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PHYSIOTHERAPY

# CSP COVID-19

## Rehabilitation Standards

Rehabilitation of adults who  
are hospitalised due to Covid-19:  
physiotherapy service delivery.

## Version 1, published 13th May 2020

These standards cover rehabilitation for adults of 16 years and over who are admitted to hospital with Covid-19. The standards apply from the point that rehabilitation starts in hospital critical and acute care settings through to step-down rehabilitation facilities and/or ongoing rehabilitation in the community. The standards do not apply to end of life rehabilitation care pathways.

The standards are for physiotherapists delivering rehabilitation in a multidisciplinary care context. They should be used in conjunction with local policies and procedures.

In the extenuating circumstances of Covid-19, decisions about rehabilitation needs and where it is delivered for individual patients takes place rapidly. The standards are key for facilitating safe and rapid decision making and ensuring the delivery of high quality assessment and personalised physiotherapy.

## Quality standards:

1. Assessment and goal setting
2. Timing and intensity of rehabilitation
3. Continuity of care and communication
4. Ongoing rehabilitation in the community
5. Personal Protective Equipment (PPE) and infection control during rehabilitation

# Quality standard 1:

## Assessment and goal setting

### Quality statement 1

- 1. Adults who are hospitalised due to Covid-19 have their rehabilitation needs and goals assessed as soon as practicably possible.**
  - 1.1** Initial assessment of rehabilitation needs takes place as soon as clinically possible and is regularly reviewed.
  - 1.2** Assessment is holistic and includes consideration of risk, co-morbidities, prognosis and what is currently known about Covid-19
  - 1.3** Physiotherapy assessment is documented and contributes to the overall multidisciplinary team (MDT) clinical assessment
  - 1.4** Personalised short- and medium-term goals are developed and documented in collaboration with the MDT and the patient.

### Rationale

Adults who are hospitalised due to Covid-19 need a comprehensive assessment to establish their rehabilitation needs and to put a holistic, individualised rehabilitation plan in place. Time frames for assessment need to be individualised due to the wide variation of presentation in patients with Covid-19. Rehabilitation goals need to be agreed with the patient as early as possible to inform their rehabilitation plan. The needs of patients hospitalised with Covid-19 can change very quickly, therefore goals should be continually reviewed and updated within the rehabilitation plan.

### Source guidance

[\*COVID-19 rapid guideline: critical care in adults\*](#) (2020) NICE guideline NG159, recommendation 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

[\*Intermediate care including reablement\*](#) (2017) NICE guideline NG27, recommendation 1.1.1, 1.1.3, 1.5.10-1.5.12

[\*Rehabilitation after critical illness in adults\*](#) (2009) NICE guideline CG83, recommendation 1.4

[\*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

# Quality standard 2:

## Timing, intensity and frequency of rehabilitation

### Quality statement 2

#### **2. Adults who are hospitalised due to Covid-19 start rehabilitation as early as clinically possible based on individualised clinical assessment and rehabilitation goals.**

- 2.1** Decision on when to start rehabilitation is undertaken in discussion with the multidisciplinary team (MDT) taking into account the patient's medical status
- 2.2** During rehabilitation the patient's clinical presentation (e.g. respiratory and haemodynamic function) requires continuous monitoring
- 2.3** Timing, intensity and frequency of rehabilitation is individualised and flexible to the patient's clinical and individual needs.

### Rationale

Delays in starting rehabilitation can increase the risk of further deterioration in the patient's condition and lead to reduced independence. Starting rehabilitation early can improve physical, psychological (including cognition) and emotional recovery and prevent future problems. However, patients with Covid-19 often have complex medical presentations and therefore the decision of when to start rehabilitation requires discussion amongst the MDT. Early mobilisation, simple exercises and functional activities of daily living are encouraged early in the course of illness when safe to do so.

Patients who are critically ill due to Covid-19 can deteriorate rapidly. Fatigue, breathlessness and oxygen desaturation are common symptoms in these patients and must be monitored and managed carefully during rehabilitation.

### Source guidance

[\*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

[\*Clinical management of severe acute respiratory infection \(SARI\) when COVID-19 disease is suspected\*](#). Version 1.2 (2020) WHO interim guidance, section 9

[\*Physiotherapy management for COVID-19 in the acute hospital setting. Recommendations to guide clinical practice\*](#). Version 1.0. (2020) Thomas P et al, recommendations 6.4-6.6.

*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) Recommendation 4.18

*British Society of Rehabilitation Medicine report: Rehabilitation in the wake of Covid-19 - A phoenix from the ashes.* Version 1 (2020) recommendations 1 and 2

*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

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

# Quality standard 3:

## Continuity of care and communication

### Quality statement 3

**3. The personalised rehabilitation needs and goals of adults who are hospitalised due to Covid-19 are communicated effectively with the patient and with teams responsible for their ongoing care at every transfer point along their care pathway.**

**3.1** 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
- information, including documentation, is communicated between hospitals and to other hospital-based or community rehabilitation services and primary care services.

**3.2** Personalised information developed through shared decision making is communicated in an accessible format with the patient about:

- the patient's critical illness, interventions and treatments
- ongoing rehabilitation, relevant contact details and follow up arrangements
- any resources to support self-directed rehabilitation and equipment needs.

**3.3** Adults 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.

### Rationale

Continuity of rehabilitation is very important because any breaks or gaps can set back or slow down recovery. An agreed transition plan at each point of transfer will help to ensure that a person's specific needs are met, transfers to other services are successful and the likelihood of hospital re-admission is reduced. This helps ensure continuity of care and improve the person's experience of transfer along their care pathway.

People should have overall responsibility for managing their health. This needs to be recognised when providing rehabilitation services and interactions with them. Patients who are hospitalised due to Covid-19 should be able to work with services to actively manage their health and rehabilitation needs, rather than passively receive care from services. Both the multidisciplinary team (MDT) and patients 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, patients contribute the experience of their illness, how they manage their illness, social circumstances, attitudes to risk, values and preferences.

People 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. Partners, family members, friends and carers might need information to help in planning for discharge to home. The physiotherapy workforce need to know and understand these preferences and be aware that they may change over time. Communication may need to take place remotely rather than in person.

## Source guidance

[\*COVID-19 rapid guideline: critical care in adults\*](#) (2020) NICE guideline NG159, 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, standards 2 and 3

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

[\*Rehabilitation after critical illness in adults\*](#) (2009) NICE guideline CG83, recommendations 1.1 and 1.7, 1.21, 1.22

[\*British Society of Rehabilitation Medicine report: Rehabilitation in the wake of Covid-19 - A phoenix from the ashes\*](#). Version 1 (2020) recommendations 8-10

[\*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

[\*Chartered Society of Physiotherapy's Code of Members' Professional Values and Behaviour\*](#) (2019) CSP, principle 3

[\*Standards of proficiency- Physiotherapists\*](#) (2013) HCPC, standard 8

# Quality standard 4: Rehabilitation pathway

## Quality statement 4

**4. Adults who are hospitalised due to Covid-19 receive ongoing rehabilitation delivered by the most appropriate service/team for their needs.**

**4.1** Ongoing and regular assessments are completed to ensure that people are referred to the most appropriate services/team at the right time

**4.2** The physiotherapy workforce are aware of local rehabilitation pathways, referral criteria, follow-up arrangements and safety-netting arrangements to re-enter the pathway.

## Rationale

Patients with Covid-19 present with different recovery trajectories and have different levels of rehabilitation need. Assessment will help determine the most suitable rehabilitation pathway in accordance with the Covid-19 hospital discharge service requirements.

Ongoing rehabilitation is important to support physical, psychological and emotional recovery following a period of critical illness. Regular assessment ensures that progress towards rehabilitation goals is monitored. Any new physical, psychological (including cognition) or emotional problems identified require onward referral to appropriate services. Patients who are discharged from the rehabilitation pathway need to be informed of safety-netting arrangements available if further rehabilitation becomes necessary.

## Source guidance

[\*Covid-19 hospital discharge service requirements\*](#) (2020) Department of Health and Social Care.

[\*COVID-19 rapid guideline: critical care in adults\*](#) (2020) NICE guideline NG159, recommendation 5

[\*Rehabilitation after critical illness in adults\*](#) (2017) NICE quality standard QS158, standard 4

[\*Rehabilitation after critical illness in adults\*](#) (2009) NICE guideline CG83, recommendations 1.1 and 1.23

[\*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

[\*British Society of Rehabilitation Medicine report: Rehabilitation in the wake of Covid-19 - A phoenix from the ashes\*](#). Version 1 (2020) recommendations 6, 7 and 11.

*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

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

# Quality standard 5:

## Personal Protective Equipment (PPE) and infection control during rehabilitation

### Quality statement 5

- 5. When providing face to face rehabilitation with adults with or after Covid-19, the physiotherapy workforce have access to and are provided with the correct and appropriate level of Personal Protective Equipment (PPE).**
- 5.1** Liaise with local infection control policies, in conjunction with national guidance on PPE so that:
- 5.1.1** Adults with or after Covid-19 and the physiotherapy workforce are appropriately protected from spreading or receiving the virus during rehabilitation sessions
  - 5.1.2** Further risk assessment is considered in specific situations if deemed necessary, to ensure staff have access to appropriate PPE prior to rehabilitation sessions
  - 5.1.3** Adequate training is available to ensure confidence in the application and removal of PPE prior to and after rehabilitation sessions
  - 5.1.4** The physiotherapy workforce are aware of reporting procedures if the correct level of PPE 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 PPE, including respiratory protective equipment (RPE), will ensure that the risk of spreading the virus to patients, 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

[\*COVID-19: infection prevention and control guidance\*](#) (2020) Department of Health and Social Care.

[\*Guidance: COVID-19 personal protective equipment \(PPE\)\*](#) (2020) Department of Health and Social Care. Section 4.

[\*Personal protective equipment \(PPE\) FAQs\*](#) (2020) CSP

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

[\*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



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