

Recovery Beyond Survival

A review of the quality of rehabilitation care provided to patients following an admission to an intensive care unit

SUMMARY



RECOVERY BEYOND SURVIVAL

A review of the quality of rehabilitation care provided to patients following an admission to an intensive care unit

A report published by the National Confidential Enquiry into Patient Outcome and Death (2025)

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Cohort: 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.

The Medical and Surgical Clinical Outcome Review Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). HQIP is led by a consortium of the Academy of Medical Royal Colleges and the Royal College of Nursing. Its aim is to promote quality improvement in patient outcomes. The Clinical Outcome Review Programmes, which encompass confidential enquiries, are designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers, and policy makers to learn from adverse events and other relevant data. HQIP holds the contract to commission, manage and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies www.hqip.org.uk/national-programmes.
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SUPPORTING INFORMATION

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INFOGRAPHIC SUMMARY

While many patients admitted to an intensive care unit (ICU) will make a good recovery, the impact of a stay in an ICU can be profound with long-lasting effects, and people may require ongoing rehabilitation to support their recovery. The population included in this study represented a range of specialities and ward areas, highlighting the need for organisations to recognise the importance of rehabilitation not just within intensive care units but across all specialty areas, wards and in the community.

1,018 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 who survived to hospital discharge were included. A total of 365 sets of case notes and 671 clinician questionnaires were reviewed, along with 248 primary care clinician questionnaires, 166 organisational questionnaires and 67 community trust organisational questionnaires. In addition, 420 healthcare professional and 102 patient surveys were returned.

KEY MESSAGES



IN INTENSIVE CARE



ON THE WARD



AFTER DISCHARGE



Rehabilitation care was not well co-ordinated throughout the pathway; on admission to an ICU, at step-down to the ward and in the community.

70/166 (42.2%) organisations had a policy or standard operating procedure for the delivery of rehabilitation, and only 24/70 undertook audits against them.

The data showed an absence of good multidisciplinary team working and communication across the recovery pathway as the patient moved between healthcare settings. Key workers to co-ordinate rehabilitation care were rarely available, yet when present they were associated with improved markers of care quality throughout the rehabilitation pathway.



Initial and subsequent assessments of rehabilitation need to set/update goals were not always undertaken.

104/365 (28.5%) patients had a baseline screen, and 327/574 (57.0%) patients had a comprehensive assessment on the ICU.

80/309 (25.9%) patients had a comprehensive assessment on the ward.

102/210 (48.6%) patients who attended a critical care follow-up following discharge were comprehensively reassessed.



Full multidisciplinary team (MDT) input was rarely available to meet all the rehabilitation needs of patients.

Physiotherapists were most involved in rehabilitation (604/671; 90.0%); other specialties, such as psychologists (37/671; 5.5%) much less so.

111/318 (34.9%) patients had input from the ICU MDT; usually an intensive care nurse (70/111; 63.1%) or critical care outreach (44/111; 39.6%) with less focus on rehabilitation.

98/254 (18.2%) patients did not have all appropriate referrals made.



Ongoing rehabilitation needs/goals were often not shared between healthcare providers as the patient moved through the pathway.

125/671 (18.6%) patients had no evidence of any handover related to rehabilitation needs.

357/576 (62.0%) patients were provided with an ICU follow-up appointment.

GPs were aware that a patient they saw had spent time in the ICU in 170/248 (68.5%) cases.



Information for the patient or their family about the ICU admission and any lasting impact it may have was limited.

The patient and their family were updated in 165/302 (54.6%) instances.

131/435 (30.1%) patients were given a copy of the ICU discharge summary.

40/102 (39.2%) survey respondents reported they were given a leaflet or discharge booklet.

RECOMMENDATIONS

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These recommendations have been formed by a consensus exercise involving all those listed in the acknowledgements. The recommendations have been independently edited by medical editors experienced in developing recommendations for healthcare audiences to act on.

The recommendations in this report support those made previously by other organisations, and for added value should be read alongside:

- [NICE Guideline \[CG83\]: Rehabilitation after critical illness in adults, 2009](#)
- [NICE Quality Standard \[QS158\]: Rehabilitation after critical illness, 2017](#)
- [Intensive Care Society: Framework for assessing early rehabilitation needs following treatment in intensive care, Version 1. 2020](#)
- [GIRFT programme: National Specialty Report on Adult Critical Care, 2021](#)
- [Intensive Care Society and the Faculty of Intensive Care Medicine: Guidelines for the Provision of Intensive Care Services, 2022](#)
- [NHS England: Service specification for Adult Critical Care](#)
- [NHS England: Improving Rehabilitation](#)
- [Commissioning Guidance for Rehabilitation](#)

The recommendations highlight areas that are suitable for regular local clinical audit and quality improvement initiatives. The results should be presented at quality or governance meetings, and action plans to improve care should be shared with executives in trust/health boards.

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.
FOR ACTION BY	Commissioners, integrated care boards, hospital trusts/health boards
ADDITIONAL STAKEHOLDERS	Intensive Care Society, Faculty of Intensive Care Medicine, British Dietetic Association, Royal College of Speech and Language Therapists, Royal College of Occupational Therapists, Chartered Society of Physiotherapists, British Geriatric Society.
RATIONALE FOR THE RECOMMENDATION	The data showed an absence of good multidisciplinary team working and communication across the recovery pathway as the patient moved between healthcare settings.
ASSOCIATED GUIDANCE	NICE Guideline [CG83] Rehabilitation after critical illness in adults, 2009 NICE Quality Standard [QS158] Rehabilitation after critical illness, 2017 Intensive Care Society: GPICS

<p>IMPLEMENTATION SUGGESTIONS</p>	<p>AT A TRUST/HEALTH BOARD LEVEL</p> <ul style="list-style-type: none"> ▪ Include a senior executive responsible for developing and overseeing implementation of a rehabilitation policy ▪ Include a senior manager responsible for the implementation of the rehabilitation policy ▪ Commission rehabilitation services and multidisciplinary team provision based on patient need rather than diagnosis, across multiple pathways of care ▪ Enable critical care survivors and their relatives/carers to be involved in the design of services ▪ Develop and introduce relevant training to non-specialists to increase knowledge of the impact of critical illness and rehabilitation requirements ▪ Regular audits would provide high level overview of rehabilitation services and evaluation of services/outcomes. <p>AT A PATIENT LEVEL</p> <ul style="list-style-type: none"> ▪ Provide access to a rehabilitation care co-ordinator in hospital and in the community following hospital discharge ▪ The rehabilitation care co-ordinator role could be like that of a major trauma co-ordinator, any healthcare professional with the appropriate skills and competency and a designated role with its own job description and ring-fenced time. There may be more than one in larger units. <p>The rehabilitation care co-ordinator role could:</p> <ul style="list-style-type: none"> ▪ Triage patients at risk while having a general oversight ▪ Co-ordinate the assessments and make sure they are being done ▪ Ensure that handovers are taking place and being received ▪ Ensure that patients are getting access to the multidisciplinary team members that they need at all stages of the pathway ▪ Support communication/information to patients, their carers and families, such as rehabilitation plans and goals ▪ Ensure that all referrals are in place as patients step-down to the community ▪ Be a named point of contact for patients following hospital discharge ▪ Liaise with primary care. Many patients only see their GP in the first year after an ICU admission. As an example, major trauma centres provide telephone follow-up by co-ordinators at two- and six-weeks following discharge. These calls can identify patients who are struggling and then generate early face-to-face review or referral to an appropriate service.
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2

Develop and validate a national standardised rehabilitation screening tool to be used on admission to an intensive care unit.

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.

FOR ACTION BY

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.

ADDITIONAL
STAKEHOLDERS

Commissioners, integrated care boards (England), Royal College of Speech and Language Therapists, Royal College of Occupational Therapists, Chartered Society of Physiotherapists British Dietetic Association, British Geriatric Society, Royal College of Psychiatrists, Association of Clinical Psychologists-UK, British Association of Critical Care Nurses, UK Critical Care Nursing Alliance.

RATIONALE FOR THE
RECOMMENDATION

Baseline assessments were infrequently undertaken, and comorbidity and functional status were the most performed evaluations. However, baseline assessments should include both physical and non-physical factors.

ASSOCIATED
GUIDANCE

[NICE Guideline \[CG83\] Rehabilitation after critical illness in adults, 2009](#)
[NICE Quality Standard \[QS158\] Rehabilitation after critical illness, 2017](#)
[The post-ICU presentation screen \(PICUPS\) and rehabilitation prescription \(RP\) for intensive care survivors](#)
[Commissioning Guidance for Rehabilitation](#)

IMPLEMENTATION
SUGGESTIONS

The tool could be developed by incorporating some of those already available (e.g. clinical frailty scales) and might include:

- Severity of illness
- Underlying comorbidities and frailty
- Pre-existing sensory deficits
- Baseline status
 - Physical factors: respiratory function, muscle weakness, activities of daily living
 - Nutrition
 - Cognition: memory, attention and performance
 - Psychological factors: post-traumatic stress disorder and affective disorders
- The tool should include the patient's voice, be validated and should be useable by any healthcare professional working in critical care services.

3

Undertake and document a comprehensive, holistic assessment of the rehabilitation needs of patients admitted to an intensive care unit at risk of physical and/or non-physical morbidity.

- Assessments should be repeated and documented at key stages along the patient’s pathway from admission to community services and GP follow-up.

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.

FOR ACTION BY	Healthcare professionals involved with patients on the intensive care unit.
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ADDITIONAL STAKEHOLDERS	Executives in trust/health boards, Royal College of Speech and Language Therapists, Royal College of Occupational Therapists, Chartered Society of Physiotherapists British Dietetic Association, British Geriatric Society, Royal College of Psychiatrists, Association of Clinical Psychologists-UK, British Association of Critical Care Nurses, UK Critical Care Nursing Alliance.
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RATIONALE FOR THE RECOMMENDATION	Elements were often missing from comprehensive assessments. Non-physical aspects of rehabilitation, nutrition and a lack of multidisciplinary team (MDT) involvement were the most frequently cited missing elements. However, the completion of comprehensive assessments was associated with better quality of care throughout the rehabilitation care pathway.
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ASSOCIATED GUIDANCE	<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</p>
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IMPLEMENTATION SUGGESTIONS	<ul style="list-style-type: none"> ▪ A standardised assessment proforma/tool of rehabilitation needs would aid this process to ensure that all required specialties are included ▪ This could be held electronically as part of the patient’s care record and repeated as required, but to include ICU discharge and hospital discharge as key milestones for reassessment ▪ The latest version of the assessment proforma could also be part of the discharge summary to general practitioners ▪ Where available, outcome measures could be used to capture progress as part of the proforma.
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4

Ensure that multidisciplinary teams are in place to deliver the required level of rehabilitation in intensive care units and across the recovery pathway. Include:

- 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
- Staff to deliver the required rehabilitation.

FOR ACTION BY

Commissioners, integrated care boards.

ADDITIONAL
STAKEHOLDERS

Hospital trusts/health boards, Royal College of Speech and Language Therapists, Royal College of Occupational Therapists, Chartered Society of Physiotherapists British Dietetic Association, British Geriatric Society, Royal College of Psychiatrists, Association of Clinical Psychologists-UK, British Association of Critical Care Nurses, UK Critical Care Nursing Alliance.

RATIONALE FOR THE
RECOMMENDATION

Multidisciplinary staffing levels often did not meet national guidance, resulting in a lack of dedicated time for patients within the intensive care unit.

ASSOCIATED
GUIDANCE

[NICE Guideline \[CG83\] Rehabilitation after critical illness in adults, 2009](#)
[NICE Quality Standard \[QS158\] Rehabilitation after critical illness, 2017](#)
[Intensive Care Society: GPICS](#) [GIRFT: Adult Critical Care](#)
[The post-ICU presentation screen \(PICUPS\) and rehabilitation prescription \(RP\) for intensive care survivors](#)

IMPLEMENTATION
SUGGESTIONS

- Rehabilitation provision should be commissioned based on patient need rather than diagnosis and cover the ICU, ward and community rehabilitation, using local clinical networks to share resources where possible.
- Along with the medical and nursing teams, these specialties could be part of the multidisciplinary team (MDT): physiotherapists, dietitians, speech and language therapists, occupational therapists, psychiatrists and mental health professionals, psychologists, and pharmacists.
- Include assessment by geriatricians for physical and cognitive rehabilitation
- Ring-fence MDT planning time
- Provide MDT care seven days per week both on the ICU and wards
- Formal MDT meetings or ward rounds within intensive care units (ICUs) could be held at least weekly and attended by all required members of the MDT. A structured tool, such as the standardised assessment proforma/passport (see recommendation 3) could be used
- Formal post-ICU ward rounds may not be practical due to the geographical spread of patients following step-down to the ward. Processes could be put in place to ensure that the MDT jointly discuss and document rehabilitation needs/discharge planning for all patients and track progress.

5

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.

FOR ACTION BY	Healthcare professionals involved with patients on the intensive care unit and hospital trusts/health boards.
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ADDITIONAL STAKEHOLDERS	Intensive Care Society, Faculty of Intensive Care Medicine, Royal College of Speech and Language Therapists, Royal College of Occupational Therapists, Chartered Society of Physiotherapists British Dietetic Association, British Geriatric Society, Royal College of Psychiatrists, Association of Clinical Psychologists-UK, British Association of Critical Care Nurses, UK Critical Care Nursing Alliance.
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RATIONALE FOR THE RECOMMENDATION	A good handover was associated with good continuity of care, including continued assessment and delivery of rehabilitation.
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ASSOCIATED GUIDANCE	NICE Guideline [CG83] Rehabilitation after critical illness in adults, 2009 NICE Quality Standard [QS158] Rehabilitation after critical illness, 2017
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IMPLEMENTATION SUGGESTIONS	<ul style="list-style-type: none"> ▪ The standardised assessment proforma/care passport could be used to aid the handover process and include the current assessment of rehabilitation needs, individualised rehabilitation plan and current goals for treatment ▪ Members of the critical care multidisciplinary team (MDT) may support the handover processes from the intensive care unit (ICU) to the ward through joint rehabilitation sessions ▪ Critical care discharge summaries could be copied to GPs and include predicted rehabilitation needs ▪ Knowledge of an admission to an ICU could be used to trigger a telephone call from the GP to the patient ▪ Alerts/flags on primary care records could be used to identify patients who have had an admission to an ICU, making it easier for primary care to search for patients who might need support – there is a SNOMED CT code for this.
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6

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.

- 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.

FOR ACTION BY

Healthcare professionals involved with patients on the intensive care unit and hospital trusts/health boards, integrated care boards, and patient organisations.

ADDITIONAL
STAKEHOLDERS

Intensive Care Society, Faculty of Intensive Care Medicine, ICUsteps.

RATIONALE FOR THE
RECOMMENDATION

The patient survey highlighted that this was the most important issue for patients but was not often carried out. Patients were often not updated by the hospital or GP, and there was a lack of follow-up.

ASSOCIATED
GUIDANCE

[NHS England: Involving patients in their care](#)
[The Faculty of Intensive Care Medicine: Life After Intensive Care](#)

IMPLEMENTATION
SUGGESTIONS

- The standardised assessment proforma could take the form of a rehabilitation passport that travels with individual patients along their care pathway
- Regular family updates could be provided regarding rehabilitation progress, including the involvement of the patient and their family in rehabilitation rounds as appropriate
- The 'All About Me' booklets help to provide insight and understanding of the person who is being looked after
- The use of rehabilitation boards in the patient's bedspace can help to share information about current goals and treatment plans
- Patient diaries can be an effective method of capturing the critical care experience
- A discharge summary (with technical terms explained) and/or providing relevant patient information booklets. Explaining the events of their critical illness, what to expect in recovery and their individualised rehabilitation plan are all vital parts of this communication to patients and their families. This could be provided digitally or part of the NHS app (or on paper if the patient is not digitally active)
- Provide contact details of a named healthcare professional (rehabilitation care co-ordinator) who has job-planned time to ensure they can respond to patients/families who get back in touch.

CHAPTER 1: METHODS AND DATA RETURNED - SUMMARY

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Study aims and objectives

The objectives of the study were to explore the clinical and organisational structures in place for the provision of rehabilitation care for patients who had been admitted to an intensive care unit (ICU).

Study population and case ascertainment

Inclusion criteria

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 who survived to hospital discharge.

Exclusion criteria

Neurology/trauma patients who received care as part of a defined care pathway.

Data collection

- A clinician questionnaire was sent to the named intensive care consultant for each patient
- A primary care questionnaire was disseminated to the named general practitioner for each patient in the sample. This short questionnaire collected data on the organisational structures in place in the GP practice, to promote quality care for patients post-discharge from an ICU
- An organisational questionnaire was sent to each acute hospital and community hospital where patients could be admitted for rehabilitation care following an admission to an ICU to collect data around the organisational structures, staffing provision and policies to deliver rehabilitation to patients in an ICU and following step-down to the ward and community care
- Copies of the case notes were requested from primary care, secondary care and community providers for peer review and a multidisciplinary group of case reviewers peer reviewed the case notes and associated clinician questionnaires
- An online anonymous clinician survey collected information on the training, experience and opinions of clinicians from each stage of the rehabilitation pathway
- An online anonymous patient survey, aimed at patients who had been in an ICU to collect data on their individual experiences of rehabilitation care throughout the rehabilitation pathway.

Data returned

- 1,018 patients included with 365 sets of case notes and 671 clinician questionnaires
- 248 primary care clinician questionnaires
- 166 organisational questionnaires and 67 community trust organisational questionnaires
- 420 healthcare professional surveys and 102 patient surveys.

Data analysis rules

- Small numbers have been suppressed if they risk identifying an individual
- Any percentage under 1% has been presented in the report as <1%
- Percentages were not calculated if the denominator was less than 100 so as not to inflate the findings, unless to compare groups within the same analysis
- There is variation in the denominator for different data sources and for each individual question as it is based on the number of answers given.

CHAPTER 2: DEMOGRAPHICS - SUMMARY

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- The mean age of the study population was 58 years, ranging from 18-95 years ([Figure 2.1](#)), indicating that a large proportion of patients with critical illness may have many socially and economically productive years ahead if they make an uncomplicated, fully rehabilitated recovery.
- Ethnicity of the study population was in line with recent census data.^[6] Although the ethnicity of 65/671 (9.7%) patients was unknown, this was a similar finding to the recent Intensive Care National Audit and Research Centre (ICNARC) dataset ([Table 2.1](#)).^[7]
- A total of 385/664 (58.0%) patients spent more than one week on an intensive care unit ICU ([Table 2.2](#)).
- There were 505/671 (75.3%) patients admitted to the ICU due to a medical condition and 166/671 (24.7%) for a surgical condition.
- 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](#)).
- 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]
- Assessing the grade of functional status by the Rockwood clinical frailty score only 224/602 (37.2%) patients left hospital with the same level of function as on admission. Of the 378/602 (62.8%) patients who had a different level of function, 59/378 (15.6%) improved and 319/378 (84.4%) deteriorated ([Figure 2.2](#)). Within the group who deteriorated, 245/319 (76.8%) had received invasive ventilation.

[THE FULL REPORT CAN BE READ HERE](#)

CHAPTER 3: ASSESSMENT OF REHABILITATION NEED AND GOAL SETTING

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CLINICAL MESSAGE: The quality of initial screening assessments and identification of 'high-risk' patients likely to need complex rehabilitation was inconsistent. Comprehensive assessments were infrequently carried out and, along with the baseline assessments tended to focus solely on physical rehabilitation. However, both should include all aspects of physical and non-physical rehabilitation. This was reflected by the healthcare professionals involved in the completion of assessments, which consisted predominantly of physiotherapists without much input from other specialties.

CHAPTER 4: MULTIDISCIPLINARY DELIVERY OF REHABILITATION

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CLINICAL MESSAGE: Multidisciplinary staffing levels often did not meet national guidance, resulting in staff being shared with other areas and a lack of dedicated time for patients within the intensive care unit and the other areas in which they are needed. This led to delays or inconsistency in the assessment and delivery of rehabilitation, with a tendency to focus on the physical/mobility aspects of care, with areas such as cognition and psychological need often not addressed.

CHAPTER 5: STEP-DOWN CARE AND COMMUNICATION

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CLINICAL MESSAGE: There was variation in the handover of rehabilitation care and often either key information was missing, or handovers were not carried out at all. However, a good handover was associated with good continuity of care, including continued assessment and delivery of rehabilitation, as well as overall quality of care.

CHAPTER 6: PATIENT AND FAMILY INVOLVEMENT FROM THE ICU ADMISSION TO DISCHARGE

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CLINICAL MESSAGE: While excellent examples exist supported by charities such as [ICUsteps](#), clinicians reported that this was rare, with often no standardised approach to the provision of information to patients before discharge from hospital.

CHAPTER 7: QUALITY OF REHABILITATION CARE

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CLINICAL MESSAGE: Involving relevant members of the intensive care multidisciplinary team and undertaking early assessments of rehabilitation led to an improved quality of rehabilitation care.