CHARTERED SOCIETY OF PHYSIOTHERAPY

CSP COVID-19 Rehabilitation Standards

Rehabilitation of adults who are hospitalised due to acute COVID-19 or Long COVID: physiotherapy service delivery

CSP STANDARD [RS1] Version 2

April 2021

Version 2, published 1st April 2021

How these standards were developed

The standards are underpinned by national guidance and standards, in particular by The National Institute for Health and Care Excellence (NICE), government and profession-specific guidance on COVID-19. COVID-19 is a new condition with an emerging evidence base.

The standards draw on available evidence, expert opinion and the lived experiences of people with Long COVID-19. The background information and scope of the standards includes papers which have not yet been peer reviewed. Where referenced, they are identified as preprints.

The standards will be reviewed and updated as the knowledge base and expert experience develop.

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Expert peer reviewers

Association of Chartered Physiotherapists in Respiratory Care (ACPRC) (version 1 and 2)

Darren Brown – Specialist Physiotherapist HIV and Oncology, person living with Long COVID (version 2)

Stephanie Mansell – Consultant Respiratory Physiotherapist, Consultant Physiotherapy Group Co-chair (version 1)

David McWilliams – Consultant Physiotherapist Critical Care (version 1)

Lucy Silvester – Major Trauma Service Lead (version 1 and 2)

CSP project team

Authors:

Fran Hallam
Gabrielle Rankin
Julie Blackburn (standard 6)

Reviewers:

Tamsin Baird
Ruth ten Hove
Rachael Wadlow

Rehabilitation of adults who are hospitalised due to acute COVID-19 or Long COVID: physiotherapy service delivery

CSP Standards [RS1] are one of a series of CSP COVID-19 Rehabilitation Standards.

They can be used in conjunction with:

- **CSP Standards** [RS2]: **Palliative rehabilitation and end of life care: physiotherapy service delivery**
- **CSP Standards** [RS3]: **Community rehabilitation: physiotherapy service delivery**

CSP Standards [RS1] cover rehabilitation for adults of 18 years and over who are admitted to hospital with COVID-19. This encompasses people with acute COVID-19 or Long COVID. The standards apply to rehabilitation for any episode of care in a hospital setting through to step-down rehabilitation facilities and/or ongoing rehabilitation in the community. This includes people who were not admitted to hospital during the acute stage of COVID-19 infection and readmission of people who were hospitalised due to acute COVID-19. Early research in England reported that 29.4% of people with COVID-19 were readmitted to hospital.[1] The standards do not apply to end of life rehabilitation care pathways.

Acute COVID-19 describes signs and symptoms of COVID-19 for up to 4 weeks.[2] Long COVID is a term commonly used to describe signs and symptoms that continue or develop after acute COVID-19.[2] There is enormous variation in the estimated prevalence of Long COVID and differences between people who were hospitalised and those not admitted to hospital.[3] It appears that at least 10% of people with COVID-19 experience at least one symptom for 12 weeks or longer.[3,4] Long COVID affects people of all ages including those with mild initial symptoms.[4] People with Long COVID have multi-dimensional symptoms across many different body systems.[3] One study (preprint) lists 205 different symptoms relating to 10 different systems.[5] Symptoms can be episodic, unpredictable and fluctuating in severity.[3] Long COVID is an umbrella term and little is known about different clusters and patterns of symptoms.[3] Various classifications have been suggested such as Post Intensive Care Syndrome, Post Viral Fatigue, Long

Term COVID and permanent organ damage, which some people may be experiencing simultaneously.[3] Organ damage has been seen in people with Long COVID, one study (preprint) showing single organ impairment in 66% and multi-organ impairment in 25% of individuals.[5] The diverse presentations of COVID-19 may have different causal mechanisms requiring a variety of rehabilitation approaches.[3]

The standards are for the physiotherapy workforce delivering rehabilitation in a multidisciplinary care context. The standards are key for facilitating safe and rapid decision making and ensuring the delivery of consistent, high quality, personalised assessment and physiotherapy. They should be used in conjunction with local policies and procedures.

In these standards the term COVID-19 encompasses acute COVID-19 and Long COVID.

1. *Epidemiology of post-COVID syndrome following hospitalisation with coronavirus: a retrospective cohort study. (2021) Ayoubkhani D et al, medRxiv, 2021.01.15.21249885.*
2. *COVID-19 rapid guideline: managing the long-term effects of COVID-19 (2020) NICE guideline NG188*
3. *The Independent SAGE Report 32: Independent SAGE Report on Long COVID (2021) The Independent Scientific Advisory Group for Emergencies (SAGE)*
4. *Living with Covid19. A dynamic review of the evidence around ongoing Covid19 symptoms (often called Long Covid) (2020). National Institute for Health Research*
5. *Characterizing Long COVID in an International Cohort: 7 Months of Symptoms and Their Impact.(2020) Davis HE et al, medRxiv, 2020: 2020.12.24.20248802.*

Updates to version 2

These standards have been updated to bring them into alignment with CSP Standards RS2 and RS3. They also take into account updated guidance and emerging evidence including people's lived experiences regarding:

- Recovery trajectories and sequelae of COVID-19 including Long COVID
- Assessment and screening tools
- Personalised symptom management
- monitoring response to rehabilitation and individualising timing, intensity and frequency of rehabilitation
- supported self-management and self-monitoring, including principles of pacing and energy management
- rehabilitation models including COVID clinics
- impact of inequalities and disparities in outcome.

In these standards the term COVID-19 encompasses acute COVID-19 and Long COVID.

Quality standards:

1. **Needs assessment, rehabilitation planning and review**
2. **Personalised rehabilitation and symptom management**
3. **Communication and information sharing with people with COVID-19**
4. **Coordinated rehabilitation and models of care**
5. **Evaluation, audit and research**
6. **Personal Protective Equipment (PPE) and infection control.**

Quality standard 1:
Needs assessment, rehabilitation planning and review

Quality statement 1

1. **People who are hospitalised due to COVID-19 or Long COVID have their rehabilitation needs assessed and a personalised rehabilitation plan with outcome measures developed with the multidisciplinary team as soon as clinically appropriate.**

    1.1. Initial assessment and planning of rehabilitation needs takes place as soon as clinically appropriate in coordination with the multidisciplinary team, regularly reviewed and documented

    1.2. Assessment is holistic and includes consideration of risk, co-morbidities, prognosis and takes into account emerging evidence about the multi-dimensional sequelae of COVID-19 including Long COVID, and variation in outcomes from COVID-19

    1.3. Consider functional screening tools to inform personalised rehabilitation planning

    1.4. Rehabilitation planning, goal setting and outcome measurement is personalised and where possible, involves shared decision making based on what matters to the individual and their individual strengths, needs and preferences

    1.5. Physiotherapy assessments contribute to the overall multidisciplinary needs assessment and identification of specialist expertise requirements

    1.6. Needs assessments, care planning and reviews are timely, take into account the person's response to rehabilitation, their personalised outcome measures and their changing needs.

Rationale

People who are hospitalised due to COVID-19 need a comprehensive assessment to establish their rehabilitation needs and to put a holistic, personalised rehabilitation plan in place. COVID-19 is a multisystem condition and responsive, individualised assessment determines which members of the multidisciplinary team (MDT) are involved in each person's rehabilitation. Outcome measures should be personalised and repeated as part of ongoing assessment, monitoring response to rehabilitation and informing the rehabilitation plan. Timings of assessments and outcome measurements need to be individualised due to the fluctuating nature and varying clinical presentations of COVID-19.

People with COVID-19 often present with a wide range of clinical, physical, psychological (including cognition), emotional, cultural and social needs due to the virus and also related to other underlying health conditions. A holistic assessment should consider all of these needs and the emerging evidence about the sequelae of COVID-19, impact of inequalities and disparities in outcomes.

Focussing on assessing needs helps the person and MDT to develop a personalised plan to manage those needs.

Functional screening tools identify problems that are likely to require further more detailed evaluation by members of the MDT to inform development of the personalised rehabilitation plan. Screening also helps to stratify rehabilitation requirements in terms of who, how and when rehabilitation is delivered including specialist expertise requirements. Specific functional screening tools for people who have been admitted to intensive care settings are available, for example PICUPS and PICUPS-Plus *(National Post-Intensive Care Rehabilitation Collaborative, 2020).* Functional screening tools have also been developed for people with Long COVID, for example the COVID-19 Yorkshire Rehabilitation Screening Tool *(Sivan, Halpin and Gee, 2020).*

Personalised rehabilitation means people have choice and control over the way their care is planned and delivered, based on what matters to them.

Personalised needs-based planning involves shared decision making between the individual and the professionals supporting them, putting the person at the centre of decisions about their rehabilitation. People's personal strengths, preferences, aspirations and needs help inform goal setting. Both the MDT and the person have a role and responsibility for contributing to the decision making process.

The MDT contribute information about diagnosis, cause of disease, prognosis, treatment options and outcomes. Whereas, the person contributes the experience of their illness, how they manage their illness, social circumstances, attitudes to risk, values and preferences. Families and carers can also play a significant role in providing information about the person's needs and circumstances.

The clinical status and symptoms of people with COVID-19 can fluctuate and their response to rehabilitation requires careful monitoring for example oxygen saturation levels. Some people with COVID-19 may experience post-exertional malaise (PEM) where symptoms are triggered or made worse by physical, cognitive, mental or emotional exertion. The timing of PEM after exertion is variable and unpredictable. This should be taken into account when assessing people with COVID-19 and planning their rehabilitation. For more information on PEM, see the *Long COVID Physio website.*

Needs assessment, outcome measurement, personalised care planning and review should be an ongoing and proactive process that is both planned and responsive to changing needs. The needs of people hospitalised with COVID-19 can change very quickly. Advance care planning is one part of personalised care planning and involves discussions about an individual's preferences and wishes for types of care or treatment available that may be beneficial in the future. It also takes into account the needs of their families and carers. Regular needs assessment and outcome measurement helps ensure signs of deterioration and episodic disability are recognised and appropriate care and/or rehabilitation is in place. For further detail in relation to palliative rehabilitation and end of life care see: *CSP COVID-19 Rehabilitation standards RS2 (Palliative rehabilitation and end of life care: physiotherapy service delivery).*

Source guidance

COVID-19 rapid guideline: critical care in adults (2020) NICE guideline NG159, recommendations 4 and 5

COVID-19 rapid guideline: managing the long-term effects of COVID-19 (2020) NICE guideline NG188, recommendations 2.2, 2.3

Intermediate care including reablement (2018) NICE quality standard QS173, quality standard 3

Intermediate care including reablement (2017) NICE guideline NG74, recommendation 1.1.1, 1.1.3, 1.5.10-1.5.12

Rehabilitation after critical illness in adults (2017). NICE quality standard QS158, standard 1

Rehabilitation after critical illness in adults (2009) NICE guideline CG83, recommendation 1.4

COVID-19 clinical management: living guidance (2021) World Health Organisation

In the wake of the pandemic. Preparing for Long COVID (2021) World Health Organisation

Covid-19 Clinical Advice. Supporting people with COVID-19 related illness in the community setting: Clinical management of those with moderate to severe illness. Version 2.1 (2020) Scottish Government

COVID-19: Guidance for the commissioning of clinics for recovery and rehabilitation (2020) NHS England and NHS Improvement London

COVID-19: Long-term health effects (2020) Public Health England

COVID-19 Hospital discharge service requirements (Wales) (2020) Welsh Government

Disparities in risks and outcomes of COVID-19 (2020) Public Health England

Developing a modelling resource to understand the rehabilitation needs of people during, and following, the Covid-19 pandemic (2020) Welsh Government

Framework for supporting people through Recovery and Rehabilitation during and after the COVID-19 Pandemic (2020) Scottish Government

Hospital discharge service: policy and operating model (2020) Department of Health and Social Care

National guidance for post-COVID syndrome assessment clinics (2020) NHS England

Reducing health inequalities associated with COVID-19. A framework for healthcare providers (2020) NHS Providers

Rehabilitation: a framework for continuity and recovery 2020 to 2021 (2020) Welsh Government

Inclusion Health: applying All Our Health (2021) Public Health England

Build back fairer: the Covid-19 Marmot review (2020) Institute of Health Equity

Keeping Me Well: COVID-19 Rehabilitation Model (2020) Cardiff and Vale University Health Board

Rehabilitation in the wake of Covid-19 - A phoenix from the ashes. Issue 1 (2020) British Society of Rehabilitation Medicine

Responding to COVID-19 and beyond: Framework for assessing early rehabilitation needs following treatment in intensive care. Version 1 (2020) National Post-Intensive Care Rehabilitation Collaborative

Silver Book II (2021) British Geriatrics Society

Guidelines for the provision of intensive care services. Edition 2 (2019) The Faculty of Intensive Care Medicine and The Intensive Care Society, section 2.6, standard 6

Chartered Society of Physiotherapy's Code of Members' Professional Values and Behaviour (2019) CSP, principle 3

Chartered Society of Physiotherapy COVID-19 Rehabilitation Standards. Palliative rehabilitation and end of life care: physiotherapy service delivery [RS2] (2020) Chartered Society of Physiotherapy

Quality standard 2:
Personalised rehabilitation and symptom management

Quality Statement

2. **People who are hospitalised due to COVID-19 receive symptom management and start rehabilitation as early as clinically appropriate based on their personalised needs assessment, outcome measurement and rehabilitation plan.**

   2.1. Decision on when to start rehabilitation is undertaken in discussion with the multidisciplinary team, taking into account the person's clinical status

   2.2. Rehabilitation and/or symptom management is holistic based on the personalised needs assessment, outcome measurement and rehabilitation plan

   2.3. During rehabilitation the person's clinical presentation (e.g. respiratory and haemodynamic function) requires continuous monitoring

   2.4. Timing, intensity and frequency of rehabilitation is personalised and flexible to clinical and individual needs

   2.5. Principles of pacing and energy management, including recognition of signs of post-exertional malaise, are incorporated into rehabilitation interventions, as well as supported self-monitoring and/or management

   2.6. The physiotherapy workforce share knowledge, skills and expertise with the multidisciplinary team so that rehabilitation and symptom management is integrated within daily care and activity.

Rationale

Delays in starting rehabilitation can increase the risk of further deterioration in the person's condition and lead to reduced independence. Starting rehabilitation early can improve physical and mental recovery and prevent future problems. However, people with COVID-19 and Long COVID often have complex medical presentations and therefore the decision of when to start rehabilitation requires discussion amongst the multidisciplinary team (MDT).

Effective rehabilitation is holistic and personalised to reduce physical, psychological (including cognitive), emotional and social impacts of COVID-19. Each individual with a diagnosis of COVID-19 may have other health conditions and may have very different abilities and rehabilitation needs. The aim of symptom management is to optimise the person's clinical status and ability to undertake rehabilitation.

COVID-19 recovery has an individualised trajectory for each person that is unpredictable and may be episodic, requiring continual input from the MDT to tailor rehabilitation.

People who are critically ill due to COVID-19 can deteriorate rapidly. Fatigue, breathlessness and oxygen desaturation are common symptoms and must be assessed, monitored and managed carefully during rehabilitation. Physiotherapists who are experiencing Long COVID have developed a *website* which includes resources about rehabilitation.

Changes to the rehabilitation plan is informed by regular, personalised needs assessment and outcome measurement, and discussion with the MDT.

Supported self-management is a key component of rehabilitation which should begin as early as clinically appropriate and based on the person's needs assessment and rehabilitation plan. Self-management includes support and advice about pacing, rest and recovery time, and managing their symptoms. Rehabilitation sessions also provide opportunity to support people to self-monitor their symptoms and to know when to seek advice from a healthcare professional.

Facilitating rehabilitation and symptom management little and often and integrated into daily care and activity supports the principles of pacing and energy management, minimises the risk of complications and empowers people to regain physical functioning and independence as soon as possible. The physiotherapy workforce provides a vital role in sharing their expertise to enable all the MDT to be actively involved in delivering personalised rehabilitation plans.

Source guidance

COVID-19 rapid guideline: managing COVID-19 (2021) NICE guideline NG191, recommendations 6.1.2-6.1.5

COVID-19 rapid guideline: managing the long-term effects of COVID-19 (2020) NICE guideline NG188, recommendations 3.5 and 5.5

Intermediate care including reablement (2018) NICE quality standard QS173, quality standard 3

Rehabilitation after critical illness in adults (2017) NICE quality standard QS158, standard 1

Rehabilitation after critical illness in adults (2009) NICE guideline CG83, recommendation 1.6

COVID-19 clinical management: living guidance (2021) World Health Organisation

In the wake of the pandemic. Preparing for Long COVID (2021) World Health Organisation

COVID-19 Clinical Advice. Supporting people with COVID-19 related illness in the community setting: Clinical management of those with moderate to severe illness Version 2.1 (2020) Scottish Government

COVID-19: Guidance for the commissioning of clinics for recovery and rehabilitation (2020) NHS England and NHS Improvement London

COVID-19: Long-term health effects (2020) Public Health England

Clinical management of COVID-19: Interim guidance (2020) World Health Organisation, section 9

Developing a modelling resource to understand the rehabilitation needs of people during, and following, the COVID-19 pandemic (2020) Welsh Government

Disparities in risks and outcomes of COVID-19 (2020) Public Health England

Framework for supporting people through Recovery and Rehabilitation during and after the COVID-19 Pandemic (2020) Scottish Government

Rehabilitation: a framework for continuity and recovery 2020 to 2021 (2020) Welsh Government

Inclusion Health: applying All Our Health (2020) Public Health England

Build back fairer: the COVID-19 Marmot review (2020) Institute of Health Equity

Keeping Me Well: COVID-19 Rehabilitation Model (2020) Cardiff and Vale University Health Board

Physiotherapy management for COVID-19 in the acute hospital setting: clinical practice recommendations. Version 1.0. (2020) Thomas P et al, Journal of Physiotherapy, 66(2):73-82. Recommendations 6.4-6.6

Rehabilitation in the wake of COVID-19 - A phoenix from the ashes. Version 1 (2020) British Society of Rehabilitation Medicine, recommendations 1 and 2

Report of an ad-hoc international task force to develop an expert-based opinion on early and short-term rehabilitative interventions (after the acute hospital setting) in COVID-19 survivors (2020) Ad-hoc International Task Force, recommendation 4.18

Responding to COVID-19 and beyond: A framework for assessing early rehabilitation needs following treatment in intensive care. Version 1 (2020) National Post-Intensive Care Rehabilitation Collaborative

Guidelines for the provision of intensive care services. Edition 2 (2019) The Faculty of Intensive Care Medicine and The Intensive Care Society, section 2.6, standard 7

Rehabilitation to enable recovery from COVID-19: a rapid systematic review (2021) Goodwin VA et al, Physiotherapy, S0031-9406(21)00017-1

Chartered Society of Physiotherapy's Code of Members' Professional Values and Behaviour (2019) CSP, principle 3

Chartered Society of Physiotherapy COVID-19 Rehabilitation Standards. Palliative rehabilitation and end of life care: physiotherapy service delivery [RS2] (2020) Chartered Society of Physiotherapy

Quality standard 3: Communication and information sharing with people with COVID-19

Quality statement

3. **Communication with people who are hospitalised with COVID-19 and their families and carers is effective, with empathetic listening and information shared in an accessible way, personalised to their needs and preferences.**

   3.1 Communicate information in a personalised, accessible and timely way with people with COVID-19, their families and carers, in order to facilitate decision making and support rehabilitation, symptom management discharge and self-management

   3.2 People who are hospitalised due to COVID-19 have their preferences for sharing information with their family members and carers established, respected and reviewed throughout their care

   3.3 Ensure that members of the multidisciplinary team with relevant expertise are involved in assessing and supporting the person's communication needs

   3.4 The physiotherapy workforce communicate personalised information using consistent and appropriate language/terminology and ensure that the person with COVID-19 can demonstrate understanding of all information

   3.5 Utilise technology where appropriate taking into account access, digital literacy, needs and preferences.

Rationale

Effective communication of the needs assessments, rehabilitation and discharge plans between the person, their families and carers where appropriate, and the teams responsible for their ongoing care ensures that rehabilitation is coordinated and personalised to each individual's needs and goals. The impact of significantly reduced communication with family and friends is an important consideration in personalised communication strategies and provision of information.

People with COVID-19 vary in whether they want partners, family members, friends and carers to be involved in their healthcare and rehabilitation, and how much involvement they want them to have. The physiotherapy workforce need to know and understand these preferences and be aware that they may change over time.

Honest conversations with people, their families and carers need to take place with sensitivity even in difficult circumstances and it is important that there is a coordinated multidisciplinary team (MDT) approach to communication.

Provision of information tailored to a person's preferences, which they can understand and act on, ensures that they are actively involved in shared decision making. Timely and responsive communication and information provision recognises that communication is a two-way process and that the person's circumstances and needs are likely to change over time. Effective communication involves empathetic listening and sharing of experiences with an honest acknowledgement of the uncertainties, acceptance of the evidence gap and openness to draw on other resources such as shared learning from people with COVID-19 and healthcare professionals.

It is important to acknowledge the person's experience of COVID-19, its impact on their wellbeing, and discuss any feelings of worry or distress. Early research has shown that a lack of recognition of the pattern of symptoms by the public and by healthcare services meant people frequently felt their experiences were not believed and this left many feeling isolated and alone in coping with their disease *(NIHR, 2020).*

Communication strategies should be individualised based on personalised needs and informed by current knowledge and experience about the sequelae of COVID-19 and Long COVID, impact of inequalities and disparities in outcomes. Cognition deficits and prolonged delirium need to be taken into account.

Intubation, laryngeal and intubation related injury and compromised respiratory function may affect the person's ability to speak. Assessment and advice from healthcare professionals with relevant expertise about the optimal means of communication may be required. Additional support such as an interpreter, translator or advocate may be required. Extra time may be necessary for effective communication.

It is important to use language and terminology that is understood and acceptable to people with COVID-19. Long COVID was a term that was collectively made by people who experienced COVID-19 and it has been suggested that terminology for long lasting COVID symptoms and the definition for recovery must incorporate their perspectives. *(Long COVID: let patients help define long-lasting COVID symptoms, 2020* ;

Callard and Perego, 2021)

Specialised technology, communication aids and equipment can be utilised to support people with cognitive and language impairments to communicate effectively. Digital resources may facilitate communication and provision of information but digital literacy and digital access, skills and confidence should be taken into account.

Communication and provision of information to support ongoing self-management is particularly important when the person is being discharged from hospital. For further information in relation to self-management refer to the *CSP COVID-19 Rehabilitation standards RS3 (COVID-19 community rehabilitation: physiotherapy service delivery, standard 3).*

Conversations may need to take place using Personal Protective Equipment (PPE) or remotely. The physiotherapy workforce should be mindful of how this may affect communication with the person, families and carers. Other ways of communicating to meet their needs should be considered.

Source guidance

COVID-19 rapid guideline: managing COVID-19 (2021) NICE guideline NG191, recommendation 4

Patient experience in adult NHS services (2019) NICE quality standard QS15, standard 5 and 6

Rehabilitation after critical illness in adults (2017) NICE quality standard QS158, standard 3

Rehabilitation after critical illness in adults (2009) NICE guideline CG83, recommendations 1.7, 1.21, 1.22

COVID-19 clinical management: living guidance (2021) World Health Organisation

COVID-19 Clinical Advice. Supporting people with COVID-19 related illness in the community setting: Clinical management of those with moderate to severe illness Version 2.1 (2020) Scottish Government

COVID-19: Guidance for maintaining services within health and care settings: infection prevention and control recommendations (2020) Department of Health and Social Care.

Implementing phase 3 of the NHS response to the COVID-19 pandemic (2020) NHS England

Living with COVID19: A dynamic review of the evidence around ongoing COVID19 symptoms (often called Long COVID) (2020) National Institute for Health Research.

Reducing health inequalities associated with COVID-19. A framework for healthcare providers (2020) NHS Providers

Your COVID recovery guidance (2020) NHS England and NHS Improvement

Inclusion Health: applying All Our Health (2021) Public Health England

Build back fairer: the COVID-19 Marmot review (2020) Institute of Health Equity

British Society of Rehabilitation Medicine report: Rehabilitation in the wake of COVID-19 - A phoenix from the ashes. Version 1 (2020) British Society of Rehabilitation Medicine, recommendations 8-10

Silver Book II (2021) British Geriatrics Society

Digital Inclusion in Health and Care: Lessons learned from the NHS Widening Digital Participation Programme (2017-2020) (2020) Good Things Foundation

Guidelines for the provision of intensive care services. Edition 2 (2019) The Faculty of Intensive Care Medicine and The Intensive Care Society, section 2.6, standard 8

Developing services for long COVID: lessons from a study of wounded healers (2021) Ladds E et al, Clinical Medicine Journal, 21(1):59-65

Standards of proficiency: Physiotherapists (2013) HCPC, standard 8

Chartered Society of Physiotherapy's Code of Members' Professional Values and Behaviour (2019) CSP, principle 3

Quality standard 4: Coordinated rehabilitation and models of care

Quality statement

4. People who are hospitalised due to COVID-19 receive equitable, individualised rehabilitation that is seamlessly coordinated within multidisciplinary teams and across all relevant settings and services.

4.1 Rehabilitation is delivered by multidisciplinary teams and is based on regular personalised needs assessment

4.2 The individualised rehabilitation plan of people who are hospitalised due to COVID-19 is communicated effectively with the person and with teams responsible for their ongoing care at every transfer point along their care pathway

4.3 Liaise with discharge coordination teams and hospital discharge teams to ensure that discharge arrangements, including equipment provision and appropriate referrals for the necessary ongoing care, are in place before completing the discharge

4.4 The physiotherapy workforce are aware of, and contribute to the development of, equitable rehabilitation models, referral criteria, follow-up arrangements and urgent care pathways.

Rationale

Holistic rehabilitation is best delivered by multidisciplinary teams (MDTs) which include the professionals required to meet the needs of people with COVID-19. This involves coordinating and integrating the necessary expertise identified from regular personalised assessment. Emerging evidence about Long COVID and rehabilitation needs is starting to inform multidisciplinary models, including assessment clinics.

Continuity of rehabilitation with regular assessment, self-management advice and support, optimises recovery. People's needs and symptoms may change quickly and responsive, coordinated communication within MDTs is essential. An agreed transition plan at each point of transfer ensures that a person's specific needs are met, transfers to other services are successful and the likelihood of hospital re-admission is reduced. This enables continuity of care and improves the person's experience of transfer along their care pathway. Effective sharing of information and the rehabilitation plan is essential to delivering integrated rehabilitation and involves close collaboration between health and social care practitioners within and across different services and organisations. A rehabilitation prescription/passport are examples of coordinated communication between the person and the MDT and help ensure consistent use of language.

Ongoing rehabilitation supports physical, psychological (including cognitive) and emotional recovery following a period of hospital admission. Regular assessment ensures that progress towards personalised goals and outcomes are evaluated, and ongoing and new symptoms are monitored. Any new physical, psychological or emotional problems identified require referral to appropriate services. People who are discharged from rehabilitation need to be informed of safety-netting arrangements available if further rehabilitation becomes necessary. The recovery trajectory of people with COVID-19 and Long COVID is not yet fully understood therefore it is essential that input from community rehabilitation services is flexible and responsive to their changing needs. Some people may present with long term sequelae at a later stage and need to be able to re-access rehabilitation services as those needs arise.

Clearly defined, equitable community rehabilitation pathways and referral processes are required to ensure people in community settings, including care homes, can access the right support from the right service and/or member of the MDT at the right time.

The physiotherapy workforce needs to be flexible and responsive to meet the unique needs of the COVID-19 and Long COVID population and facilitate the development of rehabilitation models that are co-produced. It is important to be aware of arrangements and urgent referral pathways available if the person's clinical condition, needs and preferences change. For further information in relation to people with COVID-19 approaching the end of life refer to the *CSP COVID-19 Rehabilitation standards RS2 (Palliative rehabilitation and end of life care: physiotherapy service delivery).*

Source guidance

COVID-19 rapid guideline: managing COVID-19 (2021) NICE guideline NG191, recommendation 4

COVID-19 rapid guideline: managing the long-term effects of COVID-19 (2020) NICE guideline NG188, recommendations 1.10, 7.1, 7.3

Rehabilitation after critical illness in adults (2017) NICE quality standard QS158, standards 2-4

Rehabilitation after critical illness in adults (2009) NICE guideline CG83, recommendations 1.1 and 1.23

Transition between inpatient hospital settings and community or care home settings for adults with social care needs (2015) NICE guideline NG27, recommendation 1.5

COVID-19 clinical management: living guidance (2021) World Health Organisation

In the wake of the pandemic. Preparing for Long COVID (2021) World Health Organisation

COVID-19 Clinical Advice. Supporting people with COVID-19 related illness in the community setting: Clinical management of those with moderate to severe illness Version 2.1 (2020) Scottish Government

COVID-19: Guidance for the commissioning of clinics for recovery and rehabilitation (2020) NHS England and NHS Improvement London

Developing a modelling resource to understand the rehabilitation needs of people during, and following, the COVID-19 pandemic (2020) Welsh Government

Disparities in risks and outcomes of COVID-19 (2020) Public Health England

Framework for supporting people through Recovery and Rehabilitation during and after the COVID-19 Pandemic (2020) Scottish Government

Hospital discharge service: policy and operating model (2020) Department of Health and Social Care

Hospital discharge service requirements: COVID-19 (Wales) (2020) Welsh Government

National guidance for post-COVID syndrome assessment clinics (2020) NHS England

Inclusion Health: applying All Our Health (2021) Public Health England

Universal Personalised Care: Implementing the Comprehensive Model (2019) NHS England

NHS Standard Contract for Specialised Rehabilitation for Patients with Highly Complex Needs (All Ages) (2013) NHS England, D02/S/a

Build back fairer: the COVID-19 Marmot review (2020) Institute of Health Equity

Delivering rehabilitation to patients surviving COVID-19 using an adapted pulmonary rehabilitation approach – BTS guidance (2020) British Thoracic Society

Keeping Me Well: COVID-19 Rehabilitation Model (2020) Cardiff and Vale University Health Board

Rehabilitation in the wake of COVID-19 - A phoenix from the ashes. Version 1 (2020) British Society of Rehabilitation Medicine, recommendations 6, 7, 8-11.

Report of an ad-hoc international task force to develop an expert-based opinion on early and short-term rehabilitative interventions (after the acute hospital setting) in COVID-19 survivors (2020). Section 2 and recommendations 4.3, 4.6, 4.8 and 4.18

Responding to COVID-19 and beyond: A framework for assessing early rehabilitation needs following treatment in intensive care. Version 1 (2020) National Post-Intensive Care Rehabilitation Collaborative

Guidelines for the provision of intensive care services. Edition 2 (2019). The Faculty of Intensive Care Medicine and The Intensive Care Society, section 2.6, standard 8

Developing services for long COVID: lessons from a study of wounded healers (2021) Ladds E et al, Clinical Medicine Journal, 21(1):59-65

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Chartered Society of Physiotherapy COVID-19 Rehabilitation Standards. Palliative rehabilitation and end of life care: physiotherapy service delivery [RS2] (2020) Chartered Society of Physiotherapy

Quality Statement 5:
Evaluation, audit and research

Quality statement 5

5. Physiotherapy services undertake evaluation, audit, research and share good practice to understand the needs of people with COVID-19, improve the quality of services, optimise outcome and experience, and address inequalities.

5.1 Consider the evidence and data requirements for understanding the needs of people with COVID-19, assessing quality of rehabilitation service delivery, measuring patient and carer outcomes and experience, and monitoring for inequalities throughout rehabilitation models

5.2 Physiotherapy services collaborate with people with COVID-19, their families and carers to evaluate, improve and redesign services and rehabilitation models

5.3 Physiotherapy services have robust systems of measurement and monitoring that, where available, are standardised to enable local evaluation and also regional and national interpretation

5.4 Good practice, knowledge and lessons learnt are shared locally, regionally, nationally and internationally.

Rationale

The epidemiology, recovery trajectories and short- and long- term rehabilitation needs and outcomes of people with COVID-19 are not yet fully understood. Developing the evidence base, standards and guidance around COVID-19 and Long COVID, and the impact on physiotherapy and rehabilitation is essential to provide a foundation for future improvements in COVID-19 rehabilitation. Early data and evidence is highlighting that disparities in the risk, impact, and outcomes from COVID-19 exist. Monitoring of health outcomes and social determinants of health through data collection will further improve our knowledge of the health inequalities of COVID-19. This will improve our understanding of aspects of equity, such as access, process and outcomes, in order to develop equitable rehabilitation services.

People who have a lived experience of COVID-19 are best placed to contribute to the evaluation of physiotherapy services offered and should be involved in the earliest stages of evaluation, as well as service design and development. Co-production involves working in equal partnership with people who use physiotherapy services, carers and communities to develop, deliver, monitor and evaluate rehabilitation services and models. Co-production with seldom heard groups gives voice to people who may have previously been considered hard to reach. It helps to develop inclusive participation and enable people to feel more involved with the services they use *(Social Care Institute for Excellence, 2020).*

People with COVID-19 should also be offered the opportunity to be involved in all stages of research. It is important that their expertise, knowledge and experience is incorporated into the evidence base for COVID-19 and Long COVID *(Callard and Perego, 2021).*

Robust systems of measurement and monitoring, including national datasets, such as *United Kingdom Rehabilitation Outcomes Collaborative (UKROC)* can help address gaps in rehabilitation provision and initiate quality improvement programmes. National and regional comparison supports the reduction in variation in access to, and quality of, rehabilitation services. The physiotherapy workforce needs to be aware of and engage in data collection at a local, regional and national level. Available data and emerging research findings can facilitate evaluation and service improvement initiatives.

The COVID-19 pandemic has changed the delivery of rehabilitation and new, innovative approaches have been rapidly developed. Knowledge, skills and training should be shared between services in all settings. It is important that any changes and lessons learnt are captured, evaluated, and shared widely to inform future rehabilitation models. National databases and research are essential to learn more about risk factors, causes, time course and treatments, in partnership with people who have experienced COVID-19 and Long COVID. As COVID-19 is a global pandemic, it is essential to actively seek opportunities to share data and evidence internationally.

Source guidance

COVID-19 rapid guideline: managing the long-term effects of COVID-19 (2020) NICE guideline NG188, recommendation 8.3

In the wake of the pandemic. Preparing for Long COVID (2021) World Health Organisation

COVID-19 Clinical Advice. Supporting people with COVID-19 related illness in the community setting: Clinical management of those with moderate to severe illness Version 2.1 (2020) Scottish Government

COVID-19: Guidance for the commissioning of clinics for recovery and rehabilitation (2020) NHS England and NHS Improvement London

Developing a modelling resource to understand the rehabilitation needs of people during, and following, the COVID-19 pandemic (2020) Welsh Government

Disparities in risks and outcomes of COVID-19 (2020) Public Health England

Evaluating the impact of rehabilitation services post COVID-19 (2020) Welsh Government

Framework for supporting people through Recovery and Rehabilitation during and after the COVID-19 Pandemic (2020) Scottish Government

Implementing phase 3 of the NHS response to the COVID-19 pandemic (2020) NHS England

National guidance for post-COVID syndrome assessment clinics (2020) NHS England

Reducing health inequalities associated with COVID-19. A framework for healthcare providers (2020) NHS Providers

Inclusion Health: applying All Our Health (2020) Public Health England

eHealth and Care Strategy for Northern Ireland (2016) Health and Social Care Board

Informed Health and Care: A Digital Health and Social Care Strategy for Wales (2015) Welsh Government

Ladder of engagement (n.d.) NHS England

Build back fairer: the COVID-19 Marmot review (2020) Institute of Health Equity

Keeping Me Well: COVID-19 Rehabilitation Model (2020) Cardiff and Vale University Health Board

Rehabilitation in the wake of COVID-19 - A phoenix from the ashes. Version 1 (2020) British Society of Rehabilitation Medicine

Responding to COVID-19 and beyond: A framework for assessing early rehabilitation needs following treatment in intensive care. Version 1 (2020) National Post-Intensive Care Rehabilitation Collaborative

A Co-production Model. Five values and seven steps to make this happen in reality (2016) Coalition for Collaborative Care

Developing services for long COVID: lessons from a study of wounded healers (2021) Ladds E et al, Clinical Medicine Journal, 21(1):59-65

Chartered Society of Physiotherapy's Code of Members' Professional Values and Behaviour (2019) Chartered Society of Physiotherapy, principles 1-4

Standards of proficiency- Physiotherapists (2013) Health and Care Professions Council, standards 2, 5-7, 9-12 and 14.

Quality standard 6:
Personal Protective Equipment (PPE) and infection control during rehabilitation

Quality statement

6. The physiotherapy workforce have access to and are provided with the appropriate level of Personal Protective Equipment when providing face to face care.

6.1 Liaise with local infection control policies, in conjunction with national guidance on Personal Protective Equipment so that:

6.1.1 People who are hospitalised and the physiotherapy workforce are appropriately protected from spreading or receiving the virus during physiotherapy care

6.1.2 A risk assessment is completed to ensure staff have access to appropriate Personal Protective Equipment prior to physiotherapy care

6.1.3 Adequate training is available to ensure the safe application and removal of Personal Protective Equipment

6.1.4 Personal Protective Equipment is disposed of in the correct manner and clinical waste disposal policies are adhered to

6.1.5 The physiotherapy workforce are aware of reporting procedures if the correct level of Personal Protective Equipment is not available.

Rationale

Healthcare-associated infections are caused by a wide range of microorganisms including COVID-19 virus. These infections can exacerbate existing or underlying conditions, delay recovery and adversely affect quality of life. Employers are under a legal obligation to adequately control the risk of exposure to hazardous substances where exposure cannot be prevented. The provision and use of Personalised Protective Equipment (PPE), including respiratory protective equipment, will ensure that the risk of spreading the virus to people hospitalised with COVID-19, visitors and other staff is minimal.

Employees have an obligation to make full and proper use of any control measures, including PPE, provided by their employer. Ultimately, where the physiotherapy workforce consider there is an increased risk to themselves or the individuals they are caring for, they should carry out local risk assessments to determine what level of PPE is required. There is also a need to ensure that training is provided to ensure the correct type of PPE is used, applied and removed safely.

Source guidance

Healthcare-associated infections: prevention and control in primary and community care (2017) NICE quality standard CG139, standards 1.1.1-1.1.3

Coronavirus (COVID-19): personal protective equipment (PPE) hub (2020) Department of Health and Social Care

COVID-19: Guidance for maintaining services within health and care settings: infection prevention and control recommendations (2020) Department of Health and Social Care.

Managing risk: infection prevention and control (2020) HCPC

Personal protective equipment (PPE) – guidance, resources and FAQs (2020) CSP

Chartered Society of Physiotherapy's Code of Members' Professional Values and Behaviour (2019) CSP, principles 1.1, 1.3, 3

Standards of proficiency: Physiotherapists (2013) HCPC, standard 15

CHARTERED
SOCIETY
OF
PHYSIOTHERAPY

14 Bedford Row
London WC1R 4ED

Web: ***www.csp.org.uk***

Email: ***enquiries@csp.org.uk***

Tel: ***020 7306 6666***

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