

A total of 350 charts were reviewed. The primary data abstracted for the initial transfusion, and subsequent transfusion if applicable, from each reviewed chart included clinical and laboratory data reflective of the transfusion guideline. Based on these data, the transfusion event was classified one of three ways: indicated based on hemoglobin level, indicated based on patient's symptomatic presentation, or unable to determine if transfusion indicated based on charting. **Results:** The year before guideline implementation, the total number of transfusions initiated at a hemoglobin of between 71-80 was 31 of 146 total transfusions. This number dropped by 23.6% to 22 of 136 in the year following guideline implementation. The number of single-unit transfusions increased by 28.0% from 47 of 146 in the year prior to 56 of 136 in the year after guideline implementation. The initial indication for transfusion being unable to be determined based on charting provided increased by 120%. The indication for subsequent transfusions being unable to be determined based on charting increased by 1500% ($P < 0.05$). **Conclusion:** These data suggest that implementing transfusion guidelines effectively reduced the number of transfusions given in the ED setting and increased the number of single-unit transfusions administered. However, the data also suggest the need for better education around transfusion indications and proper documentation clearly outlining the rationale behind the decision to transfuse.

Keywords: transfusions, value-added care

P005

Regional anesthesia in Canadian emergency departments: Emergency physician practices and impressions

D. Wiercigroch, BSc, MPA, S. Friedman, MD, MPH, D. Porplycia, MSc, M. Ben-Yakov, MDCM, University of Toronto, Toronto, ON

Introduction: The use of regional anesthesia (RA) by emergency physicians (EPs) is expanding in frequency and range of application as expertise in point-of-care ultrasound (POCUS) grows, but widespread use remains limited. We sought to characterize the use of RA by Canadian EPs, including practices, perspectives and barriers to use in the ED. **Methods:** A cross-sectional survey of Canadian EPs was administered to members of the Canadian Association of Emergency Physicians (CAEP), consisting of sixteen multiple choice and numerical responses. Responses were summarized descriptively as percentages and as the median and inter quartile range (IQR) for quantitative variables. **Results:** The survey was completed by 149/1144 staff EPs, with a response rate of 13%. EPs used RA a median of 2 (IQR 0-4) times in the past ten shifts. The most broadly used applications were soft tissue repair (84.5% of EPs, $n = 126$), fracture pain management (79.2%, $n = 118$) and orthopedic reduction (72.5%, $n = 108$). EPs agreed that RA is safe to use in the ED (98.7%) and were interested in using it more frequently (78.5%). Almost all (98.0%) respondents had POCUS available, however less than half (49.0%) felt comfortable using it for RA. EPs indicated that they required more training (76.5%), a departmental protocol (47.0%), and nursing assistance (30.2%) to increase their use. **Conclusion:** Canadian EPs engage in limited use of RA but express an interest in expanding their use. While equipment is available, additional training, protocols, and increased support from nursing staff are modifiable factors that could facilitate uptake of RA in the ED.

Keywords: nerve block, pocus, regional anesthesia

P006

Time for a national conversation: Practices and perspectives on HIV testing in Canadian emergency departments

D. Wiercigroch, BSc, MPA, E. Xie, MD, MSc, J. Hulme, MDCM, MPH, M. Landes, MD, MSc, University of Toronto, Toronto, ON

Introduction: Improved access to HIV testing would benefit the one in six Canadians living with undiagnosed HIV, and potentially reduce transmission. Emergency departments may be the first or only point of contact with the healthcare system for people exposed to HIV; however, HIV testing remains inaccessible in many EDs in Canada. **Methods:** We used a grounded theory approach to characterize the experiences and context of HIV testing in Canadian EDs. We conducted semi-structured phone interviews with ED and public health practitioners from a purposive sample of urban, rural, academic, and community ED catchment areas. Thematic analysis was performed through iterative readings by two authors. Results were triangulated through consultation with public health and HIV experts. **Results:** Data were obtained from 16 ED physicians and 8 public health practitioners. HIV tests were infrequently performed in the EDs of our sample. Informants from higher incidence regions believed that greater availability of HIV tests in the ED would benefit the populations they serve. In half of the sample, rapid HIV tests were available. However, indications for testing were most often occupational or known high-risk exposure. Notably, two urban EDs in British Columbia screened all patients who otherwise needed blood tests (opt-out), but had shifted to opt-in testing at the time of this study. Consent practices and perceived requirements varied widely between sites; this confused or frustrated physicians. Most EDs were unable to offer a test result to patients during their visit as results were not available until days to weeks later. Commonly, the ordering physician was responsible for communicating results. Some EDs had an assigned physician managing all results on a given day while others relied on public health units for follow-up. All EDs reported access to public health clinics for ongoing care. Barriers to offering a test in the ED included time required for consent, discomfort with pre-test counseling, delay in results availability and unclear processes for follow-up. **Conclusion:** We describe substantial regional and within-site variation in HIV testing practices across a diverse sample of EDs across Canada. These findings highlight disparities in access to HIV testing and warrant a national discussion on best practices for testing in EDs with an emphasis on reducing barriers for high-risk populations and addressing unmet needs.

Keywords: health services accessibility, human immunodeficiency virus, marginalized populations

P007

Cunningham reduction of anterior shoulder dislocation facilitated by inhaled low-dose methoxyflurane – a pilot study

H. Wiemer, BSc, MD, S. Campbell, MBChB, R. Fitzpatrick, C. Carriere, S. Teed, BAppBus:ES, P. Hico, A. Snook, J. Gallant, J. Belliveau, BSc, MHA, C. DeMone, Dalhousie University, Halifax, NS

Introduction: The Cunningham reduction method for anterior shoulder dislocation offers an atraumatic alternative to traditional reduction techniques without the inconvenience and risk of procedural sedation and analgesia (PSA). Unfortunately, success rates as