Transitioning the Complex, Technology Dependent Adult From Hospital to Home

Stacey Rice, BSN, RN, CRRN, CCM
March 14, 2019
At the end of this session, the learner will be able to:

- Identify common diseases/disorders associated with the adult client
- Identify common equipment utilized by the technology dependent client
- Explain other medical equipment utilized in the care of the client at home
- Identify the steps involved when preparing a technology dependent client and their caregivers for discharge to home
- Identify potential emergency situations associated with the client’s airway and equipment emergencies
There's No Place Like Home

- Higher client satisfaction
- Keeps families together
- Promotes healing
- Maximizes freedom
- Cost efficient
- Personalizes care

BAYADA

WE LOVE WHAT WE DO
I Need Home Care

What kind of care is needed?

- Personal Care Services

- Intermittent Therapy Visits

- Skilled hourly care - hourly nursing care by a professional, licensed nurse. (RN or LPN)
Coverage for Home Care

- The first step in determining whether home care is an option is an insurance benefit confirmation.

- Does the patient have a private duty nursing benefit for skilled high tech nursing care at home?
  - Is it limited?
  - What is the authorization process?
Alternative Coverage

- State Waiver Programs-Medicaid
- Long Term Care Insurance
- Veteran’s Administration
- Private pay
- State or Association respite programs (ALS, MS, MD)
- Workmen’s Compensation
The goal of home care is to help clients have a safe home life with comfort, independence, and dignity.
Family Readiness

- Client and Caregivers are committed and motivated to learn
- Provide time and opportunities needed for teaching
- Facility staff provides teaching. Home care staff will continue reinforcement of skills at home.
Discharge Goals

- Discharge instructions are explained to the client and family
- Prescriptions are given to the family 2-3 days ahead of discharge
- Coordinated plan—with all providers (DME, Home Care, Transportation, physician)
- Family/Caregivers comfortable with training provided

The challenge is to meet these goals before discharge!
Barriers in Facility Setting

- Medical instability
- Physicians don’t believe the client can go home safely with home care
- Inability for patient and family to accept the condition and its permanency
- Client/caregiver lack of readiness to learn, anxiety, fear
Barriers in the Home

- No consistent caregiver in the home
- Insurance approved hours of service are insufficient to the client’s needs
- Inability for a Home Care Agency to staff the hours prescribed
- Lack of physician coverage once home
Case Study: Jack

Jack is a 40 year plumber. He was injured on a construction site when a steel beam fell on him while he was in a port a john.

He went into cardiac arrest and suffered a TBI.
Jack’s had a complicated hospital stay

- He was flown by medivac to a University Hospital.
- He was diagnosed with TBI, respiratory failure and exhibited decerebrate posturing.
- Tracheostomy and ventilator dependent.
- Disorders of consciousness
- Skin breakdown
- Gastrostomy tube
- Foley Catheter
Jack wants to go home!

Jack spent 2 months in the hospital and 4 months in rehabilitation due to complications. He then went to an LTACH to attempt ventilator weaning.

His family is devastated, but trying to put the pieces of their life back together.

They want Jack to continue his care at home.
Involve Transitional Care

When the decision has been made to send the patient home, contact a Home Care Agency and enlist the assistance of their Transitional Care Manager.

The Transitional Care Manager will:
- Confirm benefits
- Assist with obtaining authorization
- Coordinate with appropriate home care service office
- Educate the family about home care
- Assist discharge planner coordinate services
About Jack’s Caregivers

- What is their understanding of Jack’s condition & prognosis?
- What is their expectation of homecare?
- What do they know about Jack’s care?
- What do they need to learn about Jack’s care?
- What is their family commitment to provide care?
What do you need to know about the home?

• Where will Jack’s primary care area be?
• Is there adequate power & outlets to support his equipment?
• Is there adequate storage & accessibility of supplies in the area of Jack’s care?
• Is there adequate lighting, heating, & phone access in his care area?
• Can he safely exit the home in an Emergency?
Home Modifications

- Ramps
- Bathroom
- Lifts-floor/ceiling
- Lower counter tops/sinks
- Voice activated doors/home
- Environmental control boards
Goals for Discharge

- Caregiver knowledge of all medical devices going home
- Jack stable on home ventilator prior to discharge
- Candy had CPR Training
- Candy has assisted with one trach change
- Candy has provided hands on care while Jack is in the facility.
- Safe home environment
Teaching for Nurses and Caregivers

- Respiratory equipment
  - Ventilator malfunction
- Tracheostomy Care
  - Routine
  - Emergency
- Skin care and transfers
- Bowel and Bladder Program
- Mobility Equipment
- Enteral therapy
Emergencies

- Emergency plan
- Emergency exit
- To Emergency Room via 911
Keys to Success

- Start planning 2-4 weeks prior to discharge (the more time the better)
- Coordination of teaching schedules between facility and home care agency staff on paper
- Commitment to get the job done
- Give family time to absorb what they learn
- Family needs hands on experience- utilize SIM if available
Who are your resources?

- Physician
- Hospital staff
- Equipment company
- Insurance Case Manager
- Discharge Case Manager
- Community Resources
- Home Care Staff
- Parents or other caregivers
Preparing the Caregiver

- Chaos shortly before discharge and two weeks after discharge
- Many different people in home - have to repeat the same things over and over, also staff have different personalities
- Just when you think you’re going to pull your hair out, all of a sudden everything falls into place.
- Sleep deprivation - even caregivers who are competent can be afraid to sleep for the first few nights / don’t know the nurses caring for their family
- Guilt - all attention on patient not other family members
Transportation

- Bringing patient home
- Customized Community Transportation /Paratransit /Accessible Services
- Obtaining a van
The Homecoming

- Nursing supervisor and nursing staff meet the transportation vehicle at home upon arrival.
- Respiratory company at home to set up equipment
- Nursing staff assist caregiver with supply organization
- Overall safety assessment

Jack is living his best life at home with his family!
Questions


