Cath Lab Cardiac Physiologists: Ill Defined, Unskilled, Unregistered and Absent. Cath Lab Cardiac Physiologists: Ill Defined, Unskilled, Unregistered and Absent. Cath Lab Cardiac Physiologists: Ill Defined, Unskilled, Unregistered and Absent.

1 M. Norman 1,2,∗, R. Wilson 1,3
2 Royal Hobart Hospital, Hobart, Australia
3 Epworth Healthcare, Richmond, Australia

Professionals in Cardiac Sciences Australia (PiCSA) is the national representative body for people working in clinical cardiac science positions. In 2015 PiCSA conducted a census of cardiologists, workplaces, and individual workers who perform cardiac science procedures across Australia (this workforce includes nurses and radiographers as well as physiologists/scientists/technologists and other industry professionals). This was the first attempt to collect Australia-wide data about professionals employed in cardiac technology/science and the environments that they work in. Current cath lab roles are not standardised: The workplace survey indicated that some cath labs now operate entirely without a cardiac physiologist. Additionally, some institutions have cardiac physiologists who scrub, and some have a nurse or physiologist performing the imaging role. Some employers reported that their radiographers were responsible for doing the haemodynamic calculations. Only 16% of managers reported adequate skills assessment of those filling the cath lab cardiac physiologist role. This contrasted with 77% for echo, 48% for electrophysiology, 25% for cardiac devices, and only 11% for ECG. Some physiologists reported declining skill levels in their own workplaces – for example where machines now do the math and staff cannot identify when automatic calculations are incorrect.

Workforce survey respondents strongly supported the idea of rationally recognised qualifications (77%), registration (70%) and CPD requirements (80%) for the cath lab science role. They also recommended that cath lab competency be required before commencing training in the advanced cardiac physiology professions (very difficult for trainees to obtain if we fail to employ cardiac physiologists in the cath lab).

http://dx.doi.org/10.1016/j.hlc.2019.06.361

Background: In pts with chest pain, timely and efficient exclusion for acute coronary syndrome is crucial. Australian guidelines recommend using risk scores to stratify pts’ risks for major adverse cardiac events (MACE), and pts discharged from the emergency department (ED) with low-intermediate risk for coronary artery disease (CAD) may benefit from rapid access chest pain clinics (RACPC) to facilitate prompt cardiologist-led assessment and management. We evaluated the correlation between chest pain risk scores during ED presentation with outcome following RACPC review.

Methods: In this study of consecutive pts presenting to ED and subsequently to RACPC between July 2014 and December 2016 we prospectively recorded investigations and outcome. HEART scores were determined by single investigator using ED documentation. Outcomes recorded were 12-month MACE, planned coronary revascularisation, and initiation of medical therapy for CAD. MACE were defined as acute coronary syndrome (ACS), unplanned percutaneous or surgical revascularisation, or cardiac death.

Results: 1047 pts were analysed (mean age 55 years old, 48% male). No pts suffered MACE prior to, and 12 months after their RACPC assessment. Higher HEART score was associated with higher probability of receiving either medical therapy or revascularisation following their RACPC investigations (C-statistics 0.73, 95%CI 0.67–0.79).

Conclusion: Higher HEART score assessed during ED presentation for acute chest pain was associated with increased likelihood of receiving medical therapy or coronary revascularisation following RACPC assessment.

“For patients presented with acute chest pain, higher HEART score assessed in ED was associated with higher likelihood of receiving medical therapy or revascularisation following RACPC assessment.”

http://dx.doi.org/10.1016/j.hlc.2019.06.362