project to implement an inter-professional team approach during handovers. **Methods:** This prospective QI project took place at an academic tertiary care centre with >160,000 ED visits/yr. An expert working group identified key components of the ideal morning handover, and developed an intervention consisting of standardizing the "location", "participants", and "time" components of our handover processes. A research assistant directly observed all 8am handovers for 2 weeks pre- and 2 weeks post-intervention. Outcomes include participant attendance; # of beside RN issues proactively brought forward; frequency of new allied health consults and/or involvement triggered; # of physician interruptions; and time metrics. We report descriptive statistics. **Results:** During the study period a total of 308 individual patient handovers were observed [Pre:162, Post:146]. Average duration of total handover each morning decreased from 24.9min to 16.3min ($p = 0.051$). Frequency of attendance at handovers increased for various allied health professionals, including care facilitators [Pre:35.7%; Post:91.7%, $p = 0.005$], social workers [Pre:7.1%; Post:66.7%, $p = 0.003$], geriatrics EM (GEM) RNs [Pre:64.3%; Post:83.3%, $p = 0.391$], pharmacists [Pre:0.0%; Post:58.3%, $p = 0.001$], and physiotherapists [Pre:0.0%; Post:58.3%, $p = 0.001$]. Number of specific beside RN issues proactively brought forward increased [Pre:0; Post:4, $p = 0.049$], while the number of physician interruptions during handover decreased [Pre:20; Post:0, $p < 0.0001$]. Frequency of new allied health consults and/or involvement triggered as a result of handover participation increased from 6.8% to 13.7% ($p = 0.057$). **Conclusion:** Implementation of a standardized team approach to morning handovers in the ED led to significant improvements in inter-professional contributions to patient care plans and overall efficiency. Future planned phases will build on this QI initiative by standardizing specific content of ED handovers.

Keywords: handover, patient safety, quality improvement

P071

Emergency physician attitudes and perceived barriers to take-home naloxone programs in Canadian emergency departments

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Introduction: Unintentional overdose is the leading cause of injurious death among Americans aged 25-64 years. A similar epidemic is underway in Canada. Community-based opioid overdose education and naloxone distribution (OOEND) programs distribute take-home naloxone kits to people at risk of overdose in several cities across Canada. Due to the high rate of drug-related visits, recurrent opioid prescribing, and routine encounters with opioid overdose, Emergency Departments (ED) may represent an under-utilized setting to deliver naloxone to people at risk of opioid overdose or likely to witness overdose. The goal of this study was to identify Canadian emergency physician attitudes and perceived barriers to the implementation of take-home naloxone programs. **Methods:** This was an anonymous web-based survey of physician and trainee members of the Canadian Association of Emergency Physicians. Survey questions were developed by the research team and piloted for face validity and clarity. Two reminder emails were sent to non-responders at 2-week intervals, per the modified Dillman method. Respondent demographics were collected and Likert scales used to assess attitudes and barriers to the prescription of naloxone from the ED. **Results:** A total of 347/1658 CAEP members responded (20.9%). Of the respondents, 62.1% were male and residents made up 15.6%. The majority (48.2%) worked in Ontario and 55.7% worked in an urban tertiary centre. Overall attitudes to OOEND were strongly positive: 86.6% of respondents identified a willingness to prescribe naloxone from the ED. Perceived barriers included allied health support for patient education (56.4%), access to follow-up (40.3%), and inadequate time in the clinical encounter (37.7%). In addition to people at risk of overdose, 78% of respondents identified that friends and family members may benefit from OOEND programs. **Conclusion:** Canadian emergency physicians are willing to prescribe take-home naloxone to at-risk patients, but better systems and tools are required to facilitate opioid overdose education and naloxone distribution implementation. This data will inform the development of these programs, with emphasis on allied health support, training and education.

Keywords: addiction medicine, opioids, naloxone

P072

Using the Bergman-Paris Question to detect ED seniors' cognitive impairment and functional status

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Introduction: Mild Cognitive Impairment (MCI) remains frequently undiagnosed and Emergency Department (ED) guidelines suggest screening for CI. The Bergman-Paris Question (BPQ) which is currently used in memory clinics, is a one-question screening test administered to the patient's relative; a negative answer suggests presence of CI. We sought to validate if the BPQ would be associated with MCI and functional status in ED elders. **Methods:** A planned sub-study of the prospective MIDI-INDEED study on ED-induced delirium, which included patients from 4 Canadian EDs was realized. Inclusion criteria were: patients ≥65 y.o., with and ED stay ≥8 hours, admitted to the hospital, non-delirious at the end of the first 8 hours and independent or semi-independent. Eligible patients were assessed in ED and at 60 days after ED visit using validated screening tests: the Telephone Interview for Cognitive Status-modified (TICS-m) for CI and the Older Americans Resources and Services scale (OARS) for functional status. The BPQ was asked at any time depending on the availability of a relative. Patients with a TICS-m score <31 are considered to have MCI. Data from patients with incident delirium, and those with documented dementia was individually analyzed. Univariate and multivariate analyses were used to ascertain outcomes. **Results:** 167 patients had a BPQ response, 126 (75.5%) were negative, and 41 positive (24.5%). For MCI, 40 (32.8%) patients of the negative group have a TICS-m below 31 comparatively to 6 (14.3%) for the positive group ($p = 0.2$). The BPQ was significantly associated with functional status. The mean OARS scores were 25.1 (3.9) in the negative group and 27.1 (1.3) in the positive group. This difference was maintained at 60 days. The number of delirium in the negative group was 24 (18%) vs 2 (5%) in the positive group ($p = 0.04$). **Conclusion:** BPQ could provide detection of MCI but further validation in a larger population is needed. BPQ was interestingly associated with ED-induced delirium and dementia. Detection of functional status and frailty shows good results. More research is needed to evaluate the usefulness of the BPQ "single" question for geriatric screening by ED professionals.

Keywords: mild cognitive impairment, delirium, emergency department

P073

Feasibility of emergency department targeted ultrasound for rib fracture diagnosis in minor thoracic injury

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