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significant variation in performance by facility, and the hospitals with the lowest admission rates were less than suggested by prior investigations. No, authors do not have interests to disclose.

35 Increasing Naloxone Prescriptions Through Electronic Medical Record Best Practice Advisory Alerts
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Study Objectives: Overdoses are now the leading cause of injury-related death in the United States with recent increases influenced by multiple factors including the COVID-19 pandemic. Among the most recent overdose deaths, about 75% involved a prescription or illicit opioid. Naloxone can rapidly reverse fatal overdose and evidence shows reduced mortality when naloxone is available in the community. Although emergency physicians are generally willing to prescribe naloxone to patients at risk of opioid overdoses, prescriptions remain uncommon. We hypothesize that the implementation of a Best Practice Advisory (BPA) alert within the electronic medical record (EMR) can increase the number of naloxone prescriptions given to high risk patients within the emergency department (ED).

Study Design/Methods: In this retrospective chart review, we measured the number of naloxone prescriptions in a 5-month period prior to the initiation of the BPA and compared that to the number of naloxone prescriptions in the 5-month period after the initiation of the BPA. The chart review was inclusive of 9 EDs across a health system with a total annual volume of 450,000 visits per year. We also quantified the total number of BPA triggers and the action taken by the type of ED clinician including physician, resident, physician assistant and nurse practitioner. The BPA was designed to prompt a prescription for naloxone for patients at-risk for opioid overdose that meet criteria including: patients prescribed opioids with comorbidities including chronic lung or heart disease, opioid use disorder, history of opioid overdose, and those with an opioid prescription greater than 50 morphine milligram equivalents per day.

Results/Findings: In the 5-month period after naloxone BPA initiation, there were 740 naloxone prescriptions. This compares to 180 naloxone prescriptions in the 5-month period prior to initiation of the BPA, a 311% increase in naloxone prescriptions after BPA initiation. The BPA fired 2,450 times after initiation and the clinician clicked to “accept” the BPA 1,428, a 58.3% acceptance rate. The rates of ED clinicians clicking “accept” who encountered the naloxone BPA by the type of ED clinician were as follows: physicians (56.5%), residents (67.2%), physician assistants (54.8%), nurse practitioners (42.5%).

Conclusion: Increasing naloxone availability should be considered an important part of a multi-pronged approach to combatting our current opioid epidemic. BPAs within the EMR could be a low-cost, effective intervention to increase naloxone prescription rates for patients at-risk for opioid overdose in the ED. Further investigation is needed to determine pharmacy fill rates of naloxone prescriptions and understand clinician perspectives toward naloxone prescription in order to characterize the most effective model for naloxone distribution.

No, authors do not have interests to disclose.

36 Stop the Vomit: Haloperidol as a Superior First-line Antiemetic
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Study Objectives: Nausea and vomiting are common chief complaints when presenting to the emergency department (ED). Ondansetron has become a first-line antiemetic in the ED due to perceived efficacy, safety, and low risk of adverse side-effects despite a lack of substantive evidence of superiority. Haloperidol is a typical antipsychotic medication, acting as a dopamine (D2) antagonist that has efficacy in treating nausea, vomiting, and headache in a variety of ED conditions including migraine headache, cannabis hyperemesis syndrome and diabetic gastroparesis. Our objective is to evaluate the efficacy of haloperidol and ondansetron on undifferentiated nausea and vomiting in ED patients. Secondary outcomes include comparisons of analgesic effects, QT prolongation, efficacy in cannabis users, and adverse side-effects.

Methods: This study is a randomized, double-blind, non-inferiority trial of patients aged 18-55 between April 2021 and March 2022. A convenience sampling of patients meeting inclusion criteria were randomly assigned to either the haloperidol or ondansetron groups. Patients were excluded if any of the following were present: abnormal blood pressure (>200/100mmHg or <90/40mmHg), fever (>100.4F), acute trauma, QT > 450ms on cardiac monitor, altered mental status (GCS < 15), chest pain, allergy to haloperidol or ondansetron, Parkinson’s disease, pregnancy or lactation, use of any antiemetic in the previous 8 hours, nausea and vomiting associated with vertigo, prisoners or any wards of the state. Patients were randomized to receive either 2.5mg of haloperidol intravenous (IV) or 4mg IV ondansetron. Symptoms were evaluated at time of enrollment and at 30-, 60-, and 90-minutes post-treatment using a validated Visual Analogue Scale (VAS) with side-effects evaluated concurrently. QT interval was evaluated at enrollment and 90 minutes post-treatment. After 90 minutes, all further treatment was determined by the primary ED physician at their discretion. Patients were contacted after 24 hours to collect follow-up data. Alpha value was set at 0.025 and all results showing non-inferiority were tested for superiority.

Results: Of 384 patients evaluated for inclusion, 312 were excluded due to screening criteria and 48 completed the study. 22 patients were randomized to haloperidol and 26 to ondansetron. Backround data, initial nausea, and initial pain scores were statistically similar between groups at enrollment. Haloperidol was found to be superior to ondansetron in treatment of nausea at 90 minutes (p = 0.0178) with reduction in median nausea VAS of 6.5 (7 to 0.5) compared to 3 (6 to 3) in the ondansetron group. Haloperidol was also found to be superior to ondansetron in treatment of abdominal pain at 90 minutes (p = 0.0006) with reduction in median VAS pain score of 5 (5 to 0) compared to 2.5 (6 to 3.5). No difference in QT interval change was found between haloperidol and ondansetron groups (p = 0.45). Haloperidol was not found to be superior to ondansetron in reducing nausea in cannabis users (p = 0.0385) at 90 minutes post-treatment.

Conclusion: This study presents novel data that haloperidol 2.5mg IV is effective and superior to ondansetron at treating nausea and pain in undifferentiated adult patients in the emergency department. This study also shows that there is no difference in QT prolongation among the two medications.