**COVID-19 Recommendations (SIAARTI)**

1. Criteria for admission and discharge are flexible and can be adapted to the resources available, including the possibility of transferring patients and the number of admissions (either current or predicted admissions). These criteria are concerning **all intensive care patients** not just those infected by Covid-19.
2. Patient allocation is a complex decision to make, as simply increasing the number of intensive care beds does not guarantee better patient care and would detract resources, attention and energy from the remaining patients in intensive care. It should also be considered that there could be a predicted increase in mortality for clinical conditions not linked with the current epidemic as a result of reduced elective services and scarce ITU resources.
3. It may be necessary to put an age limit on admission to intensive care. It is not just a question of value, but a question of reserving very limited resources for those who first of all have a **higher probability of survival** and to those who would in theory have **more years of life saved**, hereby maximising benefits for the highest number of people. In a scenario of total saturation of ITU resources, maintaining a ‘first come first served’ approach is equivalent to choosing not to manage subsequent patients and thus would be excluding them from intensive care
4. The **presence of comorbidities and functional status** must be evaluated in each patient as well as their age. What is a relatively short recovery time in healthy people could become longer and thus more resource consuming on the health service **in older, more frail patients** or in those with **severe comorbidities**. In these situations, it would be useful to consult the clinical criteria present in the 2013 SIAARTI document on end-stage organ failure. It would also be appropriate to consult the SIAARTI document on criteria for admission to intensive care
5. Careful attention must be paid to patient wishes previously expressed through the proper documents (e.g. advanced care plan), particularly those who are already chronically ill.
6. For those deemed not for ITU, the decision to appoint a **ceiling of care** should be for good reason, communicated to the patient and clearly documented. **If a patient is deemed not for ventilation this does not mean they are not for lower level care.**
7. Due to the unprecedented nature of the situation, declaring patients not fit for ITU because of an **extreme imbalance** between bed numbers and demand is justified.
8. When difficult or uncertain situations arise within any decision-making process, it could be beneficial and useful to have a **second opinion** (even if just over the phone) from someone of a higher level of experience (e.g. a regional coordinator)
9. **Criteria for ITU admission** should be discussed and defined for every patient **as far in advance as possible**, thus creating time to compose of a list of patients that are deemed for ITU care if they were to deteriorate (and assuming bed spaces and resources are available). The instruction **‘do not intubate’** should be clearly documented in patient notes and should be ready in case of a rapid deterioration in the presence of health professionals that **do not know the patient** or that have not been directly involved in the advanced care planning
10. **Palliative sedation** in hypoxic patients with disease progression is considered a necessity as well as good clinical practice and should follow existing guidelines. If a long period of palliative care is anticipated the patient should be transferred to a **non-intensive care setting**
11. All those admitted to ITU should be considered **‘ICU trial’** and reviewed daily to consider the appropriateness and the objectives of care. If a patient is borderline on the criteria and does not respond to initial treatment or develops complications, a decision to **cease active treatment** and **transition to palliative care** should not be delayed, especially given the excessively high number of patients
12. The decision to limit ITU care should be discussed and communicated within the multidisciplinary team and, if possible, to the patient themselves and to their family in a timely manner. It is possible that needing to make these decisions on a regular basis may make the decision-making process within each ITU more straightforward and better adapted to the limited resources.
13. **ECMO support** is considered very **resource consuming** compared to a more straightforward ITU treatment plan and, in situations where patient numbers are very high, should be reserved only for extreme cases and patients should be weaned off as soon as possible. It should ideally be reserved for larger hospitals with a high number of beds, as it is less draining on larger hospitals than smaller ones with less expertise.
14. It is extremely important to maintain **confidentiality** between centres and amongst healthcare professionals. Once the working conditions allow enough time and once this emergency is over, it is important to dedicate time to **debriefing**, monitoring of **burnout** and monitoring of **moral distress** amongst healthcare professionals.
15. It is important to consider the burden on the **family members** of those admitted with Covid-19 infection, especially as patients may pass away at a time when visiting hours may be restricted.