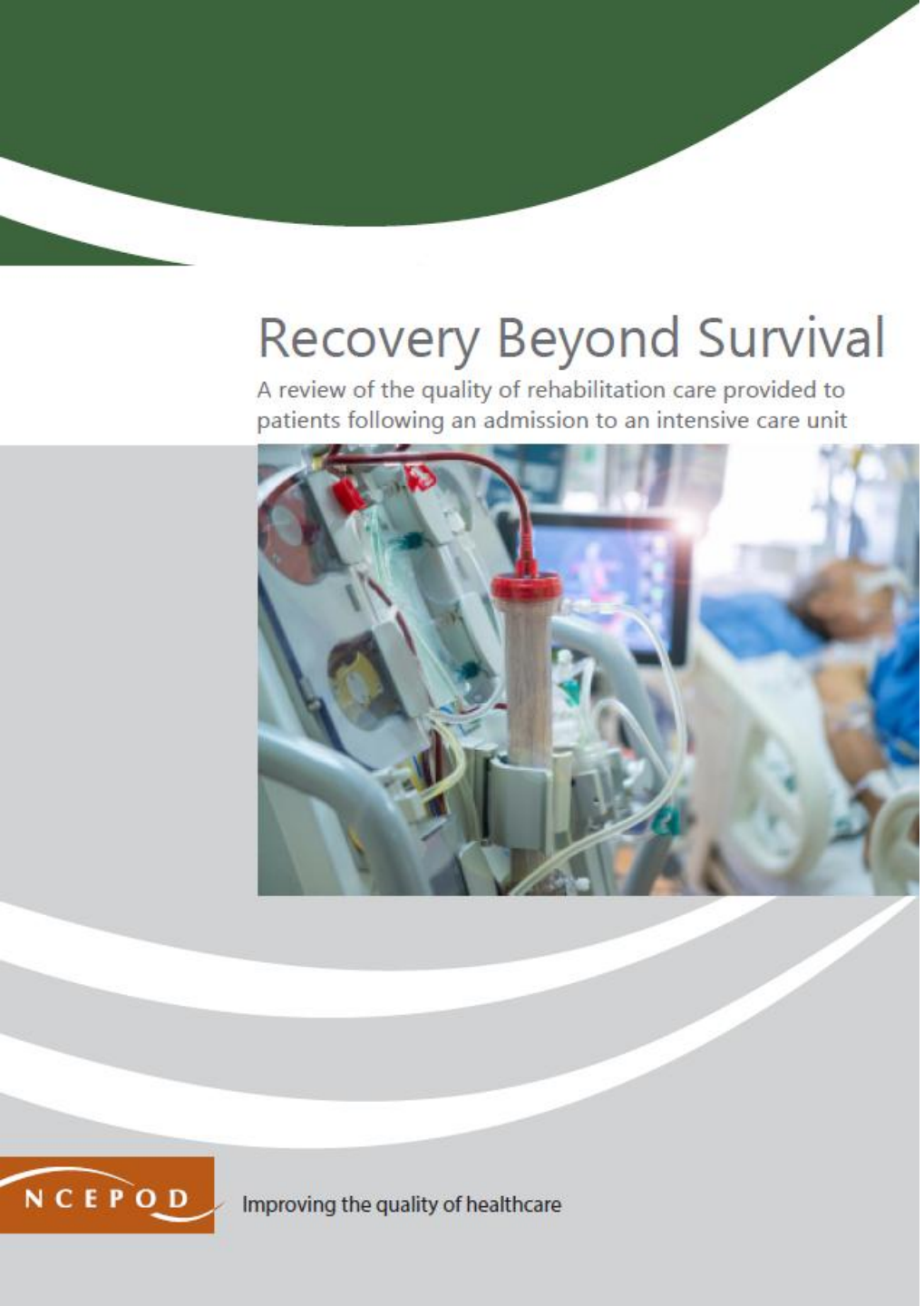


40th Annual BACCN Conference

Celebrating 40 Years of Advocating for Critical Care Nursing:

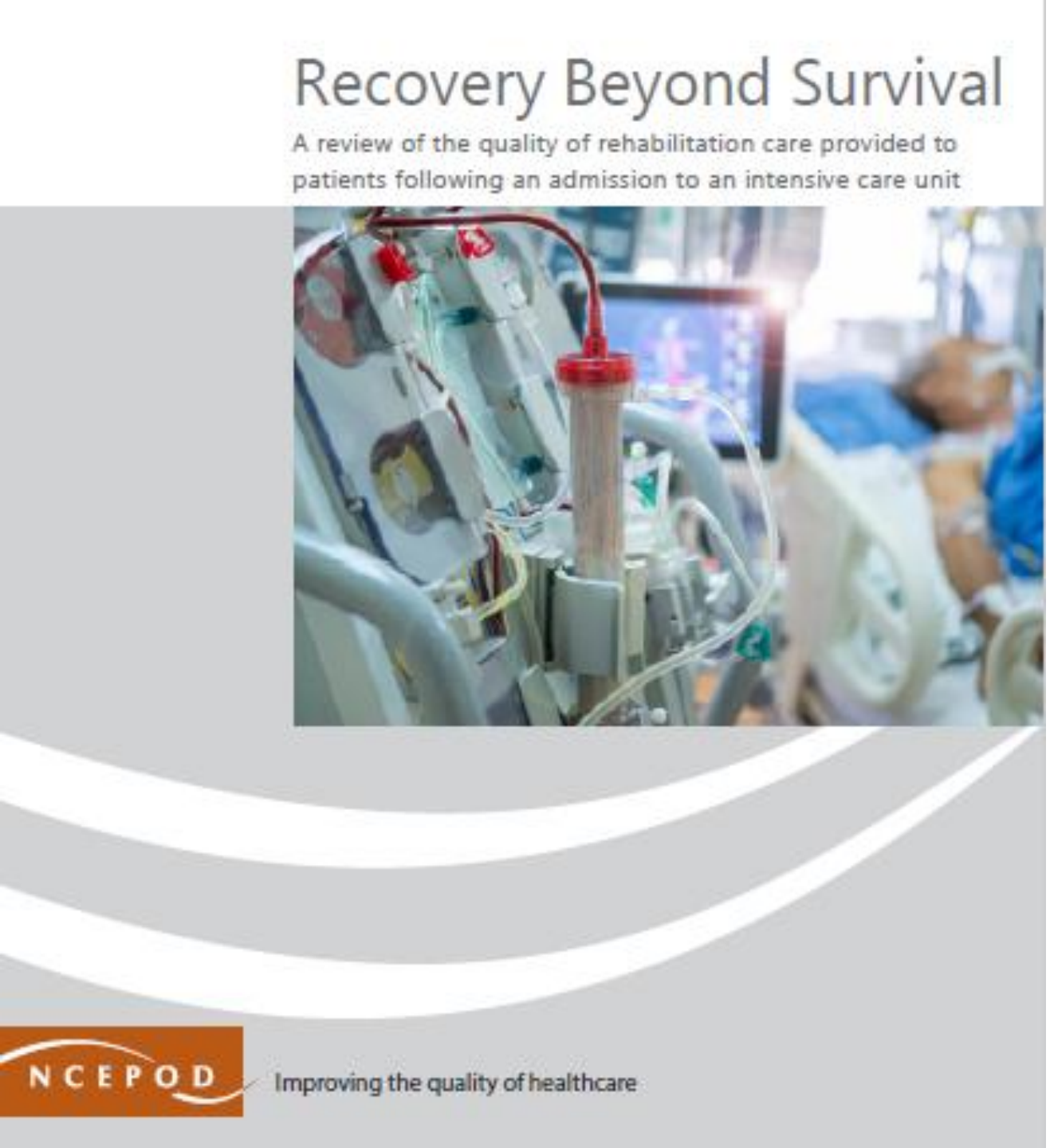
Adapting to a Changing Landscape

07 - 08 October 2025: The Winter Gardens, Blackpool

NCEPOD Community of practice: From recommendations to reality

Professor David McWilliams

NCEPOD Clinical Co-ordinator
Professor of Critical Care and Rehabilitation
University Hospitals Coventry & Warwickshire NHS trust and
Coventry University Centre for Care Excellence



RECOMMENDATIONS

RECOMMENDATIONS

1. Improve the co-ordination and delivery of rehabilitation following critical illness

- *At an organisational level by assigning a trust/health board rehabilitation lead with oversight and responsibility for the provision of holistic rehabilitation.*
- *At a patient level by having a named rehabilitation care co-ordinator(s) role to oversee patients' rehabilitation needs within the ICU, on the ward and in the community.*

2. Develop and validate a national standardised rehabilitation screening tool

- *This would identify patients at risk of long-term physical, psychological, cognitive or social effects and trigger an earlier comprehensive assessment of their rehabilitation needs sooner than 'day four' currently defined by NICE Quality Standard 158.*

3. Undertake and document a comprehensive, holistic assessment of the rehabilitation needs of patients admitted to an intensive care unit

- *Assessments should be repeated and documented at key stages along the patient's pathway from ICU to community services and GP follow-up.*

RECOMMENDATIONS

4. Ensure that multidisciplinary teams are in place to deliver the required level of rehabilitation in intensive care units and across the recovery pathway. Include:

- *All relevant healthcare professionals needed to provide co-ordinated, consistent care in the ICU, ward and community*
- *Regular communication between specialties and discussion of patients' needs at a dedicated multidisciplinary team meeting or rehabilitation rounds*

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 , impact of critical illness and likely trajectory of recovery.

- *Include the contact details of a named healthcare professional or rehabilitation care co-ordinator*
- *Involve patients/family/carers in multidisciplinary team discussions and rehabilitation planning.*

THEMES

- Coordination (and oversight) – R1&4
- Assessment & Transition (R2&3)
- Patient Information (R5&6)
- Education (All!)

COORDINATION

- Who has rehabilitation coordinators / key workers in ICU
- How does the role work
  - ICU – Ward – Community
  - Uni professional vs MDT

ASSESSMENT & TRANSITION

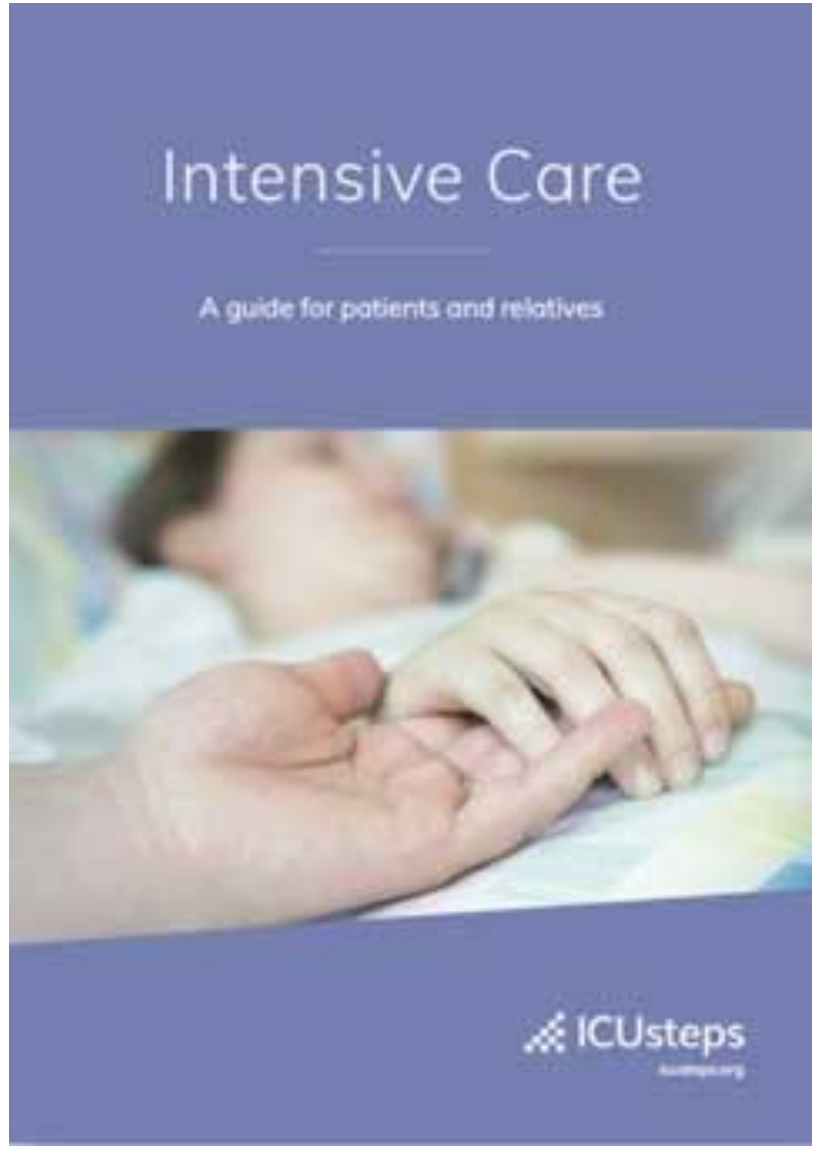
- Do you have standardised forms?
- Is any additional care / support provided by ICU team?

NCEPOD - Community of Practice

ICS 2/7/25

PATIENT INFORMATION

- Local options
- Charities
- Are your patients provided with a copy of discharge summaries
- Diaries
  - When and how are they given?



EDUCATION

- Who should we target
  - Locally
  - Nationally
  - Undergraduate curriculum

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