for misuse in our cohort: 5,600 pills. **Conclusion:** After an ED visit for acute pain a significant portion of opioids prescribed is unused and available for misuse. A large pragmatic study should be done to confirm that an opioid prescription strategy based on our results will limit unused opioid pills while maintaining pain relief.

**Keywords:** opioids

**LO11**

**Opiate prescribing in Ontario emergency departments**

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**Introduction:** Increased prescribing of high potency opioids has been associated with increasing opioid addiction and linked to serious adverse outcomes including misuse, diversion, overdose and death. Problems related to opioids are a major Canadian public health concern yet few data are available on prescribing in most Canadian provinces. The objective of this study was to describe opioid prescribing in Ontario EDs and patient harms associated with this practice. **Methods:** We conducted a population-based cohort study among Ontario residents aged 15-64 years who were eligible for public drug coverage between April 2008 and March 2012. Using administrative databases, we identified patients with no opioid use in the past 12 months who received a prescription opioid from an emergency or family physician. Patients were followed for 2 years following their index prescription. The primary outcome was hospital admission for opioid toxicity and secondary outcome was dose-escalation exceeding 200 mg morphine equivalents (MEQ). **Results:** Of the 77,270 unique patients included, 33,492 (43.3%) and 43,778 (56.7%) prescriptions were issued by emergency physician (EP) and family physicians (FP), respectively. EP patients were older (45.9 vs 41.2 yr, MSD 0.35), had fewer ED visits (0.9 vs 2.3, MSD 0.46), and more FP visits (11.5 vs 8.7 MSD 0.31) in the year prior to their index visit. For combination products, EPs were more likely to prescribe oxycodone compared to FPs (37.2% vs 16.7%, Δ 20.5, 95% CI: 19.9, 21.2). For single agent products, EPs were more likely to prescribe hydromorphone compared to FPs (44.5% vs 21.7%, Δ 22.8, 95% CI: 20.4, 25.2). FPs were more likely to prescribe codeine either as a combination or single agent formulation. EP prescriptions led to significantly more hospital admissions for opioid toxicity (0.5% vs 0.3%, Δ 0.2, 95% CI: 0.1, 0.3), while FP prescriptions more often resulted in dose escalation beyond 200 mg MEQs (0.1% vs 0.7%, Δ 0.6, 95% CI: 0.4, 0.7). **Conclusion:** A large percentage of opioid-naïve patients receive an initial opioid prescription in the ED, where the use of high potency opioids is much more common, with 1/200 of these patients subsequently hospitalized for opioid toxicity. Creation of a physician accessible provincial registry would be useful to monitor opioid prescribing and dispensing, inform clinical practice, and identify patients at high-risk who may benefit from early interventions.

**Keywords:** survey, regional anesthesia, emergency department

**LO13**

**GridlockED: an emergency medicine game and teaching tool**

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**Introduction/Innovation Concept:** In the controlled chaos of the emergency department (ED) it can be difficult for medical trainees similarly recognize that there is definite order to the chaos, and many may never truly appreciate its complexity. How should medical learners develop this skill? Didactic teaching cannot effectively portray the complexities of managing the ED. Much like education in cardiac arrest, trauma, and multi-casualty incident management, it is our belief that the management of patient flow through the ED is best learned through simulation. Thus, we developed GridlockED, a board game that requires players to work cooperatively to manage a simulated ED to win the game. **Methods:** GridlockED development took place over a six-month period during which iterative cycles of gameplay and redevelopment were used to optimize game mechanics and improve player engagement. The patient cases were created by medical students (PS, DT, JR) and subsequently reviewed for content validity by two attending emergency physicians (TC, AP). Input from attending emergency physicians, residents, medical students, and laypeople was integrated into the game through a Plan-Do-Study-Act (PDSA) model. **Curriculum, Tool, or Material:** Our game includes: 1) The game board; 2) Patient cards, which describe a patient, their level of acuity, and the tasks that must be completed in order to disposition the patient; 3) Event cards, which cause random positive or negative events to occur-much like random procedures and many have never received training in how to do so. Future efforts should focus on improving access to education, disseminating information regarding the effectiveness of PNB, and addressing logistical barriers in the ED.

**Keywords:** opioid, physician prescribing, toxicity