

## Recovery Beyond Survival

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



## Lessons in Recovery: What NCEPOD tells us about critical care rehabilitation

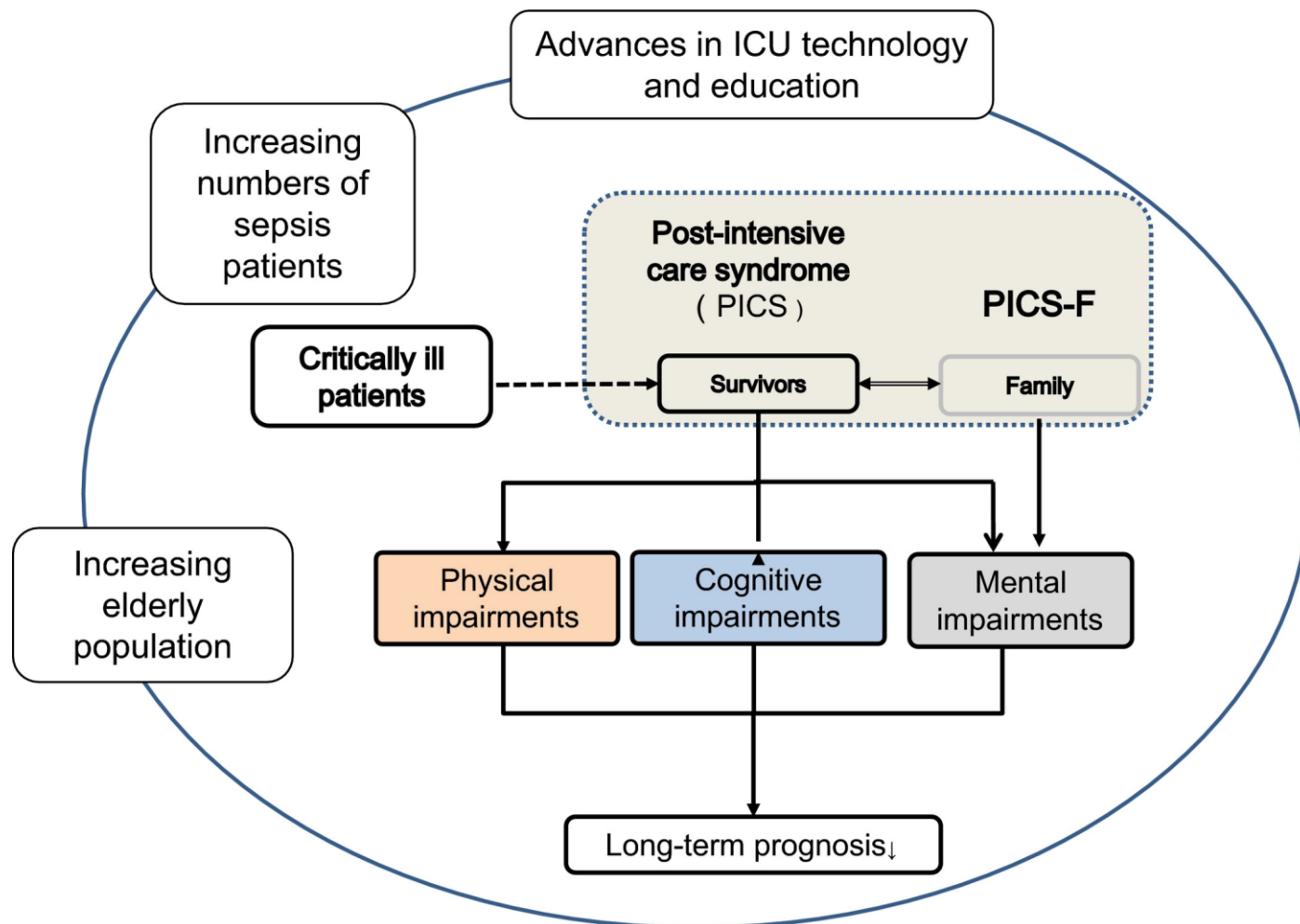
### Professor David McWilliams

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*Professor of Critical Care and Rehabilitation*

*University Hospitals Coventry & Warwickshire NHS trust and  
Coventry University Centre for Care Excellence*

# Why was a study needed



At 1 year

- 1/3 still require help with ADL's
- Only 40% of patients back at work
- Up to 50% readmitted to hospital
  
- 1/3 patients cognitive dysfunction
- 1/3 anxiety +/- depression
- 1/5 PTSD
  
- Up to 30% of family / caregivers experience stress, anxiety, depression and complicated grief

# National Guidelines

**NHS**  
National Institute for  
Health and Clinical Excellence

Issue date: March 2009

## Rehabilitation after critical illness

NICE clinical guideline 83  
Developed by the Centre for Clinical Practice at NICE

**NICE** National Institute for  
Health and Care Excellence

## Rehabilitation after critical illness in adults

Quality standard  
Published: 7 September 2017  
[www.nice.org.uk/guidance/qs158](http://www.nice.org.uk/guidance/qs158)

**NICE**  
quality  
standard

The Faculty of  
**Intensive  
Care Medicine**

**Intensive  
Care  
Society**



## **GUIDELINES FOR THE PROVISION OF INTENSIVE CARE SERVICES**

**Version 2.1**  
June 2022

# Topic Proposal Submitted Sept 2021

Supporting letters received from the following organisations:



# Aim

*“To evaluate the rehabilitation provided to critically ill adults within intensive care units, as well as throughout the recovery pathway to encompass both ward based and community care.”*



# Method

## **Study population:**

- 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.

## **Data sources:**

- 671 clinician questionnaires
- 365 sets of case notes
- 166 organisational questionnaires
- 248 primary care questionnaires
- 67 community trust questionnaires
- 102 patient and 420 healthcare professional survey responses



# 1

## CO-ORDINATE REHABILITATION THROUGHOUT THE PATHWAY

*Rehabilitation care was not well coordinated within ICU, on step down to the ward or in the community*

- 70/166 (42%) of organisations had a policy or standard operating procedure for the delivery of rehabilitation, and only 24/70 undertook audits against them
- Data showed an absence of teamwork and communication, and siloed approaches to rehabilitation delivery
- Key workers to coordinate rehabilitation were rarely available (107/420, 26%), but when present were associated with improved markers of care quality throughout the rehabilitation pathway



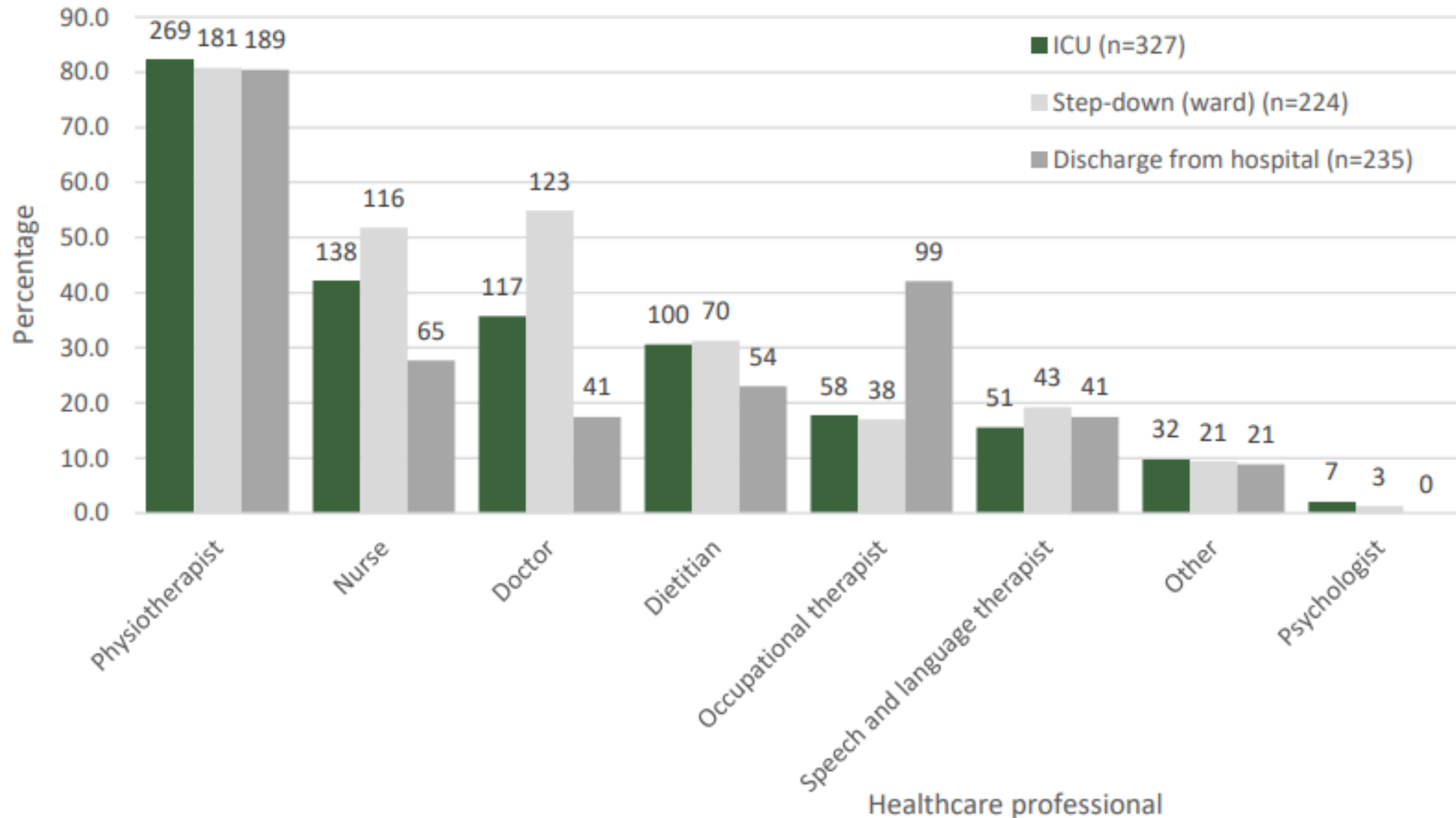
## 2

### INITIAL AND SUBSEQUENT ASSESSMENTS OF REHABILITATION NEED TO SET/UPDATE GOALS WERE NOT ALWAYS UNDERTAKEN.

*There was a failure to identify rehabilitation needs for some patients, and even when identified this was often delayed or focused on physical function*

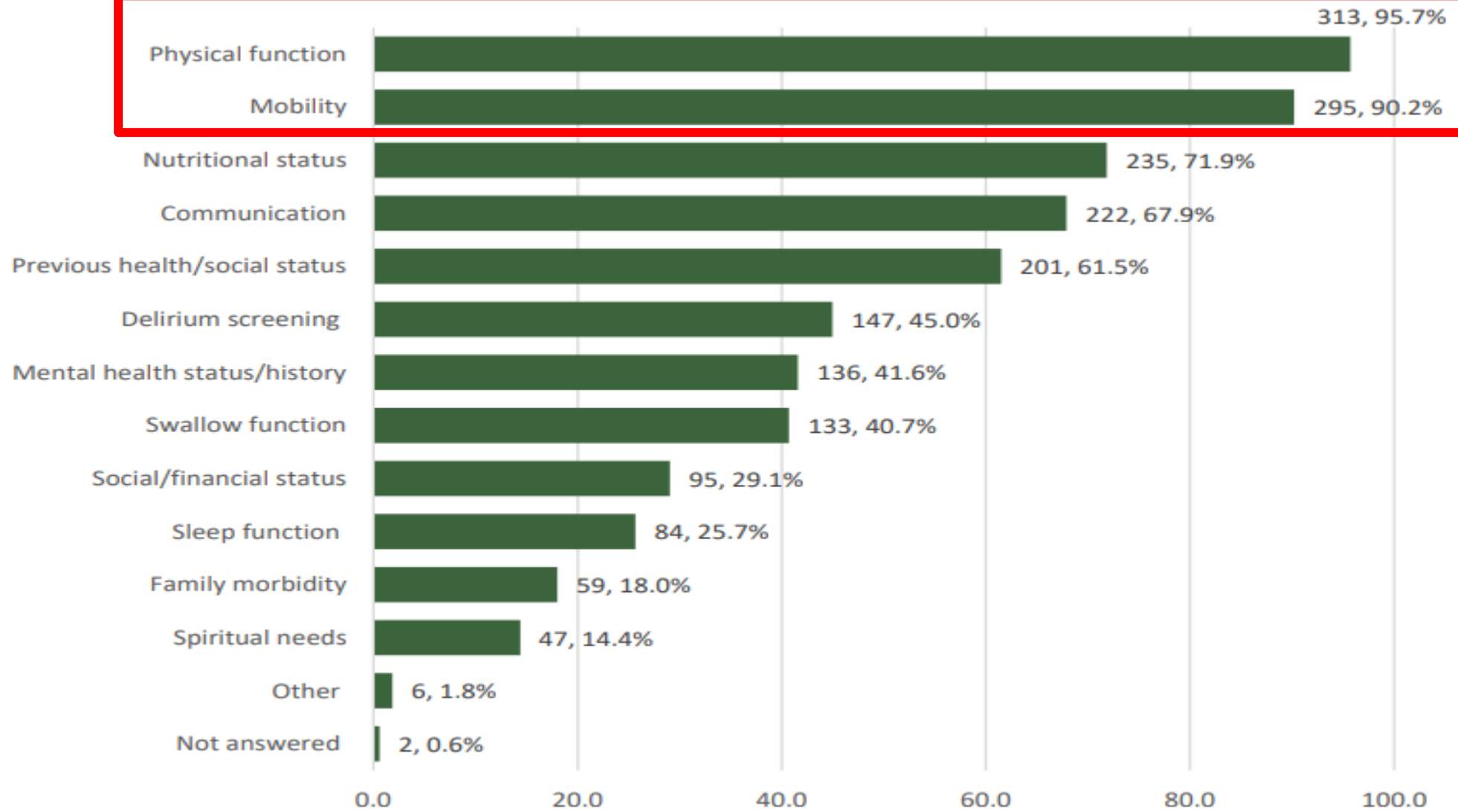
- 104/345 (29%) patients had a documented baseline screen on ICU admission.
- 71% had no baseline psychological assessment despite:
  - 17% previous contact with MH services
  - 19% History of excess alcohol
  - 9% recreational drug use
- Clinicians reported 327/574 (57%) of patients had a comprehensive assessment on the ICU

# RAF – Assessments were not comprehensive



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Components of the comprehensive assessment (n=327)





## 2

### INITIAL AND SUBSEQUENT ASSESSMENTS OF REHABILITATION NEED TO SET/UPDATE GOALS WERE NOT ALWAYS UNDERTAKEN.

*A lack of comprehensive assessments adversely affected care ratings*

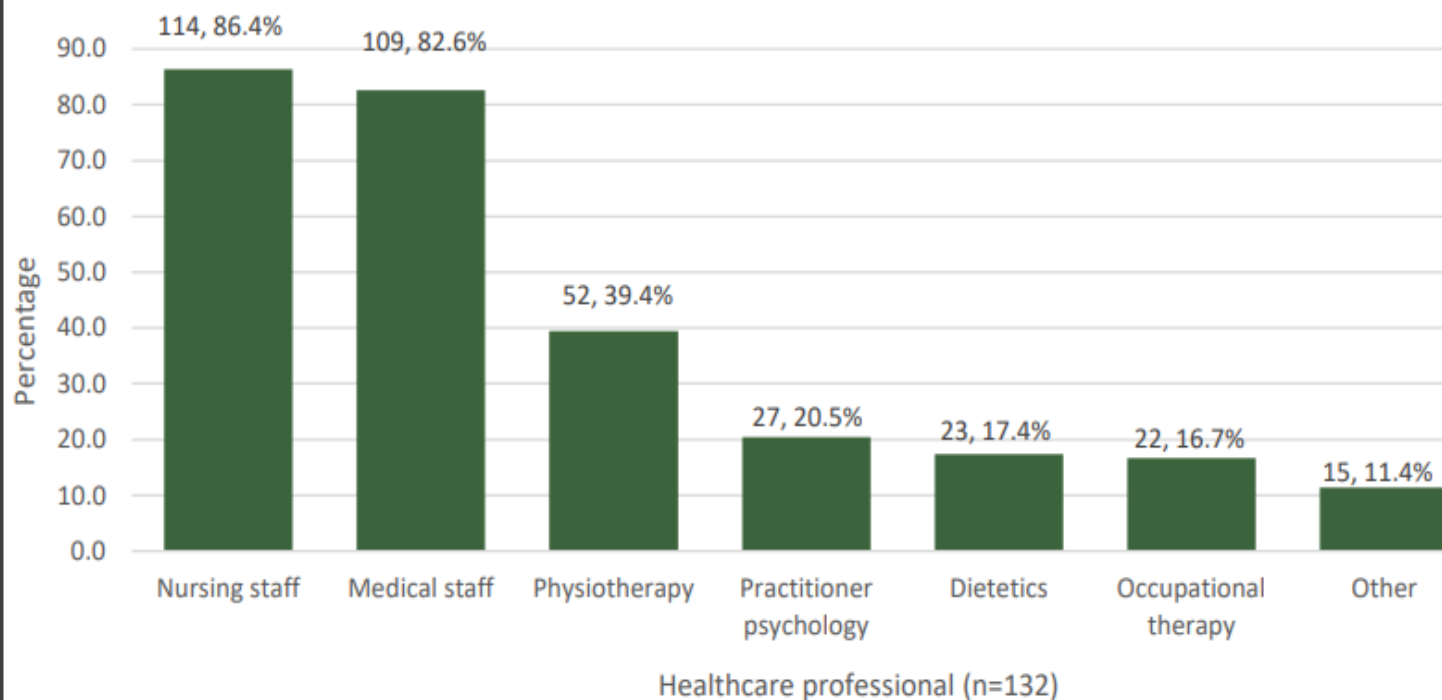
- Goals set for 138/365 (38%) patients and only 94/365 (26%) had an individualised plan
- Affected care in 2/3 of cases
- 80/309 (26%) of patients had a comprehensive assessment completed on the ward
- 357/576 (55%) of patients were offered a follow up appointment. Of those who attended, around half were (49%) were comprehensively assessed



# 3

FULL MULTIDISCIPLINARY TEAM (MDT) INPUT WAS RARELY AVAILABLE TO MEET ALL THE REHABILITATION NEEDS OF PATIENTS.

*MDT staffing levels did not meet national guidance, with staff often shared with other areas and having a lack of dedicated time for patients within ICU and other areas*





# 3

**FULL MULTIDISCIPLINARY TEAM (MDT) INPUT WAS RARELY AVAILABLE TO MEET ALL THE REHABILITATION NEEDS OF PATIENTS.**

*MDT staffing levels did not meet national guidance, with staff often shared with other areas and having a lack of dedicated time for patients within ICU and other areas*

- Physiotherapy (90%) and dietitian (69%) involvement was most common
- Room for improvement was identified in both the timing (128/549, 23%) and the consistency (90/562, 16%) of rehabilitation delivery for all staff groups.
- 111/318 (35%) had input from the ICU team on step down to the ward.
- 98/254 (18%) did not have required referrals in place at hospital discharge



# 3

FULL MULTIDISCIPLINARY TEAM (MDT) INPUT WAS RARELY AVAILABLE TO MEET ALL THE REHABILITATION NEEDS OF PATIENTS.

*MDT rounds provide an ideal opportunity to complete or update comprehensive assessments, coordinate care and review patient goals*

- Clinicians reported patients were discussed at MDT ward rounds in 272/546 (50%) of cases
- Reviewers found documentation related to this in only 70/365 (19%) of cases and reported a lack of full MDT involvement in rounds
- Patients discussed at an MDT were 3 times more likely to have a comprehensive assessment and twice as likely to have rehabilitation goals



# 4

**ONGOING REHABILITATION NEEDS/GOALS WERE OFTEN NOT SHARED BETWEEN HEALTHCARE PROVIDERS AS THE PATIENT MOVED THROUGH THE PATHWAY.**

*There was variation in the handover of care, with key information often missing. A good handover was associated with good continuity of care, continued assessment and rehabilitation delivery*

- At ICU step down, 125/671 (19%) patients had no evidence of any handover related to rehabilitation needs. Where present, 76% had information missing
- At hospital d/c, 107/420 (32%) patients had a named key worker. Without this GP became main point of contact with 86% attending a GP appt in the first year after discharge
- GPs were aware that a patient they saw had spent time in the ICU in 170/248 (68.5%) cases
- 60/204 (29%) patients required onward referrals related to rehabilitation

# What patients and HCP said

*"When patients step down from ICU to a ward, this is where continuity often stops... I got forgotten by the ICU team. Once you've been through ICU, that connection should continue right through to discharge and beyond, certainly to GPs as well."*

*"I felt that once I was discharged, I was left on my own to get better with no other offer of assistance"*

*"As long as patients 'belong' to different medical specialties once they step down who then have different priorities (rehab usually not being one of them) patients are always going to have inequitable care and poor outcomes..."*

# Ongoing rehabilitation needs

“There is no information available in primary care as to what help is available for rehabilitation. The wait list for any community services in our area is so long that any input is irrelevant by the time it is received.”

GP notification	Number of patients	%
A copy of the discharge summary would be received and filed in the patient's notes	234	94.4
Details of the ongoing community-based rehabilitation would be recorded on the patient's electronic record	83	33.5
It would trigger the practice contacting the patient	78	31.5
Other	47	19.0
A flag would be placed on the patient's electronic record	14	5.6
Unknown	4	1.6

*Primary care clinician questionnaire data: answers may be multiple; n=248*



# 5

**INFORMATION FOR THE PATIENT OR THEIR FAMILY ABOUT THE ICU ADMISSION AND ANY LASTING IMPACT IT MAY HAVE WAS LIMITED.**

*There was often no standardised approach to the provision of information to patients and families within hospital or before discharge*

- 'All about me booklets' were identified in 113/446 (25%) of cases
- 199/483 (41%) patients had an ICU diary
- 131/435 (30%) patients were given a copy of the ICU discharge summary, 343/671 (51%) hospital discharge summary
- Patient and family were adequately updated in 165/302 (55%) of cases
- Only 37/91 (40%) of patients surveyed were satisfied with information and advice given

# Patient and carer information

Table 6.1 Information given to the patient prior to discharge from hospital

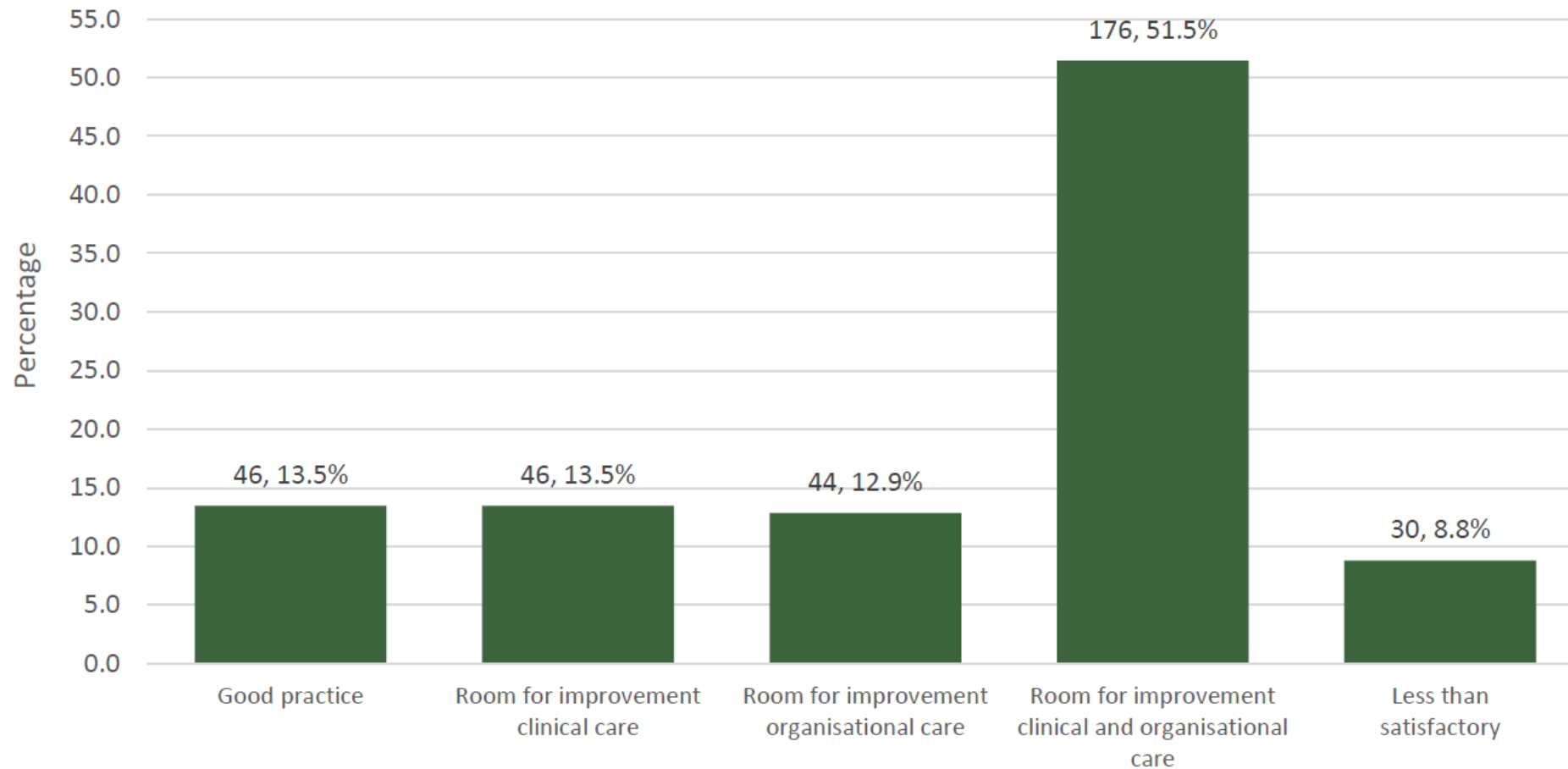
Information given	Number of patients	%
What to do if they become acutely unwell	184	27.4
Managing their activities of daily living	159	23.7
General guidance, especially for the family and/or carer, on what to expect and how to support the person at home	159	23.7
Who to contact if the recovery is not going well	151	22.5
Their physical recovery based on goals set	132	19.7
Information about local statutory and non-statutory support	78	11.6
General information leaflet	15	2.2

*Clinician questionnaire data: answers may be multiple; n=343*

# Patient and carer information

“I think when you are in ICU it is such a shock to you and your family it is too much to process. You need regular reassurance even if there are no answers. My GP was unsure what to do with me and wanted me to contact the hospital for advice, the hospital felt the GP should deal with me. I ended up feeling a nuisance, so trying to cope alone now without asking for advice/help/researching things myself.”

# Overall quality of care (n=342)



The presence of comprehensive assessments, patient goals, outcome measures and complete handovers were associated with better reported care

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## RECOMMENDATIONS

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## **1. Improve the co-ordination and delivery of rehabilitation following critical illness**

- *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.*

## **2. Develop and validate a national standardised rehabilitation screening tool**

- *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.*

## **3. Undertake and document a comprehensive, holistic assessment of the rehabilitation needs of patients admitted to an intensive care unit**

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

# RECOMMENDATIONS

**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*

**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**

**6. Provide patients and their family/carers with clear information about their admission to , 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.*



## REPORT AND TOOLS

[www.ncepod.org.uk/2025icur.html](http://www.ncepod.org.uk/2025icur.html)

- Report
- Summary
- Infographic
  
- Audit tool
- Driver diagram
- Fishbone diagram
- Recommendation checklist
  
- Commissioners guide



ANY QUESTIONS?

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