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Introduction: Utilization of the Emergency Department (ED) for non-urgent care increases demand for services, therefore reducing avoidable attendance is an important area for intervention in the prevention of ED crowding. This study aims to develop a consensus among clinicians across care settings about the “appropriateness” of attendance at the ED in Ireland.

Method: The Better Data, Better Planning study was a multi-center, cross-sectional study investigating factors influencing ED utilization in Ireland. Following ethical approval, data was compiled in patient summary files which were assessed for measures of appropriateness by an academic General Practitioner (GP) and academic Emergency Medicine Consultant (EMC) National Panel. In cases where consensus was not reached charts were assessed by an Independent Review Panel (IRP). At each site all files were autonomously assessed by local GP-EMC panels.

Results: The National Panel determined that 11% (GP) to 38% (EMC) of $n=306$ lower acuity presentations could be treated by a GP within 24–48h ($k=0.259$; $p<0.001$) and that 18% (GP) to 35% (EMC) of attendances could be considered “inappropriate” ($k=0.341$; $p<0.001$). For attendances deemed “appropriate” the admission rate was 47% compared to 0% for “inappropriate” attendees. There was no consensus on 45% of charts ($n=136$). Subset analysis by the IRP determined that consensus for appropriate attendances ranged from 0–59% and for inappropriate attendances ranged from 0–29%. For the Local Panel review ($n=306$) consensus on appropriateness ranged from 40–76% across sites.

Conclusion: Multidisciplinary clinicians agree that “inappropriate” use of Irish EDs is an issue. However, obtaining consensus on appropriateness of attendance is challenging and there was a significant cohort of complex heterogeneous presentations where agreement could not be reached by clinicians in this study. This research again demonstrates the complexity of ED crowding, the introduction of evidence-based care pathways targeting avoidable presentations may serve to alleviate the problem in our EDs.

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Deployed in Disaster: Exploratory Study of Personnel Deployed into Ontario Long-Term Care Homes during the COVID-19 Pandemic

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Introduction: The COVID-19 pandemic had a devastating impact on long-term care in Canada, exacerbating an existing crisis of staff shortages, inadequate infrastructure and funding, into a disaster. In response, the province of Ontario enacted emergency legislation and requested federal government support, resulting in the deployment of personnel from the

Canadian Armed Forces and acute care hospitals into long-term care homes across the province. This exploratory study aims to develop a rich description of the long-term care context during the pandemic, deployed personnel's perspectives on providing care in the context, and identification of lessons learned while working during the pandemic.

Method: Descriptive exploratory design with demographic questionnaire and semi-structured interviews will be used to understand the background and perspective of deployed personnel and managers on working in long-term care during the pandemic. Thematic analysis will be used to analyze the transcripts, organize codes, and identify and describe major themes. Findings will also be compared with disaster literature to understand how the perspectives of deployed personnel compare with existing disaster research.

Results: 21 interviews were initially conducted. Analysis of these interviews identified key challenges experienced by those deployed, including human resources, leadership and accountability, and policies and regulations. Perspectives and strategies for overcoming these challenges were also shared.

Conclusion: The scale, duration, and context of the redeployment of personnel into long-term is unprecedented and has seen little research. This exploratory study shares the experiences of personnel who deployed into long-term care and helps identify lessons learned from overcoming challenges in the disaster context. These findings will be able to inform future disaster research and how to better prepare responders in the future.

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A Hole in the Safety Net: Failures of the Initial COVID-19 Pandemic in Kentucky

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Introduction: The COVID-19 pandemic hit Kentucky in March of 2020. While around the world the pandemic had already reared its head and strained international hospital systems at their core, Kentucky hospitals remained wholly underprepared. University of Kentucky Hospital is a relatively resource rich hospital. However, utilization of these resources was severely misplaced and inefficiently distributed. This led to unnecessarily large upfront costs in an attempt to prepare for large volumes of patients that never actually came, as well as risk stratifying patients in a costly and unproductive way.

Method: We reviewed the initial response to the COVID-19 pandemic from the University of Kentucky as well as specifically within the emergency department. This included all system-wide preparations as well as emergency medicine-specific COVID-19 protocols regarding risk stratification of patients, testing, and delivering results.

Results: Initially the number of patients that would need to be hospitalized with COVID-19 as well as how to risk stratify or treat them was completely unknown. This led to multiple large issues within University of Kentucky's response to the pandemic. A 400-bed field hospital was constructed out of

University of Kentucky's football field and subsequently deconstructed two months later before ever being used, costing the hospital \$6.7 million dollars. Lack of tests and knowledge about the disease in combination with over ordering labs and CT scans in an attempt to risk stratify. There was no reliable way to obtain COVID-19 testing or deliver the results and this led to increased non-sick patients presenting to the ED just for information.

Conclusion: The COVID-19 pandemic highlighted many shortcomings of our hospital system and its preparedness for a pandemic or mass disaster. The silver lining of these failures was the implementation of system wide improvements in throughput and preparation within our emergency department.

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Mapping Nurses' Advanced Roles in Emergency Departments Globally

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Introduction: It is widely recognized that there is an increasing demand for healthcare in emergency departments (ED) around the world as well as a global shortage of healthcare workers (HCWs). This has led to ED overcrowding, which increases risks of avoidable complications and suboptimal care provision. Since ED overcrowding impacts patients, staff and quality of care, new strategies are needed for optimizing patient throughput and reducing waiting times. One such strategy is to reconsider the specific roles and professional duties of different cadres of HCWs. Empowering nurses to take on some of the tasks historically performed by physicians is a promising solution for improving ED healthcare provision. However, nurses' professional responsibilities and competencies differ significantly from country to country. There are few studies about best practices and how to effectively implement such task-shifting strategies. The aim of this study is to map the evidence published in the scholarly literature on nurses' advanced roles in ED as a strategy for reducing overcrowding, facilitating ED throughput, and, ultimately, improving quality of care.

Method: A mapping review was performed by searching the following databases: PubMed, Embase, Scopus and Web of Science.

Results: A total of 168 studies were analyzed and the data were grouped according to the countries where advanced tasks were implemented. The type of tasks that were carried out were: autonomous management of patients with minor injuries, triage-based ordering of exams and administration of therapy and management of patient flow.

Conclusion: In some high-income countries having nurses take on advanced roles is well-established, and it contributes to reducing overcrowding in ED. Further evidence is needed to assess the barriers and facilitating factors to implementing this strategy in other contexts.

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Critical Decision-making in Medical Command and Control During Early Covid-19: An Interview Study

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Introduction: A resilient health care system is expected to withstand disruptive events and consistently deliver high quality care by continually adapting, learning, and improving. To achieve these expectations, medical command and control teams are responsible for making relevant strategic decisions, reallocating resources, and initiating cooperation. Early during Covid-19, medical command and control teams were faced with an unforeseen increase in number of patients, as well as unknown disease mechanisms and treatment regimes. Timely and adequate decision-making to become a resilient healthcare system and maintain high quality care was necessary. The aim of the present study was to describe the challenges and strategies in a medical command and control team during the early phase of the Covid-19 pandemic.

Method: A semi-structured retrospective in-depth interview study with phenomenological approach and inductive design was used. Thirteen experienced decision makers serving in a regional medical command and control team were interviewed using the Critical Decision Method. The interviews were analyzed using manifest conventional content analyses.

Results: The respondents described twelve separate episodes during the Covid-19 management. The analysis resulted in five themes: organization, adaptation, common operational picture, assumptions, and analysis. Organization described how organizational challenges affected the decision-making process. Adaptation described the strategies to overcome the obstructive organizational factors. Common operational picture described how challenges in lack of available information affected decision-making and strategies used in creating situational awareness. Assumptions offered descriptions of strategies used to make decisions. Analysis emphasized descriptions and strategies affecting the decision-making process.

Conclusion: This study enables a better understanding of how medical command and control teams can be organized and structured, while also highlighting challenges in maintaining high-quality care during unexpected events. The findings obtained in the present study provide further knowledge about