



Rural Palliative Care Project

Interdisciplinary Team Meetings

Terms of Reference

AIMS:

- To establish a process to ensure that people referred to the MNC Rural Palliative Care Interdisciplinary Team have access to coordinated care that is provided in accordance with best evidence based palliative care practice.

Objectives

- To establish a single point of referral for palliative care patients and to plan and coordinate care for new admissions to Palliative Care Community Service, Medical Ward and Residential Aged Care Facilities
- To establish an interdisciplinary palliative care team, that includes all those providers involved in the provision of palliative care in Coffs Harbour and Bellingen Local Government Areas.
- To establish a weekly Interdisciplinary MNC Rural Palliative Care Team meeting.
- To ensure that all General Practitioners receive formal notification that their patient has been referred to the MNC Rural Palliative Care Team (Appendix 1).
- To ensure that all patients referred to the MNC Rural Palliative Care Team receive palliative care in accordance with evidence based practice and have:
 - given written consented to be involved in the project
 - been allocated a project number and URN
 - been allocated a primary case manager
 - an individual care plan developed by the interdisciplinary team following their admission that addresses their physical; psycho/social, and spiritual/cultural needs.
 - their care plan reviewed by the interdisciplinary team when they experience a phase change, in accordance with AN-SNAP classifications (unstable; deteriorating; terminal; or bereaved)



ABN: 37 062 388 130

Rural Palliative Care Project

TEAM MEMBERS:

- Aged Care Assessment Team
- ACTIP Staff
- Baringa Private Hospital NUM and/or RN's
- Bellinger River District Hospital RN's
- Breast Care Nurse
- CHHC Social Workers
- Clinical Oncologist
- Community Dietician
- Community Occupational Therapist
- Community Physiotherapist
- Discharge Planners
- Dorrigo Multipurpose Centre RN's
- DVA Nurse Coordinator
- General Practitioners
- Medical Oncologist
- Oncology CMO
- Oncology CNC
- Palliative Care CNC
- Palliative Care Community nurses
- Palliative Care Physician
- Palliative Care Social Worker
- Project Coordinator & Research Assistant
- Residential Aged Care Facility Staff

VENUE:

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

TIME:

Every Tuesday from 0800 to 0930

NOTIFICATION OF TEAM MEMBERS:

- All new referrals and patients who have experienced a phase change are to be discussed at the weekly inter-disciplinary team meeting. *No stable patients will be discussed*
- The patient's Case Manager will:
 - Contact the MNC Division General Practice Staff on 66515 774 to arrange a time for the patient to be discussed at the weekly team meeting by 5pm on the Monday prior to the meeting.
 - Notifying other health care providers involved in the patient's care of the scheduled time for discussion at the team meeting, including the patient's General Practitioner.
 - Be required to obtain the contact phone number of the patient's General Practitioner and other health care providers, if they are unable to attend in person.

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DOCUMENTATION:

- A summary of all interdisciplinary team meeting discussions is to be entered into the medical records of relevant MNC Rural Palliative Care Patients, clearly stating the following:
 - MNC Rural Palliative Care Interdisciplinary Team Meeting
 - Date and time of meeting

FACILITATION

Project Co-ordinator

OUTCOMES

- Number of new referrals
- Number of patients discussed
- Number of attendees
- Composition of meeting attendances
- Number of EPC items
- Health Care provider satisfaction survey