

What is the report looking at	<i>A review of the quality of rehabilitation care provided to patients following an admission to an intensive care unit</i>
The countries are covered	<i>England, Wales and Northern Ireland</i>
The date the data is related to	<i>All patients aged 18 and over who were admitted as an emergency to an ICU for four or more days between 1st October 2022 and 31st December 2022 and survived to hospital discharge.</i>

No.	Recommendation	Evidence in the report which underpins the recommendation	Guidance available
1	<p>Improve the co-ordination and delivery of rehabilitation following critical illness at both an organisational level and at a patient level.</p> <ul style="list-style-type: none"> ▪ At an organisational level by assigning a trust/health board rehabilitation lead with oversight and responsibility for the provision of holistic rehabilitation. ▪ At a patient level by having a named rehabilitation care co-ordinator(s) role to oversee patients' rehabilitation needs within the ICU, on the ward and in the community. <p>Target audiences: <i>Commissioners, integrated care boards, hospital trusts/health boards</i></p>	<p>CHAPTER 4 PAGE 35</p> <p>Reviewers stated that 107/250 (42.8%) patients did not receive all the appropriate referrals. They specifically cited a sparsity of referrals to dedicated specialist community rehabilitation services, alongside an absence of ICU follow-up referrals or referral to specific MDT groups such as physiotherapy, dietetics or psychology where a clear need existed.</p> <p>CHAPTER 5 PAGE 37</p> <p>Only 70/166 (42.2%) organisations reported having a policy or standard operating procedure (SOP) for the delivery of rehabilitation.</p> <p>CHAPTER 5 PAGE 37</p> <p>The same 70/166 (42.2%) organisations had an ICU rehabilitation lead but only 28/70 with designated sessions within their job plan for this leadership activity.</p> <p>CHAPTER 5 PAGE 37</p> <p>Most organisations reported the presence of named healthcare professionals to co-ordinate the rehabilitation pathway (112/114; 98.2%) (Table 5.1). However, the clinicians identified only 107/420 (25.5%) patients as having a named healthcare professional/key worker for co-ordinating rehabilitation (unknown for 251).</p> <p>CHAPTER 5 PAGE 37-38</p> <p>Where key workers were present, reviewers found that they had a positive effect on care. Patients with a named key worker were found to be more likely to have undergone a comprehensive assessment (70/101; 69.3% vs 151/290; 52.1%) and to have an individualised rehabilitation plan (77/101; 76.2% vs 143/283; 50.5%) in comparison to when no key worker was present.</p> <p>CHAPTER 5 PAGE 38-39</p> <p>Only 117/365 (32.1%) patients had documented contact details of a named healthcare professional to support them following hospital discharge, while the patient survey reported that 21/34 patients were told that the GP would be their first point of contact (not answered for 68).</p>	<p>NICE Guideline [CG83]</p> <p>Rehabilitation after critical illness in adults, 2009</p> <p>NICE Quality Standard [QS158]</p> <p>Rehabilitation after critical illness, 2017</p> <p>Intensive Care Society: GPICS</p>

<p>2</p>	<p>Develop and validate a national standardised rehabilitation screening tool to be used on admission to an intensive care unit.</p> <p><i>This would identify patients at risk of long-term physical, psychological, cognitive or social effects and trigger an earlier comprehensive assessment of their rehabilitation needs sooner than ‘day four’ currently defined by NICE Quality Standard 158.</i></p> <p>Target audiences: Intensive Care Society, Faculty of Intensive Care Medicine, National Institute of Health Research (area of potential research), NHS England, Welsh Government, Health Department of Northern Ireland, Jersey.</p>	<p>CHAPTER 2 PAGE 16</p> <p>Only 56/671 (8.3%) patients had no pre-existing comorbidities, while 170/671 (25.3%) had a single comorbidity and 421/671 (62.7%) had two or more comorbidities (Table 2.3).</p> <p>CHAPTER 2 PAGE 16</p> <p>Whilst noting that that some patients will have received multiple organ support, respiratory support was the most common organ support (543/671; 80.9%), the majority of which was invasive mechanical ventilation (intubation) (451/543; 83.1%) (Table 2.4 and Table 2.5). It is well evidenced that patients receiving respiratory support are more likely to functionally deteriorate so early rehabilitation planning is essential.^[8,9]</p> <p>CHAPTER 3 PAGE 17</p> <p>A total of 115/166 (69.3%) participating organisations confirmed that initial screening for rehabilitation needs was routinely undertaken, and clinicians completing questionnaires confirmed that this was the case (356/585; 60.9%) (unknown for 86). However, case reviewers found that only 104/365 (28.5%) patients had evidence of an initial screen recorded in their case notes.</p> <p>CHAPTER 3 PAGE 17</p> <p>In their opinion the failure to screen impacted the care of 102/186 (54.8%) patients (unknown for 75), due to no goals being set, no multidisciplinary team (MDT) involvement, delay and the opportunity to address complex social and psychological needs being missed.</p> <p>CHAPTER 3 PAGE 17</p> <p>In those patients whose initial screen was documented, 63/104 (60.6%) were on a proforma, 37/104 (35.6%) consisted of a written entry in the case notes and 5/104 (4.8%) were on a label in the notes.</p> <p>CHAPTER 3 PAGE 17</p> <p>Baseline assessments of comorbidity and functional status were the most performed evaluations (comorbidity: (550/671; 82.0%); functional status (514/671; 76.6%) (Table 3.1). However, baseline assessments should include both physical and non-physical factors. For 474/671 (70.6%) patients no psychological assessment was carried out. This was despite 89/530 (16.8%) patients having had contact with mental health services prior to the admission (unknown for 141).</p>	<p>NICE Guideline [CG83] Rehabilitation after critical illness in adults, 2009</p> <p>NICE Quality Standard [QS158] Rehabilitation after critical illness, 2017</p> <p>The post-ICU presentation screen (PICUPS) and rehabilitation prescription (RP) for intensive care survivors</p>
<p>3</p>	<p>Undertake and document a comprehensive, holistic assessment of the rehabilitation needs of patients admitted to an intensive care unit at</p>	<p>CHAPTER 3 PAGE 18</p> <p>It was reported in 130/166 (78.3%) organisational questionnaires that patients routinely underwent comprehensive assessments of rehabilitation need. However, only 30/130 (23.1%) had a policy detailing which healthcare professionals were competent to carry out the assessment. Furthermore,</p>	<p>NICE Guideline [CG83] Rehabilitation after critical</p>

<p>risk of physical and/or non-physical morbidity.</p> <ul style="list-style-type: none"> Assessments should be repeated and documented at key stages along the patient's pathway from admission to community services and GP follow-up. <p><i>NB: The assessment should be undertaken by day four following admission (in line with NICE Quality Standard 158) or sooner if the patient is identified as needing a more comprehensive assessment at the screening stage (see recommendation 2), noting that elements of the assessment not possible by day four (e.g. swallow if the patient is orally intubated) should be completed as soon as clinically possible.</i></p> <p>Target audiences: Healthcare professionals involved with patients on the intensive care unit.</p>	<p>clinicians caring for the patients reported that the comprehensive assessment was only carried out in 327/574 (57.0%) patients (unknown for 97).</p> <p>CHAPTER 3 PAGE 20</p> <p>Reviewers found that a comprehensive assessment was completed for 78/346 (22.6%) patients and considered that there were elements were missing from 48/78 of the assessments. Non-physical aspects of rehabilitation, nutrition and a lack of multidisciplinary team (MDT) involvement were the most frequently cited missing elements.</p> <p>CHAPTER 3 PAGE 20</p> <p>Assessments most frequently involved physiotherapists, although reviewer identified a lack of required input across all staff groups (physiotherapist: 7/78 (9.0%), dietitian: 33/78 (42.3%); speech and language therapist: 15/78 (19.2%), occupational therapist: 14/78 (17.9%), practitioner psychologist: 27/78 (34.6%).</p> <p>CHAPTER 3 PAGE 21</p> <p>In addition, an individualised rehabilitation plan in the ICU was documented for only 94/365 (25.8%) patients, and the reviewers considered that the absence of an individualised plan negatively impacted the quality of care of 117/178 (65.7%) patients (unknown for 93).</p> <p>CHAPTER 3 PAGE 21</p> <p>The clinicians stated that reassessment had taken place in 224/671 (33.4%) patients. Reviewers found evidence of reassessment prior to discharge from the ICU in only 63/365 (17.3%) patients and only 41/63 of those assessed had any alteration or update to their rehabilitation goals.</p> <p>CHAPTER 3 PAGE 22</p> <p>Following discharge from the ICU a further comprehensive assessment was carried out in only 80/309 (25.9%) patients (unknown for 56). Of the 80 assessments carried out there were often key elements missing, these included no occupational therapist, speech and language therapist, psychologist or dietitian assessment and no MDT or inter-team communication.</p> <p>CHAPTER 3 PAGE 22</p> <p>A functional reassessment and redefinition of goals should be undertaken before discharging patients from hospital who are receiving an individualised rehabilitation programme during ward-based care.^[3] This was carried out for 235/487 (48.3%) patients (unknown for 184).</p> <p>CHAPTER 3 PAGE 23</p> <p>Physiotherapists predominantly undertook the process (189/235; 80.4%) while mental health practitioners were the least likely (0/235) to be involved in reassessment prior to discharge.</p>	<p>illness in adults, 2009</p> <p>NICE Quality Standard [QS158] Rehabilitation after critical illness, 2017</p> <p>Intensive Care Society: GPICS</p>
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4	<p>Ensure that multidisciplinary teams are in place to deliver the required level of rehabilitation in intensive care units and across the recovery pathway. Include:</p> <ul style="list-style-type: none"> ▪ All relevant healthcare professionals needed to provide co-ordinated, consistent care in the ICU, ward and community ▪ Regular communication between specialties and discussion of patients' needs at a dedicated multidisciplinary team meeting or rehabilitation rounds when appropriate ▪ Staffing to deliver the required rehabilitation. <p>Target audiences: Commissioners, integrated care boards</p>	<p>CHAPTER 4 PAGE 25</p> <p>Most organisations reported the presence of physiotherapists (152/166; 91.6%), speech and language therapists (145/166; 87.3%), and dietitians (148/166; 89.2%) as a part of the intensive care unit (ICU) MDT. The provision of occupational therapists (98/166; 59.0%), psychologists (71/166; 42.8%) and therapy support workers dedicated to rehabilitation (36/166; 21.7%) was less common.</p> <p>CHAPTER 4 PAGE 25</p> <p>Even when present, staffing levels across the MDT did not reach the national recommended levels,^[5] with particularly low levels across all non-medical/nursing roles (Figure 4.1).</p> <p>CHAPTER 4 PAGE 27</p> <p>The absence of sufficient staff often meant that where input was provided, room for improvement was identified with regard to both the timing (128/549; 23.3%) (unknown for 122) and consistency (90/562; 16.0%) of rehabilitation delivered (unknown for 109). This was the case for all members of the MDT, with the biggest delays in timing seen for speech and language and occupational therapists (Figure 4.3).</p> <p>CHAPTER 4 PAGE 27</p> <p>Reviewers found that while 192/339 (56.6%) patients received rehabilitation at the weekend, this very rarely included the full MDT (6/339; 1.8%) (Table 4.2).</p> <p>CHAPTER 4 PAGE 31</p> <p>A total of 34/111 (30.6%) patients were seen on the ward at least once by the ICU physiotherapist (Figure 4.5). The reviewers believed that 80/154 (51.9%) (unknown for 100) patients who did not receive a review would have benefited from ongoing ICU MDT involvement.</p> <p>CHAPTER 4 PAGE 32</p>	<p>NICE Guideline [CG83] Rehabilitation after critical illness in adults, 2009</p> <p>NICE Quality Standard [QS158] Rehabilitation after critical illness, 2017</p> <p>Intensive Care Society: GPICS GIRFT: Adult Critical Care</p> <p>The post-ICU presentation screen (PICUPS) and rehabilitation</p>

The largest proportion of unmet need related to psychologists, where only 21/159 (13.2%) patients who may have benefited were seen (Figure 4.6).

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Reviewers also identified room for improvement in rehabilitation on the ward, with delays in the timing and consistency of rehabilitation identified across all MDT groups. The largest delays in initiation were seen for occupational therapy (49/136; 36.0%), practitioner psychology (4/21; 19.0%) and speech and language therapy (24/97; 24.7%) (Figure 4.7).

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This theme of delays in initiating rehabilitation was also highlighted in the healthcare professional survey, where 130/420 (31.0%) respondents believed that they did not have adequate time to assess rehabilitation needs and 171/420 (40.7%) stated that they did not have sufficient access to the MDT to deliver rehabilitation following an admission to an ICU.

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Despite the significant ongoing physical and non-physical morbidity, only 114/160 (71.3%) organisations reported any form of post-ICU follow-up of patients, and clinicians found that only 357/576 (62.0%) patients were provided with an ICU follow-up appointment (95 unknown).

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Reviewers stated that 107/250 (42.8%) patients did not receive all the appropriate referrals. They specifically cited a sparsity of referrals to dedicated specialist community rehabilitation services, alongside an absence of ICU follow-up referrals or referral to specific MDT groups such as physiotherapy, dietetics or psychology where a clear need existed.

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The lack of available rehabilitation was also identified in the patient surveys, which showed that 16/88 (18.2%) patients had accessed private healthcare to support ongoing rehabilitation after hospital discharge.

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Only 70/166 (42.2%) organisations reported having a policy or standard operating procedure (SOP) for the delivery of rehabilitation.

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Clinicians reported that rehabilitation was discussed as part of an MDT ward round in 272/546 (49.8%) patients (unknown for 125), although reviewers only found documented evidence of MDT rounds in 70/365 (19.2%) cases reviewed.

[prescription \(RP\)
for intensive care
survivors](#)

		<p>CHAPTER 5 PAGE 38</p> <p>Patients discussed at an MDT meeting were more likely to have undergone a comprehensive assessment (28/70; 40.0% vs 44/295; 14.9%) and have rehabilitation goals set (41/70; 58.6% vs 94/295; 31.9%) than those who were not.</p>	
5	<p>Standardise the handover of rehabilitation needs and goals for patients as they transition from the intensive care unit to the ward and ward to community services.</p> <p><i>Target audiences: Healthcare professionals involved with patients on the intensive care unit and hospital trusts/health boards.</i></p>	<p>CHAPTER 5 PAGE 38</p> <p>Clinicians found that 304/671 (45.3%) patients had a documented, structured handover, 83/671 (12.4%) had a documented verbal handover and 125/671 (18.6%) patients had no evidence of any handover related to rehabilitation needs.</p> <p>CHAPTER 5 PAGE 38</p> <p>Clinicians found that 304/671 (45.3%) patients had a documented, structured handover, 83/671 (12.4%) had a documented verbal handover and 125/671 (18.6%) patients had no evidence of any handover related to rehabilitation needs. Where handovers were completed, reviewers believed that information was missing for 241/317 (76.0%) patients (unknown in 48), specifically a lack of information regarding the comprehensive assessment, rehabilitation goals and the current rehabilitation plan.</p> <p>CHAPTER 5 PAGE 39</p> <p>Reviewers stated that there was room for improvement in the handover of rehabilitation care in 186/292 (63.7%) cases reviewed (unknown for 73).</p> <p>CHAPTER 5 PAGE 39</p> <p>Despite the high proportion of patients accessing primary care for support, GPs were only aware that a patient they saw had spent time in the ICU in 170/248 (68.5%) cases.</p> <p>CHAPTER 5 PAGE 39</p> <p>There was evidence of GP letters at hospital discharge for 484/671 (72.1%) patients. Even when completed, reviewers reported room for improvement in discharge documentation in 245/323 (75.9%) cases reviewed (unknown for 42). Important information, including details about the ICU stay and organ support received was often missing, as well as any ongoing rehabilitation needs or plans.</p> <p>CHAPTER 6 PAGE 42</p> <p>A total of 343/671 (51.1%) patients were provided with a copy of their hospital discharge summary. The information included in the summary is shown in table 6.1.</p> <p>CHAPTER 6 PAGE 42-43</p> <p>Of the patients who responded to the survey only 40/102 (39.2%) reported they were given a leaflet or discharge booklet, and limited information was provided regarding ongoing support options in</p>	<p>NICE Guideline [CG83] Rehabilitation after critical illness in adults, 2009</p> <p>NICE Quality Standard [QS158] Rehabilitation after critical illness, 2017</p>

		<p>the community (Table 6.2). Furthermore, information was rarely shared with family members (69/671; 10.3%).</p> <p>CHAPTER 7 PAGE 46</p> <p>The presence of a formal rehabilitation handover was associated with an increased likelihood of receiving good care on the ward 52/172 (30.2%) vs 8/90 (8.9%) (Figure 7.4).</p>	
6	<p>Provide patients and their family/carers with clear information about their admission to an intensive care unit, impact of critical illness and likely trajectory of recovery.</p> <ul style="list-style-type: none"> ▪ Include the contact details of a named healthcare professional or rehabilitation care co-ordinator ▪ Involve patients/family/carers in multidisciplinary team discussions and rehabilitation planning. <p>Target audiences: <i>Healthcare professionals involved with patients on the intensive care unit and hospital trusts/health boards, integrated care boards, and patient organisations.</i></p>	<p>CHAPTER 5 PAGE 38-39</p> <p>Only 117/365 (32.1%) patients had documented contact details of a named healthcare professional to support them following hospital discharge, while the patient survey reported that 21/34 patients were told that the GP would be their first point of contact (not answered for 68).</p> <p>CHAPTER 6 PAGE 41</p> <p>While 46/88 organisations reported the use of ‘All about me’ documents, clinicians found that these were only present for 113/446 (25.3%) (unknown for 225) patients. They included information about key relationships (108/113; 95.6%), interests and hobbies (90/113; 79.6%) and patient preferences (84/113; 74.3%).</p> <p>CHAPTER 6 PAGE 42</p> <p>Reviewers found documentation that the patient and their family were adequately updated in only 165/302 (54.6%) cases (unknown for 63) and considered that there was room for improvement in this area for 114/293 (38.9%) patients (unknown for 65).</p> <p>CHAPTER 6 PAGE 42</p> <p>Diaries can help patients to make sense of what has happened to them, in a manner that they can reflect upon and engage with when they feel ready. Despite this, clinicians completing questionnaires reported diaries were used with 199/483 (41.2%) patients (unknown for 188).</p> <p>CHAPTER 6 PAGE 42-43</p> <p>Of the patients who responded to the survey only 40/102 (39.2%) reported they were given a leaflet or discharge booklet, and limited information was provided regarding ongoing support options in the community (Table 6.2). Furthermore, information was rarely shared with family members (69/671; 10.3%).</p> <p>CHAPTER 6 PAGE 43</p> <p>In total, 37/91 patients who answered the question stated that they were satisfied or very satisfied with the overall information and advice they were given (Figure 6.2).</p>	<p>NHS England: Involving patients in their care</p> <p>The Faculty of Intensive Care Medicine: Life After Intensive Care</p>