Rehabilitation after critical illness in adults

NICE quality standard

Draft for consultation

March 2017

This quality standard covers adults with rehabilitation needs as a result of a critical illness that required level 2 or level 3 critical care[1]. It describes high-quality care in priority areas for improvement. It does not cover conditions for which published quality standards already include specialist rehabilitation after a critical care stay – such as head injury, myocardial infarction and stroke.

This is the draft quality standard for consultation (from 27 March to 21 April 2017). The final quality standard is expected to publish in August 2017.

[1] Critical care is used as a term that encompasses intensive care and intensive therapy, provided in intensive care units (ICUs) or intensive therapy units (ITUs), together with what used to be called high-dependency care provided in high-dependency units (HDUs). Intensive care, or level 3 care, generally involves the support of 1 or more failing organ system, usually including the lungs, whereas high-dependency care, or level 2 care, supports 1 failing organ system only.

Quality statements

Statement 1 Adults in critical care who are at risk of physical and non-physical morbidity have short- and medium-term rehabilitation goals agreed within 4 days of being admitted to and before discharge from critical care

Statement 2 Adults transferring from critical care to a general ward have a formal handover of their individualised structured rehabilitation programme.

Statement 3 Adults who have been in critical care and are discharged from hospital are given information about what to expect after discharge.

Statement 4 Adults with rehabilitation needs identified from a functional assessment have a review 2 to 3 months after their discharge from critical care.

NICE has developed guidance and a quality standard on patient experience in adult NHS services (see the NICE pathway on patient experience in adult NHS services), which should be considered alongside these quality statements.

Other quality standards that should be considered when commissioning or providing services for rehabilitation after critical illness include:

- Delirium in adults (2014) NICE quality standard 63
- Nutrition support in adults (2012) NICE quality standard 24

A full list of NICE quality standards is available from the quality standards topic library.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?

Question 3 Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

Question 4 Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Questions about the individual quality statements

Question 5 In draft quality statement 1, we suggest that adults in critical care who are at risk of physical and non-physical morbidity should have short- and medium-term rehabilitation goals agreed within 4 days of being admitted or before discharge from critical care. This timescale is based on expert opinion. Is this timescale appropriate and feasible?

Quality statement 1: Rehabilitation goals

Quality statement

Adults in critical care who are at risk of physical and non-physical morbidity have short- and medium-term rehabilitation goals agreed within 4 days of being admitted to and before discharge from critical care.

Rationale

Setting rehabilitation goals early during the critical care stay, based on a comprehensive clinical assessment, means that rehabilitation can start as soon as possible. Goals can then be regularly reviewed to see if they are being achieved. Early rehabilitation may help to improve physical and non-physical functioning and can prevent future problems.

Quality measures

Structure

Evidence of local arrangements to ensure that adults in critical care who are at risk of physical and non-physical morbidity have short- and medium-term rehabilitation goals agreed within 4 days of being admitted to and before discharge from critical care.

Data source: Local data collection, for example, minutes of multidisciplinary team meetings.

Process

Proportion of adults in critical care who are at risk of physical and non-physical morbidity who have short- and medium-term rehabilitation goals agreed within 4 days of being admitted to and before discharge from critical care.

Numerator – the number in the denominator who have short- and medium-term rehabilitation goals agreed within 4 days of being admitted to and before discharge from critical care.

Denominator – the number of adults in critical care who are at risk of physical and non-physical morbidity.

Data source: Local data collection, for example, review of patient hospital records.

Outcome

Patient experience of being involved in their own care

Data source: Local data collection, for example, a patient survey

What the quality statement means for different audiences

Service providers (hospitals) ensure that adults in critical care who are at risk of physical and non-physical morbidity have short- and medium-term rehabilitation goals agreed within 4 days of being admitted to and before discharge from critical care. Goals should be based on a comprehensive clinical assessment and, be documented in the patient's clinical record.

Healthcare professionals with experience in critical care and rehabilitation (such as intensive care professionals or professionals with specialist training and access to referral pathways) agree short- and medium-term rehabilitation goals for adults in critical care who are at risk of physical and non-physical morbidity, within 4 days of being admitted to and before discharge from critical care. They ensure that goals are agreed with the patient if possible. Family or carers may be involved if the person agrees; they will be involved if the person is unconscious or unable to give their agreement for treatment (formal consent).

Commissioners (clinical commissioning groups and NHS England) ensure that they commission critical care services in which adults who are at risk of physical and non-physical morbidity have short- and medium-term rehabilitation goals agreed. This should be done within 4 days of being admitted to and before discharge from critical care. Family or carers may be involved if the person agrees; they will be involved if the person is unconscious or unable to give their agreement for treatment (formal consent).Goals should be based on a comprehensive clinical assessment.

Adults in critical care who are likely to benefit from more support have a thorough assessment to identify what might help them to recover (their rehabilitation needs). If they can, they talk with their healthcare team about how they hope they might recover (their rehabilitation goals), and then these goals are written in their notes. Family or carers may be involved if the person is happy with this; they will be

involved if the person is unconscious or unable to give their agreement for treatment (formal consent). Goals should be agreed within 4 days of a person arriving in critical care, or earlier if they stay in critical care for less than 4 days.

Source guidance

Rehabilitation after critical illness in adults (2009) NICE guideline CG83 recommendation 1.4

Definitions of terms used in this quality statement

At risk of physical and non-physical morbidity

People's risk of physical and non-physical morbidity should be identified in a short clinical assessment. Examples that may indicate an adult is at risk include:

- Physical
  - Unable to get out of bed independently.
  - Anticipated long duration of critical care stay.
  - Obvious significant physical or neurological injury.
  - Lack of cognitive functioning to continue exercise independently.
  - Unable to self-ventilate on 35% of oxygen or less.
  - Presence of premorbid respiratory or mobility problems.
  - Unable to mobilise independently over short distances.
- Non-physical
  - Recurrent nightmares, particularly where patients report trying to stay awake to avoid nightmares.
  - Intrusive memories of traumatic events that have occurred before admission (for example, road traffic accidents) or during their critical care stay (for example, delusion experiences or flashbacks).
  - New and recurrent anxiety or panic attacks.
  - Expressing the wish not to talk about their illness or changing the subject quickly to another topic.

[Adapted from NICE's guideline on rehabilitation after critical illness in adults recommendation 1.2 and table 1]

Physical morbidity

Muscle loss, muscle weakness, musculoskeletal problems including contractures, respiratory problems, sensory problems, pain, and swallowing and communication problems.

[NICE's guideline on rehabilitation after critical illness in adults]

Non-physical morbidity

Psychological, emotional and mental health problems, and cognitive dysfunction.

[NICE's guideline on rehabilitation after critical illness in adults]

Short-term rehabilitation goals

Goals for the patient to achieve before they are discharged from hospital.

[NICE's guideline on rehabilitation after critical illness in adults]

Medium-term rehabilitation goals

Goals to help the patient return to their normal activities of daily living after they are discharged from hospital.

[NICE's guideline on rehabilitation after critical illness in adults]

Question for consultation

In draft quality statement 1, we suggest that adults in critical care who are at risk of physical and non-physical morbidity should have short- and medium-term rehabilitation goals agreed within 4 days of being admitted or before discharge from critical care. This timescale is based on expert opinion. Is this timescale appropriate and feasible?

Quality statement 2: Transfer from critical care to a general ward

Quality statement

Adults transferring from critical care to a general ward have a formal handover of their individualised structured rehabilitation programme.

Rationale

The transition between critical care and a general ward can be difficult because of the step down in the level of care. A formal handover of the individualised, structured rehabilitation programme ensures that the general ward team understands the person's specific physical and non-physical rehabilitation needs and how best to support them. This will improve the experience of transition for the person and staff.

Quality measures

Structure

Evidence of local arrangements to ensure that adults transferring from critical care to a general ward have a formal handover of their individualised, structured rehabilitation programme.

Data source: Local data collection, for example, critical care discharge and ward admission protocols.

Process

Proportion of adults transferring from critical care to a general ward who have a formal handover of their individualised, structured rehabilitation programme.

Numerator – the number in the denominator who have a formal handover of their individualised, structured rehabilitation programme.

Denominator – the number of adults transferring from critical care to a general ward.

Data source: Local data collection, for example, review of patient hospital records.

Outcome

a) Experience of transition for adults who are discharged from critical care to a general ward.

Data source: Local data collection, for example, a patient survey.

b) Experience of rehabilitation for adults who have been discharged from critical care to a general ward.

Data source: Local data collection, for example, a patient survey.

What the quality statement means for different audiences

Service providers (hospitals) have procedures in place to ensure a formal handover of the individualised, structured rehabilitation programme for adults transferring from critical care to a general ward. Handover should include both doctors and nurses from critical care and the general ward.

Healthcare professionals (doctors and nurses from critical care and the general ward) work together using a formal process to handover the individualised, structured rehabilitation programme for adults transferring from critical care to a general ward. They include the patient's family or carer in this if the patient agrees.

Commissioners (clinical commissioning groups and NHS England) ensure that they commission critical care services in which adults transferring to a general ward have a formal handover of their individualised, structured rehabilitation programme. Handover should include both doctors and nurses from critical care and the general ward.

Adults leaving critical care to go to a general ward have information about all of their needs (physical, psychological, emotional, sensory and communication) transferred to the ward staff by the team from critical care. This means the ward team understands what might help the person to recover (their rehabilitation needs). Adults should also have their condition explained to them, and their family or carers if this is appropriate, and be encouraged to get involved in making decisions about their care.

Source guidance

Rehabilitation after critical illness in adults (2009) NICE guideline CG83 recommendation 1.12

Definitions of terms used in this quality statement

Formal handover

The handover of rehabilitation needs on transfer from critical care to a general ward is the shared responsibility of the critical care team and the ward team. [Adapted NICE's guideline on acutely ill adults in hospital recommendation 1.15].

Individualised, structured rehabilitation programme

The individualised, structured rehabilitation programme should include rehabilitation needs and goals based on the comprehensive clinical assessment. The programme should be developed and delivered by members of a multidisciplinary team, and should include appropriate referrals, if applicable. [Adapted from NICE's guideline on rehabilitation after critical illness in adults recommendations 1.16 and 1.17]

Quality statement 3: Information on discharge from hospital

Quality statement

Adults who have been in critical care and are discharged from hospital are given information about what to expect after discharge.

Rationale

Moving from hospital to a home environment can be a difficult change for adults who have been in critical care. Giving advice and information on what the person is likely to experience after leaving hospital and how to manage activities of daily living can help people to prepare for recovering at home. It can also help carers to plan how they can support the adult at home.

Quality measures

Structure

Evidence of local arrangements to ensure that adults who have been in critical care and are discharged from hospital are given information about what to expect after discharge.

Data source: Local data collection, for example, hospital discharge protocols.

Process

Proportion of adults who have been in critical care and are discharged from hospital who are given information about what to expect after discharge.

Numerator – the number in the denominator who are given information about what to expect after discharge.

Denominator – the number of adults who have been in critical care and are discharged from hospital.

Data source: Local data collection, for example, an audit of patient hospital records.

Outcome

Adults who have been in critical care and are discharged from hospital feel they have received the right information to help them recover at home.

Data source: Local data collection, for example, a patient survey.

What the quality statement means for different audiences

Service providers (hospitals) ensure that adults who have been in critical care and are discharged from hospital are given information about what to expect after discharge. They also give this information and any required further advice on how they can support the adult at home to the adult's family or carer, if the adult agrees.

Health and social care practitioners (members of the team responsible for discharge) give adults who have been in critical care information about what to expect after discharge from hospital. They also give this information and any required further advice on how they can support the adult at home to the adult's family or carer, if the adult agrees.

Commissioners (clinical commissioning groups) ensure that they commission hospitals that give adults who have been in critical care information about what to expect after discharge from hospital. They also give this information and any required further advice on how they can support the adult at home to the adult's family or carer, if the adult agrees.

Adults who have been in critical care are given information about what to expect when they leave hospital. This should explain what they can do to help their recovery and what other things they might face during this period. If they agree, this information can also be given to their family or carer.

Source guidance

Rehabilitation after critical illness in adults (2009) NICE guideline CG83 recommendation 1.22

Definitions of terms used in this quality statement

Information

The following information should be given before discharge:

- Information about physical recovery, based on the goals set during ward-based care, if applicable.
- If applicable, information about diet and any other continuing treatments.
- Information about how to manage activities of daily living, including self-care and re-engaging with everyday life.
- If applicable, information about driving, returning to work, housing and benefits.
- Information about local statutory and non-statutory support services, such as support groups.
- General guidance, especially for the family or carers, on what to expect and how to support the patient at home. This should take into account both the patient's needs and the family's or carers' needs.

The patient should be given their own copy of the critical care discharge summary.

[NICE's guideline on rehabilitation after critical illness in adults, recommendation 1.22]

Equality and diversity considerations

People who do not speak or read English well may be at a disadvantage, particularly due to the complex nature of language used in critical care. Translators should be available where needed to ensure that people understand the information given to them. Arrangements should be made to account for the extra time that this may require.

Quality statement 4: Follow-up after critical care discharge

Quality statement

Adults with rehabilitation needs identified from a functional assessment have a review 2 to 3 months after their discharge from critical care.

Rationale

Adults receiving individualised structured rehabilitation programme during ward-based care have a functional assessment before they are discharged to home or community care. This assessment allows identifying their ongoing rehabilitation needs. A follow up is needed because further needs may become apparent after the discharge. A review to reassess people's health and social care needs 2 to 3 months after discharge from critical care ensures that any new physical or non-physical problems are identified and further support is arranged as needed.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with rehabilitation needs identified from a functional assessment have a review 2 to 3 months after their discharge from critical care.

Data source: Local data collection, for example, critical care discharge protocols.

Process

Proportion of adults with rehabilitation needs identified from a functional assessment, who have a review 2 to 3 months after their discharge from critical care.

Numerator – the number in the denominator who have a review 2 to 3 months after their discharge from critical care.

Denominator – the number of adults with rehabilitation needs identified from a functional assessment, who have been discharged from critical care.

Data source: Local data collection, for example, an audit of patient hospital records.

Outcome

a) Identification of physical problems.

Data source: Local data collection, for example, an audit of patient records.

b) Identification of non-physical problems.

Data source: Local data collection, for example, an audit of patient records.

c) Adults feel supported to manage their rehabilitation after discharge from critical care.

Data source: Local data collection, for example, a patient survey.

What the quality statement means for different audiences

Service providers (hospitals) have systems in place to ensure that adults with rehabilitation needs identified from a functional assessment of health and social care needs have a review 2 to 3 months after their discharge from critical care.

Health and social care practitioners (such as nurses, intensive care professionals, physiotherapists and clinical psychologists working in critical care follow-up clinics) review adults with rehabilitation needs 2 to 3 months after their discharge from critical care by carrying out a functional reassessment of health and social care needs. The review can be either in the community or hospital.

Commissioners (clinical commissioning groups) ensure that they commission services in which adults with rehabilitation needs identified from a functional assessment of health and social care needs have a review 2 to 3 months after their discharge from critical care.

Adults who need support to help them recover have a meeting with a member of their healthcare team 2 to 3 months after leaving critical care to talk about their recovery and any problems they might have. These might include physical, psychological, emotional, sensory or communication problems. At the meeting they should also talk about any social care or equipment needs that they might have so that further support can be arranged if needed.

Source guidance

Rehabilitation after critical illness in adults (2009) NICE guideline CG83 recommendations 1.1 and 1.23

Definitions of terms used in this quality statement

Rehabilitation needs

Adults' continuing rehabilitation needs should be identified through a functional assessment of symptoms before they are discharged from critical care. Symptoms that may indicate physical and non-physical morbidity include:

Physical dimensions	
Physical problems	Weakness; inability/partial ability to sit, rise to standing, or to walk; fatigue; pain; breathlessness; swallowing difficulties; incontinence; inability/partial ability to self-care.
Sensory problems	Changes in vision or hearing, pain, altered sensation.
Communication problems	Difficulties in speaking or using language to communicate, difficulties in writing.
Social care or equipment needs	Mobility aids, transport, housing, benefits, employment and leisure needs.
Non-physical dimensions	
Anxiety, depression and post-traumatic stress-related symptoms	New or recurrent somatic symptoms, including palpitations, irritability and sweating; symptoms of derealisation and depersonalisation; avoidance behaviour; depressive symptoms, including tearfulness and withdrawal; nightmares, delusions, hallucinations and flashbacks.
Behavioural and cognitive problems	Loss of memory, attention deficits, sequencing problems, deficits in organisational skills, confusion, apathy, disinhibition, compromised insight.

Other psychological or psychosocial problems	Low-self-esteem, poor or low self-image or body image issues, relationship difficulties, including those with the family or carers.

[Adapted from NICE's guideline on rehabilitation after critical illness in adults, recommendation 1.20 and table 2]

Review

A functional reassessment of the adult's health and social care needs, carried out face to face in the community or in hospital by a healthcare professional with training and skills in rehabilitation after critical care who is familiar with the adult's critical care problems and rehabilitation care pathway. It should include the following physical and non-physical dimensions (see definition of rehabilitation needs for possible examples):

- physical problems (physical dimension)
- sensory problems (physical dimension)
- communication problems (physical dimension)
- social care or equipment needs (physical dimension)
- anxiety (non-physical dimension)
- depression (non-physical dimension)
- post-traumatic stress-related symptoms (non-physical dimension)
- behavioural and cognitive problems (non-physical dimension)
- psychosocial problems (non-physical dimension).

[NICE's guideline on rehabilitation after critical illness in adults, recommendations 1.20, 1.23 and 1.24]

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Information about how NICE quality standards are developed is available from the NICE website.

See quality standard advisory committees on the website for details of standing committee 3 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available on the quality standard's webpage.

This quality standard has been incorporated into the NICE pathways on rehabilitation after critical illness and acutely ill patients in hospital.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes:

- length of stay in critical care

- length of stay in hospital
- hospital readmission rates
- quality of life for people discharged from critical care
- employment rates for people discharged from critical care (compared with employment rates for the general population)
- mortality for people discharged from critical care.

It is also expected to support delivery of the Department of Health's outcome frameworks:

- Adult social care outcomes framework 2015–16
- NHS outcomes framework 2016–17
- Public health outcomes framework for England, 2016–19.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact products for the source guidance to help estimate local costs:

- costing report for the NICE guideline on rehabilitation after critical illness in adults
- costing report for the NICE guideline on acutely ill adults in hospital.

Diversity, equality and language

During the development of this quality standard, equality issues were considered and equality assessments are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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