

A. Carter, MD, MPH, M. Arab, MSW, M. Harrison, BSc, J. Goldstein, PhD, J. Jensen, MAHSR, M. Lecours, MD, K. Houde, BSc, K. Downer, MSc; Dalhousie University, Halifax, NS

**Introduction:** Paramedics are sometimes called for crisis management and relief of symptoms or for patients receiving palliative care. To address the mismatch between the system protocols and resources, and patient's goals of care, a new protocol, new medications, and an 8-hour training program Learning Essentials Approach to Palliative Care (LEAP) were implemented in our provincial EMS system. **Methods:** Prior to attending their training session paramedics received an invitation to complete an online survey regarding their comfort, confidence, and attitudes toward delivering palliative care. Comfort and confidence questions were scored on a 4-point Likert scale, while attitudes toward specific aspects of care were scored on a 7-point Likert scale. Descriptive statistics were calculated. Identifiers will permit linkage of these responses to a repeat survey post-implementation. **Results:** 188 (58%) paramedics completed the survey of the 325 who opened the link. 134 (68%) were male with a mean age of 38.5 years. 95 (50%) were primary care paramedics. The average experience as a paramedic was 12.7 years, with an estimated mean number of palliative calls per year of 9.6 each. On a 4 point scale, most (156, 83%) were comfortable with providing care to someone with palliative goals, and 130 (69.1%) were comfortable providing care without transport. Only 82 (43.6%) were confident they had the tools to deliver this care, and 76 (40.4%) were confident they could do so without transport to hospital. On a 7 point scale, paramedics disagreed with the statement "caring for dying persons is not a worthwhile experience for me", median 7 (IQR 5-7). Paramedics also disagreed with the statement "Dying persons make me feel uneasy", median 5 (IQR 4-6). **Conclusion:** Prior to the implementation of the new protocol, medications, and training, most paramedics were comfortable with the concept of providing care with palliative goals and felt that caring for dying persons is a worthwhile experience, but they were not confident that they have the tools and resources to do so. This suggests paramedics would be open to system improvements to meet an unmet healthcare need for crisis management of patients with palliative goals of care.

**Keywords:** system design, paramedic, expanded scope

#### P021

##### **Impact of emergency department surge and end of shift on patient workup and treatment prior to referral to internal medicine**

V. Charbonneau, MD, MSc, I.G. Stiell, MD, MSc, E.S. Kwok, MD, L. Boyle, MD; University of Ottawa, Ottawa, ON

**Introduction:** The goal of this study was to determine if emergency department (ED) surge and end of shift assessment of patients affect the extent of diagnostic tests, therapeutic interventions performed and accuracy of diagnosis prior to referral of patients to Internal Medicine as well as the impact on patient outcomes. **Methods:** This study was a health records review of consecutive patients referred to the internal medicine service with an ED diagnosis of heart failure, COPD or sepsis, at two tertiary care EDs. We developed a scoring system in consultation with senior emergency and internal medicine physicians to uniformly assess the treatments and investigations performed for patients diagnosed in the ED with heart failure, COPD or sepsis. These scores were then correlated with surge levels and time of day at patient assessment and disposition. Rate of admission and diagnosis disagreements were also assessed. **Results:** We included 308 patients (101 with heart failure, 101 with COPD, 106 with sepsis). Comparing middle of shift to end of shift, the overall weighted mean scores were 92.2% vs. 91.7% for

investigations and 73.5% vs. 70.0% for treatments. Comparing low to high surge times, the overall weighted mean scores were 89.9% vs. 92.6% for investigations and 68.6% vs. 71.7% for treatments. Evaluating each condition separately for investigations and treatments according to time of shift or surge conditions, there were no consistent differences in scores. We found overall high admission rates (93.1 % for heart failure, 91.1% for COPD, 96.2% for sepsis patients), and low rates of diagnosis disagreement (4.0 % heart failure, 10.9% COPD, 8.5% sepsis). **Conclusion:** We found that surge levels and end of shift did not impact the extent of investigations and treatments provided to patients diagnosed in the emergency department with heart failure, COPD or sepsis and referred to internal medicine. Admission rates for the patients referred were above 90% and there were very few diagnosis disagreements or diversion to alternate service by internal medicine. We believe this supports the emergency physician's ability to adapt to time and surge constraints, particularly in the context of commonly encountered conditions.

**Keywords:** Surge

#### P022

##### **Geriatrics care in the ED: Acute care use after the introduction of an interdisciplinary care program in Sunnybrook Health Sciences Centre's Emergency Department**

N. Khatib, MD, CM, MBA, J. Charles, MD, MSc, J.S. Lee, MD, MSc; University of Toronto, Toronto, ON

**Introduction:** Currently the top 5% of complex patients consume 84% of Ontario's Hospital and Home Care costs. There is a critical need for a dynamic, person-centred care planning process for medically complex patients with real time dialogue between ED/acute care and community care providers at care transitions. A care pathway was developed in the Sunnybrook Health Science Centre's Emergency Department using quality improvement methodology and team. The purpose of this study is to evaluate the impact of the emergency room huddle for complex care patients on emergency doctors' perceptions of patient safety and ED efficiency measures such as department flow and delays. **Methods:** **Intervention** - Medically complex patients with frequent ED use are now automatically flagged upon registration in the Emergency Department (ED) and an ED Care Coordination team is notified by secure email: GEM nurse, ED CCAC Care Coordinator, SW, OT/PT. The GEM nurse initiates a comprehensive patient assessment in the Emergency Department right after triage and the CCAC Care Coordinator initiates a teleconference with the patient's family physician and community Care Coordinator with the patient's consent. Usual physician assessment is preceded and followed by an inter-professional huddle (including the EM doctor, GEM nurse, CCAC nurse and SW, OT, PT) to ensure patient's needs, goals and team recommendations are clear. Emergency doctors who have participated in an inter-professional huddle for complex care patients are contacted via a semi-structured interview and Qualtrics surveys evaluating perceptions of patient safety and ED efficiency measures such as department flow and delays. **Results:** Qualitative analysis of the results will be conducted and results updated at a later date. **Conclusion:** Safety is enhanced through better communication between ED providers, patients, their family physicians and community care providers. It is essential that the inter-professional huddle is recognized by emergency physicians as an important element of patient safety and care. An evaluation of ED doctor's perception of the huddle will help us understand enablers and barriers to the process and inspire further quality improvements to enhance patient care.

**Keywords:** geriatrics, communication, patient-centered care