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Health Service Executive

Primary Care Teams - Clinical Team Meeting Guidelines

Document reference number	**CTM1**	**Document developed by**	**Bridget Farrell, TDO Geraldine Tabb, TDO Helen O'Driscoll, TDO in December 2008 Reviewed and Updated by Primary Care Specialists & National Primary Care Office in November 2011 and April 2012**
Revision number	**2**	**Document approved by**	**Primary Care Steering Group.**
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Revision date	**April 2014**	**Responsibility for review and audit**	**Primary Care Specialists**

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1.0 STATEMENT

Primary Care Teams (PCTs) deliver seamless, comprehensive care to individuals including where appropriate, inputs from specialist services. Clinical Team Meetings (CTMs) provide the forum for PCT members to develop a plan of care, for implementation, to meet the increasingly complex needs of service users who require the diverse skills of different professionals.

The purpose of the clinical team meeting is to identify, plan and coordinate care in an effective and efficient manner. This is achieved by bringing the PCT together in order to:

- Respond to the needs of individuals and families with acute or ongoing health needs;
- Share information for the effective management of client needs;
- Review and co-ordinate ongoing care for individuals and families;
- Develop, implement and review a multidisciplinary plan of care.

Donegal Addendum

- ***To help inform the development of integrated care pathways and care plans for complex cases requiring a high level of input***
- ***To identify people with complex chronic conditions requiring case management***
- ***To initiate a case conference / case discussion for complex / high risk cases***

This enables the provision of a wide range of services and resources and a seamless service to users which enhances continuity of care.

2.0 PURPOSE

The purpose of this guideline is to provide guidance and to ensure consistency in the organisation and conduction of clinical team meetings in primary care team settings.

3.0 SCOPE

This guideline is in respect of individuals discussed at CTMs as determined by PCT members. In the majority of cases, a plan of care will be developed for each client discussed at a CTM.

4.0 DEFINITIONS

- **Primary Care Team -** a multidisciplinary team of healthcare professionals who work closely together to meet the health and social care needs of defined population (7,000-10,000). Professionals on a Team include GPs and Practice Nurses, Community Nursing i.e. Public Health Nurses and Community Registered General Nurses, Physiotherapists, Occupational Therapists, etc. Primary Care Teams provide a single point of contact for the person and the health system. As Teams develop, they pioneer new programmes and services to benefits their clients in areas such as Chronic Disease Management, Management of Continuing Care Cases, Mental Health Services, and Health Promotion. PCTs have proven to support and maintain people in their local communities for as long as possible by decreasing hospital attendance and dependence, and facilitating early discharges.

- **Clinical Team Meeting** - the forum for PCT members to develop a plan of care, for implementation, to meet the increasingly complex needs of service users who require the diverse skills of different professionals.

- **Key Worker** – a clinical member of the team/network involved in the clients care, who has been nominated by the team to co-ordinate service delivery in accordance with the plan of care and to communicate with the client on behalf of the team.
  Donegal Addendum
  The term 'Case Manager' may also come into use in Donegal for some cases.

- **Plan of Care** - a document developed after the patient is discussed at a PCT CTM that identifies the actions to be taken in response to identified needs, the timeframe for implementation and the responsible person/s.

5.0 RESPONSIBILITIES

5.1 CHAIRPERSON (also referred to as the Co-Ordinator)

Responsible to:

- Prioritise clients for discussion at the CTM as a result of submissions/consultations with team members.
- Ensure all team members receive a copy of the meeting agenda.
- Ensure all members adhere to the agenda.
- Encourage input, relevance and facilitate consensus in relation to clinical discussion.
- Ensure a plan of care is completed.
- Send a copy of the plan of care to all relevant team members.
- Ensure Key Worker is identified where required.

5.2 EACH PCT TEAM MEMBER

Responsible to:

- Identify and prioritise the clients for discussion and give a list to the Chairperson prior to the meeting.
- Present all relevant client information to the team.
- Engage in clear relevant client discussion.
- Participate in the discussion/decision making process, where appropriate.
- Communicate the decisions/actions/outcomes to their relevant discipline where appropriate.
- Implement the plan of care as appropriate.

5.2.1 CLINICAL ACCOUNTABILITY AND PRIMARY CARE TEAMS

- Responsibility for the development, delivery and management of an agreed plan of care lies with the PCT members.
- Each clinician will retain accountability for his/her work in accordance with his/her professional standards and will have responsibility for his/her contribution to the care of the patient.

5.3 ADMINISTRATIVE SUPPORT

Responsible to:

- Prepare the venue for the meeting.
- Develop the CTM agenda in consultation with the Chairperson.
- Circulate and follow up on documentation as required.

5.4 KEY WORKER

The team may nominate a Key Worker when appropriate. Any clinical member of the team/network can undertake this role but he/she must be involved in the clients care. The Key Worker is the person nominated by the team to:

- Link the person into the services.
- Co-ordinate service delivery in accordance with the plan of care.
- Communicate with the client on behalf of the team.
- Act as lead contact for the client and other staff and professionals.
- Link with relevant workers in other services as required e.g. disabilities/mental health.

Donegal Addendum

- The term 'Case Manager' may also come into use in Donegal for some cases.

- Where the patient / client already has a Physical and Sensory Services Key Worker assigned to them, that worker should be involved with the clinical meeting process and they and the local Primary Care Team should agree together who should perform the Key Worker role arising from the Clinical Meeting on a case-by-case basis.

6.0 GUIDELINE

The frequency of the CTMs should be based on need and determined by each team. However, it is recommended that the meetings should be held at least weekly.

6.1 CONSENT PROCEDURES

- The consent procedure outlined in the Interim Guidelines on Information Sharing in Primary Care Teams, Version 8.0, final version (2008) will be applied (Appendix 1).
- It is the responsibility of the team member identifying the client for discussion to obtain consent from the client/clients for discussion at the CTM.

6.2 STRUCTURE OF CLINICAL TEAM MEETING

- There should be a nominated Chairperson (also referred to as the Co-ordinator) for each CTM. This role can rotate.
- A new Chairperson should be nominated as the need arises.
- Where administration support has been assigned to the team the Chairperson will be supported in his/her role by the Admin Support.
- At the initial meeting the ground rules should be agreed by team members.
- An agenda should be prepared and circulated in advance of each meeting (Appendix 2).

6.3 CRITERIA FOR REFERRAL/REVIEW AT CTM

- Clients who require/may require a multidisciplinary approach to their care.
- Clients who are being seen by more than two disciplines for more than three months should be automatically brought up for review at the CTM i.e. regular reviews for those clients with chronic conditions who are receiving multi-disciplinary services.
- Clients who are being discharged from Acute/other hospitals for whom a referral has been received which requires intervention.
- Clients who have applied/are in the process of applying for a Home Care Package or Long Term Care.
- Clients where feedback/updates from other professionals are required.
- Clients who have upcoming pre-planned elective surgery.
- Clients with acute complex needs that arise on the day of the meeting.
- Clients who were marked for review at a previous CTM..

6.4 CASES FOR REVIEW

- The PCT at a CTM decides a review date for each case that has a plan of care.
- The PCT administrative support will maintain a diary of cases for review and add these cases to the CTM agenda as necessary.
- If a case is more complex and requires longer discussion time, and/or additional network services/outside agency involvement, a specific case discussion/family meeting will be arranged.

6.5 DISCHARGE/CLOSURE OF CASES

- Cases will be closed:
    - When agreed interventions on the plan of care have been provided and the needs identified are resolved for the patient. A single discipline may remain involved but the case is closed to CTM discussion.
    - A Closing Summary Sheet is completed by the Key Worker/PCT member working with the individual/family (Appendix 3).
    - The PCT Administrative Support will circulate a copy of the closing summary to each of the relevant PCT members.

6.6 CLINICAL MEETINGS DOCUMENTATION

- A PCT meeting plan of care (Appendix 4) should be completed for each case and signed by the Chairperson.
- It is the responsibility of each professional to ensure that his/her clinical notes are updated in accordance with the plan of care.
- A record of attendance and all patients discussed (new and review) should be maintained by the PCT (Appendix 5).

6.7 FEEDBACK TO CLIENTS FROM CLINICAL MEETINGS

The person who obtained consent to discuss the case at a clinical meeting should provide feedback to the client. However, where a Key Worker has been nominated he/she will take on this responsibility.

7.0 CONSULTATION TRAIL

These guidelines were originally written by a working group in December 2008. They were reviewed and updated by the Primary Care Specialists and National Primary Care Office in November 2011 and again in April 2012.

8.0 IMPLEMENTATION

These guidelines will be implemented by PCTs.

9.0 REFERENCES

- HSE Primary Care Teams Working for You DVD (2011)

- HSE Primary Care Teams Resource Manual for PCT Staff (2010)
- Interim Guidelines on Information Sharing in Primary Care Teams (2008)
- HSE Code of Practice for Health Care Records Management (2007)
- Data Protection Acts 1988 and 2003.

10.0 AUDIT

The implementation of these guidelines will be reviewed by each PCT as part of its annual performance and review process.

APPENDICES

Appendix 1 *– Interim Guidelines on Information Sharing in Primary Care Teams, Version 8.0*

Appendix 2 *– Clinical Team Meeting Guidelines - Clinical Team Meeting Agenda Template*

Appendix 3 *– Clinical Team Meeting Guidelines - Clinical Team Meeting Closing Summary Sheet Template*

Appendix 4 *- Clinical Team Meeting Guidelines - Plan of Care Template*

Appendix 5 *– Clinical Team Meeting Guidelines - Attendance and Returns Record*

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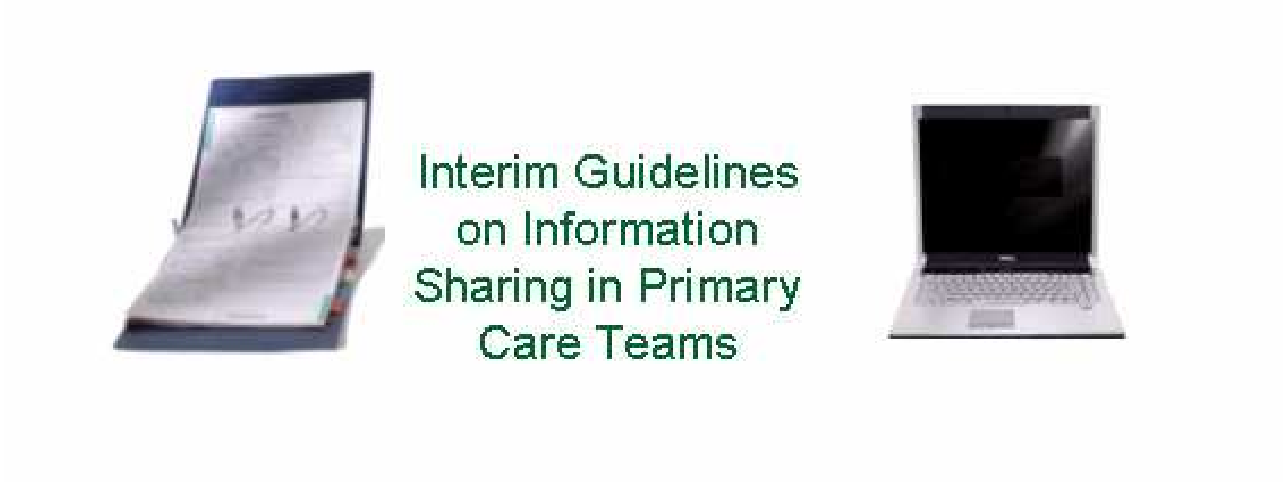

Interim Guidelines on Information Sharing in Primary Care Teams

File name:	**Interim Guidelines on Information Sharing in Primary Care Teams V8_0.doc**
Date:	**05/12/2008**
Version:	**Version 8.0, final version**
Authored by:	**Information Sharing Framework Working Group**

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1. Introduction

1.1 This document aims to help primary care team members, individually and collectively, to both safeguard and share healthcare confidential information according to best practice guidelines. Safeguarding and sharing healthcare information supports best quality outcomes for the patient. As primary care teams settle in and develop, new challenges in the area of information sharing will appear. Further evolution of these guidelines is anticipated to cope with these challenges. Proposed new legislation, such as the Health Information Bill and guidelines and standards from the Health Information and Quality Authority will also impact on this area of practice. A review of these interim guidelines will take place in the fourth quarter of 2009.

1.2 The purpose of these Information Sharing Guidelines is to provide service users with coordinated and seamless care, and to foster service user confidence. This will be achieved by facilitating and supporting all staff in Primary Care Teams (PCTs) in making good decisions about the protection, use and disclosure of service user information while taking account of their ethical and legal obligations.

1.3 These guidelines have been developed by a Working Group made up of Service Users, General Practitioner Representatives, Representative from the Office of the Data Protection Commissioner & HSE staff representatives. Please see Appendix 1 for a list of people involved in the creation of these guidelines.

1.4 It is essential that agreed and recorded guidelines for information sharing in PCTs be in place. These guidelines will ensure compliance with privacy, confidentiality and security of service user healthcare information shared by the team consistent with the duty of care.

2. Core Principles

2.1 Some core principles need to be in place in all primary care teams to protect healthcare confidentiality. These include:

2.2 Individuals have a fundamental right to the privacy and confidentiality of their health information.

2.3 Individuals have a right to control access to and disclosure of their own health information by giving, withholding or withdrawing consent.

2.4 For any non-consensual disclosure of confidential information healthcare professionals must have regard to its necessity, proportionality and attendant risks.

2.5 All staff must be aware of the need to respect their client/patient's privacy and confidentiality and should undertake training on these responsibilities. These responsibilities must be explicitly documented in their contract of employment and breaches should result in disciplinary action.

2.6 All information provided by service users should be regarded as confidential and shall only be passed on to others on a need-to-know basis.

2.7 Health professionals must comply with their legal obligations under Data Protection Legislation.

3. Duty of Care

3.1 Information sharing is often related to the concept of 'need to know'. This is a concept that can be difficult to define. Information sharing is more appropriately linked to a 'duty of care' to the patient. If you have a 'duty of care' to a patient, you have an ethical and legal responsibility to provide high quality care to that patient. The 'duty of care' relationship defines what confidential healthcare information an individual health professional needs to know.

3.2 Having a particular role in a primary care team does not necessarily entitle the professional to have access to confidential healthcare records. As well as a role, you need to have a 'duty of care' to the patient. If you are not providing care, then you should not have access to healthcare records. Where both a role and a 'duty of care' exist, then only the relevant parts of the confidential healthcare record should be accessible.

4. Referral

4.1 The commonest method of information sharing within a primary care team is referral. With patient consent, one health professional refers a patient to another health professional to make use of their special skills. This could be a Community Nurse making a referral to an Occupational Therapist or a GP making a referral to a Physiotherapist. An exchange of information, whether verbal, in letter format or in an agreed template, takes place whereby the parts of the patient record relevant to the referral scenario are shared between the healthcare professionals.

4.2 Referral is the tried and tested method of providing information on a need to know basis. A referral letter is a selective provision of all relevant information. The information content required is agreed between the generalist and the specialist, for example between a GP and a physiotherapist or between a community nurse and an occupational therapist.

5. Open Access to Records

5.1 Open access to a shared health record is not appropriate within a primary care team setting. Health professionals may share patient demographic details with patient consent. They may all keep their patient records on one primary care team information system, but access to records should be based on role and 'duty of care.' For example, a physiotherapist will see records of his or her patients, but not records of the community nurse. If the community nurse refers a patient to the physiotherapist then a referral letter or message will flow between them containing the information relevant to the service requested.

6. Clinical Team Meetings

6.1 Members of primary care teams have found they benefit from regular clinical team meetings. These serve as forums for discussion of patient problems, sharing expertise and team building. Clinical team meetings involve staff such as community nurses, physiotherapists, occupational therapists, home helps, administrative and secretarial staff, and GPs from different practices. High standards of healthcare confidentiality are needed for clinical team meetings.

6.2 Recorded patient consent should be in place before a patient is discussed at a clinical team meeting. A list of patients to be discussed at the clinical team meeting should be circulated in advance, so that individual healthcare staff could seek consent to discuss their patient's problems.

6.3 Notes of the discussion should only be shared with colleagues who have a duty of care arising from the discussions. No general clinical team meeting minutes containing confidential healthcare information should be circulated.

6.4 Many primary care teams are sited in small communities. Primary care team staff may themselves be patients of the primary care team. Service users may decide to bring different clinical problems to different GPs or choose not to attend a particular GP because of a family relationship or friendship. Healthcare confidentiality between a patient and a provider related to a particular episode of care must be maintained.

6.5 Clinical team meetings should be structured to allow patients of a particular practice to be discussed in sequence. GPs should not be party to confidential discussions at clinical team meeting when patients of another practice are being discussed by the primary care team, unless informed patient consent has been obtained. This is because they do not have a duty of care to these patients.

6.6 Notes and clinical records from the meeting should be stored and accessed according to HSE guidelines on management of confidential patient information, whether in paper or electronic format.

6.7 Communication between health care professionals, who have both a role and a duty of care to the patient, will continue to occur outside of clinical team meetings. For example, a GP and a community nurse discuss the care provision needed for an elderly patient with multiple health problems who is due to be discharged from hospital.

7. Information Security

7.1 Information systems, which are in place, even for basic demographic information, should have access controls and audit facilities to prevent unauthorised access and to monitor who accesses which records. Adequate back up and recovery routines should be in place for electronic records or Word documents which contain confidential healthcare information. Health care administrative and clinical staff should be aware of and implement HSE guidelines on information security.

7.2 Individual members of primary care teams are personally responsible for the security of their patient records, whether in paper or electronic format. They should refer to national guidelines on record management and information security published by the HSE.

7.3 Where a patient holds a personal medical record, either web based or paper based, the patient controls the record and provides permission to health care providers to access the record as needed. The patient is responsible for the security, storage and backup of their personal medical record.

8. Consent to share service user information

8.1 There are three elements to consent and they must all be present for consent to be valid. The consent must be voluntary, given by someone with capacity who is fully informed.

8.2 Consent must:

- Be freely given.
- Be specific.
- Be easily and clearly identifiable either on a consent form, which is retained as part of the healthcare record, or in the case of verbal consent documented within the healthcare record.

8.3 Consent is required when there is a material change in the anticipated use or disclosure of confidential healthcare information. Depending on the scenario and the therapeutic relationship, it may be appropriate to use a formal consent form, document verbal consent in the patient record or assume implied consent. The health professional should follow normal professional practice, but should err on the side of formal documentation of consent where possible. Where there is any doubt as to whether consent exists, the question should be asked and the answer documented.

8.4 When consent is being obtained, team members will make every effort to ensure that service users understand the type of information that is recorded about them, the purposes in sharing information, and the circumstances in which this information will be passed on to others who care for them (both within and outside the Primary Care Team), on a need to know basis.

8.5 When a service user enrols or avails of the services of a primary care team they supply specific information related to themselves, their eligibility and their contact details. This is termed demographic information and includes: name, address, date of birth, medical card number, personal public services number (PPS) and contact details. Service users should be asked if they give consent to the sharing of this demographic information between members of the primary care team. Once consent is given, the demographic data is available to the members of the primary care team & can be shared as appropriate.

8.6 Consent to share an individual's health & social care information with relevant health & social care professionals must be sought for each episode of care & the information shared shall relate to a particular episode of care. It is not appropriate to seek 'blanket' consent for all possible information sharing scenarios.

8.7 When a referral to another healthcare provider outside the Primary Care Team is being made, explicit consent to the sharing of clinical and demographic data should be sought from the service user. This can range from permission to allow access to the whole record through to a selection of the specific data items included in the referral.

8.8 When a service user is placed on a "care pathway" requiring multi-disciplinary assessment and or treatment the service user should have the need for data sharing fully explained to them and should give consent for the process to be followed – without each step in the care pathway requiring an explicit consent to be obtained.

8.9 Team members must demonstrate how consent was obtained (e.g. consent form, note on the health care record, verbally etc) which is dated and signed by the team member obtaining the consent, including full name and profession.

8.10 When service users are first referred to a service, team members will explain to them how their records are stored, shared and managed and how this is done with their consent.

8.11 A service user is entitled to attend or avail of the services of a primary care team but can decide not to share information. There should be no disadvantage in as far as is possible to the service user resulting from refusal to share information. The team member must in such instances explain to the client the implications of not consenting to sharing information and record the same.

8.12 If the team member has any doubt about whether consent exists they should confirm the service user's consent.

8.13 If a client is unconscious or unable due to mental or physical condition to give consent or to communicate a decision, the team member concerned must take decisions about the use of information. This needs to take into the account the patient's best interests and any previously expressed wishes and if appropriate be informed by the views of relatives or carers as to the likely wishes of the patient. (Health Professional must refer to their professional code of practice in such instances)

9. Disclosing Information without Consent

9.1 There are five statutory grounds for releasing client information to third parties

- When ordered by a judge in a court of law or by a tribunal established by an Act of the Oireachtas,
- Where necessary to protect the interests of the patient,
- Where necessary to protect the welfare of society,
- Where necessary to safeguard the welfare of another individual or patient,
- When required by other legislation.

9.2 In such cases, it is still best practice to inform service users if possible, whenever this is reasonable and feasible.

9.3 If a disclosure is made without consent, it is recommended that the following information is recorded:

- What information has been disclosed and to whom, (receiving individuals should be informed that this disclosure has been made without consent).
- Source of the data disclosed.
- Reason for disclosure.
- Date on which data was disclosed.

10. Client Access

10.1 Service users have the right under the following processes to access their healthcare information:

- Administrative Access
- Data Protection Acts 1988 & 2003
- Freedom of Information Acts 1997 & 2003

Interim Guidelines on Information Sharing - Appendix 1: Information Sharing Framework Group Membership

This is a list, in alphabetical order, of the people who sat on the original Information Sharing Framework Group and, in addition, people who subsequently worked on this document to bring it to fruition.

Mr Dougie Beaton
HSE Population Health

Dr Michael Boland
Irish College of General Practitioners

Dr Joe Clarke
GP Consultant to the HSE

Ms Judy Cronin
A/Health Informatics Manager, HSE South

Ms Caroline Coogan
National Contracts Office

Mr. Garry Davis
Deputy Commissioner, Office of Data Protection Commissioner

Ms Helen Deely
Transformation Development Officer

Mr Donal Devery
Freedom of Information Officer / Data Protection Officer, HSE

Mr Pat Donnelly
National Transformation Team PCCC

Mr Paddy Grace
Consumer Representative, Prospect, Mullingar

Ms. Veronica Larkin
National Transformation Team PCCC

Dr Anne Lynott
GP and Facilitator with the National General Practice Information Technology (GPIT) Group

Mr Terence Moran
Patient Focus

Ms Alice McGinley
Transformation Development Officer

Mr Dick McMahon
Assistant National Director ICT

Ms Ciara Ni Shuileabhain
Senior Compliance Officer, Office of the Data protection Commissioner

Dr. Brian O'Mahony
National ICT Project Manager – General Practice

Ms Clare O'Shaughnessy
NUI Galway

Ms Winifred Ryan
National Hospitals Office

Ms Mary Warde
Disability Services Manager Mayo PCCC

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Health Service Executive

Surname: ____________________

First Name: __________________

DOB: ____________ Sex: ______

CONSENT FORM TO DISCLOSURE OF INFORMATION

To ensure the patient/client is able to make an informed decision about consent to the disclosure of their information, the practitioner should:

☐ Explain that patient/client information is only shared on a need to know basis.
☐ Explain the multi-disciplinary nature of the PCT, including its membership.
☐ Explain the practice of recording client ***contact*** details in the client record system, which are shared by all members of the Primary Care Team.
☐ Discuss with the client any proposed referral to other services/agencies.
☐ Explain that the client's information will only be released to other services/ agencies if the client has agreed and advise that the referral for services can still proceed if the client does not want information disclosed.
☐ Provide the client with a copy of '*Practical Information guide for your Health Care Records*'.
☐ Explain that the client record may be audited from time to time for quality improvement purposes.

RECORD OF CONSUMER CONSENT:

Written patient/client Consent

My service provider has discussed with me how, when and why certain information about me may need to be provided to other services/agencies. I understand the recommendations and I give my permission for the information to be shared, as detailed above.

Client's Name: ___________________
Signature: ____________________
Date: ____________________

Witnessed by:
Practitioners Name: _______________
Position: ________________

Signature: ________________
Date: ________________

Verbal Consent (Practitioner Use Only)

I have discussed the proposed referrals and sharing of information to other services/agencies with the client.

I am satisfied that the patient/client understands the proposed uses and disclosures and they provided their informed consent to these.

Client's Name: ____________________

Practitioner's Name: ________________
Position: ____________________

Signature: ____________________
Date: ____________________

Clinical Team Meeting Agenda **Date: ___________________**

Cases for Discussion (New referrals and unplanned cases)						
NAME	**PCT & GP**	**NEW CASE**	**EXISTING CASE**	**REFERRER**	**SERVICE REQUESTED & KEY WORKER**	**REVIEW DATE**

Scheduled Reviews				
NAME	**PCT & GP**	**REFERRER**	**SERVICE REQUESTED & KEY WORKER**	**REVIEW DATE**

CLINICAL TEAM MEETING GUIDELINES – CLOSING SUMMARY SHEET TEMPLATE - APPENDIX 3

PCT – CLINICAL TEAM MEETINGS CLOSING SUMMARY SHEET

Date: _________

RE : Name _______ ______________ ***Address:*** __________________________

Time Period of Interventions: From: ___________ To: ___________________

Summary of Concerns

Summary of Interventions Undertaken

Summary of Outcomes

Closed to CTM

If remains open to Single Discipline - Specify Discipline: _______________________

Signed: ________________________________ **Key Worker / PCT Member**

Date: ________________

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CLINICAL TEAM MEEING GUIDELINES - PLAN OF CARE TEMPLATE - APPENDIX 4

Note: *This document is a Plan of Care developed after the patient is discussed at a PCT CTM that identifies the actions to be taken in response to identified needs, the timeframe for implementation and responsible person/s.*

Name of Client ______________________ ***D.O.B.*** ______________ ***PPSN No,*** __________ ***GMS No.*** ____________

Address ____ ***Contact Phone Number*** ____________________

Next of Kin ____ ***Contact Phone Number*** ____________________

Key Worker ____________ ____________________ ***Date of Meeting*** ________________________

In Attendance:

____

____

____

____

____

____

Further Relevant Information:

Issues discussed	***Action***	***Date to be achieved by***	***Person responsible***
1.			
2.			
3.			
4.			

Review Date: ____________________ ***Signed:*** ______________________________ ***Date:*** ____________________
Chairperson

Any omissions or inaccuracies in these notes should be notified to the Chairperson within 7 days of receipt, or otherwise it will be assumed that these notes are agreed and correct

CLINICAL TEAM MEETING GUIDELINES - ATTENDANCE AND RETURNS RECORD TEMPLATE - APPENDIX 5

CLINICAL TEAM MEETING ATTENDANCE AND RETURNS RECORD

PRIMARY CARE TEAM: ___________________________ ***Date***______________

Name and title	*Signature*	*Report Submitted/ Apologies*

Totals

No of New Patients	***No of Review Patients***	***No of Plans of Care Completed***	***No of Cases Closed***	***No of GPs Attending***	***No of Practice Nurses Attending***	***No of HSE Staff Attending***