ACEM COVID-19 Webinar 20th March 2020 - Highlights

These are *quick notes* taken during the session to assist ED clinicians in Australia. It may not be free from errors and most has been paraphrased and are not direct quotes.

Apparently near 950 attendees online.

Dr Didier Palmer – Director of Emergency Medicine Royal Darwin Hospital and Chair CAPP

- Hospital Preparations/Changes
    - Ceased locums unless have been quarantined
    - Ceased all elective operating
        - Released 1/3 of anaethetists to train up in intensive care
    - Cancelling outpatient clinics, outreach visits.
    - Spending a lot of time on PPE and training
        - Have locked up PPE with a video monitoring (had earlier theft)
        - Also conserving gowns – these are not in the national stockpile.
    - Trained up specific intubation teams
    - Lots of rules around staff participation
        - None over 50y.o. on intubation teams
        - None over 60y.o in COVID zones
        - Over 70y.o, immune-compromised and certain other conditions excluded from direct patient care
    - Stopped a lot of general hospital processes (accreditation, medical student teaching etc)
    - Ceasing all education programs in 10 days time
    - Ceasing all consultant non-clinical time at some point soon.
    - Whatsapp groups created for communication
- ED:
    - COVID ED and non COVID ED
    - Pre-screening in front of ED (staff with PPE)
        - Redirect them to other clinics or via safe pathway to the non COVID ED
    - Daily updates to all staff (e.g. at handovers) – including not just the nurses but also orderlies, cleaners, admin staff etc
        - Helps to allay fears and helps prevent people not turning up to work out of fear.
- NIV
    - No perfect answer
    - Preference to do in negative pressure room
    - Ideally with closed circuit and viral filter.
- Isolated staff at home
    - Initially made them use sick leave or work from home, but have moved to making a special determination (unclear what this meant – but ?? means not needing to take sick leave)
- Paeds
    - Avoiding nebs. Considering IM adrenaline instead of nebulised adrenaline (e.g. for croup)

Dr Alex Chaudhuri
Director of Infectious Diseases, The Prince Charles Hospital

- As winter approaches the COVID plan will need to change into an "Influenza Like Illness" plan as we won't be able to distinguish patients based on travel history/contacts etc.
- Trying to split hospital into infectious and non-infectious zones with adequate spacing between patients
- PPE and proper training very important.
- Intubating patients early for hypoxia on oxygen
- NIV is a risk of aerosolization
    - Newer NIV safer
    - However they will be less likely to use NIV – if do, in a negative pressure room
- Adding viral filters to BVM
- PAPR
    - PAPR not required for routine bedside care or triage
    - PAPR not necessarily better than N95
        - PAPR contamination risk is high at doffing and reprocessing device (Ebola studies)
    - Supportive of using PAPR if intubating in ED
    - If decide to use it, train in advance – don't use in a crisis if not trained.
- Regarding risk of COVID reinfection
    - Limited data had some people who were COVID positive who had recovered from illness and had a COVID negative swab. Then later had another illness and tested positive for COVID
        - So possibly this represents reinfection
        - However this could simply represent a false negative swab at the initial recovery phase and unclear if further positive swab later represented infectious virus.
    - If reinfection is a real finding – it is likely to be very uncommon.
- Considering re-deployment of registrars from other specialties to ED
- Treatments
    - Antivirals not promising yet
    - Plaquenil and hydroxychloroquine – unclear, in vitro suggestion of benefits only. Currently using agents in trials only.
    - Current antibiotic guidelines to be used as per community acquired pneumonia – no need to alter.

Notes taken by

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More information at https://edguidelines.com/covid-19-resources/