

Preparation of an ICU Patient for Transfer to LTV Unit

The Long-term Ventilation (LTV) Strategy is a provincial initiative to develop and implement an integrated service delivery model for individuals who use long-term ventilation and those at-risk of becoming ventilator dependent. One of the first activities within the strategy is to transfer suitable LTV patients out of critical care units and into one of 14 new LTV beds.

The transfer of patients from a critical care setting to a more permanent residence is an adjustment for everyone involved – patients, families, and staff. One of the goals of the LTV Strategy is that ventilator-assisted individuals experience seamless and timely transitions from one care setting to another.

As part of the transfer process, these readiness guidelines were developed with guidance from West Park Healthcare Centre's Long-Term Ventilation Centre of Excellence, and can be used as a tool for smooth transition purposes. They are suggested guidelines only, as we recognize that individuals in the ICU are in the care of the ICU team who are best able to manage and respond to their care needs.

Decrease invasive monitoring:

- Remove arterial lines, nasogastric tube, other invasive lines/tubes. If patient cannot have oral intake, switch NG tube to G-tube or J-tube
- Cap PICC lines if possible. Check with nursing to see if this is necessary
- Reduce blood work frequency
- Ensure patient is on lowest FiO₂ (to maintain SpO₂ 88 – 92%) and lowest PEEP if at all required
- Try to avoid using continuous pulse oximetry once arterial blood gases and oximetry have established oxygen requirements. Use periodic assessments of SpO₂.
- If available, switch the patient from the typical ICU ventilator to one that would be used in the LTV unit/ community setting

Treatment Plan

- If weaning is considered an option, consult/refer to Toronto East General Weaning Centre of Excellence. Request ICU staff to switch terminology used with patient from “weaning” to “ventilator free time” and encourage patient to continue as tolerated. Reinforce with staff and patient/ family that ANY possible ventilator free time increases patient's safety in case of accidental disconnection from ventilator, increases patient's sense of independence and decreases caregiver anxiety.
- Reassess patient to ensure that patient is well rested and well fed.
- Select a tracheostomy tube that is most appropriate for the patient's comfort and goals. . The most desirable features for the new tracheostomy tube are;
 - cuffless or 'Tight to Shaft' cuff - decrease secretions from irritation of cuff, increased potential for speech, increased sense of smell and taste
 - nonfenestrated. – limit cause of granulomatous tissue in airway
 - reusable inner cannula, - keep inner lumen clear, teach patient to cough to inner cannula and thereby decrease suctioning.

Other tracheostomy tube models or characteristics are fully acceptable, if these choices are not suitable. Changing the tracheostomy tube is not a necessity before transferring to LTV Unit. If referring unit does not have access to or experience with alternative tracheostomy tubes, it would be better for the patient to wait until transfer to a LTV unit. If a specialty tracheostomy tube is selected, ensure that proper documentation is available for the LTV unit including all reordering information.

- For mechanical ventilation, use the simplest settings when possible. Use assist control mode whenever possible since the most widely available 'invasive', adult ventilator does not have a pressure support option. It is possible to petition the Ministry of Health for a ventilator with pressure support if this is the only possible approach to ventilate the patient.
- Assess the patient for the ability to communicate/speak while ventilated (cuff deflation, cuffless tube or speaking valve/ one way valve usage).
- Consider a swallowing by Speech-Language Pathologist, if not already completed

Increase independence:

- Discuss differences between ICU care and care in a LTV hospital and home setting (if this is an option). ie; expectation that patient will dress daily, radically reduced patient/staff ratio, increased independence
- Educate and train patient/family on bagging and suctioning techniques. These will be reinforced in the receiving LTV hospital.
- Move to an area of the ICU with less activity if possible; step down nursing complement; encourage use of a call bell, if able
- Dress patient in his/her own clothes
- Get patient up in chair – Have Occupational Therapist assess and begin process for obtaining equipment necessary for mobility and increased independence; payment by patient/family may be necessary
- Consider taking patient out of ICU for short periods of time ie with staff and/or family
- Establish a routine bowel/bladder plan of care; regular day/night routine
- Have family tour the LTC hospital; have someone from the receiving hospital speak with family about the program

Other:

- Co-payment charges should be discussed with the family
- Possible equipment & service charges – ie TV, telephone, chiropody, hairdressing etc

***Developed by the LTV Patient Transfer Working Group through the Toronto Central Local Health Integration Network.
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