A Multidisciplinary Team (MDT) is a group of allied health professionals (AHP) working together to achieve a common goal(s) with regards to a patient's healthcare. Commonly within Care of the Elderly the team consists of Doctors, Nurses, Pharmacists, Physiotherapists and Occupational Therapists. Other colleagues we often encounter are Speech and Language Therapists, Dietitians and Social Workers.

The focus of the MDT meeting, is to establish individual goals for each patients. Bringing together professional opinions to agree on goals and a discharge plan, with a time frame to achieve this.[1] In DME wards this is done at the end of a ward round.

How does an MDT work?

1. Introduction of Team Members

   Each week may have different team members from each discipline. Therefore everyone in attendance should introduce themselves and state their name and role.

2. MDT members take turns for input on Each Patient

   a. Staff Nurse; update on how the patient is on the ward, any personal care or feeding requirements. Often records MDT outcomes in notes.

   b. Physiotherapist; focuses on how the patient transfers and moves around the ward. Recommend equipment including walking aids.

   c. Occupational Therapist; assesses patients' abilities to complete activities of daily living (ADLs) to see what support they may need.

   d. Senior Decision Maker (StR / Consultant); provides a medical update on the patient's condition and often co-ordinates AHP advice to agree a time frame for next steps to common goal. Allocates individuals with tasks e.g. update family.

3. PDD[2] (planned discharge date) Documented in Notes & Updated on Trakcare

   a. Junior Doctor (FY1, FY2 or Middle Grade) to update PDD on Trakcare simultaneously

   b. If no Junior Doctor in MDT then Nursing Staff/ AHP to update (appendix 1)

4. Completion on jobs resulting from MDT

   a. SMAT (social work referral forms) Forms to be completed during MDT

   b. Named person for updating relatives either in person or phone calls

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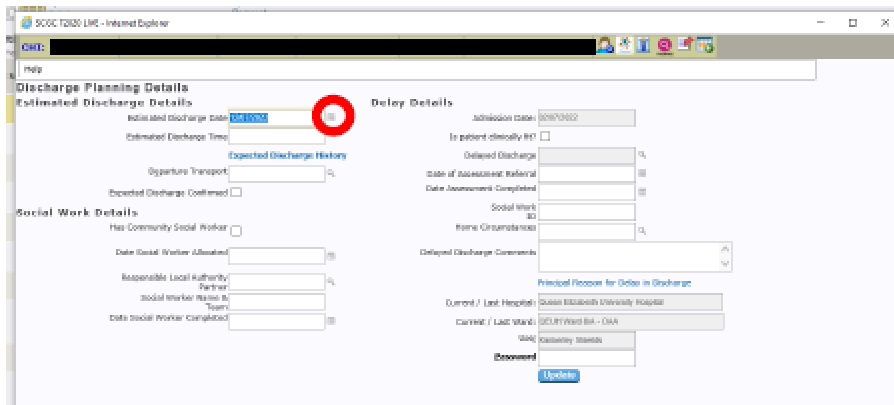
[1] Graham Ellis, Nick Sevdalis, Understanding and improving multidisciplinary team working in geriatric medicine, *Age and Ageing*, Volume 48, Issue 4, July 2019, Pages 498–505, https://doi.org/10.1093/ageing/afz021

[2] PDD refers to the date the patient is estimated to be Discharged from Hospital. The term EDD (estimated date of discharge) was previously used. Discharge can be to their own Home / Sheltered Housing / Care Home / Nursing Home. This is NOT a date of 'transfer of care' to an offsite ward. If is also NOT a date of when they are 'medically fit' for discharge as a marker of delayed discharges.

Appendix 1 – How to Set Planned Discharge Date (PDD)

1. Click on Planned Discharge Date logo (also known as EDD) for patient

2. Click on the calender icon below



3. Choose date required then put in password and click update