patients were classified under BIG-1 (10.2%), 110 under BIG-2 (32.2%) and 197 under BIG-3 (57.6%). Twenty-six patients (7%) required neurosurgical intervention, all were BIG-3. 90% of TBI-related deaths occurred in BIG-3 and none were classified BIG-1. Among the 192 transfers (51%), 14 were classified under BIG-1 (7.3%) and should not have been transferred according to the guidelines and 50 under BIG-2 (26%). In addition, 40% of BIG-1 received a repeat head computed tomography, although not indicated. Similarly, 7 % of all patients had a neurosurgical consult even if not required. Projected implementation of BIG would lead to 47% of overtriage and 0.3% of undertriage. **Conclusion:** Our results suggest that the Brain Injury Guidelines could safely identify patients with negative outcomes and could lead to a safe and effective management of complicated mTBI. Applying these guidelines to our cohort could have resulted in significantly fewer repeat head CTs, neurosurgical consults and transfers to level 1 neurotrauma centers.
Keywords: complicated mild traumatic brain injury, guidelines

P016

Feasibility of a nurse-led smoking cessation intervention in the emergency department

A. Tolmie, BSc, R. Erker, BN, MN, A. Donauer, MD, E. Sullivan, MD, MPH, T. Graham, BA, MSc, PhD, T. Oyedokun, MBChB, MMed, J. Stempien, BSc, MD, University of Saskatchewan, Saskatoon, SK

Introduction: Cigarette smoking is a leading global cause of morbidity and mortality. Multiple studies internationally have established that cigarette smoking prevalence is higher in emergency department (ED) patients than their respective communities. Previously, we demonstrated the smoking prevalence among Saskatoon ED patients (19.6%) is significantly higher than the provincial average (15.1%), and over 50% of smoking patients would be receptive to ED-specific cessation support. The purpose of this project was to identify nurses' beliefs regarding smoking cessation in the ED, and barriers to implementing it in the department. **Methods:** A questionnaire was administered to all nurses employed at St. Paul's Hospital ED in Saskatoon assessing attitudes towards ED cessations, as well as the benefit and feasibility of three potential interventions: brief cessation counselling, referral to community support programs, and distributing educational resources. The questionnaire included Likert scale numerical ratings, and written responses for thematic analysis. Thematic analysis was performed by creating definitions of identified themes, followed by independent review of the data by researchers. **Results:** 83% of eligible nurses completed the survey (n = 63). Based on Likert scores, ED nurses rarely attempt to provide cessation support, and would be minimally comfortable with personally providing this service. Barriers identified through thematic analysis included time constraints (68.3%), lack of patient readiness (19%), and lack of resources/follow-up (15.9%). Referral to community support programs was deemed most feasible and likely to be beneficial, while counselling within the ED was believed to be least feasible and beneficial. Overall, 93.3% of nurses indicated time and workload as barriers to providing ED cessation support during the survey. **Conclusion:** Although the ED is a critical location for providing cessation support, the proposed interventions were viewed as a low priority task outside the scope of the ED. Previous literature has demonstrated that multifaceted ED interventions using counselling, handouts, and referrals are more efficacious than a singular approach. While introduction of a referral program has some merit, having professionals dedicated to ED cessation support would be most effective. At minimum, staff education regarding importance of providing smoking cessation therapy, and simple ways to incorporate smoking cessation counselling into routine nursing care could be beneficial.
Keywords: emergency nursing, primary prevention, smoking cessation

P017

Chart audit of patients with no fixed address presenting to the emergency department to identify areas to improve care

S. Todorovich, MD, MPH, D. Giffin, BSc, MD, M. Columbus, PhD, Western University, London, ON

Background: Homelessness is a growing Canada-wide concern. Those with no fixed address have increased rates of emergency department (ED) utilization and increased healthcare spending compared to the general population, with higher rates of acute and chronic illnesses, as well as all-cause mortality. EDs are uniquely situated to act as an access point to the network of available community services, however referral rates from the ED is uncertain. To date, there has been no data collected on London, Ontario's homeless population, their health burden, and their utilization patterns of the ED. **Aim Statement:** The primary objective of this study is to describe ED visits for adult patients with no fixed address in London, Ontario to assess for potential areas to improve care. **Measures & Design:** This is a retrospective chart review, of patients with no fixed address visiting London, Ontario Emergency Departments in 2018. ED visits were identified and pulled using either a diagnosis of "homeless", a lack of postal code, or a postal code for a known shelter. Cases included based on postal code were manually reviewed to determine whether the patient had a resident address with the same postal code. **Evaluation/Results:** From this search, 4,294 visits were identified for 1237 unique patients. The median visits per person was 1 (IQR 1-2), with 388 patients having 3 or more visits, and the max being 138 visits. The median age was 38 (IQR 28-52), with 73% male. Ground ambulance was used for 46% of visits. 28% of visits were CTAS 1&2 and 5% were CTAS 5. Police facilitated visits in 401 cases. Top 3 discharge diagnosis categories were mental health (19%), infection (18%), drug misuse (17%). **Discussion/Impact:** Several errors were identified with our search strategy suggesting the current system of capturing homelessness in the EPR is not accurate, leading to an underestimation of the problem and limiting our ability to describe this population. The Ministry of Health mandates homelessness be applied as a tertiary discharge diagnosis during coding of the patient visit if possible. However, use of this code is inconsistent leading to large-scale omission of visits and an underrepresentation of pediatric cases. Systemic steps should be taken to improve identification of these patients moving forward.
Keywords: homelessness, quality improvement and patient safety, resource utilization

P018

Journal club functions as a community of practice that safeguards quality assurance in the era of free open access medical education: a qualitative study

D. Ting, MD, B. Bailey, MD, MPH, F. Scheuermeyer, MD, MHSc, T. Chan, MD, MHPE, D. Harris, MD, MHSc, University of British Columbia, Vancouver, BC

Introduction: The ways in which Emergency Medicine (EM) physicians interact with the medical literature has been transformed with

https://doi.org/10.1017/cem.2020.226 Published online by Cambridge University Press

the rise of Free Open Access Medical Education (FOAM). Although nearly all residents use FOAM resources, some criticize the lack of universal quality assurance. This problem is a particular risk for trainees who have many time constraints and incompletely developed critical appraisal skills. One potential safeguard is journal club, which is used by virtually all EM residency programs in North America to review new literature. However, EM resident perspectives have not been studied. Our research objective was to describe how residents perceive journal club to influence how they translate the medical literature into their clinical practice. Our research question was whether FOAM has influenced residents' goals and perceived value of journal club. **Methods:** We developed a semi-structured interview script in conjunction with a methods expert and refined it via pilot testing. Following constructivist grounded theory, and using both purposive and theoretical sampling, we conducted a focus group (n = 7) and 18 individual interviews with EM residents at the 4 training sites of the University of British Columbia. In total, we analyzed 920 minutes of recorded audio. Two authors independently coded each transcript, with discrepancies reconciled by discussion and consensus. Constant comparative analysis was performed. We conducted return of findings through public presentations. **Results:** We found evidence that journal club works as a community of practice with a progression of roles from junior to senior residents. Participants described journal club as a safe venue to compare practice patterns and to gain insight into the practical wisdom of their peers and mentors. The social and academic activities present at journal club interacted positively to foster this environment. In asking residents about ways that journal club accelerates knowledge translation, we actually found that residents cite journal club as a quality check to prevent premature adoption of new research findings. Residents are hesitant to adopt new literature into their practice without positive validation, which can occur during journal club. **Conclusion:** Journal club functions as a community of practice that is valued by residents. Journal club is a primary way that new evidence can be validated before being put into practice, and may act as quality assurance in the era of FOAM.

Keywords: free open access medical education, graduate medical education, qualitative research

P019

What happens to John Doe? Unidentified patients in the emergency department: a retrospective chart review

K. Tastad, BSc, J. Koh, MD, D. Goodridge, PhD, J. Stempien, BSc, MD, T. Oyedokun, MBChB, MMed, University of Saskatchewan, Saskatoon, SK

Introduction: Patients who are not identified upon presentation to the emergency department (ED), commonly referred to as John or Jane Does (JDs), are a vulnerable population due to the sequelae associated with this lack of patient information. To date, there has been minimal research describing JDs. We aimed to characterize the JD population and determine if it differs significantly from the general ED population. **Methods:** We conducted a retrospective chart review of 114 JDs admitted to Saskatoon EDs from May 2018 to April 2019. Patients met inclusion criteria if they were provided a unique JD identification number at ED admission because their identities were unknown or unverifiable. Data regarding demographics, clinical presentation, ED course, mode of identification, and major clinical outcomes (i.e. admission rates, mortality rates) were gathered from electronic records. A second reviewer abstracted a random 21.0% sample of charts to ensure validity of the data. The JD population was then compared to the general population of ED patients that presented during the same time period. **Results:** Male JDs most commonly presented as trauma activations (85.7%) in contrast to female JDs who most commonly presented with issues related to substance abuse (51.4%). Compared to the general ED population, a greater percentage of JDs were categorized as CTAS 1 or 2 (85.8% vs 18.9%, $p < 0.0001$), more likely to be 44 years of age or younger (82.4% vs 58.5%, $p < 0.0001$), and more likely to be male (64.9% vs 49.1%, $p < 0.0001$). Descriptive statistics on the JD population demonstrated that most JDs received consults to inpatient services (58.8%). Of JDs who presented to the ED, 34.2% were admitted to hospital. The mortality of the JD population was 13.2% at 3 months. The ED average (SD) length of stay for JDs was 8.7 (9.0) hours. How JDs were ultimately identified was recorded only 70.2% of the time. Most frequently, JDs identified themselves (26.3%), other identification methods included police services (14.9%), family members (7.9%), registered nurses (6.1%), government-issued identification (5.3%), social work (4.4%) or other measures (5.4%). **Conclusion:** JD's represent a unique population in the ED. Both their presentations and clinical outcomes differ significantly from the generalized ED population. More research is needed to better identify strategies to improve the management and identification methods of these unique patients.

Keywords: emergency department, John Doe, unidentified patient

P020

Development and early experience with the Foothills Medical Center Pulmonary Embolism Response Team (PERT)

M. Szava-Kovats, MD, J. Andruchow, MD, P. Boiteau, MD, E. Herget, MD, K. Solverson, MD, University of Calgary, Calgary, AB

Background: Pulmonary embolism (PE) is a common illness with significant mortality without appropriate treatment. Its disease severity is variable, difficult to prognosticate and triage of severe PE remains a patient safety concern. Some PE may benefit from invasive and advanced medical therapy, but these decisions require complex multi-disciplinary coordinated care. We have launched a multidisciplinary rapid response team at the Foothills Medical Center Hospital (FMC) to assist prognostication, treatment, disposition planning, and followup for high-risk PE: The Pulmonary Embolism Response Team (PERT). **Aim Statement:** PERT has been implemented to improve patient-oriented outcomes however, as severe PE is infrequent, we initially target process measures. In the first year of PERT rollout, we aim for: 1) 100% of high risk PE be detected by emergency for PERT consult 2) PERT response be within 45 minutes of activation 3) PERT treatment and disposition be made within 1 hour of consult. 4) > 80% of patient dispositions match those informed by evidence-based risk stratification tools. **Measures & Design:** Through collaboration between emergency medicine, radiology, cardiac sciences, medical specialties and critical care, a collective evidence-based PE risk stratification/treatment pathway was developed. This has been disseminated to providers and embedding into electronic medical records (EMR) for computer assisted decision-making support. EMR data has been harmonized with standardized radiographic reporting for PE to cue reporting of high risk imaging findings. Standardized imaging and EMR prognostic factors flag high risk PE suggesting PERT activation. PERT standard operating

https://doi.org/10.1017/cem.2020.226 Published online by Cambridge University Press