

Core Concepts of HL and DHL

Effective communication for people with limited HL



Promoting Healthy and Active Ageing

Lesson 12

Multidisciplinary Team Approach Across

Various Settings in Care For Older Adults

Intended Learning Outcomes

- Describe the composition and roles of the multidisciplinary team (MDT) in care for older adults.
- Discuss the importance of collaboration among different professionals across hospital, community, and long-term care settings.
- Evaluate the nurse's role in coordinating care and advocating for older adults within the MDT.
- Apply case-based thinking to demonstrate how MDTs improve outcomes in care for older adults.

What is MDT?

- Older adult patients often present with multiple chronic conditions, functional decline, and complex psychosocial needs.
- No single professional can meet all these needs → team-based care is essential.
- MDT is a collaborative partnership between health, social, and community professionals.
- Goal is to improve health outcomes, independence, functional ability, and quality of life.

Composition of the Multidisciplinary Team

- **Nurse:** care coordinator, patient advocate, education, monitoring, communication.
- **Physician/Geriatrician:** diagnosis, medical management, prescribing, oversight.
- **Psychologist/Psychiatrist:** cognitive assessments, counseling, therapy, mental health management.
- **Physiotherapist:** mobility, strength, fall prevention, rehabilitation.
- **Occupational therapist:** ADLs, home/environment modifications, assistive devices.
- **Dietitian/Nutritionist:** nutritional assessment, diet planning.
- **Pharmacist:** medication review, polypharmacy management.
- **Social worker:** financial aid, caregiver support, community resources.
- **Speech & language therapist:** swallowing difficulties, communication issues.
- **Spiritual counselor/chaplain:** support spiritual needs, dignity, coping.

MDT Across Care Settings (1. Hospitals)

Focus:

- acute management, stabilization, discharge planning.
- reduce complications, prevent readmissions.

Example: An older adult patient with post-hip fracture.

- Physician: surgery, medical management.
- Nurse: wound care, discharge teaching.
- Physiotherapist: early mobilization.
- Social worker: plan safe discharge to home or facility.
- **Who else?**

MDT Across Care Settings

(2. Primary Care / Community Setting)

Focus:

- continuity of care, chronic disease management, rehabilitation, health promotion.
- independence at home, prevents hospitalizations

Example: An older adult with COPD and diabetes.

- Nurse: home visits, education, monitoring adherence.
- Community health worker: connect to clinics.
- Dietitian: dietary adjustments.

MDT Across Care Settings

(3. Long-Term Care / Residential Care Facilities)

Focus:

- comprehensive support for older people with high dependency.
- promote dignity, prevent neglect, enhance quality of life
- End of life care, death and bereavement

Example: dementia patient in nursing home.

- Nurse: daily care, medication administration.
- OT: environment modification for safety.
- Psychologist: behavioral interventions.
- Activities coordinator: social engagement.
- Spiritual counselor: support spiritual needs, dignity, coping.

Benefits of MDT Approach

- Holistic, patient-centered care.
- Reduced duplication of services.
- Improved patient outcomes (mobility, nutrition, mental health).
- Better communication and coordination across care transitions.
- Reduced caregiver burden and family stress.
- Enhanced professional satisfaction and learning.

Challenges in MDT Work

- Role confusion or overlap.
- Poor communication between professionals.
- Resource constraints (staff shortages, time).
- Lack of coordination across hospital–community boundaries.
- Power dynamics and hierarchical barriers.

Q. How to overcome these challenges?

Mr. Perera, 82, has diabetes, hypertension, mild dementia, and mobility problems after a recent fall. He lives with his daughter, who is stressed about caregiving. He is discharged from hospital and requires long-term management.

1. Identify the MDT members needed for Mr. Perera's care.
2. What are the key roles of each member in supporting him?
3. How can nurses coordinate across hospital, home, and community?
4. What might happen if MDT collaboration is poor or absent?



Further reading

- WHO (2017). Integrated Care for Older People (ICOPE): Guidelines on Community-Level Interventions.
- McCormack, B. & McCance, T. (2017). *Person-Centred Practice in Nursing and Health Care*.
- Taberna M, Gil Moncayo F, Jané-Salas E, Antonio M, Arribas L, Vilajosana E, Peralvez Torres E, Mesía R. (2020) The Multidisciplinary Team (MDT) Approach and Quality of Care. *Front Oncol*.
- Tanaka, Makoto. (2003). Multidisciplinary team approach for elderly patients. *Geriatrics & Gerontology International*. 3. 69 - 72.

Thank
you

