

roomed next to a psychiatric patient affects patient satisfaction and perception of care. **Methods:** A survey consisting of 15 patient satisfaction questions was distributed to patients over a period of three months in the ED at a tertiary care center with >125,000 visits a year. Patients included were English-speaking adults (18 years or older) with an Emergency Severity Index of 3-5. Responses were analyzed with a chi-square across 2 groups with p-value of 0.05 considered as significant. **Results:** A convenience sample of 78 surveys was obtained. 40 surveys were completed by those roomed next to a patient with a psychiatric complaint and 38 surveys were completed by patients not roomed next to a patient being seen for a psychiatric complaint. For every satisfaction question asked, the patients placed away from mental health encounters gave significantly higher ratings than the patients roomed near psychiatric patients. Patients roomed next to psychiatric patients had a statistically significant decrease in satisfaction in nursing attentiveness, nursing promptness in responding to the call bell, attentiveness of the physician team, and of the overall encounter itself. All values were significant with all but one p-value being <0.01. There was no difference between the 2 groups with respect to gender, age range, reason for visit or wait time. **Conclusion:** This study suggests that patients being roomed next to a patient with a psychiatric complaint had significantly decreased patient satisfaction.

Keywords: patient satisfaction, psychiatric complaint

P015

Implementing the Canadian CT Head Rule in a community emergency department

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Introduction: The Canadian CT Head Rule ('the rule') is widely used across the country and its use is specifically recommended by Choosing Wisely Canada. Studies in Canadian hospitals have shown appropriate declines in CT scans when decision tools have been made readily available and useable at the point of care. Research into the implementation of the Canadian CT Head Rule in particular has shown that barriers to its use include an inability to accurately recall each criteria and forgetting to attempt to apply the rule altogether. In an attempt to provide our clinicians with effective access to the rule, we modified CT requisitions and order procedures to facilitate the use of the rule for every head CT in our emergency department (ED). **Methods:** A quality improvement (QI) approach was used to pilot, implement, and evaluate the modified CT requisition at our hospital. Several Plan-Do-Study-Act cycles involving stakeholders in the hospital resulted in iterative changes to the requisition leading to the implemented version. The new requisition required physicians to indicate which rules or exclusion criteria were met and this was made mandatory for all head CTs ordered. Demographic data was collected on all patients presenting to the ED on age, gender, CTAS level, disposition, and length of stay. Data on which exclusion criteria were appropriate, the rules met leading to CT scans, whether each requisition was used appropriately, and whether there was a significant injury found was collected for each patient receiving a head CT after implementation. **Results:** In our primary outcome (% of ED visits receiving a head CT), preliminary results have demonstrated a relative reduction in head CT ordering of 10.9%. Our study at completion is powered to detect a ~10% relative change in ordering behaviour, and a Chi square of the data to date yields a P-value of 0.0147. There are no significant differences in visit volume or any of the demographics collected to date. Final results including analysis are anticipated in March, 2016. **Conclusion:** Preliminary results on this simple, no-cost intervention are very promising. The reduction in head

CTs ordered suggests that with mandated access to an easy-to-use, well validated decision tool, ED physicians have been able to confidently defer scans that have a very low risk of having any significant injury present, reducing cost, radiation exposure, and perhaps time in department.

Keywords: decision tool, computed tomography, quality improvement

P016

Evaluating the impact of a novel mobile care team (MCT) on the prevalence of ambulatory care sensitive conditions presenting to emergency medical services in Nova Scotia

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Introduction: Hospitalization due to ambulatory care sensitive conditions (ACSC) is a proxy measure for access to primary care. Emergency medical services (EMS) are increasingly called when primary care cannot be accessed. A novel paramedic-nurse EMS Mobile Care Team (MCT) was implemented in an under-served community. The MCT responds in a non-transport unit to bookings from EMS, emergency and primary care and to low-acuity 911 calls in a defined geographic region. Our objective was to compare the prevalence of ACSC in ground ambulance (GA) responses before and after the introduction of the MCT. **Methods:** A cross-sectional analysis of GA and MCT patients with ACSC (determined by chief complaint, clinical impression, treatment protocol and medical history) one year pre- and one year post-MCT implementation was conducted for the period Oct. 1, 2012 to Sept. 30, 2014. Demographics were described. Predictors of ACSC were identified via logistic regression. Prevalence was compared with chi-squared analysis. **Results:** There were 975 calls pre- and 1208 GA/95 MCT calls post-MCT. ACSC in GA patients pre- and post-MCT was similar: n = 122, 12.5% vs. n = 185, 15.3%; p = 0.06. ACSC in patients seen by EMS (GA plus MCT) increased in the post-period: 122 (12.5%) vs. 204 (15.7%) p = 0.04. Pre vs post, GA calls differed by sex (p = 0.007) but not age (65.38 ± 15.12 vs. 62.51 ± 20.48; p = 0.16). Post-MCT, prevalence of specific ACSC increased for GA: hypertension (p < 0.001) and congestive heart failure (p = 0.04). MCT patients with ACSC were less likely to have a primary care provider compared to GA (90.2% and 87.6% vs. 63.2%; p = 0.003, p = 0.004). **Conclusion:** The prevalence of ACSC did not decrease for GA with the introduction of the MCT, but ACSC in the overall patient population served by EMS increased. It is possible more patients with ACSC call or are referred to EMS for the new MCT service. Given that MCT patients were less likely to have a primary care provider this may represent an increase in access to care, or a shift away from other emergency/episodic care. These associations must be further studied to inform the ideal utility of adding such services to EMS and healthcare systems.

Keywords: emergency medical services (EMS), ambulatory care sensitive conditions, community paramedicine

P017

Does a busy day predict another busy day? A time-series analysis of multi-centre emergency department volumes

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Introduction: Variations of patient volumes in the ED according to days of the week and month of the year are well-established. Anecdotally, ED volumes follow 'waves' that correlate with previous