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Rehabilitation medicine and Covid-19 at glance

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Description

The field of physical medicine and rehabilitation (PM&R) has come a long way from its nineteenth century informal roots in the U.S. Civil War and the postbellum modalities craze, as well as from its more formal roots in the world wars of the early twentieth century. Although an interdisciplinary team focus on the needs of individuals with acute and chronic disability has remained at the heart of the field, increasingly, the role of technology and interventional procedures to diagnose, monitor, manage, and deliver virtual care for neurologic, musculoskeletal, and disability has helped to move the field into the twenty-first century.

Rehabilitation in general forms a critical component of the acute care pathway, helping to relieve pressure on the acute and frontline services. It is shown to be both effective and cost-effective, whether through improving independence and societal reintegration; or managing the impacts of long-term disability including neuro-palliative care.

The Covid-19 pandemic has already led to a marked increase in the burden of disease and disability and will continue to do so.

It has produced many new challenges:

- A diminished workforce due to sickness, shielding and redeployment to frontline services.
- The many impacts of social distancing including o socio-economic and psychosocial effects for example; isolation of patients from their families, restrictions on interventions that involve hands-on treatment, group interventions or aerosol generating procedures.
- An as yet unquantifiable additional case-load of patients with post-Covid disability presenting with a wide range of problems due to cardio-pulmonary, musculoskeletal, neurological and psychological/psychiatric complications of the disease, compounded in many cases by deconditioning from prolonged stays in ITU.

Rehabilitation for Covid-19 patients should start as early as possible while the patient is still in intensive care. On step-down from intensive care, a rapid access acute rehabilitation programed can provide very early intervention and the opportunity for further triage into post-acute pathways in the network. The majority of patients are on a fairly fast recovery track. Their needs may be met by the local (Lever 3) rehabilitation services, but these require significant expansion to enable patients to access them in a timely manner.

Small number of patients will have more complex rehabilitation needs or a slower trajectory towards recovery. These may require specialist rehabilitation in a Level 1 or 2 services, often for longer periods. Hyper-acute specialist rehabilitation units provide rehabilitation for patients who continue to be medically unstable with input from all the relevant medical and surgical specialties. There are currently 75 specialist rehabilitation units in England catering for around 2500 admissions per year. There are currently 75 specialist rehabilitation units in England catering for around 2500 admissions per year.

Some post-Covid patients will still be shedding virus as they enter rehabilitation, especially in the early stages, so both Covid positive and Covid negative services are required. Rehabilitation typically involves close face-to-face care, so staff should have access to all the necessary Personal Protective Equipment (PPE) to manage this safely.

The Rehabilitation Prescription (RP) is used to record rehabilitation needs and make recommendations for how these should be met as patients leave the acute wards. Consultants in Rehabilitation Medicine (RM) have particular skills in the diagnosis, management and prognostication of complex disability regardless of its cause. They provide in-reach to acute services to assist with RPs and to help identify patients with complex needs and direct them down the appropriate pathway.

Rehabilitation medicine is likely face huge challenges in the future in the long-term post-Covid era. This will inevitably lead to many changes which there is little certainty about at this moment of time.

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