Conclusions 95% of people found that they were more confident, and understood the importance of patient flow following the game. Common themes learnt from the game include the importance of team work, understanding the bigger picture and understanding the pressures in other parts of the hospital. Specific quotes include ‘would like to have played for longer’, ‘this game should be made available for the public, as it might help reduce ED attendances’, ‘great way of demonstrating the importance of team work’. This early testing of the game has shown how Bed Block can educate around patient flow. Further work is needed to explore the other educational opportunities from this work and if it impacts clinical practice.

Abstract 031 Figure 3

Abstract 032 Figure 1

CFS completion runchart
Through monthly PDSA cycles, our frailty QI team introduced interventions including: info-posters disseminated through email, handover sessions, ‘Champions’ on the shop-floor, targeted educational sessions and leaflets. We utilised rapid-cycle audit information and staff perceptions survey to measure improvements and focus initiatives.

In the last 6 weeks, we looked for sustainability of improvements.

CFS documentation improved and remained accurate, which was sustained. Discussions with patients and families, and ‘thought’ given to offer holistic, individualised care both showed improvement, though this was not definitely

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**Abstract 032 Figure 2**  
EOLC runchart

**Abstract 032 Figure 3**  
Individualised care runchart
sustained. EOLC discussions did not show any definite improvement.

Frailty is a clinically important entity that is recognisable and accurately measurable by emergency physicians. If appropriately used, the CFS can help guide clinical care plans for patients.

Simple interventions in a local ED setting were able to improve documentation and utilisation of the CFS to provide patient-centred care for older patients.

Changing to a culture more open to EOLC discussions in the emergency setting was noted to be difficult both from our staff survey and audit data. This will need a more focused approach to improve departmental culture to have, and staff comfort to start an EOLC conversation.

We will continue to advocate for use of CFS, and for better care for all our older patients.

033 DIAGNOSTIC INVESTIGATION AND PREDICTION OF SHOCK (DIPS), IN THE EMERGENCY DEPARTMENT: A PROSPECTIVE OBSERVATIONAL STUDY

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Background Currently there exists no widely accepted, objective tool for determining the probability of shock in the emergency department (ED). Associated mortality outcomes remain unacceptably high. Using variables that are associated with shock and available in the ED we aimed to derive an objective tool for estimating the probability of shock.

Methods In a prospective, longitudinal study conducted in the ED, Cardiff, adult patients aged ≥18 years, presenting with NEWS ≥3 were recruited. We derived a model consisting of 8 variables, and validated it using bootstrap (1000 iterations; random number seed: 978). The primary outcome was combined 30-day mortality or ICU admission.

Results 361 patients were recruited (mean age 69.4 ±15.9 years; male 62.7%; 80 positive outcome) to the study. The multivariate model variables were: Glasgow Coma Scale 3–8 (Odds ratio (OR) 9.1 (95% CI 1.2–69.4) p=0.0324), 9–12 (OR 1.3 (95% CI 0.4–4.2) p=0.6561); capillary return >4 (OR 8.7, (95% CI 2.9–26.1) p=0.0001), 3–4 (OR 3.7 (95% CI 1.3–10.4); p=0.0113); temperature ≤35°C (OR 5.4, (95% CI 1.8–16.3); p=0.0045); bilirubin >34 (OR 4.9, (95% CI 1.6–14.5); p=0.0045); oxygen supplement (OR 1.9, (95% CI 1.0–3.7); p=0.06); respiratory rate >24 (OR 2.6, (95% CI 1.3–5.1); p=0.0069); and albumin <35 (OR 1.9, (95% CI 0.9–3.8); p=0.09).

The model was a 100-point scale where 0 was low probability and 100 was maximal probability of shock. The AUC was 0.801 (95% CI 0.756–0.841), accuracy 82%, p<0.0001, Hosmer & Lemeshow test 9.19 (p=0.326). At a cut off ≥35, and Youden Index 0.4557 the sensitivity and specificity were 56.2% (95% CI 44.7–67.3) and 89.3% (95% CI 85.1–92.7) respectively. At a fixed specificity of 80%, the estimated sensitivity was 60.5% (95% CI 49.4–71.3). At a fixed sensitivity of 80%, the estimated specificity was 62.3% (95% CI 45.9–71.2).

Conclusions An accurate 7-point ED tool for shock has been derived and internally validated.

034 EARLY CARDIOVASCULAR DYSFUNCTION DRIVES IN-HOSPITAL TRAUMA MORTALITY

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Background Improvements in trauma resuscitation practice have reduced the early in-hospital mortality from haemorrhage and its immediate sequelae. Early cardiovascular dysfunction (CVD) is a poorly understood and under-recognised major contributor to contemporary trauma deaths. The objective of this study was to demonstrate the prevalence and impact of CVD in a population of trauma patients without catastrophic TBI.

A review of data collected prospectively at a UK Major Trauma Centre from 2008–2018. Adult trauma patients over the age of 15 were included. CVD was defined as a score of 4 on admission or day 1 of admission using the cardiovascular component of the SOFA score.