P100

Une activité de simulation de table à des fins de formation interprofessionnelle pour enseigner une nouvelle procédure intra-hospitalière de code rose : une étude pilote exploratoire et rétrospective sur la perception des apprenants

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Introduction: Les erreurs médicales sont causées par des failles de système plutôt qu'un seul individu. Dans ce contexte, de multiples designs pédagogiques de formation interprofessionnelle (FIP) ont été proposés pour développer une meilleure collaboration interprofessionnelle. L'une des initiatives pédagogiques proposées en médecine de désastre est la simulation de table (TTX). La TTX consiste à simuler une situation de code orange dans un environnement informel où les participants doivent discuter de la suite logique des actions à prendre. Le protocole d'arrêt cardiaque intra-hospitalier chez le nourrisson de moins de 30 jours (code rose) ayant été mis à jour au Centre hospitalier de l'Université de Montréal (CHUM), cela a généré un besoin de FIP au sein des équipes. Ainsi, nous avons développé une FIP innovante en utilisant la TTX pour enseigner un nouveau protocole de code rose. L'objectif primaire de la présente étude est d'évaluer la perception des apprenants à propos de cette FIP. **Methods:** La présente étude rétrospective de cohorte s'est déroulée en mars 2019 au centre de simulation du Centre hospitalier de l'Université de Montréal. Un groupe interprofessionnel (médecins, infirmières, inhalothérapeutes, préposés aux bénéficiaires, etc.) a été recruté. Un sondage de satisfaction des participants leur a été remis immédiatement après la TTX. Des statistiques descriptives (n, %) ont été réalisées. Les commentaires recueillis lors du débreffage ont permis de nuancer les résultats et d'apporter des changements à la nouvelle procédure de code rose. **Results:** Un total de 13 participants ont participé à la TTX, dont 10 ont répondu au sondage (10/13 : 77%). 3 observateurs ont participé à la TTX et ont tous répondu à certaines questions du sondage (3/3 : 100%). Suite à la TTX, 80% (n = 8) des participants ont eu l'impression de mieux comprendre leur propre rôle et 90% (n = 9) des participants ont eu l'impression de mieux comprendre le rôle des autres professionnels. Tous (100%, n = 13) ont apprécié la TTX et ont affirmé qu'il était probable ou très probable qu'ils participent à nouveau à une telle activité de FIP s'ils y étaient invités et qu'ils recommanderaient à un collègue d'y participer. **Conclusion:** Il est possible de réaliser une TTX pour une autre procédure d'urgence que le code orange, c'est-à-dire pour le code rose et cela est apprécié des participants. Ces derniers se sont sentis plus confiants dans leur rôle et dans leur connaissance du rôle des autres professionnels.

Keywords: interprofessional education, tabletop exercises

P101

Seasonal variations in modes of presentation in ST elevation myocardial infarction

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Introduction: For patients with ST-elevation myocardial infarction (STEMI), time is myocardium. The sooner STEMI patients receive a definitive intervention, the better their outcomes. The first point of contact with the healthcare system for STEMI patients is either via Emergency Medical Services (EMS), or self-transportation to an Emergency Department (ED). Despite a reduced time to definitive intervention, STEMI patients who use EMS have increased mortality compared to those who self-transport. In an effort to optimize STEMI care pathways, we characterized variations in modes of presentation of STEMI patients in our region. **Methods:** This study used a retrospective cohort design from a regional STEMI registry. Patients presenting to Hamilton Health Sciences between January 1, 2016, and December 31, 2018 meeting STEMI criteria were included in our analyses. Self-transport patients were analyzed from two academic EDs in Hamilton, Ontario. One hospital was PCI capable and the other, non-PCI capable. Patients transferred from other health regions were excluded from our analyses. Dichotomous variables were compared using $\chi 2$ tests. Group means were compared using the Student t-test. **Results:** Eight hundred and seventy-one patients were included in the analysis, including 675 EMS users, and 196 self-transporting to EDs. Patients self-transporting to EDs were younger (61.5 v. 64.6 y, $p < 0.002$) and more often male (82.6 v. 69.2%, $p < 0.0002$) compared to EMS users. There was a non-significant trend towards an increased rate of all STEMI patients self-transporting in the summer months compared to the winter (63 of 215 in summer v. 41 of 185 in winter, 29.3 v. 22.2%, $p = 0.10$). Comparative analysis between both hospitals yielded an increased rate of self-transportation to the PCI-capable hospital in the summer months compared to winter (46 v. 28, 23.2 v. 16.3%, $p = 0.09$), but not the other hospital (18 v. 13, 10.6 v. 8.3%, $p = 0.57$). The majority of self-transporting patients came from postal codes bordering each hospital, and the different rates of self-transportation between hospitals were not associated with recent specialist follow up at those sites. **Conclusion:** Seasonal trends in modes of presentation in STEMI patients may present an opportunity to optimize STEMI care pathways through resource utilization and patient education. A larger dataset and possible multicenter analysis should be done to determine if significance is obtained with larger sample size.

Keywords: modes of presentation, myocardial infarction, seasonal variation

P102

What are Canadian emergency physicians' attitudes toward, understanding of, and willingness to treat patients who have attempted suicide?

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Introduction: Suicide is the 9th leading cause of death in Canada, and a common reason for patients to present to Canadian emergency departments (ED). Little knowledge exists around Canadian emergency physicians (EPs) attitudes toward and understanding of individuals who have attempted suicide. **Methods:** We developed a web-based survey on attitudes around suicide, which was pilot tested by two EPs and one psychiatrist for clarity and content. The survey was distributed via email to attending physician members of the Canadian Association of Emergency Physicians. Data were described using counts, means, medians and interquartile ranges. We used the Understanding of Suicidal Patients (USP) Scale, an 11-point questionnaire utilized in previous studies to assess healthcare providers' attitudes toward individuals who have attempted suicide. Each question was graded as a five-point Likert, with a score of 1 indicating complete agreement and a 5 indicating complete disagreement. A total USP score is calculated by adding together the score from each question and ranges from 11 to 55; a lower score indicates greater empathy and understanding of individuals who have attempted suicide.

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Results: 193 EPs responded to the survey, with 42% of EPs practicing in Ontario. 35% of EPs were female, the mean age was 48 (95% CI 47.3-48.7), and mean years in practice was 17 (95% CI 16.3-17.7). Academic practice location was reported by 55% of EPs, and 81% reported access to an inpatient psychiatry service. The mean USP score was 21.8 (95% CI 21.1-22.5) with a Cronbach's alpha of 0.75, the median was 22 [IQR 14-29]. The item that had most agreement from EPs was "I would like to help a person who has attempted suicide" (1.58, 95% CI 1.50-1.67), while the item that had the least agreement was "patients who have attempted suicide are usually treated well in my work unit" (2.54, 95% CI 2.40-2.69). **Conclusion:** Canadian EPs have a generally positive attitude toward treating individuals who have attempted suicide. EPs scored highly on a scale that measured willingness to provide care for and empathize with suicidal patients, yet identified that overall care for these patients could be improved.
Keywords: attitude, emergency physician, suicide

P103

How knowledgeable are Canadian emergency physicians about the risk factors of completing suicide in patients presenting to the ED with suicidal thoughts?

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Introduction: Suicide is the 9th leading cause of death in Canada, and a common reason for patients to present to Canadian emergency departments (ED). Little knowledge exists around Canadian emergency physicians (EPs) knowledge about the risk factors of completing suicide in patients presenting to the ED with suicidal thoughts. **Methods:** We developed a web-based survey on suicide knowledge, which was pilot tested by two emergency physicians and one psychiatrist for clarity and content. The survey was distributed via email to attending physician members of the Canadian Association of Emergency Physicians. Data were described using counts, means, medians and interquartile ranges. **Results:** 193 EPs responded to the survey (response rate 16%), with 42% of EPs practicing in Ontario. 35% of EPs were female, the mean age was 48 (95% CI 47.3-48.7), and mean years in practice was 17 (95% CI 16.3-17.7). Academic practice location was reported by 55% of EPs, and 81% reported access to an inpatient psychiatry service. Twenty four (12%) EPs had personally considered suicide, and 45% had experience with suicide in their personal lives. The top three risk factors for suicide identified by EPs were: intent for suicide (90%); a plan for suicide (89%); prior suicide attempt (88%). A majority of EPs were able to correctly identify the other risk factors for completion of suicide except for the following: diagnosis of anxiety disorder (25%), chronic substance use (43%), prior non-suicidal self-injury (37%), low socioeconomic status (34%). **Conclusion:** Canadian EPs have substantial personal experience with suicide. A majority of EPs were able to correctly identify known risk factors for suicide completion, yet important gaps in knowledge exist.
Keywords: emergency physician, knowledge, suicide

P104

What are the current practices and barriers to screening for suicidal thoughts in Canadian emergency departments?

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Introduction: Suicide is the 9th leading cause of death in Canada, and a common reason for patients to present to Canadian emergency departments (ED). Little knowledge exists around Canadian emergency physicians (EPs) current practices and barriers to screening for suicidal thoughts (ST). **Methods:** We developed a web-based survey on suicide knowledge, which was pilot tested by two emergency physicians and one psychiatrist for clarity and content. The survey was distributed via email to attending physician members of the Canadian Association of Emergency Physicians. Data were described using counts, means, medians and interquartile ranges. **Results:** 193 EPs responded to the survey (response rate 16%), with 42% of EPs practicing in Ontario. 35% of EPs were female, the mean age was 48 (95% CI 47.3-48.7), and mean years in practice was 17 (95% CI 16.3-17.7). Academic practice location was reported by 55% of EPs, and 81% reported access to an inpatient psychiatry service. 142 EPs (82%) reported no protocol for screening for ST in their ED. Of EPs reporting an existing protocol, the most common practice was routine screening at triage (43%). The most commonly identified screening tools were HEADS-ED (25%) and PHQ-9 (21%). 70% of EPs felt the ED was a good place for screening for ST, yet 66% identified slower clinical care as a potential barrier. A strong commitment to treatment and follow up was identified by 68% of EPs as a necessary requirement to implementing ST screening in their ED. A targeted 2-4 question screen was the preferred screening option for 62% of EPs responding. **Conclusion:** A majority of EPs report no protocol for screening for ST in their ED, yet identify the ED as a good place for screening efforts. Potential barriers to widespread ST screening in the ED include a strong commitment to patient treatment and follow up, and diminished clinical efficiency.
Keywords: emergency physician, screening, suicide

P105

Observational study of distribution of time and activities over the course of an emergency physician's shift

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Introduction: The growing scrutiny to improve Emergency Department (ED) wait times and patient flow have resulted in many efforts to increase efficiency and maximize patient throughput via systems improvements. This study investigates areas of efficiency improvement from the Emergency Physician (EP) perspective by examining EP workflow in a two phased observational time-motion study. In the initial phase, the distribution of time and activities of EPs were dissected to identify potential sources for streamlining to maximize physician productivity. The first phase was of the study was completed during the period immediately preceding the implementation of an Electronic Health Records (EHR). The second phase of the study will repeat the analysis one year post EHR implementation. This data will be dissected to again identify sources for streamlining in an EHR environment and to identify shifts in work flow from a paper-based system. **Methods:** An observational time motion study was conducted at St. Mary's Hospital ED, in Kitchener Ontario. An observer was paired with an EP for the duration of an 8 hour shift, to a total of 14 shifts in the first phase of the study. Nine task categories were measured concurrently with a stopwatch application on a tablet, along with the number of interruptions experienced by the EP. Means of each category were calculated and converted to percentages, representing the amount of time per 8 hour shift dedicated to each activity. The second phase will be repeated in Fall 2020, 1 year after EHR

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