during the first round of interviews at the University of Toronto during phase one. Results from phase one were used to refine the interview guide, to be used in phase two, to ensure that all potential areas of thematic generation were touched upon. Phase two occurred at the University of Toronto and McMaster University using the refined interview guide. All transcripts were coded, analyzed, and collapsed into themes. Data analysis was guided by a constructivist grounded theory based in a relativist paradigm. **Results:** Thematic analysis revealed five themes. Residents and staff alike described acquiring the skills of supervision and assessment passively, primarily through modeling the behaviours of others; the training that is available in these areas is variably used, creating a diversity of physician comfort levels within these two competencies; the many competing priorities in the emergency department represent significant barriers to improving supervision and assessment; providing negative feedback is universally difficult and often avoided, sometimes resulting in struggling trainees not being identified until late in residency; the move towards competency based education (CBE) will act as an impetus for more formal curriculum being required in these areas. **Conclusion:** As residency programs transition to a CBE model, there will be a greater need for formal training in supervision and assessment to achieve a standard level of comfort and competence among senior residents physicians in independent practice. These competencies will also need an emphasis on how to identify struggling trainees, and how to approach negative and constructive feedback.
Keywords: supervision, assessment, competency-based education

P080

Clinical lead nurse practitioner Strathcona Community Hospital

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Introduction: Prior to opening Strathcona Community Hospital (STCH) site leadership were tasked to develop an innovative care model. The central aim was quality improvement and patient safety optimization in the emergency department (ED) utilizing a nurse practitioner (NP) model. They developed 3 pillars: collaboration, multidisciplinary approach, and integration with the plan of improving patient satisfaction and ensuring no patient gets lost to follow up. NPs work in the STCH ED and the NP led Emergency Department Transition (EDT) Clinic in Ambulatory Care. In the ED NPs provide direct clinical care, judicious review of DI and microbiology reports, and care coordination for patients at risk of lost to follow up. The EDT clinic is an innovative NP lead clinic with the purpose of providing timely, high-quality follow up care for ED patients. **Methods:** Data for the service delivery indicators came from data repository and manual data collection looking at the following outcomes: timely review of DI/micro results; decreased ED visits for non-urgent/emergent issues; safe transitions in care and improved patient satisfaction. Quantitative data from service delivery, patient and surveys were analyzed using Microsoft Excel and SPSS 19. **Results:** From June 2016 to January 2017 ED NPs at STCH reviewed 3000 positive microbiology reports and made 517 f/u calls to those patients, and reviewed 3181 DI results. This has freed up approximately 2 hrs per day of ED physician time. When NPs were working in the ED, the number of patients who left without treatment (LWT) was approximately 50% less, and improved STCH ED wait times to be among the lowest in the Edmonton Zone. From June 2016 to January 2017, EDT NPs completed 837 patient visits; 371 letters to family physicians (FPs); 215 referrals; and connected 520 patients to a new FP. Patient satisfaction survey show 88-90% of the patients were satisfied with their care. **Conclusion:** NPs are integral members of the ED team at STCH, providing direct clinical care and several valuable follow up

services for ED patients. The EDT clinic provides urgent follow up for ED patients unable to get a timely appointment with their FP or no access to primary care. The clinic also prevents unnecessary returns to ED, and aids to bridge ED services to family physicians or specialist. NPs are the common thread through all departments at STCH, contributing to quality improvement and high patient satisfaction.
Keywords: quality improvement and patient safety, judicious review of DI and microbiology reports, NP led emergency transition clinic

P081

ICD-10 coding of free text diagnoses is not reliable for the diagnosis of PE in Calgary zone emergency department patients

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Introduction: Administrative data are attractive for research, policy and quality improvement initiatives as large amounts of data can often be obtained quickly and at low cost. Unfortunately, administrative data often have significant limitations owing to how they were collected and coded. In many cases, free text, often hand written, diagnoses provided by physicians are converted into ICD-10 (International Statistical Classification of Diseases and Related Health Problems, 10th Revision) codes by trained nosologists for administrative purposes. However, because of the large data sets often obtained from administrative sources, it is difficult to verify the accuracy of the data, which may lead researchers to misleading or false conclusions. The objective of this study was to evaluate the accuracy of ICD-10 codes for the diagnosis of pulmonary embolism (PE) in emergency department (ED) patients. **Methods:** As part of a larger study examining the effectiveness of a clinical decision support intervention on CT utilization and diagnostic yield for ED patients with suspected PE, all patients with an ICD-10 code corresponding to PE (126.0 and 126.9) on ED discharge were obtained from four adult urban EDs and one urgent care center from August 2016 to March 2017. PE diagnosis was confirmed by reviewing electronic medical records and imaging reports for all patients. Discrepancies between coded ICD-10 diagnoses and actual imaging findings were quantified. This study was REB approved. **Results:** Of 584 ED patients with ICD-10 codes identifying PE as a discharge diagnosis, 535 had imaging that could be reviewed. Of these, 225 (42.1%) did not have clinical diagnoses of PE, and thus were incorrectly coded, resulting in false positive ICD-10 codes. Common coding errors included physician free text diagnoses of rule out PE or query PE being coded as positive for PE. **Conclusion:** Administrative data are subject to errors in coding. In this study ICD-10 codes were not reliable for the diagnosis of PE, with 42.1% of PE diagnoses being false positives. Similar coding errors are likely for other diagnoses that require waits for confirmatory imaging (e.g. appendicitis). Nosologist coding of physician free text diagnoses is challenging and prone to errors. Consequently, validation of ICD-10 coding prior to analysis of administrative datasets is crucial for meaningful results.
Keywords: pulmonary embolism, miscoding, administrative data

P082

Kingston emergency department utilization of adults who have experienced adverse childhood experiences

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