

objectives, utilization of other educational modalities and formal assessments to better prepare residents to conduct safer patient handoffs.

Keywords: handover, education, residency

P079

Comparison of vital sign documentation for pre-hospital “lift-assist” calls and non “lift-assist” calls

L. Leggatt, MD, M. Davis, MSc, MD, M. Columbus, PhD, J. McGuire, BSc, A. Spadafora, BHSc; Western University, London, ON

Introduction: When an individual requires assistance with mobilization, emergency medical services (EMS) may be called. If treatment is not administered and the patient is not transported to hospital, it is referred to as a “Lift Assist” (LA) call. We have previously shown that LA are associated with morbidity and mortality. Subtle pathology may exist in those who require LAs and they may benefit from being transported to the Emergency Department for medical evaluation. Given that the majority of LA calls result in no-transport, there may be a bias towards not upholding the same standards of care as patients who are transported to hospital. **Objective:** To determine if there is a difference in Ambulance Call Record (ACR) documentation of vital signs between LA calls and non-LA calls. **Methods:** All LA calls from a single EMS agency were collected over a one-year period (Jan - Dec 2013). A control group of randomly selected calls of low acuity (Canadian Triage Acuity Scale 3,4,5) from the same time period was collected for comparison. ACRs from these calls were reviewed for missing vital sign documentation. **Results:** Of 42,055 EMS calls, 808 (1.9%) were LA calls. A comparison of 784 randomly-selected non-LA control calls were reviewed. There were significantly more missing vitals (12.08% vs 6.64% $p < 0.001$) and refused vitals (1.87% vs 0.51% $p = 0.013$). **Conclusion:** There is a significant discrepancy in the complete documentation of vital signs in LA calls vs non-LA calls. There were also significantly more patient refusals for obtaining vitals compared to transported patients. Abnormal vital signs may be a clue to a subtle disease process that has resulted in a LA call, thus care should be taken to ensure that these patients are treated with the same standards of care and documentation as those patients calling EMS for overt medical reasons.

Keywords: emergency medical services (EMS)

P080

Factors predicting morbidity and mortality associated with pre-hospital “lift assist” calls

L. Leggatt, MD, M. Davis, MSc, MD, M. Columbus, PhD, K. Van Aarsen, BSc, MSc, M. Lewell, MD, A. Dukelow, CHE, MD; Western University, London, ON

Introduction: When an individual requires assistance with mobilization, emergency medical services (EMS) may be called. If treatment is not administered and the patient is not transported to hospital, it is referred to as a “Lift Assist” (LA) call. We have previously shown that LA are associated with morbidity and mortality. What places patients at an increased risk for morbidity and mortality is not yet known. **Objective:** To determine factors that are associated with increased risk of 14 day morbidity, determined by an ED visit or hospital admission, and mortality in LA calls. **Methods:** All LA calls from a single EMS agency were collected over a one-year period (Jan - Dec 2013). These calls were linked with hospital records to determine if LA patients had a subsequent visit to the emergency department (ED), admission, or death within 14 days. Logistic regression analyses were run to predict ED visit or hospital admission within 14 days of the LA call from patients’ age,

gender, co-morbidities and vital signs at the initial LA call. **Results:** Of 42,055 EMS calls, 808 (1.9%) were LA calls. There were 169 (20.9%) ED visits, 93 (11.5%) hospital admissions and 9 (1.1%) deaths within 14 days of a LA. Patient age > 61 ($p < 0.001$) and history of cardiac disease ($p = 0.006$) significantly predicted ED visit, while patient age > 61 ($p = 0.001$) and an Ambulance Call Record (ACR) missing at least 1 vital sign ($p = 0.017$) significantly predicted hospital admission. There was a 10% increase in risk of ED visit and hospital admission for every 10 year increase of age after the age of 61. Of the 96 patients with at least 1 missing vital sign, 14 (14.5%) were coded as patient refusals. The sample size was too small to determine predictors for mortality. **Conclusion:** Patients at risk for morbidity are older than 61 years of age and have co-existing cardiac disease. Patients who are greater than 61 years of age and had at least one missing vital sign on the ACR were more at risk for hospital admission.

Keywords: emergency medical services (EMS), falls, geriatrics

P081

Adaptation of DECISION +, a training program in shared decision making on the use of antibiotics for acute respiratory infections in primary care, to the context of emergency department: a mixed methods study

J. Létoirneau, MD, S. Berthelot, MD, MSc, M. Labrecque, MD, PhD, M. Cauchon, MD, F. Légaré, MD, PhD, P.M. Archambault, MD, MSc; Université Laval, Québec, QC

Introduction: Antibiotic overuse for acute respiratory infections (ARIs) is a significant problem in Emergency Departments (EDs). DECISION+, a training program on shared decision making (SDM) and a decision aid for antibiotic use in ARIs, reduces patients’ use of antibiotics for ARIs in primary care, but has never been studied in the ED setting. The objectives of this study are to assess the intention of ED physicians to adopt SDM about antibiotic use in ARIs and to identify barriers and facilitators about adopting SDM and a decision aid for antibiotic use in ARIs. **Methods:** An adapted version of DECISION+ (1-hour seminar) was offered to physicians of two academic EDs (Quebec, Canada) in fall 2015. A validated questionnaire was administered to participants before and after the seminar. This questionnaire contains three items measuring the intention to adopt SDM using a 7-point Likert scale [ranging from 1 (very unlikely) to 7 (very likely)]. We performed descriptive analyses for demographic characteristics and a paired Wilcoxon signed-rank test to compare pre- and post-training intention to adopt SDM ($\alpha = .05$). A debriefing session with the participants identified potential barriers and facilitators about implementing SDM and using a decision aid regarding antibiotic use for ARIs. Two researchers analysed the recorded audio material. **Results:** 41% (23/56) of eligible physicians received the intervention. 74% of participants had already heard of SDM and 40% felt they already used SDM in their practice. The median intention to adopt SDM was 6 (IQR 5-6) before and 6 (IQR 5-6) after the seminar ($P = .23$). One participant did not answer the questionnaire after the seminar and his results were excluded from the comparative analysis. We identified 20 specific barriers to adopting SDM for deciding about antibiotics use for ARIs in the ED (e.g., lack of time) and 13 facilitators (e.g., public health campaign). **Conclusion:** ED physicians’ baseline intention to adopt SDM with patients for antibiotic use in ARIs is high. The adapted tutorial of DECISION+ did not change this intention. This could be explained by the social desirability of SDM. Further studies must be conducted to adapt DECISION+ to the ED setting and also to assess the impact of DECISION+ on the actual prescription and use of antibiotics for ARIs.