PICU discharge process map for new chronic home invasive ventilation

**Pre-Tracheostomy**

- Primary team identifies and introduces the need for a tracheostomy and chronic home invasive ventilation to family/caregiver

**Consults:**
- ENT
- Pulmonology
- Surgery
- Social Work
- RN Care Coordinator
- Child Life
- Supportive Care

**Call Transitional Care Facilities re: bed status and assess family/caregiver’s informal support system**

- Show family/caregiver the trach doll

**Family/caregiver meeting**
- *see agenda*

**Yes**

- Introduce “Trach Book” and set initial education goals

**No**

- Goals of Care discussion

**Complete Face to Face for Private Duty Nursing (PDN) and referral to Durable Medical Equipment (DME) agency**

**Post-Tracheostomy**

**Caregiver education (hands off)**

- Order bedside tracheostomy tubes

- Create education calendar with “appointments” and post bedside

- Educate family/caregiver to Medicaid waiver and SSI

- Complete Uniform Assessment Instrument (UAI) and Level II screening

- Send referrals to Transitional Care Facilities

**Post-Trach Week 1**

- Referrals: Care Connection
- Early Intervention
- Power Company

**Consults:**
- Speech/PT/OT

**Post-Trach Week 2–3**

- Education goals

**Consults:**
- ENT
- Pulmonology
- Surgery
- Social Work
- RN Care Coordinator
- Child Life
- Supportive Care

**Goals of Care discussion**

**Complete Face to Face for Private Duty Nursing (PDN) and referral to Durable Medical Equipment (DME) agency**

**Show family/caregiver the trach doll**

**Caregiver education (hands on)**

- Follow up on home nursing

- Check in with caregivers on progress of education

- Reassess informal support system

- Home inspection

**Optimize ventilator settings on hospital ventilator**

**KEY**
- PICU Provider
- RN Care Coordinator
- Nursing Leader
- Social Work
- Childlife
- Respiratory Therapy
- Pulmonology Provider
- ENT
PICU discharge process map for new chronic home invasive ventilation – post-trach week 4-7

**Post-Trach Week 4–5**
- Caregiver education (hands on)
  - Follow up on home nursing
  - Check in with caregivers on progress of education
  - Identify home ventilator to be used (consult with outside pulmonologist if follow up care will not be with CHoR)
- DME is delivered and caregiver is educated to DME
- Get prior authorizations for home medications
- Schedule follow up appointments
- Order new formula
- Home nursing meet and greet
- Caregiver education completed
- Confirm family/ caregiver is signed up MyChart
- Carseat trial
- Educate to Medicaid transport
- Fill discharge medications and give vaccinations including palivizumab (ie. Synagis) if indicated

**Post-Trach Week 6–7**
- Caregivers Room-in using patient’s home DME + Travel with patient (minimum 48 hours)
- Appointment
- Transition from hospital ventilator to hospital provided home ventilator
- Discharge to home!
  - Approximately 48 hours before discharge, ensure patient is on their DME provided home ventilator
  - Arrange discharge transport
  - Post discharge day 2–3: RNCC follow up call to caregiver
  - Post discharge day 7–10: Pulmonology RN follow up call to caregiver

**KEY**
- PICU Provider
- RN Care Coordinator
- Nursing Leader
- Social Work
- Childlife
- Respiratory Therapy
- Pulmonology Provider

**See Brook Road Path if accepted for admission and caregiver wants admission**

**Version 2: 3/20/22**
Tracheostomy family/caregiver meeting agenda

Participants

- PICU Medical Provider:
- Pulmonology Physician and Alex Bediako
- ENT Provider:
- Social Work:
- RNCC:
- Childlife:
- RT Leadership: Jen Reed
- Nursing (Clinical Coordinator):
- Family:

Agenda

- PICU- Medical update including the reason a tracheostomy is being considered, benefits of a tracheostomy?
- ENT- details about the tracheostomy surgery and management of the tracheostomy
  - What does life with a tracheostomy look like? At home? Follow up needed
- Pulmonology- Management of the ventilator- What does life with a ventilator look like? At home? (caregiver eyes on at all times), Follow up needed
- Care Coordination- Progression from OR to DC and support for DC (brief summary)
  - Home assessment, DME, Home RN
  - Expectations for participation from family- ie: two caregivers, rooming in, etc
  - Dual DC plan- Home and Transitional Care Facility
  - Weekly family meetings, complex care WATER rounds on Wednesdays, Complex Care Clinic support
- RT/RN- Education to “Trach book” and teaching process
- Family Questions
- Next Steps - Who is going to follow up with who and when?
PICU discharge process for new chronic home invasive ventilation executive summary

Children’s Hospital of Richmond at VCU health pediatric complex discharge workgroup

Care Coordination Owner: Patty Benninghove, MSW, LCSW
Pediatric Intensive Care Owner: Dale Purrington, MSN, RN, CPNP-AC
Pediatric Pulmonology: Alex Bediako, RN
Pediatric Pulmonology: Dr. Jonathan Ma, MD
Pediatric Intensive Care: Elizabeth Overstreet, RN
Pediatric Respiratory Therapy: Jennifer Reed, RT
Care Coordination Nursing: Audrey Spradling, RN

Approved (February 2022)

References


Ventilator Care Program: Caregiver Education. Children’s Hospital Colorado. 2013