Leaving the ICU and coming to Lakeview

A move out of intensive care can bring relief and new questions on the same day. Here is how to prepare, who you may meet, what recovery can involve and what to ask before the next move.

Before the move

Ask the referring clinician why hospital care must continue, which treatments are still needed and which settings were considered. Identify who is reviewing the referral, who can confirm insurance and who will call the family when the plan is agreed. Confirm the destination in Waterford and whether the family should go there directly or wait for notice.

The sending team arranges the appropriate transport with the receiving team. The handoff should include medicines and last doses, oxygen or ventilator support, lines, feeding, wound instructions, precautions and recent test results. Ask who is sending belongings and how the family can reach the new unit after arrival.

During the first assessment

Nursing staff assess the person's condition, including skin and existing wounds. The physician reviews the clinical history and orders ongoing treatment. Respiratory staff evaluate the airway and breathing support when relevant. Therapists assess what the person can do, the help they need and what they hope to regain.

Tell the team what daily life looked like before the illness. Describe the person's preferred name, usual communication, mobility aids, routines, goals and who they want involved. Ask how to take part in a care conference, how to raise new concerns and who will provide updates if a family member cannot visit.

Who does what?

- The attending clinician reviews medical stability, orders, new symptoms and the treatment plan. Ask who covers the patient when the usual clinician is away.
- Nurses monitor changes, give medicines, protect skin, manage lines and coordinate care throughout the day. They are a good first contact for a new concern during the stay.
- Respiratory therapists assess breathing support, airway clearance, oxygen and readiness for ordered trials. Ask how they coordinate with speech and mobility staff.
- Physical therapists help with bed mobility, balance, transfers, walking and endurance. Occupational therapists work on everyday activities such as dressing, bathing and safely using equipment.
- Speech-language pathologists assess communication, thinking and swallowing. Dietitians review nutrition needs, food textures and nutrition delivered through a tube or IV.
- Pharmacists review medication doses, combinations and transitions. Case managers work with the patient, family, payer and next provider on coverage, equipment, transportation and discharge.
- Tell the team about spiritual, language, hearing or other communication needs. Ask about interpreter services or how to contact a spiritual adviser the person knows.

What to include with a complex referral

- Breathing or heart support. Describe COPD, respiratory failure, pneumonia, lung cancer or heart failure, together with the oxygen, ventilation, BiPAP or CPAP currently prescribed. Report tolerance and recent changes.
- Wounds. Include the location, dimensions, stage if classified, drainage, current dressing and frequency of care. Note pressure injuries, arterial or venous ulcers, postoperative sites, fistulas, flaps, burns, amputations or infection. Specify any planned debridement or negative-pressure wound therapy.
- Infection. Include bacteremia, cellulitis, pneumonia, COVID-19 or another identified infection. Give culture results, precautions, antimicrobial route and stop or review date.
- Other medical needs. Report acute or chronic kidney failure, the dialysis plan, unstable diabetes, bowel rest or IV nutrition. Describe how these treatments affect mobility, meals and the next setting.
- Rehabilitation. Describe the effects of stroke, neurological change, orthopedic injury or trauma. Include prior function, present assistance, equipment, recent therapy and what the patient wants to regain.

Movement after intensive care

Time in bed can weaken the muscles used for breathing, standing and walking. The first goal may be rolling, sitting upright or reaching for a washcloth. If the person is ready, therapy can progress to sitting at the edge of the bed, transferring to a chair, standing or walking with the recommended help. Ask staff to show you what you can safely do together.

Mobility can be part of a care plan even while someone receives breathing support. Staff must coordinate the airway, oxygen or ventilator, lines, drains and fall precautions. Discuss what level of assistance is needed today and which symptoms or changes mean a session should stop.

Memory, attention and decisions

After a serious illness, a person may have trouble following a conversation, remembering what just happened or choosing the next step in a task. Let the team know how the person usually thinks and communicates. A sudden change in alertness or behavior deserves prompt attention.

A clinician may assess attention, memory, problem-solving, orientation and the ability to make everyday decisions. Rehabilitation can include simple cues, written reminders and practice with daily tasks. Ask how changes in thinking affect safety, balance, taking medicines and plans for support at home.

Speech and a way to be heard

A person with a breathing tube may know what they want to say and still be unable to speak. Agree on a reliable yes-or-no signal, allow time for a response and offer writing, gestures or a communication board if they work for the person. Being able to express discomfort or make a choice helps the person take part in care.

A speech-language pathologist and respiratory team can evaluate whether a speaking valve or another aid is appropriate for someone with a tracheostomy. Staff assess the airway, breathing and tolerance before a trial. Ask what the person may use now and what family can do during a visit.

Swallowing, nutrition and eating again

Heart failure, anemia, poor nutrition and fluid or electrolyte problems can increase the challenge of recovery. The dietitian considers energy, protein, fluid needs and the effect of other conditions. The speech-language pathologist evaluates swallowing. Meal texture, positioning, timing and supervision may matter as much as food preference.

Some people receive tube feeding or intravenous nutrition while they recover. The team assesses whether and how to introduce oral intake and adjusts the nutrition plan as swallowing and endurance change. Ask before offering any food, drink, ice or medicine by mouth. Tell the team about familiar foods and what help is available after discharge.

Breathing with less support

A ventilator gives breathing support while clinicians treat an illness or injury. Some people still need it after the ICU. The team looks at the underlying illness, the need for oxygen, strength, airway secretions and ability to protect the airway. A spontaneous breathing trial lets clinicians observe what happens with less machine support when it is safe to try.

A person who needs a tracheostomy may need humidification, suctioning, skin care, communication support and a plan for secretions. Ask whether the next goal is a longer breathing trial, a change in the type of support or time to recover before trying again. Progress can vary from one day to the next.

The clinician directing breathing care, respiratory therapist, nurse, pharmacist, dietitian and rehabilitation staff bring different information to rounds. Breathing and mobility sessions must fit around rest, procedures and nutrition. Ask what happened during the last trial, what led the team to stop, and what they are watching before the next trial.

Recovery accounts from the earlier family guide

These accounts describe individual experiences documented in an earlier setting. Their timing and outcomes belong to those individuals.

A person with flu and pneumonia arrived after intensive care with a ventilator, tracheostomy and feeding tube. Friends helped compare potential settings and supported the person during the transition. Respiratory treatment continued, breathing without the machine began after several days, and the person later went home. The pace of a breathing trial depends on the individual’s clinical condition.

Another person had acute heart failure and needed a pump to support the left side of the heart. Respiratory problems and kidney injury followed. At transfer, the team had to monitor the pump, heart, kidney function, breathing and diabetes together. Over several weeks the person progressed through therapy, came off the ventilator and had the tracheostomy removed. Nutrition and diabetes treatment were adjusted by the treating team as needs changed.

A third person became septic after a kidney stone and urinary infection. The person needed ventilation, another procedure for a stone and IV antibiotics. Seizures and bleeding in the brain interrupted progress and required surgery. Breathing trials resumed after stabilization. The person eventually returned home with family support, ongoing tracheostomy care and therapy. The account illustrates why a transfer plan may have to change more than once.

A family's notes on the first day

Who is the main contact for questions about the medical plan? Who is the contact for insurance, a later transfer or a question about going home? Write down each role and the best time to reach that person.

If the person can only communicate a few words or gestures, write down the signal for pain, repositioning or needing the nurse. Ask staff how they will communicate this to the next shift. If they cannot safely eat or drink, ask what the family can offer for comfort and how to help with oral care.

If ordinary movement is difficult, ask what the person can do in bed, whether sitting in a chair is appropriate and who must assist. The source described different activity and therapy schedules for different patients. Obtain the specific orders and plan for your loved one before helping.

Before leaving the bedside, check that the person can reach the call light, glasses, hearing aids or communication board as appropriate. Agree on how the family will receive the next update.

How to read earlier comparisons of settings

The earlier booklet discussed discharge home, one- and five-year survival, readmissions and independence six months after discharge. It also displayed 2019 network activity across ventilation, respiratory, infection, cardiac, kidney and neurological care. Those are distinct measures. Patient selection, timing of transfer and baseline severity affect comparisons. For a current decision, ask each setting which treatments it can continue and what recent local outcomes mean for similar patients.

The source-era bibliography discussed early mobility in intensive care (Respiratory Care, 2016, volume 61, pages 971–979), post-ICU ventilation outcomes (Annals of Internal Medicine, 2010, volume 153, page 167), and speech after tracheostomy (Journal of Critical Care, 2016, volume 33, pages 186–191).

Questions for a tour or admissions conversation

- Which clinician directs medical care? Who is available on the unit overnight and how does the team respond to a sudden change?
- How are family visiting and overnight stays handled? Ask about private rooms, Wi-Fi, a quiet place to meet, visitor age rules and pet visits if these affect your decision.
- When is skin checked, how does wound prevention start and how do the team and caregiver continue the plan after discharge?
- What are the arrangements for emergency response or transfer to a higher level of care? What advanced life support training do staff have and when is a respiratory therapist available?
- How does the team help a person begin moving safely, including someone with breathing equipment or someone who cannot yet stand?
- Who handles a concern that the bedside team cannot resolve? How can you reach a patient advocate, unit leader or hospital leader?
- Which patient outcomes does the hospital track? Ask for definitions, the period covered and which patients are included. Ask how often you will receive updates about your own loved one.

Arrange the visit and verify the transfer

Ask Lakeview Admissions about visiting or tour arrangements. Have the referring case manager share the current clinical summary and ask who can tell you when a decision has been made. Confirm financial

coverage, any authorization requirement, transport and the planned time of arrival. Keep the name or department for the next call.

From bedside rounds to the next care setting

At the bedside, ask staff to introduce their role, explain the next activity, leave room for questions and make sure the patient can reach the call light or communication aid. Small steps like these make it easier to report a change early.

At a care conference, ask the team to explain the medical goal and the function the person is working toward. Agree on how progress will be described, which barriers remain, what the patient can practice and when the plan will be reviewed. Ask which disciplines need to hear new information from home.

At the team review, bring medical treatment, nursing, respiratory care, rehabilitation, nutrition, equipment and coverage into the same plan. Identify the task, the person responsible and when an answer is expected. Discuss what would make the current setting unsafe or a lower level of care appropriate.

Before discharge, ask for an updated medicine list, instructions for equipment and wound or airway care, arrangements for supplies, follow-up appointments and a written plan for changes in symptoms. Ask a clinician to watch the caregiver practice any new task and confirm who will take the first call after the move.

Notes for the next conversation

My loved one wants to be able to _____

The change we have noticed since the last update is _____

The medical support they still need is _____

The next goal, and how we will know they have reached it _____

The question we still have _____

The person following up and how we can reach them _____

Request a Lakeview review

Ask the referring physician or case manager to discuss whether Lakeview Specialty Hospital and Rehab in Waterford can meet the person's current needs. A diagnosis or day count alone does not settle that question. Clinical review, insurance coverage, availability and transport need to fit together.

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