

Multi-Disciplinary Team Huddle Best Practice Guide

Purpose

Clear communication and effective teamwork are essential for patient safety, enhancing patient flow and achieving better health outcomes^{1,2}. Brief multidisciplinary (MDT) huddles are known to have positive impacts on patient stay including shortening length of stay (LOS), earlier in the day discharges, and lower re-admission rates³⁻⁶. Conversely, when MDT huddles are ineffective, they can lead to miscommunication, adverse events, patient dissatisfaction, and delays in clinical care delivery and patient discharge⁷.

The objective of this document is to offer clear guidance on establishing or enhancing in-patient MDT huddles to support improved patient care and streamline patient flow.

Objectives

The key objectives for MDT huddles are to:

Identify patients for discharge via Estimated Discharge Date (EDD)

Identify alternative treatment pathways

Identify complex patients and discharge barriers early

Coordinate timely patient care within the MDT

Review episode of care type

Key Components

MDT huddles should be:

Action Focused

Identify discharges, support timely interventions, reduce delays

Structured

Consistent format and script for each patient under the treating team (including outliers)

Succinct

1-2 minutes per patient

How to structure

Multidisciplinary team attendance, once or twice daily, seven (7) days per week (acknowledging reduced staffing on weekends)

Schedule huddle times to maximise attendance. Huddles should occur after shift handover so all members are prepared with up to date information

Early morning (i.e. 8:30am) huddles can assist staff with planning and identifying early discharges. If using an on-take model; consider scheduling the MDT for that team slightly later in the day to allow review of new patients

In high functioning teams or short length of stay services; twice daily huddles can lead to further improvements in patient care and flow by preparing discharges for the following day

Occur at a central location and/or online i.e. nurses' station, Patient Flow Manager (PFM)/Kyra journey board

Include all key decision makers

Start on time, everytime

MDT huddles are not case conferences and should not include:

- ✘ Lengthy background information on the patient
- ✘ Complex discharge planning discussions
- ✘ Lengthy treatment or management plans

Membership

The following staff should attend the meetings. Any other staff not listed below may be beneficial depending on the service model.

Medical

- Consultant (wherever possible) or Registrar

Nursing

- Team Leader or Nurse Unit Manager

Allied Health

- Pharmacy
- Occupational Therapy
- Social Work
- Physiotherapy
- Speech Therapy or Dietetics (if indicated)

Care Coordinators

- Discharge Facilitator or Case Manager

Huddle Lead

A senior clinician should be responsible for chairing the meeting. They have the following responsibilities:

Follow a script

To improve communication, safety, accountability, and focused discussion

Keep to time

1 - 2 minutes per patient.
Complex discussions to occur an alternative time

Document decisions

Ensure PFM/Integrated Electronic Medical Record (ieMR) is updated (can be delegated)

Alignment of Allied Health, Nursing and Medical Teams:

Geographic cohorting of patients paired with multidisciplinary huddles can reduce length of stay, adverse events, and readmission rates⁷⁻¹⁰. This supports consistent and co-ordinated MDT care by streamlining communication, reducing the number of staff medicine teams need to liaise with, and enhancing efficiency – particularly in discharge planning. It can also facilitate comprehensive MDT input and early discharge planning for those patients outlied or awaiting a ward bed.

Consider structuring huddles around the treating medical team rather than the physical location of patients. Consider aligning allied health and discharge co-ordinators with medicine unit/teams to streamline communication for staff.

Ensuring Success:

Education

- All MDT members should be educated on the meeting's purpose, with emphasis on relevant, concise communication.
- Consider providing examples of both effective and ineffective huddles.
- Encourage leadership or a "champion" to provide supervision and feedback during implementation.

Review and improve

- To ensure ongoing effectiveness and address emerging issues, it is recommended that leadership regularly attend and review the structure and outcomes of the meetings.
- Seek feedback from staff on the performance of meetings.

Script

The Huddle lead (or appropriate delegate) should come prepared with current capacity information for key alternative pathways and proactively highlight these options at the start of the meeting. Alternative pathways may include Hospital in The Home (HITH), Geriatric Evaluation and Management Hospital in The Home (GEMHITH), Transition Care Program (TCP), Rapid Access Clinics (RAC), Post-Acute Care Services (PACS), Multidisciplinary hospital Avoidance and Post-acute Service (MAPS), Virtual Care.

The following key points should be discussed:

Patient Identification

- Name and Date of Birth
- Bed number and ward (if required)
- Any infection status

Care Type/Sub and Non Acute Patient (SNAP) Codes

- State the care type and ensure it is accurate (including on PFM/ ieMR). E.g. Acute, Maintenance, Geriatric Evaluation & Management, Mental Health, Rehabilitation, Palliative Care etc

Estimated Date of Discharge

- Ensure the EDD is accurate and documented (e.g. PFM/ieMR). Ensure patient and family have been advised of the EDD.
- *Reminders:* If discharge is planned within 24 hours, ensure transport and medication scripts are arranged. Early use of the Transit Lounge supports patient flow.

Discharge Destination

- For example - home alone, Residential Aged Care Home (RACH), HITH, Rehabilitation
- *Reminder:* For patients identified for RACH placement, confirm it's a last resort (e.g. can the patient return home with family and community supports while awaiting placement?). Transfer to a non-acute bed should occur as soon as possible.

Waiting for what? When will it happen?

- **Assessment/Review:** e.g. medical/specialist consult, allied health (specify), HITH review, Aged Care Assessment Team (ACAT)
- **Treatment/Test:** e.g. infusions, response to medication, imaging, pathology
- **Transfer/Discharge:** e.g. transport home, RACH, Inter-Hospital transfer, TCP
- *Prompt for discharge:* Why not today? Why not now? (see above for alternative care options)

Result of actions from yesterday

- What happened to the patient yesterday and were all the actions completed

Criteria Led Discharge (CLD)

- Identify if Criteria Led Discharge is suitable.
- *Reminder:* Define and document clearly the specific clinical criteria that must be met for discharge.

Care Location

- Identify alternative care options (see examples above)
- *Reminder:* wherever possible, patients should be managed through ambulatory care

Actions and responsible person

- Identify who is responsible for following-up each action item; including completing referrals
- Stipulate a timeframe

Example Scripts

<p>John Doe 12/12/54 Outlied on ward 3A, Bed 4</p> <p>Contact & Droplet precautions for Acute Respiratory Infection.</p> <p>SNAP – Acute</p> <p>EDD today</p> <p>Home with HITH today post IVABs. CLD documented</p> <p><i>Can he go to transit lounge, how's he getting home?</i></p> <p>Yes - transit lounge now. Have confirmed wife picking up at 12.</p> <p>Scripts with pharmacy</p>	<p>Jane Smith 01/01/1925 Bed 22</p> <p>SNAP – Maintenance</p> <p>EDD: 8/8/25 (Next Friday) ?RACH</p> <p>ACAT referral sent yesterday.</p> <p><i>Social Work: I will chase and confirm ACAT assessment date. Doctor's, please ensure capacity assessment has been documented. Meeting with family again today to discuss RACH pathway including interim care. Some complicated family dynamics. Can Occupational Therapist, Physio and Doctor quickly meet after this ?if patient suitable to return home with son whilst awaiting placement ?with GEMRHITH.</i></p> <p>Social Work to chase ACAT Assessment date and interim pathway. Team to meet about ?GEMRHITH. Dr to document capacity assessment. Review EDD again tomorrow.</p>
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References

1. Leonard M, Graham S, Bonacum D. The human factor: the critical importance of effective teamwork and communication in providing safe care. *Qual Saf Health Care* 2004;13(Suppl 1):i85–90.
2. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. 2nd ed. – version 2. Sydney: ACSQHC; 2021
3. Hammer C, DePrez B, White J, Lewis L, Straughen S, Buchheit R. Enhancing Hospital-Wide Patient Flow to Reduce Emergency Department Crowding and Boarding. *J Emerg Nurs*. 2022 Sep;48(5):603-609.
4. Shabbir A, Wali G, Steuer A. Four simple ward based initiatives to reduce unnecessary in-hospital patient stay: a quality improvement project. *BMJ Open Quality*. 2015 Jan 1;4(1):u208974-w3661.
5. Valente R, Santori G, Stanton L, et al. Introducing a structured daily multidisciplinary board round to safely enhance surgical ward patient flow in the bed shortage era: a quality improvement research report. *BMJ Open Quality* 2023;12:e001669.
6. Sreepathy P, Kim YJ, Ahuja Z, Shroff AR, Nazir NT. The association between implementation of multidisciplinary rounds and clinical outcomes. *Front Cardiovasc Med*. 2022 Nov 4;9:1005150.
7. Patel, Hemali MD; Yirdaw, Essey MPH; Yu, Amy MD; Slater, Lisa PharmD; Perica, Katharine PharmD, BCPS; Pierce, Read G. MD; Amaro, Connie BSN (Case Manager), RN; Jones, Christine D. MD, MS. Improving Early Discharge Using a Team-Based Structure for Discharge Multidisciplinary Rounds. *Professional Case Management* 24(2):p 83-89, March/April 2019
8. Jolly Graham A, Platt A, Knutsen K, Fletcher E, Gallagher D. Impact of geographical cohorting, multidisciplinary rounding and incremental case management support on hospital length of stay and readmission rates: a propensity weighted analysis. *BMJ Open Qual*. 2024 May 23;13(2):e002737.
9. Maniaci MJ, Dawson NL, Cowart JB, Richie EM, Suryaprasad AG, Hodge DO, Joyce NE, Kernan CA, Stone LA, Burton MC. Goal-Directed Achievement Through Geographic Location (GAGL) Reduces Patient Length of Stay and Adverse Events. *Am J Med Qual*. 2020 Jul/Aug;35(4):323-329
10. Gilfillan C, Newnham E, Nagappan R, Evans J, Compton J. A 7-day team-based model of care in general medicine: implementation and outcomes at 12 months. *Internal Medicine Journal*. 2016 Jan;46(1):79-85.