these patients at risk. Validation and reliability assessments of the FRM tool are warranted.

**Keywords:** fall risk, risk management, emergency nursing

**P132**

**Developing and piloting a nurse-initiated falls risk screening tool in the emergency department**

R. Tomlinson, BScN, T. Yokota, MD, P. Jaggi, MSc, M. Bullard, MD; University of Alberta, Edmonton, AB

**Introduction / Innovation Concept:** With aging, increasing complexity, and prolonged emergency department (ED) stays, patient falls are an increasing problem. Accreditation Canada recently listed falls risk management (FRM) as a required operational practice (ROP). The University of Alberta ED had no screening tool or education program specific to falls. Gaps in identifying patients with altered consciousness, intoxication, or who are undergoing procedural sedation were noted in the Alberta Health Services (AHS) recommended tool. This gap led to the development of an ED specific FRM screening tool. **Methods:** A literature review was completed to assess current fall assessment tools and their applicability to the ED. No ED specific tools were identified. The previous knowledge of falls management followed by a survey testing their actual knowledge. They were then educated on the FRM and protocol through in-services, power point presentations, and fact sheets. A post education knowledge survey was then sent out. Multidisciplinary working groups provided feedback throughout the pilot, resulting in modifications prior to final implementation. **Curriculum, Tool, or Material:** The FRM tool consists of 10 variables with a maximum score of 20. Variables included are: falls in the last 12 months? Mechanical (1), Physiological (2), Multiple (3); age ≥ 70 or frail (2); mobility assist device (1) confusion or disorientation (5); impaired gait (1); incontinence (1); intoxicated (3); procedural sedation (3); and unconscious (5). All except for the last 3 variables were adapted from inpatient risk tools. Patients were categorized as: low (1-2 points), moderate (3-4 points), or high risk (5+ points) and those scoring ≥ 3 had a safety protocol implemented. The survey regarding perceived knowledge for management of falls led to an average score of 86.6% (n = 46). When tested on their actual knowledge they scored 48.8% (n = 29). Following training on the FRM tool and protocol, the actual knowledge of 18 respondents averaged 83%. **Conclusion:** The FRM screening tool has been implemented and a comparative study looking at ED risk predictability matched to existing falls risk scores. Based on research findings the FRM will be considered for a provincial implementation. **Keywords:** geriatrics, long term care, quality improvement

**P134**

**Evaluating barriers to clinical decision rule integration: a qualitative analysis**

D.E. Trumble, BSc; University of Alberta, Edmonton, AB

**Introduction:** Clinical decision rules for computed tomography (CT) ordering in pulmonary embolism and mild traumatic brain injury have been shown to be under-used in clinical practice. Current literature does not explain why these validated decision rules continue to be under-used despite evidence of inappropriate use and increased costs. To better evaluate potential barriers to their use, qualitative methods involving focused interviews were conducted amongst emergency department (ED) physicians. **Methods:** Physicians were recruited via a brief presentation at Calgary Zone ED rounds. Ten attending and resident physicians (4 female, 6 male) were interviewed. Questions were designed to evaluate potential barriers to the integration of decision rules into the computerized order entry system. Interviews were audio-recorded and transcribed manually. A high-level thematic analysis was conducted to draw primary themes from open-ended questions, and responses were totaled for closed-ended questions. **Results:** Emerging themes suggest concerns surrounding timing of rule application in relation to other influences on ordering, patient influences on ordering, and overuse reporting. All 10 physicians believed decision rules for CT ordering play a large role in the ED, and 8 were in favor of integration into the order entry system. However, over half expressed concern, noting that their thought process begins before order entry. A majority prioritized shared decision-making with patients. However, 8 indicated that patient expectations influence their ordering. A majority agreed that there is CT overuse in the ED, but many were hesitant in concluding that overuse

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