

This is a quick reference guide that summarises the recommendations NICE has made to the NHS in Rehabilitation after critical illness (NICE clinical guideline 83).

Who should read this booklet?

This quick reference guide is for secondary care healthcare professionals and other staff who care for adults in critical care.

Who wrote the guideline?

The guideline was developed by the Centre for Clinical Practice at NICE following the short clinical guideline process. The Centre worked with a group of healthcare professionals (including consultants in medicine and psychology, nurses, physiotherapists and occupational therapists), patient and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation. For more information on how NICE clinical guidelines are developed, go to www.nice.org.uk

Patient-centred care

Treatment and care should take into account patients' individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow patients to reach informed decisions about their care. Follow Department of Health advice on seeking consent if needed. If the patient agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

Implementation tools

NICE has developed tools to help organisations implement this guidance (www.nice.org.uk/CG83).

Further information

Ordering information

You can download the following documents from www.nice.org.uk/CG83

- A quick reference guide (this document) – a summary of the recommendations for healthcare professionals.
- 'Understanding NICE guidance' – a summary for patients and carers.
- The full guideline – all the recommendations, details of how they were developed, and reviews of the evidence they were based on.

For printed copies of the quick reference guide or 'Understanding NICE guidance', phone NICE publications on 0845 003 7783 or email publications@nice.org.uk and quote:

- N1825 (quick reference guide)
- N1826 ('Understanding NICE guidance').

Related NICE guidance

NICE has published clinical guidelines on acutely ill patients in hospital, anxiety, dementia, depression, head injury, MI: secondary prevention, nutrition support in adults, post-traumatic stress disorder (PTSD) and stroke. NICE is developing guidance on delirium. For information, see www.nice.org.uk

Updating the guideline

This guideline will be updated as needed, and information about the progress of any update will be available at www.nice.org.uk/CG83

National Institute for Health and Clinical Excellence

MidCity Place
71 High Holborn
London
WC1V 6NA

www.nice.org.uk

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Quick reference guide

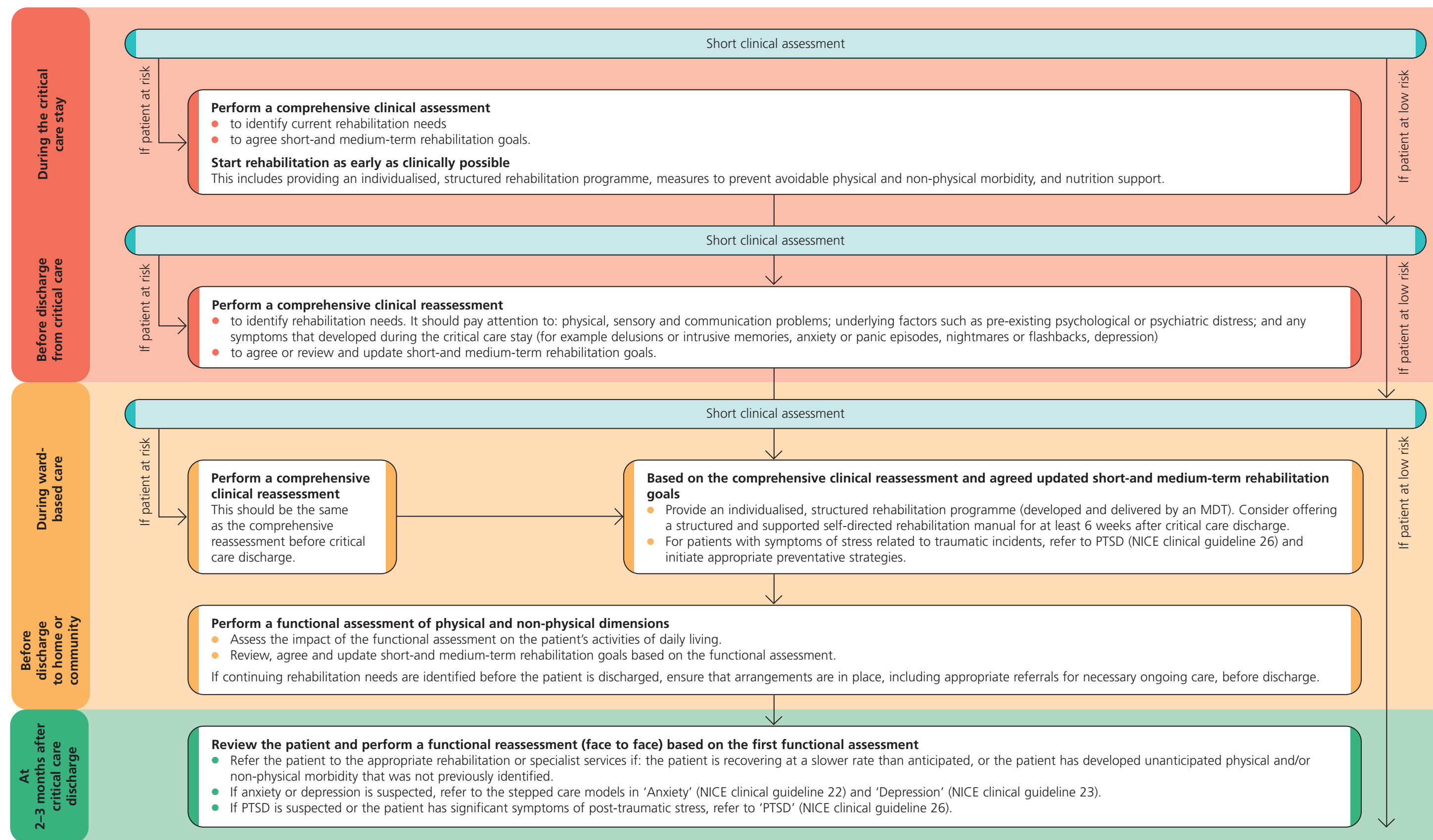
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Rehabilitation after critical illness

Rehabilitation care pathway

Definitions

- Short clinical assessment: a brief clinical assessment to identify patients who may be at risk of developing physical and non-physical morbidity.
- Comprehensive clinical assessment: a more detailed assessment to determine the rehabilitation needs of patients who have been identified as being at risk of developing physical and non-physical morbidity.
- Functional assessment: an assessment to examine the patient's daily functional ability.
- Short-term rehabilitation goals: goals for the patient to reach before they are discharged from hospital.
- Medium-term rehabilitation goals: goals to help the patient return to their normal activities of daily living after they are discharged from hospital.
- Physical morbidity: problems such as muscle loss, muscle weakness, musculoskeletal problems including contractures, respiratory problems, sensory problems, pain, and swallowing and communication problems.
- Non-physical morbidity: psychological, emotional and psychiatric problems, and cognitive dysfunction.
- Multidisciplinary team (MDT): a team of healthcare professionals with the full spectrum of clinical skills needed to offer holistic care to patients with complex problems. The team may be a group of people who normally work together or who only work together intermittently.



Key principle of care

To ensure continuity of care, healthcare professional(s) with the appropriate competencies should coordinate the patient's rehabilitation care pathway. Key elements of the coordination are as follows.

- Ensure the short-and medium-term rehabilitation goals are reviewed, agreed and updated throughout the patient's rehabilitation care pathway.
- Ensure the delivery of the structured and supported self-directed rehabilitation manual, when applicable.
- Liaise with primary/community care for the functional reassessment at 2–3 months after critical care discharge.
- Ensure information, including documentation, is communicated as appropriate to any other healthcare settings.
- Give patients the contact details of the healthcare professional(s) on discharge from critical care, and again on discharge from hospital.

Information and support

During the critical care stay, give information about:

- the patient's illness, interventions and treatments, equipment used, any short-and/or long-term physical and non-physical problems if applicable. This should be delivered more than once.

Before discharge from critical care or as soon as possible after being discharged from critical care, give information about:

- the rehabilitation care pathway and, if applicable, emphasise the information about possible physical and non-physical problems
- the differences between critical care and ward-based care and the transfer of clinical responsibility to a different medical team
- sleeping problems, nightmares and hallucinations and the readjustment to ward-based care, if applicable.

Before discharge to home or community, give information about:

- the patient's physical recovery (based on the goals set if applicable) and how to manage activities of daily living
- diet and any other continuing treatments
- driving, returning to work, housing and benefits (if applicable); also local support services
- general guidance for the family/carer on what to expect and how to support the patient at home.

Give the patient their own copy of the critical care discharge summary.