receiving care in accordance with clinical practice guidelines, including psychosocial support;
- Increases access to information, for clients particularly about psychosocial and practical support;
- Improves perception by the client that care is being managed by a team;
- Improves client care through the development of an agreed treatment plan;
- Increases client satisfaction with care;
- Means all treatment options can be considered, and treatment plans tailored for individual clients;
- Streamlines treatment/care pathways;
- Reduces duplication of services;
- Provides opportunities for health professional to interact with colleagues;
- Enhances health professional educational opportunities; and
- Improves mental well-being of health professionals. [4]

Resources Required for a MDT Meeting

A private room for 2-5 people that will accommodate teleconference and videoconference capability:

- Telephone for teleconference facilities
- Videoconferencing facilities
- Power points
- Computer projector and screen (if required for education)

MDT Meeting Process and Principles

Pre Meeting

Meeting coordinator receives and screens referrals, and compiles and distributes invitations and agenda.

Referring team members discuss with clients and their carers and family the benefits of a multidisciplinary team approach and go through the Information and Consent Form with them. (See Appendix 1)

At Meeting

There should be a minimum of three people present for the meeting.

Care plans are developed or revised for each client, and a date for review is determined.

Post Meeting

The referring team member discusses the outcomes of the meeting with the client and/or their carer and family as appropriate. This is their opportunity to accept, decline or amend the Care Plan.

The final care plan is sent to all team members.

Conduct and Confidentiality

Professional etiquette and mutual respect is maintained within the team with each person afforded the time and space to voice their opinions, concerns etc

Names of clients, meeting participants and documents relating to the meetings/Care Plans are kept confidential within the team. For more information see the Information Privacy Act 2000.

GENERAL PRACTICE
south

Community Coordinated Palliative Care Multidisciplinary Case Conference Guide

1. Client identified by a service provider as having complex needs
2. Client consent obtained for case conference
3. Request for a case conference faxed to the client's GP

Accepted → continue to step 4

Declined → Continue with case conference, keep GP informed of outcome → continue to step 5

4. Time booked with the GP, two weeks notice preferred
5. Request for case conference faxed to other services
6. Case conference held, care plan developed
7. Care plan approved by client
8. Approved care plan distributed to participants, client and GP
9. Future reviews established if appropriate utilising the same pathway

Resources Available

Download the Multidisciplinary Team Meeting Manual, Client & Family Information Sheet and Consent Form, and associated templates at:
www.gpsouth.com.au/pcp.html

Referral Criteria

- All new clients from the region admitted to the Palliative Care Service including those in the local Residential Aged Care Facilities;
- Palliative care clients with complex needs;
- Palliative care clients whom the clinician is concerned about and would like input from other members of the multi-disciplinary team;
- Palliative care clients being discharged from hospital who is being referred back to the region.

Note:

- A minimum of three care providers, including the GP, must be present for the GP to claim MBS.

General Practice South acknowledges the financial support of the Australian Government Department of Health and Ageing. • April 2011

Members of the MDT

1.**<u>The core team</u>** consists of the:

- Palliative Care Medical Specialist;
- Community/District Nurse;
- Palliative Care Nurse and/or Social Worker; and
- Client's GP.

2. **<u>Other members</u>** may attend as appropriate, eg:

- Pharmacist;
- Hospice Volunteer;
- Dietician;
- Care Coordinator;
- Podiatrist;
- Mental health professional; and/or
- Or any other person providing care and support to the client.

If a client and/or their carer and family particularly want to attend, due to time constraints, a separate case conference should be organised.

Involving GPs

If GPs are not already part of the team, it is important to involve them.

The GP is:

- usually the initial point of contact in the client's illness trajectory;
- the referral point for diagnostic tests;
- knowledgeable of the client's medical and psychosocial history/ family circumstances;
- providing ongoing supportive care and reporting on side effects related to treatment.

GPs should be invited to attend only when their client is being discussed and will only be required to attend for the duration of that discussion.

GPs are more likely to be able to attend if Tele/Video-conferencing is provided.

Medicare Claim System

GP's are able to claim through the MBS system for participating in MDT meetings. The amount and item numbers differ depending on the length of the meeting, or case conference, and whether the GP instigated the meeting or was invited to attend. A minimum of three health professionals, including the GP, must be in attendance.

See the MBS Guide for Case Conferences (Appendix 6) for information about the relevant MBS Items

Frequency of Meetings

This will be decided at each individual site. It is considered desirable to set regular meetings so that an expectation is there that members will set aside that time and make themselves available.

Provision can be made for calling extraordinary meetings, with two weeks notice where possible.

Educational Component of Meetings

By their nature, multidisciplinary meetings provide education to participants via knowledge-sharing and discussions. At times, if there are few clients to discuss, the meetings may also provide the opportunity for a more formal training session.

Roles and Responsibilities

Terms of Reference

At the initial meeting terms of reference are to be determined that will include roles and responsibilities, minute taking requirements, storage of records, frequency and location of meetings, and a review timeline for the meeting process.

Suggested roles and responsibilities:

Coordinator/Convenor is responsible for:

Prior to the meeting

- Entering clients referred, onto the meeting Agenda (template Appendix 4);
- Booking the meeting room and making sure the teleconferencing/ videoconferencing facilities are available and booked;
- Sending out an invitation to client's GP with an offer to participate, giving two weeks notice if possible, using the template (Appendix 2);
- Sending out an invitation to core members and any other participants relevant to that client to attend the next MDT meeting with the meeting Agenda at least 1 week prior to the meeting;
- Ensuring all health professionals who are invited have replied; documenting their apology if they are unable to attend.

During the meeting

- Distributing copies of amended Agenda, and Care Plans for review; and
- Ensuring that teleconference calls are made at the time indicated.

Minute Taker is responsible for:

- Documenting who is present
- Confirming individual client consent obtained and documenting same
- Documenting Care Plan development by listing the client's name on the minutes
- Taking note of care plans coming up for review
- Documenting next meeting date
- Other notes as required

Referring team members are responsible for:

- Gaining the clients consent for the meeting and its proceedings (See Appendix 1)
- Contacting any team member(s) who is not able to participate regarding any information vital for discussion
- Presenting the client (see Referral Protocols and Process) and leading the discussion about developing or reviewing the Care Plan
- Documenting the Care Plan as decided in the meeting (template Appendix 5)
- Conferring with the client after the meeting to ensure that the plan is suitable, and amending as required. Obtain client's signature on the Care Plan
- Disseminating final Care Plan to team members, including those unable to participate on the day, in a timely manner (template Appendix 3)
-

GPs

GPs are encouraged to be present for the discussion of their clients. GPs will be invited to attend if their client is being discussed and has been referred by another health professional, or they may refer a client to the meeting themselves.

The GP is responsible for:-

- Completing and returning the Invitation to the MDT case conference to the Meeting Coordinator as soon as possible after receiving it; (See Appendix 2).
- Making an appointment for the meeting day and approximate time on the medical practice books so MBS can be claimed.

Meeting Documentation

- The services attending the MDT meetings will be responsible to ensure that all records kept meet their organisations standards for documentation and storage of health records.
- It is the responsibility of each organisation participating in the MDT Meeting to complete the client's file from that organisation.
- All treatment and care recommendations from the meeting discussion will be documented in the client's file. Minimum information documented must include:-
  - Date of the meeting;
  - The proposed care plan (insert copy of care plan into client's file);
  - Client follow-up appointment;
  - The name of this person, their role, and signature.

Referral Protocols and Process for MDT Meeting

Any client of DHHS Palliative Care Services – South can be referred by any health professional, using the Client and Family Information and Consent form and forwarding the completed form to the meeting Coordinator/Convenor.

Criteria for client referral to the MDT Meeting

- All new clients from the region referred to Palliative Care Services - South including those in local Residential Aged Care Facilities;
- Palliative Care clients with complex needs;
- Palliative Care clients whom the clinician is concerned about and would like input from other members of the multidisciplinary team;
- Palliative Care clients being discharged from hospital, that are being referred back to the region.

Prior to the Meeting:

Client Consent

- The referring clinician talks with the client and/or their carer and family members through the MDT Information Sheet, ensuring that the process is understood and that the consent form is signed in order to proceed with the meeting.
- The client's needs and wishes should be identified, inclusive of their relevant family/carers;
- The client's permission about what is to be discussed in regards to their specific case needs should be obtained, recognising that the client may not want some issues discussed;
- The consent form must go into the client file of the referring clinician/agency.

All relevant information should be gathered, including latest test results, required to present a comprehensive summary of the client for the MDT meeting; (see suggested format below).

During the Meeting

Present information on the client. A suggested format commonly used is ISBAR:

Introduction	Identify yourself, your role and location
Situation	State the client's diagnosis or reason for admission and current problem
Background	What is the clinical background or context?
Assessment	What are your client's clinical observations? What do you think the problem is? Be ready to give the current observations.
Recommend	What do you recommend or what do you want the person you called to do? Be clear about your request and timeframe. Repeat to confirm what you have heard.

Case discussion

- Assess whether any previously identified outcomes have been achieved;
- Identify the desired outcomes and tasks/efforts necessary to achieve them;
- Accept the role of desired tasks/efforts by members to ensure quality care is provided;
- Decide who's role it will be to provide ongoing assessment of symptoms, when and how that will occur ;
- Any concerns about access to medications ;
- Discuss if other arrangements for admission to hospital, palliative care unit or other referrals/ assessment are required;
- Discuss the preferred setting of care and preferred place of death - who will visit to verify/certify the death if the client dies at home;
- Discuss whether a family meeting is required.

The referring health professional should write up the care plan as it is discussed, ensuring all members agree that it reflects a true record of what the recommended outcomes are.

A follow-up client appointment date will be indicated at the MDT meeting and documented in the client file.

Post Meeting

- Meeting with the client, discussing the Care Plan and making any relevant changes. The client needs to accept or decline the implementation of the Care Plan and their signature (or that of their person responsible) must be obtained on the final version;
- Notifying the MDT members of the outcome of the recommended Care Plan and ensuring that all health professionals involved in the client's care receive a copy of the agreed Care Plan within four working days, with a copy to the client.

Review and Evaluation

Meetings will be evaluated at least annually. A questionnaire and audit tool will be developed by Palliative Care Services - South to assist in this process.

Meeting Review Process

The meeting should be reviewed at 12 months, to ensure the MDT meeting is achieving its objectives, and is providing adequate benefits. Areas to be assessed may include:-

- A rating of how valued the member feels their input is to the care plan process;
- A rating of how comfortable they feel to ask questions during the MDT meeting and rate how well they were answered;
- A rating of how beneficial the member feels the meetings are to them and the client/carer/family;
- How many MDT meetings individual members have attended in 6 months.

MDT Manual Review

- The DHHS Palliative Care Services - South/General Practice South Multidisciplinary Team Meeting manual will be reviewed annually or more often as required.

References

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2. Palliative Care Australia, 2005, 'Standards for Providing Quality Palliative Care for all Australians', ACT, accessed on 15 June 2010, http://www.palliativecare.org.au/Default.aspx?tabid=2051

3. Tasmania's Health Plan, May 2007, http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0008/28484/HealthPlanSummary_nav.pdf

4. The National Breast Cancer Centre, 2005, "Multidisciplinary meetings for cancer care: a guide for health service providers, Camperdown www.nbcc.org.au

Further reading

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Department of Health (DoH) 2009, 'Multidisciplinary care: A model for achieving best practice cancer care', retrieved 10 February 2010, http://www.health.vic.gov.au/cancer/docs/mdcare/cosa06multicare.pdf

Strasser, F, Sweeney, C, Willey, J, Benisch-Tolley, S, Palmer, L & Bruera, E 2004, 'Impact of a Half-Day Multidisciplinary Symptom Control and Palliative Care Outpatient Clinic in a Comprehensive Cancer Center on Recommendations, Symptom Intensity, and Patient Satisfaction: A Retrospective Descriptive Study', *Journal of Pain and Symptom Management*, vol.27, no. 6, pp.481-491, retrieved 22 May 2010, Science Direct database.

Xyrichis, A & Lowton, K 2008, 'What fosters or prevents interprofessional teamworking in primary and community care? A literature review', International Journal of Nursing Studies, vol. 45, pp.145-53, retrieved 23 March 2010, Science Direct database.

Department of Health and Human Services

Palliative Care Multidisciplinary Team Meeting

Client and Family/Carer Information Sheet

To assist in providing you with the best possible treatment and care we would like to discuss and plan your care with other health care providers. This will improve the consistency and continuity of your care.

A collaborative specific treatment plan will be developed that will enhance your quality of life and provide optimal outcomes for you. The plan will then be presented to you, and you will have the opportunity to accept, decline, or alter the plan.

Before the meeting, we need to obtain consent from you (or the person who can legally give consent on your behalf) that you agree to the case conference and understand how these meetings are conducted.

Membership of the Multidisciplinary Team Meeting may comprise of:

- Palliative Care Medical Specialist
- Representative from the Community Nurses (or your local nurses)
- Palliative Care Clinical nurse and/or Social Worker
- Your GP
- Other health professionals or service providers who are working with you

Consent

____________________________________ (Staff Name) has explained the purpose of the Multidisciplinary Team Meeting to me. I give permission to discuss my diagnosis, medical history, health and care issues to plan care that is specific to me and my needs whilst I am a patient of the Palliative Care Service.

I have advised ______________________________________(Staff Name) of the information that I do not want discussed at this meeting and understand that my care will not change until I have been informed of the outcome of the MDT meeting.

Client Name: ___________________________ DOB: _____________________ UR: _____________

Client Signature: ____ Date: ________________

Staff Signature: ____ Date : ________________

Department of Health and Human Services

GP Invitation to Palliative Care

Multidisciplinary Case Conference

Date: **Fax:**

Please Respond By <<Due Date>> To Fax: <<insert fax no.>>

To: **«Name»**

From: <<Insert Referring Health Professionals Name>>

Re: «Client's Name»

A case conference will be conducted next **<<insert date and time>>** to review the care of your client:

«Client's Name»

We recognise your time is valuable but your input will be most beneficial. Discussion of your client will take approximately 15 minutes and would be **MBS claimable under item number *747*** (attendance by a medical practitioner, including a general practitioner, as a member of a case conference team).

The meeting will be held in <<insert meeting room name, and venue>> . Participation via telephone is possible and there will be a telephone or video link with <<insert specialist team names>>.

Your initials here, if you wish to participate [ ]

Your client's permission has been obtained and you will be given feedback from the meeting and a copy of the Care Plan if you are unable to participate.

You may wish to mark this as a "client appointment" in your appointment record

Notice: This message contains information intended only for the use of the addressee named above. It may also be confidential and/or privileged. If you are not the intended recipient of this message, you are hereby notified that you must not disseminate copy or take any action in reliance on it. If you have received this message in error, please notify the sender

This Document is based on that developed by P. de Klerk Peninsula Hospice Service.

Department of Health and Human Services

Multidisciplinary Team (MDT) Meeting

Care Plan Notice

FAX MESSAGE

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

Dear MDT participant,

Please find attached the Care Coordination Plan agreed on at the Palliative Care Multi Disciplinary Team Meeting, held on <<Insert date>> for <<Insert client name>>

This Plan has been accepted and signed by the client/carer.

Many thanks for your participation in the meeting.
Please do not hesitate to call if you have any queries or comments.

Sincerely,

<<Insert Name>>

<<Insert Title>>

Appendix 4

Department of Health and Human Services
PALLIATIVE CARE SERVICE

Tasmania

Palliative Care Multidisciplinary Team Meeting
Agenda

Venue: Venue
Date: Day, Date
Time: Time AmPm - Finish Time Finish AmPm
Membership: Membership
Teleconference Participants: Teleconference Participants
Apologies: Apologies

Meeting Items

(paper) indicates item has associated meeting paper
* indicates standing agenda item

Person Responsible

Item		
• **Introduction**		
○ Attendance and Apologies		
MDT Discussion		

Time	Client	Referral criteria	Reason for discussion	Invitees called	

Client Care Plan

Current Health / Service Providers
Name & contact number:

GP:
CPCS:
CHN:
Pharmacy:

Client Agreement:

The purpose of a Care Plan has been explained to me, and I agree to participate in the ongoing development and implementation of that plan of care. This may necessitate periodic assessment and review in order to address my changing needs over the course of my care.

Signed: ______________________________ Date: ____________________ Witness: ____________________

Diagnosis:

Affix ID label here

Family Contacts:

1.
2.
3.
4.
5.

Enduring Guardian / Advanced Directive / Power of Attorney (contact details):

Client Issues (in order of importance to client):

Goals of care & treatment:

Medical Alerts:

Psychosocial Alerts:

Client Name:

UR Number:

Issue: Date:	Goal:	Intervention:	Responsibility:
Issue: Date:	Goal:	Intervention:	Responsibility:
Issue: Date:	Goal:	Intervention:	Responsibility:
Issue: Date:	Goal:	Intervention:	Responsibility:

Client Name:

UR Number:

Issue: Date:	Goal:	Intervention:	Responsibility:
Issue: Date:	Goal:	Intervention:	Responsibility:
Issue: Date:	Goal:	Intervention:	Responsibility:
Issue: Date:	Goal:	Intervention:	Responsibility:

MBS Guide for Case Conferences

Item numbers for multidisciplinary case conferences for patients in the community, or patients being discharged into the community from hospital, or people living in residential aged care facilities

GP Organises and Coordinates a Case Conference

MBS Number	Conference Duration
735	15-20 minutess
739	20-40 minutes
743	At least 40 minutes

GP Participates in a Case Conference

MBS Number	Conference Duration
747	15-20 minutes
750	20-40 minutes
758	At least 40 minutes

Who Can Participate?:

The multidisciplinary case conference must consist of a minimum of three health or care providers, including a medical practitioner.

Examples of team members who may be included are: registered nurses, psychologists, social workers, physiotherapists, pharmacists, members of the specialist palliative care service, and dieticians. The team may also include home and community services such as meals on wheels providers and personal care workers.

The patient or their informal or family carer may be included if they desire, in addition to the minimum of three health or care providers.

Rebate Amounts:

Check the most recent rebates for the above item numbers at: **www.mbsonline.gov.au**

Patient and Family:

For a Client and Family Information Sheet and Consent Form on multidisciplinary team meetings, and other resources on this topic, go to **www.gpsouth.com.au/pcp.html**

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