NICE National Institute for Health and Care Excellence

NICE quality standard

Rehabilitation after critical illness in adults

Quality standard

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Contents

This standard is based on CG83 and CG50.

This standard should be read in conjunction with QS63 and QS24.

Quality statements

Statement 1 Adults in critical care at risk of morbidity have their rehabilitation goals agreed within 4 days of admission to critical care or before discharge from critical care, whichever is sooner.

Statement 2 Adults at risk of morbidity have a formal handover of care, including their agreed individualised structured rehabilitation programme, when they transfer from critical care to a general ward.

Statement 3 Adults who were in critical care and at risk of morbidity are given information based on their rehabilitation goals before they are discharged from hospital.

Statement 4 Adults 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.

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

Quality statement 1: Rehabilitation goals

Quality statement

Adults in critical care at risk of morbidity have their rehabilitation goals agreed within 4 days of admission to critical care or before discharge from critical care, whichever is sooner.

Rationale

Adults in critical care who are at risk of developing physical and non-physical morbidity need a comprehensive assessment to establish their rehabilitation needs and to put a rehabilitation plan in place. Rehabilitation goals need to be agreed with the person as early as possible to inform the rehabilitation programme. Starting rehabilitation early can improve physical and non-physical functioning and prevent future problems. The needs of a person in critical care can change very quickly, therefore goals should be continually reviewed and updated within the rehabilitation programme.

Quality measures

Structure

a) Evidence of local systems to flag when adults in critical care are at risk of morbidity.

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

b) Evidence of local arrangements to ensure that adults in critical care at risk of morbidity have rehabilitation goals agreed and documented.

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

Process

Proportion of adults in critical care at risk of morbidity who have their rehabilitation goals agreed within 4 days of being admitted to critical care or before discharge from critical care, whichever is sooner.

Numerator – the number in the denominator who have their rehabilitation goals agreed within 4 days of being admitted to critical care or before discharge from critical care, whichever is sooner.

Denominator – the number of adults in critical care who are at risk of morbidity.

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

Outcome

Levels of satisfaction with involvement in their own care among adults in critical care.

Data source: Local data collection, for example, surveys of patients and their families.

What the quality statement means for different audiences

Service providers (hospitals) ensure that critical care pathways support identifying adults at risk of morbidity through a short clinical assessment and that all those identified as being at risk have a further comprehensive clinical assessment. Service providers put arrangements in place to ensure that adults' rehabilitation goals are based on the comprehensive clinical assessment and agreed within 4 days of being admitted to critical care or before discharge from critical care, whichever is sooner.

Healthcare professionals with experience in critical care and rehabilitation (such as intensive care professionals or other professionals with access to referral pathways) agree rehabilitation goals for adults in critical care who are at risk of morbidity, within 4 days of critical care admission or before critical care discharge, whichever is sooner. They ensure that goals are agreed with the patient if possible, reviewed and updated throughout rehabilitation. 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 which use a comprehensive clinical assessment to identify adults at risk of morbidity and establish their rehabilitation goals. They monitor the providers to ensure that this is done within 4 days of critical care admission or before discharge from critical care, whichever is sooner, reviewed and updated throughout rehabilitation.

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 and what they want to achieve (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 and expert opinion

Definitions of terms used in this quality statement

Adults in critical care at risk of morbidity

People's risk of morbidity should be identified in a short clinical assessment that includes physical and non-physical elements. Examples include:

- Physical
    - Anticipated long duration of critical care stay.
    - Obvious significant physical or neurological injury.
    - Unable to self-ventilate on 35% oxygen or less.
    - Presence of premorbid respiratory or mobility problems.
    - Risk or presence of malnutrition, changes in eating patterns, poor or excessive appetite, inability to eat or drink.
    - Unable to get in and out of bed independently.
    - 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).

- Acute stress reactions, including symptoms of new and recurrent anxiety, panic attacks, fear, low mood, anger or irritability in the critical care unit.
- Hallucinations, delusions and excessive worry or suspiciousness.
- Expressing the wish not to talk about their illness or changing the subject quickly to another topic.
- Lack of cognitive functioning to continue to exercise independently.

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

Rehabilitation goals

Rehabilitation goals can be short, medium or long term and will change throughout the patient's recovery from critical illness. They can be physical as well as psychological. Goals will need to be achievable and based on regular patient assessment of physical and non-physical consequences of the critical illness throughout their recovery.

For example, in the critical care unit, reduced mobility, weakness and fatigue will be the main problems, for which the overall goal will be early mobilisation. A short-term goal might be for the patient to be able to sit on the edge of the bed with support, a medium-term goal to stand aided and a long-term goal to march on the spot or take a few supported steps. Later, on the ward, reduced mobility will continue, but the goals will change; a short-term goal might be to walk to the toilet and a long-term goal to manage the stairs before discharge.

[Expert opinion]

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

Quality statement

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

Rationale

Continuity of rehabilitation is very important because any breaks or gaps can set back or slow down recovery. A formal documented handover of care which includes the individualised, structured rehabilitation programme ensures that the general ward team understands the person's specific physical and non-physical rehabilitation needs, the goals they are working towards and how best to support them. This should ensure continuity of care and improve the person's experience of transfer from critical care to a general ward.

Quality measures

Structure

a) Evidence of formal handover processes between team discharging adults at risk of morbidity from critical care and team admitting them to a general ward.

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

b) Evidence of local arrangements to ensure that the structured rehabilitation programme is included in the formal handover between the critical care team and the team admitting adults to a general ward.

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

Process

a) Proportion of adults at risk of morbidity who have a formal handover of care when transferring from critical care to a general ward.

Numerator – the number in the denominator who have a formal handover of care.

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

Data source: Local data collection, for example, review of patient hospital records or observation in practice (to check for verbal handover).

b) Proportion of adults at risk of morbidity transferring from critical care to a general ward whose formal handover of care includes their individualised, structured rehabilitation programme.

Numerator – the number in the denominator whose handover of care includes their individualised, structured rehabilitation programme.

Denominator – the number of adults at risk of morbidity transferring from critical care to a general ward who have a formal handover of care.

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

Outcome

Level of satisfaction with continuity of care for adults who are 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 care takes place that includes the individualised, structured rehabilitation programme for adults at risk of morbidity transferring from critical care to a general ward. Handover should include members of multidisciplinary teams from critical care and the general ward.

Healthcare professionals (such as doctors, nurses, specialists in rehabilitation medicine, physiotherapists, psychologists, occupational therapists, speech and language therapists and dietitians) from critical care and the general ward work together in a formal handover of care, which includes the individualised, structured rehabilitation programme, when adults at risk of morbidity transfer from critical care to a general ward.

Commissioners (clinical commissioning groups and NHS England) ensure that they commission services in which members of multidisciplinary teams from critical care and the general ward work in an integrated way that ensures continuity of care and an uninterrupted support for adults at risk of morbidity when they transfer to a general ward.

Adults leaving critical care who are at risk of long-term problems have information about all of their needs (physical, psychological, emotional, sensory and communication) transferred to staff on the general ward 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 to 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
- Acutely ill adults in hospital: recognising and responding to deterioration (2007) NICE guideline CG50, recommendation 1.15

Definitions of terms used in this quality statement

Adults in critical care at risk of morbidity

People's risk of morbidity should be identified in a short clinical assessment that includes physical and non-physical elements. Examples include:

- Physical
    - Anticipated long duration of critical care stay.
    - Obvious significant physical or neurological injury.
    - Unable to self-ventilate on 35% oxygen or less.
    - Presence of premorbid respiratory or mobility problems.
    - Risk or presence of malnutrition, changes in eating patterns, poor or excessive appetite, inability to eat or drink.
    - Unable to get in and out of bed independently.

  - 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).
  - Acute stress reactions including symptoms of new and recurrent anxiety, panic attacks, fear, low mood, anger or irritability in the critical care unit.
  - Hallucinations, delusions and excessive worry or suspiciousness.
  - Expressing the wish not to talk about their illness or changing the subject quickly to another topic.
  - Lack of cognitive functioning to continue to exercise independently.

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

Formal handover of care

The handover of care on transfer from critical care to a general ward is the shared responsibility of the critical care team and the ward team.

The formal handover of care should be structured and should include:

- a summary of the critical care stay, including diagnosis and treatment
- a monitoring and investigation plan
- a plan for ongoing treatment, including drugs and therapies, nutrition plan, infection status and any agreed limitations of treatment
- an agreed individualised structured rehabilitation programme, including physical, psychological, emotional and cognitive needs
- specific communication or language needs.

[Adapted from NICE's guideline on acutely ill adults in hospital, recommendation 1.15 and expert opinion]

Individualised, structured rehabilitation programme

The individualised, structured rehabilitation programme should address rehabilitation needs based on the comprehensive clinical assessment done in a critical care unit and identify the most recent goals agreed with the patient. 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 were in critical care and at risk of morbidity are given information based on their rehabilitation goals before they are discharged from hospital.

Rationale

Discussions about what to expect after discharge should be happening as adults who were in critical care and at risk of morbidity continue to recover in hospital. Moving from hospital to a home environment can be difficult and cause a lot of anxiety. It is important to make information relevant to the person and their situation. They should know how to continue working towards the goals they set out while in hospital and who to contact if they need any support. This information should be given to the person and to family members or carers if the person agrees.

Quality measures

Structure

Evidence of local arrangements to provide adults who are discharged from hospital after a critical care stay with information relevant to their individual needs and rehabilitation goals.

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

Process

Proportion of adults who were in critical care and at risk of morbidity who are given information on hospital discharge based on the rehabilitation goals agreed during their hospital stay.

Numerator – the number in the denominator who are given information based on the rehabilitation goals agreed during their hospital stay.

Denominator – the number of adults who were in critical care and at risk of morbidity discharged from hospital.

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

Outcome

Levels of satisfaction with information that was relevant to recovery at home among adults who were discharged from hospital following a critical care stay.

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

What the quality statement means for different audiences

Service providers (hospitals) have protocols in place to ensure that adults who were in critical care and at risk of morbidity are given information about what to expect after discharge from hospital. The information is based on the rehabilitation goals agreed during the hospital stay. If the person agrees, this information can also be given to their family or carer.

Healthcare professionals (members of the team responsible for discharge) give adults who were in critical care and at risk of morbidity information about what to expect after discharge from hospital. The information is based on the rehabilitation goals agreed during the hospital stay. If the person agrees, this information can also be given to their family or carer.

Commissioners (clinical commissioning groups) ensure that the services they commission have arrangements in place to give adults who were in critical care and at risk of morbidity information about what to expect after discharge from hospital. The information is based on the rehabilitation goals agreed during the hospital stay. If the person agrees, this information can also be given to their family or carer.

Adults who were in critical careand at risk of long-term health problems 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

Adults in critical care at risk of morbidity

People's risk of morbidity should be identified in a short clinical assessment that includes physical and non-physical elements. Examples include:

- Physical
    - Anticipated long duration of critical care stay.
    - Obvious significant physical or neurological injury.
    - Unable to self-ventilate on 35% oxygen or less.
    - Presence of premorbid respiratory or mobility problems.
    - Risk or presence of malnutrition, changes in eating patterns, poor or excessive appetite, inability to eat or drink.
    - Unable to get in and out of bed independently.
    - 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).
    - Acute stress reactions including symptoms of new and recurrent anxiety, panic attacks, fear, low mood, anger or irritability in the critical care unit.
    - Hallucinations, delusions and excessive worry or suspiciousness.
    - Expressing the wish not to talk about their illness or changing the subject quickly to another topic.
    - Lack of cognitive functioning to continue to exercise independently.

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

Information

The following information should be given before discharge:

- Information about physical and cognitive recovery and rate of recovery, based on the rehabilitation goals set during ward-based care, if applicable.
- Information about psychological and emotional recovery, including symptoms that frequently occur in the months after critical illness (for example, low mood, anxiety, flashbacks and nightmares, changes or conflict in relationships).
- 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 person at home. This should take into account both the person's needs and the family's or carers' needs.

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

[Adapted from NICE's guideline on rehabilitation after critical illness in adults, recommendation 1.22 and expert opinion]

Equality and diversity considerations

People who do not speak or read English well may be at a disadvantage, particularly because of the complex language used in critical care. Translators should be available if 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 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.

Rationale

Follow-up is needed for adults who were in critical care for more than 4 days and at risk of morbidity, because further needs may become apparent after discharge. A review to reassess 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. Some adults who were in critical care for 4 days or less may also experience problems that need a review. Also, problems may emerge more than 3 months after discharge. The lifelong impact of a stay in critical care means that all adults who have experienced this should be able to self-refer and be reassessed at any time.

Quality measures

Structure

Evidence of local follow-up arrangements for adults who had a critical care stay of more than 4 days and were at risk of morbidity.

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

Process

Proportion of adults who were in critical care for more than 4 days and at risk of morbidity, who have a review between 2 and 3 months after discharge from critical care.

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

Denominator – the number of adults who were in critical care for more than 4 days and at risk of morbidity, who have been discharged from critical care.

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

Outcome

a) Number of physical problems identified within 3 months of discharge from critical care.

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

b) Number of non-physical problems identified within 3 months of discharge from critical care.

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

c) Levels of satisfaction with support received to manage rehabilitation needs among adults discharged 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 pathways in place to ensure that adults who stay in critical care for more than 4 days and are at risk of morbidity have a review 2 to 3 months after discharge from critical care to review their recovery and rehabilitation outcomes. They should also have arrangements in place to allow adults who have had a critical care stay to self-refer and be reassessed at any time.

Healthcare professionals (such as nurses, intensive care professionals, specialists in rehabilitation medicine, physiotherapists and clinical psychologists working in critical care follow-up clinics) carry out a review 2 to 3 months after discharge from critical care for adults who were in critical care for more than 4 days and at risk of morbidity. They do this by completing a rehabilitation assessment/ questionnaire which includes functional reassessment of health and social care needs. The review can be either in the community or hospital. They also ensure that any adult who has had a critical care stay can be reassessed if they self-refer at any time.

Commissioners (clinical commissioning groups) ensure that they commission services that follow up adults who were in critical care for more than 4 days and at risk of morbidity with a review 2 to 3 months after discharge from critical care. They also ensure that services accept and reassess all adults who have had a critical care stay if they self-refer at any time after discharge.

Adults who were in critical care for more than 4 days and at risk of long-term problems have a review by a healthcare professional 2 to 3 months after leaving critical care to talk about their

recovery and any problems they might have. These might include physical, cognitive, psychological, emotional, sensory or communication problems. At the meeting they should also talk about any social care or equipment needs so that extra support can be arranged if needed. All adults who have been in critical care should be able to attend a critical care follow-up clinic if they feel they need it.

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

Adults in critical care at risk of morbidity

People's risk of morbidity should be identified in a short clinical assessment that includes physical and non-physical elements. Examples include:

- Physical
    - Anticipated long duration of critical care stay.
    - Obvious significant physical or neurological injury.
    - Unable to self-ventilate on 35% oxygen or less.
    - Presence of premorbid respiratory or mobility problems.
    - Risk or presence of malnutrition, changes in eating patterns, poor or excessive appetite, inability to eat or drink.
    - Unable to get in and out of bed independently.
    - 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).

- Acute stress reactions including symptoms of new and recurrent anxiety, panic attacks, fear, low mood, anger or irritability in the critical care unit.
- Hallucinations, delusions and excessive worry or suspiciousness.
- Expressing the wish not to talk about their illness or changing the subject quickly to another topic.
- Lack of cognitive functioning to continue to exercise independently.

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

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, rehabilitation goals, individualised structured rehabilitation programme and rehabilitation care pathway. It should include the following physical and non-physical dimensions:

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

[Adapted from 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 for people discharged from critical care
- hospital readmission rates for people discharged from critical care

- quality of life for people discharged from critical care
- emotional wellbeing in people discharged from critical care
- physical and cognitive recovery after discharge from critical care
- psychological wellbeing in people discharged from critical care
- social care needs among 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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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Royal College of Physicians
- Intensive Care Society
- Critical Care National Network Nurse Leads
- Royal College of Nursing
- Faculty of Intensive Care Medicine
- Association of Chartered Physiotherapists in Respiratory Care