

strategies and expert skills that ED physicians possess to optimally manage the frail, older patient. **Methods:** An interpretive descriptive qualitative study was conducted. One of the investigators contacted the site leads of 12 academic and community EDs across Canada to identify ED physicians who they perceived as being highly skilled in the care of frail, older patients. 22 individual physicians were identified and 13 physicians representing 10 EDs were invited to participate in a 30-minute semi-structured interview. Transcripts were coded by two members of the research team. Data collection is ongoing and analyses will occur until thematic saturation. **Results:** All participants indicated they were very comfortable managing the frail, older patient in the ED. Awareness of issues related to this patient population were triggered by both clinical and personal experiences, as well as institutional priorities. When asked how they developed their specific skills for this patient population, participants stated they received limited formal training during residency and early practise, but relied on situational learning, access to role models and engagement in self-directed learning. Participants identified three predominant management strategies for the care of the frail, older patient: thorough patient interaction at the start of the clinical encounter to maximize efficiency; engaging in teamwork to manage complex issues; and early involvement of the family/caregivers. Interestingly, not all participants used the term frailty, however most reflected principles of the concept in their discussion. **Conclusion:** Currently, principles of caring for frail, older adults are not widespread in emergency medicine residency training. These findings suggest that frailty care frequently requires an alternative clinical approach, which is often derived from personal experience, self-directed and experiential learning. Future educational initiatives should derive, implement and evaluate a wide-spread curriculum to teach the skills required to optimally care for these patients. **Keywords:** emergency medicine, frailty, geriatrics

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Current practices of management for mild traumatic brain injuries with intracranial hemorrhage

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Introduction: The radiological and clinical follow-up of patients with a mild traumatic brain injury (mTBI) and an intracranial hemorrhage (ICH) is often heterogeneous, as there is no official guideline for CT scan control. Furthermore, public sector health expenditure has increased significantly as the number of MRI and CT scan almost doubled in Canada in the last decade. Therefore, the main objective of this study was to describe the current management practices of mTBI patients with intracranial hemorrhage at two level-1 trauma centers. **Methods:** Design: An historical cohort was created at the CHU de Québec – Hôpital de l'Enfant-Jésus (Québec City) and Hôpital du Sacré-Coeur (Montréal). Consecutive medical records were reviewed from the end of 2017 backwards until sample saturation using a standardized checklist. **Participants:** mTBI patients aged ≥ 16 with an ICH were included. **Measures:** The main and secondary outcomes were the presence of a control CT scan and neurosurgical consultation/admission. **Analyses:** Univariate descriptive analyses were performed. Inter-observer measures were calculated. **Results:** Two hundred seventy-four patients were included, of which 51.1% (n = 140) came from a transfer. Mean age was 60.8 and 68.9%

(n = 188) were men. Repeat CT scan was performed in 73.6% (n = 201) of our patients as 12.5% showed a clinical deterioration. The following factors might have influenced clinician decision to proceed to a repeat scan: anticoagulation (association of 87.1% with scanning; n = 27), antiplatelet (84.1%; 58), GCS of 13 (94.1%; 16), GCS of 14 (75%; 72) and GCS of 15 (70.2%; 111). 93.0% (n = 254) of patients had a neurosurgical consultation and only 6.7% (17) underwent a neurosurgical intervention. **Conclusion:** The management of mild traumatic brain injury with hemorrhage uses a lot of resources that might be disproportionate with regards to risks. Further research to identify predictive factors of deterioration is needed.

Keywords: intracranial hemorrhage, management, mild traumatic brain injuries

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Post-intubation sedation in the emergency department: a survey of national practice patterns

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Introduction: Endotracheal intubation (ETI) is a lifesaving procedure commonly performed by emergency department (ED) physicians that may lead to patient discomfort or adverse events (e.g., unintended extubation) if sedation is inadequate. No ED-based sedation guidelines currently exist, so individual practice varies widely. This study's objective was to describe the self-reported post-ETI sedation practice of Canadian adult ED physicians. **Methods:** An anonymous, cross-sectional, web-based survey featuring 7 common ED scenarios requiring ETI was distributed to adult ED physician members of the Canadian Association of Emergency Physicians (CAEP). Scenarios included post-cardiac arrest, hypercapnic and hypoxic respiratory failure, status epilepticus, polytrauma, traumatic brain injury, and toxicology. Participants indicated first and second choice of sedative medication following ETI, as well as bolus vs. infusion administration in each scenario. Data was presented by descriptive statistics. **Results:** 207 (response rate 16.8%) ED physicians responded to the survey. Emergency medicine training of respondents included CCFP-EM (47.0%), FRCPC (35.8%), and CCFP (13.9%). 51.0% of respondents work primarily in academic/teaching hospitals and 40.4% work in community teaching hospitals. On average, responding physicians report providing care for 4.9 ± 6.8 (mean \pm SD) intubated adult patients per month for varying durations (39.2% for 1–2 hours, 27.8% for 2–4 hours, and 22.7% for ≤ 1 hour). Combining all clinical scenarios, propofol was the most frequently used medication for post-ETI sedation (38.0% of all responses) and was the most frequently used agent except for the post-cardiac arrest, polytrauma, and hypercapnic respiratory failure scenarios. Ketamine was used second most frequently (28.2%), with midazolam being third most common (14.5%). Post-ETI sedation was provided by $> 98\%$ of physicians in all situations except the post-cardiac arrest (26.1% indicating no sedation) and toxicology (15.5% indicating no sedation) scenarios. Sedation was provided by infusion in 74.6% of cases and bolus in 25.4%. **Conclusion:** Significant practice variability with respect to post-ETI sedation exists amongst Canadian emergency physicians. Future quality improvement studies should examine sedation provided in real clinical scenarios with a goal of establishing best sedation practices to improve patient safety and quality of care.

Keywords: post-intubation, sedation