

resulted in 85% of participants properly identifying the severity of AWS, and developing an appropriate treatment strategy. The impact of this curriculum on actual patient treatment requires further evaluation.

Keywords: alcohol withdrawal syndrome, clinical institute withdrawal assessment for alcohol scale, education

P012

Why did you leave? Contacting Left Without Being Seen (LWBS) patients to understand their emergency department experience

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Introduction: As experienced in Emergency Departments (EDs) across Canada, Saskatoon EDs have a percentage of patients that leave before being assessed by a physician. This Left Without Being Seen (LWBS) group is well documented and we follow the numbers closely as a marker of quality, what happens after they leave is not well documented. In Saskatoon EDs, if a CTAS 3 patient that has not been assessed by a physician decides to leave the physician working in the ED is notified. The ED physician will: try to talk to the patient and convince them to stay, can assess the patient immediately if required, or discuss other appropriate care options for the patient. In spite of this plan patients with a CTAS score of 3 or higher (more acute) still leave Saskatoon EDs without ever being seen by a physician. Our desire was to follow up with the LWBS patients and try to understand why they left the ED. **Methods:** Daily records from one of the three EDs in Saskatoon documenting patients with a CTAS of 3 or more acute who left before being seen by a physician were reviewed over an eight-month period. A nurse used a standardized questionnaire to call patients within a few days of their ED visit to ask why they left. If the patients declined to take part in the quality initiative the interaction ended, but if they agreed a series of questions was asked. These included: how long they waited, reasons why they left, if they went somewhere else for care and suggestions for improvement. Descriptive statistics were obtained and analyzed to answer the above questions. **Results:** We identified 322 LWBS patients in an eight-month time period as CTAS 3 or more acute. We were able to contact 41.6% of patients. The average wait time was 2 hours and 18 minutes. The shortest wait time was 11 minutes, whereas the longest wait time was 8 hours and 39 minutes. It was found that 49.1% of patients went to another health care option (Medi-Clinic or another ED in Saskatoon) within 24hrs of leaving the ED. Long wait times were cited as the number one reason for leaving. Lack of better communication from triage staff regarding wait time expectations was cited as the top response for perceived roadblocks to care. Reducing wait times was cited as the number one improvement needed to increase the likelihood of staying. **Conclusion:** The Saskatoon ED LWBS patient population reports long wait times as the main reason for leaving. In order to improve the LWBS rates, improving communication and expectations regarding perceived wait times is necessary. The patient perception of the ED experience is largely intertwined with wait times, their initial interaction with triage staff, and how easily they navigate our very busy departments. Therefore, it is vital that we integrate the patient voice in future initiatives geared towards improving health care processes.

Keywords: quality improvement and patient safety, left without being seen, emergency department

P013

Management of intimate partner violence in the emergency department

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Introduction: Intimate partner violence (IPV) is a serious public health concern with complex medico-legal implications and a wide range of morbidity. While the ED is often the primary access point for these patients, IPV is under-recognized. Our objectives were to describe the characteristics of female IPV patients in the ED and determine the assessment and management patterns of physicians at a tertiary care academic ED. **Methods:** We conducted a health records review of adult (>18years) female patients seen at a tertiary care hospital ED presenting with evidence of IPV from January to September 2016. A combined search strategy of hospital records and Sexual Assault and Partner Abuse Care Program (SAPACP) patient rosters was used to identify study subjects. Data were collected for patient demographic/presenting characteristics, assault characteristics, and patterns of referral, management and patient disposition/discharge. Descriptive statistics were generated. **Results:** 100 patients met inclusion criteria with; mean age 35.1, female 100.0%, arrival by ambulance 53.0%, and mean CTAS level of 2.4. Abuse screening was completed at triage only 24.0% of the time. Presenting complaints were varied, with the most common being injury or trauma (32.0%). Most patients were only identified from the SAPACP roster. Patients reported strangulation, a strong predictor of future homicide, in 34.0% of cases. Admission to hospital occurred in 7.0% of cases with 19.0% involving specialist consultation and 7.0% leaving against medical advice or without being seen. Legal interactions including police involvement occurred 72.0% of the time and Childrens Aid Society was involved in 26.0% of cases. The final diagnosis was recorded as IPV or equivalent in only 49.0% of cases; the remainder were discharged with a final diagnosis of injury/trauma (26.0%), sexual assault (6.0%), somatic complaint (6.0%), mental health (8.0%), substance use/abuse (3.0%) or other (2.0%). **Conclusion:** Our study highlights that IPV is a common and heterogeneous entity with a wide spectrum of presentations and morbidity. Strangulation rates were high and are associated with increased risk of homicide. IPV is currently under-recognized and continues to carry stigma as ER physicians only recorded a discharge diagnosis of IPV or equivalent in half of cases. Educational strategies are required to highlight the importance of IPV to ED staff.

Keywords: intimate partner violence, domestic violence

P014

Comparison of prehospital administration of naloxone to patients with or without a history of an opioid overdose

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Introduction: Paramedics frequently make immediate life-altering decisions with minimal clinical information. This applies to their decision to treat an unconscious patient with naloxone when the history of an opioid overdose cannot be readily established. Among patients treated by paramedics with naloxone, our objective was to compare patient demographics, treatment interventions and clinical response between patients with and without a confirmed history of an opioid overdose. **Methods:** This was a retrospective cohort study design of consecutive patients treated with naloxone by paramedics between January 1, 2016, and June 30, 2017. Patients were classified based on whether paramedics did or did not document a history of an opioid overdose. Baseline characteristics, treatment interventions, and response to naloxone were compared between groups. Comparisons were done using a chi-squared or Fishers exact test. **Results:** We identified 294 patients of whom 113 (38%) did not have a confirmed history of an opioid overdose. The groups were similar in gender, bystander CPR, and bystander administration. There were no differences in the presence

of pinpoint pupils, initial oxygen saturation, initial Glasgow Coma Score (GCS), respiratory rate, or time on scene. Both patient groups were managed similarly with respect to route of naloxone administration and the use of a bag valve mask. All patients who were intubated were in the no confirmed history group ($n=5$; $p=0.003$). Post naloxone there were no differences in last recorded vital signs except the no confirmed history group was less likely to achieve a GCS 10 (57% versus 89%; $p<0.001$). The overall post-naloxone development of agitation (9%) was moderate while the need for physical/chemical restraint (2%) was low with no differences between groups. All patients were transported to the hospital. **Conclusion:** A substantial proportion of patients who received naloxone did not have a confirmed history of an opioid overdose. These patients closely resembled those with a confirmed history with respect to demographics and physical characteristics. The primary difference was a lower proportion of patients with no confirmed history who achieved a post naloxone GCS 10. Despite a moderate development of post naloxone agitation, paramedics were able to manage most of these patients without the use of physical/chemical restraints.

Keywords: emergency medical services, opioid overdose, naloxone

P015

Staff skills: a procedural skills curriculum for emergency medicine attending physicians in Calgary

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Introduction: Emergency medicine attending physicians perform many essential procedures but some infrequently. Skill proficiency and familiarity declines over time. We intended to identify skills where colleagues felt deficient and create an opportunity to demonstrate and practice in a safe environment. **Methods:** Sessions began from a review of ultrasound guided central line and pacemaker insertion. Other procedures have been added as a result of critical incidents, needs assessments by attending physicians, acquisition of new technology/equipment and expert consensus. An evaluation and needs assessment is performed after each session to adjust curricula. **Results:** Since 2011, we have held 2-3 skill sessions per year at the Advanced Trauma Surgical Skills Laboratory at the University of Calgary. Sessions are taught by attending emergency physicians, employ task trainers, simulators, animal and human cadaveric models, ultrasound, and procedural equipment stocked in our local hospitals. We are able to accommodate ~30 participants per session for 3 hours of rotating 7-8 participants through various stations. Every session has been fully attended with a wait list. Physicians register by email with preference given to new participants and those identified during clinical practice review of requiring remediation. Costs of sessions are covered by voluntary contribution to an emergency department physician support fund. Procedures practiced have included airway (basic, adjuncts, bronchoscopy, video laryngoscopy, surgical airway, chest tube), vascular access (ultrasound guided central venous insertion, transvenous pacemaker insertion, nerve blocks, IO insertion), surgical skills (thoracotomy, chest tube, canthotomy, surgical airway) and other percutaneous procedures (paracentesis, thoracentesis, nerve block, lumbar puncture). High fidelity skills videos were created to augment the sessions, available on the department website. Four point scale evaluations from our most recent session yielded 100% excellent rating for overall workshop and relevance to practice. The 6 facilitators performance received 100% excellent or good ratings. **Conclusion:** We have developed a fun, nonthreatening opportunity for attending physicians to practice infrequent but important ED procedures. The sessions are well received, well

attended, foster collegiality, confidence and competence in performance of infrequent ED skills. Our model could be generalized to other centres.

Keywords: innovations in emergency medicine education, procedural skills, attending physician

P016

Junior and senior clinician educators rank key medical education articles differently depending on topic

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Introduction: Medical education includes a diverse range of topics and disciplines. For junior clinician educators, it may be difficult to get a grasp of pertinent literature. Our study aims to retrospectively identify whether senior clinician educators (SCEs) and junior clinician educators (JCEs) differ in their selection of what they perceive as key medical education articles. **Methods:** As a part of the Academic Life in Emergency Medicine (ALiEM) Faculty Incubator program, we developed a series of primer articles for JCEs over the preceding year, designed to enhance their educational growth by identifying and discussing key articles within specific medical education arenas. Each set of articles within the primer series were selected based on data collected from JCEs and SCEs, who ranked the specific articles with respect to their perceived relevancy to the JCEs. ANOVA analysis was performed for each of the nine primer series to determine whether there was a statistically significant difference between senior and junior CE ratings of articles.

Results: 216 total articles were evaluated within the nine different primer topics. Through a multilevel regression analysis of the data, no statistically significant difference was found between the rankings of papers by SCEs and JCEs (95% CI: -0.27, 0.40). However, a subgroup analysis of the data found that 3 of the 9 primers showed statistically significant divergence based on seniority ($p<0.05$). **Conclusion:** Based on this data, involvement of JCEs in the consensus-building process was important in identifying divergence in views between JCEs and SCEs in one-third of cases. To our knowledge, no other group have compared whether junior and senior clinical educators may have divergent opinions about the relevance of medical education literature. Our findings suggest that it may be important to involve JCEs in selecting articles that are worthwhile for their learning, since SCEs may not fully understand their needs.

Keywords: innovations in emergency medicine education, mismatch between junior and senior clinical educator priorities

P017

When the rules hit the road: how emergency physicians make decisions in the era of the clinical decision rules

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Introduction: The diagnostic process is wrought with potential sources of error. Psychologists seek to coach physicians to refine their cognition. Researchers try to create cognitive scaffolds to guide decision-making. Physicians however, are caught in middle between their own daily cognitive processes and these external theories that might influence their behaviour. Few attempts have been made to understand how experienced clinicians integrate guidelines or clinical decision rules (CDRs) into their decision-making. We sought to explore experienced clinicians decision-making via a simulated exercise, to develop a model of how physicians integrate CDRs into their diagnostic thinking. **Methods:** From July 2015-March 2016, 16 practicing emergency physicians (EPs)