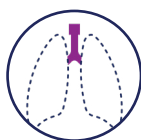


The Multidisciplinary Team (MDT) for MND should:

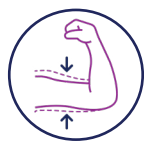
- include health and social care professionals with expertise in MND, and staff who see people at home
- ensure effective communication & coordination between everyone involved in the person's care and their family and carers
- provide co-ordinated care tailored to the person's needs
- carry out regular co-ordinated visits to assess people's symptoms and needs, including:



- ✓ weight and diet intake
- ✓ feeding and swallowing
- ✓ saliva problems



- ✓ respiratory symptoms & function
- ✓ non-invasive ventilation
- ✓ cough effectiveness



- ✓ muscle problems eg cramps
- ✓ physical function
- ✓ activities of daily living



- ✓ pain
- ✓ other symptoms eg constipation
- ✓ treatment's response



- ✓ speech & communication



- ✓ cognitive & behavioural changes
- ✓ psychological needs



- ✓ social care needs
- ✓ end of life needs



- ✓ information & support for the person, family and carers

We offer a detailed guide and online course on MDTs to support further learning.

Visit www.mndassociation.org/mdt to find out more

Core team consists of:

- ✓ neurologist
- ✓ specialist nurse
- ✓ dietitian
- ✓ respiratory physiologist
- ✓ physiotherapist
- ✓ speech & language therapist
- ✓ occupational therapist
- ✓ palliative care expert

It should have access to:

- ✓ clinical and neuro psychology
- ✓ social care and counselling
- ✓ respiratory ventilation service
- ✓ gastroenterology
- ✓ orthotics
- ✓ wheelchair services
- ✓ specialist palliative service
- ✓ assistive technology services
- ✓ community neurological care teams

Benefits include:



improved quality of life for people with MND



compliance with NICE guideline



facilitated access to timely support and intervention



improved communication and continuity of service



promotion of best practice and person-centred care



access to professional and peer support