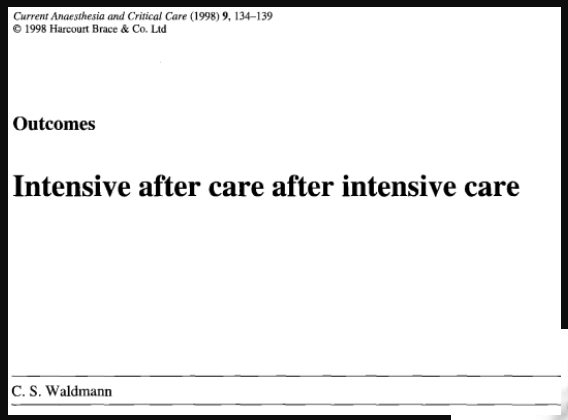
Intensive after care after Intensive Care

Kate Tantam

Huge thanks and respect to the godfathers and godmothers of ICU follow up clinic provision

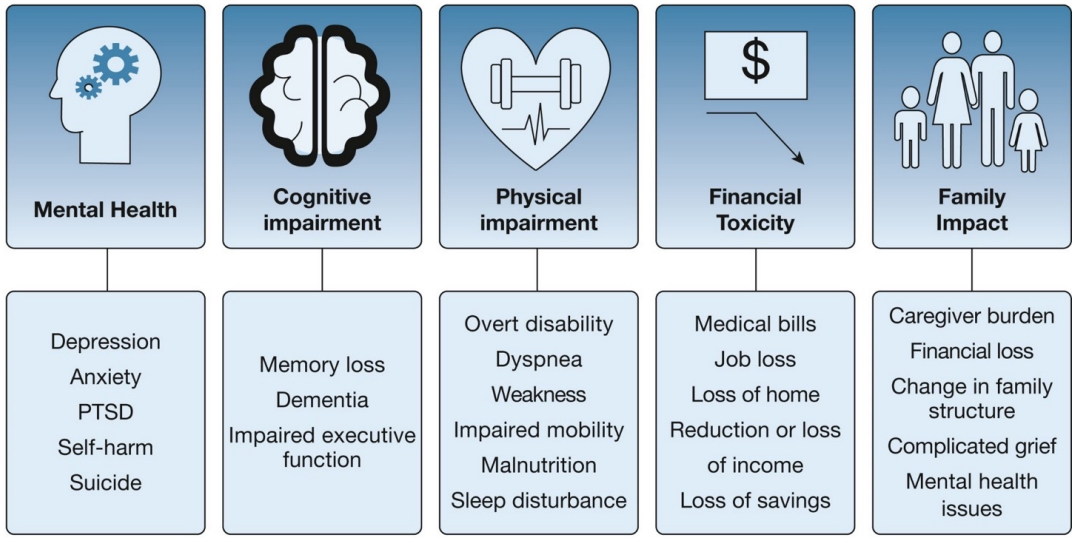

Current Anaesthesia and Critical Care (1998) **9**, 134–139

Outcomes

Intensive after care after intensive care

C. S. Waldmann

A



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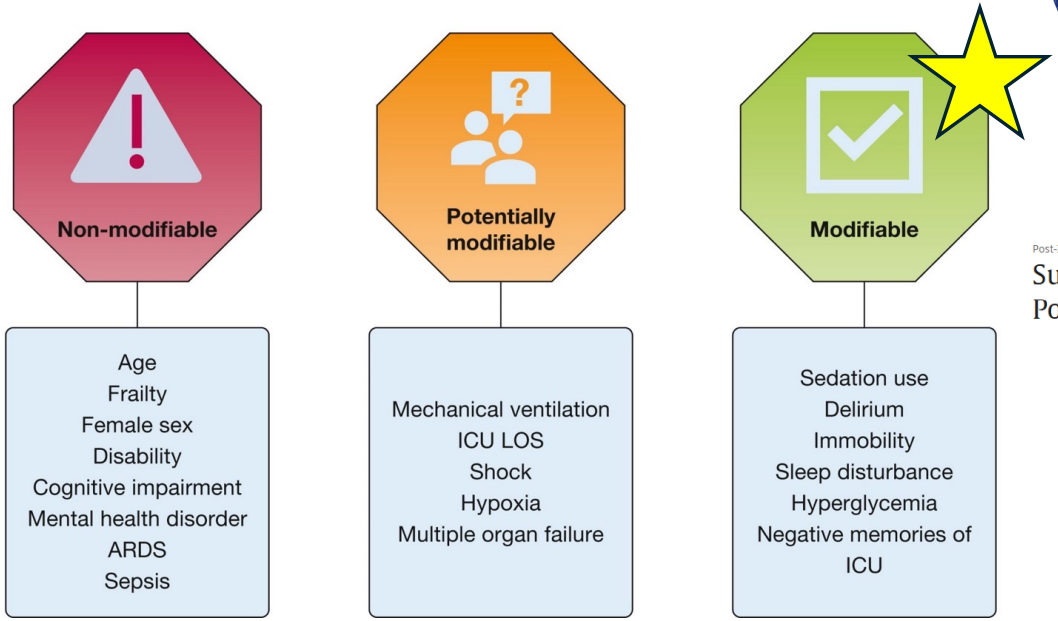


Post-ICU Syndrome: CHEST Critical Care Reviews

Survival ≠ Recovery: A Narrative Review of Post-Intensive Care Syndrome

What do patients want?

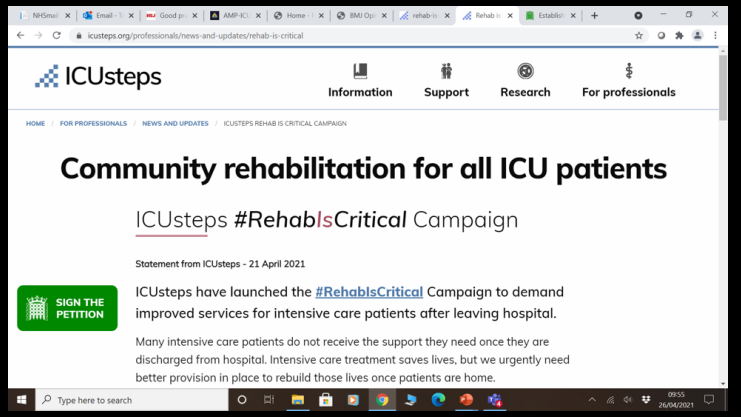
Critical illness and recovery are like travelling through a long tunnel. You start in an intensive care unit (ICU), often a harrowing experience in itself, but that part of the tunnel is well lit. You have a nurse with you 24 hours a day and a skilled multidisciplinary team looking after you.

You move to a ward and the lights in the tunnel can start flickering. There may be little understanding of what you've just been through. There may be no contact with the intensive care unit and their expertise.

Next, you get to go home, but you're in the dark now. You aren't given a map. You have no access to the multidisciplinary team. You have no information. And you don't have access to a healthcare professional who has an in-depth understanding of what you've been through and what can help you.

thebmjopinion

White, C (2021) Surviving critical illness is only the beginning: why patients must be supported in the aftermath. British Medical Journal.



The Faculty of Intensive Care Medicine

Life After Critical Illness

Survivorship following critical illness is often characterised by reduced quality of life, delayed return to work and physical, psychological and cognitive impairments. A comprehensive online survey commissioned by FICM that was sent to all hospitals within the UK shows that post ICU recovery services across all four nations are lacking.

Full details of the survey can be found at https://bmjopen.bmj.com/content/11/10/e052143.long

1 Survey response rate of 73%

176/242 UK hospitals reporting data on provision of post ICU recovery, rehabilitation, and follow-up services

Inpatient phase

2 72% of hospitals have inpatient post ICU recovery and follow-up services, commonly delivered by nurses (90.6%), physiotherapists (55.1%), and/or ICU physicians (37%)

3 Only 32% have a speech and language therapist, 31% a dietitian, 21% a pharmacist and 21% an occupational therapist

Outpatient phase

4 74% of hospitals have outpatient post ICU services, predominantly as outpatient clinics (up from 27% when surveyed in 2013)

5 Only 11% have an occupational therapist, 9% a dietitian, 8% a pharmacist and 7% a speech and language therapist

Funding

6 71% of these services are funded at risk from internal or miscellaneous funds with no financial security

Service changes

7 45% of hospitals anticipate changes to their post ICU recovery outpatient services associated with COVID-19, including change from in-person to virtual format

8 21% of hospitals report plans to expand their existing post ICU recovery service and 19% are preparing to launch a new post ICU recovery service

About Us

The Faculty of Intensive Care Medicine is the professional body responsible for the training, assessment, practice and continuing professional development of intensive care medicine doctors and practitioners in the UK.

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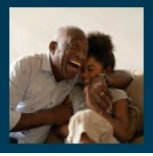
October 2021

The Faculty of Intensive Care Medicine

CRITICAL FUTURES

LIFE AFTER CRITICAL ILLNESS

A guide for developing and delivering aftercare services for critically ill patients



While many patients admitted to an intensive care unit (ICU) will make a good recovery, the impact of a stay in an ICU can be profound with long-lasting effects, and people may require ongoing rehabilitation to support their recovery. The population included in this study represented a range of specialities and ward areas, highlighting the need for organisations to recognise the importance of rehabilitation not just within intensive care units but across all specialty areas, wards and in the community.

1,018 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 and who survived to hospital discharge were included. A total of 365 sets of case notes and 671 clinician questionnaires were reviewed, along with 248 primary care clinician questionnaires, 166 organisational questionnaires and 67 community trust organisational questionnaires. In addition, 420 healthcare professional and 102 patient surveys were returned.

KEY MESSAGES	IN INTENSIVE CARE	ON THE WARD	AFTER DISCHARGE
Rehabilitation care was not well co-ordinated throughout the pathway; on admission to an ICU, at step-down to the ward and in the community.	**70/166 (42.2%) organisations had a policy or standard operating procedure for the delivery of rehabilitation, and only 24/70 undertook audits against them.**	**The data showed an absence of good multidisciplinary team working and communication across the recovery pathway as the patient moved between healthcare settings.** **Key workers to co-ordinate rehabilitation care were rarely available, yet when present they were associated with improved markers of care quality throughout the rehabilitation pathway.**	
Initial and subsequent assessments of rehabilitation need to set/update goals were not always undertaken.	104/365 (28.5%) patients had a baseline screen, and 327/574 (57.0%) patients had a comprehensive assessment on the ICU.	80/309 (25.9%) patients had a comprehensive assessment on the ward.	102/210 (48.6%) patients who attended a critical care follow-up following discharge were comprehensively reassessed.
Full multidisciplinary team (MDT) input was rarely available to meet all the rehabilitation needs of patients.	Physiotherapists were most involved in rehabilitation (604/671; 90.0%); other specialties, such as psychologists (37/671; 5.5%) much less so.	111/318 (34.9%) patients had input from the ICU MDT; usually an intensive care nurse (70/111; 63.1%) or critical care outreach (44/111; 39.6%) with less focus on rehabilitation.	98/254 (18.2%) patients did not have all appropriate referrals made.
Ongoing rehabilitation needs/goals were often not shared between healthcare providers as the patient moved through the pathway.	125/671 (18.6%) patients had no evidence of any handover related to rehabilitation needs.	357/576 (62.0%) patients were provided with an ICU follow-up appointment.	GPs were aware that a patient they saw had spent time in the ICU in 170/248 (68.5%) cases.

Recovery Beyond Survival

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

SUMMARY

ON THE WARD	AFTER DISCHARGE
80/309 (25.9%) patients had a comprehensive assessment on the ward.	102/210 (48.6%) patients who attended a critical care follow-up following discharge were comprehensively reassessed.
111/318 (34.9%) patients had input from the ICU MDT; usually an intensive care nurse (70/111; 63.1%) or critical care outreach (44/111; 39.6%) with less focus on rehabilitation.	98/254 (18.2%) patients did not have all appropriate referrals made.
357/576 (62.0%) patients were provided with an ICU follow-up appointment.	GPs were aware that a patient they saw had spent time in the ICU in 170/248 (68.5%) cases.
131/435 (30.1%) patients were given a copy of the ICU discharge summary.	40/102 (39.2%) survey respondents reported they were given a leaflet or discharge booklet.

The data showed an absence of good multidisciplinary team working and communication across the recovery pathway as the patient moved between healthcare settings.

Key workers to co-ordinate rehabilitation care were rarely available, yet when present they were associated with improved markers of care quality throughout the rehabilitation pathway.

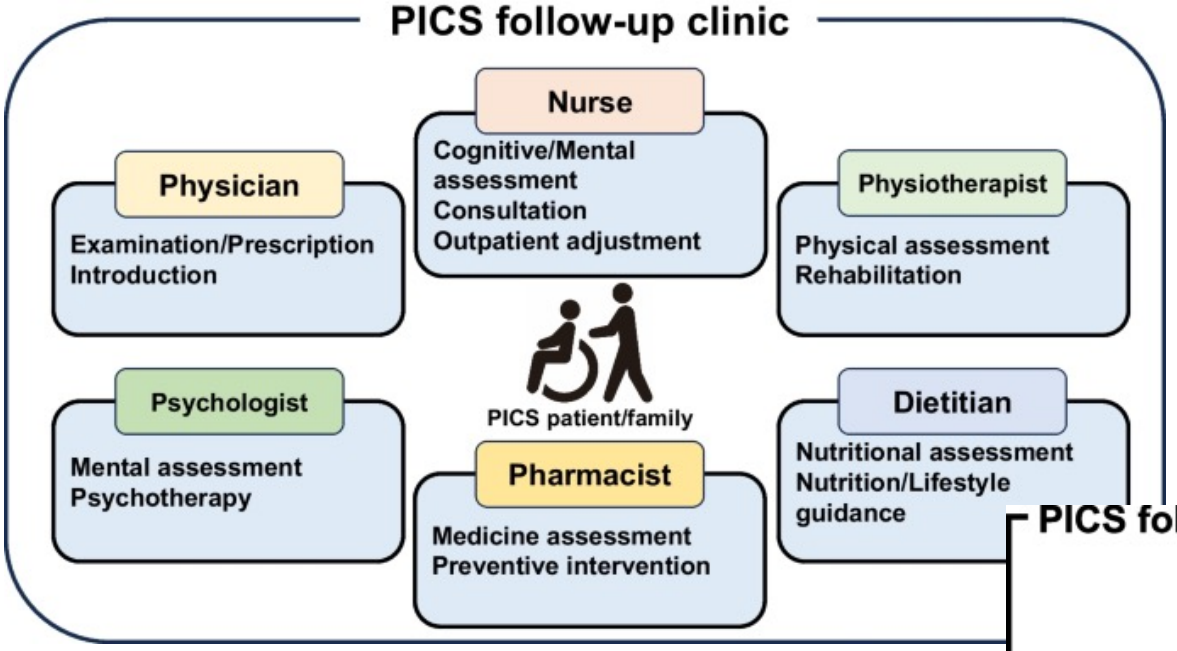
Headlines from the UK

- The first PICS follow-up clinic was established in the U.K. in 1993
- Since then they have spread across the globe

<u>6 recommendations from this report</u>

1. Improve the **co-ordination and delivery** of rehabilitation following cr both an organisational level and at a patient level.
2. Develop and validate a **national standardised rehabilitation screening tool** to be used on admission to an intensive care unit.
3. Undertake and document a comprehensive, holistic assessment of the rehabilitation needs of patients admitted to an intensive care unit at risk of physical and/or non-physical morbidity.
4. Ensure that multidisciplinary teams are in place to deliver the required level of rehabilitation in intensive care units and across the recovery pathway.
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 an intensive care unit, impact of critical illness and likely trajectory of recovery.

National Rehabililitation Collaborative in UK have a national working group to implement pragmatic solutions for these 6 recommendations.



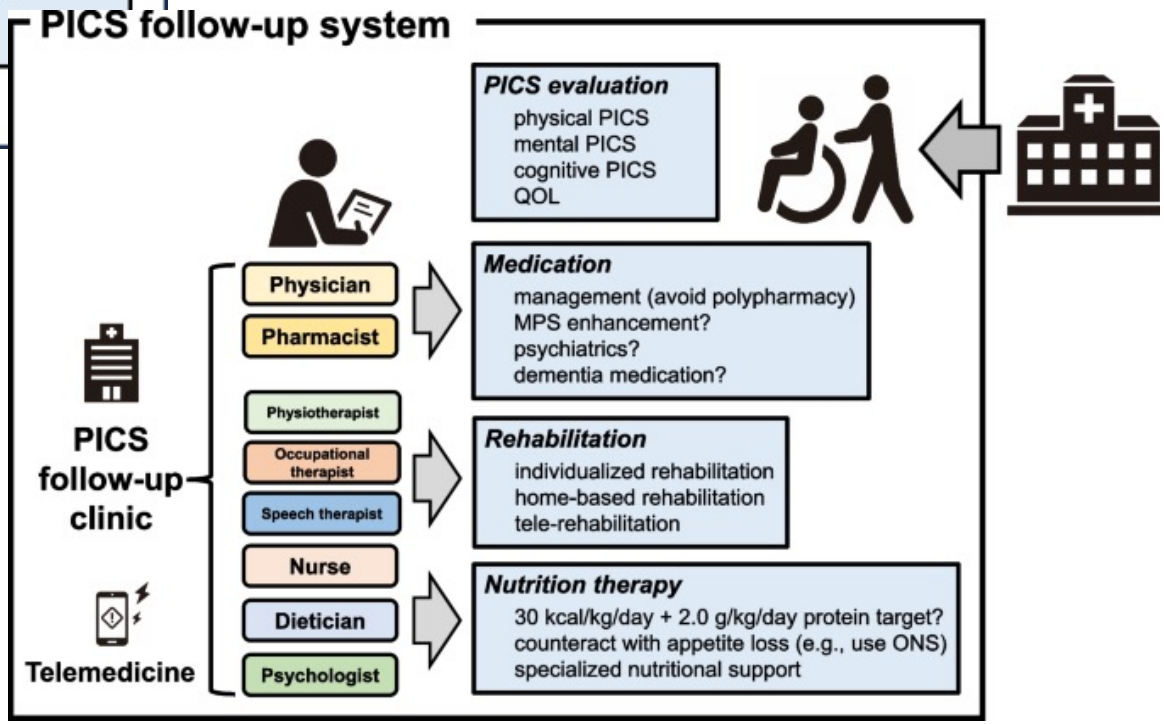
Nakanishi et al. Journal of Intensive Care (2024) 12:2
https://doi.org/10.1186/s40560-023-00716-w

Journal of Intensive Care

REVIEW Open Access

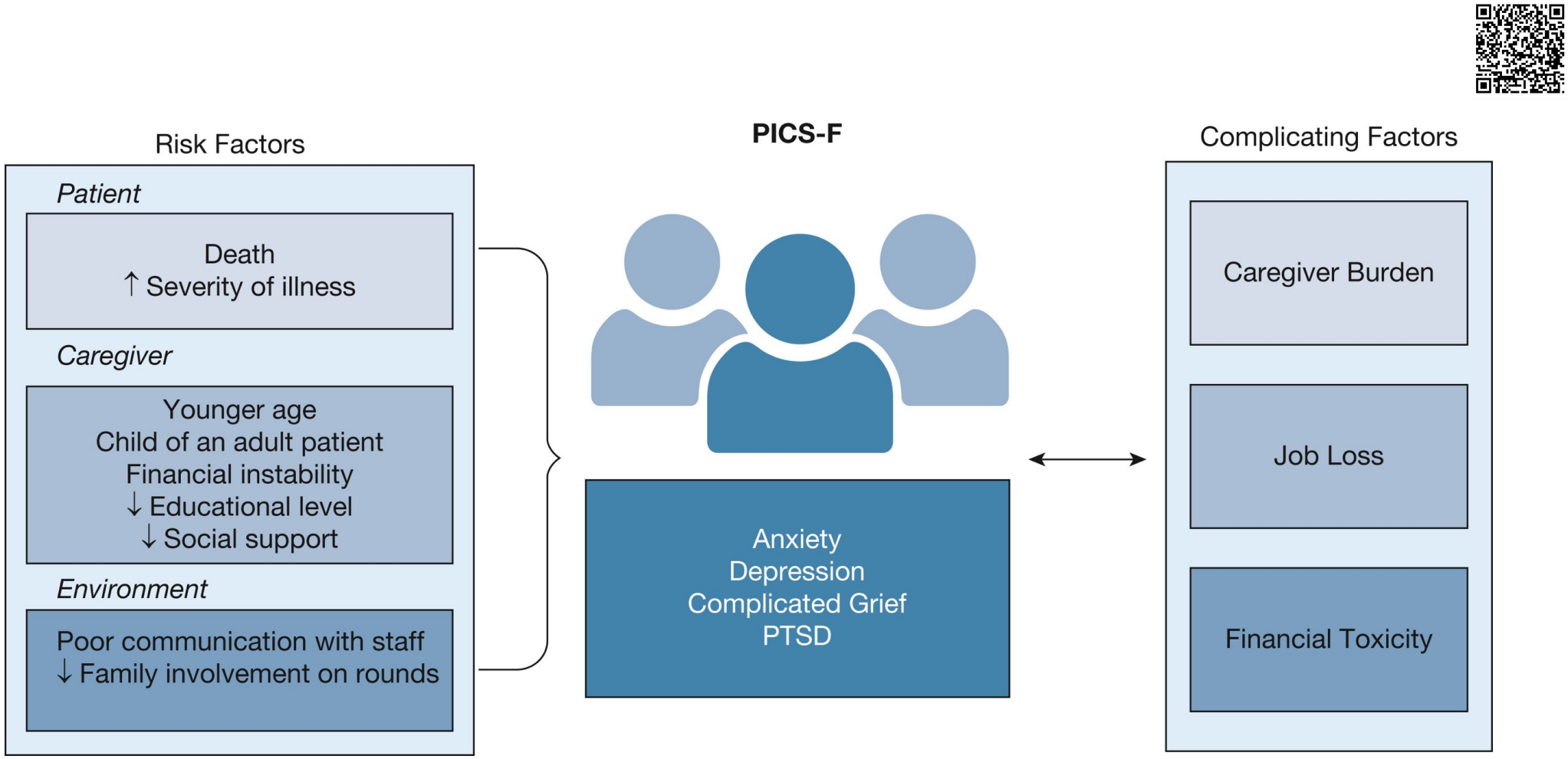
Post-intensive care syndrome follow-up system after hospital discharge: a narrative review

Nobuto Nakanishi[1], Keibun Liu[2,3,4], Junji Hatakeyama[5], Akira Kawauchi[6], Minoru Yoshida[7], Hidenori Sumita[8], Kyohei Miyamoto[9] and Kensuke Nakamura[10*]



What is missing ?

- MDT teams
- Family Support services
- Services uniformly across the UK
- Standard measures


Risk Factors
Patient
Death
↑ Severity of illness
Caregiver
Younger age
Child of an adult patient
Financial instability
↓ Educational level
↓ Social support
Environment
Poor communication with staff
↓ Family involvement on rounds
PICS-F
Anxiety
Depression
Complicated Grief
PTSD
Complicating Factors
Caregiver Burden
Job Loss
Financial Toxicity

Future – global

TAKE ACTION:

1. Integrate rehabilitation services into health systems and between primary, secondary and tertiary levels

2. Create a multi-disciplinary rehabilitation workforce

3. Have community and hospital rehabilitation services available

4. Form specialized rehabilitation units for individuals with complex needs

5. Allocate specific budgets and ensure health insurance covers rehabilitation service

6. Increase access and affordability of assistive products and train individuals in the use of these products

Sources:

1. Healthy, prosperous lives for all: the European Health Equity Status Report (2019): http://www.euro.who.int/en/publications/abstracts/health-equity-status-report-2019
2. Rehabilitation in health systems: https://apps.who.int/iris/bitstream/handle/10665/254506/9789241549974-eng.pdf?sequence=8
3. WHO website on rehabilitation: https://www.who.int/rehabilitation/en/
4. WHO Rehabilitation Fact Sheet: https://www.who.int/news-room/fact-sheets/detail/rehabilitation
5. Functional and activity limitations statistics: https://ec.europa.eu/eurostat/statistics-explained/index.php/Functional_and_activity_limitations_statistics
6. WHO European Health Equity Status Report Initiative (HESRi): https://whoeurope.shinyapps.io/health_equity_dataset/