Critical Care Surge Response During COVID-19

In 2014, a consensus statement was published on mass critical care during public health emergencies. Over the last two years, the COVID-19 pandemic has highlighted gaps in prior pandemic planning and the need for modification based on experiences acquired during the surges of COVID-19 throughout the world.

A subcommittee from the Task Force for Mass Critical Care (TFMCC) investigated the recent COVID-19 publications and TFMCC members' experience to formulate strategies to optimise contingency level care and prevent circumstances that could increase mortality.

The TFMCC committee adopted a modified version of the rapid guideline methodologies from the World Health Organization and the Guidelines International Network-McMaster Guideline Development Checklist. Based on this, they have developed pandemic surge suggestions that incorporate peer-reviewed literature, evidence from media sources and anecdotal experiential evidence.

The committee outlines ten suggestions regarding staffing, load-balancing, communication and technology. These include:

1. Using graded staff-to-patient ratios with consideration to experience level, resources and patient acuity.
2. Limiting overtime to less than 50% above normal for healthcare workers to minimise burnout and exhaustion.
3. Prioritising the mental health needs of healthcare workers to maintain an effective response and staffing capacity.
4. Minimising redundant clinical documentation requirements to focus on core elements directly related to care.
5. Actively monitoring resource strain level determined by front-line clinical leaders based on available resources and conditions.
6. Understanding the limits of contingency care when scarce resources are modified beyond routine standards and recognising critical clinical prioritisation level when requesting resources of patient transfers.
7. Ensuring early transfer of patients before a hospital is overwhelmed and promoting conservation of resources and less deviation from routine care standards.
8. Utilisation of regional transfer centres for load-balancing during surges for patient transfers and placement.
9. Ensuring active participation from clinicians actively engaged in clinical work in hospital incident command structure to improve situational awareness and ensure bidirectional communication.
10. Applying telemedicine technology to augment critical care.

It is important to recognise that before the COVID-19 pandemic, mass critical care guidelines were not actually tested under crisis conditions. However, living in this pandemic for the last two years has highlighted the gaps in these guidelines and the impact a prolonged public health emergency can have on healthcare workers, patients and the healthcare system.

Source: CHEST

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