Storyboards
The 27th Annual National Forum on Quality Improvement in Health Care
December 6–9, 2015 · Orlando, FL

Patient Safety
PS1: “I Will Fall,” A Team Approach to In-Patient Fall Reduction
Baylor Scott and White Medical Center At Irving
J. Brice King
brice.king@baylorhealth.edu

PS2: A 10-year Journey of Engaging Patients in Patient Safety Education, Research, and Improvement
MedStar Health Research Institute
Kelly Smith
kelly.m.smith@medstar.net

PS3: A Change in Culture to Improve Patient Safety
Hotel Dieu Grace Hospital
Kendra Truant
kendra.truant@hdgh.org

PS4: A Study on Effective Patient Safety Education for All Staff of Medical Institutions
Japan Association for Development of Community Medicine
Masahiko Ishikawa
masahikois@jadecom.jp

PS5: Acute Care Toolkits: Supporting the Delivery of Acute Care
Royal College of Physicians
Kevin Stewart
Kevin.Stewart@rcplondon.ac.uk

PS6: Adverse Event Review: Reflecting on the Past to Improve the Future
Mississauga Halton Community Care Access Centre
Bobbi Greenberg
roberta.greenberg@mh.ccac-ont.ca

PS7: Age Based Guidelines to Decrease Narcotic Oversedation
NCH Healthcare System
Aileen Adams
aileen.adams@nchmd.org

PS8: All Hazard Preparedness Through Ebola Simulation
North Shore-LIJ
Robert Kerner
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PS9: Approach to Communication & Resolution Program Implementation
MedStar Health
Kyle Quigley
Kyle.W.Quigley@medstar.net

PS10: Appropriate Use of Antibiotic Prophylaxis in Surgical Procedures
Clinica San Felipe
Ernesto Aspillaga
easpillaga@clnicasanfelipe.com

PS11: Assessing Risk within the Health Care Supply Chain
Medbuy
Christopher Fernandes
cfernandes@medbuy.ca

PS12: Assessment of a Swiss Adverse Drug Event Prevention Collaborative
Stat’Elite
Estelle Lécureux
estelle@stateelite.ch

PS13: Building Quality and Safety Checks in Implementing New Clinical Services
National University Hospital
Diana Santos
diana_santos@nuhs.edu.sg

PS14: Charting the Course to Patient Safety Certification
Courtemanche & Associates
Kerrie Bellisario
kerrie@courtemanche-assocs.com

PS15: Code Blue: Using In-Hospital ACLS Simulation as a Multidisciplinary Quality Improvement Tool
Erie Family Health Center
John Hayes
JohnRyanHayes@gmail.com

PS16: Compliance With Infection Control Practices Among ED Nurses During the Outbreak of MERS-COV
Hamad Medical Corporation
Bejoy Chacko
Bchacko3@hmc.org.qa

PS17: Compliance of Surgical Handwashing Before Surgery by Remote Video Auditing
The Aga Khan University Hospital
Ambreen Khan
ambreen.khan@aku.edu

PS18: Console, Coach or Discipline? The Experience and Outcomes of Implementing a Just Culture
Windsor Regional Hospital
Rosemary Petrákos
rosemary.petrakos@wrh.on.ca

PS19: Creating a Culture of Safety in the O.R. by Implementing a Briefing and Time-Out Tool
Hartford HealthCare
Rekha Singh
rekha.singh@hhchealth.org

PS20: Creating a Safe Zone Through Fall Interventions
NCH Healthcare System
Jennifer Menendez
jennifer.fonseca@nchmd.org

PS21: Creation of an Intake Process in OB Triage
Boston Medical Center
Kristine Smith
kristine.smith@bmc.org

PS22: Decreasing Healthcare Acquired Multidrug-Resistant Organisms in a Surgical Intensive Care Unit (ICU)
The Mount Sinai Hospital
Rebecca Anderson
rebecca.anderson@mountsinai.org

PS23: Decreasing Sepsis Mortality through a Comprehensive Intervention In the Emergency Department and Inpatient Setting
Mount Sinai School of Medicine
Alison Glasser
alison.glasser@mountsinai.org

PS24: Development and Implementation of Measures to Promote Early Sepsis Detection of Adult Medical Inpatients
Rush University Medical Center
Barbara Gulczynski
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PS25: Difficult Airway Identification — The Most Comprehensive Approach
Cleveland Clinic Health System
Pyush Mathur
pyush_mathur@hotmail.com

PS26: Effective Prevention Bundle to Eliminate Hemodialysis Catheter Related Bloodstream Infection in Ambulatory Hemodialysis Facilities
Hamad Medical Corporation
hicham bouanane
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PS27: Electronic Safety Checklists Reduce Severe Errors and Increase Workflow Efficiency in a Radiation Oncology Department
University of Florida
Julie Greenwalt
Julie.Greenwalt@shands.ufl.edu

PS28: Eliminating Falls Across Health Care is Possible; No One Walks Alone
King Abdullahaz Medical City - National Guard Health Affairs
Rohana Yahya
r_ann76@yahoo.com

PS29: Emergency Department (ED) Front End Process (FEP) Redesign: Improved Door to Provider (DTP) Time
Methodist Hospital of Sacramento
Chasity Ware
charity.ware@dignityhealth.org

PS30: Enhancing Patient Safety and Improving Organizational Culture of Safety
Wellspan Health
Vipul Bhatia
vbhatia@wellspan.org

Storyboard Reception
Tuesday, December 8, 4:15 PM–6:30 PM, Palms Ballroom
During this reception, presenters will be standing by their boards to answer questions.
PS31: Ensure Patients Contact Details Are Correct  
National Healthcare Group Polyclinics  
Serene Foo  
Serene_FOO@nhgp.com.sg

PS32: Establishing Safety Event Analysis Team (SEAT) “turned ordinary people into champions”  
SEHA Tawam Hospital  
Krishnan Sankaranarayanan  
Krishnanks67@gmail.com

PS33: Extent of Diagnostic Uncertainty Among Medical Referrals  
Mayo Clinic  
Monica Van Such  
vansuch.monica@mayo.edu

PS34: First Do No Harm  
St. Mary’s Hospital, SPHP  
Vasantha Natarajan  
vasantha.natarajan@spshp.com

PS35: Full Implementation and Sustainment of Project Re-Engineered Discharge at VA Palo Alto Health Care System  
VA Palo Alto Health Care System  
David Renfro  
David.Renfro@va.gov

PS36: Game on! Use of Gamification to Engage With and Motivate Clinicians to Improve Sepsis Care  
BC Patient Safety & Quality Council  
Shari McKeown  
smckeown@bcpqc.ca

PS37: Glycemic Control in the Inpatient Hospital Setting  
Dignity Health  
Heather Kendall  
Heather.Kendall@DignityHealth.org

PS38: Golden Hour for Extremely Premature Infants: Improving Time to Stability  
Nationwide Children’s Hospital  
Amina Habib  
amina.habib@nationwidechildrens.org

PS39: Guidelines for the Reversal or Perioperative Cessation of Antiplatelet and Anticoagulant Medications  
Hartford HealthCare  
Bogdan Musial  
bogdan.musial@hhchealth.org

PS40: Hand Hygiene Compliance  
NCH Healthcare System  
Mark Flood  
mark.flood@nchmd.org

PS41: Hand Hygiene: A Continual Challenge  
The Aga Khan Secondary Hospital, Hyderabad  
Sanija Amar Khowaja  
sanija.amar@aku.edu

PS42: Have Mannequin, Will Travel: In Situ Simulation  
Novant Health  
Stacy Capel  
scapel@novanthealth.org

PS43: Health Human Resource Factors: An Analysis on Patient Safety Indicators  
Critical Care Services Ontario  
Bernard Lawless  
bernard.lawless@uhn.ca

PS44: Healthy Babies Team Redesign: Eliminating Early Term Elective Deliveries  
Bon Secours St. Francis  
Edward Heidtman  
saria_saccocio@bshsf.org

PS45: High Quality Care for the Older Person  
Homerton University Hospital Foundation  
Victoria Newlands-Bentley  
victoria.newlands@homerton.nhs.uk

PS46: HRO Journey to Reduce Heparin Errors  
William W Backus Hospital  
Michael Smith  
michael.smith@hhchealth.org

PS47: Identifying and Reducing Code Grey Events in the Acute Care Hospital Setting  
NCH Healthcare System  
Jeannie Kellogg  
jeannie.kellogg@nchmd.org

PS48: Identifying Opportunities for Improving Safety from the Bedside: A Protocol for IVIG Administration  
Northwestern Memorial Hospital  
Trevor Barnum  
tbarnum2@uic.edu

PS49: Impact of Influenza Like Illness on Critical Care Units: Early Findings from 206 Ontario ICUs  
Critical Care Services Ontario  
Bernard Lawless  
bernard.lawless@uhn.ca

PS50: Implementation of a Nursing-Driven Sliding Scale Electrolyte Protocol in Five Adult Intensive Care Units  
Boston Medical Center  
William Vincent  
william.vincent@bmc.org

PS51: Implementation of A Perioperative Nurse-to-Nurse Report Across Victoria Hospital and University Hospital  
London Health Sciences Centre  
Kristen Webb  
webb.kristen@gmail.com

PS52: Implementation of a Surgical Safety Checklist in a Swiss University Hospital  
University hospital  
Estelle Lécureux  
estelle.lecureux@chuv.ch

PS53: Implementation of Transsphenoidal Pituitary Surgery Clinical Pathway to Improve Quality of Care and Patient Safety  
Singapore General Hospital  
Ulina Santoso  
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PS54: Improved Response to Serious Adverse Events as a Means to Culture Transformation  
Mount Sinai School of Medicine  
Bonnie Portnoy  
bonnie.portnoy@moun tsinai.org

PS55: Improvement of Resident Reported Patient Safety Events  
University of Wisconsin Hospital and Clinics  
Sarah Tevis  
samend@gmail.com

PS56: Improving ACS Surgical Risk Calculator  
Clinica San Felipe  
Ernesto Aspillaga  
easpillaga@clinicasanfelipe.com

PS57: Improving Clinical Performance and Safety Culture through TeamSTEPPS Implementation  
HCA  
Bill Laxton  
Bill.Laxton@hcahealthcare.com

PS58: Improving Compliance with VTE Prophylaxis Assessment Completion  
Boston Medical Center  
Abhinav Vemula  
abhinav.vemula@bmc.org

PS59: Improving HCW Influenza Vaccination  
Castle Medical Center  
Anne Massie  
anne.massie@ah.org

PS60: Improving hospital Acquired CLABSI Rates by Culturing on Admission: An Inpatient Cancer Unit’s Journey  
Penn State Hershey Medical Center  
Ruth Gundermann  
rgundermann@hmc.psu.edu

PS61: Improving Immunization Status in Peritoneal Dialysis Population  
Hamad Medical Corporation  
Yolanda Arroyo  
yarroyo@hamad.qa

PS62: Improving Medication Reconciliation Accuracy in a VA Resident Primary Care Clinic Using After Visit Summaries  
University Hospitals Case Medical Center/ LSCVAMC Center of Excellence in Primary Care Education  
Andrew Harris  
andrew.harris@uhospitals.org

PS63: Improving Patient Safety by Reducing Hypoglycemia Events  
Mercy Hospital St. Louis  
Julie Binder  
Julie.Binder@Mercy.net

PS64: Improving the Response of Code Blue Team in the In-Patient Pediatric Units  
Hamad General Hospital  
Magda Wagdy  
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PS65: Improving the Safety of Clinical Alarm Systems  
New Hanover Regional Medical Center  
Billie T. Robinson  
billie.robinson@nhrc.org

PS66: Increased Error Reporting Through a Great Catch Program  
Penn State Hershey Medical Center  
Desiree Albright  
dalbright@hmc.psu.edu

PS67: Inculcating Patient Safety Culture Among Junior Doctors Through Interactive Teaching  
National University Hospital  
Bhuvaneshwari Mohankumar  
bhuvaneshwari@nuhs.edu.sg
PS68: In-Hospital Cardiac Arrest Response Redesign
Northwestern Memorial Hospital
Gabriel Kleinman
gabriel.kleinman@northwestern.edu

PS69: Innovative Ideas for Preventing Falls from Frontline Staff
Boston Medical Center
Katherine Scanlon
katherine.scanlon@bmc.org

PS70: Inpatient Glucose Management Program in the Asian Healthcare Setting
Singapore General Hospital
Desmond Lee
desmond.lee.x.y@sgh.com.sg

PS71: Inspiring a Culture of Safety through Patient Safety Event Reporting and Analysis
Penn State Hershey Medical Center
Brian Lentes
blentes@hmc.psu.edu

PS72: Inventing Med Rec 2.0: Patient-centered Medication Reconciliation for Children
The Mount Sinai Hospital
Rebecca Anderson
rebecca.anderson@mountsinai.org

PS73: I-PASS with SAFETY: Standardized Nursing Bedside Handoff
Boston Medical Center
Katherine Scanlon
katherine.scanlon@bmc.org

PS74: It Takes a Village: Hospital Based Inpatient Psychiatric Services
Stanford Health Care
Catherine Mortl
CMortl@stanfordhealthcare.org

PS75: Lost to Follow-up Patients
Cincinnati Children's Hospital Medical Center
James Brown
James.brown@chmc.org

PS76: Medical Student Perceptions on Patient Safety Prior to Pilot of Healthcare Leadership Track
Georgetown University
Omar Rahman
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PS77: Mental Health Patient Placement Matters
Health Sciences North
Natalie Kennedy
nkennedy@hsnsudbury.ca

PS78: Mental Health Service Changes and Suicide: Examining the Impact by Age and Gender
The University of Manchester
Adam Moreton
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PS79: MISSION Asthma Modern Innovative Solutions to Improve Outcomes in Asthma
Portsmouth Hospitals NHS Trust
Claire Roberts
claire.roberts2@porthosp.nhs.uk

PS80: Monitoring Transfusion Reaction Activity Through Surveillance
Provincial Health Services Authority
Aimee Beauchamp
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PS81: Nurse Led Implementation of the ABCDE Bundle
Dignity Health
Brenda Downs
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PS82: On a Journey to High-Reliability A Systems Approach to Communication & Resolution Program Implementation
MedStar Health
Kyle Quigley
Kyle.W.Quigley@medstar.net

PS83: One Year Post Life or Limb Policy Implementation: Evaluation to Support Acute Care Quality Services
Critical Care Services Ontario
Bernard Lawless
bernard.lawless@uhn.ca

PS84: Partnering with Patients and Families to Dispel Misconceptions of Delirium - A System Approach
MedStar Health / H2Pi
Armando Nahum
anahum@safearecampaign.org

PS85: Path to Develop a Toolbox for Undergraduates
Robert Gordon University
Jennifer Ross
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PS86: Patient Safety from Boardroom to Bedside: Clinical Red/Green Meetings
Windsor Regional Hospital
Karen McCullough
karen.mccullough@wrh.on.ca

PS87: Patient-Involved Structured Debriefings after Cesareans Improve Labor and Delivery Team Perception of Communication and Safety
The University of Kansas School of Medicine - Wichita
Taylor Bertschy
tbertschy@kumc.edu

PS88: Patients as Partners in High Reliability - A Case Study of We Want to Know
MedStar Health Research Institute
Caitlin Quigley
Kyle.W.Quigley@medstar.net

PS89: Pediatric Catheter Associated Urinary Tract Infection Reduction Nationwide Children's Hospital
Mike Fetzer
mike.fetzer@nationwidechildrens.org

PS90: Pharmacy Presence in the Pediatric Emergency Center-Cultivating Safer Practice
All Children’s Hospital
Pamela Neely
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PS91: Pressure Ulcer Incidence in Six Intensive Care Units — Data for Improvements
University of Michigan Health System
Candace Friedman
candacef@med.umich.edu

PS92: Preventing Avoidable Death — An EMR-Powered Chief Quality Officer
Houston Methodist Medical Center
Stuart Dobbs
sdobbs@tmh.org

PS93: Preventing Delays by Promptly Dealing Urgency of Cesarean Sections — The Implementation of Color Codes
The Aga Khan University Hospital
Sidrah Naushena
sidrah.naushena@aku.edu

PS94: Preventing Falls in Outpatient Rehab
NCH Healthcare System
Vince Laz
vince laz@nchmd.org

PS95: Preventing Insulin Dispensing Errors
Hamad Women’s Hospital
hanan khalifa
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PS96: Preventing Kernicterus in Canadian Hospitals
HIROC
Joanna Noble
jnoble@hiroc.com

Foundation Fighting Fatal Infection & Disease
David Flinchbaugh
doctorflinchbaugh@yahoo.com

PS98: Promoting a Culture of Safety in A Multi-Site Pediatric Hematology/Oncology Practice
All Children’s Hospital
John’s Hopkins Medicine
Tracy West-Grubb
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PS99: Promoting an Ambulatory Care Culture of Safety with an Interdisciplinary Preventative Falls Program (Falling Leaves)
Penn State Hershey Medical Center
Paula Sheaffer
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PS100: Protecting Patients From Risks Associated With The Use of Electrosurgical Unit (ESU)
National University Hospital
Sandhya Mujumdar
sandhya_mujumdar@nuhs.edu.sg

PS101: Providing Early Definitive Care: A Mitigating Measure for Patients Waiting for Beds at Emergency Department
National University Hospital
Sandhya Mujumdar
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PS102: Pulse Oximetry Alarms: Can We Take Alarms Down Another Notch
Boston Medical Center
Deborah Whalen
deborah.whalen@bmc.org

PS103: Pump In & Pump Out: Increasing Hand Hygiene Compliance and Observations through Mobile Form
Adventist HealthCare Physical Health and Rehabilitation
Marya De La Cruz Sabalbaro
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PS104: Quality Improvement Initiative of Pediatric Inpatient Discharge Summary
Metropolitan Hospital Center
Visalakshi Sethuraman
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PS105: Rapid Start Up of a Large Scale Patient Safety Organization
HCA
Ruth Westcott
Ruth.Westcott@hcahealthcare.com
PS106: rapID-PASS: An Emergency Department Standardized Handoff
Boston Medical Center
Anton Manasco
anton.manasco@gmail.com

PS107: Reducing Bottleneck Delays in a South African Emergency Centre
Thames Valley and Wessex Leadership Academy
Lucy Parker
lucy.polsk@gmail.com

Rumford Hospital
Becky Hall
HallBe@cmmc.org

PS109: Reducing Harm from Opioids
Southern District Health Board
Lucia Magee
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PS110: Reducing Hospital-Acquired Pressure Ulcers at Florida Hospital
Florida Hospital
Namrata Sachdev
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PS111: Reducing Hyperglycaemia in Fasting Diabetic Patients Awaiting Procedures
Singapore General Hospital
Stephanie Chung Shuk Ying
Stephanie.chong.s.t@sgh.com.sg

PS112: Reducing Radiation Dose During CT Exams
NCH Healthcare System
Lindsay DeLorme
lindsay.delorme@nchmd.org

PS113: Reducing the Risk of Venous Thromboembolism (VTE) Events: An Interprofessional Approach
Penn State Hershey Medical Center
Mary Trauer
mkost07@comcast.net

PS114: Reducing Urinary Catheters at The Ottawa Hospital: Experience from the medicine ward
The Ottawa Hospital Research Institute
Krista Wooller
kwooller@toh.on.ca

PS115: Reduction in Post Prostate Biopsy Infections
St. Luke’s Regional Medical Center
John Werdel
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PS116: Reduction of Adverse Events (AEs) in an AMC Over a Decade — The NUH Experience
National University Hospital
Sucharita Hota
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PS117: Respiratory Therapist and Nurses Collaborate to Prevent Respiratory Device-Related Pressure Ulcers
Orlando Health
Tara Mahramus
Tara.mahramus@orlandohealth.com

PS118: Risk-Scoring Systems Improve Patient Safety
Signature Healthcare Brockton Hospital
Cheryl McCallion
ccmcallion@signature-healthcare.org

PS119: Safe Passage: Optimizing Transitions of Care to Labor and Delivery
University of Pennsylvania Hospital
Daniel Lee
daniel.lee@uphs.upenn.edu

PS120: Safety and Savings: Improve Obstetric Hemorrhage-Screening Decreases Massive Transfusion Requirements
Winnie Palmer Hospital: Arnold Palmer Medical Center a part of Orlando Health
Sharon Sabella
sharon.sabella@orlandohealth.com

PS121: Safety by Design: Creating the Prototype for Design Thinking in Patient Safety at Stanford
Lucile Packard Children’s Hospital
Krisa Hoyle Elgin
kelgin@stanfordchildrens.org

PS122: Safety Initiatives Implemented on an Inpatient Unit for Patients with Substance Use Disorders
The Ohio State University Medical Center
Julie Niedermier
julie.niedermier@osumc.edu

PS123: Save a Life — Call an RRT! New Hanover Regional Medical Center
Steve Johnson
steve.johnson@nhrmc.org

PS124: Saving Sacrums: Reducing Pressure Ulcers
NCH Healthcare System
Erin Raney
erin.raney@nchmd.org

PS125: Screening for Anxiety and Depression in Cancer Patients: A Nursing Intervention
Hamad Medical Corporation
Fiona Milligan
FMilligan@hmc.org.qa

PS126: Sentinel Events Eliminated by Implementation of Direct Admission Policy
Saint Michael’s Medical Center
Susanna Yim
susanna.yim@mail.mcgill.ca

PS127: Shining a Light on Patient Safety
Mercy Hospital St. Louis
Debbie Nihill
Debbie.Nihill@Mercy.net

PS128: Standardizing and Tightening Home Leave Process to Ensure Patient Safety
National University Hospital
Bhuvaneshwari Mohankumar
bhuvaneshwari@nuhs.edu.sg

PS129: Standardizing Total Parenteral Nutrition (TPN) to Reduce Errors All Children’s Hospital Johns Hopkins Medicine
Jacquelyn Crews
jcrews7@jhmi.edu

PS130: Sticking it to the Flu
NCH Healthcare System
Paul Slack
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PS131: Strengthen the Hand Over Process
The Aga Khan University Hospital
Ambreem Memon
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PS132: Surgical Antibiotic Prophylaxis: Choice and Dose Matters!
Yale New Haven Hospital
Nicole Colandrea
Nicole.Colandrea@ynhh.org

PS133: Surgical Leadership Huddle to Review Debriefing
Thomas Jefferson University Hospital
Monica Young
stephanie.landmesser@jefferson.edu

PS134: Sustaining the Gain in Reducing Falls
Newark Beth Israel
Sheri Cleaves
scleaves@barnabashealth.org

PS135: Systems & Human Factors Engineering Approach to Reducing System-wide CAUTI at an Academic Medical Center
University of Texas Southwestern
Eleanor Phelps
eleanor.phelps@utsouthwestern.edu

PS136: TeamSTEPPS and Surgical Safety Checklist: Improving Patient Safety
Mount Sinai Medical Center
Yessenia Valentin-Salgado
yessenia.valentin-salgado@mountsinai.org

PS137: The Addition of Cranberry and Bacitracin to the Standard Foley Bundle Significantly Reduced/Eliminated CAUTI
Signature Healthcare Brockton Hospital
khaled Sorour
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PS138: The Development of an Anesthesia Department Communications Compact
H Lee Moffitt Cancer Center
Jonathan Cohen
jonathan.cohen@moffitt.org

PS139: The Impact of Influenza Like Illness on Critical Care Units: Early Findings from Ontario ICUs
Critical Care Services Ontario
Bernard Lawless
bernard.lawless@uhn.ca

PS140: The Journey Continues, Using Lean Methodology at an A3 Status Update
New Hanover Regional Medical Center
Sandy Andrews
sandy.andrews@nhrmc.org

PS141: The Role Of A Naloxone Task Force In Improving Safety
H Lee Moffitt Cancer Center
Diane Garry
diane.garry@moffitt.org

PS142: The Role of HeROs in the Creation of a Culture of Reliability
Mednax
Jeffrey Shapiro
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PS143: The Telluride Experience: A New Approach to Patient Safety Education
MedStar Health
Stacey Gonzalez
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PS144: To Improve Design of Limb Restrainer
Singapore General Hospital
Shanmugavalli P.Ramasamy
shanmugavalli63@gmail.com
PS145: To Improve Hand Hygiene Compliance Among Doctors  
Singapore General Hospital  
Shuwei Zheng  
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PS146: Toronto Western Hospital Emergency Department Bed Utilization Project  
University Health Network  
Lucas Chartier  
lucas.chartier@uhn.ca

PS147: Tracheostomy Care Optimization  
Ann & Robert H. Lurie Children’s Hospital of Chicago  
Rowsha LaBranche  
rlabranche@luriechildrens.org

PS148: Unsuitable Communication with Older People Declines the Heart Function  
EGPRN; NAPCRG / member  
Sofica Bistriceanu  
bistriss@hotmail.com

PS149: Use of High-Fidelity Simulation to Enhance Interdisciplinary Collaboration and Reduce Patient Falls  
Mayo Clinic  
April Bursiek  
bursiek.april@mayo.edu

PS150: Using Common Cause Analysis on the Journey to Zero Patient Harm  
Memorial Hermann Health System  
Anne-Claire France  
Anne-Claire.France@memorialhermann.org

PS151: Using Fake Mommies to Change Real Patient Care  
Novant Health  
Lindsey Horne  
lrlomax@novanthealth.org

PS152: Using Medication Safety Data to Drive Performance Improvement  
Pharmacy Systems, Inc.  
Steven Johnson  
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PS153: Using Mindfulness for Critical Thinking and Patient Safety During Medication Administration  
University of Illinois at Chicago  
Marianne Durham  
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PS154: Using the Global Trigger Tool to Identify Adverse Events in a Brazilian Hospital  
ACSC - Associação Congregação de Santa Catarina  
Camila Lajolo  
clajolo@post.harvard.edu

PS155: Using Tracers to Evaluate Implementation of an Improvement Strategy  
Center for Quality  
Inge Pedersen  
inge.pedersen@rsyd.dk

PS156: Utilizing Electronic Triggers to Identify Adverse Events, Harm, and Improvement Opportunities in a Pediatric Hospital  
Cook Childrens Health Care System  
Shana Rasmussen  
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PS157: Utilizing Slow-Pressure Volume Loops to Determine Optimal PEEP and Improve Patient Outcomes  
Geisinger Medical Center  
Michael Bingaman  
msbingaman@geisinger.edu

PS158: VA Palo Alto Health Care System Nursing Service Project RED Implementation of Teach Back  
Va Palo Alto Health Care System  
Denise Renfro  
Denise.Renfro@va.gov

PS159: Venous Thromboembolism: Establishing a Quality System for Hospital-wide Identification and Prevention  
Nationwide Children’s Hospital  
Sheilah Harrison  
sheilah.harrison@nationwidechildrens.org

PS160: Ventilator-Associated Pneumonia: Using Evidence, Interdisciplinary Teamwork & Continuous Rapid Improvement to Drive Culture Change  
The Children’s Hospital of Philadelphia  
Louise Hedaya  
hedaya1@email.chop.edu

PS161: Virtual Monitors Reduces Fall Rate in Hospital Intermediate Care Units  
Brigham and Women’s Hospital  
Escel Stanghellini  
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PS162: Weighing in on Patient Safety  
Novant Health  
John Gardella MD  
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PS163: Working Towards Zero, No Pressure: Preventing Pediatric Pressure Ulcers  
All Children’s Hospital John’s Hopkins Medicine  
Kris Rogers  
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