performance improvement (PPI) sessions: 1) improve physicians' receptiveness to their practice data, and 2) encourage physicians to both identify opportunities for practice change and create action plans. **Methods:** Peer facilitators were trained to facilitate PPI sessions using the CAFF model. In Calgary, 51/180 emergency physicians have attended at least one of the six PPI sessions. The sessions were evaluated using surveys, commitment to change forms, and the Feedback Orientation Scale (FOS). The FOS is a scale developed to measure a participant's orientation to performance feedback across the four domains of utility, accountability, social awareness, and feedback self-efficacy. **Curriculum, Tool, or Material:** The PLP has developed and implemented CAFF as a framework to help foster socially constructed learning in audit and group feedback sessions. The CAFF model ensures that the aforementioned four key factors are considered for design and implementation of audit and group feedback. The PLP found that establishing the meaning and credibility of the data is a necessary precursor to reflection and action planning. **Conclusion:** The FOS was completed for 25/32 physicians. The mean FOS score improved by 0.339 ($p < 0.001$; $z=-3.863$). While the mean scores all four domains increased, 'Feedback Self-Efficacy' increased the most by .0620 ($p < 0.001$; $z=-3.999$). Participants reported that examples of changes made by the peer facilitators were particularly helpful. Evaluations from the sessions suggested physicians overwhelmingly agreed or strongly agreed that the peer comparison was valuable, that the reports helped them reflect on their practice, and that the session helped them identify learning opportunities and strategies to change their practice.

Keywords: innovations in EM education, physician practice reports, practice improvement

MP30

Reducing unnecessary oral contrast in patients undergoing enhanced abdomen/pelvis computed tomography in the emergency department: A multicentre project

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Background: Traditionally, radiologists have routinely recommended oral contrast agents (such as Telebrix®) for patients undergoing a computed tomography of the abdomen/pelvis (CTAP), but recent evidence has shown limited diagnostic benefits for most emergency department (ED) patients. Additionally, the use of oral contrast has numerous drawbacks, including patient nausea/vomiting, risk of aspiration and delays to CTAP completion and increased ED length of stay (LOS). **Aim Statement:** The aim was to safely reduce the number of ED patients receiving oral contrast prior to undergoing CTAP and thereby reduce ED length of stay. **Measures & Design:** An evidence-based ED protocol was developed in collaboration with radiology. PDSA cycle #1 was implementation at a pilot site to identify potential barriers. Challenges identified included the need to change the electronic order sets to reflect the new protocol, improved communication with frontline providers and addition of an online BMI calculator. PDSA cycle #2 was widespread implementation across all 4 ED's in the Calgary zone. The protocol was incorporated into all relevant electronic ED order sets to act as a physician prompt. Using administrative data, we extracted and analyzed data using descriptive and inferential statistics for the outcomes and balancing measures from a period of 12 months pre- and 12 months post-intervention. **Evaluation/Results:** A total of 14,868 and 17,995 CTAP exams were included in the pre and post periods, respectively. There was a reduction in usage of oral contrast from 71% to 30% ($P < 0.0001$) in the pre- and post-study period, respectively. This corresponded to a reduction in average time of CT requisition to CT report completed from 3.30 hours to 2.31 hours (-0.99 hrs, $P = 0.001$) and a reduction in average ED LOS from 11.01 hours to 9.92 hours (-1.08 hrs, $P < 0.0001$). The protocol resulted in a reduction of 19,434.6 patient hrs in the ED. Run charts demonstrate change was sustained over time. Our protocol did not demonstrate an increase in rates of repeat CTAP ($P = 0.563$) at 30 days, nor an increase in patient re-admission within 7 days ($P = 0.295$). **Discussion/Impact:** Successful implementation of an ED and radiology developed protocol significantly reduced the use of oral contrast in patients requiring enhanced CTAP as part of their diagnostic work up and, thereby, reduced overall ED LOS without increasing the need for repeat examinations within 30 days or re-admission within 7 days.

Keywords: computed tomography, oral contrast, quality improvement and patient safety

MP31

Optimizing ketorolac dosing by leveraging computerized order entry

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Background: Ketorolac has long been used to manage pain in the Emergency Department and has the advantage of being the only parenteral NSAID formulation. Despite multiple studies demonstrating an analgesic ceiling dose of 10mg for intravenous ketorolac, higher doses (30-60mg) are commonly ordered. Use of optimal doses of ketorolac (10mg) has the advantage of lower side effects and cost. **Aim Statement:** The aim of this project was to increase the usage of the optimal dose parenteral ketorolac (10mg) without increasing the use of additional, concomitant or rescue opioids (balancing measures). **Measures & Design:** This pre-/post-intervention comparison study (May 1, 2016 to April 30, 2018) included all patients ≥18 years of age that received parenteral ketorolac at one of 4 EDs in the Calgary zone. All data was captured via administrative data records. Stakeholders (ED leadership, analgesia committee, nursing and pharmacy) provided feedback and support for the project. Our multi-modal intervention included modifying all ED computerized order sets such that the default parenteral ketorolac dose was 10mg (post-intervention) from 30mg (pre-intervention), education (dissemination of evidence to support the changes to clinicians) and our pharmacy securing 10mg vials of ketorolac. At their discretion, physicians' were still able to order other doses of ketorolac. **Evaluation/Results:** During the 2 year study period, 19290 patient records were identified where parenteral ketorolac was administered during the ED visit. Baseline characteristics were similar between the pre/post periods. Prior to the change in default dosing, 10.5% of orders were for ketorolac ? 10mg compared to 87% in the post-intervention period ($p < 0.000$). Statistical process charts support the above results and demonstrate that the changes have been sustained. There were no differences in patients receiving ketorolac as the only analgesic between the pre/post periods (42% vs 42%, $p = 0.396$), nor where there significant changes in concomitant opioid usage (46% vs 46%, $p = 0.817$), or rescue analgesia (11% vs 12%, $p = 0.097$). **Discussion/Impact:** In this large cohort, our multi-modal intervention, resulted in a significant increase in optimal ketorolac parenteral dosing without a significant change in additional opioid use. The results support the utility of

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