

contextual features of acute care influence HF-EOL. Using an ethnographic methodological approach with methods including observation and interviews, the findings of this research aim to improve EOL care by highlighting opportunities for changes in acute care.

In this session the investigator will overview the in-progress "HF-EOL Study". Discussion will include background, methodological considerations, preliminary study results, and potential practice implications including change opportunities and education. Implications for practice will be presented in a multi-level framework addressing individual, organizational, and systemic outcomes to improve HF-EOL in acute settings and beyond.

### **N032**

#### **USE OF AN AUTOMATED CHEST COMPRESSION SYSTEM DURING STEMI: A CATH LAB'S EXPERIENCE USING LUCAS™**

**S MacLeod**

*St Paul's Hospital / Providence Health, Vancouver, BC*

Patients experiencing ST elevation myocardial infarction or shock associated with myocardial infarction may require activation of the cath lab for emergent percutaneous coronary intervention (PCI). The goal for these patients is to open the blocked coronary artery and reestablish coronary blood flow as soon as possible. These patients are also at risk of cardiac arrest while undergoing PCI. When a cardiac arrest occurs, patients require manual chest compressions (CPR) from staff members, which may interrupt the PCI and significantly delay coronary reperfusion, which can result in a larger infarction. Also, the risk of musculoskeletal injury while performing CPR on the cath lab table or excess radiation exposure from ongoing fluoroscopy is higher for staff.

The use of an automated chest compression system (Physio-Control LUCAS™ CPR) for patients in cardiac arrest can provide uninterrupted chest compressions during PCI. The PCI is interrupted only to apply the device, position it and turn it on. The procedure can then resume while the patient is receiving compressions.

A quaternary, university-affiliated hospital acquired funds to obtain a LUCAS™ chest compression system for both the emergency and cath lab departments. Data will be presented on the number of times the automated chest compression system was used in the cardiac cath lab over the past year, case examples of its use during cardiac arrest in STEMI and PCI, as well as a cost-benefit analysis in relation to potential loss of work from injury performing CPR.

### **N033**

#### **READMISSION RATES UNDER THE MICROSCOPE**

**H Sherrard, N Rodger, B Bowes**

*University of Ottawa Heart Institute, Ottawa, ON*

The growing rise in healthcare costs has led to an increasing focus on reducing readmission rates as a means to improving

the quality of care while contributing to the sustainability of the healthcare system. Readmission rates can be influenced by a variety of factors, including the quality of inpatient and outpatient care, the effectiveness of the care transition and coordination, and the availability and use of effective disease management community-based programs.

A quality initiative was undertaken which analyzed 12-months of 30-day readmission data in six areas: Coronary Artery Bypass Graft (CABG), Valve, Heart failure, Arrhythmia, Acute Myocardial Infarction (AMI), and Percutaneous Coronary Intervention (PCI). The results of this analysis will be presented including comparisons with national and/or published sources. The top 3 causes of readmission are identified for each of the six areas. Data on the average number of days from discharge-to-readmission and actual length of stay vs expected length of stay in all areas will be discussed. Finally, an analysis of readmission strategies currently in place will be made against the Project Re-Engineered Discharge (Project RED) best practice intervention developed by Boston University Medical Center to identify further initiatives to improve the hospital discharge process in a way that promotes patient safety and reduces readmission rates.

### **N034**

#### **ANGINA MANAGEMENT IS POOR AFTER PERCUTANEOUS CORONARY INTERVENTION**

**S Dawkes,<sup>1</sup> G Smith,<sup>1</sup> R Raeside,<sup>1</sup> L Elliott,<sup>2</sup> J Donaldson<sup>3</sup>**

<sup>1</sup>*Edinburgh Napier University, Edinburgh, Scotland*

<sup>2</sup>*Glasgow Caledonian University, Glasgow, Scotland*

<sup>3</sup>*University of Stirling, Stirling, Scotland*

Self-management of coronary heart disease (CHD) is critical after elective percutaneous coronary intervention (PCI). While elective PCIs should reduce patients' stable angina symptoms, recurring pain is a common problem post-procedure and effective self-management of this seemed poor. The aims of the study were to identify how patients self-managed their angina symptoms after undergoing PCI and to explore barriers to their effectiveness in this.

This mixed methods study used an explanatory, sequential design. In phase one quantitative data were collected from a convenience sample (n=93) approximately three months after elective PCI using a validated self-administered survey tool. Quantitative data were subject to univariate, bivariate and multi-variate analysis. Phase one findings were used to purposively select ten participants from the original sample for interview in phase two of the study. Thematic analysis was used to analyse qualitative data.

Participants had a mean age of 66.25 years (SE±10.56), were mostly male (n=70/75.3%) and Caucasian (n=80/86%). After PCI, 74.2% (n=69) of participants managed their angina symptoms inappropriately and many felt unsupported by their family doctors and cardiology teams. Unsure of how to manage angina, 17.2% (n=16) of participants summoned

an emergency ambulance to help them deal with any recurrence of symptoms, however slight or short-lived. Older age, the existence of co-morbidities, low self-efficacy and fear compromised participants' effective self-management of angina symptoms.

Self-management of angina symptoms is sub-optimal after elective PCI. To lessen unnecessary burden on emergency health services, patients require more guidance and support to allow them to effectively self-manage their angina symptoms.

### **N035 HEART TEAMS: MOVING BEYOND WORKING TOGETHER**

**H Sherrard, N Rodger, B Bowes**

*University of Ottawa Heart Institute, Ottawa, ON*

The value of multidisciplinary teams is understood in many work environments. Most organizations who have cardiac programs can describe situations in which teams come together to make decisions about care approaches for patients. More recently, the concept of 'heart teams', has been gaining momentum particularly around decision-making for complex revascularization and TAVI patients. In both settings these teams are focused on ensuring the patients have a multidisciplinary approach to determining which procedure/approach might be best— particularly when indications may not be definitive.

While this approach in which heart teams work together is still evolving, the next major step is creating teams which think and innovate together — providing the opportunity to create new approaches that cross traditional clinical silos. This presentation will review the current literature on heart teams. It will then outline how one organization developed a strategic approach to heart teams focusing on innovation, standardized outcomes and sustainability. The presentation will include: staging the implementation of six heart teams across the organization, defining the terms of reference for each team; the resource requirements; the outcome requirements for each team and the role of nursing within each team.

### **N036 WHY EQUITY OF ACCESS FOR COMMUNITY-BASED CARDIAC CATH PATIENTS BECAME THE HEART OF WHAT WE DO**

**B Jones, T Federico, C Roach, M Biegler, K Craig, K Foudy, D Troubsi**

*Foothills Medical Center, Calgary, AB*

Foothills Medical Centre's Cardiac Catheterization Laboratory (Calgary) performs 8,900 procedures annually. There was inequity of access to service for our community-based patients as these referrals were being directed to individual

physicians with no mechanisms to accurately compare physicians wait times. Thus, a provincial mandate to report these wait times could not be met with existing processes.

By June 2015, the Centralized Referral project aimed to implement a central intake for community-based referrals, incorporating a data repository to ensure all outpatients have equitable and measurable access to diagnosis and treatment. The project was jointly supported by a Clinical Nurse Specialist, a Nurse Clinician and a Quality Improvement Consultant.

A working group was formed from key stakeholders to lead change, which formulated recommendations for operating Central Referral. This included the following:

- Standardized referral management process;
- Referral criteria;
- Triage guidelines for priority setting;
- Central data reporting;
- Strategies for communication with referring physicians and patients.

As a result, a nurse-led Central Referral team was created. Post-implementation, the team has the ability to analyse activity and service access times. A newly devised nursing triage process that is consistent, reproducible and evidence-based was also implemented. Combined, this new information allowed nursing to influence equitable access to service. To ensure sustainability and consistency across all nursing and clerical team members, an operational manual was developed.

### **N037 ETHNICITY-BASED DIFFERENCES IN TREATMENT-SEEKING FOR SYMPTOMS OF ACUTE CORONARY SYNDROME**

**E Iacoe,<sup>1</sup> P Ratner,<sup>2</sup> S Wong,<sup>2</sup> M Mackay<sup>1</sup>**

<sup>1</sup>*Providence Health Care/St. Paul's Hospital, Vancouver, BC*

<sup>2</sup>*University of British Columbia, Vancouver, BC*

Patient-related delay in seeking treatment for acute coronary syndrome (ACS) is a major factor limiting the delivery of optimal treatment. Despite intensive campaigns aimed at raising awareness, no improvements have been achieved in patients' treatment-seeking intervals (i.e., from onset of symptoms to healthcare contact). In Canada's multi-ethnic society, understanding how ethnicity relates to treatment-seeking is important to guide future interventions.

The aim of this cross-sectional study was to determine if there are ethnicity-based differences in the time-to-treatment-seeking intervals of patients experiencing symptoms of ACS. We obtained patient-reported data pertaining to their time-to-treatment seeking and ethnicity. We defined time-to-treatment seeking as the time of symptom onset to the time of decision to seek treatment. Ethnicity was collected by self-report and was then re-categorized as Chinese, South Asian, or "Other".