STANDARD OPERATING PROCEDURE
MULTIDISCIPLINARY MEETINGS
FOR COMMUNITY INPATIENT UNITS

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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
2.0	*18/07/19*	*Changes to attendance*
2.1	*17/11/22*	*Updates reflective of HDS involvment and discharge process changes including capturing delayed transfer of care as potential harm via datix.*

Contents

1. INTRODUCTION

Across Community services inpatient unit all registered staff are to comply with the following Standard Operating Procedure (SOP) to ensure safe and efficient MDT working for patients from community inpatient units. This SOP is to ensure a consistent approach to multidisciplinary team working. To ensure robust, consistent and safe discharge planning. The multidisciplinary team meeting is an integral part of the patient's discharge plan it provides a forum for discussion in order to co-ordinate treatment planning of inpatients and a timely and appropriate discharge for patient, It should encourage collaboration in order to ensure effective use of resources and their availability and is a network for communication across Health and Social Care.

The Trust will ensure that all staff, including clinicians, senior managers, general practitioners and all other relevant agencies are fully conversant with this SOP.

The Trust is committed to ensuring all staff are appropriately qualified and competent to deliver this SOP.

2. SCOPE

This SOP will be used across all Community inpatient units within Humber Teaching NHS Foundation Trust. It includes both registered and unregistered staff that are permanent, temporary, bank and agency staff excluding students, on commencement of working within the community inpatient units. To promote a safe and consistent multidisciplinary team approach to active rehabilitation and patient centred discharge planning.

3. DUTIES AND RESPONSIBILITIES

Service Managers, Locality Matrons and appropriate professional leads will ensure dissemination and implementation of the policy within the sphere of their responsibility. They should also ensure staff are supported in attending relevant training and that time is dedicated to the provision and uptake of training and sign off competencies.

Charge Nurses/team leads will disseminate and implement the agreed SOP. They will maintain an overview of associated training needs for their respective teams. The Charge Nurse/Team Leader will ensure mechanisms and systems are in place to facilitate staff to attend relevant training as part of their Performance and Development Review (PADR) process in order to undertake training and sign off competencies.

All clinical staff employed by the Trust will familiarise themselves and follow the agreed SOP and associated guidance and competency documents. They will use approved documentation and complete relevant paperwork as per policy and Standard Operating Procedures as relevant to each clinical activity. They will make their line managers aware of barriers to implementation and completion.

4. PROCEDURES

4.1. Principles

A **multidisciplinary approach** involves drawing appropriately from multiple disciplines to explore problems outside of normal boundaries and reach solutions based on a new understanding of complex situations.

Multidisciplinary and multiagency working involves appropriately utilising knowledge, skills and best practice from multiple disciplines and across service provider boundaries, e.g. health, social

care or voluntary and private sector providers to redefine, re scope and reframe health and social care delivery issues and reach solutions based on an improved collective understanding of complex patient need(s)

Perhaps the most important common guiding principle for all multi-disciplinary/integrated teams, is having a shared commitment to the delivery of person-centred coordinated care from the perspective of the individual:

> "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me"

4.2. Attendance

Core members are present for the discussion of all cases where their input is needed – it is for the coordinator to decide (in consultation with others as he/she sees fit) whether there is adequate representation at a single meeting to make safe recommendations about any/all patients and the action to take if not.

Every effort should be made to ensure that a clinician who has met the patient is present at the meeting.

The coordinator is responsible for raising concerns about non-attendance of particular members (or their deputies) and escalating these concerns if regular non-attendance is impacting on the quality of MDT working/recommendations to the ward manager/service manager.

Meetings should be set on a regular pattern. If that date falls on a bank holiday, then the MDT should happen on the next working day to ensure ongoing communication, discharge planning arrangements.

Coordinator

The MDT coordinator is responsible for the organisation and the running of the MDT meetings.

- Prepares and/or agrees the agenda
- Ensures the meeting is quorate and takes action if not;
- Ensures all patients are discussed and prioritised as necessary;
- Ensures all relevant team members are included in discussions;
- Ensures discussions are focussed and relevant;
- Ensures good communications/a pro-discussion environment;
- Ensures the current patient discussion and treatment/care plan recommendations are complete before the next patient discussion starts;
- Ensures recommendations are clearly summarised, recorded and fed back to the patient, GP and clinical team within a locally agreed timeframe
- Ensures that it is clear who is going to take any resulting actions post meeting and that this documented in SystmOne.

The team has agreed what is acceptable team behaviour including:

- Mutual respect and trust between team members;
- An equal voice for all members - different opinions valued;
- Resolution of conflict between team members;
- Encouragement of constructive discussion/debate;
- Absence of personal agendas;

4.3. Patient-Centred Care

Patients are aware of the MDT and that their case is being/has been discussed and are given the outcome within 24 hours.

A patient's views/preferences/holistic needs are presented at the meeting. Where the patient lacks capacity any previous statement of wishes / advanced care plans or nominated LPA will be considered.

To ensure that all patients have an estimated date of discharge set within 48 hours for first multidisciplinary meeting after the patient's admission to the Community Hospital

A named individual at the MDT has responsibility for ensuring that the patient's information needs have been (or will be) assessed and addressed.

4.4. Purpose

- The multidisciplinary team meeting is an integral part of the patient's discharge plan
- The meeting provides a forum for discussion in order to co-ordinate treatment planning of inpatients and to achieve a timely and appropriate discharge for patients
- The meeting encourages collaboration in order to ensure effective use of resources and their availability
- The multidisciplinary team provides a network for communication across Health and Social Care
- The multidisciplinary team is responsible for agreeing the appropriate categories for reporting delayed discharges

4.5. Procedure for Meetings

- The meeting will be coordinated by a senior member of staff, preferably a ward manager or a nominated deputy.
- The Coordinator will provide essential information referring to each patient in order that all members of the team have the same information.
- Each member of the team will have an opportunity to discuss specific patient issues. The team will provide an action plan to support the discharge and submit a target discharge date.
- The EDD will be reviewed at each meeting to amending accordingly if required.
- The Coordinator's role is to agree with each team member their responsibility within the action plan and document this in the Patient's notes using the MDT template on S1. This must be undertaken at every meeting until the patient is discharged. This will require a member of the MDT meeting to have a mobile device so the members of the meeting can access the patient's progress notes to inform the meeting of the patient's current situation.
- The Coordinator will ensure the patient and carers are aware of the action planning and decisions and that they are kept up to date.

4.6. Key Duties Undertaken

To ensure that all patients, appropriate others or relatives/carers have been given the relevant welcome leaflet on admission to the Community Hospital.

To ensure that plans for future discharge have been discussed with the patient and their family and/or appropriate others within 24 hours of admission to the Community Hospital.

If family members are to be part of a discharge care package then to encourage participation at an early stage in care delivery on the ward so support and areas of risk can be identified and resolved.

Where there are concerns with capacity- a Mental Capacity Assessment must be completed and if the patient lacks capacity a best Interest meeting held with all relevant parties invited to contribute to the discussion. At this stage it may be appropriate to consider DOLs and Power of Attorney for Health and if an IMCA needs to be involved

To agree rehabilitation goals for therapy, nursing and treatment required to achieve this estimated discharge date.

To agree a date for a home visit or access visit if required at the first multidisciplinary meeting after the patient's admission to the Community Hospital if possible or necessary.

To ensure that all equipment is ordered following any home visit so that this is available in the home prior to the agreed discharge date.

To ensure that a trusted Assessment is completed in a timely manner to request support on discharge from social care / home from hospital / other community services as required.

Any Safeguarding concerns should be discussed with the matron / therapy lead and/or the Safeguarding Team who will advise. If there are concerns regarding safeguarding and vulnerability a VARM may need to be considered

To review all estimated discharge dates at the multidisciplinary meeting to ensure that these are still appropriate. Where the patient is not medically or clinically fit, to agree a revised discharge date the discharge planning assessment will continue once the patient is deemed fit for discharge even though there may be ongoing medical needs.

To ensure that the reporting for all delayed discharges is reviewed at every multidisciplinary team meeting, and agreed by the multidisciplinary team and reported appropriately on a daily basis

Ensure the patients multidisciplinary team meeting progress record is updated for every patient

Ensure that all the patients' documentation is updated after the meeting which will initiate the interventions required for discharge. This will include referrals to other agencies and specialist nurses as agreed at the meeting;

Ensure that referrals to other agencies are actioned this may be delegated to the most appropriate team member to action;

Ensure that information is communicated to the patient and relatives and the nurse in charge of the next shift and is included on the appropriate handover sheet.

It is the responsibility of all members to contribute to discussion and use their expert knowledge to ensure all services are provided to ensure a safe and timely discharge of the patients;

Each team member will ensure that actions delegated to them are undertaken and feedback given at the next meeting;

4.7. Discharges

A trusted assessment is required for all patients who require ongoing services on discharge.

Complete the appropriate multidisciplinary records for all patients at every multidisciplinary team meeting including updating the discharge checklist which is to be completed prior to discharge.

Where patients are being discharged and the package of care / placement is not available, record the date that an offer of an interim bed or placement or package was made by the discharge hub for the patient.Maintain communication with HDS team for daily updates from the discharge hub regarding these patients. A Datix should be completed for all delayed discharges, where the datix relates to lack of availability of care packages, placements for the patient.

Where an interim bed is available and this has been declined by the patient then consider the Discharge and Transfer policy and local guidance. The Locality Matron/Service manager should be informed so this can be commenced without delay and appropriate Discharge letters circulated.

4.8. Monitoring and Recording of Delayed Discharges in Relation to Sit Rep Reporting

Home visits are only recorded as a delay if the date set will delay the discharge of the patient beyond the agreed discharge date when they are medically fit for discharge.

Equipment ordered does not constitute a delay unless the arrival date in the home will delay the agreed discharge date.

In circumstances where there is deemed no vacancy in the patient's first choice of nursing/residential care home, alternative arrangements will be discussed with the patients and carers.

A Datix should be completed for all delayed discharges, where the datix relates to lack of availability of care packages, placements for the patient and any harm that occurs for the patient. .

All discharge delays should be escalted to the HDS on a daily basis as part of the daily bed state.