LAKEVIEW / CLINICAL PARTNERS

Long-term acute care for referring clinicians

Use this guide to prepare a referral, compare possible settings and identify the information the next clinical team needs before a transfer.

Who may still need hospital care?

People may survive the acute phase of catastrophic illness and still need prolonged ventilation, management of cardiopulmonary disease, treatment of complications from a neuromuscular disorder or support for several failing organs. Deconditioning and vulnerability to infection can limit recovery. A referral should describe what is unstable, what is improving and what must continue at the bedside.

The earlier clinician letter described national clinical leadership and advisory structures. For a Lakeview referral, identify the clinical contact in Waterford responsible for medical acceptance and the point of contact for the first shift. Coordinate with the sending physician, nursing team, respiratory therapist, pharmacist, rehabilitation team and case manager as appropriate.

What the referring team needs from the review

Confirm who will perform the assessment, which records are missing, whether an on-site or remote evaluation is useful, and whom to contact for timing, coverage and after-hours questions. A prompt, complete handoff lets the referring team plan bed and transport needs while protecting the patient from a premature move. Ask for notification of acceptance, admission and the next handoff.

Comparing care settings

A general acute hospital, including the emergency department and ICU, can evaluate urgent changes and stabilize people with new or rapidly changing illness. An LTACH is a hospital for people who still need extended hospital-level treatment after that first stage. Discuss the need for physician review, advanced nursing or respiratory support and medical monitoring.

An inpatient rehabilitation hospital provides intensive, coordinated rehabilitation for eligible people who can participate and still need medical oversight. A skilled nursing facility may offer nursing and rehabilitation at a different level of intensity. Long-term residential or custodial care helps with ongoing daily needs. At home, equipment, caregiver training and intermittent clinical services may be needed.

Ask each setting which services are on site, who can respond overnight, how often the medical team reviews changes, what therapy the person can tolerate and what happens if their needs increase. Check whether pharmacy, imaging, dialysis, specialized wound procedures or a needed specialist is available. Arrangements vary by setting and patient need.

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.

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.

Pulmonary history and treatment goals

Report mechanical ventilator dependence, COPD, interstitial lung disease, emphysema, asthma, cystic fibrosis, neuromuscular conditions, pneumonia or recent surgery. Stroke, spinal cord or brain injury and metabolic encephalopathy can also affect the airway or ventilation. Include medication effects, recent diagnostic studies, the last trial and family teaching needed before discharge.

Wounds and infection

A wound that is deep, slow to heal or repeatedly infected may affect the entire plan of care. The team assesses the wound, surrounding skin, pressure, circulation, pain, nutrition and other illnesses. A serious pressure injury, nonhealing surgical wound, fistula or amputation site may need frequent care and careful positioning during therapy.

Vascular and arterial ulcers, burns, infected wounds and bone infection can require different approaches. The clinician selects dressings, assesses the need for negative-pressure therapy or debridement, and considers measures to improve blood flow or relieve pressure. Some procedures, including operative or ultrasonic cleaning or specialized lymphedema care, require separate expertise. Confirm where any proposed procedure will occur.

Bacterial, fungal and viral infections need different treatment. Bring recent culture results, antimicrobial medicines, the date of the next review, precautions and signs of worsening. Sepsis, an infected surgical site or pressure injury, osteomyelitis and severe soft-tissue infections may require urgent hospital assessment. Report a new concern to staff immediately.

Brain injury, stroke and post-trauma care

After a stroke, brain injury, spinal cord injury or severe trauma, breathing, circulation, nutrition and infection control can remain urgent while rehabilitation starts. A stroke interrupts blood flow or involves bleeding in the brain. A traumatic brain injury is caused by an external force. Either may affect movement, thinking, speech and swallowing.

Describe airway support, breathing trials, surgical wounds or pressure injuries, renal treatment, infection or isolation needs, infusions, nutrition and feeding tubes. A person who cannot yet sustain intensive therapy

may still take short, supervised steps toward communication, comfort and movement as medically appropriate.

Rehabilitation assessment can include aphasia (trouble using or understanding language), dysphagia (trouble swallowing), and changes in attention, judgment or memory. A clinician may recommend a swallowing study when it would change care. Ask how balance, coordination, joint movement and strength affect getting out of bed, using a wheelchair, walking, bathing, eating and dressing.

Family members can help identify the person's usual communication and what would matter most to recover. Ask the team to demonstrate transfers or communication strategies before you try them. If longer therapy sessions become possible, ask when an inpatient rehabilitation assessment would be appropriate.

Cardiac, kidney and other complex conditions

A person recovering from heart failure, heart attack, valve disease, peripheral vascular disease, endocarditis or cardiac surgery can have several needs at once. Describe blood pressure, rhythm monitoring, fluid changes, breathing and the current response to activity. Ask which change needs urgent reassessment.

Diabetes, kidney failure, malnutrition, cancer, severe infection or a complicated recovery after abdominal, cardiac or chest surgery may affect the pace of care. Treatment may involve IV medicines, antibiotics, dialysis, bowel rest or tube or IV nutrition. Include recent results, current orders and pending procedures when requesting a review.

If the person uses a specialized support device such as a ventricular assist device or needs an infusion, extracorporeal support or a procedure, explain this at the first call. The sending and receiving clinicians should agree on who can provide and monitor that specific treatment before the transfer is arranged.

Referral detail by specialty

For a cardiac referral, specify whether the active problem is heart failure, valve or congenital heart disease, cardiomyopathy, peripheral vascular disease, complications of myocardial infarction or recovery after a cardiac operation. Include the current rhythm, recent symptoms, response to treatment and any order for monitoring during activity or transport.

For neurological care, distinguish stroke, brain injury caused by lack of oxygen, mechanical trauma, seizure disorder and spinal cord injury with weakness or paralysis. A person with quadriplegia, for example, may need very different airway, skin and transfer support from someone with a new language difficulty after a stroke. Report current abilities and precautions.

For medically complex recovery, state whether the patient is recovering from general, gastric, chest or cardiac surgery. Include ongoing treatments for sepsis, malnutrition, cancer, uncontrolled diabetes, renal failure or obesity-related care needs. After trauma, identify head or spinal injury, cerebral hemorrhage, fractures or orthopedic precautions alongside the medical problem.

For a lung referral, ask the sending team to identify pulmonary specialists involved, current drug and oxygen orders, diagnostic studies and the next treatment milestone. If family training will be needed for an airway, oxygen, equipment or medicines, identify the learner early. Confirm when they can participate.

Questions about operational coverage

When coordinating a weekend or after-hours move, ask which clinician will accept the handoff, when equipment and medicines can be available and whether transport support matches the patient's needs. Obtain the receiving unit's direct instructions before scheduling departure.

At the first transfer update, distinguish clinical acceptance, financial authorization and physical bed readiness. Let the referring team and family know when each has been resolved. If a change in the patient's condition occurs while waiting, ask for reassessment before proceeding.

Reading a hospital's quality results

Ask which patients were included, when they were treated, whether there was a comparison group and how the outcome was defined. A percentage for one patient group cannot predict the course of an individual. The following examples explain the measures used in the archived clinician booklet.

- Ventilator liberation. The historical network reported that about 69% of a selected group who could not wean during a short-stay hospitalization later came off the ventilator. Ask whether an outcome means one completed trial or sustained independence and how transfers and deaths were counted.
- Patient experience. The historical report described an overall average near 90% and survey participation above 50%. Ask who received the survey, who responded, which questions were asked and how the answers were scored.
- Falls and skin injury. The source reported fewer than one injurious fall per 1,000 patient-days and fewer than two hospital-acquired pressure ulcers per 1,000 patient-days, with the pressure-injury measure down nearly 40% from its earlier reference period. A rate per 1,000 patient-days accounts for time at risk. Check whether a wound was present at admission.
- Discharge destination and readmission. The earlier network reported an average 30-day readmission rate of 12%. Home, inpatient rehabilitation, skilled nursing and return to a short-stay hospital are distinct destinations. Ask whether planned transfers count and whether results are adjusted for patient severity.
- Antimicrobial use. The booklet tracked antibiotic charges per patient-day from 2009 to 2013. Charges can change with prices as well as use. A clinical comparison should also examine indications, treatment duration, culture review, adverse effects and resistance.
- Patient severity. The archived network reported an unadjusted case mix index of 1.16 using diagnosis-related group weights. It describes the mixture of cases under that grouping system. It does not measure a person's progress.
- Device-associated infection. The booklet compared catheter-associated urinary tract infections and central-line bloodstream infections with national benchmarks. Its historical series reported central-line infection rates up to 38% below its benchmark. Ask for the period, device-days, definition, comparison and risk adjustment behind a current figure.

These figures came from another network's historical data, principally 2009–2014. Request current Waterford-specific data for any comparison involving Lakeview.

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.

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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