

and dynamic process that is influenced by their perceived roles as a doctor, coach, and assessor. Understanding the way attendings view and juggle their roles may provide insight into potentially new approaches to assessment and feedback. Results and implications will be discussed.

Keywords: medical education, qualitative, emergency department

P094

A computerized provider order entry strategy to improve the quality of clinical information on neuroimaging requisitions from the emergency department: an interim analysis

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Introduction: Clinical context is critical for accurate radiologic interpretation of neuroimaging investigations. The aim of this study was to determine the impact of a change in the Emergency Department (ED) computerized provider order entry (CPOE) interface on the quality of clinical information conveyed in ED neuroimaging requisitions for suspected stroke patients. **Methods:** Four local EDs utilizing a common CPOE ED Stroke order set were studied before and after the introduction of a mandatory blank free text field requiring clinical information for the radiologist before a computed tomography angiography (CTA) request could be submitted. Prior to this modification, the indication (acute stroke) was pre-filled in the CTA request for convenience with the option of providing additional information at the discretion of the ordering physician. ED physicians were informed of the change as well as the rationale for its implementation. A retrospective pre (90 days) post (30 days) analysis was conducted across four local EDs to evaluate the impact of the CPOE user interface change on the quality of clinical information provided on neuroimaging orders. Patients aged 18 with CTA head and/or neck orders submitted from the order set were included. Patients were excluded if the CTA order was submitted outside of the ED Stroke order set, if order entry was by non-physician personnel, or if the order was modified by the diagnostic imaging department after ED submission. Clinical information from CTA orders were scored as complete, partial, or absent/uninformative based on a standardized rubric of critical elements, including: description of neurological deficit(s), lateralization, and timing of symptom onset or duration. Results were analyzed using chi square analysis. **Results:** Pre-implementation data from Oct 1, 2015 Jan. 1, 2016 (N=652) was compared to post-implementation data from Nov. 1 30, 2016 (N=227). The proportion of complete, partial, and absent/uninformative clinical histories were: 45.3%, 31.4%, and 23.3% in the pre-implementation period and 62.6%, 37.4%, and 0% in the post-implementation period respectively. There was a 38.2% relative increase in complete clinical histories, a 19.1% relative increase in partial clinical histories, and a 100% reduction in absent/uninformative clinical histories ($p < 0.001$). **Conclusion:** The introduction of a mandatory free text field significantly increased the overall quality of clinical information provided on ED neuroimaging orders. This CPOE strategy has the potential to improve diagnostic accuracy and reduce unnecessary delays to imaging interpretation caused by lack of clinical information.

Keywords: quality improvement and patient safety, computerized provider order entry, diagnostic imaging

P095

Do resident as teacher programs increase emergency medicine residents comfort level with teaching junior learners?

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Introduction: At academic hospitals, it is a residents responsibility to teach junior learners. Residents endorse that there is limited education on how to effectively teach junior learners, and suggest a more formal curriculum on how to teach would be beneficial. Emergency Medicine (EM) residencies in North America may have a resident as teacher (RAT) curriculum, however, no Canadian EM study has characterized the impact of a RAT curriculum on residents. Our educational concept was to implement a formalized RAT workshop for residents in an EM residency. We assessed residents attitudes and comfort levels towards teaching in response to the curriculum. **Methods:** A formal RAT curriculum, provided at a single center in a 6-hour session, was provided for both Royal College and College of Family Physician EM residents. Residents completed a survey evaluating attitudes and behaviours regarding their ability to teach and give feedback as part of their roles as teachers, consistent with Kirkpatrick's second level of program evaluation. The surveys were administered pre-workshop, immediately post-workshop, and at 3 and 6 months following the RAT workshop. **Results:** Residents were surveyed in terms of their attitudes towards teaching on a 5-point likert scale. Our educational concept was delivered through a 6-hour workshop with emphasis on practical teaching skills that residents could incorporate into their practice. Lecture topics included orientation of the learner, giving effective feedback, teaching within a short time frame, as well as an introduction to theory of learning. Lectures were geared to be interactive, and included breakout sessions and group discussions. 21 residents participated in the workshop. Of 18 pre-survey respondents, 89.8% (n=16) had no previous formal training in how to teach, yet 72.21% (n=13) 'sometimes' or 'often' have a learner on shift with them. There were 15 post survey respondents. 53.33% (n=8) respondents somewhat agreed or agreed they were more likely to teach in response to the workshop, and 56.25% (n=8) responded that they somewhat agreed or agreed they were more comfortable with teaching while in the Emergency Department in an immediate post workshop survey. **Conclusion:** After a formal RAT curriculum, residents reported that they had increased comfort and were more likely to teach junior learners. Although small and single-centered, our study will help provide a basis for larger RAT studies, evaluating the effect on both residents and junior learners.

Keywords: innovations in emergency medicine education, resident as teacher, medical education

P096

Real-time 72 hour readmission alert

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Introduction: Hospital admission within 72 hours of emergency discharge is a widely accepted measure of emergency department quality of care. Patients returning for unplanned admission may reveal opportunities for improved emergency or followup care. Calgary emergency physicians, however, are rarely notified of these readmissions. Aggregate site measures provide a high level view of readmissions for managers, but don't allow for timely, individual reflection on practice and learning opportunities. These aggregations may also not correctly account for variation in planned readmissions and other workflow nuances. There was a process in place at one facility to compile and communicate readmission details to each physician, but it was manual, provided limited visit detail, and was done weeks or months following discharge. **Methods:** A new, realtime 72 hour readmission notification recently implemented within the Calgary Zone provides direct and automated email alerts to all emergency physicians and residents