



**Creating a
Multidisciplinary Team Approach
to Care Planning in
Residential Aged Care Facilities**

**Tool kit
2nd Edition**

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2nd Edition: 2007

Aged Care GP Panels Initiative, Pope, J. and Integrated Network Palliative Care Project Mildenhall, J. in consultation with Residential Aged Care Facilities Multidisciplinary Team Meeting Coordinators - Dever, M. (Masonic Aged Care Facility), Dover, V. (Woolgoolga and District Retirement Village), Pirie, H. (Coffs Harbour Nursing Centre), Rendoth, A. (Mater Christi Aged Care Facility) and West, P. (Catholic Healthcare: St Augustine's, St Josephs and Ozanam Villa [Coffs Harbour] Aged Care Facilities)

1st Edition: 2006

Rural Palliative Care Project and Aged Care GP Panels Initiative

Suggested citation

Mid North Coast (NSW) Division of General Practice (MNCDGP) 2007, ***Toolkit: Creating a Multi-Disciplinary Team Approach to Care Planning In Residential Aged Care Facilities 2nd Edition***. MNCDGP: Rural Palliative Care Project, Aged Care GP Panels Initiative and Integrated Network Palliative Care Project, Coffs Harbour.

Acknowledgement:

Developed by the following projects, funded by the Australian Government Department of Health & Ageing
Rural Palliative Care Project
Aged Care GP Panels Initiative
Integrated Network Palliative Care Project

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 multidisciplinary 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 multidisciplinary care meetings can operate within the aged care arena and promote the delivery of a palliative approach.



Ms Jane Phillips
Rural Palliative Care Project Coordinator, 2006

Following the successful trial of implementing multidisciplinary team meetings in local residential aged care facilities, as part of the Rural Palliative Care Project, the Aged Care GP Panels Initiative and Integrated Network Palliative Care Project have undertaken to revise and enhance the toolkit.

Consultation with the multidisciplinary team meeting coordinators involved has enabled their individual and collective experience of refining the tools and processes to be incorporated in this second edition. The individual tools are provided in order of their application to the process from scheduling and gathering relevant information to running the meeting, documenting and distributing the plan and collecting outcomes data.

The *Toolkit: Creating a Multidisciplinary Team Approach to Care Planning in Residential Aged Care Facilities* 2nd edition, is provided in PDF format, with individual tools available in Word format for your convenience. We welcome any feedback.

Janet Pope
Aged Care GP Panels Initiative

Julie Mildenhall
**Integrated Network Palliative Care Project
Local Palliative Care Grants Program**

Australian Government Dept of Health & Ageing



Terms of Reference

Multidisciplinary 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 multidisciplinary 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 multidisciplinary 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 multidisciplinary 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 multidisciplinary 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 multidisciplinary 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 multidisciplinary team comprising of core disciplines (usually three or more people from different disciplines) that meet 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 MULTIDISCIPLINARY TEAM MEMBERS:

- Aboriginal health workers
- Aged Care Assessment Team
- Care assistants
- Chaplains/pastoral care workers
- Complementary therapists
- Dietician
- Discharge Planner
- Generalist nurses (RN and EN)
- General practitioners
- Link nurses
- Medical Specialists
- Occupational therapists
- Pharmacists
- Psychologists
- Psycho-geriatrician
- Physiotherapists or physio aids
- Podiatrists
- Speech Pathologists
- Specialist nurses (aged care, palliative care, wound care)
- Others as appropriate

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

CRITERIA

1. All new residents will have their care planned at a multidisciplinary care planning meeting.
2. Discharged from acute health care setting
3. Recent increase in the frequency of falls
4. A change in their clinical status (physical, psychological, social or spiritual) which requires additional nursing, medical or the input of external health care providers
5. In accordance with the Commonwealth Government's Regulation (ACFI) and other reasons.

RESIDENT CONSENT

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

BROCHURE: "A Palliative Approach" discusses delivering palliative approach, decision making, advance care planning and enduring guardian. This is a great tool to use when discussing care needs with the resident.

NOTIFICATION OF TEAM MEMBERS

It is responsibility of the Coordinator/Facilitator 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 and DOCUMENTATION

The Multidisciplinary Care Coordination Nurse, in the RACF will:

- Identify all residents who meet the criteria for discussion at the multidisciplinary care planning meeting
- Develop a meeting schedule for each multidisciplinary meeting
- Ensure all relevant attendees are aware and invited to be at the relevant care planning meeting
- Chair the in-house multidisciplinary care planning meeting
- Document the outcomes of each care planning case discussions, using the case conference template
- Ensure a copy of the care planning case conference summary be placed into the resident's records and care plan updated to reflect the changes
- Ensure 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 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 (National Breast Cancer Centre 2005 p.26)

The meeting will be chaired by the in house Multidisciplinary Care Coordination Nurse or their Delegate

- Introductions
- 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 multidisciplinary care planning forum in person or via teleconference.
- To focus on the issues relevant to planning effective care for the resident.

ROLE OF THE GP ADVOCATE

The function of this role is to ensure that a general practitioner perspective is present at the meeting, 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).

The Mid North Coast Division of General Practice will endeavour to assist with the appointment of a general practitioner to attend the in-house multidisciplinary care planning forum, depending on availability of funding by the Aged Care GP Panel Initiative.

MEASURABLE OUTCOMES

The Multidisciplinary Team Meeting Coordination Nurse will be required to maintain the following statistics and submit these on a monthly basis to the Mid North Coast Division of General Practice Aged and Palliative Care Projects Officer's.

- Number of attendees at Multidisciplinary Team Meeting
- Composition of attendees
- Number of residents discussed according to criteria:
 1. New admissions to facility
 2. Following discharge from hospital
 3. Increasing frequency of falls
 4. Change in clinical status
 5. ACFI and other reasons
- Number of reviews of previous case conferences
- Number of EPC items/per item number
- Outcomes of case conference action plan
 - Number of CMA's recommended from the case conference
 - Number of Residential Medication Management Reviews recommended from the case conference
 - Number of residents recommended for Advance Health Care Directive or documented Plan
- Additional data:
 - Number of residents newly admitted to the facility]
 - Number of residents admitted to hospital
 - Number of resident admitted to hospital who had MDT and date of MDT
- Learning identified that occurred during the meeting
- Learning needs identified



Tool 1

Planning Checklist

Multidisciplinary Team Meetings

Planning Checklist

This checklist is to help you plan and conduct the multidisciplinary team meeting (MDT).

PART A: GROUNDWORK: (Up to four weeks prior to meeting)

- SCHEDULING:** Identify and schedule resident case conferences according to the following criteria and to ensure an annual review for ACFI requirements.
- MDT CRITERIA:** Resident to be presented in accordance with the following criteria:
 1. New residents
 2. Discharge from acute health care setting
 3. Recent increase in the frequency of falls
 4. A change in their clinical status (physical, psychological, social or spiritual) which requires additional nursing, medical or the input of external health care providers
 5. In accordance with the Commonwealth Government's Regulation (ACFI)/other reasons.
- CONSENT:** All residents or their Person Responsible will be asked to provide written consent, for the case conference on the 'Multidisciplinary Team Meetings Resident and Family Information Sheet and Consent Form'. Ensure there is understanding of the purpose, who will be present and identify any issues not to be discussed. Introduce the Palliative Approach Brochure and encourage identification of issues important to the resident and family. Arrange a time to meet with the resident and family.
- CREATING THE INDIVIDUAL TEAM:** Identify and list all health care professionals whose input is relevant to the individual needs of the resident and family eg GP, Facility care staff, Oncology, ACAT, dietician, speech therapy, OT, physiotherapist, activities officer, etc. Identify the time to be allocated for the case conference, taking into consideration the complexity of issues to be discussed and the number of participants.
- MEETING VENUE:** Book the relevant meeting room and confirm teleconference facility available if required.
- NOTIFY THE TEAM MEMBERS IN PERSON:** Contact all relevant team members and the family and/or Person Responsible of the MDT Meeting Date, Time and Place. Inform each member who else will be involved and ask if anyone else needs to be included.
- INVITING THE GP:** Follow up the phone invitation to the GP with the fax, 'Fax Invite GP to MDT'. Notify practice staff or the practice manager to book the MDT into the GP's patient appointment schedule.
- TELECONFERENCE:** If the team members are participating via teleconference, ensure you have contact number, and an alternate number (mobile).
- GATHER RELEVANT RESIDENT INFORMATION:**
 - Meet (in person or by telephone) with the resident/Person Responsible and family to discuss care issues, including advance care planning decisions. Explain how the meeting is run.
 - Meet with care staff to identify issues for inclusion. Encourage all staff to contribute by placing the "Staff Communication on Resident issues" sheet in the resident's file along with the Residents Care Needs Checklist. Identify the most appropriate team member to present the information at the case conference.
- ASSESSMENTS:** Based on the issues identified, ensure that that all relevant assessments, including evaluation have been completed. For residents with palliative needs ensure Palliative Care Clinical Assessment tools are used. Findings from the assessments should be documented in the resident's medical record.

PART B: PRE-MEETING PREPARATION: (One week prior to meeting)

- CONFIRMING TEAM MEMBERS:** Contact all of the relevant team members, resident/person responsible and the family, confirming the MDT Meeting Date, Time and Place. Confirm contact numbers for teleconferencing if applicable (check return of Fax Invite GP to MDT response).
- CLARIFY ROLES, MEETING PROCESS & ISSUES TO BE DISCUSSED:** Speak with all participants prior to the meeting, clarifying their role, the MDT process and clearly identify and prioritise and desired outcomes.

- MEETING PLAN:** Ensure the team member presenting the information is prepared and has all relevant documentation and understanding of the issues to be addressed.

PART C: FACILITATION

- 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. Check teleconference phone system functional (if using).
- START AND FINISH ON TIME:** Inform participants of the time allocated to discuss each residents care needs.
- WELCOME AND INTRODUCTIONS (include new participants), CONFIDENTIALITY**
- SIGN CASE SUMMARY SHEET:** All participants attending the MDT are required to sign the MDT Case Conference Summary Sheet.
- BEFORE COMMENCING EACH INDIVIDUAL CASE CONFERENCE:**
 - Issues that are not to be discussed are identified and a team member takes responsibility for ensuring confidentiality is not breached.
 - State time allocated for each case conference.
- 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. Promote use of common palliative care language.
- FACILITATE PARTICIPATION ENSURING COMPREHENSIVE DISCUSSION:** Ensure that everyone gets to contribute to the discussion. As the facilitator, you may need to invite their input.
 - History – Medical and social
 - Issues (patient/carer/health professional)
 - Physical
 - Psychological/Social
 - Cultural
 - Spiritual
 - Advance Care Planning
 - Current Management
 - Clarify goals of care, formulate Action Plan, who will implement, time frame and review date (gain consensus from team)
- REVIEW OF PREVIOUS CASE CONFERENCE PLANS**
- AT COMPLETION:** Acknowledge participation, disconnect from teleconference phone if applicable.
- FEEDBACK:** Ask participants for feedback about the meeting, any learning achieved and identify any learning needs for future education.
- CLOSE MEETING**

PART D: COMPLETION AND DISTRIBUTION

- DOCUMENTATION:** Complete the MDT Case Conference Summary Sheet/Action Plan. Ensure information is concise using accepted medical/nursing language, not abbreviations. Check spelling and grammar. Fax a copy to the GP using the fax cover sheet. If also posting the copy to the GP, include the “with compliments slip” identifying the relevant Medicare Item Number entitlement. Offer a copy to other relevant health care providers involved in the resident’s care. Please place the original in the designated area in the residents’ medical records.
- UPDATE CARE PLAN:** Update care plan to reflect the decisions made at the multidisciplinary team meeting.
- ENTRY IN RESIDENTS PROGRESS NOTES:** Document- “MDT MEETING HELD. List the issues discussed and the outcomes and refer to the Summary Sheet and Action Plan.
- DATA COLLECTION:** Complete the form for your records. Provide staff with regular feedback.



Tool 2

Resident and Family Information Sheet & Consent Form

Multidisciplinary Team Meetings

Insert Facility Name and Logo

Multidisciplinary Team Meetings Resident and Family Information Sheet and Consent

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 residents and families, and ensures decisions are made according to evidence based best practice.

To ensure that all our residents and families get the best possible care we would like to plan your care with other health care providers. Case conferencing to plan care occurs within this facility as a matter of routine after your admission and with changes in your condition.

Before discussing your care we need to get consent from you or the person who can legally give consent on your behalf (person responsible) and be sure that there is full understanding of how these meetings operate.

The care providers who will most likely make up your multi- disciplinary team will include:-

- Your General Practitioner
 - Registered Nurse/s from your Residential Aged Care Facility
 - Care staff including Enrolled Nurses, Assistants in Nursing, Personal Carers
 - Allied Health staff including Physiotherapist, Diversional Therapist
 - Other facility staff relevant to your individual needs
- **Delete this line after adding/deleting from the above list to reflect your facility's core meeting attendees**

Other health care providers from outside the facility may be involved if it is relevant to your particular needs, such as:

- Aboriginal Health Staff
- Aged Care Assessment Team (ACAT)
- Allied Health: Dietician, Occupational Therapist, Physiotherapist, Speech Pathologist, Social Worker
- Medical Specialists
- Nursing Consultants: Continence, Diabetes, Wound Care, Palliative Care
- Others, according on individual needs

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. I have been provided with a copy of the Facility Privacy Information YES

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

Consent

_____ has explained the purpose of the case conference to me and **I*/person responsible***
(Staff Name)

give permission for a case conference to discuss diagnosis, medical history, health and care issues to formulate a care plan at the Multidisciplinary Team Meeting.

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).

Resident/Person Responsible Name _____ Signature _____

Staff Member Signature _____ Date: _____



Tool 3

Fax invite GP

Multidisciplinary Team Meetings

Fax Invite GP to MDT

Insert Facility logo

FAX MESSAGE

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

Dear Dr ,

Insert Resident name, will have his/her case discussed at insert facility name Multidisciplinary Team Meeting, in order to formulate a care plan. As a vital member of the care team we invite you to participate. Medicare EPC items allow reimbursement for case conferences of at least 15 mins.

The reason for this case conference is:

- New admission to this facility
- Recent discharge from Hospital
- Increased frequency of falls
- Change in clinical status
- Required for ACFI (Funding instrument)
- Other _____

To ensure that all the resident's care needs are effectively addressed in the time available at this care planning forum, pre-meeting preparation is essential. In preparation for the case conference we routinely meet with the resident/family and care staff to identify care needs and issues to be discussed.

We have reviewed the resident's file and do not have record of:

- Comprehensive Medical Assessment (CMA)
- Residential Medication Management Review (RMMR)

You may wish to arrange for these to be attended. If already completed please provide copies.

Date:

Start Time:

Expected duration of case conference:

Venue:

Fax No:

Response by insert date would be appreciated.

Attending in person

Attending via teleconference

Telephone Number: _____

Unable to attend

Looking forward to your reply,

Sincerely,

Insert Name, Multidisciplinary Team Meeting Coordinator,

Facility

Contact number



Tool 4

Resident Issues: Care Needs Checklist

Multidisciplinary Team Meetings

Resident Issues: Care Needs Checklist

Attach Resident ID sticker

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 Nursing and Care Staff involved in the residents care.

Tick to indicate issues are present and describe:

Advance Care Planning

Communication

- Hearing/speech
- Specific Needs
- Interpreter, Language _____

Cultural Needs

- Ethnic background
- Indigenous background
- Other identified

Medication

Physical

- Food and fluids
- Personal hygiene
- Transfer/Mobility
- Bladder Management
- Bowel Management

Psychological/Social

- Problem wandering or intrusive behaviours
- Verbally disruptive or noisy
- Depression
- Anxiety
- Danger to self or others
- Other behaviour _____
- Family and friends needs

Spiritual Needs

- Meaning and purpose
- Dignity/personhood
- Completion (unfinished business)
- Ritual and religious practices

Specific Needs

- Pain Assessments/Management
- Symptom Management
- Wound Care
- Other _____



Tool 5

Resident Issues: Staff Communication Sheet

Multidisciplinary Team Meetings

Resident Issues: Staff Communication Sheet

Insert Facility logo

MULTIDISCIPLINARY TEAM MEETING

Resident issues for case conference

A Case Conference has been arranged for Insert resident name _____

on ____ / ____ / ____ at _____ hrs.

The reason for this case conference is: (Coordinator please circle)

1. New admission to this facility
2. Recent discharge from Hospital
3. Increase in frequency of falls
4. Change in clinical status (physical, psychological, social or spiritual)
5. Required for ACFI, Other _____

As valuable members of the team your contribution to the case conference is vital in identifying the issues relevant to the care we give to this resident and their family/friends.

To ensure that all staff have the opportunity to contribute to the case conference, please list below any issues, concerns or suggestions, you would like included or discuss them with the meeting coordinator before the above date. If you are available and would like to attend the case conference, please contact the Coordinator.

Issue, concern or suggestion	Name (optional)	Date

More space over the page

Insert Coordinator Name

Multidisciplinary Team Meeting Coordinator

Issue, concern or suggestion	Name (optional)	Date



Tool 6

Advance Care Planning Resources

Multidisciplinary Team Meetings

Advance Care Planning Resources (New South Wales)

The following documents are sourced from ASLaRC (Aged Services Learning and Research Collaboration).

Refer to the website below for current documents as they are periodically updated and modified.
<http://aslarc.scu.edu.au/downloads.html>

The following lists of documents are currently available:-

Documents for Use in Residential Aged Care Facilities:

- [NSW Enduring Guardianship Form \(for use in residential aged care facilities\)](#)
- [NSW Advance Health Care Directive \(for use in residential aged care facilities\)](#)
- [NSW - Factsheets: Advance Health Care Directive and Appointing an Enduring Guardian \(for use in residential aged care facilities\)](#)
- [Capacity Screening - Information Sheet & Checklist](#)
- [Summary Sheet - Advance Health Care Directive \(for resident's medical records in residential aged care facilities\)](#)
- [Statement From Person Responsible \(for resident's medical records in residential aged care facilities\)](#)

Documents for General Use:

- [NSW Advance Health Care Directive](#)
- [NSW Enduring Guardianship Forms](#)
- [NSW Enduring Power of Attorney \(form can be downloaded from the NSW Guardianship Tribunal\)](#)
- [NSW Advance Health Care Directive Fact Sheet](#)
- [NSW Appointing an Enduring Guardian Fact Sheet](#)
- [Powerpoint Presentation by Prof Cartwright \("Advance Care Planning - What is it and Why is it Important"\)](#)
- [Powerpoint Presentation by Prof Cartwright \("Advance Care Planning: The Legal Framework"\)](#)



Tool 7

Resident Issues: Palliative Care Clinical Assessment Tools

Multidisciplinary Team Meetings

Palliative Care Clinical Assessment Tools

1

Palliative Care Phases

- 1 Stable
- 2 Unstable
- 3 Deteriorating
- 4 Terminal Care
- 5 Bereaved

Definitions of Palliative Care Phases

(1) Stable Phase

All clients not classified as unstable, deteriorating, or terminal.

The person's symptoms are adequately controlled by established management. Further interventions to maintain symptom control and quality of life have been planned.

The situation of the family/carers is relatively stable and no new issues are apparent. Any needs are met by the established plan of care.

(2) Unstable Phase

The person experiences the development of a new problem or a rapid increase in the severity of existing problems, either of which requires an urgent change in management or emergency treatment

The family/carers experience a sudden change in their situation requiring urgent intervention by members of the multi-disciplinary team.

(3) Deteriorating Phase

The person experiences a gradual worsening of existing symptoms or the development of new but expected problems. These require the application of specific plans of care and regular review but not urgent or emergency treatment.

The family/carers experience gradually worsening distress and other difficulties, including social and practical difficulties, as a result of the illness of the person. This requires a planned support program and counselling as necessary.

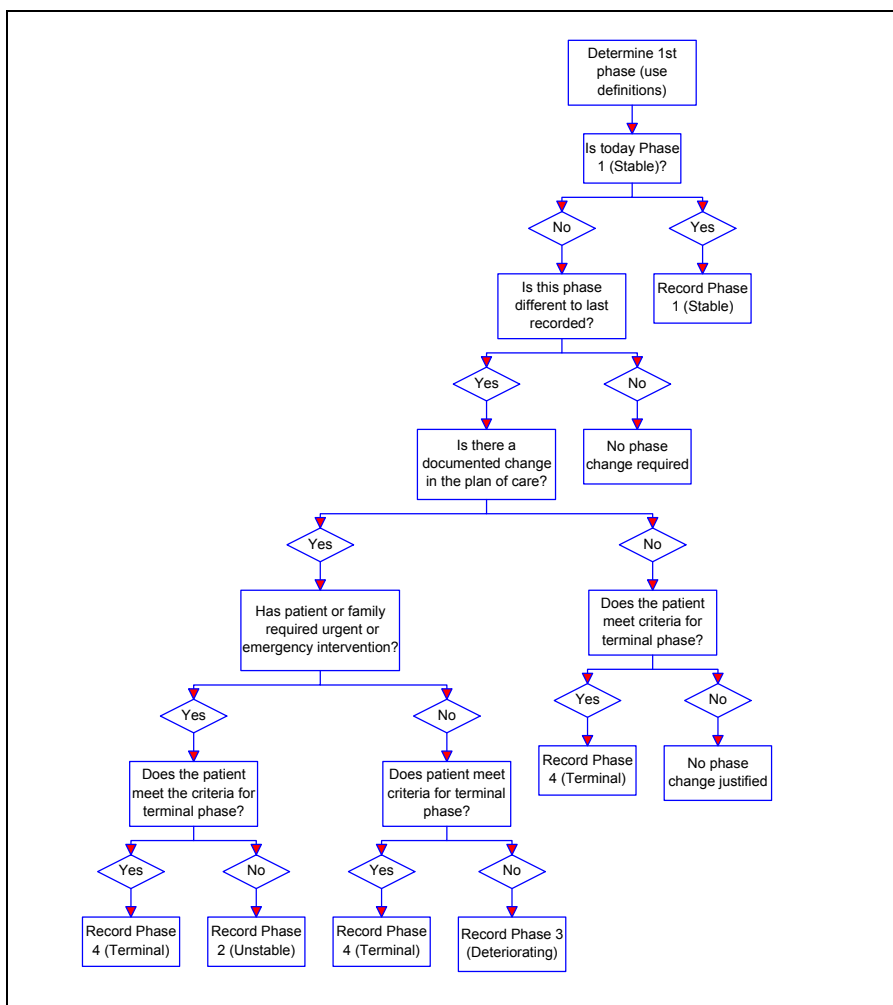
(4) Terminal Care Phase

Death is likely in a matter of days and no acute intervention is planned or required. The typical features of a person in this phase may include the following:

- Profoundly weak
- Essentially bed bound
- Drowsy for extended periods
- Disoriented for time and has a severely limited attention span
- Increasingly disinterested in food and drink
- Finding it difficult to swallow medication
- This requires the use of frequent, usually daily, interventions aimed at physical, emotional and spiritual issues.
- The family/carers recognise that death is imminent and care is focussed on emotional and spiritual issues as a prelude to bereavement

(5) Bereaved Phase

Death of the patient has occurred and the carers are grieving. A planned bereavement support program is available including counselling as necessary.



2

Australian-modified Karnofsky Performance Scale (AKPS)

- 100 Normal, no complaints, no evidence of disease
- 90 Able to carry on normal activity, minor signs or symptoms
- 80 Normal activity with effort, some signs or symptoms of disease
- 70 Cares for self, unable to carry on normal activity or to do active work
- 60 Requires occasional assistance but is able to care for most of own needs
- 50 Requires considerable assistance and frequent medical care
- 40 In bed more than 50% of the time
- 30 Almost completely bedfast
- 20 Totally bedfast and requiring extensive nursing care by professionals and/or family
- 10 Comatose or barely arousable
- 0 Dead

3

Symptom Assessment Scale (SAS) SCORED 0 (NOT AT ALL) TO 10 (WORST POSSIBLE)

- Difficulty sleeping
- Appetite
- Nausea
- Bowels
- Breathing
- Fatigue
- Pain
- Other Symptoms.....

4

Palliative Care Problem Severity Score (PSS) FOR ALL (PC) PROBLEM SEVERITY ITEMS SCORE: 0-absent 1-mild 2-moderate 3-severe

Score each problem group, then add for total score eg:
Pain: 1; Other Symptoms: 2; Psychological/Spiritual: 1; Family/Carer: 3: Total= 7/12

Pain Score	The degree of overall pain symptoms.
Other Symptom Score	Record the degree of overall other symptoms. The following list may be used as a guide: Nausea/vomiting, anorexia, itch/irritation, constipation/diarrhoea, wound/ulcer, dysphagia, incontinence, weakness/fatigue, oedema, dyspnoea, confusion/delirium.
Psychological/Spiritual Score	Record the score for overall degree of psychological/spiritual problems of the patient. The following list may be used as a guide: Anxiety/fear, anger, unrealistic goals, agitation, request to die, depression/sadness, confusion.
Family/Carer Score	Record the score for overall degree of family/carer problems. The following list may be used as a guide: Denial, care giver fatigue, unrealistic goals, anger, difficult communication - non-English speaking-sensory impairment, financial, family/carer conflict, legal, family/carer anxiety, accommodation, cultural.

5

Resource Utilisation Groups- Activities of Daily Living Score (RUG-ADL)

Score for each activity, then add for total score eg:
Bed mobility: 3; Toileting: 4; Transfers: 3; Eating: 1: Total= 11/18

For bed mobility, toileting & transfers:

- 1 Independent or supervision only
- 3 Limited physical assistance
- 4 Other than 2 persons physical assist
- 5 2 person physical assist

For eating:

- 1 Independent or supervision only
- 2 Limited assistance
- 3 Extensive assistance/total dependence/
tube fed

Source: Palliative Care Outcomes Collaboration



Tool 8

Multidisciplinary Case Conference: Summary Sheet

Multidisciplinary Team Meetings

Multidisciplinary Case Conference Summary Sheet

Add RACF name:

Resident DETAILS:

Attach Resident ID sticker

MDT DATE:

Consent has been given by the resident/person responsible and is on file at the facility YES

PRINCIPLE DIAGNOSES	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 ___:___

General Practitioner name:

GP Organises & coordinates a case conference in a RACF

- Item 734 (15 < 30 mins)
 Item 736 (30 < 45 mins)
 Item 738 (>45 mins)

GP Participates in a case conference in RACF

- Item 775 (15 < 30 mins)
 Item 778 (30 < 45 mins)
 Item 779 (>45 mins)



Tool 9

Multidisciplinary Case Conference: Action Plan

Multidisciplinary Team Meetings

MULTIDISCIPLINARY CASE CONFERENCE ACTION PLAN

RESIDENT DETAILS: Attach ID sticker

Reason for Case Conference:

- 1- New Resident
- 2- Hospital discharge
- 3- Increasing falls
- 4- Clinical status change
- 5- ACFI & other

CASE CONFERENCE DATE _____

GOALS OF CARE: _____

RESIDENT ISSUES	ACTION PLAN	TEAM MEMBER RESPONSIBLE	ACTION DATE	REVIEW OF PLAN	REVIEW DATE

Review this action plan at the next MDT. If the resident's issues are not adequately managed consider:

- Scheduling a further case conference involving additional relevant health care providers
- If issues are palliative, refer to Palliative Care MDT (see Referral to Palliative Care Multidisciplinary Team Meeting)

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



Tool 10

Fax Cover Sheet to GP: Summary & Action Plan

Multidisciplinary Team Meetings

Fax Cover Sheet to GP: Summary and Action Plan

Insert Facility logo

FAX MESSAGE

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

Dear Dr ,

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

Included:

- Case conference summary sheet
- Case conference action plan

The original documents will be posted to you.

If not posting original documents please delete above and substitute below.

Please consider these as the original documents.

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

Participate in case conference RACF	Organise & Coordinate Case Conference RACF
<input type="checkbox"/> 775 (15<30 mins)	<input type="checkbox"/> 734(15<30 mins)
<input type="checkbox"/> 778 (30<45 mins)	<input type="checkbox"/> 736(30<45 mins)
<input type="checkbox"/> 779 (>45 mins)	<input type="checkbox"/> 738 (>45 mins)

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

Sincerely,

Insert Name

Multidisciplinary Team Meeting Coordinator

Insert Facility Name

Insert Contact Number



Tool 11

Medicare EPC Items: With Compliments Slip

Multidisciplinary Team Meetings

**Insert facility Logo WITH COMPLIMENTS
Residential Aged Care Multidisciplinary Team Meeting**

Date _____ Patient _____

Dr _____ is entitled to claim for the following EPC item:

Participation in a case conference- Residential Aged Care Facility:

Item 775 (15<30 mins) Item 778 (30<45 mins) Item 779 (>45 mins)

Organise and coordinate case conference- Residential Aged Care Facility

Item 734 (15<30 mins) Item 736 (30<45 mins) Item 738 (>45 mins)

Insert Facility postal address

Phone: _____ Fax: _____ Email: _____

**Insert facility Logo WITH COMPLIMENTS
Residential Aged Care Multidisciplinary Team Meeting**

Date _____ Patient _____

Dr _____ is entitled to claim for the following EPC item:

Participation in a case conference- Residential Aged Care Facility:

Item 775 (15<30 mins) Item 778 (30<45 mins) Item 779 (>45 mins)

Organise and coordinate case conference- Residential Aged Care Facility

Item 734 (15<30 mins) Item 736 (30<45 mins) Item 738 (>45 mins)

Insert Facility postal address

Phone: _____ Fax: _____ Email: _____

**Insert facility Logo WITH COMPLIMENTS
Residential Aged Care Multidisciplinary Team Meeting**

Date _____ Patient _____

Dr _____ is entitled to claim for the following EPC item:

Participation in a case conference- Residential Aged Care Facility:

Item 775 (15<30 mins) Item 778 (30<45 mins) Item 779 (>45 mins)

Organise and coordinate case conference- Residential Aged Care Facility

Item 734 (15<30 mins) Item 736 (30<45 mins) Item 738 (>45 mins)

Insert Facility postal address

Phone: _____ Fax: _____ Email: _____



Tool 12

Monthly Outcomes Summary

Multidisciplinary Team Meetings

MONTHLY Outcomes Summary
Residential Aged Care Facility Multidisciplinary Team Meeting

RACF: _____

Month: _____

Date	Attendance Record numbers for each discipline			EPC Number for each item		MDT Criteria Number for each criteria		Outcomes			Review of previous MDT plans		
	GP	RN	EEN/EN/AIN	PC Link Nurse	Specialist Nurse	ACAT	Allied Health	Resident	Family	Other		CMA	RMMR
	GP	RN	EEN/EN/AIN	PC Link Nurse	Specialist Nurse	775		1- new					
						778		2- hosp d/c					
						779		3- increased falls					
						other		4- status change					
								5- ACFI/other					
	GP	RN	EEN/EN/AIN	PC Link Nurse	Specialist Nurse	775		1- new					
						778		2- hosp d/c					
						779		3- increased falls					
						other		4- status change					
								5- ACFI/other					
TOTAL	GP		ACAT			775		1- new					
	RN		Allied Health			778		2-hosp d/c					
	EEN/EN/AIN		Resident			779		3- increased falls					
	PC Link Nurse		Family			other		4-status change					
	Specialist Nurse		Other					5-ACFI/other					

Action Learning:

Learning that occurred during the MDT	Learning Needs



Tool 13

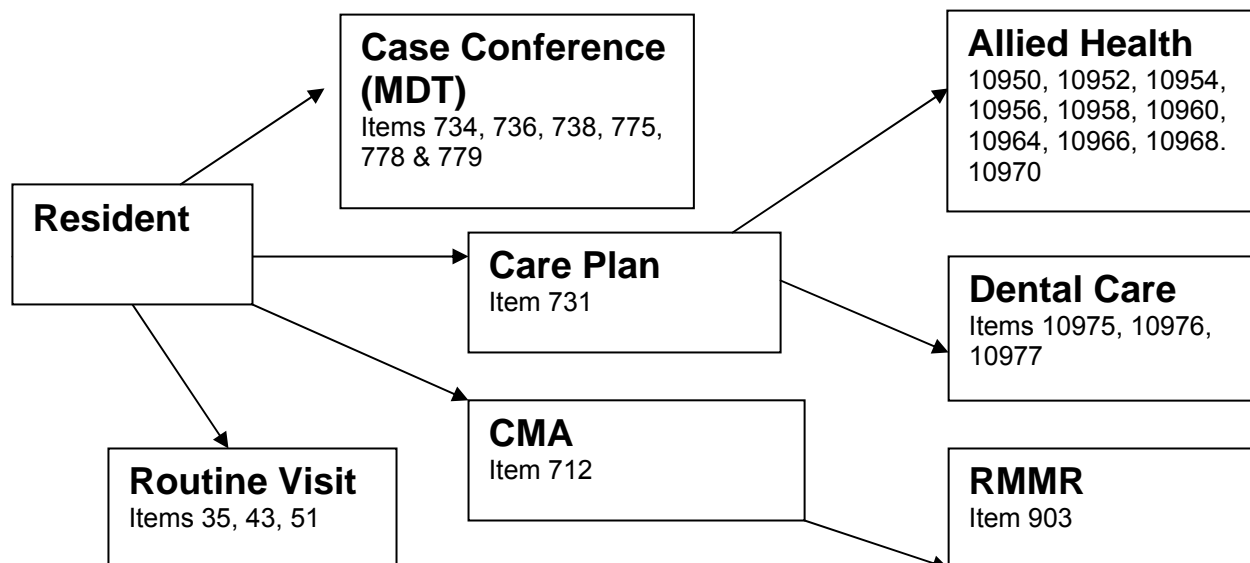
GP Reference Information Sheet: Medicare EPC Items

Multidisciplinary Team Meetings

GP REFERENCE INFORMATION SHEET

Implementation of Enhanced Primary Care in Residential Aged Care Facilities

(Insert Facility name)



Resident: Permanent residents in an aged care facility with chronic/complex care needs, admission to RACF or change in resident medical status (**RACF**).

Routine Visit: Items 35, 43 and 51, routine resident medical care, GP consultation at a RACF (**GP**).

Case Conference (MDT): Multidisciplinary Team meeting, items 734, 736, 738, 775, 778 & 779, either face-to-face or telephone (at least 15 mins), GP organizes and coordinates, or participates in MDT care planning forum. Requires at least 2 other contributing members each providing a different kind of service. Record of forum must be kept and copy offered to resident/person responsible (**GP, RACF, 2 or more other health professionals**).

CMA: Comprehensive Medical Assessment, item 712, within 6 weeks of admission or as required (eg post hospitalisation), usually conducted once every 12 months. Can be completed over one or more visits. Patient/person responsible consent required. Provide CMA summary report to RACF medical file and resident. Report to include, list of principal diagnoses/problems, allergies and drug intolerance, current medication, issues for medication management review, other services/treatment required, immediate action required (**GP, RACF**).

Care Plan: Item 731, at the request of the RACF, the GP contributes to a care plan prepared by the RACF (**RACF, GP**).

Allied Health: Items 10950, 10952, 10954, 10956, 10958, 10960, 10964, 10966, 10968 and 10970. Identify provider(s) who best suits resident's specific needs. Ensure provider is registered with HIC/ Medicare Australia. Residents eligible for up to 5 services per year (**GP, various Allied Health Professionals**).

Dental Care: Items 10975, 10976, 10977. Identify provider(s) who best suits resident's specific needs. Ensure provider is registered with HIC/ Medicare Australia. Residents eligible for up to 3 services per year (**GP/Dentist/Dental Therapist**).

RMMR: Residential Medication Management Review, item 903, can be linked to CMA, new residents on admission or existing residents eg change in condition, discharge from hospital, significant medication changes. GP assess resident need for review, gain consent. Refer to pharmacist. Review pharmacist report and discuss with pharmacist, Prepare medication management plan. Copy to resident's medical file (**GP/Pharmacist**).

Checking who has a Care Plan?

MEDICARE PROVIDER ENQUIRY LINE: 132 150 (GPs)

MEDICARE ENQUIRY LINE: 132

011(for patients)

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