

(ED). Frequent reflection on current practices is required to detect areas in need of improvement. The Ontario Hospital Association (OHA) outlined five 'Leading Practices' (LPs) targeted to increase patient satisfaction in this setting. The ED volunteers are a group of individuals who have unique perspectives on ED practices that are unbiased by confounders affecting patients and staff. The goal of this study was to explore the unique perspectives of ED volunteers involving what they believe will improve the delivery of patient-centered care, as well as to examine to what extent Saskatoon EDs are embracing the principles outlined in the OHA LPs. **Methods:** A two-phase mixed methods approach, with a survey followed by interviews that allowed participants to expand on survey findings was used. The pool of 45 ED volunteers was extended the opportunity to participate resulting in 36 survey responses and 6 interviews. The 13 Likert-grade survey questions were generated to align to each of the LPs and allowed room for qualitative feedback. Interview questions were generated following 15 survey responses to expand on the LPs that were rated below average. **Results:** Analysis of responses identified inefficient ED processes leading to increased waiting times, inefficient patient location, inadequate signage, a lack of physical space, unclean environments, and a lack of staff and volunteer awareness regarding spiritual care and interpreter services, perceptions of received care by patients due to long wait times and level of cultural safety training of ED staff. Themes reduced from interviews yielded common themes such as patient frustration, disorganization, uncomfortable environment, overcrowding, prolonged wait times, and patient misconception of ED processes at Site 1. Themes common to Site 2 included organization, patient-friendly environment, patient misconception of ED processes, and prolonged wait times. Additionally, the volunteers suggested a plethora of interventions that could improve the current processes in Saskatoon's EDs to make them more patient friendly. **Conclusion:** Saskatoon EDs comply reasonably well to the OHA Leading practices. Surveying ED volunteers provides important insight into current practices and areas for improvement, and should be considered at other sites to improve adherence to the OHA LPs.

Keywords: emergency department, quality improvement and patient safety, volunteers

P141

Identifying causes of delay in interfacility transfer of patients by air ambulance

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Introduction: Vast geography and low population density limit availability of specialized trauma and medical care in many areas of Ontario. As such, patients with severe illnesses often require a higher level of care than local facilities can provide and thus require an interfacility transfer to access tertiary or quaternary care. In Ontario, Ornge, a provincially run air ambulance, serves as the sole provider of air-based medical and critical care transport. Patient outcomes are impacted by the time to definitive care, yet little research about reasons for delay in interfacility transfer within Ontario has been conducted. This study aimed to identify causes of delay in interfacility transport by air ambulance in Ontario. **Methods:** Causes of delay were identified by manual chart review of electronic patient care records (ePCR). All emergent adult interfacility transfers for patients transported by Ornge between Jan. 1-Dec. 31, 2016 were eligible for inclusion. Patient records were flagged to be manually reviewed if they met one or more of the following criteria: 1) contained a standardized

delay code; 2) the ePCR free text contained "delay", "wait", "duty-out", or common misspellings therein; 3) were above the 75th percentile in total transport time; or 4) were above the 90th percentile in time to patient bedside, time spent at the sending hospital, or time to receiving facility. Each trip was categorized as having delays that fall into one or more of the following categories: time-to-sending delays, in-hospital delays, and time-to-receiving/handover delays.

Results: Our search strategy identified 1,220 records for manual review and a total of 872 delays were identified. The most common delays cited included aircraft refuelling (234 delays); waiting for land EMS escort (144); and unstable patients requiring advanced care such as intubation, procedures, or transfusion (79). Other delays included handover or delays at the receiving facility (42); mechanical issues (36); dispatch-related issues (53); environmental hazards (43); staffing issues (47); and equipment problems (38). **Conclusion:** Some common causes of interfacility delay are potentially modifiable: better trip planning around refueling, and improved coordination with local EMS could impact many delayed interfacility trips in Ontario. Our analysis was limited by number and completeness of available records, and documentation quality. To better understand causes for delay, we would benefit from improved documentation and record availability.

Keywords: delay, medical transport, prehospital care

P142

Gaps in public preparedness to be a substitute decision maker and the acceptability of high school education on resuscitation and end-of-life care: a mixed-methods study

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Introduction: When a patient is incapable of making medical decisions for themselves, choices are made according to the patient's previously expressed, wishes, values, and beliefs by a substitute decision maker (SDM). While interventions to engage patients in their own advance care planning exist, little is known about public readiness to act as a SDM on behalf of a loved one. This mixed-methods survey aimed to describe attitudes, enablers and barriers to preparedness to act as a SDM, and support for a population-level curriculum on the role of an SDM in end-of-life and resuscitative care. **Methods:** From November 2017 to June 2018, a mixed-methods street intercept survey was conducted in Ottawa, Canada. Descriptive statistics and logistic regression analysis were used to assess predictors of preparedness to be a SDM and understand support for a high school curriculum. Responses to open-ended questions were analyzed using inductive thematic analysis. **Results:** The 430 respondents were mostly female (56.5%) with an average age of 33.9. Although 73.0% of respondents felt prepared to be a SDM, 41.0% of those who reported preparedness never had a meaningful conversation with loved ones about their wishes in critical illness. The only predictors of SDM preparedness were the belief that one would be a future SDM (OR 2.36 95% CI 1.34-4.17), and age 50-64 compared to age 16-17 (OR 7.46 95% CI 1.25-44.51). Thematic enablers of preparedness included an understanding of a patient's wishes, the role of the SDM and strong familial relationships. Barriers included cultural norms, family conflict, and a need for time for high stakes decisions. Most respondents (71.9%) believed that 16 year olds should learn about SDMs. They noted age appropriateness, potential developmental and societal benefit, and improved decision