

were employed. **Results:** Sixteen (16) staff members participated in interviews and 40 participated in small focus group discussions. Data analysis revealed workplace violence and personal health risks have been normalized as expected, acceptable features of everyday life at work in the ED given that patients are perceived to be sick people in need of help that ED staff are trained for and prepared to provide. In contrast, weapons and active shooters challenge the boundaries of professional responsibility and readiness to respond to Code Silver is perceived by staff as a fallacy. **Conclusion:** Knowledge from this study gives us crucial insight into important areas for targeted training and opportunities for knowledge translation on the topic of implementing Code Silver in EDs across the country. Future interventions must include how to overcome normalization of workplace violence in the ED setting and negotiating competing professional obligations during crisis situations. Attention to these are crucial if we are to truly keep our staff safe during these traumatic events.

Keywords: workplace violence, code silver, qualitative research

P026

Opioid use and dependence three months after an emergency department visit for acute pain

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Introduction: Most studies evaluating prescription opioid dependence or misuse are retrospective and are based on prescription filling rates from pharmaceutical databases. These studies cannot evaluate if opioids are really consumed nor differentiate if used for a new pain, chronic pain, or for misuse/dependence. The aim of this study was to assess the opioid consumption in emergency department (ED) patients three months after discharge with an opioid prescription. **Methods:** This prospective cohort study was conducted in the ED of a tertiary care centre with a convenience sample of patients aged 18 years and older, recruited 24/7, who consulted and were discharged for an acute pain condition (2 weeks). We excluded patients who: did not speak French or English, were using opioid medication prior to their ED visit, with an ED stay >48 hours, or suffering from cancer or chronic pain. Three months post-ED visit, participants were contacted by phone for a structured interview on their past two-week opioid use, their reasons for consuming them, and also answered the Rapid Opioid Dependence Screen (RODS) questionnaire. **Results:** In the 524 participants interviewed at three months (mean age \pm SD: 51 \pm 16 years, 47% women), 44 (8.4%) patients consumed opioids in the previous two weeks. Among those, 72% consumed opioids for their initial pain, 19% for a new unrelated pain, and 9% for another reason. In this entire cohort, only five patients (1%) tested positive to opioid dependence from the RODS test. The low dependence incidence could be affected by a social desirability bias. **Conclusion:** This study suggests that opioid use at 3-month, for patients initially treated for acute pain, is associated with opioid dependency in 1% or possible misuse in only 9%. Additional prospective studies using multiple methods to measure opioids consumption, misuse, and dependence are needed.

Keywords: opioids, dependence, misuse

P027

A descriptive needs-based assessment of paramedic continuing education

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Introduction: Objective: To identify self-perceived knowledge deficits of paramedics, barriers to training and desired methods of self-directed continuing education. **Methods:** A written 58 question survey was delivered to all 1262 paramedics under the jurisdiction of a single base-hospital in Ontario, Canada. Respondents were asked to select deficit, no deficit or not applicable from a 37-point, anatomic systems-based list. They were then asked to identify from a 15-point list which educational modalities they would choose to address any knowledge deficits. Finally, they were asked which factors they took into consideration when choosing their self-directed continuing education. **Results:** Seven hundred forty-six of 1262 paramedics (59.11%) completed the surveys. Of these respondents, 82 (10.99%) were advanced care paramedics, while 664 (89.01%) were primary care paramedics. Of the 645 who responded with their primary geographical setting: 136 (21.09%) listed a primary urban practice, 126 (19.53%) listed a primary rural practice and 287 (44.50%) reported a split urban and rural practice. The most common perceived deficits (respondent number, percentage); were electrolyte disturbance (418, 56.03%), neonatal resuscitation (386, 51.74%), pediatric respiratory disorder (381, 51.07%), arrhythmia (377, 50.53%), and pediatric cardiac arrest (317, 42.49%). The top 5 educational opportunities they were most likely to choose included online module (464, 62.20%), in-class lecture (423, 56.70%), web-based review (403, 54.02%), webinar (301, 40.35%) and peer consult (237, 31.77%). The top 3 barriers to choosing continuing education were work scheduling (479, 64.21%), location/ease of attending (382, 51.21%), and cost (305, 40.88%). **Conclusion:** Paramedics in this base hospital system identified pediatric critical care situations, electrolyte abnormalities and cardiac arrhythmia as self-perceived deficits. The most commonly selected educational opportunities included online learning, in-person training and peer consult. These preferred modalities are consistent with the identified barriers of work scheduling, ease of attending and cost. Targeted educational needs based assessments can help ensure that appropriate topics are delivered in a fashion that help overcome identified barriers to self-directed learning.

Keywords: paramedic, prehospital, education

P028

Self-directed learning in advanced care paramedics: perceived deficits and completed activities

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Introduction: In Ontario, Advanced Care Paramedics (ACPs) are required to perform a minimum of 24 educational credits per year of Continuing Medical Education (CME). Of these 24 credits, 12 are chosen by the paramedic, while 12 credits are mandated by the Base Hospital. The combined mandatory and optional CME frame is used so paramedics can target their personal needs appropriately, while ensuring new medical directives and global knowledge deficits identified by Quality Assurance (QA) means can be addressed by the Base Hospital. **Objective:** To determine if there is a difference between what ACPs identify as their knowledge deficits and what CME they complete. **Methods:** Methods: Request for participation in a written survey was delivered to all ACPs in an Ontario Base Hospital, prior to the CME cycle for the year. Respondents were asked to identify deficits from a 37-point, organ systems-based list, with free-text option for any deficits not itemized. Following the annual cycle, CME credits were evaluated by the Regional Base Hospital education coordinator, and Base Hospital medical directors for content. The deficits identified prior to the CME cycle were then compared to the CME attended for each respondent. In