Nurses’ role in helping to rehabilitate patients to return to health after critical illness

A member of the NICE guideline development group highlights the key issues from the latest evidence-based guideline for readers of Nursing Times

The new NICE (2009) guideline on rehabilitation after critical illness highlights patients’ need for coordinated care planning. It outlines recommendations from admission to ICU through to the first few months at home.

Structured rehabilitation after critical illness in the UK has been very patchy to date. Physiotherapy in hospital often stops once patients can walk to the toilet unaided, while psychological and cognitive problems are often not recognised in the majority of patients.

**CARE PATHWAY**

The guideline gives a clear care pathway that allows resources to be targeted appropriately. It makes it clear that rehabilitation starts while patients are still in ICU, with the emphasis on prevention, early treatment and information-giving to patients, where possible, and their families.

Nurses are ideally placed to provide this early information as they are at the bedside for the majority of the shift.

The guideline recommends that evaluating rehabilitation needs should start in ICU, using clinical assessment. Short-term rehabilitation goals should then be set.

The plan should be reassessed before discharge home and medium-term goals should be set and communicated to community care providers.

How this is done is left to each hospital’s discretion. However, it is clear there is a need for a suitably skilled healthcare professional to coordinate the rehabilitation pathway and act as a point of contact for patients and their families.

A specialist nurse could potentially fulfil that role, with the ability to make appropriate referrals to specific services such as clinical psychology.

The guideline recommends using a structured, self-directed rehabilitation manual, such as the *ICU Recovery Manual*, where assessed as appropriate. This is a six-week multi-modal programme designed to start once patients are on general wards, with support from families.

Nurses ran the original study on this manual, and a trained nurse introduced the programme to patients (Jones et al, 2003). The study showed that patients who received the manual had a quicker physical recovery than controls.

However, despite the manual having detailed information about the after-effects of critical illness, there was no impact on psychological recovery. Patients with recall of delusional memories, such as hallucinations, nightmares and paranoid delusions, had the poorest psychological recovery.

Such patients should be identified and referred to psychological services where necessary, and the guideline refers to other NICE guidance on post-traumatic stress disorder for those indications.

It lists some of the symptoms that should be looked for so appropriate referrals can be made. For many hospitals where outreach teams are established but no other ICU follow-up is available, nurses on these teams may need extra training to recognise non-physical problems.

**LONG-TERM REHABILITATION**

The guideline also recommends that reassessment of longer-term rehabilitation needs after patients’ discharge should be carried out face to face, by an appropriately skilled healthcare professional, either in the community or in hospital at around two months.

Only a minority of ICUs have a follow-up clinic where this could be done. Where such facilities are in place, specialist nurses could carry out this assessment.

Their role here could be combined with the coordinating role as this practitioner would have a clear picture of the patient’s whole rehabilitation pathway.

However, hospitals without follow-up services will need to discuss with PCTs where this assessment should take place and the most appropriate healthcare professional to carry it out.

The practitioner coordinating a patient’s rehabilitation pathway from ICU to general ward and acting as a contact point for advice after discharge has the best knowledge of problems during recovery.

It would be sensible for that person to be involved in the final assessment and to be able to make appropriate referrals as needed. This will help critical care patients return to the best possible physical and psychological health they can achieve.

**REFERENCES**
