People with disabilities with suspected novel coronavirus (COVID-19) infections: Considerations for emergency departments

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Emergencies increase the vulnerability of people with disabilities. People with disabilities already experience significant disadvantages in the healthcare they receive, but in times of adversity, the impact is magnified. For example, the fatality rate for people with disabilities during the earthquake and tsunami affecting Japan in 2011 was 2.06% as opposed to 1.03% in the general population.

During the early days of the COVID-19 pandemic, concerns arose within the disability community about the preparedness of infrastructure to support people with disabling conditions. In emergency departments and community health systems, awareness of the following considerations may facilitate flow, reduce disruption, and encourage good quality care. Of course, national, state, and local guidelines and advice should always take precedence over these considerations. However, it may save valuable lives if we all think cautiously about the additional impact of COVID-19 on those with disabilities in our community.

1. Accessing emergency departments

a. As people with disabilities face difficulty in accessing medical facilities, presentations may be delayed, resulting in more severe symptoms and more likelihood of transmission.

b. In regional and remote areas in particular, people with disabilities are more reliant on emergency departments for standard treatment so may now be reluctant to seek care for conditions that affect their ongoing health.

c. People with disabilities may face transport issues, as well as physical access challenges so temporary facilities need to be audited for access.

d. Certain visual, auditory, physical, and intellectual disabilities can mean that people with disabilities may not be aware of best practice. They may miss signage regarding COVID-19 or be unable to follow good infection control practices. Social distancing may not be an option when care needs necessitate physical contact with caregivers.

e. Indicators of COVID-19, such as a fever and cough and respiratory challenges may be present or impaired in certain disabilities, requiring vigilance from caregivers and consideration of the entire clinical picture during triage.

2. Caregivers

a. Out of 2.65 million unpaid Australian carers, 861,000 are primary carers for someone with a disability. The potential impact of COVID-19 and the restrictions imposed on society to prevent its spread are therefore twofold. If caregivers become unwell, the impact will be felt by people with disability who depend on them.

b. Caregivers are often intimately acquainted with the needs of the person they are caring for. They are a resource for the health provider and usually want to play a large role in the care delivered to the person.

c. In the event that a carer, or a care team, becomes isolated or ill; the person being cared for runs a risk of neglect, lack of care, or care from inadequately trained teams. Therefore, early access to social work and staff acquainted with emergency provisions provided by schemes such as the National Disability Insurance Scheme will help mitigate risks.

d. In the event that the person being cared for becomes ill with or without the need for isolation, involving the existing care team to the greatest possible extent will minimise distress, unforeseen injury, or exacerbation of existing conditions, such as pressure ulcers that may not be immediately visible. Such involvement will require consideration of infection control precautions.

e. In the event that person with disability becomes isolated from his or her caregivers, an alternative caregiver may need to be identified. A contingency plan is essential.

f. Caregivers may play a particularly important role when the person being cared for has communication challenges. Seek advice from caregivers about how to best communicate.

g. In people who are susceptible to emotional distress, such distress will be exacerbated in situations requiring physical isolation. Challenging behaviours should not be ignored as they are often an indicator of distress.

h. Caregivers may be able to reduce nursing loads if they are familiar with, or given instruction in, infection control measures and are able to continue their role across multiple settings.

i. If the primary caregiver, or care team, presents to a department with a suspected infection accompanied by the person being cared for, a social admission may become necessary. Ensure that appropriate

arrangements are made for the person with disability if a social admission to hospital is not possible.

j. Additional nursing staff may be required to manage certain patient groups, particularly if their personal care staff becomes unavailable and they become distressed or confused.

k. When patients are reliant 24 hours a day as in those who are ventilator dependent, enabling carers to take a role in caring for patients may reduce load on intensive care units.

3. Infection control

a. People who are ventilator-dependent may have additional infection control precautions in the prehospital phase and during hospitalisation.

b. Equipment such as wheelchairs, indwelling catheter attachments, walking sticks, and other assistive equipment may require specific cleaning regimes for infection control.

c. People with sensory impairments, including visual challenges, may require additional considerations particularly when relying on tactile input. Consider alternative formats for information (e.g., Braille, Auslan, captions, descriptions of images).

4. Social support

a. Increased social work staffing may be of value to support people with disabilities, both in the community and in the hospital system.

b. Rapid access to community support networks and caseworkers for schemes such as the National Disability Insurance Scheme may prevent

unnecessary admission or facilitate a rapid transition back to the community.

c. Contribute to any initiatives that support the independence of people with disabilities in the community and during stressful engagements with the medical system.

5. Underlying medical conditions

a. Some people may present with atypical symptoms due to the impairment of normal physiological responses such as a fever or cough.

b. Respiratory capacity will be impaired in many respiratory, neuromuscular, or other conditions and may require a vigilant approach with early aggressive interventions, and timely discussions with the relevant local specialist teams.

c. Medical conditions that may predispose people to emotional distress (e.g., mental illness, brain injuries, intellectual disability) may require additional care to prevent disruption of infection control measures in the event of physical agitation.

d. In the event of providing community self-isolation advice, certain people with disabilities will require the isolation of their entire care team. This situation may require a brief admission to a short stay unit to support and prepare the community care team.

6. Stopping stigma and fear

a. Consider the stigma being experienced by people with disabilities in the face of this pandemic and do not add to this burden. Behave with respect

to all people with disabilities and acknowledge the increased challenges they face.

b. Public announcements have emphasised the vulnerability of this group and have therefore increased levels of anxiety and fear. Check on the mental wellbeing of people with disabilities whenever you can.

c. Some public messages have also hinted at the different value placed on different lives by stating that only the elderly and those with existing disabilities are likely to die as a result of infection. This is not true.

d. In the community, it is also important to remember that every cough is not COVID-19. Many people with disabilities have respiratory symptoms all the time and cannot physically follow recommended hygiene practices. Being shamed in social settings is never appropriate.

d. When taking a panic-driven response to COVID-19 (e.g., panic buying and hoarding, abusing others for their actions, or disregarding regulations), remember that your actions have greater impact on people with disabilities.

[Image 1]

[Alt text: An elderly man in a wheelchair with a female carer]
[End Image 1]

[Image 2]

[Alt text: Image of four medical professionals in personal protective equipment including masks, walking in a hospital environment]

[End Image 2]

IMPORTANT CONTACTS AND ONGOING SUPPORT

Emergency – 000

National Coronavirus Helpline – 1800 020 080

Qld COVID-19 Hotline – 13HEALTH (13 43 25 84)

Department of Health – 1800 020 103

Community Recovery Hotline – 1800 173 349

Health Direct – 1800 022 222

National Disability Insurance Scheme (NDIS) – 1800 800 110

Queensland Disability Network (QDN) – 1300 363 783

Carers Qld – 1800 242 636

Beyond Blue – 1300 22 4636

Lifeline – 13 11 14 or 0477 13 11 14 (SMS)

Salvation Army Australia – 13 SALVOS (13 72 58)

Vision Australia – 1300 84 74 66

Expression Australia – AUSLAN Coronavirus updates

Assistance for Hard of Hearing – 131 450

National Relay Service Website

Translating and Interpreting Service

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