Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

first anti-emetic used, route of administration (IV, PO, or IM), and need for subsequent dosing of an antiemetic up to 3 doses was recorded.

Results: Charts reviewed totaled 3340; first line medications were: 1,802 (59.99%) patients received ondansetron, 609 (20.27%) received prochlorperazine, 502 (61.71%) received metoclopramide, 91 (3.03%) patients received haloperidol and 0 received promethazine. 78% of the ondansetron group, 96% of the prochlorperazine group, 81.6% of the metoclopramide group, and 53% of the haloperidol group did not need a second dose of anti-emetics. Of the percentage of patients who required a second dose; if ondansetron was given, 78% of patients did not need a third dose of anti-emetics, if prochlorperazine was administered, it was 93%, metoclopramide 69%, and haloperidol 89%.

Conclusion: Ondansetron was not superior to prochlorperazine for first-line use for N&V. Patients receiving prochlorperazine and not ondansetron, were least likely to need a second dose of antiemetics. Ondansetron was not superior to haloperidol as a second line antiemetic. Patients receiving haloperidol as a second antiemetic were least likely to need a third dose of antiemetics. Further studies should adjudicate the need for repeat antiemetic dosing when the antiemetic chosen is matched to the apparent cause and mechanism of N&V.

213 Evaluation of a Multidisciplinary Electronic Discharge Medication Prescribing Process in an Academic Center's Emergency Department

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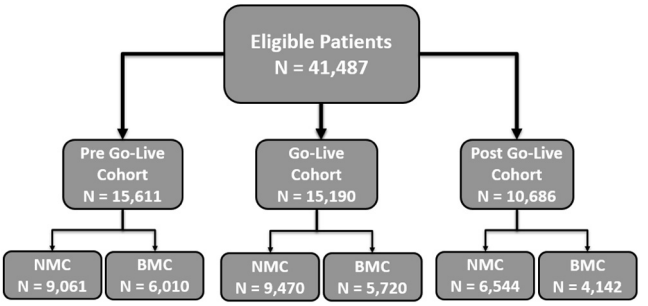
Study Objectives: There has been a consistent increase in emergency department (ED) visits since 2017.Research has shown that medication-related errors have been implicated in nearly 1% of ED discharge prescriptions. With a growing concern for providing safe and effective care during patient transitions, pharmacist involvement in the discharge processes can lead to improvements in quality of care and decreased healthcare costs. Because of this, a collaborative multidisciplinary effort in the ED led to the initiation of a novel e-prescribing process in November of 2019. The objective of this study was to determine the impact a collaborative multidisciplinary effort would have on whether or not a novel e-prescribing process increased ED patient length-of-stay.

Methods: This quasi-experimental retrospective cohort across two medical centers (Nebraska Medical Center (NMC) and Bellevue Medical Center (BMC)) involved patients discharged using a novel multidisciplinary-driven initiative using an e-prescribing process from the ED. The cohort was divided into three trial arms: Pre Go-Live (August – October 2019), Go-Live (December – February 2020), and Post Go-Live (August – October 2020). Two weeks worth of patients in the Post Go-Live arm were excluded due to a prolonged EP IC downtime. This study evaluated whether or not a novel e-prescribing process increased ED patient length-of-stay (LOS). Outcomes such as time to verify prescription, time from disposition to discharge (DTD), time from ready to go to discharge, ED pharmacies outreach call, and number of pharmacy/patient call-backs were also assessed.

Results: Among the 41,487 eligible patients, the average median LOS and DTD at NMC was 216 minutes and 20 minutes, while and BMC was 152 minutes and 19 minutes. A statistically significant difference in median LOS and DTD occurred at the NMC ($p < 0.001$ and $p = 0.002$, respectively), but not at the BMC ($p = 0.07$ and $p = 0.2$). The main difference for NMC occurred between the Pre Go-Live arm and Post Go-Live arm & Go-Live arm and Post Go-Live arm, while Pre Go-Live arm & Go-Live arms were not significantly different. Across both locations, no difference was seen in time to discharge pharmacy order verification or ready to-go to discharge. Phone calls post discharge from patients remained unchanged, while phone calls post discharge from outpatient pharmacies decreased by 38.8% (from 49 to 30 calls).

Conclusions: Following implementation of a novel ED discharge e-prescribing process, there was a statistically significant difference in patient LOS and DTD at NMC. However, no significant change was observed at BMC The difference seen is likely due to the trial being over-powered - the magnitude of effect may be small and unlikely to have operational significance. As median time to discharge pharmacy order verification remained constant across arms, it is unlikely the implementation of pharmacy to the process was the cause of the difference in length-of-stay. This process also decreased pharmacy related work-flows and increased the safety of prescriptions.



214 Preliminary Results From an Emergency Department Pain Coach Service and Discharge Toolkit Pilot Project During COVID-19

Pain Assessment and Management Initiative, Hendry P, Suffield D, Sheikh S, Spindle N, Schmitzberger M, Velasquez E, Lott M, Fishe J, Johnson B, Kendall Webb L, Norse A/University of Florida College of Medicine - Jacksonville, Jacksonville, FL

Study Objectives: Amid the US opioid epidemic, emergency providers and patients are searching for non-opioid or nonpharmacologic pain treatment options. The challenge of managing pain without opioids was escalated by the COVID-19 pandemic with opioid related overdoses and deaths increasing by 20-40%. Most healthcare professionals have limited knowledge, resources or time for pain education, especially in the emergency department (ED). To address these needs a novel pain coaching program was designed including a menu of nonpharmacologic patient discharge toolkit materials. Study objectives were to determine descriptive patient and toolkit utilization data and challenges in the first 4 months of a novel pain program.

Methods: Target population consisted of patients ≥14 years of age seen by a new ED Pain Coaching staff from January 4, 2021- April 30, 2021. The two ED sites consisted of an urban, academic center with trauma center, pediatric ED, etc. and an affiliated community ED. Patients were determined by ED rounding, ED census review and consultation by ED staff, physicians, physical therapy, palliative care and pharmacy. Summary statistics for patient demographics, pain type, REALM-SF score, educational topics, toolkit materials, challenges and other data were abstracted from coaching and patient notes on a daily basis using a REDCap database for analysis. Upon request, there were select inpatient and repeat coaching encounters.

Results: During this 4-month pilot, 296 coaching sessions were completed on 276 unique patients; 20 screen outs for severe pain, procedures, violent behavior or other obstacles. Average age was 43 with 85% between 20-70 years of age; 62% female; 60% African American. Pain was 46% acute, 50% acute on chronic and 4% chronic with patients often having multiple pain etiologies: musculoskeletal (74%), inflammatory (71%), post-trauma (15%), headache (14%), post-surgical (4%) and neuropathic (3%). Education topics provided with accompanying toolkit items: hot/cold gel packs (90%), car with 4 flat tires analogy (90%), pain neuroscience education (88%), aromatherapy inhalers (82%), breathing techniques (69%), virtual reality (51%), exercise (38%), stretching (35%), diet (20%), acupressure (11%). The majority of patients were seen in 2 EDs or associated trauma center (87%); however, the coach received referrals for selected inpatients (13%). Seventeen educational brochures were made available to patients with aromatherapy, managing pain, pain and stress, and nonpharmacologic management being most utilized. Challenges to coaching included medical condition (14%), too much pain (11%), time constraints (7%); 52% had no challenges. Regarding patient feedback, 61% indicated the session was helpful and 39% were unsure at the time.

Conclusion: Results from this novel ED pain coach and discharge toolkit model provide valuable insights for development of a national pain coach model. Coaching scripts, note template, brochures, videos, inventory and other programmatic materials will be published for further implementation. Future plans include longitudinal patient follow-up, staff satisfaction assessment and addition of new modalities.