the study. We included English and Spanish speaking providers. The survey questions were as follows:

Did your provider greet you and introduce himself/herself upon entering the room?

Did your provider communicate with you about your child's treatment plan and any delays in care?

Is there any staff member you wish to recognize for providing excellent care?

How well are we doing with your child's pain control? (5-point Likert scale and option of "does not apply.")

Do you have any specific comments and feedback about the care we are providing for your child?

Results: A total of 1261 surveys were completed. Of these, 891/1261 (70.6%) were treated in the main ED site, and 370/1261 (29.4%) in the satellite ED. 80/1261 (6.3%) of the participants had limited English proficiency. Mean length of stay was 343 minutes (SD=138 min). In univariable analysis, a positive patient experience was associated with all 5 survey elements. Multivariable analysis revealed that for the 187/1261 (14.8%) patients who had reported pain, the adequacy of pain control was the single factor independently associated with a positive ED experience [OR 4.3 (1.15-10.220]. For all participants, regardless of whether pain was reported, staff recognition, [OR 5.85 (2.92-11.68)], communication of care plan, [OR 4.41 (2.30-8.40)] and improvement feedback [OR 0.16 (0.08-0.31)] were associated with a positive patient experience, while provider greeting and introduction was not associated with a positive patient experience.

Conclusion: Pediatric patient caregivers were more likely to report a positive ED visit if pain was addressed, when providers communicated the plan of care, and when the caregiver was given the opportunity to provide real-time feedback about their ED visit.

204 Haloperidol Undermining Gastroparesis Symptoms in the Emergency Department
Stalcup P, Croft B, Ramirez R, Darracq M/UCSF Fresno, Fresno, CA

Study Objective: Gastroparesis (GP) associated nausea, vomiting, and abdominal pain are common presentations to the emergency department (ED). A Nationwide Emergency Department Sample (NEDS) Study suggested 200,000 visits annually to US EDs for GP. Current ED treatment attempts symptom control via administration of antiemetic, prokinetic, opioid and nonopioid agents. Haloperidol (HP) has been shown to have analgesic, antiemetic and anti-serotonergic properties. We sought to evaluate the effectiveness of HP in the ED as an alternative treatment of GP-associated nausea, vomiting, and abdominal pain (GP NV/AP).

Methods: Using an electronic medical record (EMR), a retrospective case-control study of 52 patients who presented to the ED with GP NV/AP and were treated with HP were identified. Patients who received HP were compared with their most recent previous encounter where HP was not administered. ED length of stay (LOS), Hospital LOS, antieemics administered, and morphine equivalent doses of analgesia (ME) from each visit were recorded. ME were calculated using an online opioid equivalency calculator (http://www.medcalc.com/narcotics.html). Descriptive statistics, categorical (Chi square test) and continuous (Wilcoxon signed rank test) comparisons were calculated between HP administered and not administered. Statistical significance was considered for two p-values less than 0.05.

Results: We found a statistically significant reduction in ME (Median 6.75 [IQR 7.93] to 10.75 [IQR12; p=0.001) and reduced admissions for GP (5/52 vs 14/52; p=0.02) when HP was administered. There were no statistically significant differences in antiemetic, ED LOS, or Hospital LOS between HP administration and not administered. No cardiovascular or other complications were identified in patients who received HP.

Conclusion: The rate of admission and amount of opioid administration was found to be significantly reduced in patients with GP who received HP. HP may represent an appropriate and effective alternative to traditional analgesia and antiemetic therapy in the ED management of GP NV/AP.

205 Ketadex for Adult Procedural Sedation in the Emergency Department: A Pilot Study
Woods RM, Miller PT, Prater NI, Eggleston MD, Smith AH/St. Elizabeth Youngstown Hospital, Youngstown, OH

Study Objectives: The 2014 ACEP Clinical Policy on Procedural Sedation and Analgesia (PSA) offers several evidence-based recommendations on selecting an agent for use in the emergency department (ED). However, current literature suggests that the most commonly used agents such as propofol and “ketadex” are associated with a 40% risk of respiratory adverse event, leading to an intervention 50-75% of the time.

Dexmedetomidine is an alternative agent that lacks clinically significant respiratory depression, although it has a somewhat longer time to onset, provides minimal analgesia, and may potentially cause adverse effects such as bradycardia or hypotension. When combined with ketamine, or what we termed “ketadex,” may provide both adequate analgesia and sedation while lacking significant respiratory depression.

The objective of our study was to determine the safety and efficacy of a novel combination of ketamine and dexmedetomidine for adult patients undergoing PSA in the ED. The primary endpoint was the frequency of respiratory adverse events. Patient satisfaction, procedural success, patient recall, rates of hypotension and bradycardia were secondary endpoints.

Methods: This IRB-approved prospective, open-label pilot study enrolled adult ED patients at a Level 1 trauma center that required PSA for an expected duration of 10 minutes or greater, including patients at a higher risk for respiratory depression (ASA risk score of three or four). Patients received a loading dose of “ketadex” (1 mg/kg ketamine and 1 mcg/kg dexmedetomidine combined in 100 mL of normal saline) over 10 minutes. If further sedation was required following the loading dose, a dexmedetomidine infusion was started at 1 mcg/kg/hr and patients were able to receive ketamine bolus doses of 0.25 mg/kg as needed every 5-15 minutes. Once the procedure was complete or sedation was no longer required, the “ketadex” or dexmedetomidine infusions were stopped.

Results: In this pilot study using the combination of ketamine and dexmedetomidine (n=24), most of our patients were less than 65 years of age (range 18-88), a majority were male and less than 100 kg (range 52.8-181.4 kg), and almost half had an ASA risk score of three or four (40%). An interim analysis reveals the rate of respiratory adverse events was 4% (1 of 24) with a 4% rate of hypotension (1 of 24) and no bradycardia. All adverse events were transient and without complications or clinical interventions required. We observed a high rate of procedural success and patient satisfaction with a very low rate of patient recall. In contrast to previous studies with procedural sedation, our pilot study includes patients at a higher risk of respiratory depression, including higher extremes of age, more comorbidities, and an ASA risk score greater than two.

Conclusions: The preliminary results from this pilot data suggest that our combination of ketamine and dexmedetomidine for adult PSA in the ED is a safe and effective alternative to other currently available agents for PSA. Additionally, our experience with “ketadex” indicates a low incidence of respiratory adverse effects and a safety profile that holds true in a population at an increased risk for these events. Future studies are warranted to confirm the findings and potential role for the combination of ketamine and dexmedetomidine in patients at higher risk for respiratory adverse events than those seen in current literature.

206 Predictors of Hydromorphone Administration in US Emergency Departments, 2007-2011
Amirshahi M, Lakdany D, Mullins PM, Perrone J, Pines JM, Nelsion LS/MedStar Washington Hospital Center, Kensington, MD; MedStar Washington Hospital Center, Washington, DC; George Washington University, Washington, DC; Hospital of the University of Pennsylvania, Philadelphia, PA; New York University, New York, NY

Study Objective: The past two decades have seen dramatic increases in the administration of opioid analgesics in U.S. EDs, particularly hydromorphone. Hydromorphone is a high-potency semi-synthetic opioid with significant abuse potential. The potential contribution of rising ED hydromorphone administration to prescription opioid abuse and overdose nationally is uncertain but concerning. This study examines recent trends and in and predictors of hydromorphone administration in U.S. EDs.

Methods: A retrospective review of data from the National Hospital Ambulatory Medical Care Survey (NHAMCS), from 2007-2011 was performed. All adult encounters during which an opioid analgesic was administered in the ED were included. Discharge prescriptions were not included. Trends in overall hydromorphone administration and predictors of visits where hydromorphone was administered as compared to visits where other opioids (ie, morphine, oxycodone, etc.) were administered were assessed using logistic regression analysis.

Results: An estimated 245.6 million visits were included. Hydromorphone administration increased 24.4%, from 8.2% of visits in 2007 to 10.2% in 2011, p=0.007. Patient characteristics associated with hydromorphone administration compared to other opioids included age <65 years, white race, having private insurance or Medicare, having more than 2 visits in the past year, and a report of severe pain (pain score ≥ 8). Visit characteristics associated with an increased likelihood of hydromorphone administration included ordering of bloodwork, having a procedure performed, and admission to a general medical/surgical unit. Several conditions were associated with higher rates of hydromorphone administration, particularly back pain. Hydromorphone was more likely to be administered in hospitals in the Midwest, west, and south, those in urban areas, and non-teaching hospitals (Table).