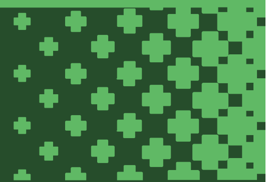
PROVINCIAL LONG-TERM VENTILATION STRATEGY

# LTV to COMMUNITY DISCHARGE CHECKLIST

*To be used to help teams prepare for the transition of Ventilator Assisted Individuals from hospital to the community.*

*Please Note: Some regional differences may exist*



## 1. INITIAL DISCHARGE PLANNING

☐ Medical team feels community is an appropriate discharge location

☐ Patient has adequate family support (if applicable)

☐ Patient has a primary care provider (MD or NP)

☐ Patient has a follow-up plan for respiratory care (Respirologist has agreed to manage patient)

☐ Discharge location determined – home, attendant living, group home or other

☐ Available Resources:

- ☐ Financial situation of patient/family reviewed (e.g. CPP Disability, WSIB, ODSP, Private Insurance)
- ☐ Funding options discussed (e.g. direct funding)
- ☐ Nursing model of care discussed (privately hired, family managed care, traditional shift nursing)

☐ Patient has access to community respiratory therapy support (e.g. Respiratory home care vendor; Home and Community Care Support Services (HCCSS); Comprehensive Respiratory Care (CRC); or privately hired)

☐ **Initial Meeting with medical team (physician, discharge planner, respiratory therapist, HCCSS, patient, family, caregivers, and community partners) to discuss target discharge date, program details and expectations.**

## 2. PROGRAM GOALS AND DISCHARGE

☐ Optimize ventilation and reduce burden of care wherever possible (e.g. reduce or discontinue oxygen, discontinue any non-necessary care needs, maximize ventilator free time if possible)

☐ Required in hospital Caregiver and Family Training completed (e.g. Tracheostomy Care, Ventilator, Ventilator Troubleshooting, Medication Administration, Nutrition, Bowel Routine, Transfers, Personal Care, What to Do in Emergencies, Who to Call for: Medical Care, Ventilator Troubleshooting, Power Outages, Replacement Supplies etc.)

Free interactive e-learning modules, checklists and other valuable resources are available on www.ontariolongtermventilation.com

☐ A written record of all ventilator and alarm settings and medications

☐ Caregiver schedule completed (where applicable) with a backup plan for sick calls, vacations, etc.

☐ Appropriate funding applications submitted

  ☐ ADP or other applications submitted for devices (e.g. ventilator, mechanical in-exsufflator) and supplies required in the community

  ☐ Vendor for respiratory supplies identified, ADP applications submitted and supplies ordered (e.g. suction machine, catheters, tracheostomy supplies)

  ☐ Any other devices and supplies ordered (e.g. feeding pump, bed, lifts, commode, etc.)

  ☐ Others (e.g. WSIB, Veteran's Affairs)

☐ Ensure home is accessible and safe (e.g. home modifications)

☐ **Midway meeting with medical team, patient, family, caregivers, and community partners to discuss discharge date, caregiver availability and any other issues of concern**

☐ Switch patient to Ventilator Equipment Pool (VEP) equipment close to discharge; provide training on VEP equipment.

Equipment manuals, videos and print material are available on http://www.ontvep.ca

☐ Ensure all ordered supplies and equipment have arrived and are familiar to patient and caregivers to ensure they are usable at home. Use a checklist

☐ **Final discharge meeting with medical team, patient, family, caregivers, and community partners to ensure final details and concerns have been addressed including review of caregiver schedule and backup plan**

☐ Confirm transport to discharge location as required

☐ Convey care plans to all providers including but not limited to: primary and specialist care, HCCSS, Ventilator Equipment Pool, respiratory therapy community care providers, vendors and pharmacist.

☐ Ensure equipment is set up in discharge location

☐ Provide patient/family with prescription for medications to be filled prior to discharge

## 3. Day of Discharge

- ☐ Should be early during the day and not on Fridays
- ☐ Emergency equipment to accompany patient during transport (e.g. resuscitation bag, portable suction).
- ☐ Trained caregiver to accompany invasively ventilated patients
- ☐ Ensure completed discharge summary including ventilator and alarm settings is provided to community providers and primary care team
- ☐ Ensure all medications have been dispensed by pharmacy

## 4. Follow-Up

- ☐ In-home visit by HCCSS, community partners (e.g. CRC, community respiratory care) within 48 hours
- ☐ Primary care appointment booked for within 30 days
- ☐ Respirologist follow-up 2-3 months post discharge or as indicated
- ☐ Regular in-person or virtual follow up with patient by HCCSS care coordinator

## Additional Notes