VP Shunt Failure, MRSA Pneumonia and Ventilator Weaning

Families' FAQ: “Talking points for Monday's ICU meeting” | Quick tip for families in intensive care

A husband's wife has been in ICU for eight weeks after VP shunt valve failure and several shunt revision surgeries. She has been ventilated almost the whole time and has had MRSA pneumonia twice. She is now on low ventilator settings and starting tracheostomy collar trials, but the team is pressing him to transfer her to a long-term acute care (LTAC) facility or nursing home. Here are the talking points for his family meeting.

Q. What is going on clinically?

A **VP shunt** drains excess cerebrospinal fluid from the brain. When its valve fails, pressure builds quickly, which is a serious emergency. Multiple revision surgeries mean multiple anaesthetics, intubations and repeated stress on an already struggling brain, a big reason weaning has been so hard. **MRSA** is an antibiotic-resistant, hospital-acquired infection that hits vulnerable patients hardest, and MRSA pneumonia on top of mechanical ventilation is a serious complication.

Q. Where is she now in the weaning process?

Pressure support of 7 means she starts each breath and the ventilator gives a small boost; **PEEP of 5** is also low. Many ICU teams consider a spontaneous breathing trial at pressure support 5 to 8 with PEEP 5, if other criteria are met, and she is already there. Her chest X-ray is clearing, infection markers are normal, antibiotics are complete and **tracheostomy collar trials** (breathing through the tracheostomy without ventilator assistance) start tomorrow. Moving her mid-weaning is a significant decision that needs careful consideration.

Q. Talking point 1: Was the first weaning attempt too early?

He wasn't sure she had recovered from the first MRSA pneumonia when the team first weaned her. She was moved out of ICU and came back within a day with a second MRSA infection. Ask: *“In retrospect, was my wife clinically ready to be weaned and transferred the first time? Is it possible she was moved too soon?”* This is not accusatory; it is a legitimate clinical question.

Q. Talking point 2: What is the evidence for the LTAC?

The neurosurgeon said LTACs specialise in ventilator weaning. Ask: *“Which specific LTACs are you recommending, and what are their published outcomes for ventilator and tracheostomy weaning patients? What are their MRSA and C. diff infection rates?”* LTACs and nursing homes can be reservoirs for antibiotic-resistant organisms, and the infection risk may be higher or lower than in ICU depending on infection control, staffing and the facility.

Q. Talking point 3: She is almost at the finish line

Ask: *“She's on pressure support 7 and PEEP 5 and starts trach collar trials tomorrow. If she passes, what is the rationale for transferring her before weaning is complete? What would it take to complete weaning here?”* Make them answer specifically.

Q. Talking point 4: Clarify the neurological picture

Ask: *“Is her shunt functioning correctly now? What does neurosurgery expect in terms of neurological recovery? Is her ventilator dependence primarily respiratory, neurological, or both?”*

Q. Talking point 5: What is palliative care's role?

Palliative care at the meeting doesn't automatically mean the team is giving up, but ask directly: *“What is the role of palliative care in this meeting? Is the team recommending a change in goals of care, and on what clinical basis, given she's actively weaning and tolerating it well?”* If there is pressure to change goals of care or withdraw treatment, you can state: **“I am not consenting to any change in the goals of care today. I want to wait for the outcome of the tracheostomy collar trials.”**

Q. Which medical records should we get?

All of them: observation charts, nursing and medical progress notes, microbiology results, chest X-ray reports, every documented weaning trial, ventilation, vital sign and medication charts, laboratory results and fluid balance charts. They show what her condition actually was at the first weaning attempt and may show whether she was moved too early. Legal access depends on applicable laws; ask the caseworker at the meeting, and contact the medical records department if there is resistance.

Q. What if she can't be weaned off the ventilator?

You don't have to choose only between ICU, an LTAC and a nursing home, whether she is not fully weaned or is weaned but can't have her tracheostomy removed. **Intensive Care at Home** (Australia's only third-party accredited specialist home intensive care nursing service, ISO 9001:2015, NDIS registered) sends critical care registered nurses into the home 24 hours a day for invasive ventilation, BiPAP/CPAP or tracheostomy care alone. This is ICU-level care at home, not community nursing, and may suit her whether or not weaning succeeds, depending on her clinical needs, services and funding. It operates in all Australian states and territories; families elsewhere can reach out too.

Q. How can we prepare for Monday's meeting?

A consulting call with Intensive Care Hotline before the meeting can help you prepare, review the medical records and formulate questions, and we can join the family meeting to help you understand the recommendations being made. You are not wrong to ask questions: prepare them, get the records and trust your instincts.

Need independent expert advocacy? Intensive Care Hotline can help.
Patrik Hutzel brings 25 years of critical care nursing experience. We review records in plain language, help you prepare before family meetings, and can join the meeting to ask relevant clinical questions. Book a **free 15-minute consulting call**.
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Mobile 041 094 2230 (within Australia) or email via **info@intensivecareathome.com**
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General information for families, not a substitute for advice from your loved one's treating medical team.