THE MULTIDISCIPLINARY TEAM

MND Care Coordinator

Specialist Consultants

Specialist Nurses

Occupational Therapist

Speech and Language therapist

Physiotherapist

District Nurses

Dietician

Medical Secretary

MND Association

Respiratory Specialists

Palliative care & Hospice Team

WHAT IS A CARE COORDINATOR

The care coordinator aims to ensure that anyone living with or affected by Motor Neurone Disease in North Wales receives high quality coordinated care at all times. Every person with a diagnosis of MND will be offered the name and contact details of the relevant MND coordinator. They will act as the key contact for the person living with this disease as well as their families and carers.

OUR ROLE IN YOUR CARE

People living with this disease will usually have a number of health and social care professionals involved in their care at any one time. They are known collectively as the Multidisciplinary Team or MDT.

It can sometimes be complex and confusing to understand the different roles of all of these people.

We offer to provide a single point of contact for patients and health care professionals by offering support and guidance and by liaising with everyone involved to coordinate patient care and thereby minimize the impact of this on the person and their families.

SHARING OF INFORMATION

Once a month the multidisciplinary team meet to discuss the care of people known to the team. All information shared at these meetings is confidential and given on a need to know basis. Some of this information may be stored on a secure database for use in auditing statistics.

If you have any concerns about the sharing of information please highlight this to your care coordinator who will be happy to answer any questions that you may have.