Te Whatu Ora
Health New Zealand

NEW ZEALAND
DEMENTIA
FOUNDATION

MULTI-SERVICE MULTIDISCIPLINARY TEAM REVIEWS

Three tools to support end-of-life care for aged care residents living with dementia mate wareware

E TORU NGA TAPTAPU, THREE TOOLS. #2

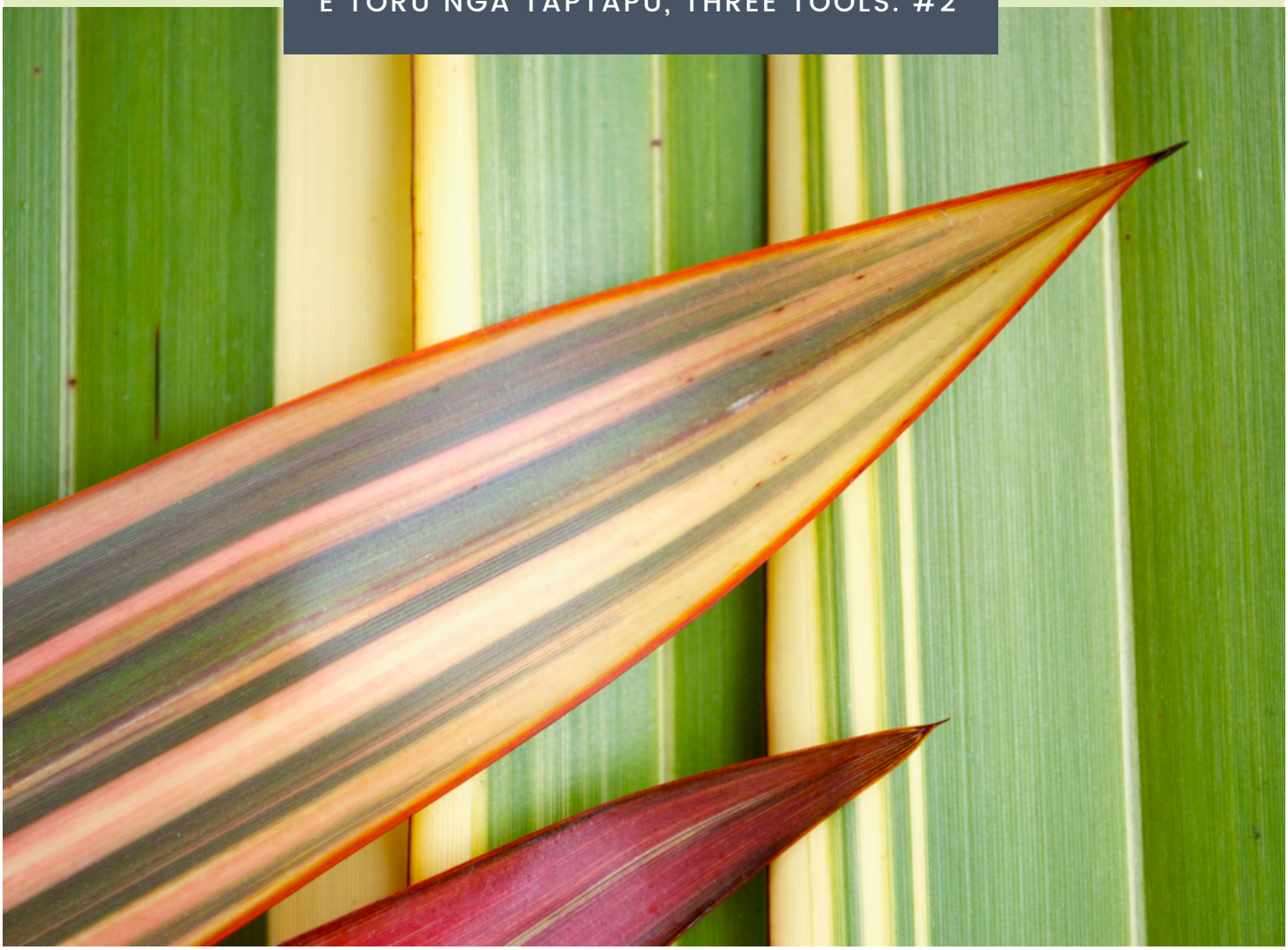


TABLE OF CONTENTS

3. Introduction to three tools

5. Multi-service MDT reviews: What are they and why are they important?

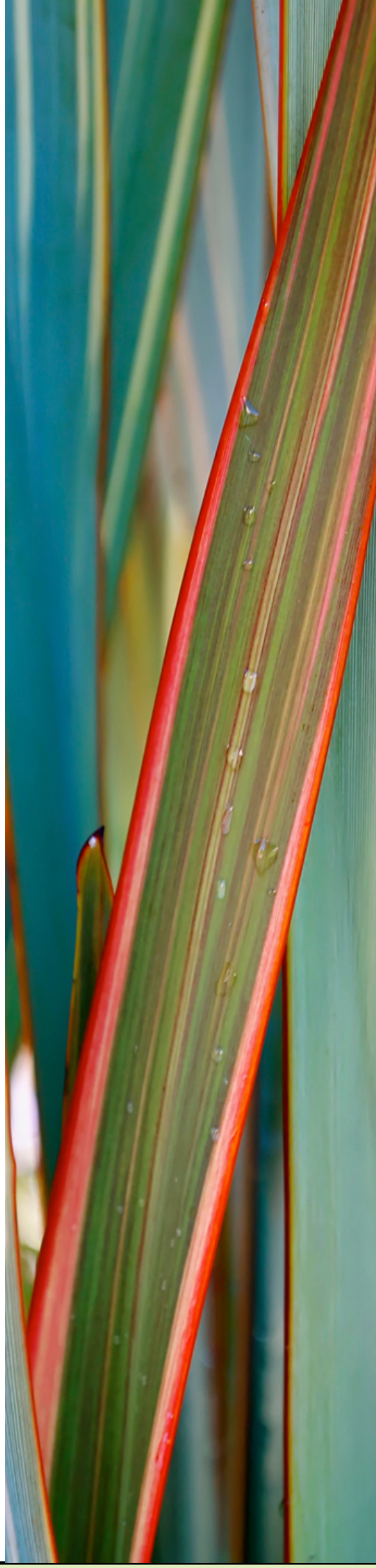
6. Multi-service MDT Agenga

8. Multi-service MDT Terms of Reference

11. Principles for supporting tangata whenua

12. References and acknowledgements

KA MAHI TAHI MĀTOU, KIA OHOKA TE PITOMATA HAI PUANANĪ.
WE WILL WORK TOGETHER IN ORDER TO AWAKEN POTENTIAL TO FREELY TRAVEL IN ANY CHOSEN DIRECTION.





We started the Dementia End of Life Project by listening. We engaged with staff across aged residential care, Māori health, home care, health, mental health, and palliative care in surveys, focus groups, and working groups.

We heard about three key challenges for best practice end-of-life care for aged residential care residents with dementia :

- residents often enter the facility without any prior advanced care planning.
- coordination amongst services, including primary care, can sometimes be difficult
- teams sometimes lack confidence in developing and implementing individual end-of-life care plans.

The project identified three existing evidence-based tools that, when used routinely, can help address these challenges and support high-quality, person-centred end-of-life and palliative care for our residents living with dementia. In short, three tools that every aged residential care facility should know about!

In these *E nga toru nga tapu tapu / Three tools* booklets we introduce each of the three tools in the context of dementia and aged residential care. The tools support community teams (Gerontology, Mental Health Services Older People, Palliative Care, Primary Care etc) to be involved and work jointly. In this way, the tools and workbooks are for providers across the continuum. We also provide easy access to the tools through a webpage hub

www.nzdementia.org/3tools

Thank you for your commitment to meeting the unique end-of-life care needs of people living with dementia. We warmly encourage you to find out more and embed any of the tools you are not already using regularly.

Jane Large

Project Leader
Dementia End of Life Project

E TORU NGA TAPUTAPU: THREE TOOLS TO SUPPORT END OF LIFE CARE FOR PEOPLE LIVING WITH DEMENTIA IN AGED RESIDENTIAL CARE

Find out more at www.nzdementia.org/3tools



Talk.

Shared goals of care conversations

1

When: as early as possible in the disease progression
Goal: early discussion around care planning

The diagnosis of dementia activates a partnership throughout the person's time in the facility. It supports the resident and family/whānau to express what is important to them and their preferred achievable goals for care, before times of crisis. It can help us to understand, document, and respect what is important to them.

Teamwork.

Multi-service team meetings

2

When: Periods of instability in the disease progression
Goal: Collaborating and communicating across services

Multi-service planning is activated in response to unstable or complex changes. All relevant teams review the case to facilitate an integrated, holistic approach to the residents' care. This coordinated collaborative approach can efficiently enable access to consultation and expert advice across services so that complex issues are considered jointly.

Te Ara Whakapiri.

Guide for last days of life

3

When: the last days of life
Goal: An individual plan of care that address physical, mental, social, cultural and spiritual issues

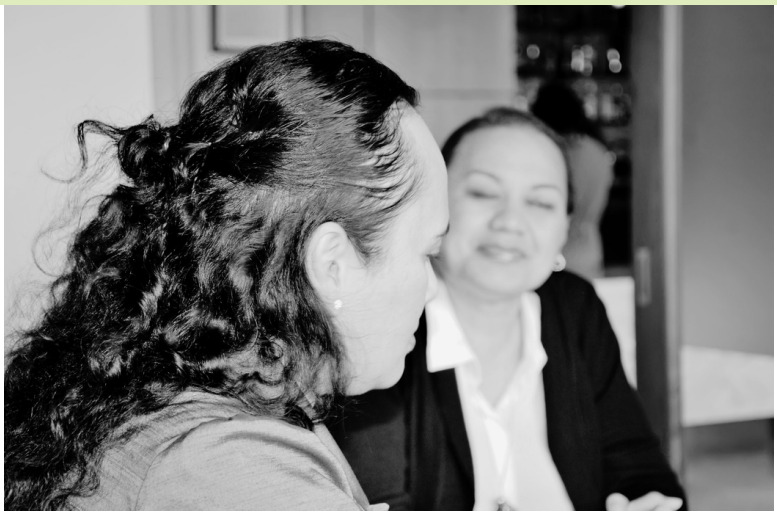
Te Ara Whakapiri is activated when a person is identified as actively dying. Te Ara Whakapiri provides a structure to build an individualised care plan and offers tools and resources for best-practice end-of-life care. It can help us ensure good quality end-of-life care and a dignified death that respects what is important to the person and their family/whānau. It includes supporting the family/whanau during and after the death.

Te Whatu Ora Health New Zealand

NEW ZEALAND DEMENTIA FOUNDATION

MULTI-SERVICE MULTIDISCIPLINARY TEAM REVIEWS: WHAT ARE THEY AND AND WHY ARE THEY IMPORTANT?

Multi-service multidisciplinary teams (Multi-service MDTs) are especially suitable for people with complex needs and long term-conditions, who benefit most from a holistic provision of care.



Multi-service MDTs are a way to organise and coordinate best practice integrated care for residents with complex care needs, including people living with dementia mate wareware approaching the end of life. The Multi-service MDT brings together the expertise and skills of different healthcare professionals to assess and plan care jointly.

Multi-service multidisciplinary team members may work in:

- Health of Older People (Te Whatu Ora Geriatric Medicine teams / ATR teams)
- Mental Health Services for Older People (Te Whatu Ora Psychogeriatric teams)
- Palliative Care
- Māori Health
- Hospital Liaison
- Age Residential Care
- Primary Care

This booklet provides some practical advice and resources to help you get started. We acknowledge Carla Arkless NP, Margaret O'Connor NP, and the teams in Invercargill who began this journey in 2013 and have developed much of this material.

POTENTIAL BENEFITS FOR RESIDENT CARE AND OUTCOMES:

- development of agreed treatment plans
- a greater likelihood of meeting clinical best practice guidelines.
- a proactive rather than reactive approach
- reduced emotional toll of preventable hospital admissions

POTENTIAL BENEFITS FOR WHANAU:

- greater psychosocial support and reassurance
- improved satisfaction with treatment and care
- increased access to information

POTENTIAL BENEFITS FOR STAFF AND SERVICES:

- Less duplication of services
- Educational opportunities for health professionals
- Facilities feel more supported
- Potentially reduced hospital admissions, ED visits, readmissions, and unplanned health professional callouts
- Increased skill and confidence in asessment and critical thinking
- Developing relationships across services



Multi-service MDTs have been successfully trialed in Invercargill to support ARC facilities with residents who had complex issues. The pilot proved beneficial and has continued. Here are some tips from their experience.

There are two ways in which the MDT team meeting may be initiated:

- District and community teams may identify ARC facilities that need frequent support or have several complex and high-risk residents.
- ARC facility may identify residents and families/whānau with complex needs that would benefit from a multi-disciplinary team review.

In both instances, contact should be made between the ARC facility and the MDT team members most appropriate to join the meeting.

Coordinating the day, place, and time can be difficult. It becomes easier once attendees can see how much work can be done in a meeting to optimize residents' care, reducing the number of visits needed later.

Don't give up because of COVID situations; virtual meetings can still work.

The key is to be organized, stick to time and co-ordinate:

- the residents for discussion
- invites to the meeting
- the Chair of the meeting
- who will present each patient with the supporting information
- who will document the key points and actions

The person who documents the key points should have a clinical background to maintain the clinical context. Visiting health professionals may also make separate progress notes of recommendations they contribute to.

ON THE FOLLOWING PAGES WE PROVIDE SOME SAMPLE DOCUMENTS:

- ◯ **Agenda**
- ◯ **Record of key points of discussion**
- ◯ **Terms of reference**

Fillable versions of these forms are available on the Three Tools hub webpage: www.nzdementia.org/3tools

MDT AGENDA

Date:

Venue:

HOUSE KEEPING

Attending:

1. **Apologies:**

2. Minutes:

MATTERS ARISING

3. Residents for follow-up discussion from previous meeting

Name. NHI		**Presenter:**	
Name, NHI		**Presenter:**	
Name, NHI		**Presenter:**	
Name, NHI		**Presenter:**	

NEW DISCUSSION

4. Residents for new MDT discussion

Name. NHI		**Presenter:**	
Name, NHI		**Presenter:**	
Name, NHI		**Presenter:**	

5. Hospital presentations

Name. NHI		**Presenter:**	
Name, NHI		**Presenter:**	
Name, NHI		**Presenter:**	

6. Deaths / discharges

Name. NHI		**Presenter:**	
Name, NHI		**Presenter:**	
Name, NHI		**Presenter:**	

OTHER

7. Other business

Item	
Item	

MDT **SUMMARY**

DATE

RESIDENT

Full Name	
NHI	
DOB	

ROLES

Presenter:	
Notes by:	

OVERVIEW OF RELEVANT HISTORY

WHY REFERRED

CARE TO DATE

WHAT WAS DISCUSSED?

WHAT WAS DECIDED?

CHECKLIST FOR DISCUSSION

- [ ] General condition
- [ ] Services / professionals involved
- [ ] Met / unmet needs
- [ ] Urine/output
- [ ] Labs of note
- [ ] Radiology – CT scan etc
- [ ] Food and fluid
- [ ] Weight trend
- [ ] Vitals
- [ ] Past medical history
- [ ] Dental
- [ ] Pain and analgesia
- [ ] Mobility
- [ ] Responsive behaviours
- [ ] Medications review, changes
- [ ] Important people, culture, values
- [ ] Is EPOA activated, on file
- [ ] Advance Care Planning
- [ ] Shared goals of care, DNR

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.



PRINCIPLES FOR SUPPORTING TANGATA WHENUA

Titiro, whakarongo, kōrero means to look and listen and then to speak. It's important to look and listen to develop understanding of people and their whānau realities, priorities and aspirations.[4]

Whanaungatanga

This refers to the building and maintenance of relationships. Take time to build a relationship with whānau. By having this, you then have a connection which will make care delivery easier.{5]

Mōhiotanga

Good communication is essential.[5]

Aroha

Aroha means love but it also means respect. This concept is about planning and being seen to put the needs of the person and whānau first.[5]

Manaakitanga

Manaakitanga describes sharing, hosting and being generous [4]. Responsive care and support is key. We seek to do the best for the person living with dementia and their whānau. If there are limits to what we can deliver then work with whānau to engage other services (e.g., expertise to communicate in Te Reo, to interpret possible cultural manifestations of illness, or to navigate protocol). [5]

Kaitiatanga

This is about leadership and mutual respect. Professional health services are respected for their expertise within their tikanga. They are expected to know best how to support and manage what is happening from their perspective. However, this will be done in partnership with the person living with dementia and their whānau. [4]

Rangatiratanga

Whānau need to feel they have an appropriate level of control, so the service needs to demonstrate that it can work respectfully with whānau to get the best outcomes in a culturally safe way. All important clinical or non-clinical decisions should ideally be made with whānau. This reduces any tensions or stresses that may arise.[5]

Kotahitanga

A joint vision of care with whānau will improve the planning and delivery of services. It also means each person and their whānau are seen as unique and are being valued as such.[5]

Arotakenga

This means ensuring care plans and wider performance are reviewed so that there is ongoing improvement and that the focus on meeting the needs of Māori living with dementia and their whānau is continuously maintained.

REFERENCES AND ACKNOWLEDGEMENTS

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