

expectations; (3) care and symptom management and (4) potential improvements. Overall patients and caregivers felt communication between PMH and TGH, and from providers could have been better. Many felt there was a break-down in communication as they did not expect to go through the usual ED triage process, which caused additional anxiety and frustration with the wait times. The majority felt their symptoms were managed in a timely manner and reported the staff to be friendly, caring and professional; however, often felt forgotten and anxious due to a lack of “checking-in”. Their experience could have been improved by receiving more information on the process, a more welcoming environment and separate waiting area or private room for those who are immunocompromised. **Conclusion:** Although referral from an outpatient oncology clinic to the ED of an affiliated hospital is a common process within Canada, this is the first study to explore the patient and caregiver experience. Understanding the patient and caregiver experience is valuable for identifying quality improvement initiatives. Our analysis revealed the patient and caregiver experience could be improved with better communication and expectation setting regarding the ED process before and throughout the visit.

Keywords: cancer, emergency department, patient experience

P098

Patterns of utilization and time-course of events for cancer-related emergency department visits following same-day outpatient oncology appointments

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Introduction: Nearly 50% of Canadians will develop cancer in their lifetime (1), and the vast majority of those with cancer will visit the emergency department (ED) in their last 6 months of life (2). Considering the aging population, improvement in cancer survival and current practice of managing cancer in outpatient settings, cancer-related emergencies are becoming a significant aspect of emergency medicine. The presenting symptoms and rates of hospitalization for cancer-related ED visits have largely been established. The current study characterizes the patterns of ED utilization and time-course of events for cancer-related ED visits following same-day outpatient oncology appointments resulting in admission to hospital compared to those not admitted. **Methods:** A retrospective chart-review was used to identify 231 adult patients who visited the ED at a large academic hospital (i.e., Toronto General Hospital) following a same-day outpatient oncology appointment at an affiliated cancer centre (i.e., Princess Margaret Hospital) from March to May 2019, using administrative data. **Results:** All visits occurred on weekdays (avg = 4 visits/d) and 57% of visits resulted in hospitalization. Between those admitted and not admitted to hospital, there was no difference in triage time [17:23 + 0:14 vs. 17:01 + 0:20 h, $p = 0.47$; mean(SD)]. Visits resulting in hospitalization were more urgent (median CTAS score = 2 vs. 3, $p < 0.001$) and required more consultation services (64 vs. 17 % of visits, $p < 0.001$), but did not differ for imaging (36 vs. 33 % of visits, $p = 0.63$). The length of stay in the ED was longer for those admitted [16.6(0.9) vs. 5.3(0.3) h, $p < 0.01$], they waited longer for their initial assessment [2.6(1.9) vs. 1.8(1.3) h, $p < 0.01$] and spent 10.1(9.9) h waiting for a bed on the ward. There was no difference in time from initial assessment to disposition, imaging or consult reports ($p > 0.05$) between groups. The patients

transferred from oncology clinics were triaged at 17:13(0:11) h compared to 13:56(0:03) h for all ED visits during the same time frame. **Conclusion:** Most patients sent from oncology clinics to the ED are admitted, and when admitted they spend an additional 10 h waiting for a bed on the ward. These patients tend to arrive later in the day compared to other ED patients. Understanding utilization patterns and time-course of events allows for objective identification of quality improvement initiatives. 1 Canadian Cancer Society, 2015 2 Barbera et al. CMAJ, 2010

Keywords: cancer, emergency department, oncology

P099

Extending the trimodal distribution of death; trauma patients die at increased rates after discharge. Linking trauma registry data to vital statistics and hospital datasets identifies opportunities to save life

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Introduction: The New Brunswick Trauma Registry is a database of injury admissions from eight hospitals throughout the province. Data tracks individuals in-hospital. By linking this information with vital statistics, we are able to observe outcomes post-discharge and can model health outcomes for participants. We want to know how outcomes for trauma patients compare with the general population post discharge. **Methods:** Using data from 2014-15, we followed over 2100 trauma registry observations for one year and tracked mortality rate per 1,000 people by age-group. We also compared the outcomes of this group to all Discharge Abstract Database (DAD) entries in the province (circa. 7500 total). We tracked mortality in-hospital, at six months, and one year after discharge. We truncated age into groups aged 40-64, 65-84, and 85 or older. **Results:** In-hospital mortality among those in the trauma registry is approximately 20 per 1,000 people for those age 40-64, 50 per 1,000 people for those aged 65-84, and 150 per 1,000 people aged 85 or older. For the oldest age group this is in line with the expected population mortality rate, for the younger two groups these estimates are approximately 2-4 times higher than expected mortality. The mortality at six-month follow-up for both of the younger groups remains higher than expected. At one-year follow-up, the mortality for the 65-84 age group returns to the expected population baseline, but is higher for those age 40-64. Causes of death for those who die in hospital are injury for nearly 50% of observations. After discharge, neoplasms and heart disease are the most common causes of death. Trends from the DAD are similar, with lower mortality overall. Of note, cardiac causes of death account for nearly as many deaths in the 6 months after the injury in the 40-64 age group as the injury itself. **Conclusion:** Mortality rates remain high upon discharge for up to a year later for some age groups. Causes of death are not injury-related. Some evidence suggests that the injury could have been related to the eventual cause of death (e.g., dementia), but questions remain about the possibility for trauma-mitigating care increasing the risk of mortality from comorbidities. For example, cardiac death, which is largely preventable, is a significant cause of death in the 40-64 age group after discharge. Including an assessment of Framingham risk factors as part of the patients rehabilitation prescription may reduce mortality.

Keywords: epidemiology, mortality, trauma

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 débriefing 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 χ^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.