

the rise of Free Open Access Medical Education (FOAM). Although nearly all residents use FOAM resources, some criticize the lack of universal quality assurance. This problem is a particular risk for trainees who have many time constraints and incompletely developed critical appraisal skills. One potential safeguard is journal club, which is used by virtually all EM residency programs in North America to review new literature. However, EM resident perspectives have not been studied. Our research objective was to describe how residents perceive journal club to influence how they translate the medical literature into their clinical practice. Our research question was whether FOAM has influenced residents' goals and perceived value of journal club. **Methods:** We developed a semi-structured interview script in conjunction with a methods expert and refined it via pilot testing. Following constructivist grounded theory, and using both purposive and theoretical sampling, we conducted a focus group (n = 7) and 18 individual interviews with EM residents at the 4 training sites of the University of British Columbia. In total, we analyzed 920 minutes of recorded audio. Two authors independently coded each transcript, with discrepancies reconciled by discussion and consensus. Constant comparative analysis was performed. We conducted return of findings through public presentations. **Results:** We found evidence that journal club works as a community of practice with a progression of roles from junior to senior residents. Participants described journal club as a safe venue to compare practice patterns and to gain insight into the practical wisdom of their peers and mentors. The social and academic activities present at journal club interacted positively to foster this environment. In asking residents about ways that journal club accelerates knowledge translation, we actually found that residents cite journal club as a quality check to prevent premature adoption of new research findings. Residents are hesitant to adopt new literature into their practice without positive validation, which can occur during journal club. **Conclusion:** Journal club functions as a community of practice that is valued by residents. Journal club is a primary way that new evidence can be validated before being put into practice, and may act as quality assurance in the era of FOAM.

Keywords: free open access medical education, graduate medical education, qualitative research

P019

What happens to John Doe? Unidentified patients in the emergency department: a retrospective chart review

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Introduction: Patients who are not identified upon presentation to the emergency department (ED), commonly referred to as John or Jane Does (JDs), are a vulnerable population due to the sequelae associated with this lack of patient information. To date, there has been minimal research describing JDs. We aimed to characterize the JD population and determine if it differs significantly from the general ED population. **Methods:** We conducted a retrospective chart review of 114 JDs admitted to Saskatoon EDs from May 2018 to April 2019. Patients met inclusion criteria if they were provided a unique JD identification number at ED admission because their identities were unknown or unverifiable. Data regarding demographics, clinical presentation, ED course, mode of identification, and major clinical outcomes (i.e. admission rates, mortality rates) were gathered from electronic records. A second reviewer abstracted a random 21.0%

sample of charts to ensure validity of the data. The JD population was then compared to the general population of ED patients that presented during the same time period. **Results:** Male JDs most commonly presented as trauma activations (85.7%) in contrast to female JDs who most commonly presented with issues related to substance abuse (51.4%). Compared to the general ED population, a greater percentage of JDs were categorized as CTAS 1 or 2 (85.8% vs 18.9%, $p < 0.0001$), more likely to be 44 years of age or younger (82.4% vs 58.5%, $p < 0.0001$), and more likely to be male (64.9% vs 49.1%, $p < 0.0001$). Descriptive statistics on the JD population demonstrated that most JDs received consults to inpatient services (58.8%). Of JDs who presented to the ED, 34.2% were admitted to hospital. The mortality of the JD population was 13.2% at 3 months. The ED average (SD) length of stay for JDs was 8.7 (9.0) hours. How JDs were ultimately identified was recorded only 70.2% of the time. Most frequently, JDs identified themselves (26.3%), other identification methods included police services (14.9%), family members (7.9%), registered nurses (6.1%), government-issued identification (5.3%), social work (4.4%) or other measures (5.4%). **Conclusion:** JDs represent a unique population in the ED. Both their presentations and clinical outcomes differ significantly from the generalized ED population. More research is needed to better identify strategies to improve the management and identification methods of these unique patients.

Keywords: emergency department, John Doe, unidentified patient

P020

Development and early experience with the Foothills Medical Center Pulmonary Embolism Response Team (PERT)

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Background: Pulmonary embolism (PE) is a common illness with significant mortality without appropriate treatment. Its disease severity is variable, difficult to prognosticate and triage of severe PE remains a patient safety concern. Some PE may benefit from invasive and advanced medical therapy, but these decisions require complex multi-disciplinary coordinated care. We have launched a multi-disciplinary rapid response team at the Foothills Medical Center Hospital (FMC) to assist prognostication, treatment, disposition planning, and followup for high-risk PE: The Pulmonary Embolism Response Team (PERT). **Aim Statement:** PERT has been implemented to improve patient-oriented outcomes however, as severe PE is infrequent, we initially target process measures. In the first year of PERT rollout, we aim for: 1) 100% of high risk PE be detected by emergency for PERT consult 2) PERT response be within 45 minutes of activation 3) PERT treatment and disposition be made within 1 hour of consult. 4) > 80% of patient dispositions match those informed by evidence-based risk stratification tools. **Measures & Design:** Through collaboration between emergency medicine, radiology, cardiac sciences, medical specialties and critical care, a collective evidence-based PE risk stratification/treatment pathway was developed. This has been disseminated to providers and embedding into electronic medical records (EMR) for computer assisted decision-making support. EMR data has been harmonized with standardized radiographic reporting for PE to cue reporting of high risk imaging findings. Standardized imaging and EMR prognostic factors flag high risk PE suggesting PERT activation. PERT standard operating