



A quick guide for occupational therapists: **Rehabilitation for people recovering from COVID-19**

At the present time, understanding and evidence of the acute and long-term symptoms and impairments experienced by people recovering from COVID-19 are still emerging. The health and social care response to the pandemic, however, is evolving rapidly as more is known about the ways in which the virus affects people.

Occupational therapists and other health professionals are observing a range of respiratory, musculoskeletal, neurological and psychological deficits in individuals who have received hospital treatment for the virus. This means that as more people are being discharged from hospital, combined with those recovering in the community, the number requiring rehabilitation is growing rapidly. It is critical that these people have access to rehabilitation in order to have the best possible chance of maximising their recovery.

As experts in holistic rehabilitation, occupational therapists have a vital role to play in addressing the debilitating effects of COVID-19

As experts in holistic rehabilitation, occupational therapists have a vital role to play in addressing the debilitating effects of COVID-19. By offering a personalised and occupation-focused approach to care, they support the recovery of people experiencing functional challenges arising from the virus and its treatment, especially where treatment has been received in an Intensive Care Unit (ICU).



What does this quick guide cover?

The purpose of this guide is to provide occupational therapists and service managers with a practical checklist of points to consider in relation to the potential rehabilitation needs of people recovering from COVID-19. It can be used to plan and structure appropriate occupational therapy provision.

It is intended for use by occupational therapists based in acute and community services, within NHS, local authority, integrated and non-statutory settings. It should be read alongside current government and national COVID-19 guidance.

This guide provides a broad overview of the interventions that occupational therapists should consider at each stage of a person's treatment and recovery journey. It does not cover specific strategies for interventions. Guidance, information and resources to inform occupational therapy practice and support development of interventions that address a range of therapeutic needs are available at: rcot.co.uk

Keeping up to date with the evidence

As registered healthcare professionals, occupational therapists are advised to keep informed of the emerging evidence base regarding the functional impacts of COVID-19 and its treatment, and to utilise the existing evidence base regarding specific occupational therapy interventions.

The RCOT library is compiling and updating a repository of documents relating to occupational therapy and COVID-19. Members can access this information via the RCOT Library Catalogue using the search term COVID-19. Available at: rcot.co.uk/practice-resources/library-resources/search-library-catalogue

Impairments affecting COVID-19 patients

Evidence regarding the acute and long-term functional impacts of COVID-19 is currently limited, and will continue to grow as more people are treated for, and recover from, the virus globally. The following list, though not intended to be exhaustive, outlines deficits that have been observed by health professionals working with people being treated for COVID-19, which are likely to affect functional performance.

As evidence continues to emerge, the prevalence of specific symptoms will become more apparent, and we will develop a greater understanding of the long-term functional impacts of the virus on different populations. It is important to consider that some of the impairments listed below may be common in people being treated in acute settings, but may have resolved by the time a person is discharged. Similarly, additional impairments may be identified over time, which had not been apparent in the early stages of treatment and recovery.

Musculoskeletal/Physical

- | | |
|---|--|
| <ul style="list-style-type: none"> • Overwhelming fatigue • Muscle deconditioning • Global muscle weakness • Neuropathy | <ul style="list-style-type: none"> • Reduced range of movement in upper limb • Upper limb oedema • Pain and discomfort • Changes to vision, and sight loss |
|---|--|

Cardiopulmonary

- | | |
|---|---|
| <ul style="list-style-type: none"> • Breathlessness • Limited exercise tolerance • Postural hypotension • Rapid oxygen desaturation during exertion | <ul style="list-style-type: none"> • Dysfunctional breathing patterns • Hyperventilation • Continued cardiac issues e.g. atrial fibrillation and arrhythmias |
|---|---|

Communication

- | | |
|--|--|
| <ul style="list-style-type: none"> • Post intubation swallowing and feeding needs (dysphagia) • Speech difficulties (dysarthria and dysphasia) | <ul style="list-style-type: none"> • Difficulty using alternative communication aids due to cognitive and musculoskeletal impairments |
|--|--|

Neurological

- | | |
|---|--|
| <ul style="list-style-type: none"> • Reduced wakefulness • Impaired consciousness • Ongoing delirium • Severe attention deficits and poor concentration • Visuospatial • Agitation, pacing and 'wool picking' | <ul style="list-style-type: none"> • Disorientation • Executive dysfunction • Critical illness neuropathy / myelopathy • Impulsivity • Disinhibition • Reduced working memory and no memory of admission |
|---|--|

Psychological

- | | |
|---|--|
| <ul style="list-style-type: none"> • Loss of confidence and trust in own body • Fear – particularly when waking in an environment of personal protective equipment (PPE) • Loss of dignity and control • Anxiety, panic attacks • Low mood, depression | <ul style="list-style-type: none"> • Grief • Problems with body image, related to treatment • Reduced grounding in own experiences • Exacerbation or relapse of existing mental health conditions • Post traumatic stress disorder (PTSD) |
|---|--|

The impact of being a patient in an Intensive Care Unit (ICU)

For people who have experienced a prolonged stay in the ICU, lung function, physical functioning and emotional wellbeing are affected.¹ Common symptoms reported one year later by people who have been in ICU include anxiety (34%), depression (33%) and post-traumatic stress disorder (19%).² People with acute respiratory distress syndrome may also experience cognitive abnormalities, particularly in memory and executive function.³

Post-intensive care syndrome (PICS) describes a collection of difficulties that people may experience following a critical care admission. These include physical, cognitive and psychological difficulties which can be prolonged, lasting as long as 15 years, and are known to impact on return to usual occupations and work.⁴ This can have a significant financial impact on the person, their family and on the state. Families have to take on new care roles and may also experience the psychological impacts of PICS-F with anxiety, depression and PTSD. Early rehabilitation is indicated by occupational therapy, physiotherapy and speech and language therapy to improve the person's outcomes and quality of life.

The prevalence of PICS in people who have received ICU treatment for COVID-19 is yet to become apparent, but there is a growing awareness that there is likely to be a considerable increase in the number of people requiring rehabilitation to address difficulties associated with the syndrome.⁵

Estimating the rehabilitation needs of COVID-19 patients

The full extent of the rehabilitation needs of people recovering from COVID-19 are not yet known, however, the *NHS Discharge to Assess Model*⁶ predicts that:

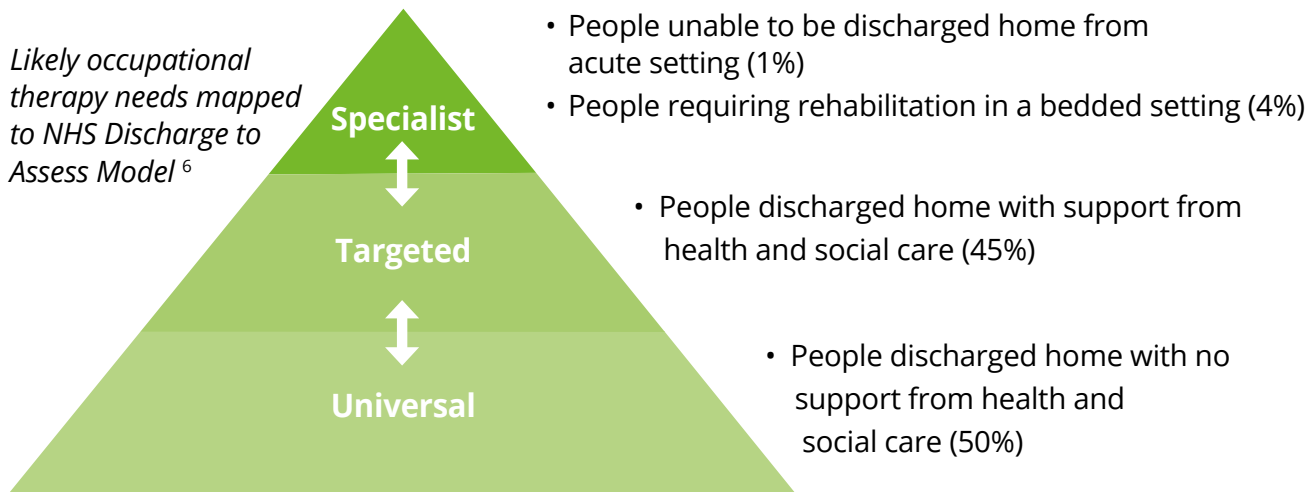
- 50% of people will not require health or social care input post-discharge
- 45% of people will be able to be discharged home with support from health and social care
- 4% of people will require rehabilitation in a bedded setting
- 1% of people will have experienced a life-changing event and will be unable to be discharged home from the acute setting.

It is likely that some people who have experienced COVID-19 but have not been hospitalised will also have rehabilitation and support needs, and the extent of this need is not yet understood.

The type and intensity of occupational therapy input required by people recovering from COVID-19 is likely to vary greatly and should be identified and delivered using person-centred principles. It is worth noting that people who are most affected by COVID-19 may be more likely to have other underlying health conditions,^{7,8} and some previous life experiences may increase the likelihood of psychological difficulties arising from COVID-19 treatment.⁹ Appropriate consideration should be given to individuals' personal, medical and functional history when selecting appropriate assessment and intervention approaches.

When structuring occupational therapy provision and identifying an appropriate staff and skills mix, it is helpful to consider whether the needs of patients and service users are likely to be specialist, targeted or universal.

- **Specialist** approaches support individuals with the most complex needs who require individualised input
- **Targeted** approaches support people whose needs are less complex and who are at lower risk, but still require bespoke input
- **Universal** approaches facilitate self-management for those with straightforward needs, and may also complement targeted approaches.



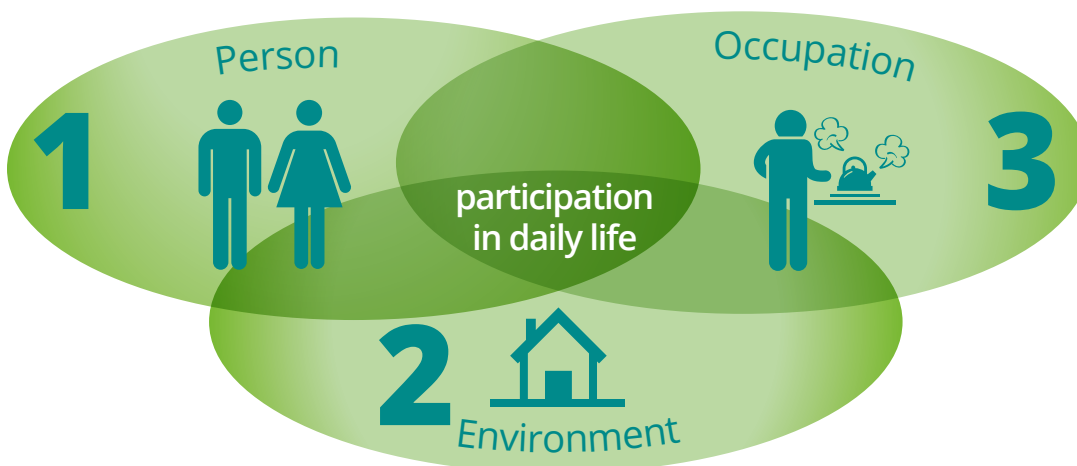
Best practice principles for all settings

The person being supported, and the occupations that matter to them, should be at the heart of all occupational therapy practice, regardless of the setting.

Models, such as the Person-Environment-Occupation (PEO) Model,¹⁰ can be used to guide practice and ensure that interventions retain an occupation focus, especially in critical and acute settings where participation in activities of daily living is likely to be restricted. The model also supports therapists to consider how the person's needs might change over time and in different environments, assisting with long-term goal setting and discharge planning.

Occupational therapy approach

(PEO model¹⁰)



Person:

Occupational therapists bring a unique perspective to a multidisciplinary approach, focusing on a person's ability to participate in daily life. Sudden and traumatic changes impact on a person's psychological, physical and cognitive ability to function. Ongoing assessment should also consider the impact on the person's identity, relationships, roles and responsibilities in the immediate and longer term, as well as identifying retained skills and strengths that can be used to overcome barriers to performance and participation in occupations.

Environment:

The person's environment will have an impact upon each stage of rehabilitation, supporting or hindering their performance or ability to participate. Occupational therapists will consider how the person can adapt to the physical environment and how the environment may be modified, but the social environment is very important in this context with barriers such as personal protective equipment (PPE) and ongoing social isolation. Facilitating communication while in isolation and holding difficult conversations about future outcomes will be fundamental to successfully working with and supporting the person. Family members and carers should be included in these discussions wherever appropriate.

Occupations:

Working with the person and, when appropriate, family members and carers, occupational therapists support people to identify valued occupations, establish goals and participate in interventions that facilitate recovery and rehabilitation of daily living skills. For individuals who have received intensive treatment for COVID-19, this will inevitably start with personal care, but supporting the person to achieve an occupational balance throughout their stages of recovery will support motivation and wellbeing.

Occupational therapists must also consider the impact of infection control on commonly used assessment and treatment techniques, and will need to adapt accordingly. The Royal College of Occupational Therapists' *Code of Ethics and Professional Conduct*¹¹ clearly states:

3.2.11. You must take appropriate precautions to protect service users, their carers and families, and yourself from infection in relation to personal, equipment and environmental cleanliness. Local infection control guidance and policy should be followed.

When providing occupational therapy for people recovering from COVID-19, routine professional activity such as record keeping, risk management, and safeguarding confidentiality is every practitioner's responsibility. Adherence to regulatory and professional body requirements is assumed.^{11,12,13,14,15,16}

Occupational therapists' duty of care extends to considering their own health and wellbeing. Resources supporting the mental health and wellbeing of the occupational therapy workforce can be found at: rcot.co.uk/coronavirus-covid-19-0

Assessment and outcomes:

Assessment is fundamental to effective occupational therapy practice. It underpins all subsequent decisions including agreeing individualised goals and selecting appropriate interventions. There are a number of existing evidence-based tools that cover the areas of functional impairment experienced by people recovering from COVID-19.

Some assessment tools can be used as an outcome measure if they have robust measurement properties (e.g. in terms of validity, reliability and responsiveness). RCOT does not make specific recommendations about what assessments and outcome measures individual practitioners or teams should use. It is important to apply clinical reasoning, taking into consideration the needs of the people who are being supported, and the parameters of the service.

When selecting an assessment or outcome measure practitioners should consider:

- The reliability, validity and responsiveness of the assessment/outcome measure
- Whether it has been validated for use with a UK population, and for the relevant client group
- Whether the handling and storage of data complies with the General Data Protection Regulation (GDPR) and other information governance requirements.

Advice and further information is available at:

rcot.co.uk/practice-resources/occupational-therapy-topics/assessments-and-outcome-measures

Areas for suggested occupational therapy interventions

The suggested assessment and intervention areas provided in this guide are not exhaustive, and not all suggestions will be necessary or appropriate for every individual.

The intention is to provide a broad overview of the interventions that occupational therapists should consider at each stage of a person's treatment and recovery journey. This has been structured around the main practice settings where occupational therapists are working with people with COVID-19.

1. Critical care settings

2. Inpatient/step-down rehabilitation following discharge from ITU or acute ward

3. Community rehabilitation

4. Outpatient clinics

Practitioners should apply person-centred reasoning to identify appropriate, personalised approaches that address the needs of each individual they work with, informed but not constrained by the practice settings in the following tables.

Occupational therapy needs

People being supported in this setting are likely to have highly complex needs requiring specialist intervention.

The Faculty of Intensive Care Medicine and Intensive Care Society *Guidelines for the provision of intensive care services*¹⁷ recommend that:

The critical care team should include a senior occupational therapist with sufficient experience to contribute to and develop rehabilitation programmes that address the complex functional, cognitive and psychosocial needs of the patient cohort.

If there is no existing provision of occupational therapy within the critical care unit, consultative in-reach of occupational therapists into ICU should be made available when required. Where occupational therapy staff are redeployed to critical care settings they should be provided with appropriate training and supervision to ensure that they have the necessary knowledge and competencies to practice safely and effectively in the setting.^{12,14}

With appropriate supervision and training, unregistered occupational therapy and AHP staff can provide support.

Occupational therapy knowledge and skills

- Ability to assess and manage people who are critically unwell, with very complex needs
- Ability to risk assess whether therapy input is appropriate, and recognise changes in vital signs that indicate when sessions should be stopped
- Experience of working with people on ventilators, with tracheostomies and other medical attachments
- Competence in manual handling and positioning
- Experience of working with people with complex neurological presentations and in low wakefulness or arousal
- Competence around need for splinting.

Considerations for occupational therapy interventions

Screening and assessment

Maintaining an occupation focus:

- Information gathering – from the person, family members, carers Identify occupational baselines, social and mental health history
- Cognition – through function, as well as standardised screening and assessment tools
- Delirium
- Wakefulness and awareness – for those who are slow to wake from sedation or experience prolonged consciousness disorders
- Physical abilities – strength, tone, gross and fine motor skills, coordination
- Myopathy and neuropathy
- Communication
- Perception and vision
- Mental health – fear, anxiety and mood
- Mental capacity
- Functional outcome, independence and activity measures.

Goal setting	<ul style="list-style-type: none"> • Completed with the person whenever possible, or family and carers • Activity analysis and grading of tasks to support gradual regaining of function for people with limited exercise and activity tolerance • Short-term goals – what does the person want and need to be able to do? Interventions to reduce likelihood of long-term impairments; skills to support hospital discharge (mobility, seating, self-care) • Long-term goals – skills to support return to desired occupations (self-care, productivity, leisure).
Prevention and management of physical disability	<ul style="list-style-type: none"> • Advice on bed and chair positioning regimes, to maintain range of movement, manage muscle tone changes and facilitate occupational engagement • Manual handling and proning assistance, alongside MDT colleagues • Provision of specialist seating to enable occupational engagement • Consideration of pressure care needs, alongside MDT colleagues • Upper limb management, addressing loss of range and oedema • Upper and lower limb splinting, when of clinical benefit (not routinely).
Occupational engagement	<ul style="list-style-type: none"> • Advice on management of breathlessness and fatigue. Consider grading and pacing of tasks, and teach energy conservation strategies • Early and complex rehabilitation to improve static and dynamic sitting balance and tolerance • Early and complex rehabilitation to promote mobility and function • Personal care – daily practice of washing, dressing and grooming tasks • Facilitate autonomy and control through adaptation of yanker suction tubing, bed controls and engagement in routine, timetabling and goal setting • Communication – alongside speech and language therapists, consider compensatory, adaptive strategies and use of technology as appropriate • Feeding and drinking – consider compensatory/adaptive equipment as required to improve independence and use of gross upper limb movements. Provide advice to nursing staff regarding cognitive strategies • Engagement in leisure activities to promote physical, cognitive and psychological recovery as well as provide diversion. Individually selected based on person's choice and equipment available.

Psychological interventions

- Listen to the patient's lived experience, normalising their experience and supporting a feeling of safety
- Enabling connection with family and friends – using digital tools, photographs and letters
- Rest and relaxation – provide access to appropriate mindfulness and wellbeing tools, with the support of technology when available
- Encourage use of sleep hygiene strategies
- Consider use of patient diaries to promote recovery following discharge.
- Management strategies for anxiety symptoms, including referral to appropriate psychological services in liaison with MDT. Consider anxiety component to breathlessness and dysfunctional breathing
- Consideration of low mood and strategies to improve mood, including timetabling and engagement in enjoyable activities. Referral to appropriate psychological/ psychiatric services in liaison with the MDT.

Discharge planning and onward referrals

- Onward referrals to inpatient and community services as early as possible to expedite discharge process
- Early preparation for community discharge through liaison with family
- Risk assessment for step-down to ward, particularly for individuals with delirium, agitation or inability to communicate or call for help
- Handover to onward therapy teams regarding current goals and rehabilitation plans, sharing results of assessments and outcome measures as appropriate and permitted
- Advice to person and/or their family regarding legal rights in relation to work, sick pay and what to inform their employer of. Signposting regarding finances and benefits to manage bills during hospital stay
- Information for the person and their family/carers about the possible long-term functional impact of critical care treatment.

2. Inpatient/step down rehabilitation following discharge from ITU or acute ward

Specialist



Targeted

Occupational therapy needs

People being supported in this setting are likely to have complex needs, requiring specialist and targeted interventions.

Occupational therapists with experience of assessing and supporting people with complex needs and with tracheostomies can provide supervision for occupational therapists without this experience, or with limited experience of working with people following critical care.

Consultative out-reach of occupational therapists from ICU may be appropriate where competencies required are complex and occupational therapists do not have critical care experience.

With appropriate supervision, unregistered occupational therapy and AHP staff can provide support.

Occupational therapy knowledge and skills

From ICU:

- Experience of assessing and supporting people with complex needs
- Experience of working with people with tracheostomies
- Knowledge of impairments following critical care admissions
- Knowledge of discharge planning and community referral pathways.

From acute:

- Experience of assessing and supporting people with complex needs
- Knowledge of discharge planning and community referral pathways.

Considerations for occupational therapy interventions

Screening and assessment

Applying an occupation focus, consider what assessments and interventions have already been completed with the person in the critical care and/or acute setting, refer to previous results as appropriate and only repeat where needed to establish current level of function.

- Breathlessness
- Fatigue
- Specialist assessment of posture and seating for provision of appropriate seating on the rehabilitation unit and to identify seating requirements for discharge
- Physical abilities – strength, tone, gross and fine motor skills, coordination
- Equipment and assistance required with activities of daily living
- Cognition – through function, as well as standardised screening and assessment tools
- Perception and vision
- Communication
- Need for step-down care
- Mental health – fear, anxiety and mood
- Mental capacity
- Identification of post intensive care syndrome (PICS) and recommendations for management plan
- Functional outcome, independence and activity measures.



Goal setting	<ul style="list-style-type: none"> • Discuss and agree with the person, and family and carers if appropriate, taking a <i>'what matters to you'</i> approach • Short-term goals – interventions to reduce likelihood of long-term impairments; skills to support hospital discharge (mobility, seating, self-care) • Long-term goals – skills to support return to desired meaningful occupations, which may be progressed further in the community (self-care, productivity, leisure) • Apply activity analysis and graded tasks to support regaining function for people with limited exercise and activity tolerance • Risk assess to support positive risk taking strategies to help the person regain function and confidence.
Occupational engagement	<ul style="list-style-type: none"> • Position management – advising on range of movement and muscle tone changes through 24-hour positioning regime and interventions, including splinting as required for the upper limb, correct positioning of feet and lower limb splints • Intensive rehabilitation to improve functional sitting ability, tolerance, balance and mobility • Advice on management of breathlessness and fatigue, alongside physiotherapists. Consider grading and pacing of tasks, and teach energy conservation strategies • Functional upper limb rehabilitation and retraining • Rehabilitation of transfers and mobility • Personal care – toileting and continence management; daily practice of washing, dressing and grooming tasks • Interventions to aid communication, drinking and feeding, in conjunction with speech and language therapists • Cognitive rehabilitation and delirium management • Engagement in leisure activities to promote physical, cognitive and psychological recovery as well as provide diversion. Individually selected based on person's choice and equipment available.
Psychological interventions	<ul style="list-style-type: none"> • Listen to the person's lived experience, normalising their experience and supporting a feeling of safety • Enabling connection with family and friends – using digital tools, photographs and letters • Rest and relaxation – provide access to appropriate mindfulness and wellbeing tools, with the support of technology when available • Encourage use of sleep hygiene strategies • Consider use of a diary to promote recovery following discharge • Application of trauma-informed approaches • Management strategies for anxiety symptoms, including referral to appropriate psychological services in liaison with MDT. Consider anxiety component to breathlessness and dysfunctional breathing • Consideration of low mood and strategies to improve mood, including timetabling and engagement in enjoyable activities. Referral to appropriate psychological/psychiatric services in liaison with the MDT.

Discharge planning and onward referrals

- Cognitive review and intervention prior to discharge including strategies and education
- Consider physical environment of discharge location, and arrange provision of necessary equipment and environmental adaptations
- Consider social environment of discharge location and support needs of the household, making onward referrals to social care as needed
- Ensure discharge arrangements protect other vulnerable members of the household, e.g. if person requires an additional period of self-isolation upon discharge
- Provide welfare and return to work advice, including graded adaptation discussions
- Make onward referrals for community-based physical and psychological rehabilitation
- Education and liaison with family and carers regarding discharge and support needs
- Complex discharge planning and risk assessment if patient is to be discharged with artificial airway or non-invasive ventilation
- Provide information to person, family and carers regarding post-COVID-19 fatigue, psychological changes, cognition, and breathlessness.

3. Community rehabilitation

Occupational therapy needs

People being supported in the community may have a wide range of short and long-term rehabilitation needs. Complex needs will require a specialist occupational therapy approach, while more straightforward needs will benefit from targeted, occupation-focused support and application of universal self-management techniques.

Occupational therapists may be based in health, local authority or integrated statutory services, as well as being employed by charities and other non-statutory providers.

With appropriate training and supervision, unregistered occupational therapy and AHP staff can provide support. Colleagues from other professions with relevant training may also be well-placed to deliver certain targeted and universal interventions, for example social prescribing link workers and exercise professionals.



Occupational therapy knowledge and skills

- Experience of assessing and supporting people with complex needs
- Experience of supporting people receiving oxygen therapy
- Experience of supporting people with tracheostomies
- Experience of environmental assessment and specification of adaptations
- Knowledge of a range of physical and neurological impairments
- Knowledge of mental health conditions including anxiety, depression and PTSD
- Competence in screening for mental health needs and providing psychosocial interventions to aid wellbeing and acceptance
- Triage and risk assessment skills – to identify the right support to address people's needs and establish need for immediate or delayed occupational therapy input
- Awareness of existing community pathways and availability of specialist local services, e.g. psychological, pulmonary, respiratory.

Considerations for occupational therapy interventions

Screening and assessment

Maintaining an occupation focus:

- In liaison with hospital discharge team, urgent environmental assessment to facilitate safety and independence in the home
- Information gathering from individual, family and carers – establish pre-morbid baseline and any reported or perceived changes to functional independence in activities of daily living
- Functional assessments to identify:
 - cognitive and physical abilities during activities of daily living, mobility and transfers
 - attention, memory, executive functioning, orientation
 - posture and positioning, tolerance, muscle strength, upper limb function
- Screening for visual difficulties and sensory changes
- Screening for anxiety and depression
- Capacity and insight assessments
- Safeguarding review and alerts/implementation of Adults with Incapacity Procedures (Scotland).¹⁸

Goal setting

- Ongoing goal setting and review that follows a model of coaching and active listening: supporting the person to have complex and difficult conversations around what matters to them
- Building confidence through positive experiences
- Supporting the person to establish a healthy occupational balance between self-care, productivity and leisure
- Using a graded approach to build resilience and skills to return to roles, routines and occupations.

Occupational engagement

Specialist/Targeted

- Environmental interventions – teach strategies, advise on assistive technology and adapt the home to aid safety and independence
- Cognitive rehabilitation – executive functioning, memory, orientation. Teaching strategies, use of memory aids and communication approaches to enhance independence. Referring to specialist neurological and memory services as needed
- Provision and grading of occupation-focused upper limb exercise programme
- Moving and handling interventions – specification of hoisting equipment and training of carers
- Mobility interventions and specification of mobility aids. Onward referrals for wheelchair services, falls prevention and strength and balance programmes
- Identify need for long-term compensatory measures, e.g. home adaptations, re-housing and referral as appropriate
- Vocational rehabilitation – grading, work hardening, employer liaison
- Education and intervention around psychological wellbeing. Address the barriers to people staying connected with families, friends, work and their community
- Encourage engagement in meaningful occupations, physical activity and relaxation to promote wellbeing and reduce symptoms of mental ill health
- Onward referral and collaboration where additional specialist input is required, e.g. cardiac, pulmonary, psychological.

Targeted/Universal

- Leadership and supervision of reablement services
- Breathlessness and fatigue management – education, intervention and review. Self-management techniques – pacing, grading, prioritising, relaxation
- Sleep hygiene education
- Facilitation of group/individual rehabilitation delivered by other competent professionals, e.g. upskilling and training of therapy assistants, support workers and leisure providers
- Provision of 'remote' services where interventions can be provided effectively via phone or video call
- Referrals to social prescribing schemes and signposting to community organisations and welfare rights advice
- Creation of self-management resources suitable for a range of audiences
- Education, advice and support for family and carers.

4. Outpatient clinics

Occupational therapy needs

People recovering from hospital admissions due to COVID-19 may have a wide range of short and long-term rehabilitation needs.



Some areas may consider setting up local post-COVID-19 MDT clinics, or follow-up of people recovering from the virus in existing outpatient settings. The role of occupational therapists in these clinics will overlap with colleagues in community-based services, and collaboration and communication between settings should be encouraged to provide an effective and efficient service to individuals.

Acknowledgements

This guide has been compiled with support and expertise from occupational therapists working in a range of settings, including critical care and neurological, respiratory and pulmonary practice. The Royal College of Occupational Therapists would like to thank all contributors for their valued input.

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