Agencja Oceny Technologii Medycznych i Taryfikacji

Wydział Świadczeń Opieki Zdrowotnej

Załącznik 4. Przegląd rekomendacji i wytycznych klinicznych wybranych elementów procesu diagnostyczno-terapeutycznego rehabilitacji leczniczej

Zmiana technologii medycznych w zakresie rehabilitacji neurologicznej

Nr: AOTMiT-WS.431.5.2018

Data ukończenia: 24.04.2019 r.

Opis metodyki

W dniach 7 – 16 styczeń 2018 r. przeszukano strony internetowe polskich oraz zagranicznych i międzynarodowych towarzystw naukowych, organizacji i instytucji zajmujących się rehabilitacją, a także strony internetowe wybranych organizacji zajmujących się HTA i EBM w celu odnalezienia dokumentów zawierających aktualne zalecenia dotyczące:

- zasadności przeprowadzenia wstępnej **porady kwalifikacyjnej (lekarskiej)** oraz **wizyty kwalifikacyjnej (fizjoterapeutycznej)** - mają one na celu ocenę stanu pacjenta (przede wszystkim funkcjonalną), wyznaczenie realnego celu, udzielenie instruktażu i zasadności dalszej rehabilitacji/fizjoterapii;
- zasadności o**ceny stanu funkcjonalnego pacjenta**, zdefiniowania **celu terapeutycznego**, określenia **planu terapii** oraz przeprowadzenia oceny **efektów terapii,** jako integralnych elementów procesu diagnostyczno-terapeutycznego w rehabilitacji;
- zasadność oceny stanu funkcjonalnego pacjenta za pomocą **narzędzi pomiarowych wskazanych przez nas dla poszczególnych świadczeń rehabilitacji neurologicznej.**

Przeprowadzono również wyszukiwane wolnotekstowe z wykorzystaniem słów kluczowych: „neurological rehabilitation", „rehabilitation", „physiotherapy", „neurorehabilitation", „guidelines", „recommendations" oraz nazwy poszczególnych chorób neurologicznych.

Wyszukiwaniem objęto lata 2003–2018, uwzględniając wyłącznie publikacje w językach polskim i angielskim. Wyszukiwanie przeprowadziło 6 analityków, w kolejnym etapie prace były poddawane szczegółowej analizie, a w kwestiach wątpliwych dążono do konsensusu lub zasięgano opinii osoby trzeciej.

W wyniku prac znaleziono 81 dokumentów, z których w 23 nie zidentyfikowano informacji odnośnie do rehabilitacji pacjentów. W 29 dokumentach nie odnaleziono zaleceń dotyczących kwalifikacji pacjentów oraz szczegółowych wymagań odnośnie do oceny stanu funkcjonalnego pacjentów. W opracowaniu uwzględniono ostatecznie 29 dokumentów, w tym: 27 dokumentów wytycznych postępowania klinicznego oraz 2 dokumenty opisujące standardy opieki. Publikacje poddano ocenie pod kątem jakości metodologicznej zgodnie z wymaganiami domeny 3. narzędzia AGREE II. Spośród poddanych ocenie publikacji większość została oceniona jako publikacje o dostatecznej jakości (wynik w Domenie 3 wynosił ponad 40%), ocenę dobrą (powyżej 70%) otrzymało kilkanaście publikacji. Szczegóły przedstawiono w punkcie dotyczącym *Ograniczeń analizy.*

Podsumowanie i wnioski

Zalecenia dotyczące przeprowadzenia porady lub wizyty kwalifikacyjnej przed rozpoczęciem przez pacjenta rehabilitacji odnaleziono w 29 dokumentach wytycznych praktyki klinicznej. Wszystkie z odnalezionych dokumentów rekomendują przeprowadzenie oceny stanu pacjenta przed zakwalifikowaniem go do świadczenia rehabilitacji, określenie celów rehabilitacji oraz przygotowanie planu terapii. W odnalezionych dokumentach pojawiają się znaczne różnice w określeniu specjalizacji osoby udzielającej porady kwalifikacyjnej. Część dokumentów wskazuje, iż świadczenia udzielić powinien lekarz podstawowej opieki zdrowotnej, lekarz rehabilitacji medycznej lub fizjoterapeuta. Jednocześnie, 13 dokumentów zaleca przeprowadzenie porady kwalifikacyjnej przez zespół multidyscyplinarny, w którego skład wchodzić powinni m.in.: neuropsycholog, logopeda, terapeuta zajęciowy, fizjoterapeuta, dietetyk. (Szczegółowe zalecenia dotyczące składu zespołu mogą różnić się pomiędzy poszczególnymi dokumentami.)

Odnaleziono 5 dokumentów (BSRM 2003, AANSCNS 2013, NICE 2013, LCA 2014, RCP 2016) zalecających wykorzystanie narzędzi pomiarowych w celu oceny stanu pacjenta, z kolei w trzech dokumentach zaproponowano konkretne nazwy skal:

- AANSCNS 2013: The American Spinal Injury Association international standards, The Spinal Cord Independence Measure III, The International Spinal Cord Injury Basic Pain Data Set,
- NICE 2013: National Institutes of Health Stroke Scale oraz Barthel Index,
- LCA 2014: International Classification of Functioning, Disability and Health (ICF).

L.p.	Schorzenie	Publikacja	Zalecenia	Uwagi
1	2	3	4	5
1.	**Fizjoterapia domowa dla pacjentów z ogniskowymi uszkodzeniami mózgu**			
1.1.1.	Udar mózgu	NSF 2010	3.5.a. Pacjenci po udarze, u których po zakończeniu formalnej rehabilitacji utrzymuje się upośledzenie resztkowe, powinni co roku być poddani kontrolnym badaniom lekarskim przeprowadzonym przez lekarza POZ lub rehabilitanta w celu określenia, czy konieczna jest dalsza rehabilitacja. W przypadku pojawiania się nowych problemów zdrowotnych lub zmian w najbliższym środowisku pacjenta, należy go skierować do dalszej oceny przez odpowiednich pracowników służby zdrowia lub specjalistów z zakresu rehabilitacji. [GPP] *3.5.a. Stroke survivors who have residual impairment at the end of the formal rehabilitation phase of care should be reviewed annually, usually by the general practitioner or rehabilitation provider to consider whether access to further interventions is needed. A referral for further assessment should be offered for relevant allied health professionals or general rehabilitation services if there are new problems not present when undertaking initial rehabilitation, or if the person's physical or social environment has changed. [GPP]* 3.5.b. Pacjenci po udarze z upośledzeniem resztkowym, u których stwierdzono dalsze potrzeby rehabilitacyjne, powinni otrzymać świadczenia terapeutyczne w celu wyznaczenia nowych celów i poprawy funkcji zorientowanych na zadania. *3.5.b. Stroke survivors with residual impairment identified as having further rehabilitation needs should receive therapy services to set new goals and improve task-orientated activity. [B]* 3.5.c. W przypadku pacjentów po udarze z potwierdzonymi trudnościami w wykonywaniu zadań osobistych, podstawowych czynności, pracy zawodowej lub czynności rekreacyjnych należy przygotować i wdrożyć zaktualizowany i udokumentowany plan wsparcia pacjenta w radzeniu sobie z tymi problemami [GPP] *3.5.c. Stroke survivors with confirmed difficulties in performance of personal tasks, instrumental activities, vocational activities or leisure activities should have a documented management plan updated and initiated to address these issues. [GPP]*	<u>Poziomy dowodów:</u> **B** – Zebrany materiał dowodowy potwierdza stosowanie zalecenia w większości sytuacji **Good practice point (GPP)** – Najlepsze postępowanie zalecane na podstawie doświadczenia klinicznego i opinii eksperckiej
1.1.2.		NICE 2013	1.1.1 Pacjenci z niepełnosprawnością będąca następstwem udaru powinni otrzymać świadczenie rehabilitacyjne na dedykowanym (stacjonarnym) oddziale poudarowym a następnie rehabilitacja powinna być kontynuowana przez zespół specjalistów zajmujących się udarami w ich środowisku domowym. *1.1.1 People with disability after stroke should receive rehabilitation in a dedicated stroke inpatient unit and subsequently from a specialist stroke team within the community.* 1.1.5 Członkowie multidyscyplinarnego zespołu udarowego powinni przeprowadzić szczegółowe badania pacjenta z udarem w celu określenia występujących ubytków i niepełnosprawności oraz podjęcia decyzji odnośnie do i kwalifikacji pacjenta do dalszej oceny i leczenia. *1.1.5 Members of the core multidisciplinary stroke team should screen the person with stroke for a range of impairments and disabilities, in order to inform and direct further assessment and treatment.* 1.2.2 Przeprowadź pełną ocenę kliniczną pacjenta z udarem, łącznie z oceną możliwości poznawczych (uwaga, pamięć, orientacja w terenie, apraksja, percepcja), wzroku, słuchu, napięcia mięśniowego, siły, czucia i równowagi.	<u>Siła rekomendacji interwencji w publikacji NICE 2013 była wyrażona za pomocą użytych czasowników:</u> **Perform/Should** – Silna rekomendacja. Autorzy rekomendacji są pewni, że dla znacznej większości pacjentów, dana interwencja przyniesie więcej korzyści niż strat oraz jest efektywna kosztowo. Zaprzeczenia podobnych wyrażeń (np. 'do not offer') stosowane są do interwencji, dla których autorzy są pewni, że nie będą one korzystne dla większości pacjentów.

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			1.2.2 Perform a full medical assessment of the person with stroke, including cognition (attention, memory, spatial awareness, apraxia, perception), vision, hearing, tone, strength, sensation and balance. 1.2.4. Informacje od pacjentów z udarem powinny być zbierane w momencie przyjęcia i wypisu z wykorzystaniem obowiązujących, wiarygodnych i elastycznych narzędzi w tym: • National Institutes of Health Stroke Scale • Barthel Index. *1.2.4 Information collected routinely from people with stroke using valid, reliable and responsive tools should include the following on admission and discharge:* • *National Institutes of Health Stroke Scale* • *Barthel Index.*	
1.1.3.		RCP 2016	2.9.1.A. Assessment measures used in stroke rehabilitation should meet the following criteria as far as poss ble: – they should collect relevant data across the required range (i.e. they are valid and fulfil a need); – they should have sufficient sensitivity to detect change within a person and differences between people; – their reliability should be known when used by different people on different occasions and in different settings; – they should be simple to use under a variety of circumstances; – they should provide scores that are easily understood. 2.9.1.B. A stroke service should agree on a standard set of assessment measures that should be collected and recorded routinely. 2.10.1.C. People with stroke should be supported and involved in a self-management approach to their rehabilitation goals.	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.
1.1.4.		AHA/ASA 2018	4. It is recommended that all individuals with stroke be provided a formal assessment of their activities of daily living and instrumental activities of daily living, communication abilities, and functional mobility before discharge from acute care hospitalization and the findings be incorporated into the care transition and the discharge planning process. [I, B-NR] 5. A functional assessment by a clinician with expertise in rehabilitation is recommended for patients with an acute stroke with residual functional deficits. [I, C-LD]	<u>Siła zalecenia:</u> I – Silne <u>Siła dowodu:</u> B-NR – nierandomizowane C-LD – ograniczone dane
1.2.1.	Urazowe uszkodzenie mózgu	BSRM 2003	G24. Goal-setting should involve the patient (B) and the family if appropriate. [C] G29. The team should have an agreed minimum dataset for documenting outcome from the programme, and this should include: • assessment tools which are shown to be valid and reliable [C] • re-assessment at appropriate intervals [C] • regular audit and evaluation. [C]	<u>Siła zalecenia:</u> C – Expert committee reports, opinions and/or experience of respected authorities
1.2.2.		NZGG 2007	Assess the need for rehabilitation before discharging people with TBI. Consider referring all people with TBI for a neuropsychological assessment to evaluate cognitive functioning.	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.

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			Communicative assessments should be performed by a speech-language therapist, in conjunction with others in the team. All people with clinically significant TBI should have a neuropsychological assessment of cognitive and behavioural/emotional functioning by a neuropsychologist.	
1.2.3.		ONF 2016c	A 1.3 Rehabilitation programs should have clearly stated admission criteria, which include a traumatic brain injury diagnosis, medical stability, the ability to improve through the rehabilitation process, the ability to learn and engage in rehabilitation and sufficient tolerance for therapy duration. (INESSS-ONF, 2015) [Fundamental, C] A 1.4 The assessment and planning of rehabilitation should be undertaken through a coordinated, interdisciplinary team and follow a patient-focused approach responding to the needs and choices of individuals with traumatic brain injury as they evolve over time. (Adapted from NZGG 2007, 4.4, p. 76 and ABIKUS 2007, G1, p. 16) [Fundamental, C]	Siła zalecenia: **Fundamental Recommendations** are defined as the elements that rehabilitation programs/services need to have in place, in order to build the rest of the system properly. These are primarily for program managers and their leaders as they reflect the service conditions for optimal rehabilitation provision. **Priority Recommendations** are clinical practices or processes deemed most important to implement and monitor during the course of rehabilitation for people having sustained a TBI. These practices are most l kely to bring on positive outcomes for people with TBI. Poziomy dowodów: A – Recommendation supported by at least 1 meta-analysis, systematic review, or randomized controlled trial of appropriate size with relevant control group. B – Recommendation supported by cohort studies that at minimum have a comparison group, well-designed single subject experimental designs, or small sample size randomized controlled trials. C – Recommendation supported primarily by expert opinion based on their experience, though uncontrolled case series without comparison groups that support the recommendations are also classified here.
2.	**Fizjoterapia domowa dla pacjentów z ciężkimi uszkodzeniami centralnego układu nerwowego**			
2.1.1.	Uszkodzenie rdzenia kręgowego	MASCIP 2017	2. Local rehabilitation services are provided which: • Address vocational needs during review of a person's integrated care plan and as part of any rehabilitation programme 3. Specialist vocational services are provided for people with neurological conditions to address more complex problems in remaining in or returning to work or alternative occupation including: • Specialist vocational assessment and counselling	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.
3.	**Opieka lekarska rehabilitacyjna**			
3.1.1.	Nowotwory mózgu	NICE 2018a	1.10.1 Consider referring the person with a brain tumour for a neurological rehabilitation assessment of physical, cognitive and emotional function at diagnosis and every stage of follow-up.	Siła rekomendacji interwencji w publikacji NICE 2018 była wyrażona za pomocą użytych czasowników:

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				Consider – Autorzy publikacji są pewni, że dana interwencja przyniesie więcej korzyści niż szkód dla większości pacjentów i jest kosztowo efektywna, ale inne metody mogą być podobnie efektywne kosztowo. Wybór interwencji lub całkowita rezygnacja zależą bardziej od preferencji pacjenta niż od siły rekomendacji
4.	**Fizjoterapia ambulatoryjna dla pacjentów z chorobami układu nerwowego**			
4.1.1.	Nowotwory mózgu	LCA 2014	Assessment and interventions in rehabilitation should consider the impact of the disease at different levels of the International Classification of Functioning, Disability and Health (ICF) framework such as impairments, activity limitation, restriction in participation and contextual factors (environmental or personal). Assessment areas should include: patients' ideas, concerns and expectations; social history; levels of function (including work, leisure, activities of daily living); impairments (including physical, cognitive, perceptual, psychological, communication and nutritional status); and assessment of the carer's ability to actively participate in ongoing management. Reassessment should be considered at any stage of the patient's disease trajectory dependent on clinical presentation of symptoms.	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.
4.2.1.	Nowotwory rdzenia nerwowego	LCA 2014	Assessment and interventions in rehabilitation should consider the impact of the disease at different levels of the International Classification of Functioning, Disability and Health (ICF) framework such as impairments, activity limitation, restriction in participation and contextual factors (environmental or personal). Assessment areas should include: patients' ideas, concerns and expectations; social history; levels of function (including work, leisure, activities of daily living); impairments (including physical, cognitive, perceptual, psychological, communication and nutritional status); and assessment of the carer's ability to actively participate in ongoing management. Reassessment should be considered at any stage of the patient's disease trajectory dependent on clinical presentation of symptoms.	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.
4.3.1.	Padaczka (G40)	EC 2017	7.10 Management after epilepsy surgery In patients who have cognitive and behavioural impairments before surgery, comprehensive rehabilitative efforts are needed post-surgery, in accordance with goals established during presurgical evaluation.	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.
4.4.1.	Udar mózgu	NSF 2010	3.5.a. Pacjenci po udarze, u których po zakończeniu formalnej rehabilitacji utrzymuje się upośledzenie resztkowe, powinni co roku być poddani kontrolnym badaniom lekarskim przeprowadzonym przez lekarza POZ lub rehabilitanta w celu określenia, czy konieczna jest dalsza rehabilitacja. W przypadku pojawiania się nowych problemów zdrowotnych lub zmian w najbliższym środowisku pacjenta, należy go skierować do dalszej oceny przez odpowiednich pracowników służby zdrowia lub specjalistów z zakresu rehabilitacji. [GPP] *3.5.a. Stroke survivors who have residual impairment at the end of the formal rehabilitation phase of care should be reviewed annually, usually by the general practitioner or rehabilitation provider to consider whether access to further interventions is needed. A referral for further assessment should be offered for relevant allied health professionals or general rehabilitation*	Poziomy dowodów: **B** – Zebrany materiał dowodowy potwierdza stosowanie zalecenia w większości sytuacji **Good practice point (GPP)** – Najlepsze postępowanie zalecane na podstawie doświadczenia klinicznego i opinii eksperckiej

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			services if there are new problems not present when undertaking initial rehabilitation, or if the person's physical or social environment has changed. [GPP] 3.5.b. Pacjenci po udarze z upośledzeniem resztkowym, u których stwierdzono dalsze potrzeby rehabilitacyjne, powinni otrzymać świadczenia terapeutyczne w celu wyznaczenia nowych celów i poprawy funkcji zorientowanych na zadania. *3.5.b. Stroke survivors with residual impairment identified as having further rehabilitation needs should receive therapy services to set new goals and improve task-orientated activity. [B]* 3.5.c. W przypadku pacjentów po udarze z potwierdzonymi trudnościami w wykonywaniu zadań osobistych, podstawowych czynności, pracy zawodowej lub czynności rekreacyjnych należy przygotować i wdrożyć zaktualizowany i udokumentowany plan wsparcia pacjenta w radzeniu sobie z tymi problemami [GPP] *3.5.c. Stroke survivors with confirmed difficulties in performance of personal tasks, instrumental activities, vocational activities or leisure activities should have a documented management plan updated and initiated to address these issues. [GPP]*	
4.4.2.		NICE 2013	1.1.1 Pacjenci z niepełnosprawnością będąca następstwem udaru powinni otrzymać świadczenie rehabilitacyjne na dedykowanym (stacjonarnym) oddziale poudarowym a następnie rehabilitacja powinna być kontynuowana przez zespół specjalistów zajmujących się udarami w ich środowisku domowym. *1.1.1 People with disability after stroke should receive rehabilitation in a dedicated stroke inpatient unit and subsequently from a specialist stroke team within the community.* 1.1.5 Członkowie multidyscyplinarnego zespołu udarowego powinni przeprowadzić szczegółowe badania pacjenta z udarem w celu określenia występujących ubytków i niepełnosprawności oraz podjęcia decyzji odnośnie do i kwalifikacji pacjenta do dalszej oceny i leczenia. *1.1.5 Members of the core multidisciplinary stroke team should screen the person with stroke for a range of impairments and disabilities, in order to inform and direct further assessment and treatment.* 1.2.2 Przeprowadź pełną ocenę kliniczną pacjenta z udarem, łącznie z oceną możliwości poznawczych (uwaga, pamięć, orientacja w terenie, apraksja, percepcja), wzroku, słuchu, napięcia mięśniowego, siły, czucia i równowagi. *1.2.2 Perform a full medical assessment of the person with stroke, including cognition (attention, memory, spatial awareness, apraxia, perception), vision, hearing, tone, strength, sensation and balance.* 1.2.4. Informacje od pacjentów z udarem powinny być zbierane w momencie przyjęcia i wypisu z wykorzystaniem obowiązujących, wiarygodnych i elastycznych narzędzi w tym: • National Institutes of Health Stroke Scale • Barthel Index. *1.2.4 Information collected routinely from people with stroke using valid, reliable and responsive tools should include the following on admission and discharge:* • *National Institutes of Health Stroke Scale* • *Barthel Index.*	<u>Siła rekomendacji interwencji w publikacji NICE 2013 była wyrażona za pomocą użytych czasowników:</u> **Perform/Should** – Silna rekomendacja. Autorzy rekomendacji są pewni, że dla znacznej większości pacjentów, dana interwencja przyniesie więcej korzyści niż strat oraz jest efektywna kosztowo. Zaprzeczenia podobnych wyrażeń (np. 'do not offer') stosowane są do interwencji, dla których autorzy są pewni, że nie będą one korzystne dla większości pacjentów.

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4.4.3.		RCP 2016	2.9.1.A. Assessment measures used in stroke rehabilitation should meet the following criteria as far as poss ble: – they should collect relevant data across the required range (i.e. they are valid and fulfil a need); – they should have sufficient sensitivity to detect change within a person and differences between people; – their reliability should be known when used by different people on different occasions and in different settings; – they should be simple to use under a variety of circumstances; – they should provide scores that are easily understood. 2.9.1.B. A stroke service should agree on a standard set of assessment measures that should be collected and recorded routinely. 2.10.1.C. People with stroke should be supported and involved in a self-management approach to their rehabilitation goals.	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.
4.4.4.		AHA/ASA 2018	4. It is recommended that all individuals with stroke be provided a formal assessment of their activities of daily living and instrumental activities of daily living, communication abilities, and functional mobility before discharge from acute care hospitalization and the findings be incorporated into the care transition and the discharge planning process. [I, B-NR] 5. A functional assessment by a clinician with expertise in rehabilitation is recommended for patients with an acute stroke with residual functional deficits. [I, C-LD]	<u>Siła zalecenia:</u> I – Silne <u>Siła dowodu:</u> B-NR – nierandomizowane C-LD – ograniczone dane
4.5.1.	Urazowe uszkodzenie mózgu	BSRM 2003	G24. Goal-setting should involve the patient (B) and the family if appropriate. [C] G29. The team should have an agreed minimum dataset for documenting outcome from the programme, and this should include: • assessment tools which are shown to be valid and reliable [C] • re-assessment at appropriate intervals [C] • regular audit and evaluation. [C]	Siła zalecenia: C – Expert committee reports, opinions and/or experience of respected authorities
4.5.2.		NZGG 2007	Assess the need for rehabilitation before discharging people with TBI. Consider referring all people with TBI for a neuropsychological assessment to evaluate cognitive functioning. Communicative assessments should be performed by a speech-language therapist, in conjunction with others in the team. All people with clinically significant TBI should have a neuropsychological assessment of cognitive and behavioural/emotional functioning by a neuropsychologist.	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.
4.5.3.		ONF 2016c	A 1.3 Rehabilitation programs should have clearly stated admission criteria, which include a traumatic brain injury diagnosis, medical stability, the ability to improve through the rehabilitation process, the ability to learn and engage in rehabilitation and sufficient tolerance for therapy duration. (INESSS-ONF, 2015) [Fundamental, C] A 1.4 The assessment and planning of rehabilitation should be undertaken through a coordinated, interdisciplinary team and follow a patient-focused approach responding to the	<u>Siła zalecenia:</u> **Fundamental Recommendations** are defined as the elements that rehabilitation programs/services need to have in place, in order to build the rest of the system properly. These are primarily for program managers and their leaders as they reflect the service conditions for optimal rehabilitation provision. **Priority Recommendations** are clinical practices or processes deemed most important to implement and monitor during the

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1	2	3	4	5
			needs and choices of individuals with traumatic brain injury as they evolve over time. (Adapted from NZGG 2007, 4.4, p. 76 and ABIKUS 2007, G1, p. 16) [Fundamental, C]	course of rehabilitation for people having sustained a TBI. These practices are most l kely to bring on positive outcomes for people with TBI. Poziomy dowodów: A – Recommendation supported by at least 1 meta-analysis, systematic review, or randomized controlled trial of appropriate size with relevant control group. B – Recommendation supported by cohort studies that at minimum have a comparison group, well-designed single subject experimental designs, or small sample size randomized controlled trials. C – Recommendation supported primarily by expert opinion based on their experience, though uncontrolled case series without comparison groups that support the recommendations are also classified here.
4.6.1.	Uszkodzenia rdzenia kręgowego	MASCIP 2017	2. Local rehabilitation services are provided which: • Address vocational needs during review of a person's integrated care plan and as part of any rehabilitation programme 3. Specialist vocational services are provided for people with neurological conditions to address more complex problems in remaining in or returning to work or alternative occupation including: • Specialist vocational assessment and counselling	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.
5.	**Kompleksowa rehabilitacja ogólnoustrojowa dzienna dla pacjentów z porażeniami i niedowładami będącymi skutkiem uszkodzeń układu nerwowego o różnej etiologii**			
5.1.1.	Długoterminowe schorzenia neurologiczne, m.in. nabyte uszkodzenie mózgu, stwardnienie rozsiane, choroba Parkinsona	BSRM 2009	S11. Patients who are in hospital for >48 hours with impaired consciousness or immobility following sudden onset of neurological illness or injury should be assessed by a specialist neuro-rehabilitation team (or at least a member of the team) to provide advice on interim management to prevent secondary complications. The patient should be assessed by that team within 5 working days of referral. Specific advice and information should be given to the person and/or their family relating to sources of support and further information. S12. Patients who are unable to go home directly and require a period of post-acute in-patient rehabilitation should be transferred to a specialist neurological rehabilitation unit as soon as they are medically stable and fit to participate in rehabilitation. The patient should be assessed by that unit within 5 working days of referral. If accepted, the patient should be transferred within 2 weeks of being fit for transfer. S13. Patients with highly complex needs requiring referral to a complex specialised rehabilitation service, (CSRS)* should be identified and referred as early as poss ble in the acute phase to allow time for any additional arrangements, eg negotiation of funding to be put in place. The CSRS should assess within 10 working days of referral (target 7 days) If accepted, the patient should be transferred within 6 weeks of being fit for transfer (target 1-3 weeks)	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.

L.p.	Schorzenie	Publikacja	Zalecenia	Uwagi
1	2	3	4	5
			S14. Following assessment, a written summary should be provided to the referrer within 3 working days which includes: • A summary of the case and the individual's rehabilitation needs • Specific recommendations for management and the intervention plan • Recommendations for alternative placement if specialist rehabilitation is not considered to be the most appropriate solution for the individual's needs • Specific information for the person and/or their family on sources of further support The assessment summary should be copied to the GP and other relevant agencies, including the individual and/or their family, if appropriate	
5.2.1.	Pląsawica Huntingtona (G10)	EHDN 2013	Podstawowa ocena poziomu sprawności powinna być dokonana przed planowaniem kinezyterapii. należy udzielić informacji na temat zmęczenia, czasu trwania ćwiczeń oraz przeprowadzić instruktaż na temat zasad bezpieczeństwa podczas ich wykonywania. *Baseline testing for fitness level should be completed prior to exercise prescription. Consider education on fatigue and the timing of intervention/exercises during the day as well as careful instruction on safety during exercise.*	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.
5.3.1.	Uszkodzenia rdzenia kręgowego	MASCIP 2017	2. Local rehabilitation services are provided which: • Address vocational needs during review of a person's integrated care plan and as part of any rehabilitation programme 3. Specialist vocational services are provided for people with neurological conditions to address more complex problems in remaining in or returning to work or alternative occupation including: • Specialist vocational assessment and counselling	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.
5.4.1.	SMA (G12)	Mercuri 2018	Clinical assessment in SMA includes performing a physical examination, with a focus on the musculoskeletal system and related functional impairments. The choice of the assessments used will reflect the aspects that are more relevant for each level of severity. These should include different means of assessments of strength and range of joint motion, relevant motor functional scales and timed tests to monitor those aspects of function that reflect activities of daily living. These assessments should be performed routinely by trained examiners every 6 months, unless there are special circumstances requiring different follow up.	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.
5.5.1.	Stwardnienie zanikowe boczne (G12.2)	ENFS 2012	Patients should generally be reviewed every 2–3 months, although they may require more frequent review in the months following diagnosis or in the later stages of disease, and less frequent review if their disease is progressing slowly. The patient support team should maintain regular contact with the patient and relatives between visits (GCPP).	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.
6.	**Kompleksowa rehabilitacja ogólnoustrojowa dzienna dla pacjentów po udarze mózgu**			

L.p.	Schorzenie	Publikacja	Zalecenia	Uwagi
1	2	3	4	5
6.1.1.	Długoterminowe schorzenia neurologiczne m.in. nabyte uszkodzenie mózgu, stwardnienie rozsiane, choroba Parkinsona	BSRM 2009	S11. Patients who are in hospital for >48 hours with impaired consciousness or immobility following sudden onset of neurological illness or injury should be assessed by a specialist neuro-rehabilitation team (or at least a member of the team) to provide advice on interim management to prevent secondary complications. The patient should be assessed by that team within 5 working days of referral. Specific advice and information should be given to the person and/or their family relating to sources of support and further information. S12. Patients who are unable to go home directly and require a period of post-acute in-patient rehabilitation should be transferred to a specialist neurological rehabilitation unit as soon as they are medically stable and fit to participate in rehabilitation. The patient should be assessed by that unit within 5 working days of referral. If accepted, the patient should be transferred within 2 weeks of being fit for transfer. S13. Patients with highly complex needs requiring referral to a complex specialised rehabilitation service, (CSRS)* should be identified and referred as early as possible in the acute phase to allow time for any additional arrangements, eg negotiation of funding to be put in place. The CSRS should assess within 10 working days of referral (target 7 days) If accepted, the patient should be transferred within 6 weeks of being fit for transfer (target 1-3 weeks) S14. Following assessment, a written summary should be provided to the referrer within 3 working days which includes: • A summary of the case and the individual's rehabilitation needs • Specific recommendations for management and the intervention plan • Recommendations for alternative placement if specialist rehabilitation is not considered to be the most appropriate solution for the individual's needs • Specific information for the person and/or their family on sources of further support The assessment summary should be copied to the GP and other relevant agencies, including the individual and/or their family, if appropriate	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.
6.2.1.	Udar mózgu		*Nie odnaleziono zaleceń dotyczących rehabilitacji pacjentów w trybie dziennym.*	
7.	**Kompleksowa rehabilitacja ogólnoustrojowa dzienna dla pacjentów z chorobami demielinizacyjnymi OUN**			
7.1.1.	Długoterminowe schorzenia neurologiczne, m.in. nabyte uszkodzenie mózgu, stwardnienie rozsiane, choroba Parkinsona	BSRM 2009	S11. Patients who are in hospital for >48 hours with impaired consciousness or immobility following sudden onset of neurological illness or injury should be assessed by a specialist neuro-rehabilitation team (or at least a member of the team) to provide advice on interim management to prevent secondary complications. The patient should be assessed by that team within 5 working days of referral. Specific advice and information should be given to the person and/or their family relating to sources of support and further information. S12. Patients who are unable to go home directly and require a period of post-acute in-patient rehabilitation should be transferred to a specialist neurological rehabilitation unit as soon as they are medically stable and fit to participate in rehabilitation. The patient should be assessed by that unit within 5 working days of referral. If accepted, the patient should be transferred within 2 weeks of being fit for transfer. S13. Patients with highly complex needs requiring referral to a complex specialised rehabilitation service, (CSRS)* should be identified and referred as early as poss ble in the	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.

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			acute phase to allow time for any additional arrangements, eg negotiation of funding to be put in place. The CSRS should assess within 10 working days of referral (target 7 days) If accepted, the patient should be transferred within 6 weeks of being fit for transfer (target 1-3 weeks) S14. Following assessment, a written summary should be provided to the referrer within 3 working days which includes: • A summary of the case and the individual's rehabilitation needs • Specific recommendations for management and the intervention plan • Recommendations for alternative placement if specialist rehabilitation is not considered to be the most appropriate solution for the individual's needs • Specific information for the person and/or their family on sources of further support The assessment summary should be copied to the GP and other relevant agencies, including the individual and/or their family, if appropriate	
7.3.1.	SM (G35)	NICE 2014b	1.5.9. Ensure people with MS and mobility problems have access to an assessment to establish individual goals and discuss ways in which to achieve them. This would usually involve rehabilitation specialists and physiotherapists with expertise in MS.	Siła rekomendacji interwencji w publikacji NICE 2014b była wyrażona za pomocą użytych czasowników: **Ensure** – Silna rekomendacja. Autorzy rekomendacji są pewni, że dla znacznej większości pacjentów, dana interwencja przyniesie więcej korzyści niż strat oraz jest efektywna kosztowo. Zaprzeczenia podobnych wyrażeń (np. 'do not offer') stosowane są do interwencji, dla których autorzy są pewni, że nie będą one korzystne dla większości pacjentów.
8.	**Kompleksowa rehabilitacja neurologiczna stacjonarna dla pacjentów z zaburzeniami funkcji mózgu**			
8.1.1.	Długoterminowe schorzenia neurologiczne, m.in. nabyte uszkodzenie mózgu, stwardnienie rozsiane, choroba Parkinsona	BSRM 2009	S11. Patients who are in hospital for >48 hours with impaired consciousness or immobility following sudden onset of neurological illness or injury should be assessed by a specialist neuro-rehabilitation team (or at least a member of the team) to provide advice on interim management to prevent secondary complications. The patient should be assessed by that team within 5 working days of referral. Specific advice and information should be given to the person and/or their family relating to sources of support and further information. S12. Patients who are unable to go home directly and require a period of post-acute in-patient rehabilitation should be transferred to a specialist neurological rehabilitation unit as soon as they are medically stable and fit to participate in rehabilitation. The patient should be assessed by that unit within 5 working days of referral. If accepted, the patient should be transferred within 2 weeks of being fit for transfer. S13. Patients with highly complex needs requiring referral to a complex specialised rehabilitation service, (CSRS)* should be identified and referred as early as poss ble in the acute phase to allow time for any additional arrangements, eg negotiation of funding to be put in place. The CSRS should assess within 10 working days of referral (target 7 days) If accepted, the patient should be transferred within 6 weeks of being fit for transfer (target 1-3 weeks)	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.

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8.2.1.	Nowotwory mózgu	CCA 2009	Patients having residual problems after treatment of a glioma, with stable medical status, should be referred to a rehabilitation service with a range of medical, nursing and allied health professionals, for multidisciplinary assessment and appropriate therapy and support of their problems, involving both the patient and their carers.[III] Therapy by a speech pathologist should be offered to these glioma patients with residual problems related to swallowing, communication and cognitive function. Where the services are available, this should be supported by assessment and intervention by a clinical psychologist, or a neuropsychologist. [III] Glioma patients expecting to return to driving after treatment of their tumour should be referred to a rehabilitation service for full assessment of their ability to drive safely. Any resulting determinations of the driver licensing authority must be observed. For those who can return to driving, regular ongoing follow-up by the rehabilitation service is indicated, to review and manage any on-going risk associated with driving. Those who continue to drive unsafely, contrary to advice and the determinations of the driver licensing authority, should be counselled about the need to behave respons bly and the advice of the authority be sought, if they still continue to drive. In some situations, cancellation of the driver's licence may be necessary. [I]	<u>Siła dowodu:</u> I – Evidence obtained from a systematic review of all relevant randomised controlled trials. III – Evidence obtained from well-designed pseudo-randomised controlled trials (alternate allocation or some other method); or Evidence obtained from comparative studies with concurrent controls and allocation not randomised (cohort studies), case-control studies, or interrupted time series with a control group; or Evidence obtained from comparative studies with historical control, two or more single-arm studies, or interrupted time series without a parallel control group.
8.2.2.		LCA 2014	Assessment and interventions in rehabilitation should consider the impact of the disease at different levels of the International Classification of Functioning, Disability and Health (ICF) framework such as impairments, activity limitation, restriction in participation and contextual factors (environmental or personal). Assessment areas should include: patients' ideas, concerns and expectations; social history; levels of function (including work, leisure, activities of daily living); impairments (including physical, cognitive, perceptual, psychological, communication and nutritional status); and assessment of the carer's ability to actively participate in ongoing management. Reassessment should be considered at any stage of the patient's disease trajectory dependent on clinical presentation of symptoms.	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.

L.p.	Schorzenie	Publikacja	Zalecenia	Uwagi
1	2	3	4	5
8.2.3.		NHS 2016	The MDT will advise on the need for further clinical assessments including: • Urological assessment for any reported/documented sphincter disturbance. Subsequent advice from continence advisor may be required. • Assessment by spinal rehabilitation service. • Occupational therapy assessment. • Physiotherapy assessment. It is not poss ble in this guidance to provide a comprehensive description of the role of each AHP but general themes relating to their involvement in patient care are as follows: • Speech and language therapist (SALT) – Assessment and management of slurred speech (dysarthria). – Assessment and management of dysphasia. – Assessment and management of swallowing difficulties. – Assessment and management of patients who are "nil by mouth" but who want to eat and drink for pleasure/comfort. • Physiotherapist – Assessment and management of motor deficits (ie limb weakness, proprioception, inattention). – Assessment and management of reduced mobility/balance problems. – Assessment and management of pre-existing chest problems. – Assessment and management of spinal pain/referred pain. – Assessment and management of spasticity. • Occupational therapist – Assessment and management of reduced functional status caused by motor / perceptual deficits. – Assessment and management of cognitive deficits ie memory deficit, confusion, disorientation – Assessment and management of fatigue. • Dietetics – Assessment and management of significant weight gain arising as a side-effect of treatment with steroids (weight loss arising from a primary brain or other CNS tumour is very rare). – Assessment and management of anorexia or altered sense of taste following adjuvant oncology treatment. • Neuropsychology – Assessment and management of changes in cognitive processing, personality and / or behaviour arising from brain tumours with the aim of ensuring the patient has mental capacity to support informed decision making, promote independent functioning, and participation in valued activities at any stage of the patients journey.	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.
8.3.1.	Senność, osłupienie, śpiączka (R40)	AAN 2018	Recommendation statement 1: Clinicians should refer patients with DoC who have achieved medical stability to settings staffed by multidisciplinary rehabilitation teams with specialized training to optimize diagnostic evaluation, prognostication, and subsequent management, including effective medical monitoring and rehabilitative care (Level B).	<u>Siła rekomendacji:</u> Level A – the strongest recommendation level and is denoted by use of the helping verb must; based on high confidence in the evidence and require both a high magnitude of benefit and low risk.

L.p.	Schorzenie	Publikacja	Zalecenia	Uwagi
1	2	3	4	5
				Level B – corresponds to the helping verb should. The requirements are less stringent but still based on the evidence and benefit−risk profile. Level C – corresponds to the helping verb may, represents the lowest allowable recommendation level the AAN considers useful within the scope of clinical practice and can accommodate the highest degree of practice variation.
8.4.1.	Udar mózgu	NSF 2010	3.5.a. Pacjenci po udarze, u których po zakończeniu formalnej rehabilitacji utrzymuje się upośledzenie resztkowe, powinni co roku być poddani kontrolnym badaniom lekarskim przeprowadzonym przez lekarza POZ lub rehabilitanta w celu określenia, czy konieczna jest dalsza rehabilitacja. W przypadku pojawiania się nowych problemów zdrowotnych lub zmian w najbliższym środowisku pacjenta, należy go skierować do dalszej oceny przez odpowiednich pracowników służby zdrowia lub specjalistów z zakresu rehabilitacji. [GPP] *3.5.a. Stroke survivors who have residual impairment at the end of the formal rehabilitation phase of care should be reviewed annually, usually by the general practitioner or rehabilitation provider to consider whether access to further interventions is needed. A referral for further assessment should be offered for relevant allied health professionals or general rehabilitation services if there are new problems not present when undertaking initial rehabilitation, or if the person's physical or social environment has changed. [GPP]* 3.5.b. Pacjenci po udarze z upośledzeniem resztkowym, u których stwierdzono dalsze potrzeby rehabilitacyjne, powinni otrzymać świadczenia terapeutyczne w celu wyznaczenia nowych celów i poprawy funkcji zorientowanych na zadania. *3.5.b. Stroke survivors with residual impairment identified as having further rehabilitation needs should receive therapy services to set new goals and improve task-orientated activity. [B]* 3.5.c. W przypadku pacjentów po udarze z potwierdzonymi trudnościami w wykonywaniu zadań osobistych, podstawowych czynności, pracy zawodowej lub czynności rekreacyjnych należy przygotować i wdrożyć zaktualizowany i udokumentowany plan wsparcia pacjenta w radzeniu sobie z tymi problemami [GPP] *3.5.c. Stroke survivors with confirmed difficulties in performance of personal tasks, instrumental activities, vocational activities or leisure activities should have a documented management plan updated and initiated to address these issues. [GPP]*	Poziomy dowodów: **B** – Zebrany materiał dowodowy potwierdza stosowanie zalecenia w większości sytuacji **Good practice point (GPP)** – Najlepsze postępowanie zalecane na podstawie doświadczenia klinicznego i opinii eksperckiej
8.4.2.		SIGN 2010	The core multidisciplinary team should include appropriate levels of nursing, medical, physiotherapy, occupational therapy, speech and language therapy, and social work staff. [**B]** Patients and carers should have an early active involvement in the rehabilitation process. [**B]** Stroke patients should have a full assessment of their cognitive strengths and weaknesses when undergoing rehabilitation or when returning to cognitively demanding activities such as driving or work. [GPP] All stroke patients should be screened for visual problems, and referred appropriately. [C]	Poziom dowodu: **1+** Well conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias Poziom rekomendacji: **B** A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 1++ or 1+ **C** A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 2++

L.p.	Schorzenie	Publikacja	Zalecenia	Uwagi
1	2	3	4	5
				GPP Recommended best practice based on the clinical experience of the guideline development group
8.4.3.		NICE 2013	1.1.1 Pacjenci z niepełnosprawnością będąca następstwem udaru powinni otrzymać świadczenie rehabilitacyjne na dedykowanym (stacjonarnym) oddziale poudarowym a następnie rehabilitacja powinna być kontynuowana przez zespół specjalistów zajmujących się udarami w ich środowisku domowym. *1.1.1 People with disability after stroke should receive rehabilitation in a dedicated stroke inpatient unit and subsequently from a specialist stroke team within the community.* 1.1.5 Członkowie multidyscyplinarnego zespołu udarowego powinni przeprowadzić szczegółowe badania pacjenta z udarem w celu określenia występujących ubytków i niepełnosprawności oraz podjęcia decyzji odnośnie do i kwalifikacji pacjenta do dalszej oceny i leczenia. *1.1.5 Members of the core multidisciplinary stroke team should screen the person with stroke for a range of impairments and disabilities, in order to inform and direct further assessment and treatment.* 1.2.2 Przeprowadź pełną ocenę kliniczną pacjenta z udarem, łącznie z oceną możliwości poznawczych (uwaga, pamięć, orientacja w terenie, apraksja, percepcja), wzroku, słuchu, napięcia mięśniowego, siły, czucia i równowagi. *1.2.2 Perform a full medical assessment of the person with stroke, including cognition (attention, memory, spatial awareness, apraxia, perception), vision, hearing, tone, strength, sensation and balance.* 1.2.4. Informacje od pacjentów z udarem powinny być zbierane w momencie przyjęcia i wypisu z wykorzystaniem obowiązujących, wiarygodnych i elastycznych narzędzi w tym: • National Institutes of Health Stroke Scale • Barthel Index. *1.2.4 Information collected routinely from people with stroke using valid, reliable and responsive tools should include the following on admission and discharge:* • *National Institutes of Health Stroke Scale* • *Barthel Index.*	<u>Siła rekomendacji interwencji w publ kacji NICE 2013 była wyrażona za pomocą użytych czasowników:</u> **Perform/Should** – Silna rekomendacja. Autorzy rekomendacji są pewni, że dla znacznej większości pacjentów, dana interwencja przyniesie więcej korzyści niż strat oraz jest efektywna kosztowo. Zaprzeczenia podobnych wyrażeń (np. 'do not offer') stosowane są do interwencji, dla których autorzy są pewni, że nie będą one korzystne dla większości pacjentów.
8.4.4.		CSBPR 2015	7.5.i. Medically stable patients with an acute ICH should be admitted to a stroke unit or neuro-intensive care unit [Evidence Level B], and undergo interprofessional stroke team assessment to determine their rehabilitation and other care needs.	<u>Siła dowodu:</u> B – Evidence from a single randomized controlled trial or consistent findings from two or more well-designed nonrandomized and/or noncontrolled trials, and large observational studies. Desirable effects outweigh or are closely balanced with undesirable effects or undesirable effects outweigh or are closely balanced with desirable effects
8.4.5.		RCP 2016	2.9.1.A. Assessment measures used in stroke rehabilitation should meet the following criteria as far as poss ble: – they should collect relevant data across the required range (i.e. they are valid and fulfil a need); – they should have sufficient sensitivity to detect change within a person and differences between people; – their reliability should be known when used by different people on different occasions	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.

L.p.	Schorzenie	Publikacja	Zalecenia	Uwagi
1	2	3	4	5
			and in different settings; – they should be simple to use under a variety of circumstances; – they should provide scores that are easily understood. 2.9.1.B. A stroke service should agree on a standard set of assessment measures that should be collected and recorded routinely. 2.10.1.C. People with stroke should be supported and involved in a self-management approach to their rehabilitation goals.	
8.4.6.		AHA/ASA 2018	4. It is recommended that all individuals with stroke be provided a formal assessment of their activities of daily living and instrumental activities of daily living, communication abilities, and functional mobility before discharge from acute care hospitalization and the findings be incorporated into the care transition and the discharge planning process. [I, B-NR] 5. A functional assessment by a clinician with expertise in rehabilitation is recommended for patients with an acute stroke with residual functional deficits. [I, C-LD]	<u>Siła zalecenia:</u> I – Silne <u>Siła dowodu:</u> B-NR – nierandomizowane C-LD – ograniczone dane
8.5.1.	Urazowe uszkodzenie mózgu	BSRM 2003	G24. Goal-setting should involve the patient (B) and the family if appropriate. [C] G29. The team should have an agreed minimum dataset for documenting outcome from the programme, and this should include: • assessment tools which are shown to be valid and reliable [C] • re-assessment at appropriate intervals [C] • regular audit and evaluation. [C]	Siła zalecenia: C – Expert committee reports, opinions and/or experience of respected authorities
8.5.2.		NZGG 2007	Assess the need for rehabilitation before discharging people with TBI. Consider referring all people with TBI for a neuropsychological assessment to evaluate cognitive functioning. Communicative assessments should be performed by a speech-language therapist, in conjunction with others in the team. All people with clinically significant TBI should have a neuropsychological assessment of cognitive and behavioural/emotional functioning by a neuropsychologist.	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.

L.p.	Schorzenie	Publikacja	Zalecenia	Uwagi
1	2	3	4	5
8.5.3.		ONF 2016c	A 1.3 Rehabilitation programs should have clearly stated admission criteria, which include a traumatic brain injury diagnosis, medical stability, the ability to improve through the rehabilitation process, the ability to learn and engage in rehabilitation and sufficient tolerance for therapy duration. (INESSS-ONF, 2015) [Fundamental, C] A 1.4 The assessment and planning of rehabilitation should be undertaken through a coordinated, interdisciplinary team and follow a patient-focused approach responding to the needs and choices of individuals with traumatic brain injury as they evolve over time. (Adapted from NZGG 2007, 4.4, p. 76 and ABIKUS 2007, G1, p. 16) [Fundamental, C]	Siła zalecenia: **Fundamental Recommendations** are defined as the elements that rehabilitation programs/services need to have in place, in order to build the rest of the system properly. These are primarily for program managers and their leaders as they reflect the service conditions for optimal rehabilitation provision. **Priority Recommendations** are clinical practices or processes deemed most important to implement and monitor during the course of rehabilitation for people having sustained a TBI. These practices are most l kely to bring on positive outcomes for people with TBI. Poziomy dowodów: A – Recommendation supported by at least 1 meta-analysis, systematic review, or randomized controlled trial of appropriate size with relevant control group. B – Recommendation supported by cohort studies that at minimum have a comparison group, well-designed single subject experimental designs, or small sample size randomized controlled trials. C – Recommendation supported primarily by expert opinion based on their experience, though uncontrolled case series without comparison groups that support the recommendations are also classified here.

L.p.	Schorzenie	Publikacja	Zalecenia	Uwagi
1	2	3	4	5
8.6.1.	Zapalenie mózgu / następstwa zapalenia mózgu	NICE 2009	<u>During the critical care stay</u> 1.2 During the patient's critical care stay and as early as clinically possible, perform a short clinical assessment to determine the patient's risk of developing physical and non-physical morbidity. 1.3 For patients at risk of physical and non-physical morbidity, perform a comprehensive clinical assessment to identify their current rehabilitation needs. This should include assessments by healthcare professionals experienced in critical care and rehabilitation. 1.4 For patients at risk, agree short-term and medium-term rehabilitation goals, based on the comprehensive clinical assessment. The patient's family and/or carer should also be involved <u>Before discharge from critical care</u> 1.8 For patients who were previously identified as being at low risk, perform a short clinical assessment before their discharge from critical care to determine their risk of developing physical and non-physical morbidity. 1.9 For patients at risk, and patients who started the individualised, structured rehabilitation programme in critical care, perform a comprehensive clinical reassessment to identify their current rehabilitation needs. The comprehensive reassessment should pay particular attention to: physical, sensory and communication problems underlying factors, such as pre-existing psychological or psychiatric distress symptoms that have developed during the critical care stay, such as delusions, intrusive memories, anxiety, panic episodes, nightmares, flashback episodes or depression (see the NICE guideline on the prevention, diagnosis and management of delirium). 1.10 For patients who were previously identified as being at risk during critical care, the outcomes of the comprehensive reassessment should inform the individualised, structured rehabilitation programme. 1.11 For patients at risk, agree or review and update the rehabilitation goals, based on the comprehensive reassessment. The family and/or carer should also be involved, unless the patient disagrees.or carer should also be involved. <u>During ward-based care</u> 1.14 For patients who were previously identified as being at low risk before discharge from critical care, perform a short clinical assessment to determine their risk of physical and non-physical morbidity. 1.15 For patients at risk, perform a comprehensive clinical reassessment to identify their current rehabilitation needs. 1.16 For patients at risk, offer an individualised, structured rehabilitation programme, based on the comprehensive clinical reassessment and the agreed or updated rehabilitation goals set before the patient was discharged from critical care.	<u>Siła rekomendacji interwencji w publikacji NICE 2009 była wyrażona za pomocą użytych czasowników:</u> **Perform/Offer/Agree** – Silna rekomendacja. Autorzy rekomendacji są pewni, że dla znacznej większości pacjentów, dana interwencja przyniesie więcej korzyści niż strat oraz jest efektywna kosztowo. Zaprzeczenia podobnych wyrażeń (np. ‘do not offer’) stosowane są do interwencji, dla których autorzy są pewni, że nie będą one korzystne dla większości pacjentów.

L.p.	Schorzenie	Publikacja	Zalecenia	Uwagi
1	2	3	4	5
8.6.2.		ABN 2012	All patients irrespective of age should have access to assessment for rehabilitation (A, III)	Siła rekomendacji: A – Strongly recommended Siła dowodów: III – Expert opinion only
8.6.3.		Britton 2015	Rehabilitation assessment (medical and non-medical) should be considered, especially in those with neurological or neuropsychological deficits at discharge.	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.
8.7.1.	Zapalenie opon mózgowych	NICE 2009	During the critical care stay 1.2 During the patient's critical care stay and as early as clinically possible, perform a short clinical assessment to determine the patient's risk of developing physical and non-physical morbidity. 1.3 For patients at risk of physical and non-physical morbidity, perform a comprehensive clinical assessment to identify their current rehabilitation needs. This should include assessments by healthcare professionals experienced in critical care and rehabilitation. 1.4 For patients at risk, agree short-term and medium-term rehabilitation goals, based on the comprehensive clinical assessment. The patient's family and/or carer should also be involved Before discharge from critical care 1.8 For patients who were previously identified as being at low risk, perform a short clinical assessment before their discharge from critical care to determine their risk of developing physical and non-physical morbidity. 1.9 For patients at risk, and patients who started the individualised, structured rehabilitation programme in critical care, perform a comprehensive clinical reassessment to identify their current rehabilitation needs. The comprehensive reassessment should pay particular attention to: physical, sensory and communication problems underlying factors, such as pre-existing psychological or psychiatric distress symptoms that have developed during the critical care stay, such as delusions, intrusive memories, anxiety, panic episodes, nightmares, flashback episodes or depression (see the NICE guideline on the prevention, diagnosis and management of delirium). 1.10 For patients who were previously identified as being at risk during critical care, the outcomes of the comprehensive reassessment should inform the individualised, structured rehabilitation programme. 1.11 For patients at risk, agree or review and update the rehabilitation goals, based on the comprehensive reassessment. The family and/or carer should also be involved, unless the patient disagrees.or carer should also be involved. During ward-based care 1.14 For patients who were previously identified as being at low risk before discharge from critical care, perform a short clinical assessment to determine their risk of physical and non-physical morbidity. 1.15 For patients at risk, perform a comprehensive clinical reassessment to identify their current rehabilitation needs.	Siła rekomendacji interwencji w publikacji NICE 2009 była wyrażona za pomocą użytych czasowników: **Perform/Offer/Agree** – Silna rekomendacja. Autorzy rekomendacji są pewni, że dla znacznej większości pacjentów, dana interwencja przyniesie więcej korzyści niż strat oraz jest efektywna kosztowo. Zaprzeczenia podobnych wyrażeń (np. 'do not offer') stosowane są do interwencji, dla których autorzy są pewni, że nie będą one korzystne dla większości pacjentów.

L.p.	Schorzenie	Publikacja	Zalecenia	Uwagi
1	2	3	4	5
			1.16 For patients at risk, offer an individualised, structured rehabilitation programme, based on the comprehensive clinical reassessment and the agreed or updated rehabilitation goals set before the patient was discharged from critical care.	
8.7.2.		McGill 2016	For patients with rehabilitation needs a rehabilitation plan should be agreed with the patient, and their family/carers (AR)	Siła rekomendacji: AR – authors' recommendation
8.7.3.		ESCMID 2016	Routine neuropsychologic examination is not recommended. If cognitive defects occur, neuropsychologic examination should be performed, and referral to a (neuro)psychologist/rehabilitation physician may be indicated. [B]	Siła rekomendacji: B – ESCMID moderately supports recommendation for use.
9.	**Kompleksowa rehabilitacja neurologiczna stacjonarna dla pacjentów z zaburzeniami funkcji rdzenia kręgowego i korzeni nerwowych**			
9.1.1.	Długoterminowe schorzenia neurologiczne, m.in. nabyte uszkodzenie mózgu, stwardnienie rozsiane, choroba Parkinsona	BSRM 2009	S11. Patients who are in hospital for >48 hours with impaired consciousness or immobility following sudden onset of neurological illness or injury should be assessed by a specialist neuro-rehabilitation team (or at least a member of the team) to provide advice on interim management to prevent secondary complications. The patient should be assessed by that team within 5 working days of referral. Specific advice and information should be given to the person and/or their family relating to sources of support and further information. S12. Patients who are unable to go home directly and require a period of post-acute in-patient rehabilitation should be transferred to a specialist neurological rehabilitation unit as soon as they are medically stable and fit to participate in rehabilitation. The patient should be assessed by that unit within 5 working days of referral. If accepted, the patient should be transferred within 2 weeks of being fit for transfer. S13. Patients with highly complex needs requiring referral to a complex specialised rehabilitation service, (CSRS)* should be identified and referred as early as possible in the acute phase to allow time for any additional arrangements, eg negotiation of funding to be put in place. The CSRS should assess within 10 working days of referral (target 7 days) If accepted, the patient should be transferred within 6 weeks of being fit for transfer (target 1-3 weeks) S14. Following assessment, a written summary should be provided to the referrer within 3 working days which includes: • A summary of the case and the individual's rehabilitation needs • Specific recommendations for management and the intervention plan • Recommendations for alternative placement if specialist rehabilitation is not considered to be the most appropriate solution for the individual's needs • Specific information for the person and/or their family on sources of further support The assessment summary should be copied to the GP and other relevant agencies, including the individual and/or their family, if appropriate	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.
9.2.1.	Nowotwory rdzenia nerwowego	LCA 2014	Assessment and interventions in rehabilitation should consider the impact of the disease at different levels of the International Classification of Functioning, Disability and Health (ICF) framework such as impairments, activity limitation, restriction in participation and contextual factors (environmental or personal). Assessment areas should include: patients' ideas, concerns and expectations; social history; levels of function (including work, leisure, activities of daily living); impairments (including	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.

L.p.	Schorzenie	Publikacja	Zalecenia	Uwagi
1	2	3	4	5
			physical, cognitive, perceptual, psychological, communication and nutritional status); and assessment of the carer's ability to actively participate in ongoing management. Reassessment should be considered at any stage of the patient's disease trajectory dependent on clinical presentation of symptoms.	
9.2.2.		NHS 2016	The MDT will advise on the need for further clinical assessments including: • Urological assessment for any reported/documented sphincter disturbance. Subsequent advice from continence advisor may be required. • Assessment by spinal rehabilitation service. • Occupational therapy assessment. • Physiotherapy assessment. It is not poss ble in this guidance to provide a comprehensive description of the role of each AHP but general themes relating to their involvement in patient care are as follows: • Speech and language therapist (SALT) – Assessment and management of slurred speech (dysarthria). – Assessment and management of dysphasia. – Assessment and management of swallowing difficulties. – Assessment and management of patients who are "nil by mouth" but who want to eat and drink for pleasure/comfort. • Physiotherapist – Assessment and management of motor deficits (ie limb weakness, proprioception, inattention). – Assessment and management of reduced mobility/balance problems. – Assessment and management of pre-existing chest problems. – Assessment and management of spinal pain/referred pain. – Assessment and management of spasticity. • Occupational therapist – Assessment and management of reduced functional status caused by motor / perceptual deficits. – Assessment and management of cognitive deficits ie memory deficit, confusion, disorientation – Assessment and management of fatigue. • Dietetics – Assessment and management of significant weight gain arising as a side-effect of treatment with steroids (weight loss arising from a primary brain or other CNS tumour is very rare). – Assessment and management of anorexia or altered sense of taste following adjuvant oncology treatment. • Neuropsychology – Assessment and management of changes in cognitive processing, personality and / or behaviour arising from brain tumours with the aim of ensuring the patient has mental capacity to support informed decision making, promote independent functioning, and participation in valued activities at any stage of the patients journey.	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.
9.3.1.	Uszkodzenia rdzenia kręgowego	CSCMCPD 2008	72. Develop protocols that allow rehabilitation specialists to become involved early in the management of persons with SCI, immediately following injury during the acute hospitalization	<u>Siła dowodu:</u> NA – not applicable

L.p.	Schorzenie	Publikacja	Zalecenia	Uwagi
1	2	3	4	5
			phase. (Scientific evidence–NA; Grade of recommendation–NA; Strength of panel opinion–5)	<u>Siła rekomendacji:</u> NA – not applicable <u>Poziom konsensusu panelu:</u> Low – 1.0 to less than 2.33 Moderate – 2.33 to less than 3.67 Strong – 3.67 to 5.0
9.3.2.		MASCIP 2017	2. Local rehabilitation services are provided which: • Address vocational needs during review of a person's integrated care plan and as part of any rehabilitation programme 3. Specialist vocational services are provided for people with neurological conditions to address more complex problems in remaining in or returning to work or alternative occupation including: • Specialist vocational assessment and counselling	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.
10.	**Kompleksowa rehabilitacja neurologiczna stacjonarna dla pacjentów z zaburzeniami funkcji obwodowego układu nerwowego i dystrofii mięśniowych**			
10.1.1.	Długoterminowe schorzenia neurologiczne, m.in. nabyte uszkodzenie mózgu, stwardnienie rozsiane, choroba Parkinsona	BSRM 2009	S11. Patients who are in hospital for >48 hours with impaired consciousness or immobility following sudden onset of neurological illness or injury should be assessed by a specialist neuro-rehabilitation team (or at least a member of the team) to provide advice on interim management to prevent secondary complications. The patient should be assessed by that team within 5 working days of referral. Specific advice and information should be given to the person and/or their family relating to sources of support and further information. S12. Patients who are unable to go home directly and require a period of post-acute in-patient rehabilitation should be transferred to a specialist neurological rehabilitation unit as soon as they are medically stable and fit to participate in rehabilitation. The patient should be assessed by that unit within 5 working days of referral. If accepted, the patient should be transferred within 2 weeks of being fit for transfer. S13. Patients with highly complex needs requiring referral to a complex specialised rehabilitation service, (CSRS)* should be identified and referred as early as possible in the acute phase to allow time for any additional arrangements, eg negotiation of funding to be put in place. The CSRS should assess within 10 working days of referral (target 7 days) If accepted, the patient should be transferred within 6 weeks of being fit for transfer (target 1-3 weeks) S14. Following assessment, a written summary should be provided to the referrer within 3 working days which includes: • A summary of the case and the individual's rehabilitation needs • Specific recommendations for management and the intervention plan • Recommendations for alternative placement if specialist rehabilitation is not considered to be the most appropriate solution for the individual's needs • Specific information for the person and/or their family on sources of further support The assessment summary should be copied to the GP and other relevant agencies, including the individual and/or their family, if appropriate	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.

L.p.	Schorzenie	Publikacja	Zalecenia	Uwagi
1	2	3	4	5
10.2.1.	Uszkodzenia rdzenia kręgowego	CSCMCPD 2008	72. Develop protocols that allow rehabilitation specialists to become involved early in the management of persons with SCI, immediately following injury during the acute hospitalization phase. (Scientific evidence–NA; Grade of recommendation–NA; Strength of panel opinion–5)	Siła dowodu: NA – not applicable Siła rekomendacji: NA – not applicable Poziom konsensusu panelu: Low – 1.0 to less than 2.33 Moderate – 2.33 to less than 3.67 Strong – 3.67 to 5.0
10.2.2.		AANSCNS 2013	Neurological Examination: The American Spinal Injury Association international standards for neurological and functional classification of spinal cord injury are recommended as the preferred neurological examination tool for clinicians involved in the assessment and care of acute spinal cord injury patients. [Level II] Functional Outcome Assessment: The Spinal Cord Independence Measure III is recommended as the preferred functional outcome assessment tool for clinicians involved in the assessment, care, and followup of patients with spinal cord injuries. [Level I] Pain Associated With Spinal Cord Injury: The International Spinal Cord Injury Basic Pain Data Set is recommended as the preferredmeans to assess pain, including pain severity, physical functioning, and emotional functioning, among SCI patients. [Level I]	Siła zalecenia: **Level I** – Standards – Reflection of a high degree of clinical certainty **Level II** – Guidelines – Reflection of a moderate degree of clinical certainty **Level III** – Options – Reflection of unclear clinical certainty
10.2.3.		MASCIP 2017	2. Local rehabilitation services are provided which: • Address vocational needs during review of a person's integrated care plan and as part of any rehabilitation programme 3. Specialist vocational services are provided for people with neurological conditions to address more complex problems in remaining in or returning to work or alternative occupation including: • Specialist vocational assessment and counselling	W publikacji nie zamieszczono legendy dotyczącej siły rekomendacji oraz poziomu jakości dowodów.

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