

MACSTRAK QUARTERLY

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Acute Cardiac Care and the EMS

The local Emergency Medical Services are an important aspect of acute cardiac care. The first graph shows that over half of our patients admitted to a CCU present through EMS. This includes both patients with and without an acute coronary syndrome.

This rate is increasing for all diagnostic groups such that almost 60% of

Acute Coronary Occlusion patients now present through EMS. The cause for this increase is unclear but extends to all diagnostic groups.

Although presentation through EMS is not a major predictor of reperfusion therapy, it is associated with the choice of Primary PCI vs Thrombolysis. This is a new association not evident in 2006. If a lab knows a patient is en route, the time to a patent artery can be significantly reduced.

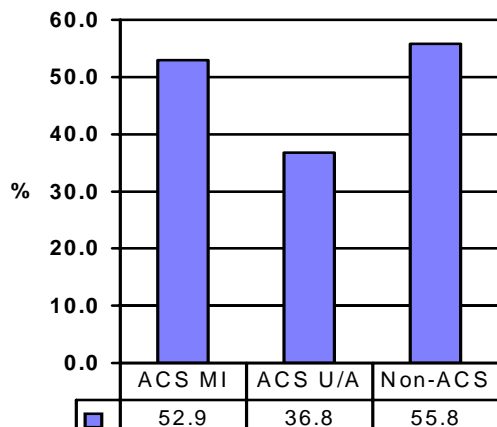
Capabilities in the field are also improving. The numbers of ECGs by EMS are increasing but still only about a quarter of patients with an acute coronary occlusion, presenting through EMS, will have a first ECG prior to arrival. As Emergency Medical teams commit to providing this enhanced process we should see a further improvement. There is still, however, very little thrombolytic therapy given in the field.

As teams provide more process in the field it will be important to monitor time intervals. Median times in the field are gradually increasing, and the interval of >40 minutes from arrival of EMS to first hospital arrival has also increased to 25% of cases.

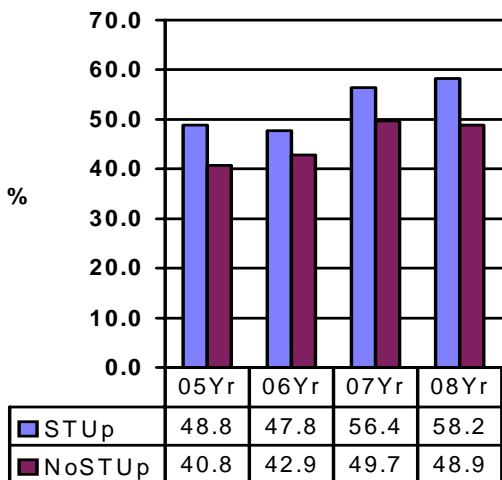
Data provides an excellent opportunity to engage our EMS colleagues in a dialogue to improve patient

care. With more patients accessing EMS, a greater commitment to ECGs in the field, and programs to stream patients to either Primary PCI or thrombolysis in the field, we should see further improvement in process of care and cardiac outcomes.

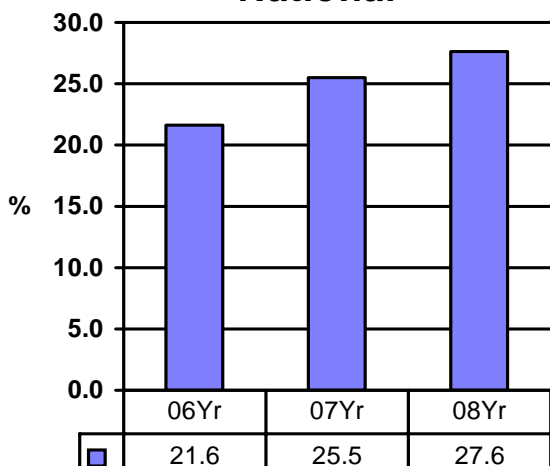
CCU EMS National 08Yr



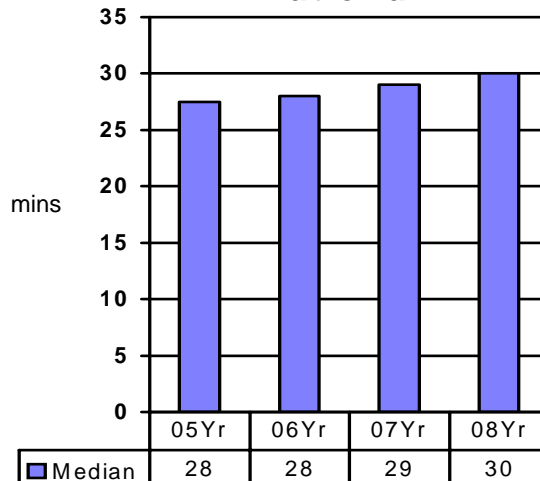
EMS AMI National



ECG by EMS STUP National



EMS to Hosp Arrival STUP National



TIMELINE ESSENTIALS

Have you ever asked yourself, “Do I need to complete the Timeline for this patient?” If any of you have ever thought that – here’s the answer! If you’re patient has:

- 1) AMI as an admitting diagnosis
- 2) REPERFUSION THERAPY (thrombolysis or PCI) as part of their initial management

PLEASE COMPLETE the TIMELINE.

Tips for a perfect Timeline:

Always use the **24 hour clock**.

Enter a time or > 24hrs – unfortunately we can’t get an accurate time from “last evening” or “AM”

Symptom Onset should be start time of the *episode that prompted the patient to come to the hospital*.

If the patient was having pain on and off for two weeks but it was an episode of pain that started at 14:30 that finally brought him to the hospital, his symptom onset is 14:30.

EMS at Scene is the time *EMS arrived at the patient* NOT the time EMS arrived at the hospital.

If you are a tertiary centre receiving many of your patients from other hospitals for PCIs, **First Hosp. Arrival, First ECG, Diag ECG, Tlysis** (if applicable), **Transfer (Departure)** are all times that will have *occurred prior to the patient arriving at your hospital*.

First ECG EMS should only be marked if the first *ECG was done via EMS*. A number of centres a marking an ‘X’ in this box to indicate that the ECG wasn’t done but please remember, a mark in a box is a piece of data captured!

You may have to **call the sending or receiving hospital** to get a complete timeline. This does take some time and effort on your part but it will give you a more complete and accurate picture of what is happening to your patients. And, it can be done – we’ve seen the evidence in perfectly completed timelines!

THE MACSTRAK PROJECT OFFICE

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Important Dates

Please keep in mind the following dates for 3rd quarter 2008:

Sept 8th

Supply Mailout

Oct 10th

All 3rd quarter forms due at project office

Oct 29th

DCF deadline – please fax them to us!

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