Conclusion: Emoji can be a useful tool in tracking a patient’s mood during the ED visit. We did not observe any effect from wait time or length of stay in the ED on the patients’ emoji selection. These emoji surveys are simple to administer and could impact the overall management and care within the ED.

Study Objectives: The purpose of this study is to analyze emergency department (ED) complaints received at a community teaching hospital, create benchmarks with complaint rates and to correlate this with litigation.

Methods: A prospective study analyzed logged patient complaints forwarded to the ED Medical Director between 2014 and 2018. Our community teaching ED has an approximate annual volume of 50,000 visits with ED attending and mid-level provider coverage. Our ED satisfaction scores place us in the 85th percentile in our peer group and 65th percentile nationally. Qualitative evaluation was performed based on a systematic taxonomy and the following data was extracted: patient’s provider, reason of complaint, origin of complaint, patient date of service, the date case opened, and the date the case closed. The complaints were totaled by year and categorized, correlating to the context of complaints, mode of case opening, and time frame for resolution. ED litigation was reviewed over the same five-year interval and correlated to the complaint log.

Results: The most common reason for a complaint was based on clinical care concerns, followed by billing issues, and then by patient satisfaction issues. Satisfaction concerns were received the earliest at 19.7 days, clinical concerns occurred in 38 days and finally billing at 160 days. Most complaints were resolved within 19.5 days after the case was opened. Cases that took more than 90 days to open from the date of service were most likely associated with billing. Most complaints originated from the Patient Satisfaction and Billing Departments. We have found that our facility had an annual complaint rate ranging from 24.2 to 33.3 per 10,000 visits during the five-year period, for a rate of 9 per 251,012 visits attributed to the ED over the five-year period, for a rate of 9 per 251,012 or 0.36 lawsuits per 10,000 patient visits. The rate of a complaint associated with a lawsuit was 2 per 731 or 27.4 lawsuits per 10,000 complaints when extrapolated. Only one suit would assign attribution to the ED provider; all others were related to supporting services.

Conclusion: The complaint incidence in our ED is low at 29.1 per 10,000 visits and remained constant over the five-year observation period. Only two complaints out of the 731 complaints led to litigation for a rate of 27.4 lawsuits per 10,000 complaints. This rate was substantially higher in magnitude than the general rate of 0.36 per 10,000. Moreover, most cases that ended up in litigation did not have an associated complaint filed in advance of the claim. Clinical complaints of quality of care, billing, and satisfaction were the most common. Satisfaction and quality of care complaints tend to come in earlier, while billing complaints are more likely to come in later and take longer to be resolved.
HAS-BLED score (0.70, 0.58-0.85) vs low risk respectively, and highest stroke risk (CHA2DS2-VASC score 6-9) (0.70, 0.60-0.84) vs lower risk (CHA2DS2-VASC scores 2-4). The odds of receiving any action was 2.6 times higher in 2017 compared to 2010 (aOR 2.60, 2.08-3.24).

Conclusion: Within a community-based ED population of AFF patients at high-stroke risk, the rate of appropriate stroke prevention action increased over the 7-year study period. However, there remains an opportunity to improve AFF thromboprophylaxis as more than half of the eligible patients in 2017 were not receiving appropriate stroke prevention action within 10 days of their index visit. Additionally, female sex and those greater than 74yo were less likely to receive appropriate action compared to men and those younger than 65yo. The undertreatment of those greater than 74yo suggests a misunderstanding of the net clinical benefit associated with OAC in the elderly. Furthermore, opportunities to address sex disparities exist as we seek to improve stroke prophylaxis in non-valvular AF patients discharged from the ED.

Methods: This was a retrospective multicenter chart review of all ED patients presenting with the diagnosis of AAD from January 1, 2006 to December 31, 2016 in a large health care system. The EDs in the system were comprised of an urban academic quaternary care center, 5 urban community EDs, 3 suburban community EDs, and 3 free-standing EDs with a current census of over 506,500 patients per year. Patients aged 18 years and older with a diagnosis of aortic dissections (AAD) as a potential screening tool for risk stratifying patients with this rare but often fatal diagnosis.

Study Objectives: To identify new ischemic changes on electrocardiogram (ECG) in patients presenting to the emergency department (ED) with undiagnosed acute aortic dissections (AAD) as a potential screening tool for risk stratifying patients with this rare but often fatal diagnosis.

Methods: This was a retrospective multicenter chart review of all ED patients presenting with the diagnosis of AAD from January 1, 2006 to December 31, 2016 in a large health care system. The EDs in the system were comprised of an urban academic quaternary care center, 5 urban community EDs, 3 suburban community EDs, and 3 free-standing EDs with a current census of over 506,500 patients per year. All patients with the following 3 criteria were included in the analysis: 1) diagnosis of AAD as reported by ICD code, 2) confirmed AAD by CT imaging performed in the ED, and 3) ECG done at the time of presentation and a prior ECG in the electronic medical record. ECGs were reviewed independently by two board-certified Emergency physicians and findings were compared to the prior ECG. We reviewed all changes between ECGs. Ischemic changes were defined as T-wave inversions, q waves, ST elevations or depressions, and/or a new left bundle branch block (LBBB). Other significant ECG changes such as change in axis, rate, or rhythm were recorded but not considered to be ischemic changes. Non-specific T-wave changes were not considered significant. Data management and analysis were calculated and reported using descriptive methods.

Results: A total of 147 patients were identified with the diagnosis of AAD. Of this group, 87 patients qualified for inclusion as they had a prior ECG available for comparison. 41 patients had Type A dissection and 46 patients had Type B dissection. Mean age of patients was 66.4 years. 62% were male, and 51% were Caucasian. On ECG review, at least one change in ischemic pattern was found in greater than half of patients presenting with AAD (51.7%, 45/87; Table 1). 35.6% (31/87) had new ischemic findings at the time of AAD diagnosis and 16.1% (14/87) had normalization of ischemic findings seen on the prior ECG. The most common new ischemic finding was new T-wave inversions (23.0%, 20/87). The presence of new ischemic findings was similar in patients with a Type A dissection (36.6%, 15/41) compared to a Type B dissection (34.8%, 16/46). The most common non-ischemic change was a change in axis (17.2%, 15/87). Many patients had multiple changes to their ECG. For example the 50 ischemic changes seen were shared across ECGs from 45 patients. Overall, 81.6% (71/87) of patients with AAD had a significant change in ischemic pattern and/or non-ischemic change on ECG when compared to their most recent ECG.

Conclusion: Acute ischemic changes on ECGs in patients with a diagnosis of AAD were common. New T-wave inversions and axis changes on ECG used in conjunction with patient presentation can help heighten concern for the rare finding of an acute aortic dissection.