conscious, how should information be given? Should a 'patient discharge summary' be part of common practice to aid patients make sense of their experience?[2]

Who should be involved?

The multidisciplinary team undoubtedly plays an important role in, and following discharge from, ITU. Without standardised care pathways and with limited resources, how well are staff coping? Should family have a role in the rehabilitation pathway? We feel that family involvement in a patient's recovery is often invaluable.

To conclude, recovery from critical illness and an ITU admission is one with many subjective and unclear elements. We suspect with a wide range of clinical practice and without standardised approaches patients may be at risk of further complications. Therefore we urge a need for further data on how, when and who should be involved in the recovery from critical illness. ■

SARAH MCCORMICK
CT2 anaesthetics, Department of Anaesthesia, Dudley NHS Foundation Trust, Russells Hall Hospital, Dudley, UK

CHANDRESH PATEL
Consultant anaesthetist and intensivist, Department of Anaesthesia, Dudley NHS Foundation Trust, Russells Hall Hospital, Dudley, UK

References

1 National Institute for Health and Care Excellence. *Rehabilitation after critical illness*. NICE clinical guideline 83. London: NICE, 2009. www.nice.org.uk/guidance/cG83 [Accessed 5 August 2014].
2 White C, Bench S, Hopkins P. *Critical care patient discharge summary and training pack*. London: Kings College London, 2014. www.icusteps.org/assets/files/ccpatient-discharge-pack.pdf [Accessed 5 August 2014].

Conscientious care for the unconscious patient

Editor – Prof Derick Wade has eloquently summarised a complex issue in 'Conscientious care for the unconscious patient: new guidance from the Royal College of Physicians' (*Clin Med* June 2014 pp 290–1). It has been mentioned that national specialist commissioning should fund all active healthcare while someone is in a vegetative or minimally conscious state. The bed availability at a tertiary neurological rehabilitation unit can be variable and the study of the utilisation of these beds has received little attention.

We conducted a study with the aim to establish the frequency of and reasons for the inappropriately delayed discharges (IDD) from a regional specialist neurological rehabilitation unit. 51 out of 67 patients admitted to the unit were included in this study. Only 19 (37.3%) of them were discharged from hospital on time. The discharge of 32 (62.7%) patients was delayed and the delay was inappropriate in 18 (56.2%) of the 32 cases. Delays in social service provision was the main reason for IDD. This occurred despite the fact that the discharge process was started early and was supported by discharge coordinators. Although other factors may contribute to IDD, addressing the delays of social service provision would be important in reducing IDD.

The new Royal College of Physicians' *Prolonged disorders of consciousness: national clinical guidelines* recommend that continuing healthcare funding should be responsible for all long-term care costs. If these guidelines are followed through we could reduce IDD, thus leading to enhanced availability of beds at tertiary neurological rehabilitation units. ■

SUNIL J ANKOLEKAR
StR in rehabilitation medicine, Birmingham Community Healthcare NHS Trust, Birmingham, UK

ABDEL MAGID BAKHEIT
Professor of neurological rehabilitation, Birmingham Community Healthcare NHS Trust, Birmingham, UK