Terms of Reference

BACKGROUND

A team approach to care is one of the key elements of effective palliative care service delivery. 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 and personal preferences of the patient, and then collaboratively develop an individual care plan that best meets the needs of each patient and their family [1]. There is compelling evidence to suggest that a multidisciplinary approach to care helps to enhance the patient’s quality of life, ensures that decisions are based on evidence-based practice and enhances a clinician’s mental well-being [1]. The principles for multidisciplinary care emphasise the need for:

- A **team approach**, involving core disciplines integral to the provision of good palliative care, including general practice, with input for all relevant specialities
- **Communication** among team members regarding care planning
- **Establishment of systems** to ensure that all patients have access to all relevant services
- Provision of care in accordance with **nationally agreed standards**
- Involvement of patients in the decisions about their care [1]

A regular multidisciplinary palliative care meeting is a forum by which this approach to care is facilitated. These terms of reference detail how the multidisciplinary palliative care meeting will operate.

AIM

To establish a multidisciplinary team to facilitate collaborative care planning for people with a life limiting illness to ensure effective delivery of evidence-based palliative care in accordance with the needs of each individual patient and family.

OBJECTIVES

- To establish a multidisciplinary team comprising core disciplines as identified, that meets on a regular basis to develop a palliative care plan for individual patients and families according to their needs
- To ensure that patients with a life limiting illness have access to evidence based palliative care and relevant services
- To provide multidisciplinary team members with an opportunity for enhanced palliative care education by action learning principles, when expertise is shared between providers at the meeting.
MULTIDISCIPLINARY TEAM MEMBERS:

Core Team Members
• Chairperson: Medical Director (Mid North Coast Division of General Practice) or delegate
• Palliative Care MDT Coordinator
• Coffs Harbour Health Campus Chaplain
• General Practitioners—patient’s own if available
• Palliative Care Clinical Nurse Consultant
• Palliative Care Physician
• Palliative Care Social Worker
• Referring provider
• Invited relevant key health professionals as specified by the referring provider
• Patient/carer (or if electing not to attend, referring provider to advocate on their behalf)

Network of Extended Team Members
• Aboriginal Health/Medical Service
• Aged Care Assessment Team
• ACTIP Team
• Baringa Private Hospital
• Breast Care Nurse
• Community Care Agencies
• Community Nurses
• Dietician
• Discharge Planners
• Haematologist
• Hospital Inpatient staff (Coffs Harbour Health Campus, Bellinger River District Hospital, Dorrigo Multipurpose Service)
• Link Nurses
• Medical Oncologist
• Medical Students
• Nursing Students
• Oncology Staff
• Occupational Therapist
• Palliative Care Community Nurses
• Palliative Care Volunteer Coordinator
• Palliative Care Volunteers
• Physiotherapist
• Private Nursing Providers
• Radiation Oncologist
• Residential Aged Care Facility Staff
• Social Worker
• Speech Pathologist
• Visiting Medical Officers
• Other providers as relevant to the patient/resident

ATTENDANCE
All health care providers involved in the core group are expected to attend, and non core members are actively encouraged to attend on a regular basis.

All meeting attendees who attend in person, will sign the attendance record each meeting (Appendix 1).

CONFIDENTIALITY
All attendees will sign a Confidentiality Agreement at or prior to their first attendance at a meeting. The Confidentiality Agreement is provided by Baringa Private Hospital as the organisation providing the meeting venue (Appendix 2).
Signed Confidentiality Agreements will be kept on record at the Mid North Coast Division of General Practice.

CONDUCT OF ATTENDEES
All meeting attendees will adhere to the NSW Health Code of Conduct and abide by the terms of the Confidentiality Agreement.

MEETING VENUE
The meeting venue may be rotated by agreement of stakeholders.
MEETING TIMES
Fortnightly on Tuesdays, from 0800 to 0930.

PATIENTS TO BE DISCUSSED
Case conference criteria:
- Patients with complex palliative care needs, including discharge case conferences.
  In identifying “complexity” of needs, use of evidence based clinical indicators eg: Karnofsky, Palliative Care Phase, and involvement of multiple providers in the patients care can be considered.
- Review discussions will occur routinely to reassess outcomes of planned care. Review may be deferred if follow up information or the relevant provider is unavailable.

PATIENT CONSENT
All patients/residents who are discussed at the multidisciplinary team meeting need to provide consent. The Patient and Family/Carer Information Sheet (Appendix 3) is to be provided and consent obtained by the referring provider. The patient/resident, and/or carer are welcome to participate in the case conference and arrangements should be discussed with the coordinator at time of referral. If the patient/resident and/or carer elect not to participate, they are to be consulted about issues they wish included in the discussion and informed of how they will be provided with feedback.
If the patient does not have the capacity to provide consent, this should be obtained from a substitute decision maker (Person Responsible) as outlined in the Guardianship Act 1987. Consent must include identification of any issues the patient does NOT want discussed.

MEETING COORDINATION
Coordination of the Palliative Care Multidisciplinary Team Meeting is undertaken by the Palliative Care MDT Coordinator, employed by the Mid North Coast Division of General Practice or their nominated delegate.

The Palliative Care MDT Coordinator will facilitate identification of patients for discussion by:
- Liaison with the palliative care team, palliative care Link Nurses and other key providers within health services and organisations

It is responsibility of the health care provider referring the patient for a case conference to notify (ideally at least one week in advance) the Palliative Care MDT Coordinator, using the Referral Form (Appendix 4) and/or by phone (0419 295 795).
Information required:
- Preferred meeting date and estimated time required
- Patient details including date of birth
- Confirm patient consent, including identification of issues to be excluded
- Reason for case conference
- Diagnosis and issues
- Name of provider presenting the case
- Names and contact details of health care providers with relevant skills and knowledge to be invited to participate in the case conference
- If the patient/carer elect to participate a summary of their issues is to be prepared prior to the meeting where possible (issues to be discusses at the MDT before the patient/carer is involved in the discussion). Establish how the patient/carer will be involved.
It is the **responsibility of the Palliative Care MDT Coordinator or nominated delegate** to:

- Confirm with the referring provider, the case conference date and time
- Invite other identified relevant health care providers to participate, informing them of the patient’s name, case conference date and time. Confirm their intention to attend by either teleconference or in person.
- If the patient/carer elect to participate a summary of their issues (supplied by the referring provider where possible) is to be included in the agenda. Confirm how the patient/carer are to be involved.
- Provide teleconference phone and PIN number details as relevant.
- Provide the chairperson, Palliative Care Physician, Palliative Care Clinical Nurse Consultant and Social Worker and Coffs Harbour Health Campus Chaplain with an agenda prior to the meeting.

Case conference “reviews” are to be arranged by the referring provider contacting the Palliative Care MDT Coordinator to schedule a suitable MDT date and time and do not require a new referral form.

### MEETING DOCUMENTATION

The **Palliative Care MDT Coordinator** or nominated delegate will:

- Document a summary of the case conference in letter format for the patient’s GP, identifying the relevant EPC item number (if applicable). Copies of the letter will be provided to other health care providers involved in the patient’s direct clinical care.
- Disseminate the case conference summary letter and copies by Argus secure messaging or fax on the day of the MDT.
- Letters may be posted if this is requested by health care providers, in an envelope marked confidential.
- For patients of the Palliative Care Service, provide an electronic copy of the case conference summary to the Clinical Nurse Consultant using a USB drive to enable inclusion in the patient’s electronic health record within Palliative Care Information Clinical Information System (PalCIS). The MDT Coordinator will be responsible for ensuring confidentiality of the USB drive until it is delivered to the Palliative Care CNC or Palliative Care Service staff member if the CNC is unavailable.

The **referring provider** will:

- File the provided case conference summary in the patient’s medical record.
- In case conferences involving patients of the Palliative Care Service, the Clinical Nurse Consultant will copy the case conference summary provided on the USB drive, into the patient’s electronic health record within Palliative Care Information Clinical Information System (PalCIS). The files on the USB drive are then to be deleted. The Palliative Care Service is responsible for ensuring confidentiality of the USB drive once received from the MDT Coordinator.
- If a summary letter is not deemed as relevant in the case of brief review discussions, the provider will document any relevant information into their patient medical record file or system.

### CHAIRING THE MEETING

Good leadership and facilitation are key factors in the success of multidisciplinary meetings.

“…The Chairs 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." [1 p.26]

The chairperson role will be undertaken by the Medical Director of the Mid North Coast Division of General Practice and delegated at their discretion.

Roles of the Chair:
• Ensure all participants are introduced
• Use of teleconference phone when indicated
• Keep meetings to the agenda
• Commence discussions
• Promote the full range of input into discussions if it is not forthcoming
• Conclude the discussion by inviting any further input before moving to the next case
• Negotiate resolution of conflict if necessary
• Promote mutual professional respect among all team members[1p. 26]

CASE CONFERENCE CONTENT

To optimise patient/carer and health care provider outcomes, the case conference should utilise all available information and ensure relevant issues are identified and addressed as per the following guidelines:

* As per MDT philosophy individual patient/carer issues needs must be the priority,
  • Patient demographics
  • Identify the team involved in providing care: GP, main service/provider and others
  • Patient’s current and relevant past medical history
  • Palliative Care Assessments: most recent available-Phase, Karnofsky RUG- ADL, Problem Severity Score, Symptom Assessment Scale
  • Medications: current, allergies and relevant previous medication issues
  • Psychosocial situation
  • Cultural background
  • Carer, family and support network
  • Spiritual beliefs and existential concerns if known
  • Advance care planning: the patient’s current and future wishes
  • Symptoms and issues identified by health care provider/s
  • Discuss options to address each issue

At this point if the patient/carer are participating, they are invited to join the discussion
  • Patient goals, issues and concerns
  • Carer/Family goals issues and concerns

Clarify issues (prioritise if appropriate)

Summarise discussion of options to address each issue

Gain team consensus on the plan and identify responsibilities for implementing and providing patient/family/carer with feedback (if not participating).

Consider a review case conference

EDUCATION

Multidisciplinary team meetings provide opportunities for sharing of expertise, enhancing understanding of the diversity of provider roles and dissemination of information to enhance best practice in provision of Palliative Care.

This can be achieved by:

• Multidisciplinary case discussions and care planning.
• Participation by all providers.
• Scheduling presentations by team participants and guests on relevant palliative care issues.

If no cases are scheduled for the MDT, a de-identified “case study” for educational purposes may be provided, with all stakeholders responsible for preparing and presenting on a rotating basis.
OUTCOMES

MDT statistics will be collected by Palliative Care MDT Coordinator. Including:

- Number of new case conferences
- Number of review case conferences
- Case conference referral source
- Number of MDT attendees
- Discipline of MDT attendees
- Number of eligible EPC items generated
- Learning occurring during the MDT
- Learning needs identified.

A review of participant’s experiences and outcomes will be undertaken informally at the end of meetings and by formally by survey as deemed relevant by participants.

TERMS OF REFERENCE REVIEW

Review of the Palliative Care Multidisciplinary Team Meeting Terms of Reference will be undertaken annually or earlier if indicated. All stakeholders will be provided with an opportunity to participate in the review and any changes made should reflect a consensus decision.

Reviews undertaken:
October 2006
October 2007
August 2008
October 2009

Next review due:
October 2010

REFERENCE LIST


APPENDICES

1. Palliative Care Multidisciplinary Team Meeting: Attendance List
2. Palliative Care Multidisciplinary Team Case Conference Meeting: Confidentiality Agreement: Ramsay Health Care (Coffs Harbour)
3. Palliative Care Multidisciplinary Team Meeting: Patient and Family/Carer Information Sheet
4. Palliative Care Multidisciplinary Team Meeting: Referral Form
PALLIATIVE CARE MULTIDISCIPLINARY TEAM MEETING
ATTENDANCE LIST

DATE: _______________________________ TIME: From 8 to 9.30am

The Mid North Coast Division of General Practice, North Coast Area Health Service, Baringa Private Hospital and Coffs Harbour Nursing Service are committed to safeguarding the privacy of client information, and have implemented measures to comply with its obligations under the Health Records and Information Privacy Act 2002.

All staff who are involved in the Palliative Care Multidisciplinary Team Meetings are bound by law and ethical practice to keep client information confidential. Client information will only be disclosed for purposes directly related to client treatment and in ways the client would reasonably expect for their current and future care. Client health information will be shared in order to determine the best treatment for them and to assist in the management of the health services provided to them.

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Via teleconference
Via teleconference
Via teleconference
Via teleconference
Via teleconference

April 2009
Palliative Care Multidisciplinary Team Case Conference Meeting

Confidentiality Agreement

As a fundamental condition of participation in the Palliative Care Multidisciplinary Team Case Conference Meetings, all persons must agree to observe the following code in relation to confidentiality:

1. To not directly or indirectly discuss any patient, or divulge any information concerning any patient to any person except as necessarily required in the course of their work;

2. Medical records are confidential and may only be viewed by medical, nursing or other staff involved in the direct care of patients or by administration staff in the clerking of records;

3. To not directly or indirectly discuss Health Service business or divulge any information concerning the Health Service to any other person except as necessarily required in the course of their work;

4. To respect the rights of patients to privacy and confidentiality, and not violate the trust thereby imposed;

6. Persons responsible for supervising students must always respect the rights of patients/clients by seeking permission of the patient/client for the student to be in attendance;

7. To ensure that all confidential records are stored securely and confidentially and in accordance with legislative requirements.

A conflict of interest should be declared by any meeting member and they should ‘opt out’ of attendance and all decision making if the patient is personally known to them.

I acknowledge by signing this declaration, that any person in breach of this Confidentiality Agreement will face disciplinary proceedings.

I have read the above information and agree to the terms and conditions.

Name: ________________________________    Signature: ____________________________

Date signed: ___________________________
Palliative Care Multidisciplinary Team Meeting

Patient and Family/Carer Information Sheet

The multidisciplinary team approach brings together a wide range of knowledge and skills in managing the often complex needs experienced by patients and families requiring palliative care or the palliative approach to care. Using the team approach enhances quality of life and ensures decisions are made according to evidence based best practice and the individual needs and wishes of patients and families.

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 is done by holding a Case Conference at the Palliative Care Multidisciplinary Team Meeting. Before the meeting we need consent from you or the person who can legally give consent on your behalf (person responsible) that you agree to the case conference and understand how these meetings operate.

The Palliative Care Multidisciplinary Team Meeting is held each fortnight on a Tuesday morning at Baringa Private Hospital.

The health care providers who make up your multidisciplinary team are:
- Your General Practitioner
- The health care provider making the referral, who will advocate on your behalf
- Members of the Palliative Care Team: Clinical Nurse Consultant, Social Worker and a Palliative Care Physician (when available)
- Coffs Harbour Health Campus Chaplain
- Chairperson- Medical Director (GP) Mid North Coast Division of General Practice
- The Palliative Care Multidisciplinary Team Meeting Coordinator
- Other health care providers invited relevant to your individual needs

In addition, other care providers may be involved, such as:
- Allied & Other Health Professionals
- Community Care Agencies
- Medical & Nursing Staff/Students

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.

Please discuss with your care team:
- issues or concerns you or your family you would like discussed
- any medical or other information you want withheld from the discussion
- how you will be provided with feedback about the care plan suggested

If you would like to participate in the case conference, please discuss this with the person making the referral on your behalf as they will need to contact the Multidisciplinary Team Meeting Coordinator to arrange.
**Patient Details:**

Surname:  
Given Names:  
Address:  
Sex:  M /  F  
Date of Birth:  /  /  

**GP/Provider making referral**  
Attending MDT:  □ in person (Baringa)  □ via teleconference  
Contact phone number:  

**Consent** for the case conference is required from the patient or person responsible (if patient lacks capacity) and any issues to be withheld identified. Refer to Information Sheet.

Consent obtained and documented  □ Yes  
Who provided consent  □ Patient  □ Other (state below)  
□ No  
Please confirm consent before case conference can proceed.

Are there any issues the patient does NOT want discussed?  □ Yes  □ No  

Name of person providing consent (if other than patient):  
Relationship:  □ Enduring Guardianship  □ Spouse  □ Carer (unpaid)  □ Close friend/relative  

**Reason for Case Conference:**

Priority:  □ < 2 weeks  □ 2-4 weeks  □ > 4 weeks  
Estimated time required:  mins  

**Diagnosis**  

Other relevant information:  

**Issues for discussion:**  

**Other Providers:** please list other providers/services to be invited to participate at the MDT

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Palliative Care Multidisciplinary Team Meeting Coordinator to complete

MDT Date:  /  /  
Time:  
Duration:  
Confirmed:  □ Yes  /  /  

**Mid North Coast Division of General Practice**

Referrals only FAX: 66519822