**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 …………………………..

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| --- | --- | --- | --- | --- |
| **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 Therapist (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 |  |

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| **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  O2 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 |  |  |
| Function  Use of call bell, toileting, washing, dressing, feeding, brushing teeth |  |  |

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| **Considerations** | **Current Status** | **Ongoing needs** Please give contact details of referrals made |
| 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 needs |  |  |