Critical Care Rehabilitation Summary Document

Background

The optimisation of recovery from critical illness, rather than mere survival, has developed increasing prominence as the physical and psychological ramifications of a stay in critical care have become widely acknowledged. Research on the longer term consequences of critical illness has shown that significant numbers of patients surviving critical illness have important continuing problems.

"For many, discharge from Critical Care is the start of an uncertain journey to recovery characterised by, among other problems, weakness, loss of energy and physical difficulties, anxiety, depression, post-traumatic stress (PTS) phenomena and, for some, a loss of mental faculty (termed cognitive function). Family members become informal care givers, and that itself can exert a secondary toll of ill-health; family relationships can become altered and financial security impaired." (NICE 2009)

In response to a growing awareness, a number of hospitals established follow up clinics to both better understand what really happens to critical care survivors and to try to address their problems. Over time, a number of service delivery models have been developed. Whilst evidence suggests that multidisciplinary rehabilitation strategies after critical illness can aid physical recovery and help people cope with their physical and non-physical problems, the evidence base remains patchy and outcomes of specific interventions have yet to be proven.

NICE Clinical Guideline and Quality Standards

Recognition of the unmet clinical needs of patients surviving critical illness prompted the National Institute for Health and Care Excellence (NICE) to publish guidelines for rehabilitation. The recommendations within NICE GG83 are consensus based due to the lack of hard evidence that then existed on the outcomes of specific models of rehabilitation. More recently, NICE published a quality statement (NICE QSD158) that supplements the initial guidance. NICE refrains from prescribing a set model but does outline the expectation that:
all patients admitted to critical care should be assessed to determine their risk of developing ongoing morbidity, this is frequently multi-factorial and can include physical, psychological and cognitive sequelae

all patients deemed at risk of morbidity should have a comprehensive assessment to identify their individual rehabilitation needs and have rehabilitation goals agreed within four days of admission to critical care or prior to discharge from critical care, whichever is sooner

rehabilitation strategies are to be commenced as early as possible and continue throughout the entire recovery pathway; commencing in critical care, continuing throughout transfer to the ward and following discharge home

all patients at risk of morbidity should have a formal handover of care, including their agreed individualised structured rehabilitation programme, when they transfer from critical care to a general ward

Patients who were in critical care and identified as at risk of morbidity should be given information based on their rehabilitation goals before they are discharged from hospital

All patients who stayed in critical care for more than 4 days and were at risk of morbidity have a review 2 to 3 months after discharge from critical care

the rehabilitation service should be multi-disciplinary and be provided by staff with an understanding of critical care and who understand the context of the patients' clinical stories

patients and their families must be involved and informed at all stages of the pathway

the initiation of audit and research is required to inform the debate about best service delivery models

For a detailed assessment of the implementation of rehabilitation NICE has developed an Audit Support tool.
South East Critical Care Network

Securing the resource to fulfil the recommendations remains a challenge for many Trusts, those within South East being no exception. However, many Trusts have been very proactive in developing rehabilitation pathway documents and delivering rehabilitation and follow up. It is the aim of SECCN to support the widespread adoption of robust rehabilitation and follow up in South East for all patients who need it.

The commitment of SECCN is to:

- engage with critical care service providers across the region
- recognise current rehabilitation strategies
- share best practice
- support the development of pathways of care
- support the instigation of care pathways by Trusts where the service is less well developed
- engage with Critical Care Commissioners
- liaise with primary care providers of rehabilitation for other patient groups
- scope and understand service delivery across the region
- assist with audit and analysis of outcome data

It is the expectation that Critical Care Units within the ODN will:

- participate in Critical Care rehabilitation forums
- develop and instigate pathways of care
- share best practice
- participate in audit of rehabilitation service delivery
- engage with SECCN and local commissioning groups

Critical Care rehabilitation forums will continue in Kent & Medway; Surrey and Sussex with overarching co-ordination by the SEC ODN. Standards and practice initiatives discussed in each forum will be shared with rehabilitation, clinical and nursing leads.

Updated by Caroline Wilson, Network Manager/Lead Nurse and Mike Carraretto, Medical Lead, South East Coast Adult Critical Care ODN
July 2018