At what level of surge capacity do quality of care indicators suffer?

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Key Findings:

No studies directly evaluated the association between level of surge capacity and quality of care indicators for COVID-19 patients. However, in more broad studies, the findings suggest that mortality and other adverse events increase when the strain on the intensive care capacity increases.

A tiered staffing strategy is recommended to meet surge capacity needs in the ICU: High critical care nurse to patient ratios (1:1 or 1:2) are recommended to provide high quality patient care.

There is a lack of high-quality evidence to support ICU triage protocols tailored for patients with COVID-19. Nevertheless, the protocols must be flexible, adaptable according to the availability of local resources, and effective for inter-hospital patient transfer.

While the Crisis Standards of Care (CSC) guidelines (e.g., Saskatchewan's Critical Care Resource Allocation Framework, published on September 2020) can be used to triage newly admitted COVID-19 patients requiring critical care, there is contradicting evidence about using the Sequential Organ Failure Assessment (SOFA) score for ICU triage of patients with COVID-19.

The literature suggests the use of mathematical modeling to support capacity planning (e.g., very low, low, medium, and high intensity patient surge response)

To relieve pressure from ICUs, other types of units (e.g., Step Down Unit [SDU] or Surge Clinic) can be implemented.

Category: Administration
Healthcare Services
Subject: Health Planning
Facilities
Triage
Population: All adults
Clinical Setting: ICU
Priority Level: Level 1 2-3 days
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