COVID-19 patients on Ward 32

During the COVID-19 pandemic, I have been working on a renal ward, where we have received some patients that have stepped down from ITU.

Patient 1

The first patient who arrived on the ward from ITU had been intubated and ventilated and weaned from a tracheostomy. She had been completely independent prior to her admission but was so deconditioned when she arrived that she could not sit unsupported or even press the call button to alert the nursing staff of her needs. Initial limitations to rehabilitation included her fatigue and breathlessness but also urinary incontinence and her anxiety around this. She had a background of myocarditis and hypertrophic cardiomyopathy and experienced a myocardial infarction during rehabilitation despite all observations being stable.

Following specialist input, her continence has started to recover and she did not require any renal replacement therapy following her stepdown to the ward. Oxygen support was able to be weaned steadily and she no longer requires any oxygen. She herself reports that she feels 'she has now much more energy' and her exercise tolerance has greatly improved. Physically she has recovered well and following two weeks worth of twice daily physiotherapy sessions, she is now independently mobile with a wheeled zimmer frame and can manage all of her transfers independently. Her rehabilitation sessions have included: functional tasks (rolling; bridging; reach and grasp); balance exercises (static and dynamic sitting balance before progression to standing); strength exercises (bed-based, chair-based, standing and theraband work) and mobility/transfer practice (progressed from hoist to wheeled zimmer frame). She has now swabbed COVID negative and it is likely she will be medically fit for discharge within the coming week.

Patient 2

Next arrived a patient, who had spent time on ITU for CPAP and dialysis. The staff on ITU had handed over that she was very oxygen dependent and it had been a long process to wean her oxygen requirements down. When she arrived on the ward, she was requiring 5 litres of oxygen via a facemask and her chest x-ray still showed significant bilateral infiltrates. Like patient 1, she was completely independent prior to admission but demonstrated a good retention of her strength. She was able to straight leg raise bilaterally and transfer herself independently onto the edge of the bed and into standing. Her main limitation within physiotherapy continues to be her breathlessness.

Whilst she has been weaned to 3 litres of oxygen, she continues to require additional oxygen (5 litres via a portable cylinder) for any functional tasks that will cause exertion. Transferring from lying to sitting leaves her exhausted and she requires regular rests. She does not need much physical assistance when mobilising - she only requires a light handhold from a therapist but is only able to manage distances of 10 metres. After mobilising, she desaturates to values in the late seventies/early eighties and it can take five to ten minutes for her to recover to values within a normal range. She has further continued to require renal

replacement therapy on the ward and her post-therapy fatigue has further contributed to her reduced exercise tolerance. There has been no real change in her presentation in the initial five days of rehab. Her physiotherapy sessions include: transfer practice; bed and chair-based bodyweight strength exercises; mobility practice with an emphasis on relaxed breathing and pacing; and closely monitoring oxygen saturations during tasks with the intention to wean as able.

She has now swabbed COVID negative but there are no plans for discharge.

Patient 3

The final and most recent patient admitted to the ward from ITU is by far the most complex, despite being the youngest (48 yr old). He had been intubated, ventilated and proned, before being slowly weaned from a tracheostomy. He is a bariatric gentleman with a history of kidney transplant - the kidney had began to fail during his ITU admission and he required renal replacement therapy. He has not required this on the ward as there have been indications that the kidney has started to recover. His oxygen requirements are stable and he is currently only requiring 2 litres via a nasal cannula.

However, he has an extensive Grade 4 pressure sore to his sacrum. Following discussion with Tissue Viability and the ward consultant, it was decided that the sore may be osteomyelitis and that he would require an MRI. At present, he is not medically stable enough and there is some concern that his body dimensions will not be compatible with the scanner. From a physiotherapy point of view, we were advised that attempting to sit on the edge of the bed or hoist him could be detrimental to the sore and likely cause him severe pain. Instead, he is for regular turns and physiotherapy is limited to bed rolling and bed exercises. He is globally deconditioned and only able to achieve plantargrade in his ankles with passive stretching - this has been managed with Leeder boots. He has no active movement in his right elbow or shoulder as this is likely to have been subluxed when he was proned. He is due to have a CT to investigate this further and at present is requiring a third person during rolling to de-weight and support the right upper limb.

Other notable factors are psychological ones. He is incredibly frustrated by his current situation, having been independent and working prior to his admission. He is extremely upset about the fact that he is unable to take himself to the toilet or reposition himself in the bed to get comfortable. He will often express that he ‘is never getting left alone’ due to the amount of support he is requiring at present He is disturbed from his ITU admission, which has left him having nightmares and unable to sleep at night, meaning he is then fatigued and experiencing hypersomnia. Finally, he is displaying signs of post-ITU delirium - he has difficulty retaining information and following instructions and he lacks insight into decisions that are within his best interest. For example, he has started to decline oxycodone in preference for paracetamol but then expresses he is in too much pain to be repositioned or rolled due to his pressure sore.

He is likely to have a lengthy admission.

From a colleague of Paul