

## COVID-19 emergency department guidance drawn from principles in the NSW Health Influenza Pandemic Plan (PD2016\_016)

### Key issues:

To date it appears that COVID-19 is likely to have broad spectrum of disease from mild to severe, although the distribution of infections within this spectrum remains unclear. Because COVID-19 is a new virus, a large percentage of the population will be susceptible to disease. This means that demand on services could be high, particularly if the virus co-circulates with seasonal influenza.

Reports of illness in children are so far uncommon. Most cases of severe disease and deaths appear to be in people with pre-existing significant illnesses and the elderly, however due to the number of people naive to the illness, presentations of otherwise healthy people with significant respiratory illness could increase.

Unlike influenza, there is currently no specific treatment recommended to either modify the course of the disease in those who are sick, or to limit the spread of the disease. As such, should the disease develop sustained community transmission people will be encouraged to undertake self-care at home (eg: paracetamol, fluids) and only attend hospitals if they are significantly ill. Alternate care pathways through General Practice and Health Direct (phone based assessment) will be promoted for those with milder disease severity.

Public health action such as isolation of cases and quarantining of close contacts, promotion of respiratory hygiene messages for the community, and social distancing measures will continue when and if community transmission of COVID-19 is occurring. These measures are evidence based and will slow community transmission to allow the health system to manage the increased presentations.

Modelling data will be provided for a range of possible scenarios. The modelling will be revised and updated with local data as this becomes available. It is prudent to plan for a significant increase in respiratory presentations of variable severity over a 10-12 week period and note that this may occur at the same time as peak influenza season. Clinically it is impossible to distinguish between COVID-19 and influenza or other respiratory pathogens in the absence of diagnostics testing. A key aspect of the approach will be to reduce both COVID-19 and seasonal influenza impacts.

### Infection control

A number of resources are available on the CEC website, which will continue to be updated.

<http://www.cec.health.nsw.gov.au/patient-safety-programs/infection-prevention-and-control/novel-coronavirus-2019-ncov>

Notably, the response should be similar to other potentially severe respiratory infections, including decisions to cohort people who have confirmed disease together. It should be noted that there may be both seasonal influenza and the COVID-19 virus circulating simultaneously, which may make it difficult to cohort patients on the basis of symptoms alone.

Patients should be screened at triage, but is important that the right care is being delivered to the right patient in the right location. This means that people with symptoms of COVID-19 who present

with other health issues (eg: trauma, cardiovascular acute presentations) must be managed appropriately in the most appropriate location, using appropriate infection control.

It will be important to wear the correct PPE when caring for patients, including those presenting with upper respiratory tract symptoms or gastrointestinal symptoms as it will not be possible to distinguish those presenting with the COVID-19 virus by symptoms alone.

### **Will Pandemic Assessment Centres be required?**

The Pandemic Assessment Clinics had the following functions when community transmission of pandemic influenza was widespread in previous years:

1. Providing care at a time when General Practice capacity was also stretched
2. Providing early antiviral treatment to those with influenza who were at risk of severe for individual and population health benefits
3. Minimising the transmission of influenza within the emergency department

Unlike an influenza pandemic, there is currently no specific antiviral treatment recommended and therefore the function of COVID-19 clinics would have functions 1 and 3.

All LHDs need to plan for how they will manage a significantly increased level of ED presentations for respiratory illnesses over a 10-12 week period which may coincide with peak influenza season at all their ED departments.

The establishment of an acute respiratory infection clinic pathway or COVID-19 clinic (similar to a fever or flu clinic concept) may be appropriate and all EDs should consider how they would establish an acute respiratory clinic in their planning.

It is not appropriate to divert all patients with COVID-19 symptoms to a separate clinic if they require specialist Emergency Department care for another reason (eg: trauma, cardiac arrhythmia). Emergency Departments and health facilities will need to have appropriate plans to manage such patients. It should be recognized that patients presenting with other symptoms may also have COVID-19. Hence it is important that there is an enhanced focus on infection prevention and control in the ED.

Community spread of COVID-19 may impact different areas of the state at different times, and as such, Local Health Districts are responsible for monitoring the need for these additional pathways and ensuring they are promptly activated.

An important learning from the 2009 pandemic is that staff will need to be sourced from areas with less demand. This also applies to the staffing considerations for the acute respiratory infection clinic. Operational support to the ED should be prioritised to support the healthcare outcomes of all patients presenting to the ED at a time of increased demand. LHDs and SHNs will need to allocate staffing resources accordingly.

The Public Health Emergency Department Surveillance System and Patient Flow Portal will be monitored during the response to assist in identifying areas that may be under increased stress.

### **Triage to Critical Care**

Assessment of patients being triaged for intensive care should ideally be undertaken prior to the patient being transported to the ICU. Triage should occur in the ED or referring unit/ward, or other

hospital where clinicians need to have effective collaboration between ED/specialty and ICU clinicians to achieve the best outcome for the patient. This may be face-to-face or via telephone or telehealth to connect clinicians to discuss appropriateness for intensive care admission.

Triage will be enacted at the same level across the state, to promote equity of access of patients to intensive care. It is important that these tools are used for all potential admissions, not just infection-related admissions. Such tools are being refined to promote national consistency.

### **Retrieval capacity**

Where a patient in a remote area has COVID-19, consideration should be given regarding the appropriate timing of transport to a centre which can provide a higher level of care (where this is appropriate). In some cases, especially if transfer times are likely to be prolonged, it may be appropriate to initiate retrieval of patients at high risk of complications at an earlier stage than usual.

### **Reducing presentations to the Emergency Department**

As far as possible, activities to reduce presentations to the ED should be considered at a facility or LHD level. Residential aged care facilities are likely to be significantly impacted by COVID-19 and also influenza. Strategies need to be developed to minimise transfers to hospital (eg: limiting transfers from residential aged care facilities to A1 hospitals) and have residents managed appropriately within the aged care facility.

Influenza prevention, including use of antivirals should be prioritised where indicated. Influenza immunisation should be promoted to staff and patients.

### **Monitoring and managing system performance**

NSW Health has made significant investment in the development of near real-time information regarding critical care bed availability and system capacity (the Patient Flow Portal). This allows facility, LHD and MOH staff to monitor whether the health system is coping with increased demand. There are well-established systems for managing system surge as it occurs and usual processes will be followed regarding day to day system management.

Peak Activity Team teleconferences lead by the Deputy Secretary, Patient Experience and System Performance, will be initiated and will be the major channel for communicating surge response. Where significant decisions around scheduling of elective surgery, activation of surge plans, provision of different models of care this will be primary channel of communication. The frequency of these teleconferences will be tailored to meet demand pressure as is usual practice.

The State Pandemic Management team, chaired by the Secretary, is meeting regularly to review the whole-of-Health preparedness and response.

Key information will be disseminated in a number of ways.

1. General clinician updates will be available through the NSW Health website and the ECI website. These will also be distributed through LHD clinical networks.
2. General system management will be through the usual Peak Activity Team teleconferences led by the Deputy Secretary, Patient Experience and System Performance. Where significant decisions around scheduling of elective surgery, activation of surge plans, or provision of different models of care, this will be primary channel of communication. The frequency of

these teleconferences will be tailored to meet demand pressure as is usual practice.

3. Information specific to emergency clinicians (eg: specific guidelines for care as the evidence base improves) will be disseminated both generally and specifically through the LHD CEs, ECI Network, and MoH coordinated clinician webinars.

### **General system preparedness – Principles (from PD2016\_016)**

Principles guiding the management of demand and capacity within healthcare services include:

- That care given to people will be maximised within the available resources
- Plans should be consistent with the aim of preserving and maintaining essential healthcare services
- Changes to service delivery and clinical protocols should reflect changes in local and/or regional demand where appropriate
- Decisions regarding surge capacity and demand management should be coordinated at a strategic level within the health care service to ensure consistency of approach
- That a phased approach be used in scaling back any healthcare services to ensure demand management reflects the COVID-19 status impact at the time
- Coordination by health system support staff to ensure cross-district consistency of access is maintained.

LHDs and SHNs should consider inter-related elements of healthcare services, including:

- physical aspects of capacity (eg: beds, wards and ventilation equipment)
- hospital staff numbers (eg: of clinical, allied health and administrative staff) and ability for staff to cross over to other areas
- clinical services and protocols (eg: types of services and models of care).

While governance for service delivery changes within LHDs rests with LHD Chief Executives, state-wide agreement will be sought wherever possible for any major changes to services, such as criteria for admission, triage or discharge, or new clinical management guidelines. This will be with the aim of promoting equitable delivery of healthcare across all districts.