

# ICU Rehabilitation: Reviewer Assessment Form

## A. CASE REVIEW DETAILS

### What is this study about

To identify and explore remediable factors in the care of adults who survived to hospital discharge following a stay on ICU, looking at the rehabilitation provided in hospital and in the community

### Inclusion criteria

Patients aged 18 and over, who were admitted to hospital as an emergency and who survived to hospital discharge, following a stay for 4 or more consecutive days on a critical care unit, (who received level 3 care during this time), during the study period (1st October - 31st December 2022)

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### 2a. Date of Case Reviewer meeting

### 2b. Case Reviewer initials

### 2c. Was a completed clinician questionnaire available at the time of case review?

Yes  No

### 2d. NCEPOD site ID

### 2e. Notes available for this case review

- |   |  |
|---|--|
| <input type="checkbox"/> In hospital annotations- index admission | <input type="checkbox"/> Onward referrals from discharge |
| <input type="checkbox"/> Community-based clinic notes             | <input type="checkbox"/> GP notes                        |

Please specify any additional options here...

## B. PATIENT DETAILS

### 1. What was the age of the patient on admission to hospital?

  
Years

### 2. What was the sex of the patient?

- Male  Female

### 3. Date of admission to hospital:

  Unknown

### 4. Mode of admission to hospital:

*Answers may be multiple, please select all that apply*

- |   |  |
|---|--|
| <input type="checkbox"/> Via the emergency department | <input type="checkbox"/> Referral from general practitioner (GP) |
| <input type="checkbox"/> Blue light / ambulance       | <input type="checkbox"/> Directly to the ward                    |
| <input type="checkbox"/> Transfer from other hospital | <input type="checkbox"/> Referred from outpatient clinic         |

Please specify any additional options here...

### 5. Date of admission to ICU:

  Unknown

### 6a. Did the patient receive invasive ventilation?

- Yes  No  Unknown

### 6b. If answered "Yes" to [6a] then: Number of days ventilated:

  
days

### 7. B Did the patient receive any non-invasive ventilation whilst on ICU?

- Yes  No  Unknown

### 8. Did the patient have a tracheostomy?

- Yes  No  Unknown

### 9a. Was this patient receiving any other organ support?

- yes  No  Unknown

### 9b. B If Yes, please provide details (organ support):

**10. Mode of admission to the ICU**

- From level 0/1 ward- this hospital
- From level 2 ward- this hospital
- Transfer from other hospital- level 0/1
- Transfer from other hospital- level 2-3
- From the emergency department

If not listed above, please specify here...

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**11a. Was an ALL ABOUT ME form (or equivalent) included in the notes?**

- Yes
- No
- Unknown

**11b. If answered "Yes" to [11a] then:  
Was it completed?**

- Yes
- No
- Unknown

C. PAST MEDICAL HISTORY

**1a. B Was a record made of the patient's baseline co-morbidities?**

- Yes  No  Unknown

**1b. If answered "Yes" to [1a] then:**

**B In your opinion, was the assessment of baseline co-morbidities adequate?**

- Yes  No  Unknown

**1c. If answered "No" to [1b] then:**

**B1 If no, please explain:**

**2a. B Was a record made of the patient's baseline functional status?**

- Yes  No  Unknown

**2b. If answered "Yes" to [2a] then:**

**B In your opinion, was the baseline assessment of functional status, adequate for this patient?**

- Yes  No  Unknown

**2c. If answered "No" to [2b] then:**

**B2 If no, please explain:**

**3. B What was the patient's functional status/ Rockwood frailty score (prior to hospital admission)**

*If the frailty score is not recorded, please estimate from recorded functional status- see definitions*

1. Very fit  2. Well  3. Managing well  
 4. Vulnerable  5. Mildly frail  6. Moderately frail  
 7. Severely frail  8. Very severely frail  9. Terminally ill

**4a. B Was a psychological history recorded in the notes prior to/ during the admission to hospital?**

- Yes  No  Unknown

**4b. If answered "Yes" to [4a] then:**

**In your opinion, was the record of baseline mental health status adequate?**

- Yes  No  Unknown

**4c. If answered "No" to [4b] then:**

**B3 If no, please explain:**

**5a. B Was a social history recorded in the notes prior to/ during the admission to hospital?**

*eg. Support provided by family at home*

- Yes  No  Unknown

**5b. If answered "Yes" to [5a] then:**

**B In your opinion, was the record of baseline social status adequate?**

- Yes  No  Unknown

**5c. If answered "No" to [5b] then:**

**B If no, please explain (social)**

**6. If it was not possible to obtain all of the required information above from the patient, was any attempt made to obtain this information from the patient's family ?**

- Yes
- No
- Unknown
- Not applicable- it was possible to obtain the information from the patient

**Initial assessment of rehabilitation need**

within 24 hours of admission to ICU

**1. C Was an initial assessment for likely rehabilitation need completed?**

*This is a short screening of rehabilitation need on arrival to the ICU (separate from the comprehensive assessment which should have full MDT involvement and be carried out within 4 days of admission to the ICU)*

- Yes                       No                       Unknown

**2a. If answered "No" to [1] then:**

**C If Yes, was the reason clearly documented in the notes?**

- Yes                       No                       Unknown

**2b. If answered "No" to [1] then:**

**C If no initial assessment of rehabilitation need was completed, in your opinion, did this have an impact on the patient's quality of care?**

- Yes                       No                       Unknown

**2c. If answered "Yes" to [2b] then:**

**C Please provide details:**

**3. If answered "Yes" to [1] then:**

**C How was the initial assessment of rehabilitation need documented?**

*Answers may be multiple, please select all that apply*

- Recorded as a written entry in the case note annotations
- Recorded on a specific proforma
- Recorded via a sticker/ label in the notes
- Not recorded in the notes
- Unknown

Please specify any additional options here...

**4a. If answered "Yes" to [1] then:**

**C In your opinion, was the initial assessment of rehabilitation need performed at the right time?**

- Yes                       No                       Unknown

**4b. If answered "No" to [4a] then:**

**C\* if NO, please provide details**

5a. If answered "Yes" to [1] then:

**C In your opinion, was the initial assessment of rehabilitation need adequate?**

- Yes  No  Unknown

5b. If answered "No" to [5a] then:

**C\*\*If no, please provide details**

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**Comprehensive assessment of rehabilitation needs**

6. c2 Was a comprehensive assessment of rehabilitation needs completed?

*See definition*

- Yes  No  Unknown

7a. If answered "No" to [6] then:

**If no, was the reason clearly documented in the notes?**

- Yes  No  Unknown

7b. If answered "No" to [6] then:

**C- In your opinion, were there clinical reasons for not carrying out a comprehensive assessment of rehabilitation needs?**

- Yes  No  Unknown

7c. If answered "Yes" to [7b] then:

**C7c If No, please provide details:**

8a. If answered "Yes" to [6] then:

**C Which healthcare professionals were involved in the comprehensive assessment of rehabilitation need?**

- Intensivist  Other doctor  Nurse specialist  
 Other nurse  Physiotherapist  
 Speech and language therapist  Dietitian  
 Occupational therapist  Practitioner psychologist  Unknown

Please specify any additional options here...

8b. If answered "Yes" to [6] then:

**C Please select any healthcare professionals who were not involved in the comprehensive assessment of rehabilitation need, but who in your opinion should have been?**

- Intensivist  Other doctor  
 Nurse specialist  Other nurse  
 Physiotherapist  Speech and Language therapist  
 Dietitian  Occupational therapist  
 Practitioner psychologist  Unknown  
 None of these- everyone required was involved

Please specify any additional options here...

**9. If answered "Yes" to [6] then:**

**C Did the comprehensive assessment of rehabilitation needs include an assessment/ record of:**

*please select all that apply*

- |  |  |                                     |  |
|--|--|-------------------------------------|--|
| <input type="checkbox"/> Physical function | <input type="checkbox"/> Mobility      | <input type="checkbox"/> Nutrition  | <input type="checkbox"/> Swallow           |
| <input type="checkbox"/> Communication     | <input type="checkbox"/> Anxiety       | <input type="checkbox"/> Depression | <input type="checkbox"/> Sleep             |
| <input type="checkbox"/> Previous health   | <input type="checkbox"/> Social status | <input type="checkbox"/> Unknown    | <input type="checkbox"/> None of the above |

Please specify any additional options here...

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**10. If answered "Yes" to [6] then:**

**C Was the comprehensive assessment of rehabilitation need completed within 4 days of admission to ICU?**

- Yes                       No                       Unknown

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**11a. If answered "No" to [10] then:**

**C- Were there clinical reasons why the comprehensive assessment of rehabilitation needs was not completed within 4 days of admission to ICU?**

- Yes                       No                       Unknown

**11b. If answered "Yes" to [11a] then:**

**C- Please provide details 1?**

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**12a. If answered "Yes" to [6] then:**

**C In your opinion, were there any elements that were missing from the comprehensive assessment of rehabilitation need?**

- Yes                       No                       Unknown

**12b. If answered "Yes" to [12a] then:**

**C- Please provide details 2:**

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**13a.E Were short-term rehabilitation goals set for this patient?**

- Yes                       No                       Unknown

**13b.If answered "Yes" to [13a] then:**

**Were the rehabilitation goals set at the right time?**

- Yes                       No                       Unknown

**13c.If answered "Yes" to [13a] then:**

**Were the rehabilitation goals reasonable for this patient?**

- Yes                       No                       Unknown
- 

**14a.Was an individualised rehabilitation plan devised for the patient?**

- Yes                       No                       Unknown

**14b.If answered "No" to [14a] then:**

**C- If no, did this impact on the quality of the care provided?**

- Yes                       No                       Unknown

**14c.If answered "Yes" to [14a] then:**

**D If Yes, was it appropriate?**

- Yes                       No                       Unknown

**14d.If answered "No" to [14c] then:**

**C If No, please provide details (plan)**

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**15a.C Was the patient screened daily for delirium?**

- Yes                       No                       Unknown

**15b.If answered "No" to [15a] then:**

**C If Not, please explain why:**

**15c.If answered "No" to [15a] then:**

**Was there any impact of this on the quality of care provided?**

- Yes                       No                       Unknown

**15d.If answered "Yes" to [15c] then:  
Please provide details (delirium screen)**

**1a. D Was rehabilitation care delivered by a physiotherapist whilst the patient was in ICU?**

- Yes                       No                       Unknown

**1b. If answered "No" to [1a] then:**

**E If No, in your opinion, would this patient have benefitted from receiving care from a physiotherapist?**

- Yes                       No                       Unkn

**1c. If answered "Yes" to [1a] then:**

**E In your opinion, was the rehabilitation care provided by the physiotherapist, initiated at the appropriate time?**

- Yes                       No                       Unknown

**1d. If answered "Yes" to [1a] then:**

**E In your opinion, was the rehabilitation care provided by the physiotherapist, delivered with the appropriate consistency?**

- Yes                       No                       Unknown

**2a. E In your opinion, was there a delay/ room for improvement in the treatment for mobility?**

- Yes                       No                       Unknown

**2b. If answered "Yes" to [2a] then:**

**E Please give details of delay/ room for improvement in treatment for mobility**

**2c. In your opinion, was there a delay/ room for improvement in the treatment for muscle strength?**

- Yes                       No                       Unknown

**2d. If answered "Yes" to [2c] then:**

**E Please give details of delay/ room for improvement in treatment for muscle strength**

**3a. E Was rehabilitation care delivered by an SLT whilst the patient was in ICU?**

- Yes                       No                       Unknown

**3b. If answered "No" to [3a] then:**

**E If No, in your opinion, would this patient have benefitted from receiving care from a SLT?**

- Yes                       No                       Unknown

**3c. If answered "Yes" to [3a] then:**

**E In your opinion, was the rehabilitation care provided by the SLT, initiated at the appropriate time?**

- Yes                       No                       Unknown

**3d. If answered "Yes" to [3a] then:**

**E In your opinion, was the rehabilitation care provided by the SLT, delivered with the appropriate consistency?**

- Yes                       No                       Unknown

**4a. E In your opinion, was there a delay or room for improvement in treatment for communication?**

- Yes                       No                       Unknown

**4b. If answered "Yes" to [4a] then:**

**E Please give details of delay/ room for improvement in treatment for communication**

**4c. In your opinion was there any delay/ room for improvement in the treatment for swallow?**

- Yes  No  Unknown

**4d. If answered "Yes" to [4c] then:**

**E Please give details of delay/ room for improvement in treatment for swallow**

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**5a. E Was rehabilitation care delivered by a Dietitian whilst the patient was in ICU?**

- Yes  No  Unknown

**5b. If answered "No" to [5a] then:**

**E If No, in your opinion, would this patient have benefitted from receiving care from a Dietitian?**

- Yes  No  Unknown

**5c. If answered "Yes" to [5a] then:**

**E In your opinion, was the rehabilitation care provided by the Dietitian, initiated at the appropriate time?**

- Yes  No  Unknown

**5d. If answered "Yes" to [5a] then:**

**E In your opinion, was the rehabilitation care provided by the Dietitian, delivered with the appropriate consistency?**

- Yes  No  Unknown

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**6a. In your opinion , was there any delay / room for improvement in the treatment of nutrition?**

- Yes  No  Unknown

**6b. If answered "Yes" to [6a] then:**

**E Please give details of delay/ room for improvement in treatment for nutrition**

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**7a. E Was rehabilitation care delivered by a Practitioner Psychologist whilst the patient was in ICU?**

- Yes  No  Unknown

**7b. If answered "No" to [7a] then:**

**E E If No, in your opinion, would this patient have benefitted from receiving care from a Practitioner psychologist?**

- Yes  No  Unknown

**7c. If answered "Yes" to [7a] then:**

**E In your opinion, was the rehabilitation care provided by the Practitioner Psychologist, initiated at the appropriate time?**

- Yes  No  Unknown

**7d. If answered "Yes" to [7a] then:**

**E In your opinion, was the rehabilitation care provided by the Practitioner Psychologist, delivered with the appropriate consistency?**

- Yes  No  Unknown

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**8a. In your opinion was there any delay/ room for improvement in the treatment for anxiety / depression/ mental health?**

- Yes  No  Unknown

**8b. If answered "Yes" to [8a] then:**

**E Please give details of delay/ room for improvement in treatment for anxiety/ depression/ mental health**

**9a. E Was rehabilitation care delivered by a Occupation Therapist whilst the patient was in ICU?**

Yes  No  Unknown

**9b. If answered "No" to [9a] then:**

**E IfE If No, in your opinion, would this patient have benefitted from receiving care from an Occupational Therapist?**

Yes  No  Unknown

**9c. If answered "Yes" to [9a] then:**

**E In your opinion, was the rehabilitation care provided by the Occupational Therapist, initiated at the appropriate time?**

Yes  No  Unknown

**9d. If answered "Yes" to [9a] then:**

**E In your opinion, was the rehabilitation care provided by the occupational therapist, delivered with the appropriate consistency?**

Yes  No  Unknown

**10a. In your opinion was there any delay/ room for improvement in the treatment of cognition?**

Yes  No  Unknown

**10b. If answered "Yes" to [10a] then:**

**E Please give details of delay/ room for improvement in treatment for cognition**

**11a. In your opinion was there any delay/ room for improvement in the treatment for sleep?**

Yes  No  Unknown

**11b. If answered "Yes" to [11a] then:**

**E Please give details of delay/ room for improvement in treatment for sleep**

**12a. Was there any delay/ room for improvement in the delivery of any other aspect of rehabilitation?**

Yes  No  Unknown

**12b. If answered "Yes" to [12a] then:**

**E Please give details of delay/ room for improvement in any other aspect of rehabilitation delivered in ICU**

**13a.E Was rehabilitation care delivered over the weekend for this patient?**

*Please select the answer that best fits*

- Yes - Full MDT delivered rehabilitation care was delivered 7 days/ week
- Yes - but not full MDT delivered rehabilitation care over the weekend
- No - No rehabilitation care was provided over the weekend
- N/A - This patient did not stay in the ICU over a weekend

If not listed above, please specify here...

**13b.If answered "Yes - but not full MDT delivered rehabilitation care over the weekend" or "No - No rehabilitation care was provided over the weekend" to [13a] then:  
E Did this impact the quality of care provided?**

- Yes
- No
- Unknown

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**14a.Is there evidence in the notes of a MDT ward round?**

- Yes
- No
- Unknown

**14b.If answered "Yes" to [14a] then:  
E if yes, in your opinion, was it frequent enough?**

- Yes
- No
- Unknown

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**15a.E In your opinion, was there any room for improvement in the discussions with the patient's family whilst the patient was in ICU?**

- Yes
- No
- Unknown
- Not applicable

**15b.If answered "Yes" to [15a] then:  
Please provide details (family)**

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**16a.In your opinion, were the short/ medium term rehabilitation goals updated with appropriate frequency?**

- Yes
- No
- Unknown

**16b.If answered "No" to [16a] then:  
If no please provide details (goals update)**

**17. Is there evidence of the following with regards to ventilator weaning?**

- A structured management plan  SLT involvement  
 Physiotherapist involvement  Dietitian involvement  None of these  
 Unknown  Not applicable

Please specify any additional options here...

**18a.E Is there any evidence in the notes that outcome measures were used in the assessment of rehabilitation.**

- Yes  No  Unknown

**18b.If answered "Yes" to [18a] then:  
If Yes please select which:**

- Local PROMS  Manchester Mobility Score  ICU mobility Scale  
 Barthel index  CPAX  IPAT  
 PICUPS

Please specify any additional options here...

**Discharge from ICU**

**19a.Is there evidence of a comprehensive re-assessment of rehabilitation needs performed at discharge from ICU?**

- Yes  No  Unknown

**19b.If answered "Yes" to [19a] then:  
E In your opinion, was anything missing?**

- Yes  No  Unknown

**19c.If answered "Yes" to [19b] then:  
E please give details (reassess)**

**20a.If answered "Yes" to [19a] then:**

**Was this carried out by all the appropriate healthcare professionals?**

- Yes  No  Unknown

**20b.If answered "Yes" to [19a] and "No" to [20a] then:  
If NO, please provide details**

**21a.If answered "Yes" to [19a] then:**

**E Were the rehabilitation goals updated (dc ICU)**

- Yes  No  Unknown

**21b.If answered "No" to [21a] then:  
if the rehabilitation goals were not updated, please explain:**

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**22a.How was information handed over to the team providing care on the ward (post discharge from ICU)**

- Verbal handover  Written as entry in case notes  
 Structured handover - proforma

Please specify any additional options here...

**22b.In your opinion, was any information missing from the handover process?**

- Yes  No  Unknown

**22c.If answered "Yes" to [22b] then:  
E What was missing?**

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**23a.Please rate the quality of rehabilitation care provided to this patient in ICU?**

*up to and including the handover to the team at discharge from ICU to the ward*

- Good  Adequate  Poor  Unacceptable  
 insufficient data

**23b.If answered "Good", "Adequate", "Poor" or "Unacceptable" to [23a] then:  
D Please provide the main reasons for your rating**

F. ASSESSMENT OF REHABILITATION NEEDS AND DELIVERY OF REHABILITATION POST-DISCHARGE FROM ICU

**1a. Was a comprehensive re-assessment of rehabilitation needs carried out whilst the patient was on the ward (following step down from ICU)**

- yes                       No                       Unknown

**1b. If answered "yes" to [1a] then:**

**In your opinion, were there any missing elements or healthcare professionals from the comprehensive assessment of rehabilitation need that was carried out on the ward (post-step down from ICU)?**

- Yes                       No                       Unknown

**1c. If answered "Yes" to [1b] then:**

**F Please provide details of who / what was missing from the re-assessment of rehabilitation need**

**2a. F Was any ongoing rehabilitation provided by the ICU MDT once the patient had stepped down to the ward?**

- Yes                       No                       Unknown

**2b. If answered "Yes" to [2a] then:**

**F If Yes, who provided this:**

- |  |  |                                  |
|--|--|----------------------------------|
| <input type="checkbox"/> ICU Physiotherapist           | <input type="checkbox"/> ICU Dietitian | <input type="checkbox"/> ICU SLT |
| <input type="checkbox"/> ICU Doctor                    | <input type="checkbox"/> ICU Nurse     | <input type="checkbox"/> ICU OT  |
| <input type="checkbox"/> ICU Practitioner Psychologist |  |                                  |

Please specify any additional options here...

**2c. If answered "No" to [2a] then:**

**If No, In your opinion, would the patient have benefitted from this?**

- Yes                       No                       Unknown

**2d. If answered "Yes" to [2c] then:**

**F Please provide details**

**3a. F Was any rehabilitation care delivered by a physiotherapist whilst the patient was in on the ward following step-down from ICU?**

- Yes                       No                       Unknown

**3b. If answered "No" to [3a] then:**

**F If No, in your opinion, would this patient have benefitted from receiving care from a physiotherapist?**

- yes                       No                       Unknown

**3c. If answered "Yes" to [3a] then:**

**F In your opinion, was the rehabilitation care provided by the physiotherapist, initiated at the appropriate time?**

- Yes  No  Unknown

**3d. If answered "Yes" to [3a] then:**

**F In your opinion, was the rehabilitation care provided by the physiotherapist, delivered with the appropriate consistency?**

- Yes  No  unknown

**3e. F In your opinion was there any delay/ room for improvement in treatment for mobility (on ward)**

- Yes  No  Unknown

**3f. If answered "Yes" to [3e] then:**

**F Please give details of delay/ room for improvement in treatment for mobility (on ward)**

**3g. F In your opinion was there any delay/ room for improvement in treatment for muscle strength (on ward)?**

- Yes  No  Unknown

**3h. If answered "Yes" to [3g] then:**

**F Please give details of delay/ room for improvement in treatment for muscle strength (on ward)**

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**4a. F Was any rehabilitation care delivered by a SLT whilst the patient was in on the ward following step-down from ICU?**

- Yes  No  Unknown

**4b. If answered "No" to [4a] then:**

**F If No, in your opinion, would this patient have benefitted from receiving care from a SLT?**

- Yes  No  Unknown

**4c. If answered "Yes" to [4a] then:**

**F In your opinion, was the rehabilitation care provided by the SLT, initiated at the appropriate time?**

- Yes  No  Unknown

**4d. If answered "Yes" to [4a] then:**

**F In your opinion, was the rehabilitation care provided by the SLT, delivered with the appropriate consistency?**

- Yes  No  Unknown

**4e. In your opinion was there any delay/ room for improvement in treatment for swallow (on ward)**

- Yes  No  Unknown

**4f. If answered "Yes" to [4e] then:**

**F Please give details of delay/ room for improvement in treatment for swallow (on ward)**

**4g. F In your opinion was there any delay/ room for improvement in treatment for communication (on ward)**

- Yes  No  Unknown

**4h. If answered "Yes" to [4g] then:**

**F Please give details of delay/ room for improvement in treatment for communication (on ward)**

**5a. If answered "No" to [5b] then:**

**F If No, in your opinion, would this patient have benefitted from receiving care from a Dietitian?**

- yes                       No                       Unknown

**5b. F Was rehabilitation care delivered by a Dietitian whilst the patient was in on the ward following step-down from ICU?**

- yes                       No                       Unknown

**5c. If answered "yes" to [5b] then:**

**F In your opinion, was the rehabilitation care provided by the Dietitian, initiated at the appropriate time?**

- yes                       No                       Unknown

**5d. If answered "yes" to [5b] then:**

**F In your opinion, was the rehabilitation care provided by the Dietitian, delivered with the appropriate consistency?**

- yes                       No                       Unknown

**5e. In your opinion was there any delay/ room for improvement in the delivery of treatment for nutrition (on ward)**

- Yes                       No                       Unknown

**5f. If answered "Yes" to [5e] then:**

**F Please give details of delay/ room for improvement in treatment for nutrition (on ward)**

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**6a. F Was rehabilitation care delivered by a OT whilst the patient was in on the ward following step-down from ICU?**

- yes                       No                       Unknown

**6b. If answered "No" to [6a] then:**

**F If No, in your opinion, would this patient have benefitted from receiving care from a OT?**

- yes                       No                       Unknown

**6c. If answered "yes" to [6a] then:**

**F In your opinion, was the rehabilitation care provided by the OT, initiated at the appropriate time?**

- yes                       No                       Unknown

**6d. If answered "yes" to [6a] then:**

**F In your opinion, was the rehabilitation care provided by the OT, delivered with the appropriate consistency?**

- yes                       No                       Unknown

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**7a. F Was rehabilitation care delivered by a Practitioner Psychologist whilst the patient was in on the ward following step-down from ICU?**

- yes                       No                       Unknown

**7b. If answered "No" to [7a] then:**

**F If No, in your opinion, would this patient have benefitted from receiving care from a Practitioner psychologist?**

- yes                       No                       Unknown

**7c. F E Please give details of delay/ room for improvement in any other aspect of rehabilitation delivered on the ward after step down from ICU**

**7d. If answered "yes" to [7a] then:**

**F In your opinion, was the rehabilitation care provided by the Practitioner Psychologist, initiated at the appropriate time?**

- yes                       No                       Unknown

**7e. If answered "yes" to [7a] then:**

**F In your opinion, was the rehabilitation care provided by the Practitioner psychologist, delivered with the appropriate consistency?**

- yes                       No                       Unknown

**7f. In your opinion was there any delay/ room for improvement in the treatment of anxiety/ depression/mental health (on ward)**

- Yes                       No                       Unknown

**7g. If answered "Yes" to [7f] then:**

**F Please give details of delay/ room for improvement in mental health (on ward)**

**8a. F In your opinion was there any delay/ room for improvement in the treatment for sleep (on ward)**

- Yes                       No                       Unknown

**8b. If answered "Yes" to [8a] then:**

**F Please give details of delay/ room for improvement in treatment for sleep (on ward)**

**8c. F In your opinion was there any delay/ room for improvement in the treatment for cognition (on ward)**

- Yes                       No                       Unknown

**8d. If answered "Yes" to [8c] then:**

**F Please give details of delay/ room for improvement in treatment for cognition (on ward)**

**9a. F Was there any delay/ room for improvement in the delivery of any other aspect of rehabilitation (on the ward)?**

- Yes                       No                       Unknown

**9b. If answered "Yes" to [9a] then:**

**Please give details of any other aspect of rehabilitation that was delayed/ had room for improvement**

**10. Was any rehabilitation care delivered over the weekend whilst the patient was on the ward following step down from ICU?**

- Yes                       No                       Unknown  
 N/A- not on ward at weekend

**11. F Was a review of medications carried out at any time (on the ward following step-down from ICU)?**

- yes                       No                       Unknown

**12a. Please rate the quality of rehabilitation care provided on the ward - post step-down from ICU**

- Good                       Adequate                       Poor                       Unacceptable  
 insufficient data

**12b. F please provide the reasons for your rating**

**Hospital discharge**

**1. G Is there evidence of a comprehensive re-assessment of rehabilitation needs performed at discharge form hospital?**

- yes                       No                       Unknown

**2a. If answered "yes" to [1] then:**

**G If Yes, was it completed by all the appropriate healthcare professionals?**

- yes                       No                       Unknown

**2b. If answered "No" to [2a] then:**

**G If no, who was missing?**

**2c. If answered "yes" to [1] then:**

**G Did the comprehensive assessment of rehabilitation needs identify continuing rehabilitation needs?**

- yes                       No                       unknown

**3a. G What onward referrals were made at the time of discharge?**

- Physiotherapy appointment - this hospital
- Physiotherapy appointment - community-based
- Occupational therapist appointment- hospital based
- Occupational therapist appointment - home visit
- SLT- hospital-based
- SLT-community based
- Practitioner Psychologist- this hospital
- Practitioner Psychologist- Community- based
- Practitioner psychologist- mental health trust
- Other mental health referral
- Other specialty - this hospital
- Other hospital appointment
- Dietetics appointment: hospital-based
- Dietetics appointment- community based
- Other community based rehabilitation clinic
- Hospital- based rehabilitation
- Community nurse
- Other nurse

Please specify any additional options here...

**3b. G In your opinion, were all the appropriate onward referrals made for continuing rehabilitation?**

*given the rehabilitation needs of this patient at the time of hospital discharge*

- yes                       No                       Unknown

**3c. If answered "No" to [3b] then:**

**G2 Please provide details of any onward referrals that should have been made for this patient at the time of discharge but were not**

**4a. F In your opinion, was there any room for improvement in the discharge documentation?**

- yes                       No                       Unknown

**4b. If answered "yes" to [4a] then:**

**F What was missing? (dc summary)**

- |   |  |
|---|--|
| <input type="checkbox"/> Documentation of rehabilitation needs          | <input type="checkbox"/> Follow up appointment with ICU                  |
| <input type="checkbox"/> Detailed care plan for rehabilitation          | <input type="checkbox"/> Appropriate onward referrals for rehabilitation |
| <input type="checkbox"/> Patient information- managing recovery at home |  |
| <input type="checkbox"/> Patient information - expectations             | <input type="checkbox"/> Patient information - when to ask for help      |
| <input type="checkbox"/> Who to contact in case of deterioration        | <input type="checkbox"/> Medications plan                                |
| <input type="checkbox"/> GP communication                               | <input type="checkbox"/> Named case worker/ co-ordinator                 |
| <input type="checkbox"/> Functional status at time of discharge         |  |

Please specify any additional options here...

**5a. G Date of discharge:**

- Unknown

**5b. G What was the discharge destination for this patient?**

- |  |  |   |
|--|--|---|
| <input type="radio"/> Home               | <input type="radio"/> Rehabilitation unit    | <input type="radio"/> Other hospital ward |
| <input type="radio"/> Hospice/ care home | <input type="radio"/> Mental health hospital | <input type="radio"/> Prison              |

If not listed above, please specify here...

**5c. G In your opinion, was the discharge destination appropriate?**

- yes                       No                       Unknown

**6a. G In your opinion was there room for improvement in the handover of rehabilitation care at discharge from hospital?**

- Yes                       No                       Unknown

**6b. If answered "Yes" to [6a] then:**

**G If there was room for improvement in the handover of care, please provide details**

**7a. G In your opinion, was this patient discharged at the appropriate time?**

*Discharge occur too soon or too late given the patient's clinical condition?*

Yes                       No                       Unknown

**7b. If answered "No" to [7a] then:**

**G If no (not discharged at the appropriate time), please provide details**

**Follow-up and community care**

**8a. G Was a follow-up appointment made for this patient with ICU?**

yes                       No                       Unknown

**8b. If answered "No" to [8a] then:**

**G If NO, why not?**

**9a. If answered "yes" to [8a] then:**

**G When was the follow-up appointment with ICU?**

*If multiple follow-up appointments- refer to the first one*

<1 month after discharge     1- <2 months after discharge     2-<3 months after discharge  
 3-<4 months after discharge     4-<6months after discharge     6- <12 months after discharge  
 >12 months after discharge

If not listed above, please specify here...

**9b. If answered "yes" to [8a] then:**

**G In your opinion, was the timing of follow-up appointment appropriate for this patient?**

Yes                       No                       Unknown

10. If answered "yes" to [8a] then:

**G How many times did the patient have a follow-up appointment with ICU?**

*in the year following discharge from hospital (based on the case notes/ clinician questionnaire present)*

Unknown

11. If answered "yes" to [8a] then:

**G At the follow-up appointment, did the patient undergo a comprehensive assessment of rehabilitation needs?**

Yes

No

Unknown

12a. If answered "Yes" to [11] then:

**G Was the assessment of rehabilitation needs carried out by all the relevant healthcare professionals?**

*Covering all required aspects of rehabilitation*

Yes

No

Unknown

12b. If answered "No" to [12a] then:

**G Please provide details of who/ what was missing?**

13a. If answered "Yes" to [11] then:

**G Did the comprehensive assessment of rehabilitation needs (carried out at the follow-up) identify continuing rehabilitation needs?**

Yes

No

Unknown

13b. If answered "Yes" to [11] then:

**G Did the comprehensive assessment of rehabilitation needs identify new rehabilitation needs?**

yes

No

Unknown

14a. If answered "yes" to [8a] then:

**Were any changes made to the rehabilitation care plan?**

Yes

No

Unknown

14b. If answered "Yes" to [14a] then:

**G Was there adequate communication of any changes to the rehabilitation care plan?**

yes

No

Unknown

Not applicable- no changes

14c. If answered "No" to [14b] then:

**G If not, please give details:**

**15a.G In your opinion, were all appropriate referrals for ongoing rehabilitation care made following discharge from hospital?**

*Taking into account any changes in the rehabilitation needs of this patient following hospital discharge referrals if required*

- yes                       No                       Unknown

**15b.If answered "No" to [15a] then:**

**G Please provide details of any room for improvement in onward referrals for ongoing care**

---

**16a.G Is there evidence in the notes that the patient received adequate ongoing rehabilitation care from community team/s?**

- Yes - this patient received good community-based rehabilitation following discharge  
 No- Referrals were made but no community notes are available  
 No- Community notes show room for improvement in care  
 Not applicable - not required for this patient

If not listed above, please specify here...

**16b.If answered "Yes - this patient received good community-based rehabilitation following discharge", "No- Referrals were made but no community notes are available", "No- Community notes show room for improvement in care" or "Not applicable - not required for this patient" to [16a] then:**

**Please expand on your answer**

---

**17a.G Did the GP see/ contact this patient in relation to their ongoing rehabilitation following discharge from hospital?**

- Yes     No  
 Unable to answer- insufficient data

**17b.If answered "Yes" to [17a] then:**

**G Please provide details (GP)**

**17c. If answered "Yes" to [17a] then:**

**G Did the GP make any referrals in relation to the ongoing rehabilitation for this patient?**

- Yes                       No                       Unknown

**17d.If answered "Yes" to [17c] then:  
G2 Please provide details (GP)**

**Readmission to hospital**

**18. G Was this patient readmitted to hospital during the year following discharge from hospital**

- Yes  No  Unknown

**19. If answered "Yes" to [18] then:  
G How many times was the patient readmitted to hospital?**  
*According to the notes/ clinician questionnaire*

- Not Applicable  Unknown

**20. If answered "Yes" to [18] then:  
G what was the reason for the first readmission?**

**21. If answered "Yes" to [18] then:  
G How long after discharge from hospital was the first readmission to hospital?**

- <7 days  7-14 days  >14-21 days  >21-30 days  
 >30 days

If not listed above, please specify here...

**22. If answered "Yes" to [18] then:  
G In your opinion, was the reason for the first readmission related to the ICU stay?**

- Yes  No  Unknown

**23a.If answered "Yes" to [18] then:  
G In your opinion, could the first readmission to hospital have been the result of a failure of the rehabilitation care received by this patient?**

- Yes  No  Unknown

**23b.If answered "Yes" to [23a] then:  
G Please provide details 1**

**24a.If answered "Yes" to [18] then:**

**G In your opinion, could the re-admission have been prevented?**

- Yes                       No                       Unknown

**24b.If answered "Yes" to [24a] then:**

**G Please provide details 2**

---

**25a.G Did this patient die within 30 days of discharge from hospital?**

*the index admission*

- Yes                       No                       Unknown

**25b.If answered "Yes" to [25a] then:**

**G what was the cause of death?**

---

**26a.If answered "Yes" to [25a] then:**

**G Was the death related to the co-morbidity that necessitated the ICU stay?**

- Yes                       No                       Unknown

**26b.If answered "Yes" to [26a] then:**

**G Please provide details 3**

---

**27a.Please rate the overall quality of rehabilitation care received by this patient following discharge from hospital:**

*including rehabilitation care plan at discharge, follow-up with ICU team, GP, community-based rehabilitation and readmission to hospital*

- Good practice  
 Room for improvement in clinical aspects of care  
 Room for improvement in Organisational aspects of care  
 Room for improvement in both clinical and organisational aspects of care  
 Less than satisfactory  
 insufficient data

**27b.If answered "Good practice", "Room for improvement in clinical aspects of care", "Room for improvement in Organisational aspects of care", "Room for improvement in both clinical and organisational aspects of care" or "Less than satisfactory" to [27a] then:  
Please provide reasons for your rating**

## H. OVERALL QUALITY OF CARE

**2a. H Throughout the whole pathway of rehabilitation care, in your opinion, was there room for improvement in the communication of information to the patient and / or their family?**

*From admission to ICU, step-down to the ward, hospital discharge and post-discharge, from all the healthcare professionals involved in the patient's care*

- Yes                       No                       Unknown

**2b. If answered "Yes" to [2a] then:**

**H Please provide details: (patient comm)**

Please use the following grading to rate the overall quality of care received by this patient  
GOOD PRACTICE: A standard that you would accept from yourself, your trainees and your institution  
ROOM FOR IMPROVEMENT: Aspects of CLINICAL care that could have been better  
ROOM FOR IMPROVEMENT: Aspects of ORGANISATIONAL care that could have been better  
ROOM FOR IMPROVEMENT: Aspects of CLINICAL AND ORGANISATIONAL care that could have been better  
LESS THAN SATISFACTORY: Several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution.  
INSUFFICIENT DATA: Insufficient information submitted to NCEPOD to assess the quality of care

**3a. Please rate the overall quality of rehabilitation care received by this patient across the whole pathway**

- Good practice  
 Room for improvement in clinical aspects of care  
 Room for improvement in organisational aspect of care  
 Room for improvement in both clinical and organisational aspects of care  
 Less than satisfactory  
 insufficient data

**3b. If answered "Good practice", "Room for improvement in clinical aspects of care", "Room for improvement in organisational aspect of care", "Room for improvement in both clinical and organisational aspects of care" or "Less than satisfactory" to [3a] then: Please give details as to why you graded the case this way:**

**3c. Are there any themes/ issues from this case you feel should be highlighted in the final report?**

- yes                       No

**3d. If answered "yes" to [3c] then:  
Please expand on your answer (illustrative vignette)**

**CAUSE FOR CONCERN**

Occasionally NCEPOD will refer cases that have been identified as 'LESS THAN SATISFACTORY' when it is felt that further feedback to the Trust/ Health Board concerned is warranted. This is usually due to an area of concern to the hospital or clinician involved, and not for issues highlighted across the body of case notes.

This process has been agreed by the NCEPOD Steering Group and the GMC. The medical director of the Trust/ Health Board is written to by the Chief Executive of NCEPOD explaining our concerns. This process has been in operation for 10 years and the responses received have always been positive in that they feel we are dealing with the concerns in the most appropriate manner.

**3e. Do you feel that this case should be considered for such action?**

- yes                       No

---

**Impact of Health inequalities**

**4a. During review of this case did you notice any evidence of one or more health inequality or bias that impacted on the care provided?**

- Yes                       No                       Unknown

**4b. If answered "Yes" to [4a] then:**

**What health inequalities exist in relation to this patient?**

*(Please select all that apply)*

- |   |   |
|---|---|
| <input type="checkbox"/> Age  | <input type="checkbox"/> Disability - physical      |
| <input type="checkbox"/> Disability - learning/cognitive                | <input type="checkbox"/> Gender reassignment        |
| <input type="checkbox"/> Marriage and civil partnership                 | <input type="checkbox"/> Pregnancy and maternity    |
| <input type="checkbox"/> Race   | <input type="checkbox"/> Religion or belief         |
| <input type="checkbox"/> Sex  | <input type="checkbox"/> Sexual orientation         |
| <input type="checkbox"/> Socioeconomic status                           | <input type="checkbox"/> Geographic deprivation     |
| <input type="checkbox"/> Part of a vulnerable or inclusion health group | <input type="checkbox"/> Severe mental illness      |
| <input type="checkbox"/> Chronic respiratory disease                    | <input type="checkbox"/> Early cancer diagnosis     |
| <input type="checkbox"/> Hypertension case finding                      | <input type="checkbox"/> English not first language |
| <input type="checkbox"/> Travel time to hospital                        |   |

Please specify any additional options here...

**4c. If answered "Part of a vulnerable or inclusion health group" to [4b] then:**

**If 'part of a vulnerable or inclusion health group' which group? (Please tick all that apply)**

*(Please select all that apply)*

- |  |  |
|--|--|
| <input type="checkbox"/> Homelessness                | <input type="checkbox"/> Drug and alcohol dependence               |
| <input type="checkbox"/> Drug and alcohol dependence | <input type="checkbox"/> Gypsy, Roma and Traveller communities     |
| <input type="checkbox"/> Sex workers                 | <input type="checkbox"/> People in contact with the justice system |
| <input type="checkbox"/> Victims of modern slavery   |  |

Please specify any additional options here...

**4d. If answered "Yes" to [4a] then:**

**If Yes to part (A) Please provide any further details**

*of how the patient's inequalities impacted on the care provided*