Code Red practice has improved since our last audit. There are still improvements to be made in TXA administration and time to blood products.

043 SHOULD ADULTS WITH MILD HEAD INJURY TAKING DIRECT ORAL ANTICOAGULANTS UNDERGO CT SCANNING? A SYSTEMATIC REVIEW

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Background Patients taking direct oral anticoagulant medications (DOACs) commonly undergo computed tomography (CT) head scanning following mild head injury, regardless of symptoms or signs. International guidelines have noted a lack of evidence to support management decisions in such patients.

Methods A systematic review, pre-registered (CRD42017071411) and following Cochrane Collaboration recommendations, was performed. Studies of adults with mild head injury (GCS 13–15) taking DOACs, which reported the risk of adverse outcome following the head injury, were eligible for inclusion. A comprehensive range of bibliographic databases and grey literature were examined using a sensitive search strategy. Selection of eligible studies, data extraction, and risk of bias was evaluated independently by separate reviewers. A random effects meta-analysis was used to provide a pooled estimate of the risk of adverse outcome. The overall quality of evidence was assessed using the Grades of Recommendation, Assessment, Development and Evaluation Working Group approach.

Results 4,185 articles were screened for inclusion, of which 7 cohort studies, including 346 patients, met inclusion criteria. All studies were at high or unclear risk of bias secondary to selection and information bias. Estimates of adverse outcome (any death, intracranial hematoma (ICH), or neurosurgery) ranged from 0% to 8%. A random effects meta-analysis showed a weighted composite outcome risk of 4% (95% CI 2–6%, I^2=3%). The overall quality of the body of evidence was low secondary to imprecision, indirectness and risk of bias.

Conclusions There is limited data available to characterize the risk of adverse outcome in patients taking DOACs following mild head injury. A sufficiently powered prospective cohort study is required to validly define this risk, identify clinical features predictive of adverse outcome, and inform future head injury guidelines.

044 STEMMING THE FLOW

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Standardising the practice of epistaxis care in an emergency department to improve patient outcomes.

Having a regional ENT centre on site we see a disproportionate number of epistaxis patients with over 500 cases a year.

All atraumatic haemodynamically stable epistaxis patients who had active ongoing bleeding in the department were included.

Developing a standard operating procedure based around the standard treatment arm of the NoPac study we focused on the step by step management of epistaxis to measure if this improves patient outcomes.

A tailored education package for the protocol was used in the department with posters, emails and information during handover to all staff in the department.

It follows a step by step method, starting with nasal pegs in triage, clot removal, cautery and adrenaline soaked rolls, depending on the persistence of the bleeding, eventually discharge or referral.

I Analysed TRAK data for all 'Epistaxis' diagnoses prospectively for 2 months pre and post intervention.

Any patient with a documented 'active' bleeding that was not haemodynamically unstable or a traumatic injury for the following outcomes;

Primary outcome was rate of Admission to ENT.

Secondary outcomes were, time in department and reattendance within 2 weeks.

A total of 34 patients were studied, 17 before and after the intervention.

Primary outcome of ENT admissions – Down from 41% to 11%.

Secondary outcomes of time in department - reduced by 39 minutes to 2h36 from 3h03.

And re-attendance rate remains the same at 24%

	Before the protocol was introduced	*After the protocol was introduced*
Referral to ENT rate	41%	11%
Re-attendance (in 2 weeks)	24%	24%
Average time in department	3:03	2:36

Abstract 044 Figure 1

In conclusion we have seen a significant drop in ENT admissions alongside a decreased time in department without increasing re-attenders. Having a standardised plan for all epistaxis patients to receive early intervention with a clear protocol for the medical staff has improved patient safety and outcomes. These projects further benefit our department by keeping up with active research projects.

045 WE'RE GOING TO NEED A BIGGER BOAT! EVENING OPENING OF MOTHBALLED OUTPATIENT AREAS TO REDUCE CROWDING IN A CHILDREN'S EMERGENCY DEPARTMENT

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10.1136/emermed-2019-RCEM.45

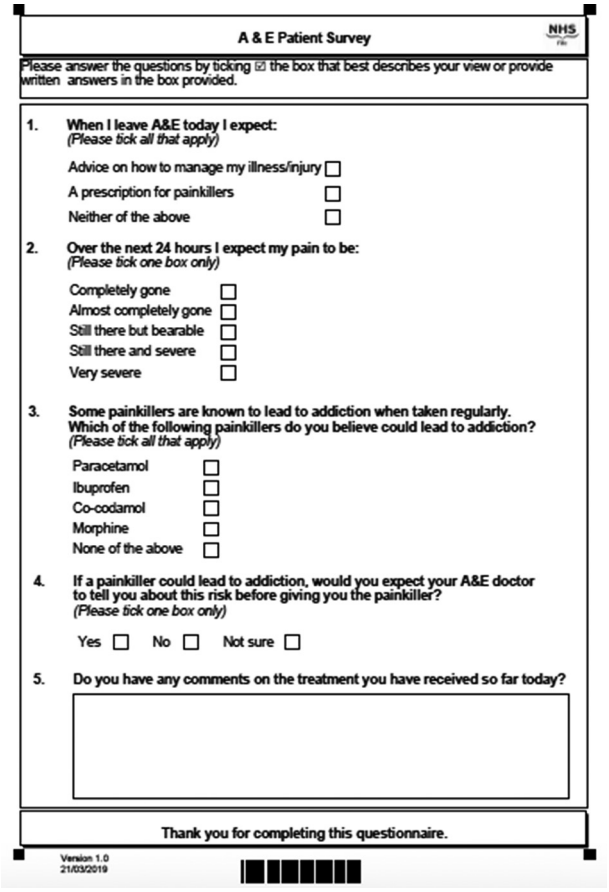
Background EDs are increasingly crowded, with negative impact on care quality. This is multifactorial, but tends to peak during evenings. On mapping our contributing constraints, staffing was adequate, but available ED space was a major factor. We identified evening opening of mothballed

clinical areas as a potential strategy, of which one was our outpatient department (OPD); housed one minute away on the same floor this closes at 1700. Through the 2018/19 winter this opened between 1800–2330; we evaluated impact on service provision and staff morale.

Method and results Continuous PDSA cycles were initiated; a living standard operational policy evolved based on staff/patient feedback. Flow and patient acuity markers were monitored using electronic tracking systems. Staff were surveyed to explore opinions and impact on morale.

Conclusions During November 2018–April 2019 the OPD opened on 76 days (50%), with 1082 patients seen. Opening was more frequent during November-February; during peak activity >10% all daily attendances were seen in this stream. Mean time to see clinicians was 77 minutes and mean time to discharge was 133 minutes; both compared favourably with patients remaining in ED. This partly reflects lower patient acuity, but other crowding measures including total patients in department, and total patient minutes, also improved. The most common diagnoses were soft tissue injury, fracture, head injury, and URTI. No safety incidents occurred and <1% left without being seen. Staff feedback reflected increased morale, and lower stress and noise levels during peak activity.

Novel use of mothballed clinical areas during peak ED activity is an attractive option for families and staff, and appears to improve safety and effectiveness. Use of existing staff was cost effective, with total additional cost pressures for nurses (£20K) and support staff (£500), in comparison to projected costs of £100K for one embedded evening GP over the same period.



A & E Patient Survey

NHS

Please answer the questions by ticking ☑ the box that best describes your view or provide written answers in the box provided.

1. When I leave A&E today I expect:
(Please tick all that apply)
- Advice on how to manage my illness/injury ☐
- A prescription for painkillers ☐
- Neither of the above ☐

2. Over the next 24 hours I expect my pain to be:
(Please tick one box only)
- Completely gone ☐
- Almost completely gone ☐
- Still there but bearable ☐
- Still there and severe ☐
- Very severe ☐

3. Some painkillers are known to lead to addiction when taken regularly. Which of the following painkillers do you believe could lead to addiction?
(Please tick all that apply)
- Paracetamol ☐
- Ibuprofen ☐
- Co-codamol ☐
- Morphine ☐
- None of the above ☐

4. If a painkiller could lead to addiction, would you expect your A&E doctor to tell you about this risk before giving you the painkiller?
(Please tick one box only)
Yes ☐ No ☐ Not sure ☐

5. Do you have any comments on the treatment you have received so far today?

Thank you for completing this questionnaire.

Version 1.0
21/03/2019

Abstract 046 Figure 1

046 WHOSE PAIN ARE WE TREATING? A STUDY COMPARING ED PATIENTS' EXPECTATIONS OF ANALGESIA WITH ED DOCTORS' PRECONCEPTIONS

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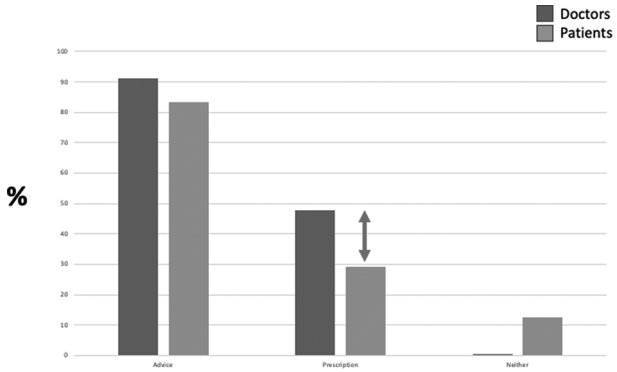
10.1136/emermed-2019-RCEM.46

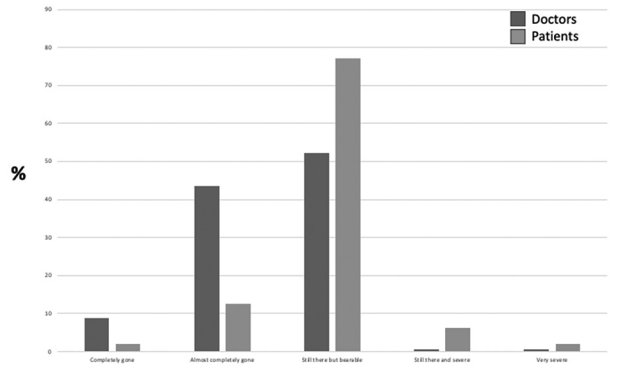
An audit at a Scottish DGH found that large numbers of Emergency Department (ED) patients were being sent home with 'To Take Out' (TTO) boxes of Co-Codamol (30/500 mg) – a concerning finding given rising rates of prescription opioid addiction in the UK. Informal conversations suggested that many clinicians were prescribing high-dose codeine because 'patients expect to be given something they can't buy over the counter'. A survey-based study was therefore designed to explore this assumption.

A short survey (figure 1) was developed to explore ED patients' expectations of analgesia and knowledge of common painkillers. In the first stage of the study, the survey was circulated among 25 ED prescribers who were asked how they thought 'most patients' with mild to moderate pain would answer these questions. In the second stage, 50 ED patients with mild to moderate pain were asked to complete the survey. Prescribers' and patients' answers were then compared.

There was a significant difference between how prescribers thought 'most patients' would answer and how most patients actually answered the questions. Fewer patients expected to be sent home with painkillers than the



Abstract 046 Figure 2



Abstract 046 Figure 3