

The Introduction of a Physiotherapy Associate Practitioner role on Critical Care: An innovative service reorganisation to enhance delivery of seven day services and improve efficiency and quality of care.

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Introduction

Rehabilitation after Critical Illness (RaCI) and Enhanced Recovery after Surgery (ERAS) have been areas of increasing focus in acute care over the last decade. Physiotherapy is integral to the delivery of both these pathways. Historical physiotherapy staffing on ICU did not allow the current team to optimise the delivery of post-operative enhanced mobilisation, or to deliver adequate follow-up care for long term ICU patients.

To address these insufficiencies, we developed a non-qualified Physiotherapy Associate Practitioner (PAP) role within ICU to carry a caseload of elective surgical patients. This increased the mobilisation of ERAS patients, and also released a physiotherapist with specialist critical care skills and knowledge to coordinate a multi-disciplinary RaCI service.

Aim

- Improve outcomes and recovery pathway for surgical patients.
- Dedicate more therapeutic time to patients with complex needs.
- Provide a more consistent physiotherapy service on the ICU, seven days a week.
- Develop a multidisciplinary team (MDT) RaCI service, consisting of weekly outreach rounds and monthly outpatient clinic.

Method

1.8 WTE Band 4 PAPs were recruited on a pilot basis. This enabled ERAS over seven days, and facilitated the release of specialist physiotherapy time for RaCI service delivery.

A competency framework and training package was developed to ensure the PAPs were able to meet the specifications of the role. Functional mobility outcome scores at discharge from ICU, and weekend productivity statistics were collected for six months. These were compared with data from the 6 months prior to the pilot commencing.

The senior physiotherapist coordinated a MDT RaCI pathway, as per NICE CG83. This included involvement in each RaCI patient's rehabilitation on ICU, ward-based follow-up and subsequent outpatient review.

Data throughout the first six months of RaCI service delivery was collected and analysed.

Results

	Before pilot	At 6 months	Difference
Average no. of surgical patient reviews per weekend	1.45	17	15.55
Average ICU LOS for surgical patients (hours)	82.5	74.6	7.9
ICU capacity (admissions)	326	363	37
Average functional score (out of 40) at discharge from ICU	19.6	26.4	6.8
NICE CG83 compliance	0%	>90%	>90%
Long stay ICU patients followed up on ward	0	64	64
Long stay ICU patients attending MDT outpatient follow up	0	18	18

Results of six month service improvement pilot.

Conclusion

We have described an innovative service change within the ICU physiotherapy team. This has allowed implementation of an enhanced mobility service 7 days a week, a key component of an ERAS pathway. It has also facilitated the development of a RaCI service, to address the complex needs of long-term ICU patients. The recruitment of PAPs represents a relatively small financial investment, but one that has facilitated a restructure the physiotherapy team, allowing optimisation of resource allocation to different ICU patient groups. Given the current financial constraints on NHS services, this project represents a unique and practical approach to achieving NHS England's

recommendation for safe, sustainable staffing with “*the right staff, with the right skills, in the right place, at the right time*” (National Quality Board 2016).