



Jersey Hospice Care

MDT operational policy

Ratified 28th April 2016

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Quick reference guide

This abbreviated version of the MDT operational policy is provided as a quick reference only. The blue types are hyperlinks to the full details of that section within the policy. Please be aware that it is the responsibility of each individual to be informed and compliant with the full policy.

- i. The [Multidisciplinary Team Meeting](#) (MDT) utilises a holistic approach in the care of individual patients.
- ii. This policy defines the [core disciplines of the MDT](#) to facilitate collaborative care planning for people with a life limiting illness to ensure effective delivery of evidence-based palliative care.
- iii. There is a [core membership](#) of the MDT who are expected to attend and invitations are extended to relevant key healthcare professionals.
- iv. The [quorum](#) for an MDT is four attendees one of whom should be either the Associate Specialist or a Clinical Nurse Specialist or a Team Leader.
- v. [Confidentiality](#) is maintained in line with the Data Protection (Jersey) Law, a contract of employment or an agreement/signature.
- vi. Written [consent](#) from the patient for MDT discussion is not necessary. However, implied or oral consent is required.
- vii. Each member of the MDT has a [role to play](#) in ensuring the effectiveness of the meeting. Roles are clearly articulated to ensure that all members are aware of their responsibilities and that tasks are carried out in the manner endorsed by the meeting members.
- viii. JHC expects the [highest standard of behaviour](#) from its staff and for all staff to be aware of how their behaviour can affect others.
- ix. The [meeting venue](#) is JHC in the conference room.
- x. [Meetings are weekly](#) – including following a Bank Holiday.
- xi. Individual patient/carer issues, needs, goals and action plans are the priority of the MDT. In identifying “complexity” or “cause for concern” needs, [use of evidence based clinical indicators are considered](#).
- xii. Multidisciplinary team meetings provide opportunities for the [sharing of expertise](#) however, if no cases are scheduled a “case study” for educational purposes may be provided.

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1 Introduction

- a. A team approach to care is one of the key elements of effective palliative care service delivery. Multidisciplinary care involves appropriately utilising knowledge, skills and best practice from multiple disciplines and reach solutions based on a new understanding of a complex situation (NHS, 2014).
- a. The Multidisciplinary Team Meeting (MDT) utilises a holistic approach in the care of individual patients. To support this, an MDT should take account of the patient's views, preferences and circumstances wherever possible when considering their advice on the care that is most appropriate for the patient's condition.
- b. An MDT makes recommendations rather than decisions. These recommendations can only be as good as the information available to the MDT at the meeting. The final decision on the way forward needs to be made by the patient in discussion with their clinician. MDTs should be alerted if there are significant changes to their recommendations and the reason for this so they have the opportunity to review and learn from these cases.
- c. Recommendations/outcomes should be revisited, to ensure they have been effectively addressed.

2 Aims and scope

- a. To detail how the MDT will operate.
- b. To establish an MDT comprising core disciplines as identified, that meets on a weekly basis, to facilitate collaborative care planning for people with a life limiting illness to ensure effective delivery of evidence-based palliative care in accordance with the needs of each individual patient and family.
- c. To provide MDT members with an opportunity for enhanced palliative care education by action learning principles, when expertise is shared between providers at the meeting.

3 Target audience

This policy is applicable to relevant clinical and non-clinical staff who are either directly or indirectly involved with the purpose, formation and contribution of MDT's.

4 Core Membership and attendees

Membership consists of:

4.1 Core membership

- i. Member of medical team
- ii. Clinical Nurse Specialists -SPCT
- iii. Specialist Palliative Care Nurse
- iv. In-Patient Unit
- v. Day Services
- vi. Physiotherapist
- vii. Specialist Palliative Care Pharmacist
- viii. Bereavement Service
- ix. Social Worker – Palliative Care
- x. Family Nursing & Home Care professionals
- xi. General Practitioners

4.2 Network of extended team members

Please ensure that the Chairperson is consulted prior to inviting Health Care Professionals, who are not part of the core MDT membership e.g. medical and nursing students/Allied Health Professionals.

4.3 Attendance

- a. All health care providers involved in the core group are expected to attend, and other healthcare professionals are actively encouraged to attend, on a regular basis as appropriate.
- b. A register of attendance will be maintained and all meeting attendees will sign for each meeting (Appendix A).
- c. Anyone observing MDT meetings should be introduced to team members and their details included on the attendance list.

5 Quorum

A quorum is a fixed minimum number of attendees that must be present in order to conduct the MDT meeting to enable recommendations to be made appropriately. The quorum for an MDT is four attendees one of whom should be either a member of the medical team or a Clinical Nurse Specialist or a Team Leader.

6 Confidentiality

All meeting attendees will:

- i. Abide by the Data Protection (Jersey) Law 2005.
- ii. Abide by the confidentiality terms within their contract of employment.
- iii. Abide by either the 'sharing of information agreement' between their employer and JHC or sign the 'Confidentiality Agreement' which MUST be signed (once only) prior to participating in an MDT if they are visiting healthcare professionals (Appendix B).
- iv. Adhere to their own regulatory body Professional Code of Conduct.

7 Consent

Written consent from the patient for MDT discussion is not necessary. However, the referrer should clearly indicate on the form that the patient has been informed of the purpose of the MDT referral, who may be present and what information will be discussed/shared and they have given either implied or oral consent. If the patient does not have the capacity to consent the referrer can do so by way of a best interest decision.

8 Roles and Responsibilities

Each member of the MDT has a role to play in ensuring the effectiveness of the meeting. Roles need to be clearly articulated to ensure that all members are aware of their responsibilities and that tasks are carried out in the manner endorsed by the meeting members.

8.1 Referrer

It is the responsibility of the referrer to:

- a. Promptly forward the completed referral and outcome form to the MDT coordinator (Appendix C). The cut-off time for inclusion of a case on the MDT agenda is 5pm on the Friday preceding the meeting. There is flexibility for cases that may need to be added at the last minute due to clinical urgency.

- b. Make every effort to attend the scheduled meeting to address the referral, contribute to the discussion which will enable them to give feedback on the outcome, as appropriate, to the patient.

8.2 MDT coordinator

- a. Coordination of the MDT is undertaken by the Palliative Care MDT Coordinator or their nominated delegate.
- b. Pre- meeting they will:
 - i. Ensure the referral form is completed fully and correctly. If the referrer has omitted to obtain patient consent/make a best interest decision the chairperson should be informed prior to any discussions being undertaken in MDT.
 - ii. Liaise with the Specialist Palliative Care Team and other key providers within health services and organisations to identify patients for discussion.
 - iii. Ensure appropriate and realistic numbers of referrals are listed for discussion.
 - iv. Place identified referrals on the agenda as either patients with complex needs, deaths, discharges or new referrals.
 - v. Ensure all clinical information is available for the meeting.
 - vi. Distribute the agenda to MDT core members and any identified relevant key healthcare professionals by the close of work the day prior to the meeting.
- c. During the meeting they will:
 - i. Ensure I.T. equipment is available and ready to use.
 - ii. Ensure venue is ready
 - iii. Take minutes
 - iv. Complete MDT outcome documentation in real time
 - v. Ensure communication effective with all members of the MDT
- d. Post meeting they will:
 - i. Collate minutes of meeting, including action items and outcomes are filed appropriately after the meeting.
 - ii. Shred any copies of documents that do not require filing but have patient identifiable information included on them.
 - iii. Place a copy of the outcome MDT form in the patients' notes.
 - iv. Highlight any areas of good/poor performance re stats to Chair to feedback.
 - v. Keep a record of all education/CPD discussed at MDT.
 - vi. Liaise with other healthcare professionals.

8.3 Chairperson of the meeting

- a. Good leadership and facilitation are key factors in the success of MDT's. The Chairperson's role is to facilitate participation by all members of the MDT in clinical discussions and decision making. The role will be undertaken by the Clinical Nurse Specialist/Team leader or their appointed deputy.
- b. The chairperson has the final decision as to whether to include any incomplete referrals as brought to their attention by the MDT coordinator.
- c. The Chairperson will:
 - i. Ensure all participants are introduced.
 - ii. Use teleconference phone when indicated.

- iii. Keep meetings to the agenda.
- iv. Commence discussions.
- v. Promote the full range of input into discussions if it is not forthcoming.
- vi. Conclude the discussion by inviting any further input before moving to the next case.
- vii. Negotiate resolution of conflict if necessary.
- viii. Promote mutual professional respect among all team members.
- ix. Summarise actions for agreement.
- x. Have the final decision on whether any interruptions are justified and can be attended to or should wait until after the MDT.

8.4 Team members

Team members will:

- i. Schedule MDT meetings into their job planning.
- ii. Arrive promptly.
- iii. Contribute to discussions involving patients in your care.
- iv. Refrain from making Judgemental and inappropriate statements
- v. Respect colleague's contributions, allowing time to express these without interruption.
- vi. Lead discussions on patients they have referred to the meeting.
- vii. Identify a plan based on patient goals.
- viii. Provide feedback to the patient or relevant Health Care Professionals as required and appropriate.
- ix. Ensure mobile telephones are on silent so as to not disturb the meeting. Calls to be taken only if urgent.

9 Team working and culture

JHC expects the highest standard of behaviour from its staff and for all staff to be aware of how their behaviour can affect others. To achieve this standard the following is considered acceptable team behaviour/etiquette:

- i. Mutual respect and trust between team members.
- ii. Prompt arrival
- iii. Refraining from making Judgemental and inappropriate statements
- iv. An equal voice for all members – different opinions valued.
- v. Resolution of conflict between team members.
- vi. Encouragement of constructive discussion/debate.
- vii. Absence of personal agendas.
- viii. Ability to request and provide clarification if anything is unclear.
- ix. MDT members to play a role in sharing learning and best practice with peers.
- x. Mobile telephones/iPads are to be switched off or put onto silent. Please indicate to the Chairperson, prior to commencement of the meeting, if you are expecting to receive a call/message which you must respond to.

10 Meeting venue

- a. The meeting venue is JHC in the conference room. However, an alternative room will be booked by the MDT Coordinator if the room is not available.
- b. To minimise interruptions of the MDT the 'red' do not disturb should be displayed on the door for the duration of the meeting. .

11 Meeting times

Meetings are weekly – including following a Bank Holiday. Any time not used for case discussion should be used for educational purposes or discussion of other relevant issues.

12 MDT content and patients to be discussed

- a. Individual patient/carer issues, needs, goals and action plans are the priority. To optimise outcomes, the MDT utilises all available information and ensures relevant concerns are identified and addressed
- b. In identifying “complexity” or “cause for concern” needs, use of evidence based clinical indicators e.g.: Gold Standards Framework: Prognostic Indicator, Palliative Care (OACC) Phase of Illness, the Australian Karnofsky Performance Status and involvement of multiple providers in the patients care can be considered. It is recommended that these tools be updated at the MDT meeting following discussion. The categories for patients to be discussed are as follows:
 - i. Patients with complex needs – case presentation format.
 - ii. Deaths – case presentation format.
 - iii. Discharges
 - iv. New Referrals
 - v. Patients to be admitted to the Inpatient unit

13 Education

- a. Multidisciplinary team meetings provide opportunities for the sharing of expertise, increasing an understanding of the diversity of provider roles and dissemination of information to enhance best practice in the provision of Palliative Care.
- b. This can be achieved by:
 - i. Multidisciplinary case discussions and care planning.
 - ii. Participation by all healthcare providers.
 - iii. Requesting/scheduling presentations by team participants and guests on relevant palliative care issues.
- c. If no cases are scheduled for the MDT, a “case study” for educational purposes may be provided with all stakeholders responsible for preparing and presenting on a rotating basis.

14 Development and consultation process and schedule

An outline of who has been involved in developing the procedural document, including JHC staff and committees, service users and relevant experts or professionals, during the draft stages e.g. police, drug and alcohol service, Medical Health Related Alerts (MHRA).

Name and Title of Individual	Date Consulted
SPCT and MDT core members	Each draft
Name of ratification committee	Date of ratification and inclusion onto data base
Clinical Effectiveness	April 2016

15 Dissemination and Implementation plan

Following ratification of this policy in the Clinical Effectiveness meeting it will be available to all via JHC Intranet in the Policies & Procedures Centre. There is no formal training identified for this policy however,

prior to any staff participating in an MDT they should ensure they have familiarised themselves with this policy.

16 Review

This policy will be reviewed by the Team Leader of the SPCT in line with JHC writing policies guidance.

17 Audit

- a. Ongoing MDT data collection, analysis and audit of outcomes will be conducted by the Palliative Care MDT Coordinator. This will include:
 - i. Number of cases discussed in each category e.g. Complex needs, deaths etc.
 - ii. MDT referral source.
 - iii. Number of MDT attendees.
 - iv. Discipline of MDT attendees.
 - v. Scheduled presentations and ad hoc informal education.
 - vi. Participant's educational requests.

- b. A review of the professional participant's experiences and outcomes will be undertaken informally at the end of meetings and formally via an annual survey.

18 References

NHS (2014) MDT Development - Working towards an effective multidisciplinary/multiagency team, available at:

<https://www.england.nhs.uk/wp-content/uploads/2015/01/mdt-dev-guid-flat-fin.pdf>

20 Appendix B - Confidentiality Agreement

Confidentiality Agreement

Confidential information is defined as any information found in a patient’s medical record, personal information, and work-related information (including salary information). All information relating to a patient’s care, treatment, or condition constitutes confidential information.

The confidentiality agreement covers all permanent and temporary staff, trustees, visiting healthcare professionals, volunteers, sub-contractors and students who will be collectively referred to as ‘staff’.

- Staff shall never discuss a patient’s medical condition with any non-employee, friends, or family members.
- Confidential matters will not be discussed in areas where they might be overheard by other patients or other non-employees of the Jersey Hospice Care.
- Staff members are to be aware at all times that conversations regarding patients are not to be overheard by others and take appropriate steps to ensure this confidentiality.
- All salary information is confidential and may not be shared with others in Jersey Hospice Care or with patients.
- Only authorised individuals may relay salary information to employees or non-employees.

Any unauthorised disclosure of confidential information by staff could render Jersey Hospice Care liable for damages. Any staff that violates confidentiality is subject to disciplinary action up to and including termination from employment.

I have received a copy of, read, understand, and agree to uphold this written agreement on matters of confidential information.

I also understand that in my daily job duties, I will have access to confidential information and any violation of confidentiality, in whole or in part, could result in disciplinary action up to and including termination and/or legal action.

I recognise that this signed document of my agreement to uphold the provisions of this agreement will be kept on file in my personnel file.

Print name: _____

Signed: _____ Date _____

Witness _____ Designation _____

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Please refer to the Intranet (Generic Forms) for the most up to date version

21 Appendix C - Multidisciplinary Team Meeting (MDT) Referral and Outcome Form

Multidisciplinary Team Meeting (MDT) Referral and Outcome Form

Date of referral: _____ Name of referrer: _____
 Date of _____ Present at _____

The patient has been informed of the purpose of the MDT referral, who may be present, what information will be discussed/shared.				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
The patient has given either implied or oral consent for MDT discussion.				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
The patient does not have capacity therefore consent for MDT discussion is by way of a best interest decision by the referrer.				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Specific issues patient does not want discussed at MTD							
Surname:				Diagnosis			
Given name:							
Address:							
				PMH			
D.O.B.		Age	Gender	Allergies:			
PPC:		PPD:		URN No:		Index No:	
GSF Code <i>(please tick)</i>	Blue (A) <input type="checkbox"/> <i>Year Plus prognosis</i>	Green (B.) <input type="checkbox"/> <i>Months prognosis</i>	Amber (C) <input type="checkbox"/> <i>Weeks prognosis</i>	Red (D) <input type="checkbox"/> <i>Days prognosis</i>			
Phase of illness:				Karnofsky performance status			
GP:		Patient goals:		Keyworker and other health professionals involved in patient care:			
Reason for referral to MDT				Clinical details with relevant results e.g. DNACPR			
For Hospice use only							
Previous MDT outcomes				Plan of care to achieve the outcome			

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