evaluate the impact of the curriculum changes. **Conclusion:** A collaborative, modular, longitudinal QIPS curriculum for UT FRCP emergency medicine residents that met CanMEDS requirements was created using multiple educational methods. The first resident cohort that completed the curriculum demonstrated an absolute increase in QI knowledge and its applicability (as measured by the QIKAT-R) by 19.6%. Two PDSA cycles were completed to improve the curriculum with the change ideas generated from resident feedback. Ongoing challenges include limited staff availability to teach and supervise resident QI projects. Future directions include incentivising staff participation and providing mentorship for residents with a career interest in QI beyond what is offered by the curriculum.

**Keywords:** quality improvement and patient safety, residency training, CanMEDS

## MP26

**An emergency department team-based quality improvement initiative reduces narcotic and benzodiazepine 'to-go' medication administration**

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**Introduction:** The administration of "to-go" medications in the Kelowna General Hospital Emergency Department was identified as an issue. Frequently, multiple administrations of "to-go" medication pre-packs were administered to individual patients on a frequent basis. In addition, the variability in "to-go" medication was substantial between providers. Recognizing the patient issues (addiction, dependency and diversion) and system issues (costs, risk) a team-based quality improvement initiative was instituted, utilizing a variety of quality improvement techniques. The aim was to reduce the number of "to-go" medications by half, within a year. **Methods:** The project began January 2015, and is ongoing. Multiple stakeholders were engaged within the emergency department; these included leaders of the physician, nursing and pharmacy teams, including an executive sponsor. Using change theory, and traditional Plan-Do-Study-Act (PDSA) cycles, an iterative methodology was proposed. The outcome measure proposed was number of "to-go" medications administered; secondary measures included number of opioid "to-go" and benzodiazepine "to-go"pre-scriptions. Balancing measures were the number of narcotic prescriptions written. Physician prescribing practice and nursing practice were reviewed at meetings and huddles. Individualized reports were provided to physicians for self-review. Data was collated at baseline then reviewed quarterly at meetings and huddles. Run charts were utilized along with raw data and individualized reports. **Results:** At baseline (January 2015), the number of "to-go" medications was 708. Over the next year, this value reduced to 459, showing a 35% reduction in "to-go". Two years later (June 2017), this had reduced to 142, resulting in an overall reduction of 80% "to-go" medications. Secondary measures are currently under analysis. Further, no increase in prescribing of narcotics was seen during this time period. **Conclusion:** The administration of "to-go" medications from the emergency department has significant individual and societal impact. Frequently, these medications are diverted; meaning, sold for profit on the black market. Further, opioid prescribing is under increased scrutiny as the linkage between opioid prescriptions and addiction / dependency becomes more evident. This quality improvement initiative was successful for a number of reasons. First, we had strong engagement from the full emergency department clinical teams. The issue was first identified collaboratively, and teamwork and participation was strong from the outset. Second, we

used individual and aggregate data to provide feedback on a regular basis. Third, we had strong support from our executive sponsor(s) who were able to support the efforts and champion and present the results locally, and now, throughout the Health Region.

**Keywords:** quality improvement and patient safety, opioids, prescribing practices

## MP27

**Publishing emergency department wait times in the waiting room: implementation and evaluation of a co-designed patient centered solution**

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**Introduction:** Patients in our ED were dissatisfied with their waiting experience, which resulted in patient anxiety and complaints. In 8 months, we aimed to (1) improve patient satisfaction with the ED waiting experience from triage to physician initial assessment by a 15% improvement in patients who rate their experience very good/excellent on a Likert Scale, and (2) improve patient knowledge of ED wait time by a 50% increase in understanding on a Likert Scale. **Methods:** We co-designed a display with ED patients to notify those in the waiting room of their wait process and wait time. The intervention was selected after root cause diagnostics including: Fishbone exercise, Pareto Diagram, and Driver Diagram. The display was co-designed with ED patients and improved via PDSA cycles to establish information displayed and how to incorporate it into the waiting experience. After co-design, a low-fidelity display was piloted in the waiting room. **Results:** A family of measures were evaluated using patient/provider surveys and hospital data metrics. Outcome measures were (1) percentage of patients who rated their ED experience as very good/excellent on a Likert scale, and (2) patients who had a clear/very clear understanding of their wait time on a Likert scale. Process measures were the percentage of patients who (1) looked at the wait time display, and (2) felt they could communicate their wait time to others. Balancing measures were clerk/nurse satisfaction and self-reported interruptions of patients asking wait time. Outcomes were tracked using statistical process charts and run charts. Following display implementation, patient rating of their ED experience and patient understanding of wait time showed positive improvement. Clerks/nurses were also more satisfied with their jobs and self-reported interruptions decreased. **Conclusion:** A low-fidelity wait time display co-designed with patients improved patient satisfaction and understanding of ED wait times. We plan to develop an automated electronic display that resembles the low-fidelity display and evaluate the impact of the intervention on the established measures. This intervention has the potential to be sustainable, feasible for other EDs, and require minimal upkeep costs.

**Keywords:** quality improvement and patient safety, patient-centered, patient co-design

## MP28

**Reducing door-to-needle times across Alberta to 36 minutes**

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**Introduction:** The effectiveness of intravenous alteplase is highly time dependent, and very short door-to-needle times (DNT) of 30 minutes or