

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

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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 are undergoing procedural sedation were noted in the Alberta Health Services (AHS) recommended tool. This gap led to the development piloting 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 leading to the development of the FRM tool. Prior to the FRM tool being piloted, nursing staff were asked to respond to a voluntary survey on their perceived 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: fall risk, risk prevention, nurse screening

P133

Characterizing how institutionalized and community-dwelling elderly patients use emergency department services in Regina, Saskatchewan

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Introduction: In light of recent local initiatives aimed at improving emergency department (ED) patient flow, we sought to characterize how patients aged 65 and older who reside in long term care (LTC) facilities utilize the services of the EDs in Regina, Saskatchewan as compared to an age-matched comparison of community dwelling individuals. **Methods:** A retrospective chart review was performed with a

convenience sample of the first 50 patients who presented to each ED at both hospitals in Regina starting January 1, 2012 for each population. Two separate patient populations were included: those who reside in the health region run LTC facilities and those who live in the community. We abstracted data from a variety of different clinical, demographic and administrative parameters. **Results:** The charts of 100 patients were reviewed for the LTC population (54 females, mean age 82.6) and 99 patients for the community dwelling population (55 females, mean age 77.3). The CTAS distribution for the LTC patients was found to be CTAS 1: 5%, CTAS 2: 9%, CTAS 3: 43%, CTAS 4: 33% and CTAS 5: 10%. For the community dwelling individuals, the distribution was CTAS 1: 1%, CTAS 2: 21%, CTAS 3: 44%, CTAS 4: 22%, CTAS 5: 10%. This is a significantly different distribution ($p = 0.047$). From the LTC population, we found that 50% of patients were admitted, with 46% being discharged and 4% leaving without being seen. Furthermore, we also noted that 75% of patients were brought to the ED by EMS. From the community dwelling population, we noted that 43% of patients were admitted, with 55% being discharged and 1% leaving without being seen. This population used EMS services 41% of the time. With respect to length of stay, LTC patients had a mean duration of 5.7 (± 4.3 hours) compared to 4.8 (± 4.0) hours for the non-LTC population ($p = 0.111$). **Conclusion:** Our findings suggest that the highest volume of acuity for the LTC patients falls within the CTAS 3 or 4 categories whereas there is a higher proportion of CTAS 2 acuity patients in the community dwelling population. Exactly half of our LTC sample was admitted as compared to 43% of the community population. The LTC population also required EMS services for a considerably higher proportion of their presentations to the ED (75% compared to 41%). It is our intent that the findings of this study will help guide future quality improvement initiatives.

Keywords: geriatrics, long term care, quality improvement

P134

Evaluating barriers to clinical decision rule integration: a qualitative analysis

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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 test 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