

Capital District Emergency Services Council

“CDESC”

Quarterly Report

Quarter 3 - 2013

With focus on QEII

Charles V. Keating Emergency & Trauma Centre



Introduction

Emergency Medicine is the medical specialty dedicated to the diagnosis and treatment of unforeseen illness and injury. It includes the initial evaluation, diagnosis, treatment, and disposition of any patient requiring expeditious medical, surgical, or psychiatric care <1>. Thus, the operationalization of “Integrated Networks of Emergency Care” is inherently interdisciplinary and interdependent upon multiple in-hospital and Health System wide structures and processes.

In alignment with the Capital Health/IWK/EHSNS commitment to patient safety and with the Better Care Sooner standards (as well as with recommended national Emergency Department quality reporting guidelines) this quarterly report focuses on Key Process Indicators, and outcomes when available, to help drive the Continuous Quality Improvement imperative and to improve care to the patients and populations that we serve.

Emergency Medicine	Unforeseen Unscheduled	Predictable Schedulable
CTAS 1, 2, 3	<ul style="list-style-type: none"> Often described as “real” emergencies 97% of fixed costs of ED to meet population burden of acute illness and injury<4> Does include exacerbations of chronic problems 	<ul style="list-style-type: none"> “avoidable” CTAS 3 (ED as safety net) <ul style="list-style-type: none"> - frail elderly with no acute event or problem - partial diagnosis requiring further work up - chronic condition requiring follow up or has predictable clinical course
CTAS 4, 5	<ul style="list-style-type: none"> DO NOT cause ED overcrowding<2,3> Very low marginal cost to see in ED<4,5> 9/10 most common successful lawsuits in EM 	<ul style="list-style-type: none"> “inappropriate” ED visits (ED as gate keeper) <ul style="list-style-type: none"> - Medication refill - “sick note” for work or school - Queue jumping to see specialist

1. ACEP definition of Emergency Medicine: <http://www.acep.org/Content.aspx?id=29164>

2. **MYTH:** Emergency room overcrowding is caused by non-urgent cases - October 2009 Canadian Health Research Foundation Myth Buster of the year series

3. The Effect of Low-Complexity Patients on Emergency Department Waiting Times [Schull MJ](#), [Kiss A](#), [Szalai JP](#). [Ann Emerg Med](#). 2007 Mar;49(3):257-64, 264.e1. Acad Emerg

4. **THE COSTS OF VISITS TO EMERGENCY DEPARTMENTS** ROBERT M. WILLIAMS, M.D., .PhD (N Engl J Med 1996;334:642-6.)

5. Emergency Medical Care: 3 Myths Debunked, Huffington Post. Leigh Vinocur, M.D. Director of Strategic Initiatives at the University of Maryland School Medicine.

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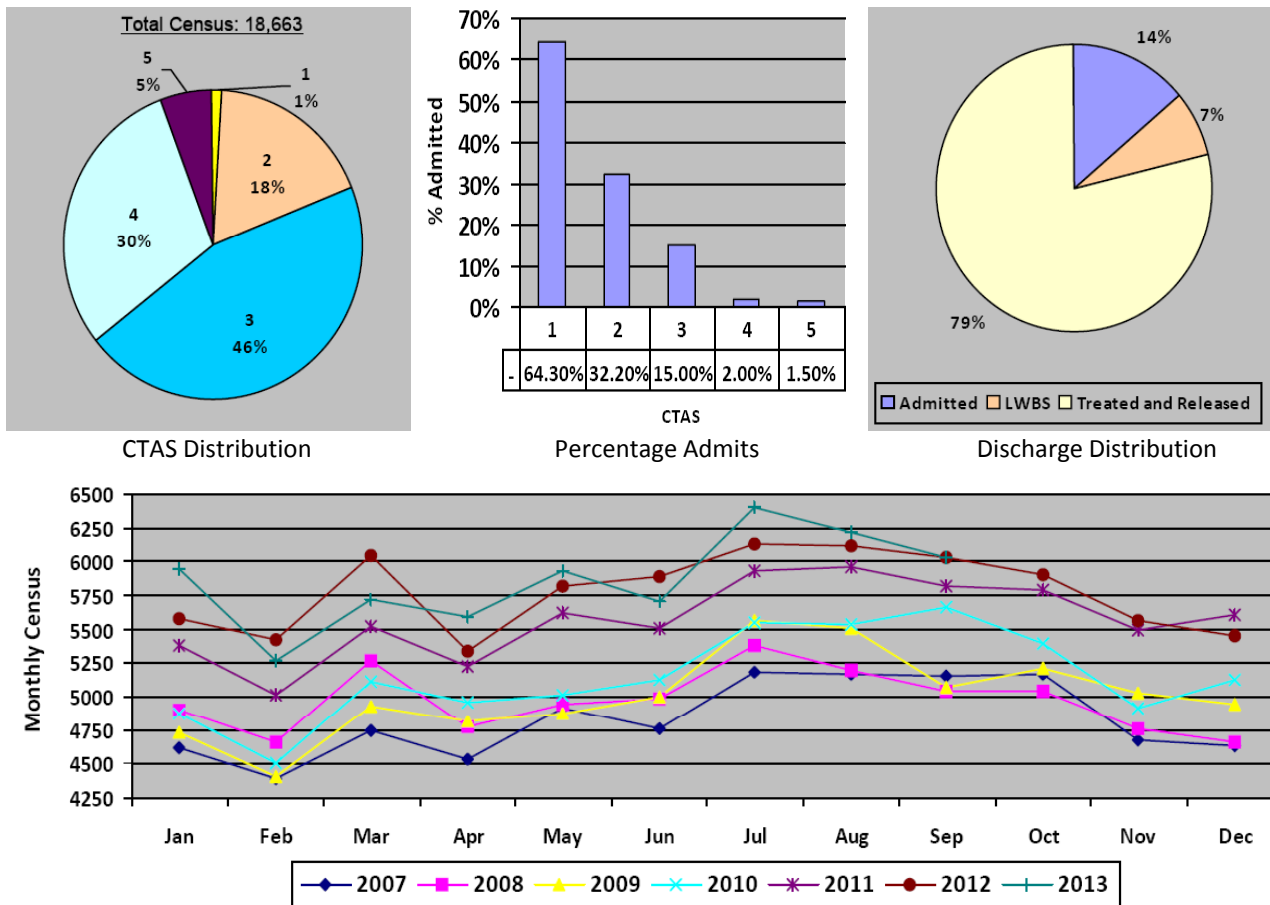
Demand

Census – Halifax Infirmary Emergency Department

Reporting Date: July 1 – Sept 30, 2013

Context :

Emergency Departments are designed to meet the unscheduled (from life threatening to relatively minor) health care needs of the population. The 5 level CTAS score is used to differentiate acuity (1 being severe and time dependent) though it is only a surrogate marker for the complexity of care. Left Without Being Seen (LWBS) is a reflection of decreased access secondary to wait times (target 2-3%). Percentage admitted national benchmark is 16-18% for CTAS 3s.



Analysis:

The daily census this summer has been higher than in any previous years. CTAS 3 remains the largest category in terms of acuity. Left without being seen has increased from 6% in the last quarter to 7%. In spite of the significantly increased load, flow through the hospital has improved somewhat. Physician hours have also been extended, targeted to times of greatest demand. It is hoped that this will decrease the left without being seen numbers.

Sam Campbell, Site Chief, HI ED

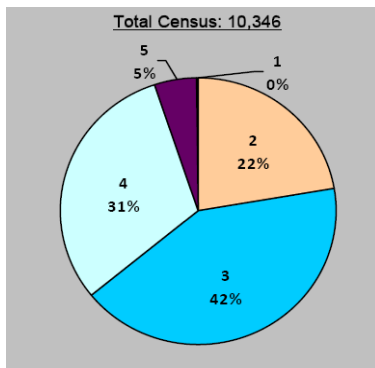
Demand

Census – Dartmouth General Emergency Department

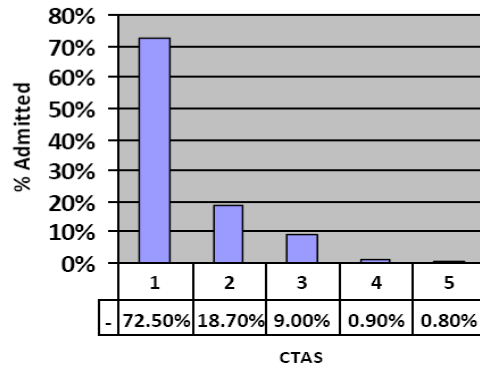
Reporting Date: July 1 – Sept 30, 2013

Context:

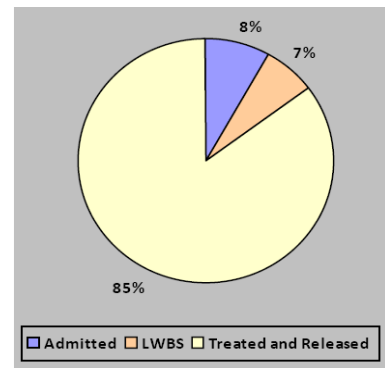
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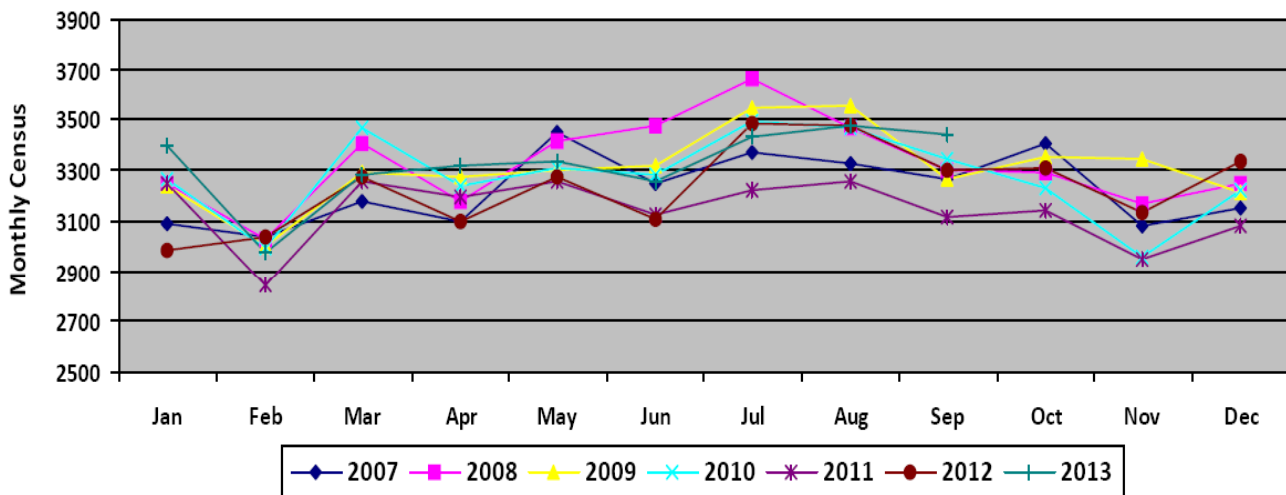
CTAS Distribution



Percentage Admitted



Discharge Distribution



Analysis

Left Without Being Seen at 7% high. Requires further analysis and breakdown by CTAS.

Ravi Parkash, Site Chief, DGH ED

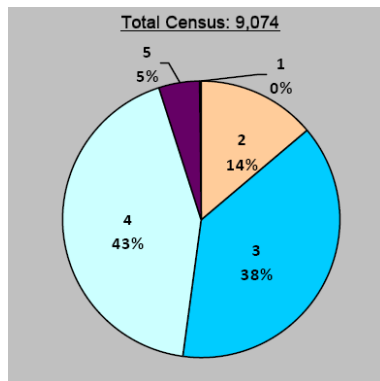
Demand

Census – Cobeguid Community Emergency Department

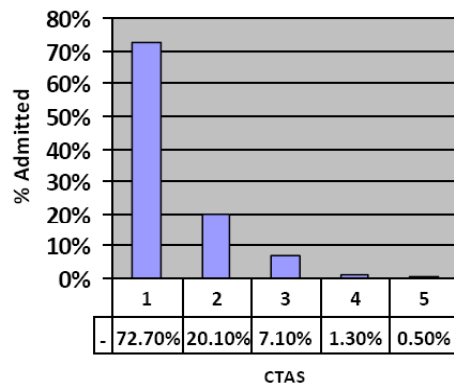
Reporting Date: July 1 – Sept 30, 2013

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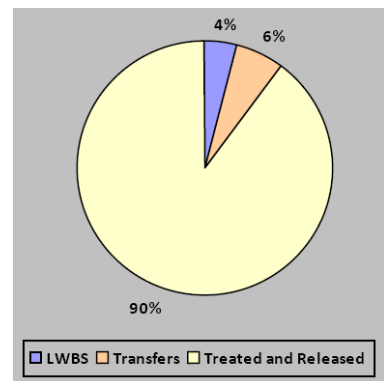
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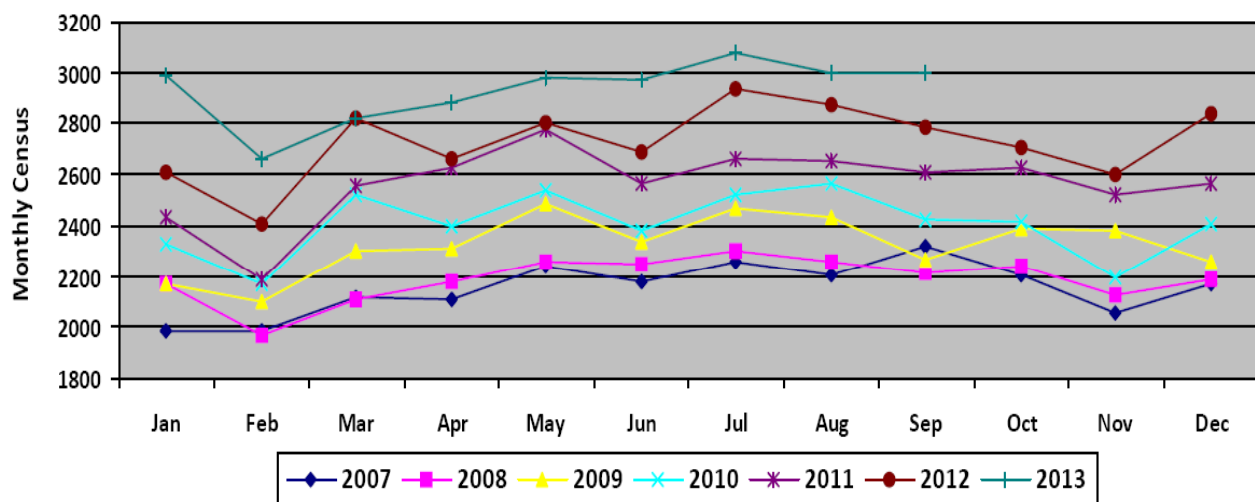
CTAS Distribution



Percentage Transferred



Discharge Distribution



Analysis:

Volumes at CCHC continue to increase with a an 8.2 percentage increase in patient volumes from 2012 to 2013. Despite this increase utilization the LWBS percentage was reduced from 5% to 4% from the previous quarter. Factors contributing to this improvement include improved patient process procedures and deploying nursing and physician resource to best match volume distribution of patient presentations.

Mike Clory, Site Chief, CCHC ED

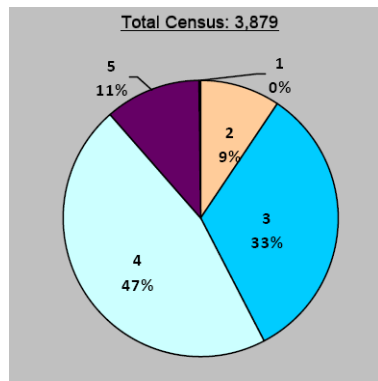
Demand

Census – Hants Community Emergency Department

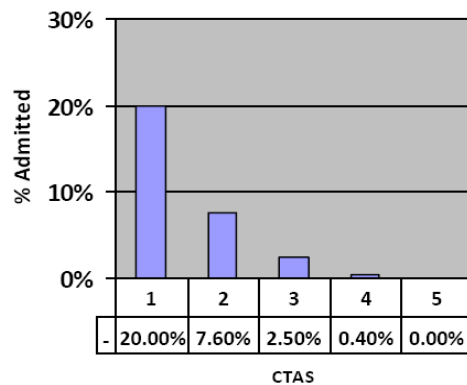
Reporting Date: July 1 – Sept 30, 2013

Context:

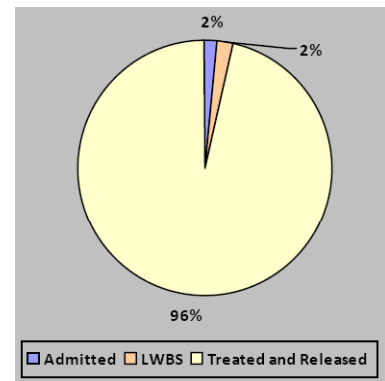
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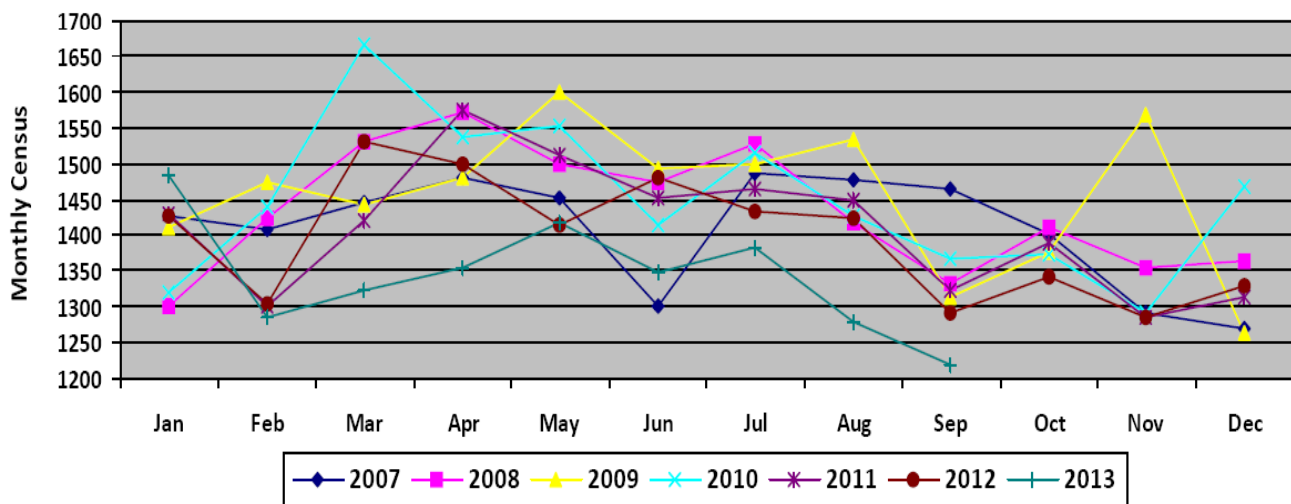
CTAS Distribution



Percentage Transferred



Discharge Distribution



Analysis:

Hants' monthly census has declined in July, August and September. Large percentages of patients treated and released being CTAS 3 and 4 acuity. Transfers to the HI site for tertiary care account for 4-6%.

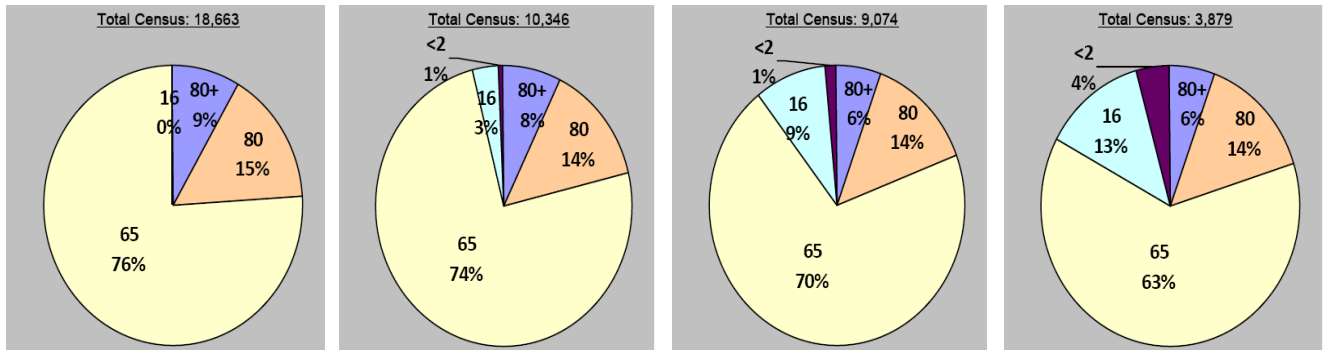
Tanya Penney, Health Services Manager, HCH ED

Demand

Demographics – Halifax Infirmary ED / Dartmouth General ED / Cobequid Community ED / Hants Community ED

Context:

The complexity of patients presenting to the Emergency Department is a function of CTAS, age, presenting complaint, and many other factors. This data looks at the percentage of census in the following age groups (IWK excluded at this time): < 2 yrs, 2-16 yrs, 16-65 yrs, 65-80 yrs, and > 80 yrs.

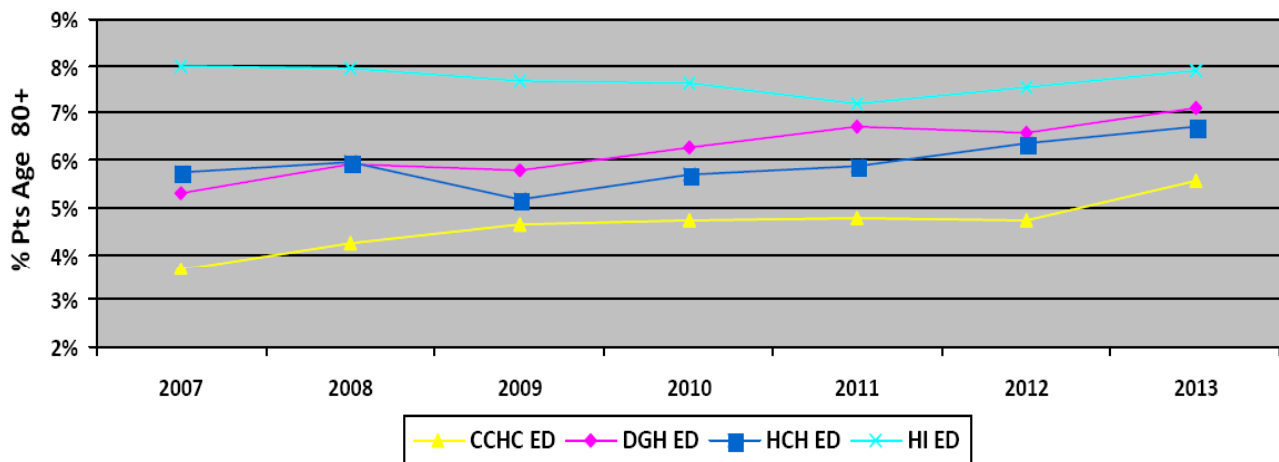


Halifax Infirmary
ED Distribution

Dartmouth General
ED Distribution

Cobequid Community
ED Distribution

Hants Community
ED Distribution



Analysis:

The volumes of patients are up significantly in the district and the proportion presenting to the Emergency Department over 80 years of age has risen slowly. The differences between sites is likely reflected by the geography of new families buying homes in the region and potentially the need for increasing levels of care for the elderly.

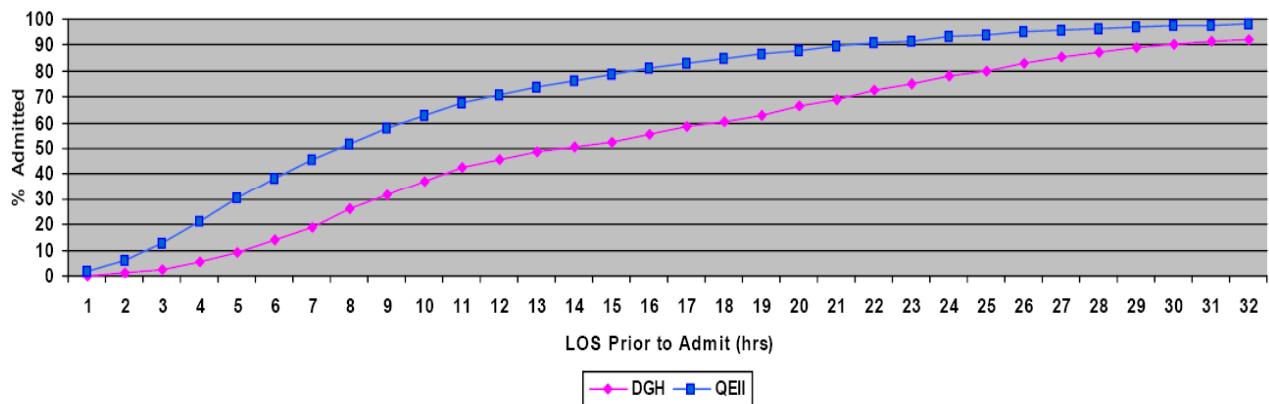
David Petrie, District Chief, Capital Health

Flow and Network Integration

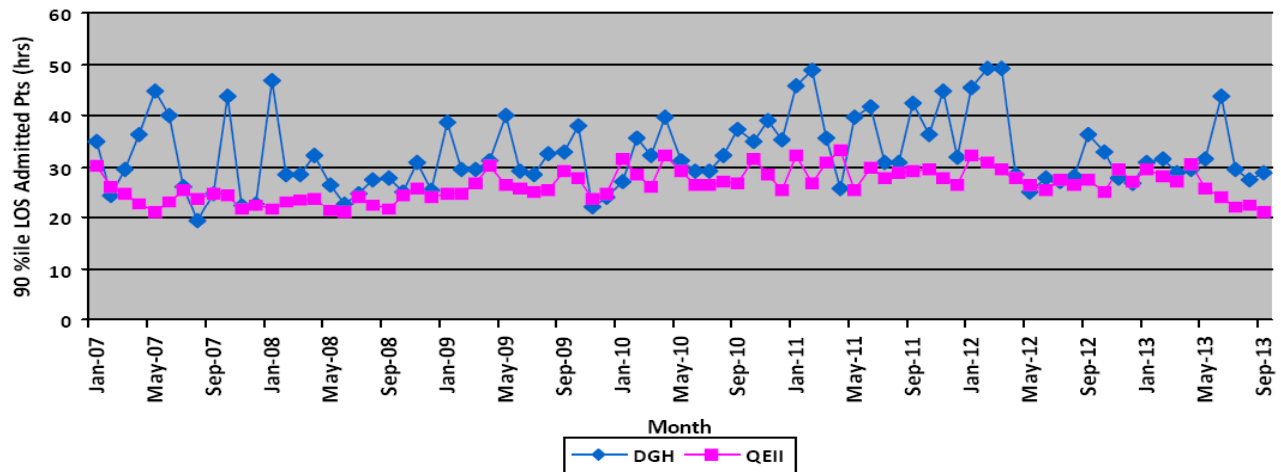
Emergency Department Length of Stay for Admitted Patients

Context:

Emergency Department Length of Stay of admitted patients (i.e. “ED boarding”) has been recognized as the main – 75% of the variance - cause of overcrowding in the Emergency Dept. Overcrowding is the term used to describe access block. Access block as manifested by increased patient wait times, increased ambulance offload times, and increased left without being seen (LWBS) rates is associated with increased adverse outcomes, increased mortality (in a dose/response relationship), and increased costs to the system overall.



Percentile Length of Stay for Non Clinical Decision Unit Admitted Patients



Analysis:

90th Percentile Length of Stay Admitted Patients

The upper “90th percentile performance” graph compares the Emergency Department Length of Stay for admitted patients from the Halifax Infirmary to Dartmouth General. The Better Care Sooner standard for this metric is 8 hours 90% of the time (in Ontario the 90th percentile standard is 6 hours). 50% of Halifax Infirmary patients are admitted by 8 hours and 25% of Dartmouth General patients achieve this target. The 90th percentile performance for the Halifax Infirmary is 21 hours (down from 22 hours last quarter). Dartmouth General remains greater than 20 hours. The bottom graph shows the trending of performance for this Key Process Indicator since 2007 at both Halifax Infirmary and Dartmouth General.

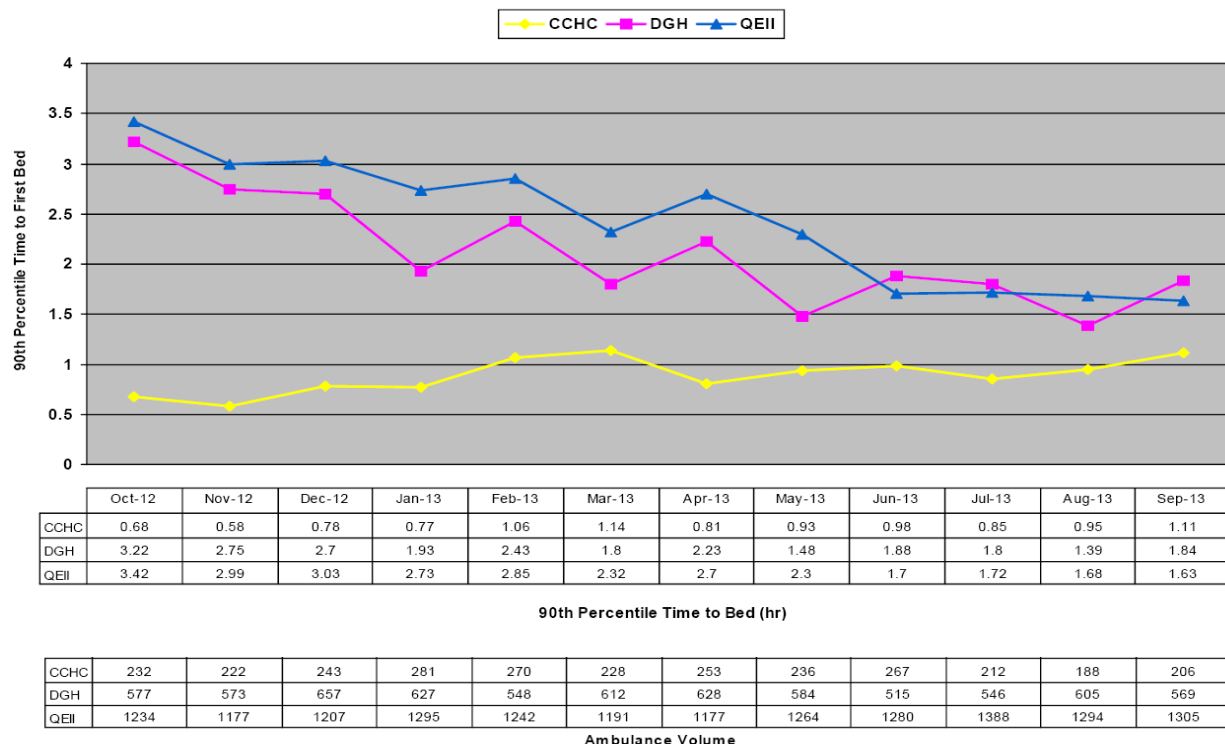
Flow and Network Integration

Ambulance Offload / Transition

Context:

Ambulance offload times are another Key Process Indicator which has implications both to the individual patient (i.e. wait times to see a Medical Doctor), and to the community (i.e. turn around times for the ambulance to get back to the streets and available to the community for the next 911 emergency call).

Because of rising ambulance offload times in the past (due to ED access block) a transition team has been in place to assume the observation of care in the “ambulance hallway” prior to the placement of the patient in an Emergency Department bed (to allow the EHSNS paramedic crew to return to service).



Analysis:

There seems to be a downward trend in time to first bed at both the Halifax Infirmary and Dartmouth General. This may possibly be due to the ambulance smoothing initiative which started in September 2012 within the district and an increased push on the efficiency of bed hours utilization in the Emergency Department. There has been a slight increase at Cobequid Community likely secondary to the increased volume of ambulances.

David Petrie, District Chief, Capital Health

Flow and Network Integration

Matching Capacity with Demand:

Context:

Ambulance smoothing has occurred in the central region based on the relative surge capacity at each Emergency Department site. This table shows the percentage of time that the Halifax Infirmary and Dartmouth General were on their escalating levels of capacity (Red being the highest surge level). Cobequid Community Health Centre is also part of this network. The surge levels are determined by 5 criteria and are measured real time so the status changes dynamically. If an ambulance patient does not meet exclusion criteria (CTAS level 2 previously determined trip destination criteria for major trauma, stroke, STEMI, or have had recent admit to hospital) then patients may be rerouted from a Red ED to a Green ED.

Halifax Infirmary ED	Dartmouth General ED	%
GREEN	GREEN	31.18%
GREEN	YELLOW	16.83%
YELLOW	GREEN	11.38%
GREEN	ORANGE	9.52%
GREEN	RED	7.05%
YELLOW	YELLOW	7.01%
YELLOW	ORANGE	4.69%
ORANGE	GREEN	3.61%
YELLOW	RED	2.58%
ORANGE	YELLOW	2.34%
ORANGE	ORANGE	1.52%
ORANGE	RED	1.03%
RED	YELLOW	0.39%
RED	GREEN	0.39%
RED	ORANGE	0.26%
RED	RED	0.23%

Analysis:

During Quarter 4, 2013, DGH Red/HI Green occurred 7.05% of the time and HI Red/DGH Green occurred 0.39% of the time. Ambulance Smoothing may occur during these times. This represents an almost 10 fold decrease in the amount of time that the HI is on Red.

David Petrie, District Chief, Capital Health

Flow and Network Integration

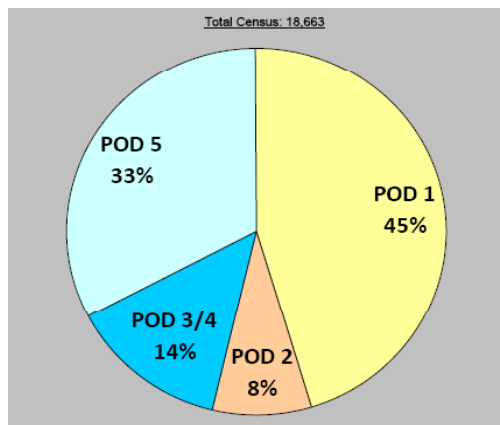
Pod of Initial Destination at the Halifax Infirmary Emergency Dept. / Rapid Assessment Unit

Context:

Internal flow within an Emergency Department needs to optimize available space / capacity to meet the volume / CTAS demands of the presenting patients.

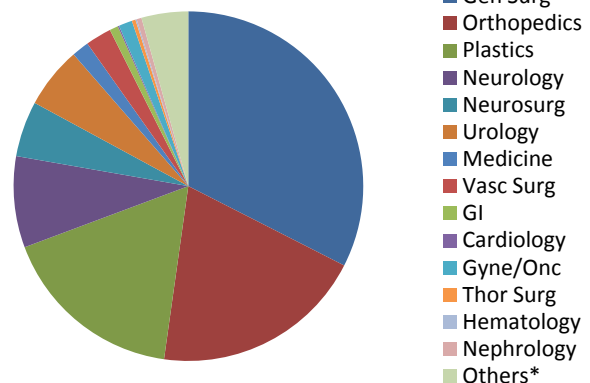
The Halifax Infirmary Emergency Department has innovated (chair centric Pod 1, fast track / paramedic assisted pod 5) to meet the needs of this demand. The Rapid Assessment Unit is another aspect of the Emergency Department which has evolved to meet the needs of transferred patients and referred patients from our own Emergency Department. This allows expedited consultations to specific services and frees up bed time to see the next Emergency patient in the waiting room or ambulance hallway.

HI ED Pod Utilization

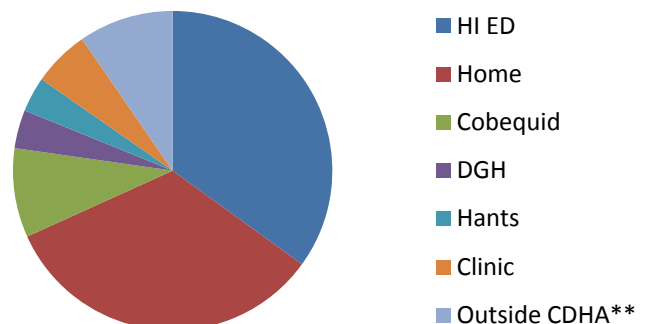


- Initial Location POD 1-2-3-4-5 or Psych
- Psych and Intake A part of Pod 1
- Intake B Part of Pod 5
- No Left Without Being Seen Counted

RAU Volume by Service



RAU Volume By Origin



Analysis:

- 1) Pod usage: The excessive use of Pod 1 is likely partially due to bed blockage in Pods 2 – 4 by admitted patients. This should become less of an issue as these beds are freed up by other initiatives. This pod is designed for patients that will tolerate part of their care conducted in a chair. It is important that every effort is made to keep sicker patients out of the chairs.
- 2) The large portion of Rapid Assessment Unit patients coming from home raises the concerns that the unit is being used as a clinic (i.e. for patients other than those that would otherwise have needed to go to the Emergency Department. General Surgery has been identified as a possible offender. This has been addressed and will be monitored.

Flow and Network Integration

Clinical Decision Unit (CDU) Utilization

Context:

The Clinical Decision Unit is a virtual unit embedded within the physical space of the Emergency Department which facilitates observation and rechecks by the Emergency Physician. The purpose is twofold; to improve the transfer of care with more explicit ordering and documentation clinical care pathways, and to try and reduce admissions for patients that potentially may “turn around” with 6 – 24 hours of treatment and observation.

Emergency Department Site	Clinical Decision Unit Patients	Clinical Decision Unit Patient Admitted	Percentage of Clinical Decision Unit Patients Admitted	Total Site Patient Volume	Percentage Total Patients Clinical Decision Unit	Median Length of Stay Clinical Decision Unit No Admitted Patients
Halifax Infirmary	159	39	24.5%	18663	0.9%	16.54
Dartmouth General	458	127	27.7%	10346	4.4%	15.85
Cobequid Community	5	1	20.0%	9075	0.1%	8.24

Analysis:

The benchmark for CDU use in the province of Ontario is 4 – 5%. Unfortunately documentation of its use has not been very good at the Halifax Infirmary or Cobequid Community but is approximately at the expected rate at the Dartmouth General.

CDU has been shown to reduce Emergency Department Length of Stay, reduce admission rates with not increase in Emergency Department revisit rates in a recent Academic Emergency Paper.

David Petrie, District Chief, Capital Health

Patient Experience

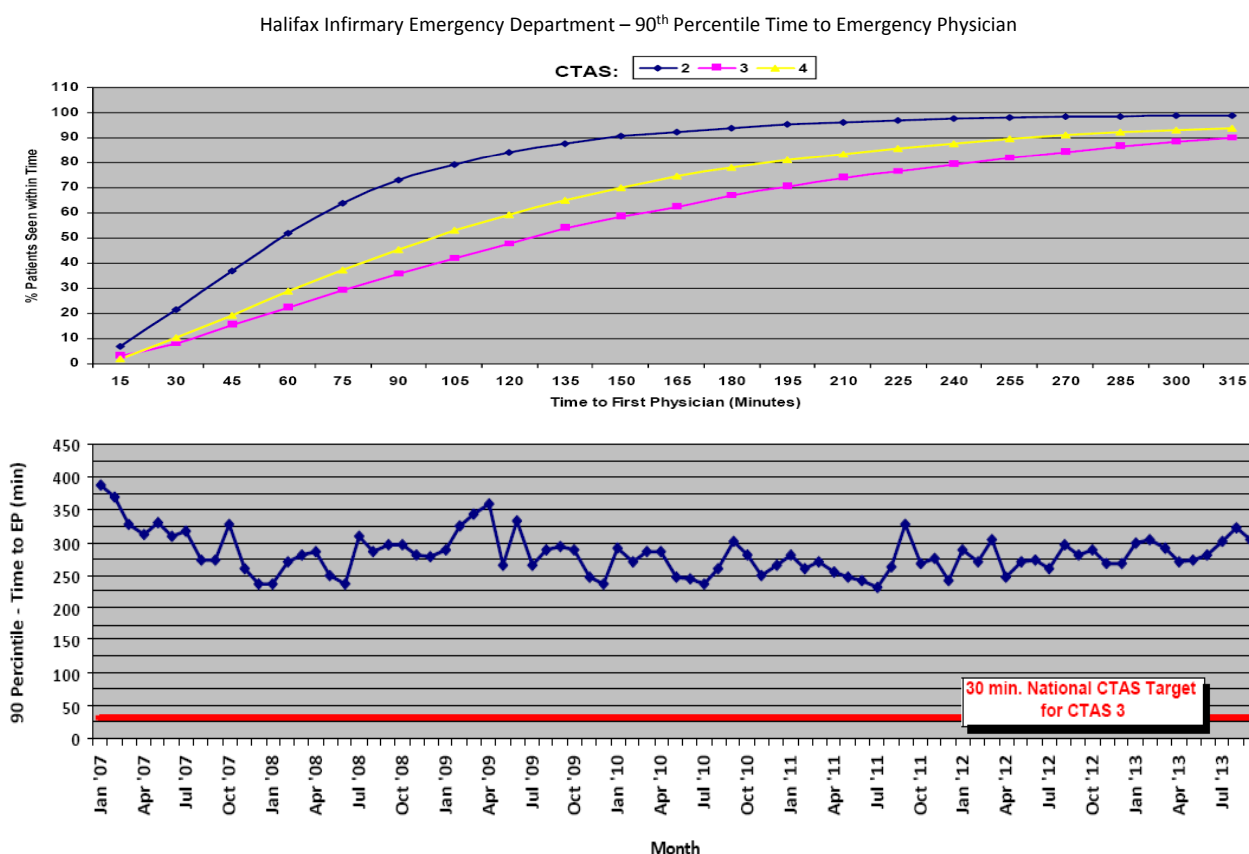
Wait Times – Halifax Infirmary Emergency Department

Context:

One of the main ways Emergency Department access block manifests itself is in patient wait times (time from registration to time to see Medical Doctor). Wait times have been shown to be associated with adverse outcomes in a dose response curve that suggests causation.

This data looks at the wait time performance curve for CTAS 2, 3, and 4s (assuming CTAS 1s get seen expeditiously and CTAS 5s have less of a time dependency).

The time targets are: CTAS 2 = 15 min, CTAS 3 = 30 min, CTAS 4 = 60 min.



Analysis:

Our patients continue to wait an unacceptably long time for their emergency care, with CTAS 3 patients being most affected. Of note times have not increased in spite of increased demand. This is likely related to a combination of flow initiatives, both inside the Emergency Department and throughout the system.

Sam Campbell, Site Chief, HI ED

Patient Experience

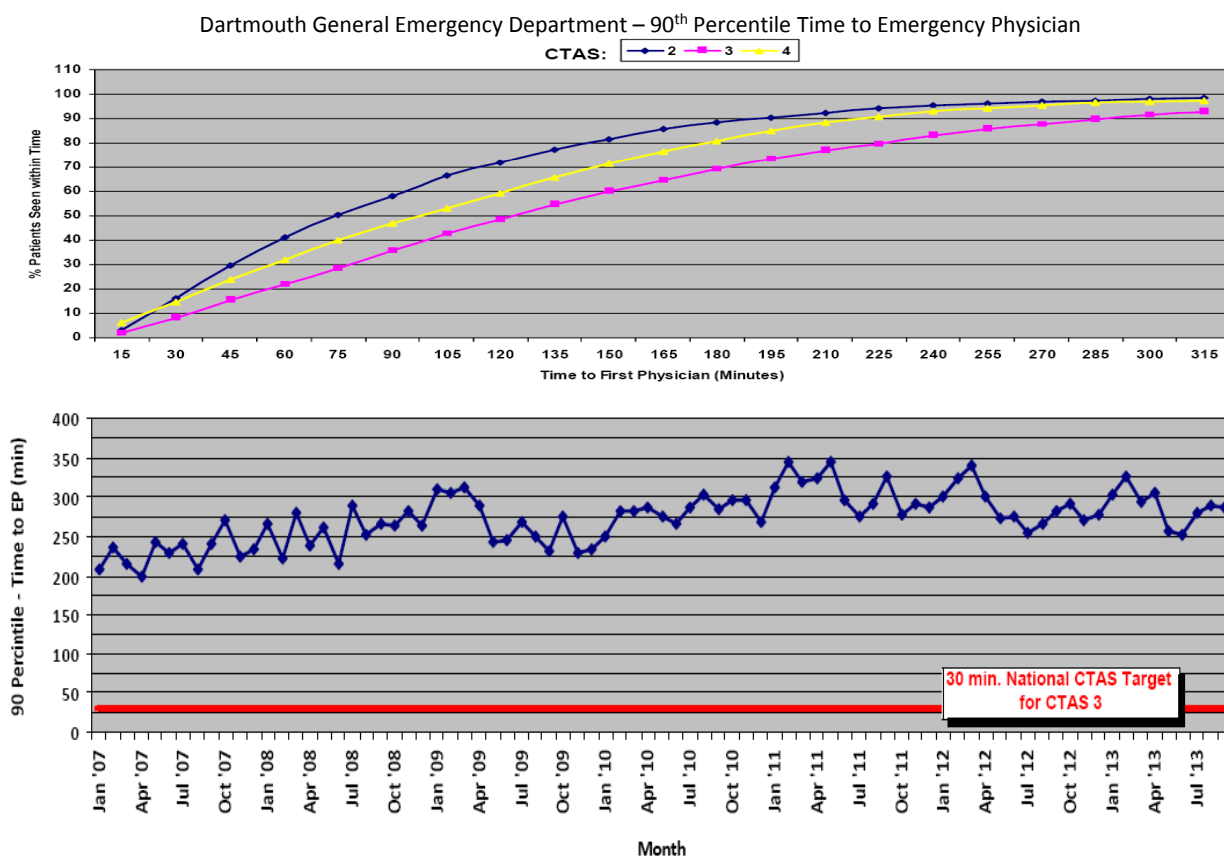
Wait Times – Dartmouth General Emergency Department

Context:

One of the main ways Emergency Department access block manifests itself is in patient wait times (time from registration to time to see Medical Doctor). Wait times have been shown to be associated with adverse outcomes in a dose response curve that suggests causation.

This data looks at the wait time performance curve for CTAS 2, 3, and 4s (assuming CTAS 1s get seen expeditiously and CTAS 5s have less of a time dependency).

The time targets are: CTAS 2 = 15 min, CTAS 3 = 30 min, CTAS 4 = 60 min.



Analysis:

Although there has been some recent improvement due to changes in fast-track these gains appear to have leveled. Lack of inpatient capacity at DGH continues to be of primary concern. We continue to develop strategies and processes to cope with overcrowding.

Ravi Parkash, Site Chief, DGH ED

Patient Experience

Wait Times – Cobequid Community Emergency Department

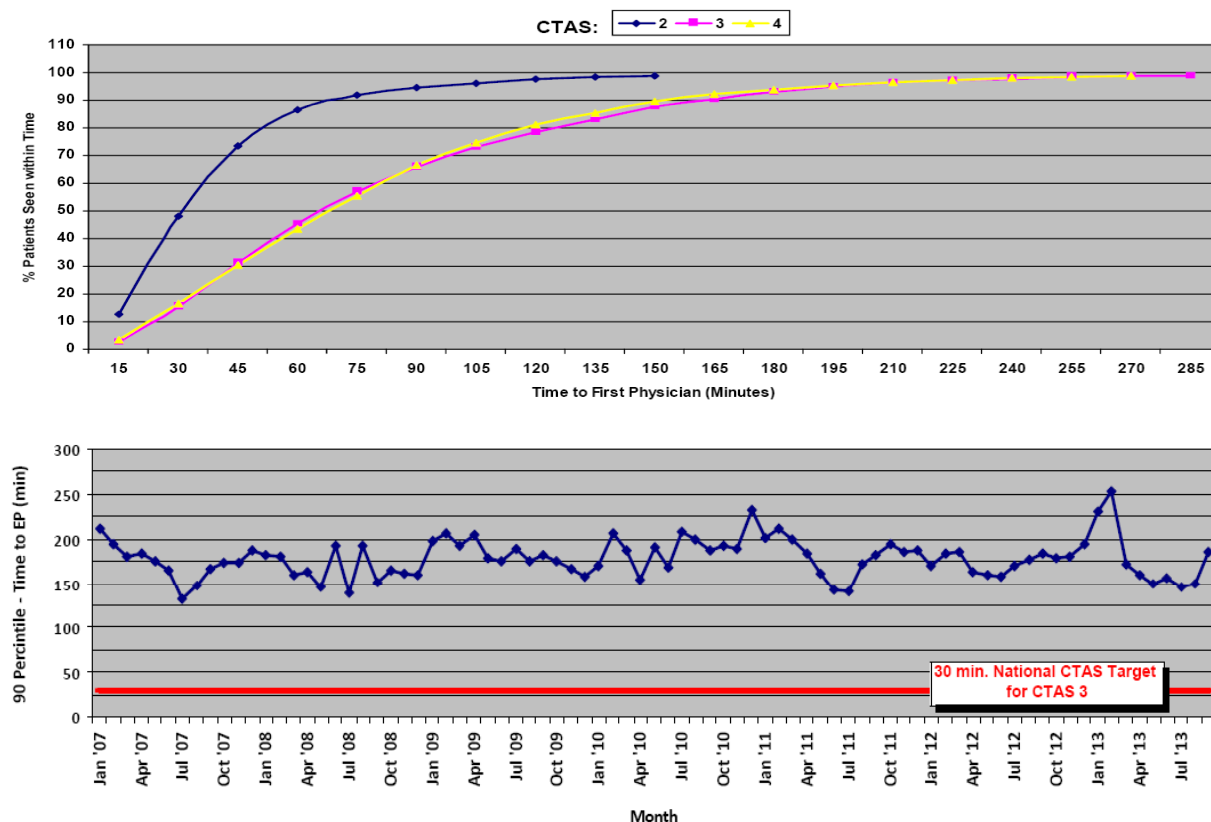
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The time targets are: CTAS 2 = 15 min, CTAS 3 = 30 min, CTAS 4 = 60 min.

Cobequid Community Emergency Department- 90th Percentile Time to Emergency Physician



Analysis:

The 30 minute time to EP standard is not totally reflective of care delivery as often care is delivered via protocols by RNs. Existing resources and registration process contribute to this being a challenging (and in the opinion of many an unrealistic) standard. CCHC has been able to maintain an average of 150 min for CTAS 3 despite significant increased patient volumes. Spikes in January and June are attributable to volume fluctuations.

Mike Clory, Site Chief, CCHC ED

Patient Experience

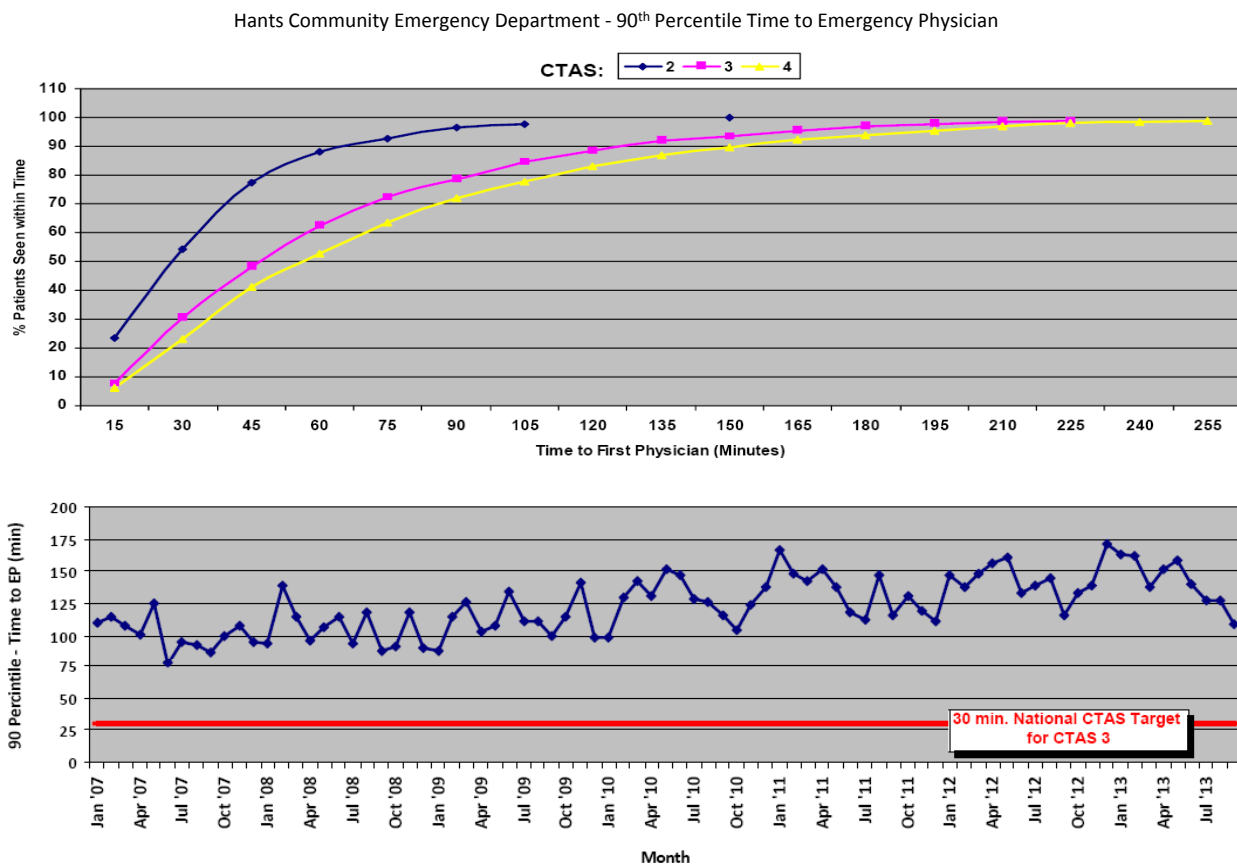
Wait Times – Hants Community Emergency Department

Context:

One of the main ways Emergency Department access block manifests itself is in patient wait times (time from registration to time to see Medical Doctor). Wait times have been shown to be associated with adverse outcomes in a dose response curve that suggests causation.

This data looks at the wait time performance curve for CTAS 2, 3, and 4s (assuming CTAS 1s get seen expeditiously and CTAS 5s have less of a time dependency).

The time targets are: CTAS 2 = 15 min, CTAS 3 = 30 min, CTAS 4 = 60 min.



Analysis:

Wait times within HCH exist due to:

1. Admitted bed shortages – creates limited space.
2. Increases time to consult/tertiary care.
3. Physician dependent (1 ERP) – limited flux.

Throughput initiative – increase initiation and use of nurse initiated protocols. LWBS rates remain above standard – time to physician (as per next slide) is a large cause of this rate.

Tanya Penney, Health Services Manager, HCH

Clinical Care

Diagnostic Imaging & Laboratory Reporting

Context:

Through put of patients in the Emergency Department is impacted by the intensity of the work up (laboratory and diagnostic imaging required). Decision rules developed in the Emergency Department setting (Cat Scan Head, Cervical-Spine, Ottawa Ankle, Rule Out Deep Vein Thrombosis, Rule Out Pulmonary Emboli, etc) all impact the cost effectiveness of patient investigation.

Reporting Period from: July 01, 2013 to: Sept. 30, 2013

Diagnostic Imaging Ordered						
Emergency Department Site	Patient Volume	CT Orders (%Pt Volume)	US Orders (%Pt Volume)	MRI Orders (% Pt Volume)	XR Orders (%Pt Volume)	Total DI Orders (% Pt Volume)
Halifax Infirmary	18663	2491 (13.0%)	881 (4.7%)	69 (0.4%)	8144 (43.6%)	11513 (61.7%)
Dartmouth General	10346	1483 (14.3%)	474 (4.6%)	0 (0.0%)	5535 (53.5%)	7492 (72.4%)
Cobequid Community	3879	3 (0.1%)	44 (1.1%)	0 (0.0%)	1112 (28.6%)	1157 (29.8%)
Hants Community	9075	779 (8.6%)	201 (2.2%)	0 (0.0%)	4582 (50.0%)	5562 (61.3%)
Total	41963	4684 (11.2%)	1600 (3.8%)	69 (0.2%)	19371 (46.2%)	25724 (61.3%)

Laboratory Ordered			
Emergency Department Site	Patients with Labs Ordered	%Pts with Labs	Volume
Halifax Infirmary	7916	42.4%	18663
Dartmouth General	5088	49.2%	10346
Cobequid Community	1159	29.9%	3879
Hants Community	3814	42.0%	9075
Total	17977	42.84%	41963

Analysis:

This is raw data looking at the percent of overall patients who receive a Cat Scan, Ultrasound, MRI (Magnetic Resonance Imaging), X-Ray or labs ordered during their assessments in the Emergency Department. This data is not adjusted to acuity, complexity, or presenting complaint / diagnosis. There are no national benchmarks for these indications but they will allow for some comparison within CDESC.

David Petrie, District Chief, Capital Health

Focus: Halifax Infirmary Emergency Department

Poison

Reporting Period: Oct. 1, 2012 to Sept. 30, 2013

Context:

The IWK Regional Poison Centre is an integral component of Emergency Care at the District, Provincial and Interprovincial level. A board certified toxicologist oversees an extremely experienced and highly educated cohort of Registered Nurses to provide timely and sometimes life-saving advice. They also play an important role in the education of Medical Doctors, Registered Nurses and paramedics with regard to care of the poisoned patient.

Total Calls – Oct 1, 2012 - Sep 30, 2013						
	NOVA SCOTIA		PEI		All Provinces	
Exposure Calls	7195	92.22%	806	95.27%	8306	92.19%
Human Exposure Calls	6952	89.11%	783	92.55%	8039	89.22%
Animal Exposure Calls	243	3.11%	23	2.72%	267	2.96%
Information Calls	607	7.78%	40	4.73%	704	7.81%
Total Calls	7802	100%	846	100%	9010	100%

Human Exposure Calls - Oct 1, 2012 - Sep 30, 2013						
	NOVA SCOTIA		PEI		All Provinces	
Managed on site (non HCF)	4659	67.02%	452	57.73%	5162	64.21%
Managed in HCF	2159	31.06%	322	41.12%	2728	33.93%
Refused Referral	87	1.25%	7	0.89%	97	1.21%
Other/Unknown	47	0.67%	2	0.26%	52	.065%
Total Calls	6952	100%	783	100%	8039	100%

Managed in Health Care Facilities (HCF) - Oct 1, 2012 - Sep 30, 2013						
	NOVA SCOTIA		PEI		All Provinces	
Patient already in or en route to a HCF	1670	77.35%	279	86.65%	2191	80.32%
Patient referred into a HCF	489	22.65%	43	13.35%	537	19.68%
Not applicable	0	0	0	0	0	0
Total Calls	2159	100%	322	100%	2728	100%

Analysis:

The IWK Regional Poison Centre is able to manage 64% of cases at home, which means avoiding unnecessary emergency department visits in the majority of cases. This can have a significant impact on utilization of resources and emergency department overcrowding. In addition, ambulance transports can be avoided when there is direct communication between paramedics on scene and the Specialists in Poison Information.

Nancy Murphy, Medical Director, IWK Regional Poison Centre

Focus: Halifax Infirmary Emergency Department

Stroke

Reporting Period: Oct. 1, 2012 to Sept 31, 2013

Context:

The Halifax Infirmary is the tertiary care stroke centre where all potentially thrombolizable strokes are brought by ambulance. Door to Cat Scan to needle and to stroke unit times are key process indicators for the Emergency Department and have been associated with outcomes.

Quarter		Onset to HIED	HIED to CT	HIED to Needle	HIED to Stroke Unit
4. 2012	Median	68	23	68	1222
(n=12)	Number in Target		8 of 12	5 of 12	0 of 12
	Percentage in Target		67%	42%	0%
1.2013	Median	100	23	68	581
(n=21)	Number in Target		13 of 20	6 of 21	2 of 21
	Percentage in Target		65%	29%	10%
2.2013	Median	72	23	74	304
(n=20)	Number in Target		11 of 20	5 of 20	3 of 20
	Percentage in Target		55%	25%	15%
3.2013	Median	53	20	59	270
(n=18)	Number in Target		16 of 18	10 of 18	2 of 18
	Percentage in Target		89%	56%	11%
Total	Median	68	22	68	361
(n=71)	Number in Target		48 of 70	26 of 71	7 of 71
	Percentage in Target		69%	37%	10%



Analysis:

In the 3rd quarter over the summer of 2013, our HI ED to CT time improved greatly with close to 90% of patients meeting the target time of 25 minutes. As well, although still no at 90% to target the HI ED to needle time also improved. This could possibly be explained by the recent improved flow through the department and fewer blocked beds over the summer. The HI ED to stroke unit time still needs improvement.

Darrell Chiasson, Director of Quality Research, HI ED

Focus: Halifax Infirmary Emergency Department

Trauma

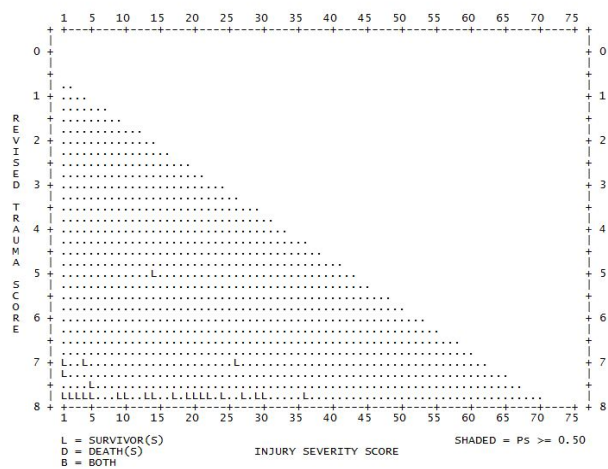
Reporting Period April 1, 2012 to Mar. 31, 2013

Context:

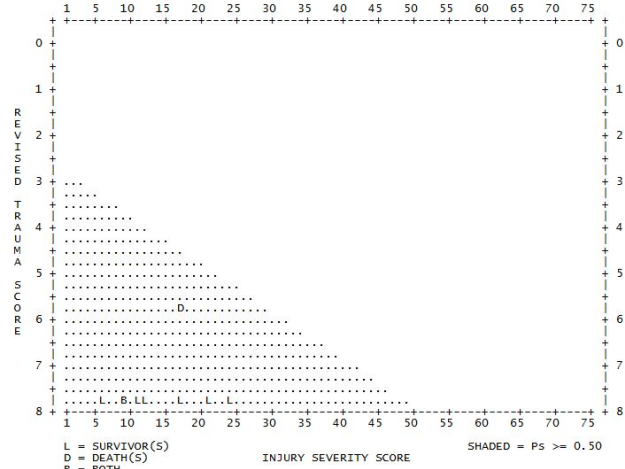
Trauma is the number one cause of loss of quality life years between the ages of 1 – 45. The Halifax Infirmary is the Level 1 Trauma Centre for the province (and plays a regional role) dedicated to the assessment, stabilization and definitive care of major trauma patients. There is good evidence in the literature that regionalized trauma care (including trip destination / by pass protocols) and a robust trauma team response saves lives.

AIS'05	# Cases	ISS - Mean	ISS - Median	AIS'05	# Cases	ISS - Mean	ISS - Median
Trauma Team Involvement	340	15.5	14.0	No Trauma Team Involvement	207	19.3	18.0
- Blunt	340	15.5	14.0	- Blunt	184	19.3	17.5
- Penetrating	33	8.5	5.0	- Penetrating	10	12.6	12.0
- Burns	<5			- Burns	7	21.7	25.0
- Drowning/Asphyxia	0			- Drowning/Asphyxia	6	25.7	26.0
Total "Major" Trauma Cases	547	17.0	16.0				

Adult Blunt (15-54) AIS 205 Coding



Adult Blunt (55+) AIS 2005 Coding



Analysis:

Injury Severity Score (ISS) of greater than 12 identifies major trauma in a Canadian system. In the past year there were 547 major trauma patients, with a mean ISS of 17. There were no unexpected deaths. ISS is a retrospectively calculated score and the relatively large number of non trauma team activation is a reflection of the number of falls in the elderly who don't initially meet the ACS guidelines for trauma team activation.

David Petrie, District Chief, Capital Health

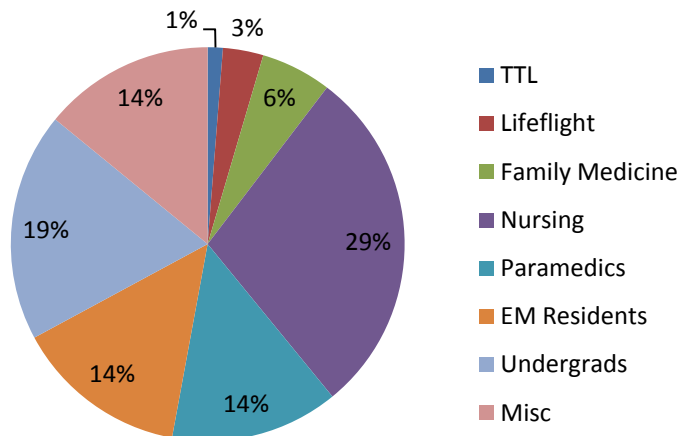
Academic

Education – Simulation Activities

Context:

Building on the initiative taken early in 2012 to create our ED Sim Bay adjacent to the Emergency Department at the Halifax Infirmary, we continued to be a centre for hands-on medical education, involving postgraduate and undergraduate learners, faculty, and clinical staff. Targeted learning sessions focus on their current and future academic and professional needs. Our strong and committed group of Emergency Physicians and other Faculty support team-based, multidisciplinary education by engaging the learners in realistic, medium/high-fidelity and anatomical human clinical grade cadaver learning experiences. Our Simulation Activities provide educational and research opportunities covering a broad spectrum, from patient safety initiatives, and CRM (Crisis Resource Management), to the performance of relatively uncommon but potentially lifesaving medical procedures.

Percentage of Simulation Lab Usage



Analysis

The further development of our simulation activities delivers on our core strategic directions: educating doctors and health care teams, advancing research, and enhancing patient care & population health. In the next year we will: focus on additional physical plant work to make the space more effective, pursue funding initiatives to make these changes, and increase awareness of our activities. On October 22/13, we will host members and guests of the QEII Foundation in Operation QEII, where participants will benefit from a hands-on simulation learning experience. On November 27/13, we will hold the 1st Halifax Resuscitation Course, bringing physicians and nurses from the Maritimes to work through real clinical cases and hands-on procedures. Upcoming events can be found

at: <http://emergency.medicine.dal.ca/HISimBay.cfm>. We are now on Facebook

at: <https://www.facebook.com/pages/Department-of-Emergency-Medicine-Halifax-NS/465879346841375#>

Louise Cornish, Chief Operating Officer, HI ED

Academic

Education – Undergraduate Students

Context:

The Halifax Infirmary Emergency Department also has a significant mandate to education at all levels within the Under Graduate Medical Education, Post Graduate Medical Education and Continuing Medical Education continuum. It is also an ideal learning environment for Nursing, Paramedicine and other health professions.

Number of Learners Scheduled Through Emergency Medicine			
Month	# Scheduled Shifts	Month	# Scheduled Shifts
October 1 - October 31, 2012		April 1 - April 30, 2013	
Med 3 & 4	85	Med 3 & 4	65
Off Service Residents	65	Off Service Residents	69
EM PGY 1 - 5	43	EM PGY 1 - 5	33
November 1 - November 30, 2012		May 1 - May 31, 2013	
Med 3 & 4	73	Med 3 & 4	55
Off Service Residents	77	Off Service Residents	71
EM PGY 1 - 5	64	EM PGY 1 - 5	87
December 1 - December 31, 2012		June 1 - June 30, 2013	
Med 3 & 4	32	Med 3 & 4	84
Off Service Residents	82	Off Service Residents	56
EM PGY 1 - 5	75	EM PGY 1 - 5	63
January 1 - January 31, 2013		July 1 - July 31, 2013	
Med 3 & 4	62	Med 3 & 4	36
Off Service Residents	91	Off Service Residents	0
EM PGY 1 - 5	77	EM PGY 1 - 5	164
February 1 - February 28, 2013		August 1 - August 31, 2013	
Med 3 & 4	71	Med 3 & 4	70
Off Service Residents	74	Off Service Residents	13
EM PGY 1 - 5	36	EM PGY 1 - 5	83
March 1 - March 31, 2013		September 1 - September 30, 2013	
Med 3 & 4	89	Med 3 & 4	103
Off Service Residents	78	Off Service Residents	92
EM PGY 1 - 5	35	EM PGY 1 - 5	30
Total Shifts October 1, 2012 – September 30, 2013		2383	