MDT
TERMS OF REFERENCE

1. Background

Given the increasing complexity of residents' care needs, a multidisciplinary team approach to care and treatment may benefit selected cases. 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 care and treatment options of the resident and collaboratively develop an individual care plan that best meets the needs and preferences of the resident and their family (Australian Government Department of Health and Ageing 2004). There is compelling evidence to suggest that a multidisciplinary approach to care helps to enhance the resident's quality of life by addressing the problems that are of most concern to the resident, reduces ambiguity around treatment and goals of care, and ensures that care decisions are based on evidence-based practice (Australian Breast Cancer Centre 2005).

A regular multidisciplinary team meeting is a forum for coordinating a multidisciplinary approach to care. Discussion may be held in person or using technology or a combination, depending on the availability of MDT members and COVID status.

2. Purpose

To facilitate an integrated, holistic and coordinated approach to the care of residents in accordance with the needs of the individual resident and their family/whānau, thus improving outcomes. It is recognised that some residents may require more input than others.

3. Aims

- To gain a good understanding of a resident's holistic needs and the overall direction of care that is required and desired by the resident and their family
- To ensure that all team members have the opportunity for formal involvement in care planning for individual residents.
- To optimise communication between all health professionals involved in a resident's care or whose involvement would benefit the resident, thus improving the efficiency and effectiveness of care.
- To provide a forum for discussion of residents whose needs are complex to optimise the process of decision-making, planning and evaluation of care in line with best evidence-based practice

4. Residents to be discussed

All residents who would benefit from having a multidisciplinary review and meet one or more of the following criteria:

- Two or more disciplines over and above nursing and GP are involved in the resident's care.
- They are a hospice patient and/ or have symptoms that are challenging for staff to manage.
- The resident requires multidisciplinary input for complex decision-making
- The resident raises a "red flag."
- There is a new presentation of responsive behaviours where staff cannot identify and/or meet underlying needs.
- To better understand increased falls.
- To better understand increased confusion.
- A family/whānau member has concerns, particularly about the care plan in place.

All residents who have transferred to or returned from the public hospital since the last meeting may be added to the agenda with the following information:

- Reason for transfer to hospital
- Diagnosis /condition before admission and on discharge
- Plan of care/follow-up

A more detailed discussion will only occur if they fit the above criteria.

5. Membership

Attendance at each meeting may include:

- Manager (Chair)
- Clinical Coordinator/manager
- ARC RN's
- Physiotherapist
- Palliative care team member
- Gerontology Nurse or HOP team member
- Mental Health Service for Older People

Case-by-case invitations to the meeting or to share information as required:

- Diversional Therapist
- Pharmacist
- Dietician
- GP
- Speech Language Therapist
- Wound Care Specialist
- Needs Assessors / social worker
- Counsellor
- Chaplain
- Geriatrician
- Hospice Community Nurse

- Community Services, Age Concern
- Director of Older Persons Services
- Cultural Advisor, Iwi member. or Kaumatua
- Inter-organisation Managers / Clinicians

6. Venue and time

- Venue: Specify a meeting room large enough to take 6 – 12 people.
- Time: Set aside a specific date / time each fortnight (e.g. Every second Wednesday at 0900hrs until 1000hrs).

7 Approach

- Meetings will be kept to one hour to avoid becoming onerous.
- Meetings will discuss residents discussed at the previous meeting or due for review unless the group feels it is no longer needed.
- Meetings will typically discuss one or two new presentations per meeting.
- The staff member presenting the new resident for discussion must attend the meeting with all the preparations completed.
- Matters that do not directly relate to the clinical discussion of scheduled individual residents will not be discussed at this meeting.

8 Notification

- Team members wishing to schedule a new resident for discussion at the meeting will notify the meeting coordinator by 5 p.m. two days before the MDT review meeting.
- The meeting coordinator will disseminate the meeting agenda by noon the next day.
- It is the responsibility of the team member scheduling the resident for discussion to contact all relevant health professionals to invite comments or request attendance at the meeting.

9 Roles

The MDT Coordinator (ARC staff) will

- Identify any residents who meet the MDT review criteria not already scheduled by another team member.
- Remind referrers to contact the relevant health professionals to invite comments or attendance.

The minute taker will

- document the names of all residents discussed and who scheduled the resident for discussion
- document other issues that arise that do not meet the criteria for this meeting but which may need to be addressed elsewhere.

The meeting Chair will

- Make introductions as necessary
- Facilitate participation of all team members in discussions
- Summarise the discussion before moving to the next case
- Negotiate resolution of conflict if necessary
- Ensure agenda and timings are adhered to

The referring clinician will

- Prepare information for the meeting as guided by the first page of the MDT summary form and refer to the checklist.
- Provide a brief overview of the resident's general condition, identified met or unmet needs, the health professionals involved, and relevant assessments.
- Identify the reason for referral and the decision that needs to be made
- Summarise the current plan of care and interventions to date

The MDT coordinator OR referring clinician [specify which] will:

- Document a summary of the discussion of each resident on the MDT meeting template and refer for action
- Ensure the MDT summary of each resident is placed in the resident's clinical file.
- Ensure a copy of the MDT summary is sent to the resident's GP and any other involved health professional as appropriate.

10 Review

Review of process and perceived outcomes

- A review discussion will be held three months after the inception of the MDT meetings and then annually. This will include consideration of facilitators and barriers to smooth flow.
- Adjustments to the process can be made as needed.

Documentation of outcomes

The ARC team may collect data to help evaluate the MDT Review benefits. This information can be used in ARC quality processes. This may include:

- Place of Death
- Use of Te Ara Whakapiri (End of Life) care plans.
- Whether the identified advice was followed and to what outcome.
- The number of ED presentations and transfers out of ARC to Public Hospital.
- The number of after-hours or unplanned calls and visits from Primary Care or other teams such as palliative care, CNSs, Allied Health, etc.