Palliative Care Multi-disciplinary Meetings

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, personal preferences of the patient and 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 multi-disciplinary approach to care helps to enhance the patients quality of life, ensures that decisions are based on evidence based practice, and enhances a clinicians mental well-being [1]. The principles for multi-disciplinary care emphasis 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
- **Establishments 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 multi-disciplinary 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 each individual patient's and families needs.

OBJECTIVES

- To establish a multidisciplinary team comprising of core disciplines that meets on a regular basis to develop a palliative care plan for individual patient's 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 ensure that the patient's GP and other health care specialists have an opportunity to be formally involved in the development of the patient's palliative care plan
- To provide multidisciplinary team members with an opportunity for enhanced palliative care educational opportunities.

POTENTIAL MULTI-DISCIPLINARY PALLIATIVE CARE MEMBERS:

- Aboriginal Health Staff
- Aged Care Assessment Team
- ACTIP Staff
- Baringa Private Hospital
- Bellinger River District Hospital
- Breast Care Nurse
- CHHC Social Workers
- Chaplain
- Community Dietician
- Community Care Agencies
- Community Occupational Therapist
- Community Physiotherapist
- Discharge Planners
- Dorrigo Multipurpose Centre
- DVA Nurses
- General Practitioners
- Haematologist
- Link Nurses
- Medical Oncologist
- Medical Students
- Nursing Students
- Oncology Staff
- Palliative Care CNC
- Palliative Care Community Nurses
- Palliative Care Physician
- Palliative Care Social Worker
- Palliative Care Network Coordinator
- Palliative Care Volunteer Coordinator
- Palliative Care Volunteers
- Radiation Oncologist
- Residential Aged Care Facility Staff
- Visiting Medical Officers
- CHHC Ward staff
- Other providers as relevant to patient/resident

ATTENDANCE

All health care providers involved in the provision of care to palliative care patients are actively encouraged to attend this meeting on a regular basis. As this meeting presents an ideal opportunity for participants to develop their palliative care knowledge and confidence every endeavour will be made to capitalise on educational opportunities that arise during this forum.

All participants will sign an attendance record at the commencement of each meeting (Appendix 1)

CONFIDENTIALITY

All attendees who are not current employees of the North Coast Area Health Service will sign a Confidentiality Agreement which will be kept on record.

CONDUCT OF PARTICIPANTS

All participants will adhere to the NSW Health Code of Conduct.

VENUE

Coffs Harbour Health Campus, Cancer Services Tutorial Room No. 010

TIME

Every Tuesday from 0800 to 0900.
Once per month 0800-0930 to accommodate education.

PATIENTS TO BE DISCUSSED

- All new referrals are to be discussed ideally within a four weeks of admission to the service. Some cases will only require brief discussion while others will require a more detailed review
- All patients with a Karnofsky score declining from 70-60 are to be discussed at the next weekly multidisciplinary care meeting
- All patients who have a change in their clinical status (physical, psychological, social or spiritual) and require the input and expertise of a multidisciplinary team

- Patients admitted to hospital should be considered for discussion routinely.
- Review discussions will occur routinely at 1 and 4 weeks to reassess effectiveness of the implementation of planned care. Review may be deferred if follow up information or relevant provider unavailable.

PATIENT CONSENT

All patients/residents who are discussed need to have documented consent to their care being discussed at a multidisciplinary team meeting.
Refer to NCAHS Multidisciplinary Meeting procedure.

NOTIFICATION OF TEAM MEMBERS

It is responsibility of the health care provider scheduling the patient for discussion (admission, re-presentation or review) at the multidisciplinary care meeting to notify (ideally 1 week in advance) the Palliative Care Network Coordinator of:

- Preferred date
- Patient name
- Provider presenting case
- Relevant health care professionals whose input into the multidisciplinary care meeting would ensure that the patient and their family receive optimal palliative care (GP, Oncology, ACAT, dietician, speech therapy, OT, physio etc

It is the responsibility of the Palliative Care Network Coordinator to:

- Confirm time and date patient booked for discussion
- Inform relevant health care providers of the scheduled time for the patients care to be discussed. Encourage input either via phone or in person. Obtain the contact phone number of all the relevant health care providers, in case they are unable to attend in person and wish to phone in.
- Provide the Palliative Care Team and the chairperson with a multidisciplinary meeting schedule prior to the meeting.

MEETING COORDINATION AND DOCUMENTATION

The Palliative Care Network Coordinator will:

- Facilitate identification of patients for discussion by:
    - Contacting the Palliative Care Link Nurses weekly
    - Collect the Multidisciplinary care meeting patient schedule list from the Palliative Care Office on the Monday morning prior to the meeting.

- Document the outcomes of the case meeting discussions into the Palliative Care Information Clinical Information System (PalCIS)
    - File a copy into the front of the Palliative Care section of the patient's CHHC medical records.
    - Generate a letter with an EPC item number (if indicated). Fax a copy of the letter on the same day, after confirming the fax number and ensuring the fax is situated in a secure location, post the original
    - Send a copy of the letter to other relevant health care providers, in envelope marked confidential

The Palliative Care Team will:

- Document the outcomes of the case meeting review discussions into the Palliative Care Information Clinical Information System (PalCIS), for patients of the Palliative Care Team.
- Print a copy of review discussion's notes for the patient file.

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 meeting will be chairperson role will be shared by the Hospital Chaplain and the Palliative Care Social Worker.

Roles of the Chair:

- Ensure all participants introduced
- Use of teleconference phone when indicated
- 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[1p. 26]

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 of regular presentations by team participants as a forum for providing feedback from conferences, disseminating current information relevant to Palliative Care issues and education specific to provider specialties.

OUTCOMES

Monthly statistical collection by Palliative Care Network Coordinator (until 2009), to include:
Number of new referrals

- Number of patients discussed
- Number of patients reviewed
- Service origin of patient's discussed
- Number of attendees
- Differentiation of providers attending
- Number of EPC items

An ongoing review of satisfaction and effectiveness will be conducted informally at the end of meetings as deemed relevant
Formal evaluation will be conducted and results communicated to the participants each 6 months

REFERENCE LIST

1. National Breast Cancer Centre, *Multidisciplinary meetings for cancer care: a guide for health service providers*, T.N.B.C. Centre, Editor. 2005.

APPENDIX

1. Attendance record

NORTH COAST
AREA HEALTH SERVICE
NSW HEALTH

MID NORTH COAST
DIVISION OF GENERAL PRACTICE

PALLIATIVE CARE MULTI-DISCIPLINARY MEETING
ATTENDANCE LIST

DATE: _____ TIME: From 8 to 9.30am

The North Coast Area Health Service and Mid North Coast Division of General Practice 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 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 with staff involved in their care in order to determine the best treatment for them and to assist in the management of the health services provided to them.

NAME	SIGNATURE	ORGANISATION
	Via teleconference	
	Via teleconference	
	Via teleconference	