Here is a first Draft of an abstract
What are the errors of omission and errors of commissions?

Background: Adolescents and young adults (youth) are at high-risk for morbidity and mortality due to risk-taking behaviours and psychosocial dysfunction [1] coupled with substandard screening and treatment by health care providers. The Emergency department (ED) is an important setting in which to identify risk-taking youth because those who rely on the ED for primary care have particularly vulnerable psychosocial profiles [46-49]. HEADDSS (Home, Education, Activities, Drinking, Drugs & Smoking, Sexual behaviour, Suicide & Depression) is a well-known psychosocial interview tool designed to screen adolescents for high-risk behaviours and situations [52].

Methods: A retrospective systematic chart review was done for documentation of HEADDSS topics addressed. The charts included were of patients 12 - 24 years less one day who were seen at either the HI or the IWK ED from March 21, 2009 – March 20, 2010. 929 charts were reviewed. HI and IWK ED physicians completed anonymous questionnaires about their HEADDSS screening practices. Chi-square analysis was done to compare proportions of youth screened with HEADDSS topics addressed comparing all of the variables.

Results: 4 patients were excluded, 2 for illegible physician writing and 2 for developmental level inadequate to address the topics. 73% of all youth seen in the IWK ED and 69% at the HI ED had no HEADDSS topics addressed. Youth at the IWK were more likely to have $\geq$ 6 HEADDSS topics addressed than youth seen that HI (18.1% vs 2.7%, $p<0.001$). Youth at the HI was more likely to have 1-5 HEADDSS topics addressed than a youth seen at the IWK (20.3% vs 4.7%, $p<0.001$). 12 and 13 year olds had the fewest HEADDSS topics addressed (88% none addressed) compared with all the other age groups ($p\leq0.001$). Youth seen in the summer had the least HEADDSS topics addressed (78.5% none addressed) compared to all other seasons ($p=0.02$). Pediatrics residents addressed fewer HEADDSS topics than non-pediatrics residents (2.9% vs 36.4%, $p<0.001$).

Conclusion: HEADDSS topics were (and likely still are) being under-addressed at the HI and IWK EDs, however they are being addressed better than in 2003. Youth seen at the IWK were more likely to have a complete HEADDSS assessment done, most of which were done by a crisis or social worker, while youth at the HI were more likely to have had some HEADDSS topics addressed. Most of the HEADDSS topics addressed at the HI were relevant to the presenting complaint, rather than being addressed as part of a regular screening interview for youth.