with TXA administration. **Conclusion**: The results from this study demonstrate that only 13% of delayed PPH patients presenting to the ED received TXA, and among those treated, 66% received TXA within 3 hours of presentation. The use of TXA was correlated with variables associated with an increased risk of morbidity. Given the rarity of delayed PPH presentation to the ED, the development of a treatment algorithm is recommended to ensure higher levels of timely TXA administration.

Keywords: postpartum hemorrhage, tranexamic acid

P006

Management of first trimester bleeding in the emergency department

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Introduction: Bleeding in the first trimester of pregnancy is a common presentation to the Emergency Department (ED) with half going on to miscarry. Currently there is no local consensus on key quality markers of care for such cases. Point of Care Ultrasound (PoCUS) is increasingly utilized in the ED to detect life threating pathology such as an ectopic pregnancy or fetal viability. PoCUS leads to improved patient satisfaction, quicker diagnosis and treatment. The purpose for this study was to examine the rates of formal ultrasound and PoCUS when compared to reported and recommended rates, and also to understand the use of other diagnostic tests. **Methods**: A retrospective cohort study of pregnant females presenting to the ED with first trimester bleeding over one year (June 2016 – June2017) was completed. A sample size of 108 patients was required to detect a moderate departure from baseline reported rates (67.8 – 77.6%). The primary outcome was the PoCUS rate in the ED. The main secondary outcome was the formal ultrasound rate. The literature recommends PoCUS in all early pregnancy bleeding in the ED, with a target of 100% of patients receiving PoCUS. Additional data recorded included the live birth rate, pelvic and speculum examination rate and lab tests. There is no clearly defined ideal practice for the additional data so these rates will be recorded without comparison. **Results**: Records of 168 patients were screened for inclusion. 65 cases were excluded because they were not pregnant or had confirmed miscarriage or other, leaving a total of 103 patients included in the analysis. The PoCUS rate was 51.5% (95% CI 42%-61%), lower than previously reported PoCUS rates of 73% (67.8 – 77.6%). The formal ultrasound rate was 67% (57%-75%). Both approaches were significantly lower than the recommended rate of 100% (95.7 – 100%). Rates for other key markers of care will also be presented. **Conclusion**: Fewer PoCUS exams were performed at our centre compared with reported and recommended rates for ultrasound. Further results will explore our current practice in the management of first trimester pregnancy complications. We plan to use this information to suggest improvements in the management of this patient population.

Keywords: first trimester bleeding, point of care ultrasound, pregnancy

P007

Development of provincial recommendations for domestic violence screening in emergency departments and urgent care settings in Alberta

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Introduction: Alberta has one of the highest rates of domestic violence (DV) in the country. Emergency departments (EDs) and urgent care centres (UCCs) are significant points of opportunity to screen for DV and intervene. In Alberta, the Calgary Zone began a universal education and direct inquiry program for DV in EDs and UCCs for patients > = 14 years in 2003. The Calgary model is unique in that (a) it provides universal education in addition to screening and (b) screening is truly universal as it includes all age groups and genders. While considering expanding this model provincially, we engaged in the GRADE Adolopment process, to achieve multi-stakeholder consensus on a provincial approach to DV screening, as herewith described. **Methods**: Using GRADE, we synthesized and rated the quality of evidence on DV screening and presented it to an expert panel of stakeholders from the community, EDs, and Alberta Health Services. There was moderate certainty evidence that screening improved DV identification in antenatal clinics, maternal health services and EDs. There was no evidence of harm and low certainty evidence of improvement in patient-important outcomes. As per Adolopment, the expert panel reviewed the evidence in the context of: a) values and preferences b) benefits and harms, and c) acceptability, feasibility, and resource implications. **Results**: The panel came to a unanimous decision to conditionally recommend universal screening, i.e., screening all adults above 14 years of age in EDs and UCCs. By conditional, the panel noted that EDs and UCCs must have support resources in place for patients who screen positive to realize the full benefit of screening and avoid harm. The panel deemed universal screening to be a logistically easier recommendation, compared to training healthcare professionals to screen certain subpopulations or assess for specific symptoms associated with DV. The panel noted that despite absence of evidence that screening would impact patient-important outcomes, there was evidence that effective interventions following a positive screen could positively impact these outcomes. The panel stressed the importance of evidence creation in the context of absence of evidence. **Conclusion**: A GRADE Adolopment process achieved consensus on provincial expansion of an ED-based DV screening program. Moving forward, we plan to gather evidence on patient-important outcomes and understudied subpopulations (i.e. men and the elderly).

Keywords: domestic violence, GRADE adolopment, screening

P008

Evaluation of outcomes after implementation of a provincial prehospital bypass standard for trauma patients – an Eastern Ontario experience

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Introduction: Trauma and injury play a significant role in the population's burden of disease. Limited research exists evaluating the role of trauma bypass protocols. The objective of this study was to assess the impact and effectiveness of a newly introduced prehospital field trauma triage (FTT) standard, allowing paramedics to bypass a closer hospital and directly transport to a trauma centre (TC) provided transport times were within 30 minutes. **Methods**: We conducted a 12-month multi-centred health record review of paramedic call reports and emergency department health records following the implementation of the 4 step FTT standard (step 1: vital signs and level of consciousness, step 2: anatomical injury, step 3: mechanism

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