Canadian Association of Ambulatory Care

In Partnership with Sunnybrook Health Sciences Centre & Women's College Hospital

Ambulatory Care: The Need for Alternatives to Hospital Based Treatments

2nd Annual Canadian Ambulatory Care (CAAC) Conference

September 13-14, 2013, Toronto Delta East Hotel

Welcome to the 2nd Annual

Canadian Association of Ambulatory Care Conference

Please mute all pagers and cell phones while participating in the conference sessions.

Registration Fees includes: Admittance to all concurrent sessions, continental breakfast, luncheon, poster presentations, door prizes and the Wine and Cheese Reception Delegates who plan to attend the workshops segment of the conference will find a blue sticker on their name tag to indicate that they will be attending the workshops.

Conconcurrent Sessions: Please review the concurrent sessions in this conference program. You should plan ahead and choose the sessions you would like to attend.

Evaluations: You will receive an online conference evaluation for your completion. immediately following this conference and we ask that you please take the time to complete and return it promptly so that we can determine your learning priorities for next year's program, and to determine what we can do better.

Badge Colours: All presenters and executive members are wearing colour-coded badges. To help identify these groups, please look for:

Board Members:	Black
Conference Chair and Conference Committee Members:	Red
Registration Staff:	Purple
Presenters:	White
Poster Presenters:	Light Blue
Sponsors:	Titanium
	Gold
	Silver

If you have any questions or if you need assistance, please find any member of the conference registration staff who will do their best to help you with your concern.

Badge Colours: All presenters and Executive members are wearing colour-coded badges. To help identify these groups, please look for:

- Board of Directors……**Red Badges**
- Presenters……**Green Badges**
- Sponsors……..**Orange Badges**
- General Public……..**White Badges**
- Conference Planning Members…..**Yellow Badges**

Canadian Association of Ambulatory Care

Introduction:
We are the first Ambulatory Care Association established in Canada to enhance practices and education for the delivery of ambulatory patient care. As we all know the underlying principle of Ambulatory Care Medicine is that a significant proportion of inpatients can be managed safely and appropriately on a same day basis without admission to an inpatient hospital bed, thus resulting in great savings to the healthcare system.

Today's health care environment is ever changing, and ambulatory care providers are expected to provide a high level of care to patients in a very busy and pressured environment. We need to come together to share and celebrate the high quality of care we provide to our patients and the performance improvement measures we implement to maintain best practices

Our Vision:
To lead the nation and influence the Practice of Ambulatory Patient Care through our research, educational agenda and practice innovations.

Our Mission:
To transform the future of Preventative Medicine in Ambulatory Care by offering our members a forum to share their knowledge and skills, and to provide the opportunity to network with other professionals in order to enhance practice in the ever growing ambulatory care environment.

Visit us at:

www.canadianambulatorycare.com

The Presidents Message

Dear Colleagues,

It gives me great pleasure to welcome you to the 2nd Canadian Association of Ambulatory Care (CAAC) Conference. We are the first and only interdisciplinary ambulatory care association in Canada. I am very pleased to relay that we have partnered with Sunnybrook Health Sciences Center again for this year's conference. We have also formed a new partnership with Women's College Hospital, As a result of these partnerships we have been able develop an impressive 2 day program that includes oral presentations, hands-on skill development through our workshops, poster presentation sessions and of course collegial networking opportunities.

Our conference has attracted a larger than expected delegate attendance this year within Canada and from the international community. I am confident that the CAAC will continue to grow and become a leader in the ambulatory care community.

This year conference will address the theme of "*The need for alternatives to hospital based care*". Whether you are from a newly form ambulatory care center, an established center, or just interested in transforming your current practice, this conference will enhance your ability to build on new ideas and initiatives. Our concurrent sessions will allow attending delegates to design a conference that meets their individual needs. Our speakers include distinguished local, national and international experts speaking on ambulatory care interventions, management and patient care issues in a variety of settings.

I want to take a moment to look forward to 2014. As the President & CEO of the CAAC, I have many plans for the enhancement of the CAAC. Our board is working diligently to develop partnerships with health care partners to develop recognized ambulatory care practices to guide the delivery of patient care. We are working on the expansion of the CAAC through the development of chapters throughout Canada to strengthen the Mission and Vision of the CAAC; and we are working with community partners for continued improvements in safety, quality and satisfaction for patients and staff in ambulatory care.

I know that you will have an enjoyable time today, thank you for your support; and I wish you a productive learning and networking experience.

Sincerely,

D Henry

Denyse Henry, RN, BHA, MHM (c)

CAAC President & CEO

Canadian Association of Ambulatory Care

Conference Chair's Message

Ambulatory Care: The need for alternatives to hospital-based treatments

Conference Chair's Message

Dear Friends and colleagues,

I am very pleased and honoured to welcome each and every one of you to our second Canadian Association of Ambulatory Care (CAAC) Conference in Toronto this September. The launch of this annual conference was a tremendous success and from the positive feedback we have developed a more diverse and comprehensive program for you to network and expand your expertise. I would like to welcome attendees from last year and the new attendees that are joining for the first time, but hopefully not the last time! The program will provide a multidiscipline perspective and approach and a multinational platform. Each of these factors with provides a unique perspective on the methods of promoting and advancing ambulatory care in the challenges we face today in the field of health care.

We are extremely pleased that you have joined us to be leaders in the forefront of this focus and movement in health care. It is an exciting and challenging time that we are honoured and pleased to be a part of.

This is an exciting to time to join the CAAC as a member to help us develop a larger platform. I welcome you to take this opportunity to become a member to join us on this educational journey in the following years and conferences. With the input and support of our members and generous sponsors' we have a goal to move the conference next fall to Niagara Falls Ontario!

It is my distinct pleasure to welcome you to our multicultural, dynamic City of Toronto. We are confident that your experience will be educational, inspirational and provide you the memories to motive and continue your educational pursuits.

Mary Beth Baxter, RN

M B Baxter

CAAC Conference Chair

Ontario

Premier of Ontario - Première ministre de l'Ontario

September 13 – 14, 2013

A Personal Message from the Premier

On behalf of the Government of Ontario, I am delighted to extend warm greetings to everyone attending the Second Annual Conference of the Canadian Association of Ambulatory Care (CAAC).

I would like to thank the association for giving members the opportunity to build skills and knowledge, keep pace with changes in the ambulatory care environment and benefit from networking. This conference is a fine example of the CAAC's dedication to supporting ambulatory care professionals in their delivery of top-quality healthcare services to Canadians.

I would also like to thank the dedicated organizers and volunteers who have devoted time and energy to making this year's event possible. I am confident that the keynote speakers, sessions and workshops will do much to further enhance the already strong skill set of delegates.

Please accept my best wishes for what I know will be an outstanding learning and networking experience.

Kathleen Wynne
Premier

PRIME MINISTER · PREMIER MINISTRE

I would like to extend my warmest greetings to everyone attending the second annual Ambulatory Care Conference, hosted by the Canadian Association of Ambulatory Care (CAAC) in conjunction with Sunnybrook Health Sciences Centre and Women's College Hospital.

This event offers an excellent opportunity for professionals across all ambulatory settings to share their knowledge and best practices while gaining new information on the most promising developments in this rapidly evolving field. I am sure that delegates will make the most of the many networking activities and educational sessions centred on this year's theme "Ambulatory Care: the Need for Alternatives to Hospital-based Treatments."

I would like to commend the CAAC for their commitment to promoting excellence in the delivery of ambulatory patient care. Your efforts are paving the way for a more efficient health care system and a healthier future for Canadians.

Please accept my best wishes for a most enjoyable and productive meeting in Toronto.

The Rt. Hon. Stephen Harper, P.C., M.P.

OTTAWA
2013

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Our Sponsors

We would like to take this opportunity to thank our many generous sponsors for their commitment to our Association and dedication to the promotion and advancement of Ambulatory Care throughout Canada.

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Special Mention

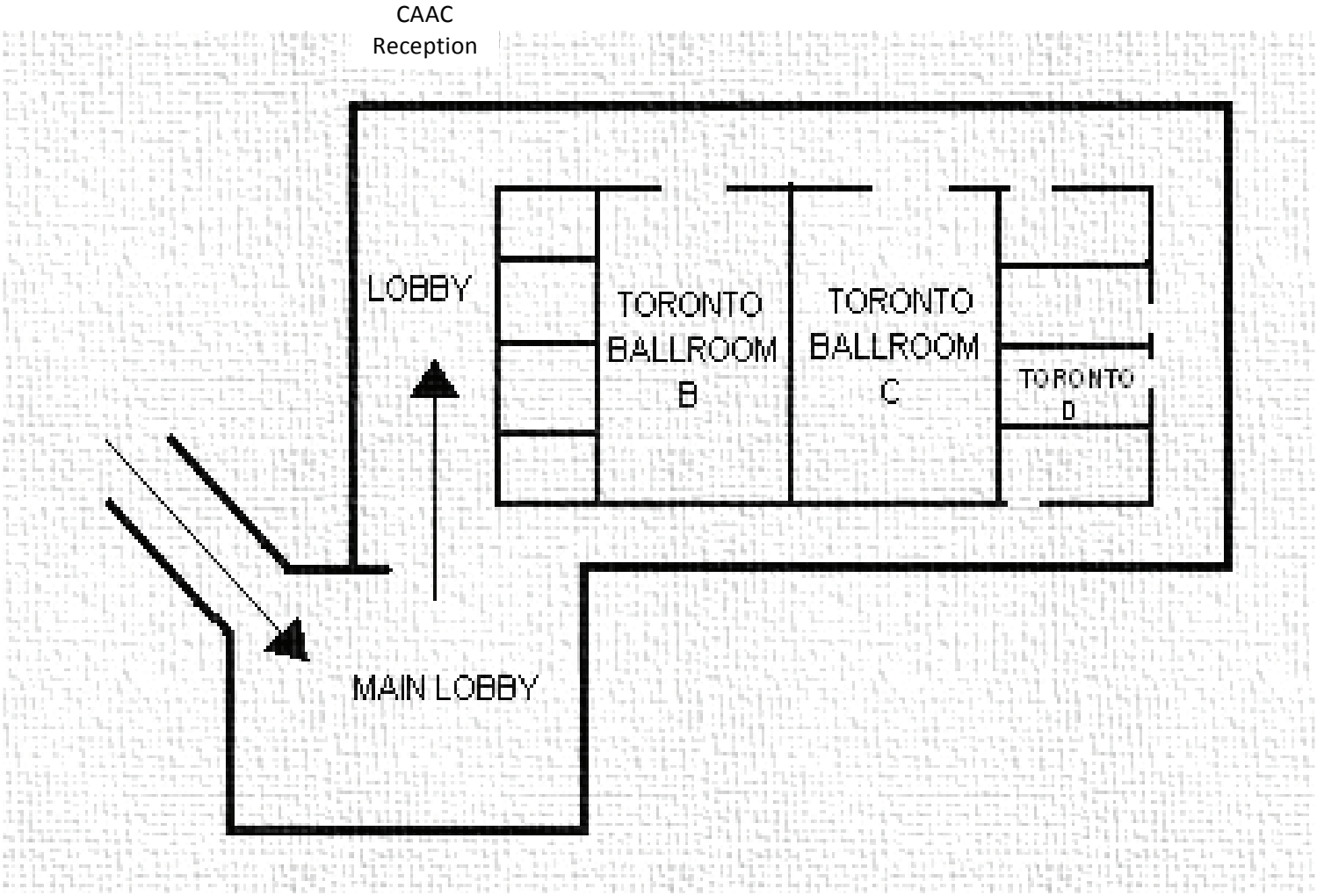
This year the Association will for the first time be presenting an award to the "Best Poster Presentation" as selected by you the attendees. This award would not be possible without the financial sponsorship of educational support from Hoffman La-Roche.

The addition and continued support of all our corporate sponsors will allow for the Association to continue being the leader in Canada for the promotion and advancement of Ambulatory Care throughout Canada. The Association has many plans on the horizon for following year and will be moving next year's conference to Niagara Falls Ontario! It would be our great pleasure to continue the sponsorship relationships that we currently have with all our generous sponsors and to have new members join our sponsorship team. Please feel free to contact me if you have any concerns or questions about becoming a sponsor and joining our prestigious sponsorship team. Once again, on behalf of The Canadian Association of Ambulatory Care I thank you for your support.

Sincerely,

Mary Beth Baxter CAAC Chair
caacrelations@gmail.com

Delta Toronto East Hotel
Conference Floor Plan



Toronto Ballroom B – Poster presentation and Sponsorship room
Toronto Ballroom C – Main presentation room/workshop
Toronto Ballroom D – Additional presentation room/workshop

07: 00 am- 8:00 am **Registration and Breakfast**

Sponsored by :

8:00 am – 08:10 **Conference Opening**

Ballroom C

Welcome and Conference Opening
Mary Beth Baxter: Conference Chair
Denyse Henry: President & CEO, Canadian Association of Ambulatory Care

Opening Remarks

08:10 – 08:20 am

Dr. Barry McLellan MD, FRCPC, , President and Chief Executive Officer, Sunnybrook Health Sciences Centre, Toronto

08:20- 09:00 am

Keynote Speaker:

Dr. Gillian Hawker, MD, FRCPC, Physician-in-Chief, Department of Medicine, Women's College Hospital, Toronto

Ambulatory Care: Alternatives to hospital-based treatments

09:00 - 09:30 am	Concurrent Sessions #1 (Please select one)

SESSION 1A

TORONTO C Ballroom

Leveraging Technology to Improve Peri-operative Patient Safety in Ambulatory Care Surgery

Mei Lei Ling RN, Nurse Educator & **Susan Bell** RN, Manager, Operating Room. Women's College Hospital

New 'state of the art' operating rooms with advanced features such as the ability for all operating room staff to visualize the safe surgery checklist activity are improving surgical services at Women's College Hospital (WCH). Enhanced medical imaging viewing equipment, large spacious rooms with integrated equipment and staged supply delivery all facilitate patient safety.

The new operating rooms were designed with a sterile to clean services pathway to reduce risk of surgical infection and improve overall air quality. Streamlined delivery of sterile equipment and instruments is integrated into the suite with an optimal removal route for contaminated materials post op.

To support critical documentation of surgical patients in WCH's ambulatory surgical unit, the existing electronic documentation system was updated and revised to support optimal, focused documentation of operative procedures.

The use of technology to support existing comprehensive manual safety practices and sound clinical judgment set the 'operating theatre stage' with all the necessary components for improved patient safety and surgical outcomes. Success factors, lessons learned and design and practice challenges will be key components of this presentation.

SESSION 1B

TORONTO D Ballroom

Navigating the Ambulatory Experience to Improve the Colorectal Cancer Patient Journey

Barbara-Anne Maier, RN, BScN, CON(c). Nurse Navigator, North York General Hospital / Sunnybrook Health Sciences Centre Colorectal Cancer Diagnostic Assessment Program

The time from a diagnostic colonoscopy to a treatment decision can be a circuitous experience for patients, due to a multitude of diagnostic tests, health care providers, institutions, and processes. This experience can create an environment encompassed in unmet information needs and anxiety that patients navigate alone. Cancer Care Ontario set out to develop and pilot seven Diagnostic Assessment Programs (DAP) led by Nurse Navigators (NN) for patients as part of the Ontario Cancer Plan (2008-2011).

Patients referred to the colorectal cancer surgeons at Sunnybrook Health Sciences Centre and North York General Hospital were able to access and utilize one of the pilot programs. The goal of this DAP is to create an efficient patient-centered pathway for patients. The nurse navigator (NN) streamlines care to minimize and optimize clinic visits, guide patients through complex multidisciplinary oncologic management, and provide virtual symptom management and psychosocial support. The development of this multisite, cross LHIN DAP program has resulted in an improved patient experience during the ambulatory phase of their journey.

This presentation will define a Diagnostic Assessment Program and look at the influence of the Cancer Care Ontario mandate to fund navigation and similar programs. Highlights of the development of this cross LHIN DAP program and its origins and successes will be shared. This program has proved beneficial and successful for patients and health care providers.

9:30 – 10:00 am	Concurrent Sessions #2 (Please select one)

SESSION 2A

TORONTO C

Ballroom

The role of Ambulatory Nursing Leadership in Mammogram screening

Jennifer Schleger, BSN, RN, Clinical Quality Specialist, and **Sarah Creswell,** BS, RN-BC, Patient Education Specialist Lehigh Valley Physician Group. Allentown, PA.

Over the past several years, our network has implemented a strategic, evidence-based Mammography quality metric. Through transparency, proactive management and strategic network alignment we have engaged the system and improved the metric performance, moving us closer to the accountability of an integrated care delivery system.

In order for our initiative to be a success, it was identified early on that not only patient but clinical staff (RNs, LPNs, MAs) engagement was necessary to facilitate the discussion of the benefits mammography screening. It is typically ambulatory clinical staff who are the first clinical professionals to have the opportunity engage the patient in the discussion of mammography screening.

- Clinical Educators, in conjunction with Clinical Quality, provided onsite educational sessions on the demographics of breast cancer and the benefits of mammography screening within multiple practices to clinical staff.
- Information Services provided the review of EMR documentation tools to help facilitate successful, reportable data on mammography screening by clinical staff.
- Clinical Informatics educated clinical staff on the use of registries to track patient populations in regards to mammogram.
- Proactive patient outreach phone calls for mammogram were piloted in order to help reach patients who may be overdue for screening.

By providing clinical staff with the rationale for screening, the discussion points for patient engagement, the tools for documentation, and the ability to track progress, we empowered them to truly make a difference in managing patient and population health. A multi-disciplinary approach to network initiatives with nursing acting as liaisons in the ambulatory care arena facilitated not only patient but provider involvement.

Our success continues with mammogram as we refine our use of EMR technology to provide clinical decision making support prompts, which allows for integrating reminders that prompt clinical staff to engage in the mammography screening discussion so it becomes standard work at each face-to-face patient interaction

SESSION 2B

TORONTO D

Ballroom

The Ambulatory Management of Obesity: "Let's Get Moving"

Dr. Lawrence Cohen, MD, Associate Professor, University of Toronto, Gastroenterologist, Sunnybrook Health Sciences Centre.

Obesity should be viewed as a multifactorial, chronic disease which often leads to an individual's increased morbidity and mortality from metabolic syndrome (type 2 diabetes, dyslipidemia, hypertension, hepatic steatosis, sleep apnea), cardiovascular and neoplastic complications. Epidemic increases in the prevalence of overweight and obese adults and children have been observed over the past 3 decades in many developed nations resulting in major public health issues and rising costs to our health care systems. An estimated 24% of Canadians are obese (4th worldwide), reflecting a doubling of obese individuals over 20 yrs of age, and tripling of those 6-19 yrs old! The physiology of obesity is a complex interaction between chemical neuro-gastrointestinal signals (adipcytokines, incretins, hypothalamic receptors) and behavioural factors. The management and treatment of obesity is challenging. Ideally, a team of health care professionals should be established to provide a care map for obesity patients (endocrinologists, gastroenterologists, dietitians, exercise physiologists, counsellors, bariatric surgeons). The accepted treatment methods include: diet modification; physical exercise, behavioural therapy regarding eating habit and lifestyle alterations; pharmacological intervention, bariatric endoscopy and/or surgery. Adherence to and maintenance of an obesity treatment program remains a challenge for the individual, but successful outcomes are rewarded by significant improvements in comorbid diseases, self esteem and reduced mortality.

The presentation will focus on epidemiology, physiology and treatment of obesity, with highlights of innovative endoscopic interventions.

10:00 - 10:15 am	**Morning Refreshment Break**

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10:15 – 10:45 am	**Concurrent Sessions #3 (Please select one)**

SESSION 3A

TORONTO C Ballroom

Quality Improvements In Out Of Hospital Premises

Shandelle Johnson CPSO, Manager, Practice Assessment and Enhancement, Quality Management, College of Physicians and Surgeons of Ontario

In 2010 the College of Physicians and Surgeons of Ontario was given enhanced regulatory authority to inspect and assess settings where anaesthesia and sedation are provided for procedures outside of a hospital. Common procedures include endoscopy, interventional pain and plastic surgery. This has resulted in the assessment of over 250 premises. This presentation will review the governing regulation for the program; describe the standards requirements and program model; summarize some of the outcomes of the inspection process to date and, looking ahead, future changes in the program

SESSION 3B

TORONTO D Ballroom

Australia's Aging population: Implication for prevention and management of chronic heart failure

Natasha Scully PhD (C), BA BN, PGDipNSc, MP, RN. School of Health, University of New England.

Chronic diseases are a leading cause of morbidity and mortality globally. Cardiovascular disease is responsible for the highest mortality rate in women worldwide. The prevalence of these conditions is expected to increase as the population ages and incidence of risk factors increase. This presents a large burden to the acute care setting and implications to boost health policy related to the management in the ambulatory care setting.

Chronic heart failure (CHF) is a growing public health challenge in Australia, and globally, and is associated with significant morbidity, mortality and economic burden, especially in the population aged 65 years and. The Australian population aged 65 years and older is set to see a 3-4 fold increase in the coming decades. The prevalence of CHF is predicted to increase in parallel with the ageing of the population and the continuing decrease in fatal coronary heart disease. Despite significant improvements in Australia's health over the past decade, to 2008, there remain significant opportunities for further progress into the 21st century.

This presentation will provide an introduction to the ageing of the Australian population along with the implications this holds for health policy and illness management. As the focus of my PhD is on the management of chronic heart failure (CHF), an outline of the epidemiology of CHF in Australia will be given, followed by the evidence-based management strategies. My PhD uses quantitative data collection methods to determine the epidemiology of CHF in the 45-64 year age group and the realistic evaluation approach to determine the acceptability of current management strategies. There will be a strong focus on the primary and secondary prevention strategies as well as management strategies in the primary and community (that is, ambulatory) care setting.

10:45 – 11:30 am **Concurrent Sessions #4 (Please select one)**

SESSION 4A

TORONTO C Ballroom

The Redevelopement of a New Ambulatory Care Centre. Queen Elizabeth Hospital Ambulatory Care.

Anne Barlett, RN, BN, Clinical Lead/Nurse Educator, QEH Ambulatory Care Centre,
Debbie Downe, RN, BN, Manager, QEH Ambulatory Care Centre.

This presentation will involve a brief project summary of QEH Redevelopment, including the critical assumptions and planning principles used for new ACC. Other topics to be included are the budgeted and operational dollars required, as well as, staffing determinants and equipment allocation and purchases.

The presenters will also include the benefits realized with the addition of the new ACC, as well as, a discussion on the ACC outcomes to date. Included in closing remarks, will be our comments on the challenges and lessons learned by those involved in the planning, design, and implementation of the new ACC.

SESSION 4B

TORONTO D Ballroom

Medication reconciliation in an ambulatory clinic: Integrating community pharmacist.

Marko Tomas, BScPhm, **Lisa McCarthy**, BScPhm, Pharm.D., MSc, **Natalie Crown** BScPhm, Pharm.D,MSc, **Debaroti Borschel**, MD, MSc. Women's College Hospital

Medication reconciliation (MR), associated with reduced discrepancies and adverse events in institutions, is challenging in ambulatory care. Patients have increased responsibility for medication use and periodic contact with multiple prescribers lacking a shared record. MedsCheck is an Ontario government-funded community pharmacy-based program that generates a best possible medication history (BPMH), serving as a starting point for the MR process. Project objectives were to integrate MedsCheck into our clinic workflow and evaluate its success.

Methods: MedIntegrate is a pharmacist-led initiative within the Complex Care Clinic (CCC), an academic internal medicine clinic at Women's College Hospital (WCH). The program involves outreach to both patients and community pharmacies - encouraging patients to receive a MedsCheck and requesting documentation from pharmacies before initial CCC visits. The documentation is then used as a starting point for MR, provides the team with a BPMH and helps clinic pharmacists identify patients that may benefit from further attention. Program evaluation (Jan-May 2013), approved by the WCH Research Ethics Board, used patient and health provider questionnaires, patient chart, and MedsCheck documentation review.

Results: Fifty-four of 86 new patients referred to the CCC were eligible for a MedsCheck (taking 3 or more medications). While 54 consented to having their community pharmacy contacted, documentation was received by CCC for 21 (38%) of these reviews. At least one medication-related problem (MRP) was reported for twelve (57%) patients with a mean number of 2.6 (SD 1.5) for each patient. Medical team members reported a mean time savings of 7.9 minutes (SD 2.4) from the program. Chart review was completed for patients who also completed the study questionnaire (n=32); 23 (72%) had 3 or more risk factors for MRPs, 31 (97%) had at least one known risk factor, the mean number of medical conditions and medications per patient was 3.9 (SD 1.8) and 9.3 (SD 4.7), respectively.

Conclusion: MedIntegrate was well received by patients and providers, feasibly integrated into our clinic workflow; shortened time spent creating BPMHs, and assisted with identification of patients who may benefit from clinic pharmacist involvement. This approach could be adopted by other ambulatory care clinics.

11:30 - 12:00 am **Concurrent Sessions #5 (Please select one)**

SESSION 5A

TORONTO C Ballroom

Robotic Surgery - A New Generation in Gynecologic Oncology?

Marcus Bernardini MD MSc FRCSC, Assistant Professor, Division of Gynecologic Oncology
Princess Margaret Hospital, University Health Network
Robotic Surgery in Gynecologic Oncology

Minimally invasive surgery has always been an important element of the treatment of women with gynecologic malignancies. The advent of the Da Vinci robotic platform, originally implemented in 2005 for gynecologic surgery, has resulted in a dramatic change in the landscape for these types of operations. In this presentation you will be familiarized with the technology itself, the advantages it provides, the challenges in implementation and some important work being performed to examine outcomes in this ever expanding field.

SESSION 5B

TORONTO D Ballroom

Ambulatory Brachial Plexus Catheter Program - A Possible Alternative to Hospital Based Pain Management.

Cherly Denton, RN, Holland Centre
Eri Maeda RN(EC), MN, NP-Adult, CNCC(c), Holland Centre

Background: Upper extremity surgeries are one of most painful surgeries. Since March 2009, patients undergoing ambulatory or short stay upper extremity surgery regimen at Sunnybrook Holland Orthopaedic & Arthritic Centre (HOAC) have been offered an ambulatory Continuous Brachial Plexus Block (CBPB) as a part of their pain management.

The sample population: 118 patients were discharged with CBPB between January 2010 and October 2012.

Methodology: On the day of surgery, brachial plexus catheter was inserted by an anesthesiologist and the patient received a bolus of local anesthetic prior to induction of general anesthetic. An elastmetric infusion pump was attached to the catheter in the recovery room and patients were given instructions for the management of the CBPB and provided with an emergency contact. Patients received daily follow-up calls from APS until the caretaker removed the catheter.

Research findings: No patients reported local anesthetic toxicity. Nearly three-quarters of patients removed their catheter without incident on POD#2. 26% of patients reported pain score of >5 (of 10), successfully managed with encouragement to use oral analgesics, or a catheter top-up. 7% of patients returned to the HOAC due to an issue with CBPB (difficulty removing or dislodged catheter) or surgical pain requiring a top-up. Less than 5% of patients visited an urgent care centre for difficulty removing catheter, hoarseness and fever, syncope during catheter removal, dislodged catheter, or uncontrolled pain.

Conclusions: The study is a quality improvement initiative; there is no comparison to hospitalized patients or those without an ambulatory CBPB for pain scores, patient satisfaction, extended healthcare use, or opioid requirements & side effects. However, the majority of our patients had good analgesia with an ambulatory CBPB and oral analgesics following upper extremity surgery, and no major complications were noted. Daily follow-up allowed for patient assessment and an opportunity to provide advice regarding oral analgesics and further treatment. The ambulatory CBPB program provides the possibility of a cost effective, patient-centered pain management alternative to hospitalized care for those patients undergoing more invasive surgeries.

12:00 – 1:00 pm	**Networking Lunch**

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1:00 – 2:00 pm	**Poster Presentations and Sponsor Booths**

2:00 – 2:30 pm	**Concurrent Sessions #6 (Please select one)**

SESSION 6A

TORONTO C Ballroom

Opportunity for Innovative Alternatives for Out-of-Hospital Birth

Sara Wolfe, RM. Seventh Generation Midwives Toronto
Jennifer Dockery, RN, BScN, MHSc Director, Primary Care Women's College Hospital
Toronto Birth Centre. Midwife-led Birth Centres in Ontario

For the majority of Ontarians, there are currently two options for where to have a baby: at a hospital or at home. This Fall, in Ottawa and Toronto there will be a third option, midwife-led birth centres. C-Section rates for midwives in Ontario are currently about half the provincial average, and close to the rate of 15% recommended by the World Health Organization. A key part of the Ontario Action Plan for Healthcare, the Ministry hopes birth centres will become one solution to mounting health care costs by becoming part of the strategy to reduce escalating caesarian section rates through safe, cost-effective, community-based care. As many as 90 registered midwives in Toronto will deliver 450 normal births per year in the heart of the new Regent Park redevelopment. By partnering with Women's College Hospital, the Toronto Birth Centre hopes to make pregnancy and birth, a circumstance that crosses all ethnic, cultural, and socieo-economic groups, a gateway to access broader innovative ambulatory care services for women and families.

The birth centre model has been proven to work in many jurisdictions around the world. Closer to home, in Quebec and in Winnipeg, there is a well-established system of midwifery-led birth centres. While both these new centres will continue using the existing model of midwifery care in Ontario, the Toronto Birth Centre will additionally create a unique first in Ontario. Aboriginal midwives are leading the development of this mainstream service with a specific goal of increasing access to midwifery and out-of-hospital birth for the City's many marginalized urban populations, starting with Canada's First Peoples. It is will known that disparities in health outcomes are largest for Aboriginal people in Canada, including an infant mortality rate of 2-4x the national average. Outcomes for Aboriginal peoples do not seem to improve when their

proximity to services gets ostensibly closer. With the increasing urbanization of Aboriginal peoples (approximately 70% of Aboriginal people now live off-reserve in urban areas), it is fitting for the government to consider innovative approaches to improving access for this and it's many other hard-to-reach segments of the population.

SESSION 6B

TORONTO D Ballroom

IMPACT (Interprofessional Model of Practice for Aging and Complex Treatments

Dr. Jocelyn Charles, MD, MScCH, CCFP. Sunnybrook Health Sciences Centre, The Sunnybrook Family Health Team

The Sunnybrook Academic Family Health Team is participating in a research study called IMPACT (Interprofessional Model of Practice for Aging and Complex Treatments) Plus: The Integrated Complex Care Clinic. The IMPACT clinic is a special clinic for seniors with multiple health conditions. In this clinic, patients of Sunnybrook Family Practice have the opportunity to meet with healthcare professionals from many disciplines, including a pharmacist, physiotherapist, social worker, dietician, community care access coordinator, geriatrician, as well as their Family Doctor and a family medicine resident in an integrated care model.

The main IMPACT intervention is a 2 hour appointment where the team meets, in real-time, to 'unpack' the patient's condition by looking at a diverse range of medical, functional and psycho-social issues.

The appointment allows the patient, an identified caregiver and the interprofessional team extra time to talk about how the patient and his/her caregiver are managing their care, the supports that are in place, and the additional resources that may be required.

The purpose of the study is to investigate whether or not the IMPACT clinic will result in a decrease of both hospital admissions and emergency room visits, and will also result in higher levels of satisfaction among patients, caregivers, and healthcare professionals.

The interprofessional nature of the team highlights communication, both between health care providers and the patient and caregiver and among team members to optimize patient care. The length and breadth of the visit highlight compassion, consideration and comfort. Patients and caregivers appreciate the dedicated time and care they receive in the clinic as well as the comprehensive list of recommendations they take home with them. Patients also appreciate meeting with several health care providers in one place at one time rather than attending a number of individual appointments. Although the results of the study will not be published until next year, the anecdotal response from patients, caregivers, and health care providers to date has been overwhelmingly positive.

2:30 – 3:00 pm **Concurrent Sessions #7 (Please select one)**

SESSION 7A

TORONTO C Ballroom

Early Weight-bearing and Mobilization vs Non-Weight-bearing and Immobilization After Open Reduction and Internal Fixation of Unstable Ankle Fractures: A Randomized Controlled Trial.

Dr. Niloofar Dehghan, MD PGY5, Orthopaedic Surgery –University of Toronto, Sunnybrook Health Sciences Centre.

Purpose: The optimal post-operative protocol with respect to weight bearing and ankle range of motion following open reduction and internal fixation (ORIF) of acute ankle fractures remains elusive. Convention dictates non-weight-bearing and immobilization for six weeks post-operatively, but early weight-bearing may expedite return to function (with the potential risk of loss of fixation or wound complications). Our goal was to conduct a randomized controlled trial comparing early weight-bearing and mobilization vs non-weight-bearing and immobilization after ORIF of unstable ankle fractures.

Methods: We conducted a multi-centered randomized controlled trial at two level one trauma centers. Patients who underwent acute surgical fixation of an unstable ankle fracture were recruited and randomized to one of two rehabilitation protocols: 1) early weight-bearing (weight-bearing and ankle mobilization at two weeks) or 2) delayed weight-bearing (non-weight-bearing and casting for six weeks). Patients with posterior malleolar fixation or syndesmosis injuries were excluded. Patients were seen in follow-up at 2 weeks, 6 weeks, 3 months, 6 months, and 12 months post operatively. The primary outcome was time to return to work; secondary outcomes included ankle range of motion (ROM), SF-36 heath scores, Olerud Molander ankle score, and rates of complications (wound complication, loss of reduction, hardware failure, re-operation).

Results: Ninety patients were recruited: 47 were randomized to early weight-bearing and 43 were randomized to the delayed weight-bearing group. Patients were 47% female, 53% male, with a mean age of 42 years; there were no differences between the two groups with regards to demographics, type of fracture, time to surgery, or type of pre-injury occupations. There was no statistically significant difference between the two groups with regards to time to return to work or ROM at any time point. The early weight-bearing group had better Olerud Molander ankle function scores at 6 weeks (62.1 vs 54.4, p=0.0018), as well as significantly higher SF-36 scores (56.3 vs 45.8, p=0.005); on both physical (60.0 vs 42.4, p=0.014) and mental (76.4 vs 66.4, p=0.0016) components. These differences were not evident at 3 and 6 months post-operatively. There were no cases of fixation failure, loss of reduction, or repeat operation in either group. There were no differences with regards to wound complications or infections.

Conclusion: This randomized study of early versus delayed weight-bearing demonstrated no significant difference with regards to time to return to work or ROM in patients with surgically treated ankle fractures. However, patients treated with the early weight-bearing protocol had significantly improved ankle function scores, and higher mental and physical health outcome scores early in the post-operative period. There were no failures of fixation or differences in wound complications between the two groups. Given the convenience for the patient, the early improved functional outcome, and the lack of an increased complication rate with early weight-bearing, we recommend early post operative mobilization and weight-bearing in patients with surgically treated ankle fractures.

SESSION 7B

TORONTO D Ballroom

Effectiveness of E-mail management in Patients with Chronic Disease

Fred Saibil, MD, FRCPC, Division of Gastroenterology, Sunnybrook Health Sciences Centre, Professor of Medicine, University of Toronto. Collaborators: Ian Plener, MD and Andrew Hayward, MD

E-mail correspondence between physicians and patients can be a useful tool to improve communication efficiency, provide economic and ecological benefits, improve therapeutic interventions and adherence, and enhance self-management. The model of self-management in chronic disease has become an integral component of North American and British medicine. From an economic and practical standpoint, the use of e-mail between physician and patients may provide this necessary adjunct as a complement to the self-management model in chronic disease. E-mail contact reduces the inefficiencies present with telecommunications. Physicians are able to document out-of-office patient encounters, reach their patients efficiently, and provide access to specialist care for patients in remote locations. This type of access has the potential to increase patient safety through physician approval of self-manager actions and earlier initiation of needed treatments. A decrease in the number of clinic visits frees up time for new consultations and sicker patients, reducing the overall burden on referral and wait times.

3:00-3:15 pm **Afternoon Break**

Sponsored by:

3:15 – 3:45 pm **Concurrent Sessions #8 (Please select one)**

SESSION 8A

TORONTO C Ballroom

Ontario Cervical Cancer Screening Guidelines: An Evidence- Based Program

Michael Shier, BSc, MD, FRCSC**,** Sunnybrook Health Sciences Centre.

In the first part of the last century, malignancies of the cervix accounted for a majority of female cancer deaths throughout the world. Because of effective screening programs and diagnostic methods that can detect and eliminate many of these diseases in the intra-epithelial stage, this statement is fortunately no longer true. However, in countries, which do not utilize modern technologies, these tumors continue to be amongst the leading causes of female death from cancer. In Africa new cases equal cancer deaths each year. Approximately 500,000 women will die of cervical cancer worldwide this year with 450 of those cervical cancer deaths in Canada.

In North America, detection of cancer of the cervix in its preinvasive stage became common only after George Papanicolaou published his treatise on cytology in 1943. In 1925 Hans Hinselman invented the colposcope and now in North America colposcopy is the cornerstone in the management of patients with cervical intraepithelial neoplasia. The modern colposcopic method has allowed for the evolution of effective, but conservative therapies. This latter development is particularly important in light of the increased number of women presenting with the pre-invasive form of cervical cancer and at an earlier age, often prior to having children.

New Cancer Care Ontario Cervical Screening Guidelines are part of the “Screen for Life” program, which involves the anatomical sites of breast, colon and cervix. These evidence-based guidelines will be described and are designed to more appropriately allocate resources to provide a more efficient, accurate and comprehensive cervical program.

SESSION 8B

TORONTO D Ballroom

Integrated Expertise – Interprofessional Teams in Ambulatory Care

Theresa Kay, MHSc, BHSc, PT, Health Discipline Professional Practice Leader**, Catherine Renwick,** RN, Nursing Professional Practice leader**, Jane Mosley.** RN, MScN, Chief Nursing Executive & Health Disciplines, Professional Affairs**,** Women’s College Hospital.

Specialization, decentralization and professionalization have contributed to the fragmentation of healthcare services between both professions and organizations.1 Women’s College Hospital (WCH) has eliminated professional and departmental boundaries through interprofessional collaboration. With a Nurse/Health Discipline staff volume balance which is more equal than that of most organizations, professionals have a deeper shared understanding of each other’s roles and scopes of practice. Using elements of collaborative practice, WCH has created models for interprofessional teams designed to work on shared goals to improve patient outcomes and the patient experience. Models of interprofessional teams are context dependent. At WCH, many ambulatory care teams are unique with representation of professionals from multiple disciplines. Involved in common assessment and care planning with either independent or joint decision-making, they provide direct services individually or with other team members to meet the needs of the patient. In many cases, the patient and their significant others are central members of the team. The team members meet formally, informally and virtually, and use various structures and tools to communicate, coordinate and monitor care. Team members divide the work based on their scope of practice, share information to support one another’s work, and coordinate processes and interventions to provide a number of

services and programs. WCH teams work to expand and amplify the practice with professionals working at an advanced level in concert with physicians, for example, our Advanced Practice Physiotherapist is a key member of our Rheumatology team. The teamwork that is required for interprofessional collaboration is not an inherent attribute of any system. It must be fostered. Communication is facilitated by congregating members around programs and patient population based service groupings. They are co-located in clinics to enhance communication and efficient patient access to service. In this presentation, successful standard and common practices across interprofessional teams, practices tailored for specific patient populations and how our interprofessional teams connect and reach out to our community.

3:45 – 4:15 pm **Concurrent Sessions #9 (Please select one)**

SESSION 9A

MyChart in Ambulatory Care: The way health record information is delivered and exchanged between healthcare providers and patients

TORONTO C Ballroom

Florin Negoita, Project Manager, Sunnybrook Health Science Centre

Personal Health Records represent one of the newest areas in the field of HIT. The potential for PHRs to contribute to improved quality of care, reduced healthcare costs, and further empowerment of patients as central participants to their own healthcare is significant, however there is a lack of awareness surrounding the capabilities that PHRs have and how to engage in their use. Sunnybrook's experience in building and continually improving one of the longest running PHR solutions in Canada will be examined with an emphasis on patient experience and multiple data providers integration.

SESSION 9B

Patient –as-observer approach-an alternative method for hand hygiene auditing in an ambulatory care setting.

TORONTO D Ballroom

Sheila Le-Abuyen, MPH, CPHI (C) Infection Prevention & Control Practitioner. Women's College Hospital.

Issue: The World Health Organization's multimodal hand hygiene (HH) improvement strategy recommends direct observations of HH practices by an independent observer to improve HH compliance. More easily applied in acute care environments, outpatient settings are often not conducive to this auditing method due to challenges of workflow disruption; privacy concerns; and observer bias. To overcome these challenges, a pilot project using an alternative method for hand hygiene auditing was implemented. This method engages patients as observers for healthcare provider (HCP) HH practices.

Project: During their visit, patients were asked to participate in a survey and monitor their HCP's HH practices. Survey cards were distributed and collected by trained volunteers. Monthly meetings with a multidisciplinary working group were used to determine workflow processes; develop a communications plan for HCPs and patients; provide feedback on survey tools; finalize the evaluation format; and monitor progress. Weekly status updates and patient feedback were forwarded to HCPs as motivation to continually improve HH practices.

Results: Results of the nine-month pilot:

- Patients returned 75% of survey cards.
- Based on patient observations, the overall HCP HH compliance before direct contact with the patient was 97%.
- As part of evaluation, the patient-as-observer approach was compared to direct observation by trained nurses. An 87% accuracy rate/concordance suggests patients are able to accurately observe HCP HH practices.
- The vast majority of patient commentary expressed satisfaction with survey participation and HCP HH practices.

Lessons learned:

- The patient-as-observer approach is a viable and cost-effective alternative for HH auditing in an ambulatory care setting.
- This auditing method allows us to engage, empower and educate patients to play an active role in their own healthcare.

4:30 -6:30 pm	**Wine and Cheese Reception**

Please join us for a Wine and Cheese reception generously provided by our Silver with Distinction Sponsor:

Location to be announced at Conference site.

07: 00 am- 8:00 am **Breakfast**

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8:00am – 8:30 am **Concurrent Sessions #10 (Please select one)**

SESSION 10A **The Breast Rapid Diagnostic Unit (RDU): An overview**

TORONTO C Ballroom

Angela Leahey, RN, BScN, MN, Advanced Practice Nurse - Breast Cancer, Sunnybrook Odette Cancer Centre, **Lisa Verity**, RN, BScN, CONC, RDU Nurse Navigator, Louise Temerty Breast Cancer Centre – a division of the Odette Cancer Centre.

The Odette Cancer Centre has the largest Breast Cancer program in Canada. Over 2000 new breast cancer patients are seen at the Odette Cancer Centre each year and one out of every 10 women diagnosed with breast cancer in Canada will be treated at the Odette. In May 2011, a team of dedicated breast surgeons, radiologists, pathologists, and specialized oncology nurses worked to better streamline the diagnostic process and wait times for breast cancer. After much planning, collaboration, and innovation, the wait time for these individuals was decreased from 6-8 weeks to a promise of a "next-day" diagnosis. The Breast Rapid Diagnostic Unit (RDU) provides rapid assessment and next-day diagnosis for women and men suspected of having breast cancer. It is comprised of breast-dedicated individuals committed to providing patients with a clearly defined process and streamlined service for rapid diagnosis. It features a dedicated Nurse Navigator who guides and supports each individual through the assessment/referral to diagnosis process, and facilitates clear and accurate communication throughout what is often an anxious time for patients. Individuals with an abnormality on a mammogram, breast ultrasound, or a clinical finding that is highly suspicious for breast cancer, are referred to the Breast RDU by a family physician. Once the referral has been received, the Breast RDU Nurse Navigator contacts the individual and begins the process for expediting investigation and ultimately diagnosis. During the presentation we will highlight the development of the Breast RDU, the Nurse Navigator role in diagnostic assessment, and our successes and challenges to date in transforming ambulatory care.

SESSION 10B **Ambulatory Care Centre Dramatically Improved Hospital Bed Utilization**

TORONTO D Ballroom

Dr. Eric Woon-Leung Ng, FHKAM, Deputy Chief of Services**, Pik-shan Cheung,** FHKAM, **Pui-Ling Ngan,** RN, MSc, and **Chung-ming Chu, MD**. United Christian Hospital, Hong Kong

Purpose: In-patient care is a major healthcare burden and hospital beds are scarce hospital resources. In 2006, the Department of Medicine & Geriatrics of the United Christian Hospital faced a reduction of in-patient beds due to service re-organization. To cope with the challenge, the United Ambulatory Care Center (UACC) was established in August 2007 to function as a one-stop integrated service hub to deliver timely and comprehensive medical care in ambulatory setting. The goal is to reduce avoidable hospitalization through innovative care pathway and careful patient selection. The Centre expanded the scope of service to receive direct referral from the Accident and Emergency Department (AED) from May 2010. This study

aims to evaluate the throughput of UACC and the impact on in-patient service in the Department of Medicine & Geriatrics, United Christian Hospital.

Methods: Number of ambulatory admission episodes in UACC was collected and described. Data on emergency admissions, bed number, average length of stay and occupancy from 2005 to 2012 were retrieved from the Executive Information System of the Hospital Authority, Hong Kong.

Results: Annual admission data for UACC was retrieved from 2007 to 2012. The annual ambulatory admission episode rose from 2,708 in 2007 to 10,253 in 2012. Among these, direct referral from AED to UACC was increased from 579 in 2010 to 1,381 episodes in 2012. Comparing the emergency admission data in 2005 to 2012, despite a rise in annual emergency admissions from 24,099 to 29,046 and a reduction of in-patient bed number from 469 to 419, the in-patient occupancy rate was reduced from 92.2% to 89.8%. This was paralleled by a reduction of in-patient average length of stay from 5.4 days to 3.8 days. The annual total number of in-patient bed days occupied was reduced from 165,562 in 2005 to 135,043 in 2012.

Conclusion: The study provided supportive evidence that the establishment of a specialized ambulatory care service significantly reduced in-patient care burden and enhanced hospital bed utilization.

Implications: Development of an intensive and integrated ambulatory care service is a strategic step in strengthening the resilience of the healthcare system to cope with rising healthcare demand.

8:30 – 9:00am **Concurrent Sessions #11 (Please select one)**

SESSION 11A

TORONTO C Ballroom

Management of Malignant Pleural Effusions in Ambulatory Care- Pleura-X catheter

Khalil Sivjee, MD, FCCP, FRCPC Associate Professor, University of Toronto, Head, Division of Respirology and Clinical Immunology, Sunnybrook Health Sciences Centre.
Harvey Wong, MD, FRCPC Associate, Division of Respirology Sunnybrook Health Sciences Centre.

Malignant pleural effusions (MPE) occur as a result of cancer cells seeding the outer lining of the lung. This can result in excessive accumulation of fluid around the lung causing the patient to feel pain, shortness of breath, respiratory failure, and sometimes death. Traditionally, MPE have been treated in the hospital by inserting a large bore tube (chest tube) into the chest, allowing the fluid to drain, and then attempting to seal the space with a sclerosing agent. Besides being a painful process, this method of treating MPE results in high resource utilization as the patient spend several days in hospital. Given that MPE represent disseminated cancer, these patients may not have long survival times and often do not want to spend their precious last weeks in hospital. A recent retrospective review at a large teaching hospital in Toronto examined 121 patients admitted with MPE from July 2010 to June 2011. It showed that the average length of stay (LOS) for these patients was 16 days. Essentially, this meant that 5 hospital beds were occupied all year round with patients being treated for MPE with a total cost to the system of over $1.6 million.

In an attempt to improve patient quality of life and to decrease the cost to the system, a novel ambulatory approach to patients with MPE has been developed. This involves placement of a smaller, flexible, tunneled catheter (PleurX catheter) into the chest and then allowing the patient to drain the fluid as needed at home with the help of a CCAC nurse. The catheter is placed in an ambulatory setting and the patient is not admitted to the hospital nor to the emergency room. Preliminary data from the program has shown that this ambulatory approach to MPE results in effective relief of symptoms, decreased resource utilization, and increased patient satisfaction

SESSION 11B **Cardiac Arrests in an Ambulatory Care Hospital.**

TORONTO D Ballroom

Zahra Ismail, BScN RN, ENC(C), MN CPRS candidate**.** Women's College Hospital

Background: The Women's College Hospital (WCH) once an acute care hospital providing basic and advanced cardiac life support (BCLS/ACLS) has evolved its mandate to providing ambulatory care services. The WCH's former emergency department now Acute Ambulatory Care Unit (AACU) manages acute illnesses or exacerbations of chronic medical conditions, and clinical staff continue to respond to cardiac arrests (CA) using ACLS/BCLS practices. Literature suggests organizations' mandates are reflective in the care that is provided; therefore, CA response practices must shift accordingly.

Purpose: This project involves conducting a baseline and gap analysis of nursing BCLS/ACLS competence, and identifying evidence based practice to support resuscitation needs of WCH's new mandate.

Methods: The unit's full-time and part-time registered nurses completed an anonymous survey, and partook in focus groups. Nurses were surveyed on self-identifying how comfortable they felt responding to CA; their level of BCLS/ACLS knowledge; and, articulating their nursing role in CAs. Focus groups were conducted to identify nurses' perceptions of what resuscitation measures WCH should provide with its mandate change. Empirical literature regarding ambulatory care setting resuscitation needs and nursing competencies were reviewed. Other ambulatory settings were consulted with for policies and strategies to support clinicians in practice to ensure patients are given the most appropriate care. A mock CA program was implemented to provide knowledge gaps based on initial surveys. Post-surveys are still to be distributed to identify changes to nurses' resuscitation comfort and knowledge, and nursing role in CA. The AACU practice standards and WCH code blue policy are currently being reviewed to reflect ambulatory care resuscitation needs.

Results: 81% of full-time and part-time nurses completed the survey. Surveys suggested more exposure to CA increases one's comfort level in practicing BCLS/ACLS guidelines, and understanding nursing roles in CA. Focus groups suggest BCLS practices are to be performed in ambulatory care settings. Review of the evidence identified best practices for providing mock CA programs, ambulatory care nurses' resuscitation competencies, and BCLS practices for ambulatory care settings

9:00- 9:30 am **Poster Presentations and Sponsor Booths**

09:30 – 10:00 am
Moderator: TBA

Concurrent Sessions #12 (Please select one)

SESSION 12A

TORONTO C Ballroom

Not Just Another Acute Care Inpatient Unit: Applying Infection Prevention & Control (IP&C) Practices to an Ambulatory Care Setting

Barbara Catt RN, BScN, CIC, Med**, Sandra Callery** RN, MHSc, CIC,Sunnybrook Health Sciences Centre, Toronto, Ontario

Issue: Literature demonstrates ambulatory care settings have lower rates of healthcare associated infections (HAIs) than inpatient settings. The level of care can range from a brief consultation to an invasive surgical procedure. Transmission of organisms can be stopped by consistent use of Routine Practices and Additional Precautions (RP/AP). In busy Ambulatory Care Clinics (ACC) lack of clarity about when additional precautions are required can result in confusion amongst healthcare workers (HCW), create unnecessary workload. It may lead to frequent calls to IP&C and concerns from patients and patient family members. At Sunnybrook Health Sciences Centre (SHSC), the HCW is responsible for performing a risk assessment and initiating additional precautions when required.

Project: The goal of the project was to determine the number and type of ACC at SHSC and to assess the IP&C risks. Areas of higher risk for patients acquiring HAIs were identified through baseline data collected during walkabouts. Observations and recommendations were documented and used to tailor education to each area incorporating medical device reprocessing needs, hand hygiene, routine practices and additional precautions.

Results: 146 ACC were identified, classified based on the type and procedures performed, and scored according to infection risk to the patient. 8 clinics perform invasive procedures; 40 perform minor procedures and 98 are basic or consultation clinics. Walkabouts with clinic staff were performed on the 8 invasive procedure clinics, 25/40 minor procedure clinics and 15/98 consultation clinics.
8 formal educational sessions have been provided. This has resulted in updates of policies, procedures, Fact sheets, and the development of an e-learning module.

Lessons Learned: In ACC, the goal is to provide patients with the highest level of care and to develop strategies in that environment that minimizes their risk of transmission of infections.
The challenge is to apply general IP&C principles and adapt them to this unique environment.

SESSION 12B

TORONTO D Ballroom

Oral chemotherapy in homecare setting

Komal Patel, MN, CON(C), CHPCN(C)Educator, de Souza Institute

The advent of oral systemic agents has changed the landscape of cancer therapy. An estimated 25 to 50% of the more than 300 new antineoplastic agents currently in development are oral products. The increase in oral chemotherapy agents affects the infrastructure of chemotherapy administration as the site of care moves from intermittent intravenous infusions in outpatient clinics to continuous oral dosing taken in the patient's home; this has created significant safety and adherence issues and shifted elements of the traditional roles and responsibilities of oncologists, nurses, and pharmacists to patients and caregivers.

The workshop will review common oral therapies, advantages and disadvantages, adherence issues, reimbursement issues, safety issues, how to assess for and monitor toxicities, and what to include in patient education.

The workshop will also cover other chemotherapy in home setting, i.e., parenteral administration of chemotherapeutic agents, or portable infusion pumps (infusor pump / baby bottle). The workshop will review care of vascular access devices at home, Medication administration and side effect management, safe handling, patient lifestyle adjustments and ongoing care and follow-up required in the home setting.

10:15 -10:45 am
Moderator: TBA

Concurrent Sessions #13 (Please select one)

SESSION 13A

TORONTO C Ballroom

Pleural Procedures in Ambulatory Setting – A New Way Forward

Dr. Eric Woon-Leung Ng, FHKAM, Deputy Chief of Services**, Pik-shan Cheung,** FHKAM, **Pui-Ling Ngan,** RN, MSc, and **Chung-ming Chu, MD**. United Christian Hospital, Hong Kong

Purpose: In Hong Kong, most patients undergoing pleural procedures require overnight observation in hospital for safety reason. At our United Ambulatory Care Centre (UACC), a new service model was adopted since January 2010 to provide day-case ultrasound (US) guided pleural procedure. Out-patients or discharged patients with newly diagnosed pleural effusion who require pleural procedures were referred to the UACC. Bedside US thorax would be performed on the day of assessment followed by chest tapping or pleural biopsy if indicated. After the procedure, patients would be observed in the UACC with hourly vital signs monitoring and Chest XR surveillance. Stable patients would be discharged home in the evening. Patients with malignant effusion were arranged interval therapeutic chest tapping if they declined or were unfit for chest drain insertion and/or pleurodesis. This study aims to evaluate the effectiveness and safety of pleural procedures performed in ambulatory setting.

Methods: A chart review was performed on patients' demographics, indication and type of pleural procedures, and procedure-related complications for all pleural procedures performed in the UACC from January 2010 to September 2012.

Results: There were 318 patient episodes with 309 thoracic US performed. Two-thirds of the patients were male. Forty-one percent of cases were referred for investigation of the etiology of pleural effusion, 36% were related to malignancies, 12% were due to infections including tuberculosis and 11% due to miscellaneous causes. Majority of patients (70%) proceeded to pleural procedures after assessment, resulting in 186 chest tapping and 29 pleural biopsies. Five patients developed post-procedural pneumothorax, 3 required admission and 2 required chest drain insertion. In addition, 15 patients required in-patient care due to the underlying medical problems including 2 patients with empyema, 11 patients with malignant effusion decided for chest drain insertion and 2 patients with significant co-morbidities. There was no procedure-related mortality.

Conclusion: In summary, 94% of ambulatory patients with pleural pathologies can be safely and successfully in an ambulatory day-case setting.

Implications: The conversion of pleural procedure from in-patient to ambulatory setting allows patients to return home more quickly, and reduces the pressure on in-patient beds

SESSION 13B

TORONTO D Ballroom

Innovation in Sexual Health for Cancer Survivors: The Role of Oncology Nurse

Margaret I. Fitch, RN, PhD Head, Oncology Nursing Director. Sunnybrook Health Sciences Centre
Innovation in Sexual health for cancer survivors: the role of Oncology nurse

Background: Gynecologic cancer treatment has a profound impact on women. Physical and psychosocial consequences often emerge with resultant changes in quality of life. Specifically, treatment can impact sexual function and sexuality and include a range of issues such as pain, bodily changes, alterations in body image, shifts in relationships, and emotional distress. As many as 50% of women treated for gynecologic cancer may experience some type of sexual problem.

Objective: Within our ambulatory cancer centre, we created an innovative clinic to address concerns about sexual health, rehabilitation, and quality of life following treatment for women with gynecologic cancer. The nursing role within this clinic is a key component to the success of this inter-professional service and to the satisfaction reported by the women attending the clinic.

Methods: The role of the nurse is a specialized oncology nursing role with focused preparation in sexual health issues. The initial clinic visit involves an in-depth assessment by the nurse using a customized tool designed for this purpose together with other standardized measures. The

customized assessment tool is based on the Supportive Care Framework and helps to prepare for tailored intervention related to physical, psychosocial, informational and practical patient concerns. Brief counseling and education are provided by the nurse, covering a range of relevant topics, and individualized resource packages are provided. Subsequently, the patient returns for a second appointment with the physician and nurse together.

Results: Feedback from patients has been very positive with rating on satisfaction with the clinic being primarily "very satisfied". In particular, women reported their information needs had been met. Learning how to better manage the effects they were experiencing and learning more about community based resources were cited as helpful. Satisfaction with the nursing role was also evident.

Conclusion: This presentation will describe the role and preparation of the nurse in this sexual health clinic for survivors of gynecologic cancer. The nature of the practice will be described in terms of the types of issues the nurse manages and the resulting impact on patient outcomes

10:45 - 11:15 am
Moderator: TBA

Concurrent Sessions #14 (Please select one)

SESSION 14A

TORONTO C Ballroom

Ambulatory Care Nursing – Evolution and Specialization

Catherine Renwick, RN**,** Nursing Professional Practice Leader, **Jane Mosley,** RN, MScN, Chief Nursing Executive & Health Discipline and **Theresa Kay**, MHSc, BHSc, (PT), Health Disciplines Practice leader, Women's College Hospital.

As healthcare systems continue their migration from hospital-based care to ambulatory care, in concert with a shift to patient self-care and self-efficacy in health activities, Ambulatory Care Nursing is pivotal to patient care, education and advocacy. Ambulatory Care Nursing includes episodic services which can be a single instance or series of intermittent episodes spanning days to years. The care episodes occur in hospital clinics, telepractice and community settings. Although episodic in nature, the therapeutic relationship developed with patients can be long term with multiple foci. As the therapeutic relationship evolves, the patient assumes greater responsibility and accountability and the nurse transitions into a consultative role. Generally nurses in an ambulatory setting provide care to large numbers of patients in a short period of time, often managing unpredictable patient presentations and situations. Working within interprofessional teams, Ambulatory Care Nurses are often the most appropriate professional to coordinate care, to act as patient advocate and over time to provide patients with mentoring and tools for self-advocacy in the continuity and cascade of their healthcare and wellness promotion.

The Ambulatory Care Nursing conceptual base advanced by Haas1 (1998) and a formal framework by Mastal2 (2012) provide a basis for discussion and dialogue. Core competencies3, 4 for care, its coordination and transition management guide the advancement of professional specialization and expertise. This presentation will focus on the unique role of Ambulatory Care Nurses in patient safety, health system transformation and a call to action for broad communication of our unique contributions and distinct value.

SESSION 14B

TORONTO D Ballroom

Patient Navigation Abstract for Canadian Association of Ambulatory Care Conference

Maureen Watt-Smit, RN, BScN, CON(C), Educator, de Souza Institute; and Education Practice Lead, Grand River Hospital, de Souza Institute

The de Souza Patient Navigation course, although geared towards cancer patients, could be applied in any context where patients have unmet needs. The nurse navigators' role includes providing information and education; offering emotional and supportive care; and facilitating continuity of care and coordination of services. The significance of nurse navigator in care provision and coordination is well recognized across disease type, trajectory of care, or type of clinical program. This presentation will review core aspects of nurse navigator training, focusing on the domains of need for patients, and the phases of need a patient may encounter along their

cancer journey. It introduces Brennan's social cognitive transitional model of adjustment to help nurses understand the patient perspectives as they experience a newly diagnosed illness, the patient's readiness to learn and how a patient might integrate assumptions of self as it relates to coping with the illness. To facilitate the application of such knowledge, the course includes a variety of assessment tools, communication strategies and teaching strategies known to be helpful to build partnerships with the patient, reduce patient distress and anxiety, and support patient centered-goals in informational, practical, emotional, psychosocial, practical, and spiritual domains of care.

The impact of cultural, political, social and economic determinants of health on patient experiences and help seeking behavior is another important aspect of patient navigation. This course devotes a specific section on this topic to highlight nurse navigators' role to advocate for patients in overcoming barriers to care by facilitating access to social supports and resources.

The last section of the Patient Navigation course denotes the importance of self-care to alleviate stress, burnout, and compassion fatigue related to caring for patients facing a life-threatening illness. Strategies to prevent burnout through positive self-care activities and personal resources are provided to help navigators maintain positive self-talk and resilience in practice.

This course has been offered six times to nurses in Ontario over the past two years. Data from participants will be presented in terms of their knowledge change before and after the course and their feedback as to the potential application of the knowledge in their day-to-day practice.

11:15 am – 12:20 pm **Lunch, Poster Presentations and Sponsor Booths**

Sponsored by:

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12:30pm **Poster Presentation Award**

12:45 - 1:30 pm

TORONTO C Ballroom

Closing Remarks

Heather McPherson, MSc., O.T Reg. (Ont), CHE. Vice President, Patient Care & Ambulatory Care Innovation

Women's College Hospital

Saturday, September 14, 2013

1:40 – 2:40pm	**Workshops (to run concurrently)**

Workshop #1 	**Vascular Access Care and Maintenance for peripheral and central lines.** **Daphne Broadhurst, RN, BScN, CVAA(c)** from the Canadian Vascular Access Association Objectives: After attending the workshops participants will be able to: 1. Identify techniques to improve peripheral vascular access. 2. Identify and trouble-shoot common peripheral and central line complications. Attendees will receive 1.0 contact education hours for participating in this workshop.
Workshop #2 	**Scope Reprocessing** **Speaker: Steve Horsley** This workshop will cover: a) Infection Prevention and Microbiology b) Reprocessing Endoscope accessories c) Service, repair and reprocessing of Endoscopes Attendees will gain valuable understanding of maintaining the integrity of endoscope equipment and decrease cost of equipment repairs and replacement 2.0 Hour session
Workshop #3 	**Assessing and Managing Cancer Related Distress in Ambulatory Care** **Dr. Mary Jane Esplen,** RN PhD Director of deSouza Institute, **Cathy Kiteley**, RN, MScN, CON(c), CHPCN(c), Advanced Practice Nurse: Clinical Nurse Specialist, Trillium Health Partners, **Jaihui Wong** PhD Manager, Curriculum and Program Evaluation for deSouza Institute This workshop will provide an overview on cancer related distress, including information on cancer impact on psychosocial, spiritual and quality of life; and assessment tools to determine how to intervene and when a referral is required. Case studies will be used to highlight the assessment technique for patients with moderate-severe level of distress at time of screening; and teach effective strategies in managing distress that can be readily applied in ambulatory settings. 1.0 Hour Session
CAAC ANNUAL GENERAL MEETING	**AGM** **This meeting is open to all active members of the Canadian Association of Ambulatory Care (CAAC).**

"Things I have learned"

New Peer Contact List:

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Poster Presentation Abstracts

Poster #1

Implementing Programmatic Screening for Distress related to Physical Symptoms and Emotional Psychosocial Concerns

Authors
Margaret I. Fitch RN PhD
Jeff Myers MD CCFP MSEd
Stephanie Burlein-Hall RN BScN Med CON(C)
Tammy Lilien BA, Sunnybrook Health Science Centre

Introduction/Background:

Distress commonly emerges as patients cope with the consequences of cancer. Often the urgency of tumor treatment takes precedence, leaving the range of personal issues overlooked.

Methodology:

We designed and implemented a programmatic approach that includes the use of a standardized tool to screen for distress, a brief assessment conversation with the patients, a subsequent dialogue for deeper assessment as required, and intervention or referral based on the assessment. The programmatic approach sets out expectations for practice and requires designated responses by the inter-professional team members. Use of evidenced-based practice guidelines and inter-professional team algorithms were also introduced. Evaluation includes both pre- and post-measures (i.e., patient and staff satisfaction, documentation, follow-up care actions).

Results:

Implementation has been undertaken in a phased approach. Staff report that conversations with patients unfold differently than before the implementation and more personal issues are being identified. The assessments provided a basis for tailoring the plan of care with the individual patient. No added referrals have been noted as most of the issues are handled by the primary oncology team. Referrals that are mobilized are considered to be appropriate and require the intervention by professionals with additional psychosocial expertise (i.e., social work, psychology, psychiatry). Staff members have reported that they identified areas of practice in which they needed additional education (e.g., sexuality, spirituality) and that it took time to gain confidence and comfort in using the standardized screening tool in routine practice

Conclusions

Successful implementation of screening for distress requires a programmatic approach. Screening must be followed by appropriate assessment and intervention at the primary team level and referral if additional expertise is required. Staff members require education to perform successfully and relevant clinical tools and supports must be available to assist the members of the inter-professional team.

Poster #2

Addressing the Emotional Aspects of Living with Osteoarthritis as a Standard Practice in the Osteoarthritis Therapeutic Education Program

Lorna Bain OT Reg (Ont.), **Sue Charette** OT Reg (Ont), **Diane Tin** BScPhm**, Carter Thorne** M.D. ,**Hyeon Kang** , **Janet Jeffrey P**hD, Southlake Regional Health Centre

Background:

The Arthritis Program (TAP) at Southlake Regional Health Centre has been offering a comprehensive Osteoarthritis Therapeutic Education Program (OAThEP) for over two decades, aiming to increase patient self-management of the disease, and improve the emotional well-being of its patients.

The goals of this study are:

1. To examine the characteristics of patients participating in the OAThEP

2. To explore the significance of participation in OAThEP on emotional aspects of living with the condition as measured by the Hospital Anxiety and Depression Scale (HADS)

3. To compare the current model of informing all participants of their HADS score in class versus previous procedure of OT making targeted phone contact; to determine which is more effective in engaging patients to connect with social worker and or take part in wellness programs offered within the chronic diseases programs.

Methods:

This study will use a descriptive-correlational design. Retrospective chart review will be done on all patients attended OAThEP from May 2012 to May 2013. Information on age, gender, pain, distribution of painful joints and concurrent medications will be extracted and analyzed. Results from the following outcome measures will be included in analysis; Hospital Anxiety and Depression Scale (HADS), Western Ontario and McMaster University Arthritis Index (WOMAC), Modified Health Assessment Questionnaire (MHAQ) and the Osteoarthritis Knowledge Questionnaire. Chi-square, paired and independent t-tests, and RM-ANOVA tests will be done.

Results

At time of abstract submission, May 2013, a preliminary analysis was conducted using SPSS 20.0 for 2 cohorts; May 2012, n =24 and April 2013, n = 19. The cohorts were similar for sex but the 2013 cohort was younger (67 ± 11.6 vs. 56 ± 10.77). Numbers of joints involved were similar, as well as pain reported in these joints. Furthermore, similar pattern of medication use was noted. Similar HADS, WOMAC, MHAQ, and Knowledge Questionnaire scores are observed pre-class for both cohorts. Knowledge significantly improved in the 2012 cohort ($t=.28$, $p=0.23$). Analysis for the entire study sample will be completed and results will be reported in a poster presentation by Aug 2013.

Implications

Literature has recognized the interrelationship between mental health, pain and disability within the OA population. TAP has embedded the emotional aspects of living with OA as a standard element in its education program to create awareness and empower patients to initiate dialogue with their health care providers for treatment options to be explored. This study aims to highlight the importance of taking a holistic approach in caring for those living with OA to assist patients with their goals of self-management and empowerment.

Poster #3

Measuring Adherence to Oral Osteoporosis Medications in Patients Attending an Osteoporosis Therapeutic Education Program

Diane Tin B.Sc. , **Sherry Hartnett** BA, **Janice Ngeno** BHS, **Carter Thorne,** M.D. , **Edward Ng.** M.D.
Liane Ginsburg Ph.D. , Southlake Regional Health Centre

Background: Osteoporosis is an increasing public health concern with our aging population. Fractures and other complications associated with osteoporosis have devastating consequences for quality of life, and exact a heavy toll on the health care system. While a number of pharmaceutical agents effectively reduce the risk of fractures, adherence to osteoporosis medication remains poor with 20-30% of patients suspending treatment within 6 to 12 months of initiating therapy.

The Arthritis Program (TAP) at Southlake Regional Health Centre (SRHC) is an award winning model of care that provides assessment, treatment and education to patients with rheumatic diseases. It has been providing a comprehensive Osteoporosis Therapeutic Education Program (OPThEP), which aims to increase patient self-management of the disease. OPThEP has two components; individual consultation and follow-up with an inter-professional team, and a one day osteoporosis workshop.

Purpose: The purpose of this pilot study is to examine the impact of participation in the OPThEP on osteoporosis medication adherence.

Population: Our sample consists of 80 participants; 40 in the intervention group, and 40 in the control group. In the intervention group, the sample consists of post-menopausal females with a mean age of 69±10 years. The age range in the intervention group is 51 to 90 years of age. Participants in the control group are currently being recruited.

Methods and Analysis: We are measuring adherence using a short, validated, self-report questionnaire (the Osteoporosis Specific Morisky Medication Adherence Scale (©OS-MMAS)) in two groups of patients: those who attended TAP's OPThEP, and a control group recruited from physicians' offices in the same geographic catchment. Data on relevant covariates are captured from a chart review and abstraction. Data is statistically analyzed to determine if participation in the OPThEP improves adherence to oral bisphosphonates. A regression will be performed to model factors that explain variance in adherence. Qualitative data is also being collected from a sample of participants who had suspended bisphosphonate use at the time OS-MMAS measurement. This data will be coded based on reasons for non-adherence. Ethics approval is obtained from SRHC and York University.

Research Findings and Conclusion: In progress.

Proposed Presentation: As research in progress, data collection and analysis are currently underway. We will present a poster with our findings.

Poster #4

Patient and Family Education – Essential for 'At Home' Recovery Post Ambulatory Day Surgery

Andrea Messner, Staff RN, Surgical Care Unit, Women's College Hospital

Norma Husbands, Staff RN, SCU, Women's College Hospital

Pre-operative education for patients, their families and individuals providing 'at-home' post-operative support is a critical component of patient safety and overall patient satisfaction.[1] Targeted and comprehensive education enables safe and effective post-op recovery at home with minimal hospital stay. At Women's College Hospital (WCH), patients and their families receive 'early' education in the pre-operative assessment visit. This is followed by subsequent information reinforcement and expansion at each phase of the ambulatory surgical journey. Our patient-centric approach includes pre and post operative verbal instruction, audiovisual and written materials and a post operative 'check-in' telephone call. The call provides reinforcement and any needed clarification of information as well as overall reassurance. For our more complex surgical patient populations, an interprofessional team approach is deployed. Where indicated, Nursing Home Care through Community Care Access Centre (CCAC) is planned pre-operatively. WCH patients receive face-to-face general pre and post-op education and written information, specific to their planned surgery. Information about and practice of the post-op use of equipment and mobility support devices, such as crutches, are included. In our new facility, our expanded surgical space, purpose built for ambulatory surgery, and dedicated patient education space has allowed the expansion and enrichment of our pre-operative education program. Opportunities, challenges, tools, and lessons learned in the development and evolution of our pre-operative education program will be shared and discussed.

[1] Patient education outcomes in surgery: a systematic review from 2004 to 2010, Ronco, M., Iona, L., Fabrro, C., et al, Udine University, Udine, Italy, International Journal of Evidence-Based Healthcare, 2012; 10:309-323

Poster #5

Improving Specialist Appointment Wait Times at Women's College Hospital

Authors:

Akshay Rajaram, BSc., MMI
Affiliation: Quality Operations Analyst at Women's College Hospital
Kimberley Stern, BSc., MMI
Affiliation: Quality Operations Analyst at Women's College Hospital

To date, Ontario has devoted significant resources through its Wait Times Strategy to reducing wait times for key procedures across the province. However, a patient's true wait time for treatment begins earlier, with the first step being a referral to a specialist either from a primary care physician or another specialist. Presently, there are variations between wait times for new specialist appointments across clinics within Women's College Hospital (WCH). Our objective is to analyze the reasons for long wait times, identify the leading practices and strategies to improve wait times, and to use this information to recommend workflows exhibiting optimal efficiency. Available wait time data will be collected for all rostered and new patients in selected clinics and programs. Next, physicians and administrative staff within each of these clinics will be interviewed to map out current practices, and to identify areas for improvement. Our aim is to reduce wait times and improve the patient experience at WCH. The results of the present study will contribute towards the new scheduling and registration module of WCH's electronic patient record system, Epic, which is currently being implemented.

Poster #6

Telemedicine
A viable model for delivering Ambulatory Care Services

Valerie Sutherland MRT(R), Clinical Telemedicine Coordinator
Sunnybrook Health Sciences Centre, Toronto

INTRODUCTION

To showcase how Sunnybrook Health Sciences Centre in Toronto has been able to use Telemedicine to deliver Ambulatory Care Services including: pre-screen assessments; follow-up assessments and ongoing treatment across a range of clinic conditions.

DESCRIPTIONS

Telemedicine

- uses two-way videoconferencing, and advanced information communication technologies such as digital stethoscopes and high-resolution patient examination cameras to deliver clinical care

Ontario Telemedicine Network (OTN)

- telemedicine services provider funded by the Ministry of Health and Long-Term Care.
- provides the infrastructure/network which enables the OTN members and partners like Sunnybrook to deliver health care services

Sunnybrook Health Sciences Centre,

- an academic health services centre, affiliated with the University of Toronto with over 12,000 health care professionals including 1000 full and part-time Physicians.
- programs – Brain Sciences, Holland Musculoskeletal, Odette Cancer Centre, Schulich Heart Centre, St. John's Rehab., Trauma, Emergency and Critical Care, Veteran's and Community, and Women's and Babies
- we have moved from a model where the request for consultation was coming from other areas in Ontario for the services of a Sunnybrook Specialist to now over 90% of our activity coming from within Sunnybrook for patients currently in the Specialists' practices

BENEFITS

- Reduced patient and family travel (time and financial)
- Improved patient care coordination and continuity
- Increased access to expert medical advice and support
- Reduced need for patient transfers between health care facilities
- Environment

PROGRAM APPLICATION

Pre-screen

- Adverse Drug Reactions
- Chronic Pain Management
- Neurosurgery
- Surgery- Abdominal Wall Reconstruction

Follow-up

- Burns
- Dermatology
- Orthopaedics

Ongoing Care

- Chronic Pain Management
- Endocrinology
- Facial Nerve Retraining
- Hematology
- Neurology
- Psychiatry
- Rheumatology

HEALTH CARE PROFESSIONALS PARTICIPATING

- Physicians
- Physio and Occupational Therapists
- Speech Language Pathologists
- Nurses
- Social Workers

VOLUME

Since 1998 – over 20,000 clinical consultations

SATISFACTION SURVEY RESULTS –OTN 2009

- 94% of patients were satisfied with their telemedicine visit
- 90% of Health Care Professionals would recommend videoconferencing to their colleagues
- 90% of Referring Providers agree it improved their ability to manage their patients in their community

CONCLUSION

Telemedicine is an effective and efficient means to deliver clinical services.

Poster #7

Creating a Patient Safety Culture in a Pediatric Ambulatory Setting

Irene Koo BSc, BScPT, MHSc, Quality Lead, The Hospital for Sick Kids

Background/Problem:
There has been less focus on ambulatory patient safety across SickKids compared to inpatient units until the creation of a new Ambulatory structure.

Aim/Objective:
To develop a patient safety culture in ambulatory care embedding the principals of a blame free culture, using the patient voice as our guide, expertise from SickKid's Quality and Risk infrastructure, and ambulatory clinical staff as our champions.

Changes/Methods:
A Quality Steering Committee was created with oversight and representation from each of the local ambulatory Quality Management groups that was previously operating in isolation.

As part of SickKids service excellence strategy, we incorporated patient safety into rounding for outcomes with front line staff to gather information on potential gaps. Rounding with families is planned in the 2013/2014 fiscal year.
All ambulatory areas are currently undergoing a documentation review to look at safe practices and comprehensiveness of clinical documentation.

Furthermore, there has been a concerted focus in Ambulatory for us to improve our transitions of our young adult patients to adult care by involving them in decision making, asking young adults to tell us what they understand about their condition, their past care, and what to prepare for in managing their condition.

Results/Learnings:

The re-framing of why we conduct our improvements based on the patient voice rather than the clinician voice has better inspired and engaged our clinical staff to work with us. It is an ongoing journey of education and engagement as the ambulatory setting has a wide footprint at Sickkids in multiple buildings and locations.

Conclusions/Next Steps:

Ambulatory care is undergoing a re-visioning exercise with families at the forefront using the Experience Based Design approach from NHS in the U.K. to have families and SickKids staff co-design the future vision of SickKids Ambulatory and care delivery. The development of a new vision and care models grounded on the patient voice will further help to advance our ambulatory patient safety culture.

Poster #8

Transitioning from Acute to Ambulatory Care Unit

Presenters with contact information:

1. **Jon Hanhuck** RPh, BScPhm, PharmD, BCACP, Assistant Professor, Leslie Dan Faculty of Pharmacy, University of Toronto, Women's College Hospital

2. **Maria Timofeeva** RN, MSN, PHC-NP, DNP candidate, Women's College Hospital

3. **Zahra Ismail** BScN RN, ENC(C), MN CPRS candidate, Women's College Hospital

This abstract is to be considered for a poster presentation. This research is completed.

Background: The Women's College Hospital (WCH) has undergone a change in its mandate from providing inpatient acute care to ambulatory care services. One example of this change has been the transition of the Urgent Care Centre to the Acute Ambulatory Care Unit (AACU). The AACU mandate includes management of acute illnesses or exacerbations of chronic medical conditions in an effort to reduce emergency department (ED) visits and inpatient admissions for a range of ambulatory care sensitive conditions (ACSC), including congestive heart failure, chronic obstructive pulmonary disease, angina, asthma, diabetes, epilepsy, hypertension, DVT/PE and cellulitis. Patients access the AACU via Family Physician referral and are accepted by the General Internist. In the AACU patients receive expedited assessment, investigation and management of these ACSCs. In order to meet the unique needs of this patient population, clinicians must adapt to the model of care delivery to proactively prevent and manage these conditions in order to limit ED visits and inpatient admissions.

Purpose: To describe ambulatory care practice roles for a range of interdisciplinary providers (clinical nurse, clinical project leader, manager, nurse practitioner, general internist, and pharmacist) and requirements to ensure clinicians are competent, skillful and knowledgeable in the provision of care to the AACU patient population toward supporting the AACU mandate.

Methods: Literature review regarding needs and competencies of clinicians delivering care in ambulatory settings were identified and analyzed, particularly in the management of ACSCs. Development of ambulatory care practice role descriptions for a range of interdisciplinary providers was undertaken.

Results: Review of the evidence identified best practices for preparing, orienting, and ensuring competency for ambulatory care providers. Role descriptions were developed. Current policies and practice standards were reviewed and edited when necessary; new policies and practice standards were developed and are currently under review by clinical leaders and teams.

Conclusion/Implications: Attention to evidence, coordination, and participation of interdisciplinary providers contributes complementary perspectives, methods of inquiry and responsibility resulting in better identification of potential issues and more comprehensive response to patients' needs.

Poster #9

Jo Mania RET R. EP T. Resource Technologist, Clinical Neurophysiology Unit, Sunnybrook Health Sciences Centre

New service offered through Ambulatory Care. Prolonged EEG monitoring not requiring hospital admission

In the Clinical Neurophysiology Unit we have seen a growing need for our Sunnybrook patients with a history of epileptic seizures, fainting, blackouts , hallucinations , behavioral changes and even spells of unknown origin who have had relatively normal routine eeg's .EEG with video monitoring provides diagnostically critical information that would not be captured in a 30 minute routine EEG

Outpatient studies obtained in an ambulatory care setting are far less expensive and much more convenient for patients. To increase the yield of seizure frequency patients are sleep deprived prior to their appointment. EEG with video monitoring over a 3 to 6 hour period is obtained in a friendly, relaxing comfortable environment. Patients are provided with information and called with instructions. They are encouraged to have a family member accompany them.

During video-EEG monitoring the patient has 29 electrodes applied with adhesive to an EEG transmitter connected to a wall outlet. Video cameras are wall mounted and capture time locked video to EEG waveforms observed by a Registered EEG technologist in a control room.

Our service is an intermediate between an epilepsy monitoring units (requiring admission) with a wait list of 6-8months. Our current wait list is 1-2 months

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Poster #10

Primary Presenter
Kendra Sonnenburg RPN, Ottawa Hospital

A. Title: **Establishing A Framework for Patient Safety in an Ambulatory Plastic and Reconstructive Surgery Clinic – and Still Maintain the Flow.**

B. Objectives:

The attendees will:

1. Identify the patient safety initiatives implemented in the clinic.
2. Describe the positive patient outcomes.
3. Discuss the role of the nurse in the establishment of the framework.

B. Description:

In the fall of 2012 after two years of planning the new Plastic and Reconstructive Surgery Clinic was opened at the Ottawa hospital. This combined the resources from two smaller crowded clinics into one large modern clinic area, offering full services including a rapid referral clinic.

The clinic provides the services from 5 plastic surgeons and one full time RPN and one part time RPN, and a small OT area.

The patients in the clinic are new consults, undergoing surgical procedures, emergency patients requiring the services of a plastic surgeon and post operative follow ups, seeing approximately 850 patients per month.

Due to the volumes and rapid turn over, a need for a patient safety framework was evident and the development of a surgical safety check list pre procedures was a major step. Hand hygiene initiative implemented, patient post operative instructions sheets, and a patient check list so they are involved in their care; "Before You go, You Need to Know". A CQI project was developed to look at the procedure surgical safety flow and how this improved patient safety.

The poster will describe the process, the barriers, how physician engagement was done, outcomes and discuss the tools used to achieve the goal.

Poster # 11

The Nurse's Role in Patient Education, Following Microdebrider Surgery for Nasal Polyps

Poster Presenter: **Joanne Stevenson,** RPN

A. Objectives:

The poster will:

1. Define what Microdebrider Surgery is, and the impact on Ambulatory care.
2. Describe the positive patient outcomes.
3. Discuss the role of the nurse in post operative education.

B. Description:

The surgical removal of nasal polyps has been done for many years, often requiring a general anesthetic and thus a prolonged recovery time for the patient. Now using the microdebrider this procedure is performed in the Ambulatory setting under a local anesthetic and the patient is back to their regular routine the following day.

The poster describes the procedure, discusses the positive impact on the patients, especially for the patients who had a general anesthetic in the past for the procedure, the nurses role and the development of a post operative teaching sheet.

Poster #12

Building a community of nursing scholars and leaders through an Ambulatory Care Nursing Journal Club

Authors:

Shelley Bouchard, RN, MScN
Osteoporosis Program
Women's College Hospital, Toronto, ON

Valerie Lawler, RN, MWH
Advanced Practice Nurse
Centre for Headache
Women's College Hospital, Toronto, ON

Sandra Walsh, RN, BSN
Phototherapy Education and Research Centre
Women's College Hospital, Toronto, ON

Objectives:

1. Describe the development of a Journal Club at Women's College Hospital.
2. Share the successes related to best practices knowledge transfer, community and academic leadership development as it relates to ambulatory care nursing
3. Discuss lessons learned and future directions for continued growth internally and as a model for other ambulatory practice environments.

Description:

A nursing journal club is an excellent way to keep current with new practices and clinical updates. It provides nurses the opportunity to build scholarship, leadership and community into their professional work lives. Some of the advantages of participating in a journal club include: keeping abreast of new nursing knowledge, promoting awareness of current nursing research findings, learning to critique and appraise research, and encouraging the use of research in practice. The WCH Ambulatory Care Nursing Journal Club arose out of the Nursing Strategic Plan in 2010 and has been meeting monthly since. The Journal Club meets to review nursing journal articles specifically related to ambulatory care nursing.

This poster presentation will provide a brief overview of the development and structure of the Ambulatory Care Nursing Journal Club. It will describe how it supports the strategic direction of Nursing at Women's College Hospital. Measures of success such as meeting evaluations, attendance, ability to attract a wide range of facilitators, how it supports the development of future nurses and nurse leaders at an undergraduate and postgraduate level will be shared. Lessons learned, as they relate to implications for future growth of the Journal Club and as a model for other ambulatory practice environments will be highlighted.

Poster #13

Infection Prevention & Control Liaison Program. Empowering Staff as Frontline IP&C Leaders

Authors:

Jessica Ng MSc**.,** CIC, Manager, Infection Prevention and Control, Women's College Hospital

Sonja Cobham , Co-ordinator of Infection Prevention and Control at Women's College Hospital

Michael Gardam, MSc, FRCPC, MD

Jane Mosley, RN, MScN, Chief Nursing Executive and Health Discipline

1) Women's College Hospital, Toronto, Ontario, Canada
2) Sunnybrook Health Sciences Centre, Toronto, Ontario, Canada

Issue: Engaging frontline staff in addressing IP&C issues in their local areas builds capacity and increases accountability. In 2010, a need for frontline involvement to address IP&C issues was identified. To meet these needs, an IP&C Liaison (IPCL) Program involving the frontline was developed.

Project: With the support of hospital administration, a multidisciplinary group of frontline staff was recruited for the IPCL Program. The purpose of the program was to empower frontline staff to display local IP&C leadership and act as an IP&C resource for their peers. In order to identify IP&C issues and promote IP&C practices in their local areas, the IPCLs attended a two-day training workshop to increase their knowledge of IP&C principles. IPCLs continued to meet monthly for education sessions and discussions about IP&C issues.

Results: The implementation of the IPCL program led to the expansion of IP&C resources, improved IP&C practices, increased frontline engagement and improved means of communication between staff and IP&C. The IPCLs utilized their frontline expertise in IP&C policy development, during IP&C audits and in identifying and increasing awareness of IP&C issues in their local areas. Opportunities for staff-to-staff education were also created as a result of their role in disseminating IP&C information and updates to their peers.

Lessons learned:

IPCLs as frontline IP&C resources maximize the impact of corporate IP&C resources in a small organization, creating a higher profile for IP&C

When equipped with training, IPCLs are effective vehicles for staff-to-staff education and communication of IP&C principles

Poster #14

Systematic evaluation of the clinical practice guidelines for the management of spontaneous pneumothorax using the agree instrument

Jatin Kaicker MD Candidate Class of 2014 McMaster University**,** and **, Vikas Srinivasan Sridhar(a), Tyler Bao(a), Philemon Leung(a), Mylinh Duong(b)*,** McMaster University Medical Centre

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Introduction & Objective: Spontaneous pneumothorax (SP) results in air entry into the pleural space with variable degrees of lung collapse. Clinical practice guidelines assist practitioners on the appropriate course of action for managing SP. The Appraisal of Guidelines for Research and Evaluation (AGREE) II instrument is a validated tool that provides a numeric scale for evaluation of guidelines. Using AGREE II, we aim to assess the methodological quality of current SP practice guidelines.

Methods: A systematic search in Medline (OVID), Embase, Cochrane, Pubmed and CINAHL for guidelines published between 2000 and 2012 was conducted. The AGREE II instrument assessed the guidelines in the following domains: scope and purpose, stakeholder involvement, rigor of development, clarity of presentation, applicability and editorial independence.

Results: A total of 114 papers were retrieved and 4 papers meeting the inclusion/exclusion criteria were reviewed. Based on the quantitative values from AGREE II, two domains were consistently lacking: applicability and editorial independence; while the domains of scope and purpose and clarity of the presentation were well scored. However, there was considerable variation noted in domain scores between the four guidelines.

Conclusion: Guidelines have the potential to improve patient care and outcomes if generated using accurate and evidence-based content. By recognizing areas of deficiency using validated evaluative tools such as the AGREE II can help future guidelines address these concerns. Therefore, the rigorous and transparent process of identifying, appraising, and adopting guidelines is crucial to appropriate patient centered care.

Poster #15

Peyronies: How the development of an Ambulatory Peyronies Clinic Improved Patient Outcomes

Ashleigh Simpson RPN
Staff Nurse, Urology Clinic
The Ottawa Hospital, Civic Campus

B. Objectives:
The poster will:

1. Identify what Peyronies disease is and how it is treated in an Ambulatory Care Clinic.
2. Describe treatment options and how these improve outcomes
3. Discuss the role of the nurse in this clinic.

Description:
Peyronies disease is often not discussed at social gatherings, treated by urologists on a one off basis and there were limited resources available for these patients. Dr A. Bella, the erectile dysfunction specialist at the Ottawa Hospital, identified the need to set up a Peyronies clinic. There were many patients in his practice who had the disease and limited office time to treat these men on a regular basis. Clinic time and space was identified and staff trained to assist in the clinic. The patients were excited as they could now be treated three times a week for the full 12-14 treatments. The role of the nurse is important in assessment and preparation of the medications, as well as the patient instruction and education. This included the development of a patient information sheet.
The poster will describe the history of setting up the clinic, the involvement of the nurse, medications used and the outcomes of the treatment, including patient satisfaction.

Poster #16

Integrated Home-Based Primary Care

Judith Manson, RN, BScN, NCMP Patient Care Manager, Family Practice and SUNDEC, Executive Director, Sunnybrook Academic Family Health Team,

Sunnybrook Health Sciences Centre
Sunnybrook Academic Family Health Team:
Family Practice Physician: Dr. Jocelyn Charles
Family Practice Nurse: Jane Smart, RN
Program Coordinator: Ingrid Wirsig

The Sunnybrook Academic Family Health Team is one of six Family Health Teams participating in the BRIDGES Integrated Home-Based Primary Care (IHBPC) project. The IHBPC project is designed to integrate care by delivering home-based primary care services to homebound patients in partnership with the Community Care Access Centre (CCAC) and Community Support Services (CSS) agencies in the Toronto Central LHIN. The IHBPC program targets patients aged 65 or older, whose health and social care needs are not adequately served by traditional office-based primary care due to physical, cognitive or social barriers, who are not living in a retirement or nursing home facility (where access to primary care is available) and whose needs are not better met by palliative care services.

At the Sunnybrook Academic Family Health Team (SAFHT), care is provided by a physician-led interprofessional team composed of a designated home care nurse, Family Practice residents, a pharmacist, a CCAC care coordinator, and other specialty care providers as appropriate. The CCAC supports the FHT team by coordinating the provision of additional skilled care and professional services to patients and provides case management to support patient transitions to long-term or palliative care. Family Practice Department Chief, Dr. Jocelyn Charles, has long been an advocate and role model for providing home based-care for frail seniors. She leads the SAFHT in this initiative, which provides caring, compassionate, comprehensive care to family practice patients in the comfort of their own homes.

The SAFHT currently has approximately 50 homebound patients. Of those patients, 28 are enrolled in the BRIDGES project. The remaining patients are seen by our home-based team but the patients do not live in the project's catchment area or do not qualify for the project for other reasons, e.g. age.

Poster # 17

"**Re-routing Integrated Prenatal Screening Results (IPS) in Low Risk Obstetrics: Small Change, Big Impact"**

Name: Anna De Marchi RN MN PNc
Clinical Leader Manager, Women's Health Centre and Paediatrics, St. Michael's Hospital, Toronto, Ontario

Summary: One cannot underestimate the little things that might provide an opportunity for caregivers, to spend more time educating patients and potentially preventing and unnecessary hospital visit. As ambulatory managers, we need to be detail-oriented and persistent to make visible, study and remove barriers which preclude nurses from spending time connecting with patients. In academic hospitals, where resources are stretched and emphasis is placed on high-profile, innovative research studies; it is easy to become complacent to smaller processes that aren't working well, yet have become normalized in the everyday course of activity. This project is an example of a little intervention which yielded significant returns.

Problem: It had been an enduring problem in the ambulatory obstetrical outpatient clinic that IPS results (antenatal screening for genetic anomalies), which are processed at a central offsite location, were never available for review in a timely manner at the appropriate prenatal visit for pregnant women. As well, there were consistent errors in the completion of these requisitions. This resulted in wasted nursing and clerical time daily as they searched for results and corrected requisitions. Most importantly, this gap in efficiency created anxiety for women who were waiting, and in turn impacted clinic credibility. The clinic was also perceived as disorganized by the external partner processing results.

Population: Low risk obstetrical women

Methods: Plan-do-act-study (PDSA), process-mapping, using an Appreciative Inquiry (AI) principles.

Findings: Process changes increased accuracy of documentation and provided reliable, timely results to the clinic. Productivity increased from decreased distractions and futile paper chases, thus providers were freed to focus on care rather than administration. A conservative estimate of 9K was saved in soft dollars (unproductive time) for both clerical and nursing. The clinic gained credibility with the external partner, staff satisfaction increased, and above all, women received their expected test results on time; alleviating stress and decreasing patient calls.

Conclusion: One cannot overlook the value of what may be perceived as "minutia". It was discovered that over 300 hours per year was being spent on useless "work" by the team. These hours can now be directed towards families.

Poster # 18

Authors: Rouge Valley Health System GAIN Team

Title: Collaborative Geriatric Care Clinic: GAIN for Everyone

Clara Tsang RN (EC), Rouge Valley Health System

Abstract:

With patients over 65 years of age representing 23% of emergency room visits, 58% of total hospital day stay, and 81% of altered level of care days at the Central East Local Health Integrated Network (CELHIN) Region in 2007-2008, it is clear that seniors are over-indexed on hospital services. In response, the CELHIN has launched a collaborative care clinic targeting the unique needs of the frail elderly. The clinic offers comprehensive inter-professional care specializing in geriatrics, and provides a holistic lens which integrated health and social care to examine opportunities for cost avoidance and prevention.

This poster outlines the program development efforts and outcomes of four Geriatric Assessment and Intervention Network (GAIN) Clinics (Lakeridge Health Oshawa, Peterborough Regional Health Centre, The Scarborough Hospital – General campus, and Rouge Valley Health System- Centenary site). The preliminary evaluation results will be discussed in addition to the lessons learned to date. This poster offers a practical blueprint for implementation of a senior-focused integrated health clinic.

Poster # 19

Abstract Presenter:

Amber Curry BScN, RN, MHSc, CHE

Manager of Ambulatory Care Unit, Fracture Clinic and Pre-operative Assessment Clinic

Abstract Title: Alternatives for Chronic Disease Management and Prevention

While the number of those living with chronic conditions is on the rise, health care funding continues to decline, creating challenges in addressing the demands of this population. Patients access health care for screening, testing, treatments and procedures but when risk factors are identified or a diagnosis is given, little support is provided in creating a lifestyle that is effective at preventing or managing chronic diseases. Resources on disease prevention and management are abundant but insufficient at reaching out and providing a supportive network to engage and empower a patient to take control of their lifestyle. Opportunities to address this gap are minimal as resources struggle to keep up to the demands for acute interventions. This support is elemental in reducing the reliance on acute interventions and improving the patient's quality of life. Rouge Valley Health System (RVHS) recognizes this and has rolled out a new portfolio of chronic disease education clinics (CDECs) to provide this support for anyone at risk or suffering from COPD, chronic pain, osteoporosis and arthritis. RVHS has worked with professional associations, community organizations, CCAC, the LHIN and specialists in the field to devise the portfolio of these nurse- led CDECs. The CDECs are held in a group format and focus on enhancing support and knowledge to equip patients for the challenges and struggles faced in disease management and prevention. The CDECs have been rolled-out over the past six months and research is in progress to determine the impact through: patient reported education outcomes; pre and post assessments; and readmission rates. Preliminary results indicate high patient satisfaction and measurable improvements in patient outcomes. The aim of the CDECs is to support the human experience in chronic disease management and prevention to improve the patient's quality of life and avoid or minimize the need for acute medical intervention.