

LETTER

Emergency departments and the COVID-19 pandemic: making the most of limited resources

Dear Editor,

The coronavirus disease 2019 (COVID-19) pandemic will stretch hospital resources all over the world. EDs in high-income countries are not immune, but those in low-income and middle-income countries (LMICs) are likely to be impacted more significantly. Emerging data speak to

overwhelming demands for care and widespread disruption of hospital functioning.¹

In order to support colleagues in resource-limited settings, the Australasian College from Emergency Medicine (ACEM) has developed a free guide for emergency care (EC) clinicians in LMICs preparing for a surge of patients with COVID-19.² Content was developed by a working party of ACEM's Global Emergency Care Committee and included EC clinicians from Timor Leste, Vanuatu, Papua New Guinea and Solomon Islands. The guide provides consensus-based advice on optimising resource utilisation during the pandemic and draws heavily on technical guidance from the WHO.³ It is intended to

complement, not replace, local and national guidelines.

The guide is structured according to the central components of ED disaster response: systems, space, supplies and staff. A small number of boxes provide specific guidance to clinicians on triage and screening, infection prevention and control and clinical management. **Figure 1** reproduces the section of the guide dedicated to 'systems'.

EC clinicians in LMICs will be deeply impacted by COVID-19, and there is a substantial risk of burnout and moral injury. ACEM's guide is an attempt to express solidarity with colleagues in resource-limited settings and will hopefully stimulate further collaboration among the global EC community.

The guide is available free online at: <https://acem.org.au/covid-19>. Feedback on the document is encouraged and should be directed to gecnetwork@acem.org.au.

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Systems

Ensure ED processes are consistent with broader public health and hospital management strategies.

Prepare the ED and hospital as much as possible. A checklist approach can be used – see [Resource 1](#), the World Health Organization's *Hospital readiness checklist for COVID-19*.

Identify suspected cases using local case definitions. Ensure staff are aware of these definitions and maintain a high level of clinical suspicion at all times.

Establish a screening and/or triage process at the entrance to the hospital – see [Resources 1 and 2](#). Use simple risk stratification tools to stream suspected cases into different areas based on clinical severity (see example on next page), for example:

- + **Low acuity patients** – divert to nearby surge clinic if available (see below)
- + **Medium acuity patients** – direct to isolation zone within the ED, or other designated area of the hospital
- + **High acuity patients** – escort to resuscitation area within the ED

Maintain IPC to the highest possible standard. Educate staff and patients about PPE requirements and ensure treatment spaces are cleaned regularly – see [Resources 3, 4 and 5](#).

Ensure that ED patients without respiratory symptoms are not forgotten – these patients are vulnerable, and can easily be neglected.

Minimise the volume of patients in the ED and isolate patients with respiratory symptoms away from others – see [Resources 2 and 3](#). The following approaches may assist with this:

- + Establish a surge clinic in a nearby area for low acuity patients with fever and/or respiratory symptoms, rather than assessing them in ED. In order to preserve resources, this clinic should not be staffed by ED personnel
- + Develop clear admission criteria and discharge as many patients as possible back to the community. Provide 'when to return' advice and clear isolation instructions to minimise spread of the virus
- + Maintain flow through the ED. Ensure the hospital has established an isolation ward and patients requiring admission are transferred as rapidly as possible

Consider developing criteria for treatment rationalisation – a palliative or comfort based approach may be appropriate in some high acuity patients who have care needs that exceed local capacity. It is estimated that 5-10% of all cases will require critical care support, which is unlikely to be available in resource limited settings.

Figure 1 Figure1 Excerpt from the guide focussed on 'systems'. IPC, Infection, Prevention and Control.

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