intensive care society
care when it matters

CRITICAL CARE NETWORKS OF ENGLAND, WALES & NORTHERN IRELAND

CC-N
Critical Care Networks-National Nurse Leads

Critical Care Rehabilitation Handover

Patient label

Date of Discharge from Critical Care / /

Length of Stay on Critical Care _____ days
Length of time on Ventilator _____ days

Tracheostomy? Yes ☐ Never ☐ Decannulated ☐

Date Decannulated / /

Discharge destination _____

Multidisciplinary team (MDT) involvement during critical care		Contact details of critical care MDT	Referral made on discharge	Date referral made:
Physiotherapy	Yes / No		Yes / No	
Occupational Therapy	Yes / No		Yes / No	
Speech & Language Therapy (SLT)	Yes / No		Yes / No	
Dietitian	Yes / No		Yes / No	
Contact for any psychological assessment / treatment	Yes / No		Yes / No	
Pain Team	Yes / No		Yes / No	
Pharmacy	Yes / No		Yes / No	
Other (specify) Alcohol specialist, smoking cessation, tissue viability etc.	Yes / No		Yes / No	

Considerations	Current Status	Ongoing needs Please give contact details of referrals made
Motivation *What are the patient's goals?* Consider barriers to attainment including low mood, ability to enjoy activities, delirium, understanding, ability to retain information		
Respiratory O_2 requirements, NIV requirements, effective cough, breathlessness, pre-existing conditions		
Mobility Able to get out of bed independently, time in chair tolerated, mode of transfer, walking aids used, muscle weakness, fatigue, pre-existing conditions		

NB: This rehabilitation handover document provides a summary of the patient's current status and on-going rehabilitation needs. Specific details (e.g. goals) can be found within the individual therapists notes.

Advisory Critical Care Rehabilitation Handover document developed by the Rehabilitation Sub-group to CC3N – June 2019

Considerations	Current Status	Ongoing needs Please give contact details of referrals made
Function Use of call bell, toileting, washing, dressing, feeding, brushing teeth		
Nutrition Mode of feeding, special diet and supplemental nutrition, need for texture modification, appetite, symptoms affecting intake (e.g. taste), weight/muscle loss		
Swallowing Evaluation of risk for dysphagia and aspiration, especially if tracheostomy in situ with referral made to SLT		
Communication Options for verbal and non-verbal communication, including access to call bell, aids for communication, hearing and vision, language support/ interpreter.		
Cognition Delirium status, confusion/agitation, dementia, learning difficulties, acute brain injury, pre-existing conditions, memory		
Psychological Signs of emotional distress, low mood, anxiety, nightmares, flashbacks AND/OR risk factors for psychological morbidity (e.g. delirium, poor sleep, extended duration of ventilation, history of mental health problems, past history of psychological trauma) Does the patient have a diary?		
Family and Carers Involvement in care, understanding, dependents, social issues, previous care packages, psychological issues		
Rest and sleep Hallucinations, dreams, nightmares, deprivation		
Pain Chronic/acute, analgesia, strategies to help, pre-existing conditions		
Pharmacology Analgesia prior to mobilisation, anti-depressants, sleep aids. Medication review e.g. in presence of delirium		
Other considerations and barriers to rehabilitation Sensory problems, infection, infection control, sideroom, pressure area/ wound care, spiritual need		

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