



College of
Respiratory Therapists
of Ontario

Identification and Preparation Tool



Evaluation and Discharge Planning

Discharge Assessment

The following is a high-level approach the interdisciplinary team can use during the preliminary stages of identifying a candidate for home or community placement.

Assessment of the Home Environment

Assessment includes geographic location, available space, and accessibility.

- ✓ A home to go to
- ✓ Home environment prepared in advance to accommodate the patient's needs
- ✓ Adequate number of grounded electrical outlets
- ✓ Respiratory equipment supplier is aware of individual
- ✓ Sturdy bedside table for the ventilator placement

Assessment of Caregivers

Caregivers must be motivated and able to learn the care routines.

- ✓ Patient is able and willing to supervise/direct care
- ✓ Individual is able and willing to participate in self care, or has sufficient caregiver assistance to adequately meet medical, respiratory, and personal care needs

Education and Training

There is a comprehensive education plan with learning objectives and evaluation for individual, family and caregivers.

- ✓ Caregivers identified and trained prior to discharge (See *Home Ventilation & Tracheostomy Care, and Education Checklist and Learning Log* provided in this manual)
- ✓ Adequate nutrition program is in place
- ✓ Successful and stable trials: for at least two weeks prior to discharge with no changes
 - On home equipment ventilator prior to discharge, (e.g. ventilator, monitor, oxygen, if applicable)
 - Leaving the hospital setting with home caregivers

Assessment of Resources

This includes professional services, support systems, individual's financial resources.

- ✓ Adequate financial resources and mechanisms for reimbursement identified prior to discharge
- ✓ Potential referrals in place: Respiriologist, Occupational Therapist, Physical Therapist, Social Worker, Registered Dietitian, Pharmacist, Community Care Access Centres (CCAC)
- ✓ Appropriate application forms completed:
 - Assistive Devices Program:
 - Tracheostomy
 - Ventilator
 - Enteral feeds, if applicable
 - Home Oxygen Program, if applicable
 - Special services at home
 - Handicapped parking permits
 - Wheelchair
- ✓ Contact the Ventilator Equipment Pool (VEP) to discuss the most appropriate equipment available and lead time for delivery

Plan of Care

A written management plan for respiratory, medical care, and emergencies.

- ✓ Individual is medically stable: oxygen requirement less than, or equal to 40%; stable blood gases; mature tracheostomy and no events requiring CPR for at least one month
- ✓ Comprehensive discharge plan in place
- ✓ The treatment plan for all medical conditions is in place
 - Plan does not require frequent changes
 - Plan is transferable to the community
- ✓ Discharge planning meetings in place, including the individual, caregivers, healthcare team and community services

Team Meetings

Initial team meetings are to take place while the ventilator assisted individual (VAI) is in the hospital.

First Team Meeting

Primary aims of this meeting are:

- ✓ Determine the short and long term goals
- ✓ Identify issues and potential barriers to discharge
- ✓ Create plans to manage issues and potential barriers to discharge
- ✓ Complete feasibility assessment of required community support
- ✓ Identify additional funding opportunities for the patient

Team members should include the individual, their caregivers and the inter-professional team:

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| ✓ Individual | ✓ Speech Language Pathologist |
| ✓ Family and caregivers | ✓ Occupational Therapist (OT) |
| ✓ Most responsible physician | ✓ Registered Dietitian (RD) |
| ✓ Nurse (RN) | ✓ Pharmacist |
| ✓ Community Respiratory Therapist (RT) | ✓ CCAC Case Manager |
| ✓ Social Worker (SW) | ✓ Discharge planner |
| ✓ Physical Therapist (PT) | |

Second Team Meeting

Primary aims of this meeting are:

- ✓ Determine if discharge to home or community facility is achievable
- ✓ Prioritize goals and timelines; those to be achieved prior to discharge
- ✓ Determine a realistic discharge date
- ✓ Delineate roles and responsibilities for all team members, including the caregiver and family
 - Care plans
 - Funding applications
 - Discharge guidelines
 - Learning needs assessments
 - Education training programs
 - Equipment acquisition

Additional team members at this meeting should include the community care providers:

- ✓ Community RT
- ✓ Community PT
- ✓ Community OT
- ✓ Nursing agency provider

Follow up Meetings

Primary aims of this meeting are:

- ✓ Monitor progress toward goals
- ✓ Update the patient and caregivers
- ✓ Identify other barriers to discharge and develop a resolution plan
- ✓ Communicate among the inter-professional disciplinary team

Placement Considerations in the Home

Adequate Daily Care Coverage

In addition to the care provided by the caregiver(s), the patient may receive additional care hours through CCAC. Access to immediate assistance is recommended for any individual who requires 24 hours ventilation or is fully dependent in their activities of daily living. This can be a trained community care provider, such as a Registered RT, Nurse, PSW or trained family member.

Individuals who live in Ontario who require suctioning or catheterization as part of their normal daily routine have a legislated exemption in the Regulated Health Professional Act (RHPA) allowing non-registered professionals to provide this service, provided they are competent to do so.

Additional Considerations

Mobility

A VAI may require a wheelchair with ventilator and oxygen carrying capacity. The vehicle used for mobility **must** be able to safely carry a ventilator and external battery without tipping. Home ventilators can weigh up to 35 lbs. Ventilator shelves can be attached to some standard wheelchairs, but some of these chairs may not be wide enough or balanced enough to hold the additional weight. Often a VAI has their own wheelchair that can be adapted by the supplier to carry the ventilator and battery. If this is not possible, an application for a customized wheelchair with ventilator carrying capability can be made.

Assessment and applications are usually made by the OT or PT and signed by the physician. The chair supplier will need the ventilator and battery dimensions. Information that can be obtained from the RT.

Other mobility devices may be required, such as ambulation aids and positioning devices (lifts).

Applying early in the process will reduce delays. Check with the equipment provider for the anticipated delivery date.

Equipment Acquisition

The Ministry of Health and Long-Term Care (MOHLTC) funds 75% of the cost of respiratory supplies through the Assisted Devices Program (ADP). **The remaining 25% is the responsibility of the individual.**

Contact the VEP or alternate provider for details on equipment acquisition. Note: some individuals are not eligible for equipment through the VEP. For example, patients discharged to long term care facilities do not have access to VEP equipment. See VEP website for more information on eligibility <http://www.ontvep.ca>.

Home Mechanical Ventilators

A VAI discharged to the community is provided with:

- ✓ Ventilator(s)
- ✓ Battery charger
- ✓ Heated humidifier
- ✓ External battery for emergency power only
- ✓ Battery cable
- ✓ Re-useable ventilator circuits

The cost of **this** equipment is 100% covered by the MOHLTC, through ADP. Applications must be signed by the physician.

The VAI should have completed several successful trials on a home mechanical ventilator, before setting them up for indefinite use.

Other Respiratory Supplies

Requests are made by the home respiratory care service, to the ADP. This equipment may include:

- ✓ Apnea cardiorespiratory monitors
- ✓ Compressors for aerosolized medication delivery
- ✓ Postural drainage boards
- ✓ Suction machines
- ✓ Tracheostomy supplies
- ✓ Percussors
- ✓ Resuscitators
- ✓ Positive airway pressure systems

75% of the cost of **this** equipment may be covered by the MOHLTC. **The remaining 25% is the responsibility of the individual.**

Some equipment, although necessary for some VAIs, may not be funded through ADP. The following equipment is **not** funded:

- cough-assist devices
- oximeters for individuals 18 years or older
- 12 volt batteries for mobility purposes

Other Medical Supplies

Other medical supplies may be necessary in the community setting and eligible for ADP funding e.g. enteral feed equipment. Check with the interprofessional healthcare team for details.

Individual, Home Care Providers and Family Education

A successful discharge requires a simplified and comprehensive transfer of care routines from healthcare team to the community provider team. Ideally the community team would receive the transfer of skills within the acute care facility. This allows them to be in direct contact with the individual and work closely with the acute care team. This training technique serves to increase the confidence and comfort of both the community care providers, the individual and the caregivers.

Information provided in respiratory teaching packages typically should cover:

- ✓ Tracheostomy and ventilator care
- ✓ Individual-specific training checklist that must be completed prior to discharge; can also be used as a scheduling guide
- ✓ Emergency guidelines that are provided to address common problems that may arise within the home environment

Respiratory Education

The training should include, but is not limited to:

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| ✓ Respiratory anatomy and physiology | ✓ Use of the manual resuscitator bag |
| ✓ Hands-on training with tracheal suctioning | ✓ Switching to ventilator battery |
| ✓ Ventilator troubleshooting and maintenance | ✓ Charging the ventilator battery |
| ✓ Tracheostomy tube cuff care; changing if applicable | ✓ Circuit assembly |
| | ✓ Emergency planning |
| | ✓ Cleaning of equipment |
| | ✓ Volume augmentation manoeuvres |

Emergency Plan and Recommended Physician Coverage

Emergency guidelines are provided to address common problems that may arise within the home environment. These guidelines are provided for each individual and placement situation. Included are: what should be done; who should do it; what services should be called, etc.

The individual's wishes regarding resuscitative efforts should be addressed and be available in the home for emergency response personnel.

The individual must have:

- ✓ A Family Physician who will manage day to day general medical needs
- ✓ A Respiriologist or other consultant who has expertise in mechanical ventilation, to manage ventilation needs
- ✓ A “home-base” hospital location should an emergency occur that cannot be solved at home. Ideally this is the acute-care facility discharging the individual home

For those caregivers wishing for Cardiopulmonary Resuscitation (CPR) certification, discuss this training with your healthcare provider.

Guidelines are provided that include contact numbers of home care providers and support services.

Communication and Transfer of Information to Community Providers

With the individual’s consent, the discharge team should ensure the community care partners receive information on:

- ✓ Medical history
- ✓ Written consent
- ✓ Care plan, preferences, daily routines, typical patterns where interventions are required
- ✓ Transfer and discharge notes from the discharging physician
- ✓ Emergency guidelines
- ✓ Equipment and supplies list

References

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