Australasian College for Emergency Medicine

Minutes

28 August 2020

COVID-19 Emergency Medicine Community of Practice (EMCoP)

Chair: **Dr Simon Judkins**
Date: **28 August 2020**
Time: **1530-1700 AEST**
Location: **Via Zoom**

1. Welcome

1.1 Acknowledgement of Country

I would like to acknowledge the Wurundjeri people of the Kulin nation as the Traditional Custodians of the lands upon which we meet today. I also acknowledge the Traditional Custodians of the lands upon which Australian emergency departments are located. I pay my respects to Elders past, present and future; for they hold the memories, traditions, culture and hopes of Aboriginal and Torres Strait Islander peoples of Australia. In recognition that we are a bi-national College, I take this opportunity to acknowledge Māori as tangata whenua and Treaty of Waitangi partners in Aotearoa New Zealand.

1.2 Introduction

- S Judkins gave an overview of the EMCoP. ACEM is convening this emergency medicine community of practice for a limited time to facilitate the sharing of information, ideas, strategies, local solutions and concerns with respect to COVID-19 pandemic preparedness and responses.
- ACEM offered to establish this Community of Practice because it felt it would be a useful way for ACEM's members and others working in emergency medicine to get access to the latest information and to key decision-makers within DHHS and Safer Care Victoria. ACEM hopes this forum will provide opportunities for the two-way flow of information between key government decision makers and the emergency care workforce.
- One of the things ACEM hopes to do is to compile a list of Issues and Actions - so if there are any questions or requests for information, please make a note of these in the chat or by email and ACEM will compile them for DHHS and Safer Care Victoria follow up before the next meeting. This is not the sort of process ACEM usually undertakes but these are unusual times.
- ACEM expects the Community of Practice will convene for 4 to 5 meetings over around 8 to 10 weeks, depending on the interests of participants. It will then be evaluated by participants at this point and either discontinued or transferred to DHHS/Safer Care Victoria.
- S Judkins acknowledged the staff at ACEM, Safer Care Victoria, DHHS and Natalie Wright (moderator) for their efforts in setting up the EMCoP.
- It was noted that a diverse group of FACEMs, nursing staff, urgent care centre staff and Ambulance Victoria staff from metropolitan, regional and rural Victoria had signed up to be part of the EMCoP.

2. Focussed discussions

2.1 **Health care worker infections** – Dr Andrew Wilson, Chief Medical Officer, Safer Care Victoria

- A Health Care Worker Wellbeing Taskforce (the Taskforce) was formed a week and a half ago and has had two meetings so far. The first week of the Taskforce focused on getting data out.

- Approximately three quarters of health care worker infections have been in aged care. Of these, approximately half are in nurses and half are in aged care attendants. Nurses represent a greater proportion of health care worker infections in hospitals. Quite a few of the hospitals who had early issues have been able to get health care worker infection rates down.
- This is a rapidly evolving area and Melbourne has had a different experience to other parts of the world. Whereas wave one was largely from overseas travellers and contacts, wave two has been largely community acquired. Contrary to wave one, most health care worker infections in wave two were acquired at work.
- The taskforce are currently collecting data on furloughing of staff and this will be published alongside data on rates of infection across various parts of the health system.
- Prior to the establishment of the taskforce, SCV had been meeting regularly with hospitals that had issues with health care worker infections to share intelligence. Based on this intelligence, guidelines have been updated in regards to:
    - N95 masks
    - Risk mitigation strategies for grouping and cohorting patients – spacing out patients so they are less dense and not sharing amenities
- In regards to preventing a third wave, the Taskforce are looking at the environment, the right PPE and work behaviours, and access to break rooms and tea rooms.
- The Taskforce are currently implementing a fit testing program. This has been called a "trial" but is more of an implementation program, and it has been decided it will continue. Key issues being looked at as part of implementation:
    - Modelling how many masks are required for fit testing and putting aside the supply
    - Ensuring equity of access for fit testing and targeting staff most at risk (staff that have contact with COVID or suspected COVID such as ED staff, staff on wards, aged care staff)
    - Making the program sustainable and manageable
    - Concerns about whether fit testing will provide enough diverse options, and what will happen where staff are unable to get the right mask. It is a legitimate question as to whether staff that don't fit any of the masks can work in a high-risk environment, and SCV haven't landed on an answer yet.
    - System security and brand security
    - Developing a profile and tailoring future orders
- A Wilson acknowledged the significant role and influence the emergency medicine workforce has had in the COVID response.

2.2 **COVID-19 Victorian governance overview** – Dr Peter Cameron, Clinical Network Lead, Emergency Care Clinical Network (ECCN)

- Emergency Care has had a clinical care network for some years which evolved into a different role following the Duckett report – it became a more hands-on network in terms of providing advice to DHHS directly, as opposed to a clinical improvement type organization. With the advent of Safer Care and Euan Wallace's leadership, the network has become more involved in providing advice to DHHS.
- The Governance structures have been rapidly changing throughout the COVID-19 pandemic. In March, the ECCN changed from a governance insight committees into an **Emergency Care Working Group (ECWG**) because it was the most efficient way of making decisions and getting advice. The ECWG has had a very direct and important role in providing feedback to CLEG, and it is hoped it will continue to have that role. It has been a very effective means of communication – issues that have been raised have been responded to.
- The current Safer Care Victoria structure includes:
    - **Clinical Leadership Expert Group (CLEG).** The CLEG is chaired by Anne Maree Keenan and provides clinical advice and back up to various structures within DHHS in regards to clinical issues. It includes CEOs. COOs and public health staff.
    - **ECWG** (discussed above). The ECWG is chaired by Peter Cameron and has 20 members with various skills and expertise. It meets weekly and feeds into the CLEG.
    - Along with the ECWG, there are other working groups that feed into the CLEG such as Cardiac, Renal and Chronic. Some of these groups (such as Perioperative) started as a result of COVID, others are continuations of previous networks. A PPE taskforce, chaired by Andrew Wilson, also feeds into the CLEG.
- The DHHS structure includes:

    - The **Health Service Pandemic Leadership Team (HSPLT).** This is the main group "controlling traffic". It includes CEOs and people from the strategy and funding planning group. It determines how money is spent and where the resources are going. The group takes advice from CLEG on clinical issues (e.g. what type of ventilators are needed and how many).
    - **Public Health.** Brett Sutton leads the overall command but delegates to DHHS for anything related to hospitals and hospital services. The Public Health arm includes an infection cell, pathology cell and case and contact management cell. They are the expert group regarding things like droplet precaution.
    - **COVID-19 Project Management Office (PMO).** The PMO determines where the money is spent.
    - **Health Care Worker Infection Taskforce** (discussed at 2.1).
- The Governance structure is complex because it looks different through a health lens, community response lens and disaster lens. For example some parts of the structure will involve the Police, but they don't necessarily report to the health response.
- For the latest guidelines or support go to the Safer Care Victoria website. Due to the need to get information out quickly, there has sometimes been 2-3 days discrepancy between information on the website and the information in the COO bulletin.

See P Cameron's slide (**Attachment One**) for a diagram of the governance structures.

2.3 **Aged care and the ED interface: A system overview** – Brett Morris, Manager, Centre of Clinical Excellence – Older People, Safer Care Victoria

- SCV's interest in aged care comes from the interface with healthcare. VIC is in a unique position in the aged care setting – it has over 5600 residential aged care beds operated by hospitals, primarily in regional or rural services, although there are a smattering across Melbourne (mostly aged care mental health beds). The model the commonwealth has built is funded through Refundable Accommodation Deposits linked to property prices. Most providers are private rather than not for profit – VIC has a greater proportion of private providers than other states.
- In regards to pandemic planning, the Commonwealth and the DHHS had some guidelines, but the next level up of how governments would work together wasn't planned for.
- Aged care wasn't starting from a good base. Aged care was and still is in the middle of a royal commission promoted by horrific examples of poor care. The Royal Commissions' interim report described a cruel and discriminatory sector where the identity of people is ignored. Key findings included that the system is failing, people are treated as transactions, basic human rights are denied, the system is hard to navigate, regulations is not transparent, and the workforce is underfunded underappreciated and lacks key skills.
- The Royal Commission held hearings on the NSW aged care response to COVID, focusing on the Dorothy Henderson Lodge and Newmarch. Findings included:
    - failures in planning/preparation for workforce and PPE (proper use and supply). Workforce was the biggest issue overall.
    - lack of clinical skills in aged care including infection control
    - the operational interface between hospitals and aged care wasn't addressed
    - a lack of coordination between commonwealth and state agencies
    - the operators management structure didn't stand up
    - the Commonwealth workforce response failed.
- During COVID the Centre of Clinical Excellence – Older People are operating working group like the ECWG for aged care and palliative care.
- Following significant outbreaks in VIC, an VIC Aged Care COVID Response Centre (the Response Centre) began operating in the last week of July. It is a coordinated approach between public health and the Defense Force. It includes AUSMAT teams, emergency response teams and the DHHS. The Response Centre has overseen 700 transfers to hospitals, the majority of which were decanting into private hospitals due to services losing workforce due to furloughing.
- The Response Centre's operating model involves health Service Hubs/Clusters taking the lead on the initial response to outbreaks in aged care services. The Response Centre meets with Service Hubs twice a week to discuss operational issues. Through the Response Centre, Service Hubs can draw on additional resources from the Commonwealth First Responder Team, AUSMAT and the Health Service In Reach Team. This structure aims to avoid the issues in the

initial response, in which there were multiple agencies responding at multiple times and a lack of continuity and accountability.

- Since 1 January there have been 170 outbreaks in Residential Aged Care Facilities and there are currently 124 ongoing. There were 13 aged care facilities considered high risk and this has now reduced to 3. There are 1519 active cases in aged care in VIC. The accumulative total in VIC for aged care is over 3500 which includes nearly 1700 residents, 1500 staffs and 460 close contacts.

2.4 **RACF challenges** – Dr Clare White, Clinical Services Director, Western Health

- C White is the Clinical Lead for the Western Health Residential In Reach Service. The In Reach Service is an ED avoidance scheme. It involves a group of hospital- based specialist doctors and nurses who go out to aged care services in their catchment and treat simple things in-place (if appropriate and possible).
- Before COVID the team was about 7-8 people and ran 7 days a week (but not 24.7). When the COVID pandemic began they saw this would be a huge challenge (based on their knowledge of sector and government planning) and quickly grew the service to 45 FTE with extended hours. They developed rapid response teams that respond within the same day.
- The service has managed a significant amount of outbreaks in North West VIC. At one time they were managing 25 outbreaks at once, another time they were managing 6 critical outbreaks at once.
- The general aims/remit of the In Reach Service – trying to prevent ED admissions and appropriately treating people in place – became extremely complex in the COVID scenario.
    - When there is an outbreak there is general chaos and confusion and providing good clinical care in a disaster site is challenging. Multiple agencies would respond and do assessments but it was difficult to determine their role/remit.
    - 70-80% of residents have some type of dementia. Wandering patients with dementia are not able to be easily isolated within the facility, but moving them from a familiar environment would be challenging.
    - There were critical staffing shortages. It was unusual for facilities to have access to surge workforce. There were lots of staff furloughed and a lot of agency staff working in facilities. In a severe outbreak, public health would stop contact tracing and declare all staff as a close contact and send them home. This happened a few times with catastrophic outcomes. COVID negative patient would deteriorate just through lack of food and hydration.
    - The facilities are not small hospitals, they are peoples homes and have couches, chairs, pictures, mementos, rugs etc everywhere. Many don't have access to oxygen and have limited coverage of general practice out of hours.
    - At times GP and locum services would not come to facilities and the In Reach Service was the only service providing care.
    - A number of facilities notified late that positive cases were scattered throughout the facility without cohorting or isolation.
    - Some residents had Advanced Care Plans that said no hospital care.
- In that context, who and what types of situations people would come into hospital was challenging. Residential In Reach services have tried very hard to avoid lots of people ending up in ED and have succeeded to some degree, but there are lots of people who have died in residential aged care facilities.
- The situation is improving slowly and the Response Centre has helped, but it is still far from sorted. Poor coordination is still occurring in some facilities. The In Reach service has made a number of recommendations through CLEG. One recommendation is to have an on the ground incident controller, rather than non-clinical staff attempting to manage a disaster from afar.

It was acknowledged in the meeting the significant contribution of the Field Emergency Medicine Officers and many hospital level nurses from Victoria in the recent Aged Care response to the outbreaks of COVID 19 in many facilities throughout Victoria. Many who have been working extremely hard from our their own services.

3. Standing agenda

3.1 **Ambulance Victoria update/Q & A** – David Llewelyn, Clinical Support Officer- COVID Support, Ambulance Victoria

- Overall workload has been reduced, but AV are still managing around 1500 cases a day. Recent key challenges have been:
    - Unloading delays and its impact on maintaining service delivery. Within metro areas there have been long delays unloading COVID or suspect COVID patients into hospitals. Last week there were about 10 delays a day. This puts people at risk and some critically unwell patients have deteriorated dramatically whilst waiting to be unloaded.
    - The Frankston and South East Network outbreaks. There has been impact on service delivery but it has been manageable.
    - Aged care – AV have been moving hundreds of patients out of those facilities in the last few weeks and this required PPE. They are now in the phase of returning COVID negative patients, but this is causing dilemmas with PPE as they are treating the facilities as positive.
    - Linen skips – AV don't have contractors that come to the hospital to manage liens, they pay through the service through DHHS. The skips have been full and overloaded. They want to engage with hospital staff where there are issues as they don't want to put anyone at risk.
- Of 4500 permanent paramedics there have only been 24 COVID positive cases.
- AV have enacted a referral program to minimise throughput into EDs. This is capturing about 700-800 calls a day.
- If there are any issues at any of the hospitals (e.g. regarding cleaning the hubs and access, stretchers) please liaise with the ambulance management group. They have a good structure in place and would like to ensure that relationship is built upon.

3.2 **CENA update/Q & A** – Jo Morey, DDON Emergency Department, Monash Medical Centre and CENA Finance Director on behalf of A/Prof Julia Morphet, Executive Director, CENA`

- CENA have been trying to actively support members Australia-wide. They recently held a nurse manager national forum and this week they started a VIC nurse manager fortnightly forum. They are continuing with branch meetings.
- Most EDs have had a different experience, whether its the influx of RACFs patients or supporting other networks as they face their challenges. Multidisciplinary leadership (allied health, medical nursing etc) has been strong in supporting departments, staff and patient care. A lot of empathy from EDs to those EDs which have been more challenged for various reasons.
- Key challenges have been:
    - PPE: inconsistency across health services with N95 and different brands causing complications for skin preservation and fit tests and checks. Lack of clarity about the use of DuoDERM and whether it affects seal.
    - Concern around staff welfare: fatigue, feelings of guilt by staff who are furloughed or positive, managing and supporting staff where there are ostracization within work groups over high risk/low risk zones.
    - Rising mental health presentations, lack of access to mental health beds, increase in occupational violence and increase in family violence
- CENA's are wanting information on:
    - SCV and DHHS' response plans for supporting health services when significant numbers of staff are furloughed. Some services have had staff deployed from another state – is that a government response or an individual service response, and is there a broader plan?
    - Consistent guidelines re concierge models and spotter roles
    - Guidelines for use of the rapid rule-out test. This has been inconsistent across health services. CENA are wanting guidelines on which cases this is used for, how many are available and what the limitations of the test are.
    - Support for rising mental health presentations
    - Support for staff mental health and wellbeing

- Health care worker infections and recommendations to reduce the rate of infections

3.3 ACEM Victoria Faculty update/Q & A – Dr Mya Cubitt, Victorian Faculty Chair

- M Cubitt acknowledge the work of the Hotel for Heroes Program. She also acknowledged the staff at ACEM for providing the resources for the EMCoP meeting.
- Recently the VIC faculty sent a letter of response to the Health Care Worker Infections Taskforce publication and will provide this to EMCoP. The publication is a good start but there is still a long way to go.
- At the beginning of the pandemic, ACEM produced some clinical guidelines (written by a team of FACEM experts across Australia and NZ) at the request of SCV. They are available on ACEM's website and are updated regularly. M Cubitt recommends that anyone on a taskforce looks at this guidance.
- A key challenge has been understanding governance structures and accessing information on the decisions of governance groups. M Cubitt encourages SCV and DHHS to provide the terms of reference for governance groups and minutes of meetings so that a wider group of clinicians can have access to information and understand how decisions are made. P Cameron noted that the ECWG receives privileged access to information that couldn't be distributed immediately, but the ECWG could do more work on getting the conclusions out to the broader community.
- M Cubitt noted that one FACEM can't engage on behalf of the whole profession, and that the ability of individual FACEMs to include the wider professions was hampered by confidentiality requirements.

3.4 Urgent Care Centres update/Q & A – Dr Tim Baker, Director, Centre for Rural Emergency Medicine

- Some rural areas have had no COVID at all, whilst others have had a lot of cases in the community.
- Emergency medicine experiences of COVID in rural areas is different to metropolitan areas, but a lack of data makes it difficult to determine how. For example, the DHHS doesn't ask about the diagnosis of any patient that comes to an urgent care centre, which makes it difficult to know how many COVID cases there have been.
- Concerns of urgent care centres are reported to DHHS through the ECWG. Key challenges include:
  - Workforce
  - PPE. They have been working hard to make sure urgent care centres have same access to PPE as metropolitan centres.
  - Working on differences between EDs and urgent care centres. Many rural hospitals are aged care facilities with an attached emergency service, which is a great idea in most times but not in pandemic. They have been working with AV to try and keep those hospitals as free of COVID as possible. All but 4 of largest urgent care won't receive patients with suspected COVID.

4. Issues and actions

4.1 Summary of issues and action from meeting and general discussion

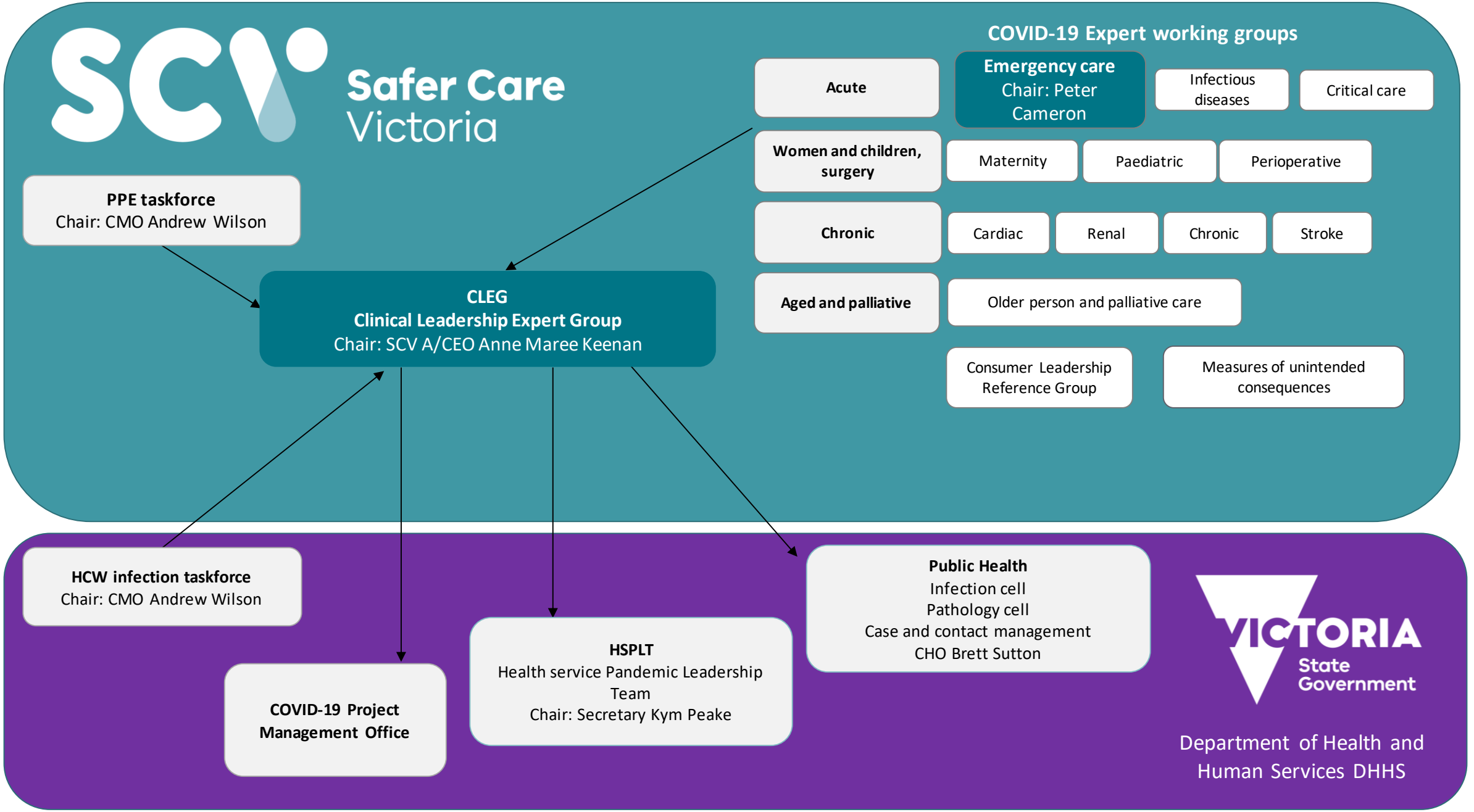
- The key issues discussed were:
  - PPE and mask types – some not working and not fitting well, brands, what do sites do if masks don't fit well, skin care and pressure ulcers
  - Governance structures for meetings and committees – establishing membership and processes
  - Communication between Commonwealth and State government, and In Reach teams
  - The aged care response moving forward
  - Mental health beds and capacity
- A number of questions and issues were received during the meeting. ACEM will create an issues log and share this with the EMCoP, as well as responses received to the questions/issues.

- Future meetings will address topics such as mental health (both care for people who present to the ED for mental health reasons, and mental health care for people on the frontline) and urgent care. Any ideas/suggestions for future meetings can be emailed to EMCommunityofPractice@acem.org.au.

Meeting closed.

For out of session questions, issues or suggestions for future meetings email EMCommunityofPractice@acem.org.au or contact Natalie Wright 0439 363 713 or Jo Tyler 0417 300 690.

To register for the EMCoP please go to the ACEM website.


Safer Care Victoria
COVID-19 Expert working groups
Acute
Emergency care
Chair: Peter Cameron
Infectious diseases
Critical care
Women and children, surgery
Maternity
Paediatric
Perioperative
Chronic
Cardiac
Renal
Chronic
Stroke
Aged and palliative
Older person and palliative care
Consumer Leadership Reference Group
Measures of unintended consequences
PPE taskforce
Chair: CMO Andrew Wilson
CLEG
Clinical Leadership Expert Group
Chair: SCV A/CEO Anne Maree Keenan
HCW infection taskforce
Chair: CMO Andrew Wilson
COVID-19 Project Management Office
HSPLT
Health service Pandemic Leadership Team
Chair: Secretary Kym Peake
Public Health
Infection cell
Pathology cell
Case and contact management
CHO Brett Sutton
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