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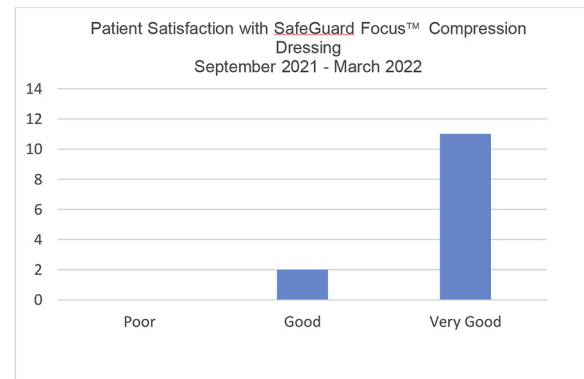
patients compared to manual compression [3]. Pocket haematomas increase infection risk and may prolong antibiotic use [4], hospitalisation or rarely re-hospitalisation, pocket evacuation and device explant [5].



Objective: To explore our initial experience with the use of the SafeGuard Focus™ compression dressing post cardiac device implantation.

Method: At Liverpool Hospital Cardiac Interventional Unit, follow-up Telehealth nurse interviews were conducted with consecutive cardiac device implantation patients using SafeGuard Focus™ from September 2021 to March 2022. Clinical outcomes data as well as patient's experiences via a survey were collected.

Results: 13 patients were recruited. 10/13 (77%) of patients were on anticoagulant therapy. No patient had any experience of skin injury, allergic reaction, bleeding or pocket haematoma after dressing usage. 1 patient had a minor skin infection managed with extended oral antibiotics. No patients required re-hospitalisation, device explant or prolonged hospitalisation. All patients reported positive "Good" and "Very good" experiences with the SafeGuard Focus™ compression dressing post cardiac device implantation procedures and would recommend future use of the dressing when required.



Conclusion: In our early experience, the SafeGuard Focus™ compression dressing was very well tolerated post-cardiac device implantation and no haematoma was experienced in our cohort. Larger studies are needed to confirm its value. When complications are minimised post-procedure, patient satisfaction is extremely high.

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Evaluation of the Emergency Cardiology Coordinator, a Senior Nursing Role Within the Emergency Department

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Background: A need was identified to streamline and expedite assessment of cardiac patients presenting to the Gold Coast University Hospital Emergency Department (ED). The Emergency Cardiology Coordinator (ECC), a senior nursing role, was implemented 14 April 2020 to 15 September 2020. Evaluation of the ECC role focussed on patients' presenting problems and time from triage to cardiology consult (TTCC).

Methods: ED and cardiology data were extracted from electronic medical records for the period from 2/9/2019 to 1/3/2021. The TTCC for each presenting problem was compared between patients seen by the ECC and those not on the days the ECC worked by the rank sum test. The effect of COVID-19 on TTCC was assessed by an interrupted time series analysis.

Results: The ECC saw 378 patients; 112 had a cardiology consult. The effect of COVID-19 was increased TTCC (0.13 hrs/mo; $p=0.027$). For all presenting problems, median TTCC was 2.07 hours (IQR 1.44, 3.16) for patients seen by the ECC compared to 2.58 hours (1.73, 3.80; $p=0.007$) for patients not seen by the ECC. Chest pain (1.94 cf. 2.41 hrs; $p=0.06$) and non-obvious cardiac presenting problems (1.77 cf. 3.05 hrs; $p=0.004$) were seen quicker when the ECC was involved. Presentations with palpitations, respiratory distress and altered level of consciousness had similar TTCCs.

Conclusions: The ECC role resulted in an overall decrease in TTCC despite the role coinciding with the emergence of COVID-19. Further analyses involving patients' risk factors and presenting problems will clarify the optimal strategy for the ECC role.

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Exploring Variability in Monitoring for and Diagnosing Post-Operative Atrial Fibrillation After Coronary Revascularisation Surgery: A Scoping Review

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Background: Atrial fibrillation (AF) is the most commonly reported complication following coronary revascularisation surgery. The reported incidence rates and clinical practices for monitoring for and diagnosing post-operative atrial

Variable	Pre-lockdown	During-lockdown	P-value (<0.05)
All STEMI presentations	214	277	0.19
Onset-to-FMC M(IQR1-3) mins	68(32-189.50)	70(35-205)	0.53
Door-to-balloon M(IQR1-3) mins	50(37-67)	55(43-80)	0.16
Patient outcomes			
Unplanned cardiac readmission (30 days)	5	6	0.92
In hospital mortality (exclude. Shock/OOHCA)	3	6	0.53
All-cause mortality (hospital and 30 days)	15	24	0.50

fibrillation (POAF) are highly variable amongst published literature.

Objective: This scoping review sought to explore variability in clinical practice related to POAF diagnosis following coronary revascularisation surgery.

Methods: The Preferred Reporting Items for Systematic Reviews and Meta-analyses extension for Scoping Reviews (PRISMA-ScR) guided the review. CINAHL, MEDLINE and ProQuest were searched to identify relevant published literature. Limits included papers published in English that included human participants over the age of 18. No date or study design limits were imposed. Eligibility screening and data extraction was conducted by one reviewer.

Results: A total of 534 papers were identified. Following the deletion of duplicates and application of inclusion and exclusion criteria 79 studies were included. The duration of time that a run of AF was required to be sustained to reach a diagnosis of POAF, ranged from 30 seconds to greater than 1 hour. A high level of variance was also identified in practices related to postoperative telemetry monitoring and the frequency of conducting postoperative twelve-lead electrocardiograms. The duration of continuous rhythm monitoring ranged from 24 hours to 5 days (up until day of discharge).

Conclusions: There is a lack of consistency regarding the diagnosis of POAF following coronary revascularisation surgery. Consensus and standardisation of clinical practices is urgently needed. This will enable future research to focus on examining the pre-disposing factors of POAF.

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Impact of COVID-19 Pandemic Lockdown on a Victorian Regional ST-Elevation Myocardial Infarction Service

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Background: The COVID-19 pandemic has impacted the utilisation of health services worldwide and was identified with a parallel decrease in global ST-elevation myocardial infarction (STEMI) presentations. Minimal published data exists on the pandemics impact on patient and systems delays, particularly in Australia.

Aim: We seek to examine the potential impact of the lockdowns associated with the COVID-19 pandemic on STEMI presentations, system delays and patient outcomes, in the largest regional area of Victoria.

Methods: Data was collected by retrospective electronic file audit, collated in REDCap, exported to SPSS Version 28. T-tests compared means between the two groups. Chi-Square and non-parametric tests were used as appropriate.

Results: There was no significant difference in STEMI presentations during the lockdown period. Door-to-balloon times comparable between the different times frames associated with lockdown (50 mins vs 55 mins, $p=0.16$). No significant difference was found for in-hospital and 30-day patient outcomes.