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Distal radial fractures: adequacy of reductions performed in the emergency department

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Introduction: Distal radial fractures (DRF) remain the most commonly encountered fracture in the Emergency Department (ED). The initial management of displaced DRFs by Emergency Physicians (EP) poses considerable resource allocation. We wished to determine the adequacy of reduction, both initially and at follow up. This data updates previously presented high level findings. **Methods:** We performed a mixed-methods study including patients who underwent procedural sedation and manipulation by an EP for a DRF. Radiological images performed at initial assessment, post-reduction, and clinic follow up were reviewed by a panel of orthopedic surgeons and radiologists blinded to outcomes, and assessed for evidence of displacement. Demographic data were pooled from patient records and included in statistical analysis. **Results:** Seventy patients were included and had follow-up completed. Initial reduction was deemed to be adequate in 37 patients (53%; 95% CI 41.32 to 64.10%). At clinic follow-up assessment, 26 reductions remained adequate; a slippage rate of 30% (95% CI of 17.37 to 45.90). Overall 7 patients (10%; 95% CI 4.65 to 19.51%) required revision of the initial reduction in the operating room. Agreement on adequacy of reduction on post-reduction radiographs between radiologists and orthopedic surgeons was 38.6% (95% CI -38.3 to -7.4, Kappa -0.229). The statistical strength of this agreement is worse than what would be expected by chance alone. There was no association found between age, sex, or of time of initial presentation and final outcomes. **Conclusion:** Although blinded review by specialists determined only half of initial EP DRF reductions to be radiographically adequate, only 10 percent actually required further intervention. Agreement between specialists on adequacy was poor. The majority of DRFs reduced by EPs do not require further surgical intervention.

Keywords: emergency department, fractures, reductions

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Parental leave policies and culture for physicians in emergency medicine

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Introduction: Medicine demands a sacrifice of physicians' personal life, but culture has slowly changed towards valuing a balanced work life. Parental leave is linked to better physical and mental health, but policies and culture surrounding parental leave are largely unstudied in the Canadian Emergency Medicine landscape. Anecdotally, experiences vary widely. This study was designed to determine what proportion of Canadian Emergency Departments have formal parental leave policies (maternity, paternity, and other ex. adoption) and what proportion of Canadian EM physicians are satisfied with their department's parental leave policies. **Methods:** Two surveys were generated; one to assess attitudes and experiences of emergency physicians, and a second survey for department chiefs assessed the policies and their features. These were approved by the UBC REB and distributed through the CAEP Research Committee. Primary outcomes were physician satisfaction with their department's parental leave policy (4-5/5 Likert Scale), and departments with a formal parental leave policy (Y/N). **Results:** 38% (8/21) of department chiefs reported having a formal policy for maternity leave, 29% (6/21) for paternity leave, and 24% (5/21) other. The survey of Emergency Physicians revealed similar rates at 48% (90/187) maternity, 40% (70/184) paternity, 29% (53/181) other. Among physicians who were aware of them, 69% (62/90) were somewhat or very satisfied with the maternity leave policies, 58% (51/88) with paternity leave policies, and 48% (39/81) with other parental leave. Less than 10% were somewhat or very dissatisfied with any of these. Several department chiefs commented that they had never refused anyone parental leave, but have no formal policy. However, 87% (147/187) of physicians reported a formal maternity leave policy was somewhat or very important to them; similarly 80% (134/187) paternity leave. Less than 15% felt each was somewhat or extremely unimportant. **Conclusion:** Presence and type of parental leave policy varies across the country. Most physicians were satisfied with the support they had available, but the vast majority felt that a formal maternity and paternity leave policy itself was important. This study would suggest that, without actually changing practice, the introduction of a formal parental leave policy is of value. Our research group will use this data to collaborate on a template parental leave policy to be made available for this purpose.

Keywords: leadership, policy, wellness

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The impact of a pancreatitis admission algorithm on emergency department length of stay in a tertiary care academic hospital

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Background: Emergency department (ED) overcrowding is associated with a broad spectrum of poor medical outcomes, including medical errors, mortality, higher rates of leaving without being seen, and reduced patient and physician satisfaction. The largest contributor to overcrowding is access block – the inability of admitted patients to access in-patient beds from the ED. One component to addressing access block involves streamlining the decision process to rapidly determine which hospital service will admit the patient. **Aim Statement:** As of Sep 2011, admission algorithms at our institution were supported and formalised. The pancreatitis algorithm clarified whether general surgery or internal medicine would admit ED patients with pancreatitis. We hypothesize that this prior uncertainty delayed the admission decision and prolonged ED length of stay (LOS) for patients with pancreatitis. Our project evaluates whether implementing a pancreatitis admission algorithm at our institution reduced ED time to disposition (TTD) and LOS. **Measures & Design:** A retrospective review was conducted in a tertiary care academic hospital in Montreal for all adult ED patients diagnosed with pancreatitis from Apr 2010 to Mar 2014. The data was used to plot separate run charts for ED TTD and LOS. Serial measurements of each outcome were used to monitor change and evaluate for special cause variation. The mean ED LOS and TTD before and after algorithm implementation were also compared using the Student's t test. **Evaluation/Results:** Over four years, a total of 365 ED patients were diagnosed with pancreatitis and 287 (79%) were admitted. The mean ED LOS for patients with pancreatitis decreased following the implementation of an admission algorithm (1616 vs. 1418 mins, $p = 0.05$). The mean ED TTD was also reduced (1171 vs. 899 mins, $p = 0.0006$). A non-random signal of change was suggested by a shift above the median prior to algorithm implementation and one below

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