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STRUCTURED COMMUNICATION AND CONTINUITY OF PHYSIOTHERAPY CARE IN CARE TRANSITIONS IN THE ICU: AN EXPERIENCE REPORT

COMUNICAÇÃO ESTRUTURADA E CONTINUIDADE DO CUIDADO FISIOTERAPÊUTICO EM TRANSIÇÕES ASSISTENCIAIS NA UTI: RELATO DE EXPERIÊNCIA

COMUNICACIÓN ESTRUCTURADA Y CONTINUIDAD DE LA ATENCIÓN FISIOTERAPÉUTICA EN LAS TRANSICIONES ASISTENCIALES EN LA UCI: RELATO DE EXPERIENCIA

Laysa Silva e Oliveira[1], Sâmia Vilarinho Martins[2], Aldenora Maria Ximenes Rodrigues[3]

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ABSTRACT
Objective: To report on the experience of organizing the continuity of physiotherapy care in the ICU, with emphasis on shift-to-shift handover, structured communication, and the identification of gaps related to care transfer between sectors. Methods: This is a descriptive experience report based on the practice of a day-shift physiotherapist in a 10-bed adult ICU between January and June 2026. Results: The main finding was that a structured handover form, based on a logic similar to the SBAR model, favored the systematization of information on ventilatory support, functional status, devices in use, intercurrent events, and therapeutic goals. Continuity of care was more consistent among physiotherapists within the same unit than during transfers between sectors, highlighting the need to extend structured communication to admissions and transfers as well. The day-shift physiotherapist served as a link between on-call physiotherapists and the multiprofessional team, and the systematization of information and standard operating procedures (SOPs) proved relevant in reducing unjustified variability in clinical practice. Conclusions: Structured communication, handover forms, updated SOPs, and admission/transfer checklists can strengthen continuity of physiotherapy care in the ICU, especially across sector transfers. Future studies should validate structured instruments and assess their effects on care and patient safety indicators.

KEYWORDS: Physical Therapy Specialty. Intensive Care Units. Continuity of Patient Care. Health Communication. Patient Safety.

RESUMO
Objetivo: Relatar a experiência de organização da continuidade do cuidado fisioterapêutico em UTI, com ênfase na passagem de plantão entre turnos, na comunicação estruturada e na identificação de lacunas relacionadas à transferência de cuidado entre setores. Método: Trata-se de um relato de experiência, descritivo, elaborado a partir da vivência de uma fisioterapeuta diarista em UTI adulta de 10 leitos. Resultados: A implantação de ficha de passagem de plantão estruturada, baseada em lógica semelhante ao modelo SBAR, favoreceu a sistematização de informações sobre suporte ventilatório, condição funcional, dispositivos em uso, intercorrências e metas terapêuticas. A continuidade do cuidado mostrou-se mais consistente entre fisioterapeutas do mesmo setor, evidenciando a necessidade de ampliar a comunicação estruturada também para admissões e transferências. A função de fisioterapeuta diarista

[1] Fisioterapeuta, mestrado em Ciências Biomédicas pela Universidade Federal do Piauí (UFPI).
[2] Fisioterapeuta pela Universidade Federal do Piauí (UFPI).
[3] Biomédica, doutora em Biotecnologia pela Universidade Federal do Piauí (UFPI), pós-doutorado em Imunologia de Tumores pela Universidade Estadual Paulista Júlio de Mesquita Filho (Unesp). Pesquisadora em Avaliação de Tecnologias em Saúde (DATS) do Instituto Nacional de Câncer (INCA).

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mostrou-se como elemento articulador entre plantonistas e equipe multiprofissional e a sistematização das informações, bem como os procedimentos operacionais padrão (POPs) mostraram-se relevantes para reduzir a variabilidade não justificada nas condutas. Conclusões: A continuidade do cuidado fisioterapêutico em UTI pode ser fortalecida por meio de comunicação estruturada, ficha de passagem, POPs atualizados e checklists de admissão/transferência entre setores. Estudos futuros devem validar instrumentos estruturados e avaliar seus efeitos sobre indicadores assistenciais e de segurança do paciente.

PALAVRAS-CHAVE: Fisioterapia. Unidades de Terapia Intensiva. Continuidade da Assistência ao Paciente. Comunicação em Saúde. Segurança do Paciente.

RESUMEN
Objetivo: Relatar la experiencia de organización de la continuidad de la atención fisioterapéutica en una UCI, con énfasis en el relevo de turno, la comunicación estructurada y la identificación de brechas relacionadas con la transferencia de la atención entre sectores. Método: Se trata de un relato de experiencia, de carácter descriptivo, elaborado a partir de la práctica de una fisioterapeuta de jornada diurna en una UCI de adultos con 10 camas. Resultados: La implementación de una ficha estructurada para el relevo de turno, basada en una lógica similar al modelo SBAR, favoreció la sistematización de la información sobre soporte ventilatorio, condición funcional, dispositivos en uso, intercurrencias y objetivos terapéuticos. La continuidad de la atención se mostró más consistente entre los fisioterapeutas del mismo sector, lo que evidenció la necesidad de ampliar la comunicación estructurada también a los procesos de admisión y transferencia. La función de la fisioterapeuta de jornada diurna se mostró como un elemento articulador entre los fisioterapeutas de turno y el equipo multiprofesional, y la sistematización de la información, así como los procedimientos operativos estándar (POE), se mostraron relevantes para reducir la variabilidad no justificada de las conductas asistenciales. Conclusiones: La continuidad de la atención fisioterapéutica en la UCI puede fortalecerse mediante la comunicación estructurada, el uso de fichas de relevo de turno, POE actualizados y listas de verificación para la admisión y transferencia entre sectores. Futuros estudios deberán validar instrumentos estructurados y evaluar sus efectos sobre los indicadores asistenciales y de seguridad del paciente.

PALABRAS CLAVE: Fisioterapia. Unidades de Cuidados Intensivos. Continuidad de la Atención al Paciente. Comunicación en Salud. Seguridad del Paciente.

INTRODUCTION

Failures in handoff communication represent a critical issue for patient safety, particularly in complex environments such as the Intensive Care Unit (ICU). Studies on handoff communication indicate that inadequate communication may be associated with adverse events, with a risk of up to 80% of serious errors, information loss, and failures in continuity of care[1,2]. Therefore, an effective handoff in the ICU enhances continuity of care, reduces delays in discharge, readmissions, and adverse events, and improves patient and professional satisfaction, representing a key moment for clinical decision-making and continuity of care[3].

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In intensive care units, critically ill patients receive care from multiple professionals throughout the day and across different shifts. During care transitions, staff changes may lead to discontinuity of care when there is no structured communication regarding functional diagnosis, therapeutic goals, response to interventions, safety limits, adverse events, and the progression plan[4,2].

In the absence of a standardized workflow, each professional may adopt different approaches, repeat unnecessary assessments, modify goals without justification, or fail to advance care due to a lack of information. This may compromise patient safety, the efficiency of care, and functional recovery[5].

Physiotherapists working in intensive care units are responsible for the assessment, monitoring, and ventilatory support of critically ill patients, whether they have a spontaneous or artificial airway. Their responsibilities also include functional kinetic assessment and diagnosis, as well as interventions related to the cardiorespiratory and neuromusculoskeletal systems. They must be able to interpret imaging examinations, perform functional tests, and implement interventions inherent to their profession[6]. These activities must be properly documented in the medical records and communicated briefly and effectively during handoffs.

In a review of internal transitions in hospital care, McCarthy et al. also highlighted that there is no standardized protocol for physiotherapy handoffs. However, adaptable models such as Situation, Background, Assessment, and Recommendation (SBAR) and Illness severity, Patient summary, Action items, Situational awareness, Synthesis by receiver (I-PASS) are widely studied, safe, and effective tools for ensuring accurate handoff communication[7].

Therefore, this article aims to report an experience in organizing the continuity of physiotherapy care in the ICU, with an emphasis on intershift handoffs, structured communication, and the identification of gaps related to care transitions between hospital sectors.

2 METHODS

2.1 STUDY DESIGN

This is a descriptive and reflective experience report based on the experience of the first author during her work as a daytime physiotherapist in an adult ICU. This role involved bedside patient care, monitoring physiotherapy handovers, participating in multidisciplinary discussions, analyzing care records, and coordinating communication among on-duty physiotherapists to promote continuity of care.

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2.2 STUDY SETTING

The experience took place in an adult ICU with 10 beds, supported by a multidisciplinary team operating 24 hours a day. Physiotherapy care was provided by on-duty physiotherapists working 12-hour shifts and by a daytime physiotherapist responsible for coordinating care and assisting with clinical activities.

2.3 PERIOD OF THE EXPERIENCE

The reported experience took place from January to June 2026, during the professional activities of the physiotherapy team in the ICU. During this period, the physiotherapy handover process was observed and monitored.

2.4 PARTICIPANTS INVOLVED IN THE EXPERIENCE

The individuals involved in the experience included the first author, who worked as a daytime physiotherapist; on-duty physiotherapists; the multidisciplinary team involved in patient care discussions; and critically ill patients cared for by the team, without individual identification.

2.5 ETHICAL CONSIDERATIONS

As this was an experience report concerning a work process, without identification of patients, professionals, or the institution, and without the collection of individualized clinical data, the report was prepared while preserving anonymity and confidentiality, in accordance with applicable ethical principles.

3 OBJECTIVES OF THE EXPERIENCE

The experience aimed to describe the physiotherapy handover process in an adult ICU, promote the continuity of care-related information between shifts, and identify weaknesses in the transfer of care between sectors. It also sought to align physiotherapy practices through structured communication, the use of a handover form, monitoring of standard operating procedures (SOPs), care bundles, and multidisciplinary discussion routines, with a view to promoting patient safety in critically ill patients and standardizing the care process.

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4 DESCRIPTION OF THE EXPERIENCE

4.1 CHARACTERIZATION OF THE CARE SETTING

The experience took place in an adult ICU with 10 beds, located within a hospital service that receives patients from different sectors, including the emergency department, hospital wards, and other intensive care units. The unit's care profile is characterized by the management of adult patients, predominantly older adults, individuals with chronic conditions, and patients with multiple comorbidities, such as chronic obstructive pulmonary disease, diabetes mellitus, systemic arterial hypertension, and chronic kidney disease.

Patient care is provided continuously, with a multidisciplinary team operating 24 hours a day. Within the physiotherapy team, care is provided by on-duty physiotherapists working rotating 12-hour shifts and by a daytime physiotherapist who works from Monday to Friday. The on-duty physiotherapists are responsible for direct bedside care, including clinical and functional assessments, analysis of laboratory and imaging tests, the planning and implementation of respiratory and motor interventions, prevention of complications, and documentation of interventions in the electronic medical record.

The complexity of the patients treated requires continuity of care between shifts, as physiotherapy interventions involve decisions related to ventilatory support, mobilization, functionality, prevention of complications, device management, safety during interventions, and the planning of therapeutic goals. In this context, the physiotherapy handover plays a strategic role in ensuring that relevant information is clearly communicated and that interventions performed during one shift can be understood, reassessed, and continued by the subsequent professional.

Furthermore, because the unit receives critically ill patients at different stages of clinical progression, including individuals already receiving invasive mechanical ventilation or with prolonged previous hospitalizations, continuity of care becomes essential to prevent fragmentation of care. In this setting, physiotherapy care is not limited to isolated interventions but involves monitoring clinical, functional, and respiratory progress, aiming to prevent complications and maintain the best possible level of functionality throughout hospitalization.

4.2 ROLE OF THE DAYTIME PHYSIOTHERAPIST IN CONTINUITY OF CARE

In the reported experience, the role of the first author as a daytime physiotherapist was a central element in ensuring continuity of care. Unlike a role restricted to individual shifts, her daily presence in the unit allowed her to monitor patients' progress throughout the week, identify

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pending care needs, observe the continuation or interruption of therapeutic goals, and coordinate information among on-duty physiotherapists and the multidisciplinary team.

Among the activities performed by the daytime physiotherapist, daily bedside visits were particularly noteworthy. During these visits, the patient's general clinical condition, devices in use, ventilatory support, tolerance to physiotherapy interventions, mobility level, and main pending care needs were assessed. This daily assessment allowed for monitoring patients' progress over time and identifying whether proposed goals were being maintained, adjusted, or interrupted between shifts.

The daytime physiotherapist also monitored physiotherapy handovers and held discussions with on-duty physiotherapists, acting as a link between professionals who succeeded one another in patient care. This role was relevant because, in a sequence of consecutive shifts, there is a risk of information loss, unjustified changes in clinical management, or interruption of previously established goals. Thus, the presence of a professional working daily in the unit promoted greater integration between shifts and contributed to more consistent and continuous care.

Another important activity was participation in multidisciplinary rounds, during which patient cases were discussed individually by the team. At these meetings, information regarding patients' clinical status, therapeutic goals, pending care needs, risks, and care priorities was updated. Physiotherapy participation in this process facilitated the integration of physiotherapy interventions with the overall care plan, allowing respiratory, functional, and mobilization-related aspects to be considered in multidisciplinary decision-making.

The daytime physiotherapist's role also involved monitoring institutional routines, such as the implementation of care bundles and checklists, particularly the bundle for the prevention of ventilator-associated pneumonia. Although this bundle was not the central focus of the report, it illustrated the importance of continuity of care between shifts, since preventive measures need to be performed and documented systematically rather than depending exclusively on the individual initiative of each professional. Maintaining these routines reinforced the need for structured communication, process standardization, and high-quality documentation.

Thus, the experience showed that the daytime physiotherapist can serve as a mediator between clinical care and care management, contributing to the alignment of interventions, identification of communication weaknesses, updating of standard operating procedures, and promotion of more continuous, safe, and patient-centered physiotherapy care.

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4.3 CHALLENGES OBSERVED IN CONTINUITY OF PATIENT CARE

Despite the existence of a routine physiotherapy handover process, variations in continuity of care were observed due to differences in how each professional conducted assessments, interpreted goals, and implemented interventions. This individuality is expected and is part of professional autonomy, since clinical decision-making depends on technical judgment in light of the patient's current condition. However, when common guidelines or updated procedures are lacking, such variation may lead to inconsistencies in care between shifts.

Among the challenges observed was the possibility of changes in therapeutic goals without clear documentation of the clinical rationale, repetition of assessments that had already been performed, interruption of interventions initiated during previous shifts, or difficulty progressing functional rehabilitation due to a lack of information regarding tolerance, adverse events, and safety limits. These factors may compromise continuity of care, particularly in critically ill patients, in whom small changes in ventilatory support, hemodynamic stability, level of consciousness, or the presence of devices may alter the feasibility of physiotherapy interventions.

Another challenge concerned the documentation of interventions and the standardization of information recorded in medical records by teams and sectors in general. Verbal handover is important but is not sufficient to ensure that information is retained across shifts and during transfers between sectors. Information related to muscle strength, mobility level, response to mobilization, respiratory changes, secretions, the need for secretion clearance therapy, use of vasoactive drugs, invasive devices, fall risk, adverse events, and other relevant aspects should be recorded objectively and made readily accessible.

In the ICU routine, preventing complications associated with prolonged hospitalization also requires continuity among professionals. Patients undergoing invasive mechanical ventilation (IMV) are at risk of ventilator-associated pneumonia, a condition described in the literature as a frequent complication associated with longer hospital stays, prolonged mechanical ventilation, increased costs, and mortality [8,9,10]. The consistent implementation of preventive measures, such as head-of-bed elevation, oral hygiene, assessment of readiness for weaning, and device care, depends on well-defined routines and effective communication between shifts.

Similarly, prolonged periods of mechanical ventilation and immobility may contribute to intensive care unit-acquired weakness and loss of muscle mass, conditions associated with poorer functional outcomes following critical illness [11,12]. In this regard, continuity of motor interventions, progressive mobilization, and functional goals is essential to reduce fragmentation of care and promote the maintenance of the highest possible level of functionality during hospitalization.

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Thus, the main challenges observed were related not only to the transfer of information but also to the need to transform that information into a shared care plan. The experience demonstrated that continuity of physiotherapy care requires structured communication, standardized documentation, updated protocols, alignment meetings, and the strengthening of evidence-based practice.

4.4 STRATEGIES, TECHNOLOGIES, AND PRACTICES USED

One of the strategies implemented in the unit to promote continuity of care was a physiotherapy handover process based on an approach similar to the SBAR model, a tool widely used to organize communication in healthcare. The SBAR model structures the transmission of information into four components: situation, background, assessment, and recommendations. This organization helps the professional taking over the shift to quickly understand the patient's current condition, recent clinical events, physiotherapy assessment, and goals established for the continuity of care.

In the reported experience, the handover included information about the patient's current condition and physiotherapy assessment, including ventilatory support and motor status; the use of sedation, vasoactive drugs, and medical devices; recent history, including clinical events and progression; level of consciousness, presence of delirium, and other relevant clinical aspects; as well as recommendations regarding mobilization, exercises, device care, therapeutic goals, and safety limits. At the end of the shift, the on-duty physiotherapist sent general information, along with the structured handover form, to the other physiotherapists and the coordination team.

In addition to the structured handover, the unit incorporated the use of standard operating procedures (SOPs) to guide the implementation of various physiotherapy interventions. The bundle for the prevention of ventilator-associated pneumonia can be used as a practical example of the importance of consistent protocols and documentation. Due to an increase in cases in the unit, guidance was provided regarding the implementation and documentation of the bundle during both day and night shifts. This strategy reinforced the understanding that continuity of care depends on the adherence of all professionals, clarity regarding responsibilities, and the maintenance of preventive measures throughout the shifts.

5 MAIN RESULTS ACHIEVED

The experience led to the recognition of structured physiotherapy handover as a relevant strategy for organizing continuity of care between shifts in the ICU. The use of a handover form based on an approach similar to the SBAR model facilitated the systematization of information

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related to ventilatory support, functional status, devices in use, clinical events, interventions performed, patient response, and goals for the subsequent shift.

The findings from this experience are consistent with the current literature [3,7], reinforcing that an effective and well-structured handover based on assertive communication among professionals provides numerous benefits for shift management, the minimization of errors, and, above all, continuity of care.

One of the main results of the experience was the identification that continuity of care was more organized during handovers between physiotherapists from the same sector than during transfers of patients arriving from other sectors. This finding highlighted the need to expand the structured communication approach beyond shift changes to also include patient admission to and transfer from the ICU, thereby reducing the loss of relevant clinical and physiotherapy-related information.

The experience also highlighted the importance of SOPs as resources for reducing unjustified variations in clinical practices, guiding evidence-based practice, and supporting the documentation of actions performed. However, the need for periodic review of these documents was observed, considering updates in the scientific literature, the resources available within the service, team demands, and the characteristics of the patients treated. SOPs are important because they help reduce unjustified variability, facilitate evidence-based practice, and support the documentation of actions performed [13,14].

Regarding the monitoring of the pneumonia prevention bundle, the guidance to implement and document the bundle during both day and night shifts reinforced the need for collective adherence to preventive measures and consistent documentation, promoting greater clarity regarding care responsibilities between shifts.

Another relevant result was the recognition of the role of the daytime physiotherapist as a coordinator of continuity of care. Her daily presence in the unit made it possible to monitor patients' progress, identify pending care needs, observe interruptions or changes in therapeutic goals, and promote alignment between on-duty physiotherapists and the multidisciplinary team. Thus, the experience contributed to identifying areas for improvement in the work process and supporting proposals to enhance communication and standardize care practices.

6 LIMITAÇÕES DA EXPERIÊNCIA

A principal limitação foi a vivência da relatora apenas no período diurno, avaliando os eventos noturnos apenas durante a passagem de plantão, por relatos dos profissionais e pelas informações documentadas em prontuário. Além da limitação espacial, visto este ser o relato de

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uma vivência em apenas um setor de UTI, sendo portanto um recorte da realidade de ambientes de terapia intensiva.

Além disso, não foram mensurados indicadores objetivos antes e após a adoção das estratégias descritas, como taxa de eventos adversos, completude dos registros ou satisfação da equipe. Também não houve validação formal da ficha de passagem de plantão ou do checklist de admissão/transferência, o que limita inferências sobre sua eficácia ou aplicabilidade em outros contextos.

7 CONTRIBUIÇÕES PARA A PRÁTICA CLÍNICA

A experiência contribui para a prática clínica ao evidenciar que a continuidade do cuidado fisioterapêutico em UTI depende de processos estruturados de comunicação, registro e alinhamento de condutas. A adoção de uma ficha de passagem de plantão pode favorecer a transmissão de informações essenciais entre fisioterapeutas. Outra contribuição refere-se à necessidade de ampliar a padronização da comunicação para os momentos de admissão e transferência de pacientes entre setores. A elaboração de um checklist específico para admissão e transferência pode auxiliar na identificação de informações clínicas e funcionais relevantes, reduzir omissões, evitar duplicidade de avaliações e apoiar a definição de metas fisioterapêuticas desde a entrada do paciente na UTI.

A experiência também reforça a importância da criação, revisão e atualização periódica de POPs, de modo que as condutas sejam orientadas por evidências científicas, adaptadas à realidade local e compreendidas por toda a equipe. Além disso, reuniões periódicas e treinamentos recorrentes podem constituir estratégias de educação permanente, permitindo discutir dificuldades do processo de trabalho, alinhar condutas, esclarecer dúvidas coletivas e fortalecer a comunicação entre os profissionais. Tais ações podem contribuir para a integração da equipe, para a segurança do paciente e para a continuidade do cuidado fisioterapêutico em ambientes de alta complexidade.

8 CONSIDERAÇÕES FINAIS

A experiência infere que a continuidade do cuidado fisioterapêutico em UTI pode ser fortalecida por meio de comunicação estruturada, ficha de passagem, POPs atualizados e checklists voltados tanto à troca de turnos quanto às admissões e transferências entre setores. Estudos futuros devem validar instrumentos estruturados e avaliar seus efeitos sobre indicadores assistenciais e segurança do paciente.

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REFERENCES

1. Ayala WL. Impact of a standardized tool on handoff quality in nurse change-of-shift [dissertation]. Minneapolis (MN): Walden University; 2017.
2. Anwar D. Handover processes and practices of critically ill patients between nursing staff from the intensive care units of private hospitals in the eThekwini District, KwaZulu-Natal [dissertation]. Durban: Durban University of Technology; 2022. doi:10.51415/10321/4447.

3. Sluisveld N van, Hesselink G, van der Hoeven JG, Westert GP, Wollersheim H, Zegers M. Improving clinical handover between intensive care unit and general ward professionals at intensive care unit discharge. Intensive Care Med. 2015;41(4):589-604. doi:10.1007/s00134-015-3666-8.

4. Appelbaum RD, Farrell MS, Hoth JJ, Jung HS, Pathak A, Nassar AK, et al. Handoffs and transitions of care in the intensive care unit: an American Association for the Surgery of Trauma Critical Care Committee clinical consensus document. Trauma Surg Acute Care Open. 2025;10:e001677. doi:10.1136/tsaco-2024-001677.

5. Reifarth E, Naendrup JH, Garcia Borrega J, et al. Übergaben auf der Intensivstation. Med Klin Intensivmed Notfmed. 2024;119:253-259. doi:10.1007/s00063-024-01127-x.

6. Conselho Federal de Fisioterapia e Terapia Ocupacional (COFFITO). Resolução nº 402, de 3 de agosto de 2011. Disciplina a Especialidade Profissional de Fisioterapia em Terapia Intensiva e dá outras providências. Diário Oficial da União. 2011 Nov 24.

7. McCarthy S, Motala A, Lawson E, Shekelle PG. Use of structured handoff protocols for within-hospital unit transitions: a systematic review from Making Healthcare Safer IV. BMJ quality & safety. 2025 Sep 18; 34 (10):680-690, DOI: 10.1136/bmjqs-2024-018385.

8. Kalil AC, Metersky ML, Klompas M, Muscedere J, Sweeney DA, Palmer LB, et al. Management of adults with hospital-acquired and ventilator-associated pneumonia: 2016 clinical practice guidelines by the Infectious Diseases Society of America and the American Thoracic Society. Clin Infect Dis. 2016;63(5):e61-e111. doi:10.1093/cid/ciw353.

9. Hellyer TP, Ewan V, Wilson P, Simpson AJ. The Intensive Care Society recommended bundle of interventions for the prevention of ventilator-associated pneumonia. J Intensive Care Soc. 2016;17(3):238-243. doi:10.1177/1751143716644461.

10. Li J, Li G, Liu Z, et al. Prediction models for the risk of ventilator-associated pneumonia in mechanically ventilated patients: a systematic review and meta-analysis. Am J Infect Control. 2024;52(12):1438-1451. doi:10.1016/j.ajic.2024.07.006.

11. Puthucheary ZA, Rawal J, McPhail M, Connolly B, Ratnayake G, Chan P, et al. Acute skeletal muscle wasting in critical illness. JAMA. 2013;310(15):1591-1600. doi:10.1001/jama.2013.278481.
12. Vanhorebeek I, Latronico N, Van den Berghe G. ICU-acquired weakness. Intensive Care Med. 2020;46(4):637-653. doi:10.1007/s00134-020-05944-4.

13. Cardell CF, Peters XD, Hu QL, Robinson-Gerace A, Mistretta S, Wescott AB, et al. Evidence review for the American College of Surgeons Quality Verification Program. Part III: Standardization, protocols, and achieving better patient outcomes. J Am Coll Surg. 2024;239(5):494-510. doi:10.1097/XCS.0000000000001126.

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Revista Científica Multidisciplinar | Journal Health and Technology – JHT – ISSN 2764-7625
v.8, n.2, 2026

14. Nachtigall I, Deja M, Tafelski S, Tamarkin A, Schaller K, Halle E, et al. Adherence to standard operating procedures is crucial for intensive care unit survival of elderly patients. **J Int Med Res.** 2008;36(3):438-459. doi:10.1177/147323000803600308

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