Can the Chelsea Critical Care Physical Assessment tool (CPAx), observed to predict hospital discharge location in the Chelsea and Westminster general adult critical care population, be similarly applied to the Oldham population? 52 patients were assessed who were discharged from Critical Care at Oldham between May 2014 and Jan 2015. Physiotherapists leading their care up to discharge were blind to their CPAx score.

In 2012, Corner et al published a validated tool to measure physical morbidity in the general adult critical care population. In 2014 Corner et al followed this up with publishing a paper looking at the construct validity of the Chelsea Critical Care Physical Assessment tool (CPAx), analysing the association between CPAx scores and hospital discharge location, as a measure of functional outcome. They observed a clear association between CPAx score on discharge from critical care and place of discharge from hospital. (sample size 499 patients)

<table>
<thead>
<tr>
<th>Aspect of Physicality</th>
<th>Level 0</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Function</td>
<td>Complete ventilator depend-</td>
<td>Ventilator dependence. Man-</td>
<td>Spontaneously breathing with continuous invasive or non-</td>
<td>Spontaneously breathing with intermittent invasive or non-</td>
<td>Receiving standard oxygen therapy (&lt;15 litres).</td>
<td>Self-ventilating with no oxygen therapy.</td>
</tr>
<tr>
<td></td>
<td>ence. Mandatory breaths only.</td>
<td>datory breaths with some spontaneous effort.</td>
<td>invasive ventilatory support.</td>
<td>invasive ventilatory support.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cough</td>
<td>Absent cough, may be fully sedated or paralysed.</td>
<td>Cough stimulated on deep suctioning only.</td>
<td>Weak ineffective voluntary cough, unable to clear independently e.g. requires deep suction.</td>
<td>Weak, partially effective voluntary cough, sometimes able to clear secretions e.g. requires yanker suctioning.</td>
<td>Effective cough, clearing secretions with airways clear- ance techniques.</td>
<td>Consistent effective voluntary cough, clearing secretions independently.</td>
</tr>
<tr>
<td>Dynamic Siting (i.e. when sitting on the edge of the bedunsupported sitting)</td>
<td>Unable/Unstable</td>
<td>Requires assistance ≥2 peo- ple (maximal).</td>
<td>Requires assistance1 person (moderate).</td>
<td>Requires assistance 1 person (minimal).</td>
<td>Independent with some dynamic sitting balance, i.e. able to reach out of base of support.</td>
<td>Independent with full dynamic sitting balance, i.e. able to reach out of base of support.</td>
</tr>
<tr>
<td>Standing Balance</td>
<td>Unstable/unstable/bedbound</td>
<td>Tilt table or similar</td>
<td>Standing fossi or similar.</td>
<td>Dependant on frame, crutches or similar.</td>
<td>Independent without aids.</td>
<td>Independent without aids and full dynamic standing balance, i.e. able to reach out of base of support.</td>
</tr>
</tbody>
</table>

Table 1 Hospital discharge categories
Survival Categories
1. Home with no rehabilitation needs, considered the optimal outcome. No community services accessed. ≥39-50
2. Home with community support, this may vary from a full package of care to outpatient physiotherapy, Package of care, Integrated care team, Domiciliary therapy Outpatient therapy. 32-39/50
3. A short stay inpatient rehabilitation facility (<6 weeks). An inpatient facility that had a maximum length of stay of 6 weeks. 25-32/50
4. A long stay rehabilitation facility (>6 weeks). An inpatient facility that had an expected length of stay of more than 6 weeks. 20-25/50
5. Nursing home level of care On-going daily nursing needs in a nursing home environment or home with a maximal care package, including a hospital bed and hoist transfers. 13-20/50
6. Non-survival categories: 1. Non-survival from ICU ≤3/50
2. Non-survival from hospital ≤22/50

Oldham Population (47 of 52 patients were included. 5 patients were discounted for incomplete data or who haven’t yet left hospital)
Survival Category and % patients who matched the predicted outcome;
1. ≥ 39-50/50—100% with this score achieved this outcome (5/5)
2. 32-39/50—50% with this score achieved this outcome. (1 of 2 went to IMC)
3. 25-32/50—73% with this score achieved this outcome. (3 died and 1 needed long term rehab)
4. 20-25/50—75% with this score achieved this outcome (2/2)
5. 13-20—0% with this score achieved this outcome (3/3 died)
6. <2—83% with this score did not survive hospital (1/8 went home with community physio)
7. ≤3—91% with this score died on ICU (1/3 went to long term rehab)

Discussion
This poster set out to test the observation that the CPAx score on d/c from Critical care can be used to predict place of discharge from hospital in the Oldham general adult critical care population. In 5 out of 7 categories it matched the Chelsea and Westminster population by over 70%. In categories 2, 3 and 5, (50%, 17% and 100%), of those that did not match the outcome, outcomes were worse than predicted. In categories 6 and 7, of those that did not match the outcome, (17% and 8%), outcomes were better. Overall 71% of the population matched their outcome to the score and as such shows that the Oldham population is close enough to the Chelsea and Westminster population to allow the CPax score to be used to predict place of d/c. The lower scores have a higher % prediction for non survival from hospital.

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