Admissions: Complex Continuing Care

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The Complex Continuing Care team serves to facilitate discharge to the community for clients up to the age of 18 years with chronic complex illness or multi-system diseases. An interdisciplinary team provides collaborative assessment and intervention for children and adolescents by facilitating habilitation/rehabilitation to assist with reintegration into the family, school and community.

Examples of Conditions:

The children we serve have diagnoses including (but not limited to): cerebral palsy, spina bifida, neuromuscular disorders, genetic disorders, respiratory insufficiency (congenital or acquired airway and respiratory abnormalities), spinal cord injuries with tracheostomy and/or ventilation needs, global developmental delay/developmental disability, congenital anomalies, cardiac conditions, seizure disorders, other complex neurological disorders, multi-system diseases

Admission Criteria:

- Patient's condition has stabilized to the point that acute care is **NOT** medically necessary but requires ongoing medical assessment and intervention; an onsite or OTN review maybe required. Example:
    - Stable oxygen requirements
    - Stable tracheostomy (i.e. initial tracheostomy change done by ENT in acute care centre prior to transfer)
    - Does not require daily blood tests and/or other diagnostic interventions
- Client is **technology dependent** and/or a user of high intensity care (at least one criterion from the following):
    - Child is dependent at least part of each day on mechanical ventilators, and/or
    - Child requires prolonged administration of nutritional substances or drugs via a central line, and/or
    - Child has prolonged (≥ 1 month) dependence on other device-based support, including: tracheostomy tube care, suctioning, oxygen support, or tube feeding, and/or
    - Child has prolonged (≥ 1 month) dependence on any other medical devices to compensate for vital bodily functions, and requires daily or near daily nursing care, e.g., urinary catheters or colostomy bags plus substantial nursing care, and/or
    - Child is not technologically dependent but has any chronic condition that requires as great a level of care as the above group, such as:
        - children who, as a consequence of their illness, are completely dependent on others for activities of daily living at an age when they would not otherwise be so dependent
        - children who require constant medical or nursing supervision or monitoring resulting from the complexity of their condition and/or the quantity of oral drugs and therapy they receive
- Client is **medically fragile** (at least one criterion from the following):
    - The child has a severe and/or life-threatening disease
    - Failure of equipment or treatment places the child at immediate risk

    - Short-term changes in the child's health status (e.g. an intercurrent illness) put them at immediate serious health risk
    - As a consequence of the child's illness, the child remains at significant risk of unpredictable life-threatening deterioration, necessitating round-the-clock monitoring by a knowledgeable caregiver
- Client has a **chronic medical issue** (i.e. the child's condition is expected to last at least 6 more months)
- The client has **complex medical issues** (at least one criterion from the following):
    - Involvement of multiple health care practitioners
    - Health care services delivered in at least 3 of the following locations:
        - Home
        - School
        - Hospital
        - Children's treatment centre
        - Community-based clinic (e.g. doctor's office)
        - Other (at clinician's discretion)
- Patient/family/community care providers require instruction and/or discharge planning prior to transitioning from acute care to the community given their child's complex medical issues
- Clients who are not a danger to themselves
- Clients with no drug/alcohol dependency
- A transition plan to home or the community has been identified prior to admission

Services Include:

- Interdisciplinary medical services
    - Including physician, nursing, pharmacy, dietician support
- Respiratory support
    - Including respiratory therapist with expertise in chronic care ventilation
    - Instruction provided to patient/family/community care providers on all aspects of the client's respiratory care including but not limited to tracheostomy with or without mechanical ventilation
    - Initiation of mechanical ventilation (invasive or non-invasive)
    - Weaning/discontinuation of mechanical ventilation and or tracheostomy
    - Non-invasive mask interface acclimatization
    - Screening sleep assessments
- Therapy services
    - Including physiotherapy, occupational therapy, speech and language pathology
    - Habilitation/rehabilitation is determined as appropriate for each client by the CTC team following a comprehensive intake assessment
- Psychosocial support
    - Including social work, child life, therapeutic recreation, therapeutic clowns, music therapy
- School/therapeutic playroom
    - As deemed appropriate based on the client's medical issues and age
- Teaching and training to facilitate discharge to the community
    - Includes but not limited to teaching/training of patient, family, community care providers, school, etc.

- Coordinate funding and equipment needs
- Discharge planning through integration with the community team
    - Liaise with the community school, CCAC, local Ontario Association of Children's Rehabilitation Services (OACRS) facility
- Graduated/stepped transition to the community to build the confidence and capacity of the family and broader community care team
    - Strategies include but are not limited to care by parent, scheduled leave of absence
- Ongoing overnight respite support following discharge