

Canadian ED patient safety quality indicator. International data exists although inconsistencies exist in the way URV are defined and measured. To our knowledge there are no published Canadian data on the percentage of ED URV admissions. This study examines our own URV data and in particular the correlation between URV admission rates and first visit Canadian Triage Acuity Scale (CTAS) category. **Methods:** A retrospective analysis of 12-month's data (January - December 2015) was completed for URV to the ED of a 445 bed regional tertiary care adult and pediatric teaching hospital with 57,000 annual attendances. URV was defined as any patient registering within 72 hours of an earlier visit that had resulted in a discharge from ED. Planned return visits were excluded. The data was analysed for an overall URV percentage, UV percentage by first visit CTAS category, overall percentage of URV admitted and URV admission percentage by first visit CTAS category. Pearson R correlation and Fishers Exact Test were used to test the relationship. **Results:** During the 12-month period there were 57,025 registrations of which 46,793 patients were discharged. There were 3566 URV (7.62% of those discharged); the number of URV admitted was 532 (1.14 % of those discharged). The return rate/admission rates by CTAS category were: CTAS 1: 6.74%/1.55%; CTAS 2: 7.86%/1.92%; CTAS 3: 8.54%/1.35%; CTAS 4: 5.99%/0.40%; CTAS 5: 5.55%/0.27%. The RR of admission on return for discharged CTAS groups 1 and 2, compared with CTAS 3, 4 and 5 was 1.90 (95 CI 1.57 to 2.30;  $p < 0.0001$ ). Rate of admission on return was negatively correlated with initial CTAS level (Pearson  $r = -0.89$  (95 CI -0.99 to -0.03);  $R^2 = 0.79$ ;  $F = 11.25$ ;  $p = 0.04$ ). **Conclusion:** We have demonstrated a relationship between first visit CTAS category and the unplanned return admission rate. If admission is taken as a marker of illness severity, then the likelihood of an inappropriate discharge is inversely proportional to first visit CTAS score. While this makes sense intuitively, our data confirms this relationship in a Canadian tertiary care hospital and supports the reporting of ED URV admission data by first visit triage category as an important quality indicator.

**Keywords:** CTAS, unplanned return visits, admission rate

#### MP009

##### Reliability and interchangeability of measures of two tissue oximeters in healthy volunteers

A. Cournoyer, MD, A. Denault, MD, PhD, S. Cossette, PhD, A. Fortier, MSc, J. Chauny, MD, MSc, R. Daoust, MD, MSc, M. Iseppon, MD, E. Notebaert, MD, MSc; Université de Montréal, Montréal, QC

**Introduction:** Near-infrared spectroscopy (NIRS) is a non-invasive, continuous and painless method of monitoring oxygen saturation of hemoglobin in any given superficial tissue. Given that hemodynamic instability can affect the oxygen saturation, NIRS could prove to be an interesting tool in quantifying tissue oxygenation, consequently guiding clinical management. The aim of this study was to compare the reliability of two commonly used tissue oximeters, the INVOS 5100c from Covidien and the Equanox 7600 from Nonin. We postulated the Equanox (a more recent tissue oximeter) would have a better reliability than the INVOS. As a secondary outcome, we evaluated whether the measures given by the two oximeters were comparable. **Methods:** The study population was composed of healthy adult volunteers. Three measurements were taken at six different sites on both sides of the body in a randomized order. Two different sensors were used for each measure. From these measures, two intra-class correlations (ICC) - one inter-sensor and the other intra-sensor - were calculated for each device and compared using the Fisher's r-to-z transformation method. An additional inter-device ICC was also calculated. We considered ICCs over 0.75 as an indicator of good reliability, while ICCs under 0.40 were considered to represent poor reliability. The sample size was calculated

based on the calculation of a unidirectional confidence interval for a parametric ICC. Expecting a 0.75 ICC value, we concluded that 53 participants needed to be recruited in order to attain 80% power and a range of 0.1 towards the low values. **Results:** Fifty-three healthy volunteers (27 men and 26 women) with a mean age of 31 years (standard deviation 10) were recruited. We found no differences between the repeatability of the INVOS and the Equanox for both inter and intra-sensor reliability (ICC = 0.94 (95% confidence interval (CI) 0.86-0.97) versus ICC = 0.92 (95%CI 0.86-0.95),  $p = 0.42$  and ICC = 0.94 (95%CI 0.89-0.96) versus ICC = 0.96 (95%CI 0.93-0.98),  $p = 0.21$ , respectively). However, when compared directly, we found that the readings produced by the two oximeters varied considerably (ICC 0.18 (95%CI -0.10 to 0.43). **Conclusion:** When taken individually, both tissue oximeters displayed good inter and intra-sensor reliability. However, they oximeters displayed poor inter-devices agreement, their readings varying considerably amongst each other.

**Keywords:** reliability, near-infrared spectroscopy, tissue oximetry

#### MP010

##### Wraparound care for youth injured by violence: a randomized control trial

C. Snider, MD, MPH, W. Chernomas, PhD, K. Cook, D. Jiang, PhD, T. Klassen, MD, MSc, S. Logsetty, MD, MSc, J. Mahmood, E. Mordoch, PhD, T. Strome, MSc; University of Manitoba, Winnipeg, MB

**Introduction:** Youth injured by violence is a major public health concern in Canada. It is the fourth leading cause of death in youth and the foremost reason youth visit an emergency department (ED). In Winnipeg, 20% of youth who visit an ED with an injury due to violence will have an ED visit for a subsequent violent injury within one year. Youth injured by violence are in a reflective and receptive state of mind, rendering the ED setting appropriate for intervention. **Methods:** We completed a randomized control trial in November 2015 comparing wraparound care for youth age 14 - 24 who were injured by violence to standard ED care. Youth were excluded if their injury was due to child maltreatment, sexual assault or self-harm. An adapted pre-consent randomization methodology was used. The intervention was developed using a community based participatory research approach. Wraparound care was delivered by a support worker with lived experience with violence. Support workers were on call 24/7 in order to start the intervention in the ED and take advantage of the "teachable moment." Care continued in the community for approximately one year. **Results:** A total of 133 youth were randomized (68 intervention, 65 control) in one year. There was no difference in age, gender, or severity of injury between the two groups. Patients randomized to the intervention spent a median of 30 minutes less in the ED than those receiving standard care ( $p = 0.22$ ). Youth are safely housed, have enrolled in education opportunities, and are engaged in addictions care. Results of a chart review examining repeat visits to the ED for violent injury, substance use and mental health will be completed in Spring 2016 and will be presented. **Conclusion:** There were no differences between standard care and intervention groups on baseline characteristics reflecting effective randomization. The introduction of an intervention at bedside in the ED did not have a negative impact on patient length of stay.

**Keywords:** youth violence, intervention, randomized control trial

#### MP011

##### Using GRADE-based recommendations for analgesia and antiemetics in electronic order sets to influence physician behaviour towards best practice and cost-savings