

**Results and Conclusion** The review to date has identified 20 studies for inclusion. Data show emergency service use among migrants were comparable to non-migrants. Migrant emergency service attendees were less likely to be registered with a general practitioner than non-migrant patients, suggesting migrants may face additional barriers to accessing primary care services. Migrants were also more likely to report self-referral to emergency services rather than referral through primary care services.

These findings raise concerns about health inequities amongst migrant populations who self-refer to emergency care (bypassing preventative care and potentially at a late stage of illness) and the implications that use of emergency services for primary care needs may have for health systems. Considering increasingly restrictive health systems for migrants, the findings highlight that it is imperative to facilitate access to effective primary care for migrant populations, to reduce the risk of poorer and more costly health outcomes and the burden on emergency services.

### 2168 ARE ACUTE CARE CLINICIANS DELIVERING OPTIMAL END OF LIFE CARE AND RECOGNISING THE DYING PATIENT?

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**Aims and Objectives** Suboptimal end of life care is being increasingly recognised in hospital and a change in attitude or education may provide a significant improvement. The purpose of this study was to outline if there was a discrepancy in patient care in the acute medical unit and discuss the need for improvement. All clinicians should be able to “identify adults approaching the end of life” and “should have skills to provide care for adults approaching the end of their life” as per NICE guidelines. This study focused on the delivery of EoL care in the emergency and acute medical services and assessed whether this met NICE standards.

**Method and Design** Data collected over a 1-month period of patients who died less than 24 hours of admission in A&E or AMU at Royal Blackburn Hospital. We reviewed documentation and decided whether recognition of dying was made during doctors’ assessments, when the dying process was recognised, whether symptom-focused management medications were prescribed and recorded if referral to palliative care was considered.

**Results and Conclusion** 44 patients met selection criteria. 10/44 patients had recognition of possible active dying on admission. 32/44 had anticipatory medications prescribed. 6/44 were considered for referral to palliative care. 36/44 remained on active treatment prior to death.

This study suggests that there is a slowness in the recognition of the dying patient and prioritising patient-focused symptom management. Recognition of dying is an essential first step in improving care for dying patients, perhaps a criterion score would be helpful in practice such as the “traffic lights” model or the “palliative performance score.” Education with the palliative care specialists would likely benefit departments. There was a predominant theme of patients being actively managed up until the point of dying, is there a

cultural reasoning behind acute physicians leaning towards active treatment and not accepting dying as an outcome?

### 2296 PREDICTING RECOVERY IN PATIENTS WITH MILD TRAUMATIC BRAIN INJURY AND A NORMAL CT USING DIFFUSION TENSOR IMAGING

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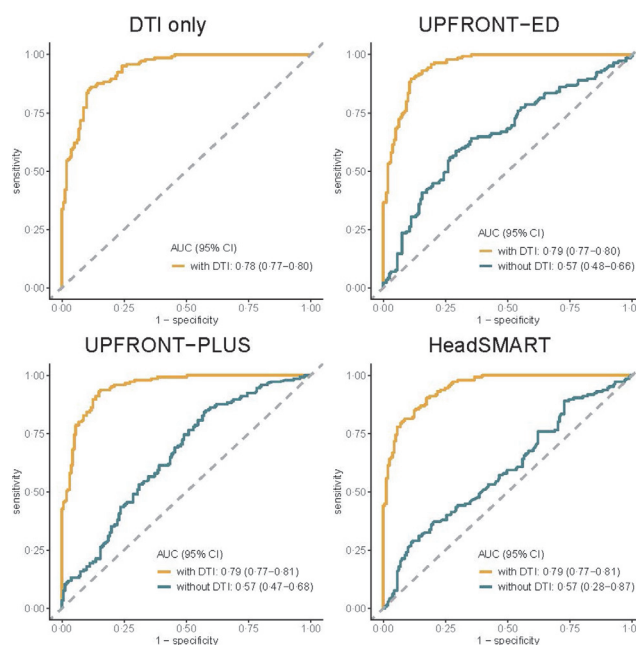
**Aims and Objectives** UK emergency departments conduct 200,000 CTs for mild traumatic brain injury (TBI) annually.

Whilst >90% of CTs are normal, 30-50% of patients report long-term functional deficits. This study aims to assess if advanced MRI (diffusion tensor imaging, DTI) improves existing models for the prediction of 3-month functional recovery in patients with mild TBI and a normal CT.

**Method and Design** This formal prognostic study followed the TRIPOD statement and used data from the prospective multi-center CENTER-TBI study. Patients aged  $\geq 16$  years were included if they had a Glasgow Coma Scale score >12, a normal CT, and DTI within 31 days of injury. Complete recovery at 3 months was defined as an extended Glasgow Outcome Scale score of 8.

DTI data was harmonized and age-corrected using matched healthy controls (n = 157). The current best prognostic models for an incomplete recovery (UPFRONT-PLUS, UPFRONT-ED and HeadSMART) were fitted with and without DTI information and internally validated using bootstrapping.

Where available (n = 107), we assessed if serum neurofilament light (NFL) can select patients for DTI.



Abstract 2296 Figure 1