**TEAM: HIGHLANDS AT BRIGHTON – VENTILATOR UNIT**

As a unique setting in healthcare, the Highlands at Brighton Ventilator unit faces diverse challenges which require a multidisciplinary, multifaceted approach to enabling our patients and families to return “home” after a tumultuous and often very lengthy hospitalization. The multidisciplinary team consisting of certified nursing assistants, LPNs, RNs, respiratory therapists, social work, physician assistants, attending physician, physical therapy, occupational therapy, speech therapy, and all of the operational staff work together to create home.

This team approaches home in two ways. Initially the focus is on transitioning from the intensive care environment to a pseudo nursing home environment. This creates a significant challenge for the team with every family. The family and patient are coming from an environment of continuous monitoring and stimulation to an environment of minimal monitoring with a focus on engaging in life activities. This transition period involves an intense period of getting to know one another. As the team works to encompass each resident into the unit family, a home is created.

Often this home is more like a hotel. The HAB staff takes pride in being able to successfully continue the transition for many families. Who would ever dream that most any family with the correct training and resources could take a ventilator patient home? Not only take them home but not return to the hospital.

This unique subgroup of patients with complex medical needs and extensive nursing care needs are an unlikely group for transitional care; however, this HAB team has achieved a 100% successful discharge program. With the help of our community partners, the ventilator dependent home discharges are results in patients living at HOME with family caregivers. By the time of discharge, the caregivers are demonstrating the competence level of a professional with the tasks required in caring for their loved one.

To achieve this success rate, the team must reconcile expectations, overcome distrust stemming from the failure to recover, coordinate with community providers and maintain a consistent educational approach. Many of our families do not believe that we can get them home. These same families have difficulty accepting the changes in monitoring and physician interaction. Our team utilizes a forward focus to achieve the transition. The care is simplified and streamlined as much as possible to ease the family burden. Trust develops over time with the skills that families learn. Education becomes a powerful tool for the families in the focus to go home.

The community respiratory service is a key element in building a successful discharge. Respiratory Services of Western New York has taken on the most difficult situations in conjunction with the HAB and built an outstanding regional team. This relationship has resulted in multistate transfers for HAB team to train and transition families home in conjunction with Respiratory Services of Western New York.

This multidisciplinary HAB team and the community partners are achieving an outstanding success rate with the medically complex and social challenging ventilator dependent individuals and families. Overcoming challenges makes HOME possible.

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Nominating Team: Mary Cole, Betty Porter, Gerri Reese