Summary
The situation in critical care units has remained intensely challenging since the update provided to NPHET on 21 January. Surge capacity has been deployed across all units and the number of beds open and staffed is now close to the limit of 350, the level at which clinical risk remains manageable. High levels of staff absenteeism are still being seen. The redeployment of non-specialist staff to support the provision of critical care is continuing. A significant number of high acuity patients are receiving advanced respiratory support in a ward setting, with associated impacts on the resources available for redeployment to ICU.

While the levels of disease in the community have begun to show signs of improvement, it is expected that a corresponding reduction of patients requiring critical care will take time given the timelag between diagnosis and admission to critical care as well as the longer length of stay of Covid patients in ICU. The HSE is continuing to actively manage the situation and to provide support to hospitals and critical care units. However, a continued reduction in the levels of disease in the community remains the only answer to reducing demand, increasing the numbers of staff available to attend work and alleviating pressure on critical care units.

Current Situation
- As of 2pm on 27 January, there were 340 adult critical care beds available and staffed. 322 of these were occupied, including 217 confirmed COVID-19 patients and a further 3 suspected COVID cases. We have far surpassed the highest number of patients seen in ICU in the first wave (156 on 11 April) and numbers have risen sharply in the past month – for comparison, on 27 December, there were 281 beds open and staffed; 214 of those beds were occupied with just 26 Covid patients receiving care. The number of Covid patients receiving care in ICUs has remained between 214 and 221 since 21 January. Critical care units therefore continue to be under immense and unprecedented pressure.
- Alongside the high numbers of patients receiving care in ICU, a significant number of patients are continuing to receive advanced respiratory support in a ward setting – estimated at over 360 as of 27 January. These patients are very ill and require a higher intensity of care, with resulting pressure on staff notwithstanding the use of additional technology to assist with the monitoring of these patients.
- At the same time as this increasing demand for care, both in volume and acuity, resource is heavily impacted by the enormous level of staff who are unable to attend work as a result of Covid-19; the impact of this in the acute hospital system cannot be overstated. As of 19 January, there were almost 7,000 staff who are absent as a result of Covid-19 across the health service, with approximately 4,000 of those in the acute hospital setting.
- Non-specialist staff are now being redeployed to support the provision of critical care. This redeployment is carried out in accordance with surge escalation plans, to ensure that staff are appropriately supported, and that redeployment is carried out safely. Initially, nurses are redeployed in a one-to-one ratio working directly with a critical care nurse in a buddy arrangement in the first instance. This then moves to one critical care nurse supervising two, and then three, non-critical care nurses as required, but maintaining a nurse-patient ratio of one-to-one for optimal safety. However, it must be acknowledged that this method of providing care does not meet the same standards as critical care provided in normal (i.e. not surge) conditions.
- The Critical Care Major Surge Working Group is continuing to meet daily, to oversee/coordinate the national critical care response and actively manage and support hospitals on an ongoing basis, including ensuring that hospitals which are reporting no available critical care beds have arrangements in place for further emergency admissions. The Mobile Intensive Care Ambulance Service (MICAS) continues to play a central and important role in this regard – there have been 25 adult critical care retrievals in the last six days, supporting the uneven distribution of resources and disease.
While the level of disease being seen in the community has now begun to reduce, the so-called “long tail” of Covid-related admissions to both general acute services and critical care units is expected to result in sustained pressure on hospital services and on staff who have endured many months of working in extremely difficult conditions.

**Conclusion**

While the reduction of disease in the community is welcome, it has not yet resulted in an easing of the pressure on critical care units. Continued public support of and adherence to public health measures is extremely important in that regard.

It is also important to reiterate that our critical care units would not be operating at the level they are now without the dedicated commitment of staff in critical care units and across our hospitals, who remain focused first and foremost on patients. These staff have been working in very difficult circumstances and under immense pressure, and their response in this crisis has been extraordinary.

ENDS