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Rhwydwaith Gofal
Critigol a Thrawma Cymru
Wales Critical Care
and Trauma Network

Welsh Intensive Care Society

Cymdeithas Gofal Dwys Cymru



COVID-19 (Novel Coronavirus SARS-CoV-2): Wales Critical Care and Trauma Network & Welsh Intensive Care Society Response Update 2 (v2.3 13 April 2020)

Introduction

The novel coronavirus (SARS-CoV-2), which causes the disease known as COVID-19, has resulted in the admission of large numbers of patients to Welsh critical care units. As at the date of publication of this update, some regions and health boards have been affected more than others, with the south east affected more than the north and west. This will change over the coming weeks and months. A huge amount of outstanding work has been done by critical care teams across Wales to massively increase the ability and capacity to deliver critical care both within units, and also in areas of the hospital not usually used to deliver critical care.

Critical care services are very grateful for the incredible support from anaesthesia, alongside medical and surgical specialities in transforming the hospitals where we work, and also the manner in which we work. This has enabled us to try and deliver the best possible critical care to the most patients in these extraordinary times.

By necessity, the usual agreed and accepted standards for the speciality of Intensive Care Medicine (Guidelines for the Provision of Intensive Care Medicine Standards – GPICS 2) have been relaxed as we go into surge capacity to meet the unprecedented increase in demand. In particular, the usual trained critical care nursing, medical and allied health professional staff to patient ratios decrease to meet demand. It is this dilution of the trained critical care team, rather than the number of ventilators, that will truly limit the total number of patients that can receive an acceptable level of critical care that really benefits patients. Critical care is, in normal circumstances, the accrual of marginal gains which added together maximise the chance of patient survival with an acceptable quality of life. If these marginal gains are diluted too much there comes a point where those gains disappear and the risks, safety and quality of care may become so poor that more harm than good ensues to patients.

The critical care outcome data and clinical experience in managing SARS-CoV-2 infection, and the disease processes that may result, should be utilised to inform firstly the decision to refer to critical care, secondly the decision to admit to critical care, and thirdly the decision to continue organ support. Because this is a new disease this information is being constantly updated and applied. To the best of our ability, the potential benefit of critical care in the individual needs to outweigh the potential risk. Despite critical care intervention those risks include dying in intensive care or dying later on a ward, or being left severely debilitated psychologically and physically without recovery and, most importantly the return to an acceptable quality of life for the individual. This is no different from normal critical care decision making where we know that in some diseases, and in some patient groups the risk benefit analysis for critical care admission means that critical care is deemed to not be in an individual's best interests. In the same way, solid organ transplantation is not routinely offered in some patients due to a risk benefit analysis. In other patients who are frail with significant comorbidities, aggressive curative chemotherapy for cancer may not be the preferred care because the treatment and its outcome is worse than the disease itself. Limitations of treatment, palliative intent and end of life care in such circumstances are not a failure of medicine decision-making but a holistic approach that fully recognises

Appendix 1. Assessment of critical care benefit and risk

n.b. this tool should not be used in isolation and must be read in conjunction with the narrative above

