Provincial Long-Stay ICU and Weaning Programs Screening Tool

Use this screening tool for **all Provincial Mechanical Ventilation Weaning Programs** including:

- **Long Stay Critical Care program (LSP)** at Mackenzie Health (MH). LongStayICU@MackenzieHealth.ca
- **Long Stay Critical Care program (LSP)** and the **Provincial Progressive Weaning Centre of Excellence (PWC)** at Michael Garron Hospital (MGH). Prolonged.ventilation@tehn.ca
  - MGH will determine which program, LSP or PWC, is best for your patient

All Provincial Mechanical Ventilation Weaning Programs are subject to the Ontario Health directive regarding repatriation of patients when needed.

Criteria	True
ICU & Respiratory Supports	
Patient is ≥ 18 years of age and is currently admitted to a Level 3 ICU in Ontario.	
Patient's ICU length of stay is ≥ 10 days with reasonable evidence of needing a much longer ICU length of stay.	
Patient requires **daytime invasive or non-invasive ventilation** (CPAP, BiPAP), **or high flow oxygen** at least part of the day.	
Patient has the potential for liberation from invasive mechanical ventilation & is not anticipated to require long term mechanical ventilation indefinitely.	
Patient is **not** tolerating continuous trach mask trials (TMTs) > 24h.	
Previous Conditions	
Patient does **not** have a condition that precludes the potential for participation in rehabilitation and liberation from mechanical ventilation.	
Other Required Supports	
Patient's current vasopressor requirement is **less than** 0.5 mcg/kg/min *norepinephrine equivalent*.	
Patient was **not** previously requiring long-term (home) invasive mechanical ventilation prior to current admission.	
Patient is **not** requiring peritoneal dialysis or cardiac mechanical devices (e.g., left ventricular assist device).	
Patient does **not** require ongoing care that can only be provided by the surgical service at the referring hospital.	
Social Supports & Goals of Care	
Goals of care are clearly established, documented, and appropriate for transfer to a Weaning Program (LSP/PWC).	
Patient and substitute decision maker (SDM) have a clear understanding of the purposes and limitations of the LSP/PWC programs & agree to LSP/PWC consultation.	

Provincial Long-Stay ICU and Weaning Programs Referral Form

Use this form for **all Provincial Mechanical Ventilation Weaning Programs** including:

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PATIENT INFORMATION	
First and last name:	
Date of birth:	
Age:	
Gender at birth:	
Gender identity:	
OHIP health card:	
Address:	
Home (Voice) phone:	
Mobile (Text) phone:	
Email address:	
ICU admission date:	

REFERRING CENTRE INFORMATION	
Referring hospital:	
Referring physician:	
Primary application contact:	
Primary contact info:	

SUBSTITUTE DECISION MAKER (SDM)	
First and last name:	
Relationship to patient:	
Home (Voice) phone:	
Mobile (Text) phone:	
Email address:	
Power of attorney paperwork available:	□ Y □ N
Is SDM supportive of application:	□ Y □ N

PATIENT'S SOCIAL SITUATION PRE-ADMISSION:

GOALS OF CARE

Code Status: □ Full Code □ DNR except invasive ventilation □ DNR full medical management □ Palliative Care

ADMISSION DETAILS

Primary admission diagnoses:

Date of hospital admission:
MM - DD - YYYY

PAST MEDICAL HISTORY and HOSPITAL COURSE:

Please provide patient's past medical history and a synopsis of the patient's course in hospital and pertinent complications (major events, complications, surgeries…)
□ see dictated chart review / transfer note instead

PAST MEDICAL HISTORY HIGHLIGHTS	
Central Nervous System Disease:	☐ Y ☐ N
Spinal Cord Injury:	☐ Y ☐ N
Hemodialysis dependent:	☐ Y ☐ N
Peritoneal dialysis dependent:	☐ Y ☐ N
Approaching long-term dialysis:	☐ Y ☐ N
If on dialysis or nearing dialysis, which Chronic Kidney Disease Program is the patient known to?	

PRE-HOSPITALIZATION FUNCTION/ INDEPENDENCE				
Activities of Daily Living (e.g., bathing, dressing, grooming, toileting, walking...)	☐ Independent	☐ Needs help	☐ Dependent	☐ Cannot do
Instrumental Activities of Daily Living (e.g., shopping, housework, finances...)	☐ Independent	☐ Needs help	☐ Dependent	☐ Cannot do

CRITICAL ILLNESS COMPLICATIONS (Please select all that apply)

- ☐ Slow to wean from IMV
- ☐ Slow to wean from NIV
- ☐ Secretions
- ☐ Mucous plugging
- ☐ Dyssynchrony with ventilator
- ☐ Respiratory acidosis
- ☐ Aspiration events/ pneumonia
- ☐ Ventilator-associated pneumonia
- ☐ Hypoxemic episodes
- ☐ Persistently decreased level of consciousness
- ☐ Persistent agitation
- ☐ Delirium
- ☐ Mood issues
- ☐ Prolonged vasopressor dependence
- ☐ Malnutrition/ nutritional deficiencies
- ☐ Intolerance of enteral feeds
- ☐ Physical deconditioning/ decreased muscle strength
- ☐ Clinical polymyoneuropathy
- ☐ EMG-diagnosed polymyoneuropathy
- ☐ Diaphragmatic paralysis
- ☐ Foot drop
- ☐ Other (please specify):

AIRWAY and BREATHING

INVASIVELY VENTILATED PATIENTS	
Date of first intubation:	
How many times has the patient required re-intubation:	
Approximate total number of ventilation days:	
History of difficult intubation:	☐ Y ☐ N
Does the patient have a tracheostomy tube in place:	☐ Y ☐ N
Date of tracheostomy tube insertion:	
Date of last tracheostomy tube change:	
Any tracheostomy or other airway concerns (e.g. tight stoma, subglottic stenosis…):	
Frequency of suctioning:	

MECHANICAL VENTILATION HISTORY				
Ventilator settings / Mode of Ventilation:				
Tolerance of ***support mode*** ventilation (e.g., pressure support or other support modes):	☐ Tolerates 24 hours per day	☐ Tolerates during the day only	☐ Tolerates for limited time (please specify minutes/hours tolerated):	☐ Does not tolerate any support mode ventilation
Does the patient tolerate spontaneous breathing trials (SBT):				☐ Y ☐ N
If no, why not:				

FOR PATIENTS WITH A TRACHEOSTOMY TUBE	
Have trach mask trials (TMTs) been attempted:	☐ Y ☐ N
Current duration of TMTs in hours:	
Date of LAST trach mask trial (TMT):	
Displayed symptoms/ signs of intolerance? Why was the trach mask trial stopped?	
Was the patient on home mechanical ventilation prior to admission:	☐ Y ☐ N
Was the patient on home non-invasive ventilation (NIV) / BiPAP prior to admission:	☐ Y ☐ N
Was the patient on CPAP prior to admission:	☐ Y ☐ N
In the opinion of the treating clinician, does the patient have the potential to be liberated from mechanical ventilation with time / rehabilitation:	☐ Y ☐ N
In the opinion of the treating physician, what are the barriers to liberation from mechanical ventilation:	

CURRENT REVIEW OF SYSTEMS

HEMODYNAMICS	
Has the patient required vasopressors in the past 72 hours:	☐ Y ☐ N
If yes, names, dosages, pattern (i.e., continuous vs. intermittent):	

RENAL FUNCTION	
Is the patient currently receiving renal replacement therapy:	☐ Y ☐ N
If yes, start date:	
Current type of dialysis:	
Frequency:	
Does the patient require chronic renal replacement therapy:	☐ Y ☐ N

NEUROLOGICAL COMPLICATIONS	
Any major neurological complications during the current hospitalization:	☐ Y ☐ N
If yes, please summarize the clinical deficits and diagnostic imaging report:	

LEVEL OF CONSCIOUSNESS	
Is the patient on sedation at least part of the time:	☐ Y ☐ N
If yes, please indicate type of sedation & dose ranges:	
Level of consciousness (LOC) in the last 72 hours:	
☐ Awake and calm ☐ Awake and agitated ☐ Drowsy but rousable ☐ Unresponsive	

DELIRIUM SCREEN	
Does the patient suffer from delirium:	☐ Y ☐ N
Has the patient been in restraints at least part of the time in the past week:	☐ Y ☐ N

PATIENT'S COMMUNICATION ABILITIES			
Is the patient able to follow commands:	□ Y	□ N	□ Not consistently
Is the patient able to communicate:	□ Y	□ N	□ Language barrier
Is the patient able to use a call bell appropriately:	□ Y	□ N	□ Not Consistently

Which of the following communication methods can the patient use appropriately:

□ Verbal (e.g., trach with speaking valve)
□ Mouths words
□ Communication devices (e.g., communication board)
□ Others, please specify: _____
□ None of the above / unable to communicate.

PHYSICAL FUNCTION

Which of the following physical activities has the patient achieved as of this application:

□ Lying in bed/ passive movements only
□ Sitting, exercises in bed
□ Sitting over edge of bed, no truncal control
□ Sitting over edge of bed, with truncal control
□ Mobilization to chair with Hoyer lift / equipment
□ Mobilization to chair with ≥ 2 person assistance
□ Mobilization to chair with 1 person assistance
□ Standing with assistance
□ Standing without assistance
□ Walking with assistance

Is the patient currently able to actively participate with physical therapy?	□ Y □ N
Is the patient mostly motivated to actively participate with physical therapy?	□ Y □ N

DIET	
□ po diet:	
□ enteral feeds:	

SIGN OFF	
Form completed by:	
Designation (i.e., MD, RN, SW…)	
Direct unit phone number:	
Date:	