

a chair. Objectives of this study were to evaluate the feature's impact on total stretcher time (TST) and ED length of stay (LOS) for patients relocated to a chair. We also sought to identify facilitators and barriers to the tool's use amongst ED MDs and RNs. **Methods:** A retrospective cohort design was used to compare TST between those where the tool was used and not used amongst patients relocated to a chair between September 1 2017 and August 15 2018. Each use of the location tool was time-stamped in an administrative database. Median TST and ED LOS were compared between patients where the tool was used and not used using a Mann-Whitney U Test. A cross sectional convenience sample survey was used to determine facilitators and barriers to the tool's use amongst ED staff. Response proportions were used to report Likert scale questions; thematic analysis was used to code themes. **Results:** 194882 patients met inclusion criteria. The tool was used 4301 times, with "Ok for Chairs" selected 3914(2%) times and "Not Ok for Chairs" selected 384(0.2%) times; 54462 (30%) patients were moved to a chair without the tool's use. Mean age, sex, mode of arrival and triage scores were similar between both groups. Median (IQR) TST amongst patients moved to a chair via the prompt was shorter than when the prompt was not used [142.7 (100.5) mins vs 152.3 (112.3) mins, $p < 0.001$], resulting in 37574 mins of saved stretcher time. LOS was similar between both groups ($p = 0.22$). 125 questionnaires were completed by 90 ED nurses and 35 ED MDs. 95% of staff were aware of the tool and 70% agreed/strongly agreed the tool could improve ED flow; however, 38% reported only "sometimes" using the tool. MDs reported the most common barrier was forgetting to use the tool and lack of perceived action in relocating patients. Commonly reported nursing barriers were lack of chair space and increased workload. **Conclusion:** Despite minimal use of the tracking board utility, triggering was associated with reduced TST amongst ED patients eventually relocated to a chair. To encourage increased use, future versions should prompt staff to select a location.

Keywords: electronic health records, overcrowding

P023

The BC Emergency Medicine Network: Evaluation approach and early findings

J. Marsden, MD, S. Drebit, BSc, MBA, MSc, R. Lindstrom, BSc, MSc, PhD, C. MacKinnon, BA, C. Archibald, R. Abu-Laban, MD, MHSc, K. Eggers, K. Ho, MD, A. Khazei, MD, A. Lund, MD, MEd, E. Martin, BA, J. Christenson, MD, BC Emergency Medicine Network, Vancouver, BC

Introduction: September 2017 saw the launch of the British Columbia (BC) Emergency Medicine Network (EM Network), an innovative clinical network established to improve emergency care across the province. The intent of the EM Network is to support the delivery of evidence-informed, patient-centered care in all 108 Emergency Departments and Diagnostic & Treatment Centres in BC. After one year, the Network undertook a formative evaluation to guide its growth. Our objective is to describe the evaluation approach and early findings. **Methods:** The EM Network was evaluated on three levels: member demographics, online engagement and member perceptions of value and progress. For member demographics and online engagement, data were captured from member registration information on the Network's website, Google Analytics and Twitter Analytics. Membership feedback was sought through an online survey using a social network analysis tool, PARTNER (Program to Analyze,

Record, and Track Networks to Enhance Relationships), and semi-structured individual interviews. This framework was developed based on literature recommendations in collaboration with Network members, including patient representatives. **Results:** There are currently 622 EM Network members from an eligible denominator of approximately 1400 physicians (44%). Seventy-three percent of the Emergency Departments and Diagnostic and Treatment Centres in BC currently have Network members, and since launch, the EM Network website has been accessed by 11,154 unique IP addresses. Online discussion forum use is low but growing, and Twitter following is high. There are currently 550 Twitter followers and an average of 27 'mentions' of the Network by Twitter users per month. Member feedback through the survey and individual interviews indicates that the Network is respected and credible, but many remain unaware of its purpose and offerings. **Conclusion:** Our findings underscore that early evaluation is useful to identify development needs, and for the Network this includes increasing awareness and online dialogue. However, our results must be interpreted cautiously in such a young Network, and thus, we intend to re-evaluate regularly. Specific action recommendations from this baseline evaluation include: increasing face-to-face visits of targeted communities; maintaining or accelerating communication strategies to increase engagement; and providing new techniques that encourage member contributions in order to grow and improve content.

Keywords: evaluation, network, quality improvement and patient safety

P024

Obtaining consensus on optimal management and follow-up of patients presenting to the emergency department with early pregnancy complications – a modified Delphi study

A. Cornelis, BSc, MD, R. Clouston, MD, P. Atkinson, MBChB, MA, Dalhousie University, Saint John, NB

Introduction: Complications in early pregnancy are common and have many physical and emotional consequences. Locally, there is no early pregnancy loss clinic or standardized guide in the emergency department (ED) for referral and follow-up decisions, and both initial management of patients and follow up can be inconsistent. This study aimed to obtain consensus on the best approach to initial work-up, management, and follow up for patients who present to the ED with early pregnancy complications, with the goal of using this consensus to produce a standardized guide for emergency provider use. **Methods:** A literature review was completed to produce evidence-based recommendations which were used to initiate a modified Delphi consensus process. A survey was distributed, with three rounds completed. Participants included emergency providers, obstetrician-gynecologists, a radiologist, a sample of family medicine physicians including some involved in primary care obstetrics, and nurse practitioners. An obstetric specialist from outside the local region was also involved. **Results:** Consensus was reached on several key recommendations, however some areas remained without clear accepted best practice. There was consensus that physical components of early pregnancy complications are addressed well, but that we could improve on patient flow and more consistent follow up. Important investigations to be done for patients were identified. The timing of formal ultrasound, necessity and timing of obstetrician consultation, and safety of discharge was addressed for various patient scenarios including stable and unstable patients, with and without adnexal pain, with