worst aspect. During the same time period, residents found the quality of the rotation to be "Excellent" based on an average of 7.83/9. Refer to tables for specific breakdown.

Retrospective Review of Rotating Student Post-Rotation Survey 8/2012-10/2016				
	Top 10 Best Aspects	Number of responses (N=306)	Top 10 Worst Aspects	Number of responses (N=241)
1	Teaching Resident	140 (46%)	Nothing/ Not Applicable	51 (21%)
2	Faculty/ Staff/ Residents	43 (14%)	No Teaching Resident at Pediatric ED	47 (19.5%)
3	Procedures	38 (12%)	Too Many Students on a Shift	29 (12%)
4	SIM/ US/ Procedure Labs	17 (5.6%)	Pediatric ED Shifts	25 (10.4%)
5	Patient Variety/ Pathology	15 (4.9%)	Limited Night/ Weekend Shifts	15 (6.2%)
6	Conference/ Journal Club	14 (4.6%)	Conferences	12 (5%)
7	Autonomy/ Ownership of Patients	13 (4.2%)	Not Enough Patients	11 (4.6%)
8	Pediatric ED	11 (3.6%)	Schedule/ Shift Turnaround	8 (3.3%)
9	Trauma Exposure	4 (1.3%)	Limited Attending Interaction	8 (3.3%)
10	Learning Environment	2 (0.65%)	Presenting to Multiple Attendings	5 (2.1%)

	Resident Responses to "Evaluate Quality of Clinical Experience" for Teaching Rotation		
	Number of Responses	Period of Evaluations	Average Response (1-9)
	7	7/1/12-6/30/13	8.43
	14	7/1/13-6/30/14	7.93
	12	7/1/14-6/30/15	7.27
	13	7/1/15-6/26/16	7.77
	6	6/27/16-7/2/17	8.33
Total	52	-	7.85

48 Small-Group Shift for Assessment of Entrustable Professional Activities in an EM Clerkship

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Background: Entrustable professional activities (EPA) have gained acceptance in UME to assess readiness to transition from medical student to intern. The best method for evaluating students within the EPA context has not been identified. Many of the EPA can be routinely evaluated in a single ED shift.

Educational Objectives: The goal is to evaluate fourth year medical student's proficiency in EPA 1-10 during an ED shift.

Curricular Design: Many methods have been described to assess a single EPA using simulated patients. This is time and resource intensive.

Small-Group Shift (SGS) consists of 4-6 students and one faculty facilitator. Each patient interaction is directly observed by the facilitator. Then follows a discussion of differential diagnosis, plan and identification as sick or not-sick. The student then enters orders and a note including a pertinent literature reference. Meanwhile the next student's patient interaction is observed. The cycle continues until all students have seen a patient. Each student presents his case to the group. At the end, each student is observed transitioning care to the next provider.

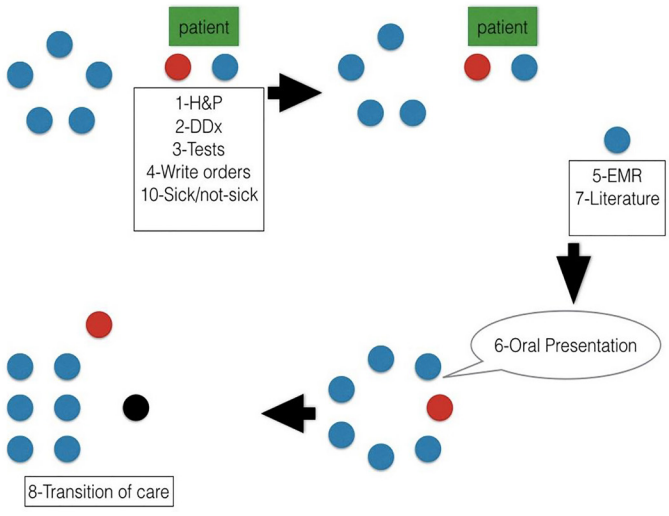
Evaluation categories for EPA 1-10 are "Entrustable", "Pre-entrustable", or "Remediation".

Several limitations were encountered. Students are idle until they see their first patient. Space is needed within the ED to allow group discussion. Assessing transition of care is not always possible if the patient has been discharged.

Impact/Effectiveness: 48% of students (n=27) felt SGS exceeded expectations and 48% felt it met expectations. 74% of students felt the facilitator's teaching skills exceeded expectations.

Positive themes from student feedback included a sense of autonomy, real-time feedback on plans and learning from peers during case discussions. Downtime was noted as a negative.

The SGS is the first method described allowing one faculty member to assess multiple students simultaneously on most EPA using real patients. The SGS offers a time- and cost-effective method of evaluating a large number of students.



Loma Linda University Emergency Medicine
Small-Group Shift Assessment Tool

Student:_____ Evaluator:_____

Date:_____ Chief Complaint:_____

Expected Level:	Entrustable "Intern"	Pre-Entrustable/Progressing "MS4"	Critical Error/Requires Remediation "MS3"
Focused H&P			
Prioritized DDX			
Recommend/Interpret Tests			
Write orders and rx			
EMR Documentation			
Oral communication			
Use of literature			
Sign-out/Transition of care			
Interprofessional teamwork			
Sick/not-sick			

Comments:

49 Staggering Transitions of Care to Provide Supervised Signouts

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Background: The CLER Pathways of Excellence clearly defines certain basic principles of care transitions which include resident education and engagement in the process, in addition to faculty engagement and assessment of the hand-off process. In a review of our own sign-out processes, we ascertained that our program is not incorporating all of these ideologies and by instituting some rudimentary changes, we could immensely impact care transition education and subsequently provide superior patient care.

Educational Objectives: To create a clinical environment in an otherwise busy Emergency Department conducive to protected and supervised care transitions while allowing for patient care and flow to continue in an unobstructed and safe fashion.

Curricular Design: Shift times were staggered throughout the day to allow for attending-supervised care transitions and protected time for directed education. Our resident services that previously all transitioned independently at 7AM and every 8 hours thereafter, now transition at 6AM, 7AM and 8AM and continue that staggering for the remainder of the day. For the 30 minutes before and after sign-out, the residents are also protected from new patients to allow for time to give and receive sign-out without additional clinical pressures that often portend to errors and substandard care. At each resident sign-out time, an attending is present to both supervise and provide real-time training on transitions of care. Attendings also have the opportunity to evaluate the residents on their ability to transition care, provide teaching points and give feedback. Furthermore, to aid in an interprofessional approach to care transitions, hand-off times are announced to the department allowing for nursing involvement.

Impact/Effectiveness: By creating a system where residents were supervised in their care transitions and concurrently not overwhelmed by increasing clinical demands, we found that the safety and care of our patients improved significantly by ensuring smooth transitions and minimizing miscommunication. Qualitative resident feedback showed that having an attending present at sign-out times provided valuable education. Feedback from our faculty exposed that supervising resident sign-outs gave them a unique perspective on our residents' ability to provide an effective sign-out, and new teaching goals directed toward this quality initiative. This can easily be implemented in any ED. With the simple action of reorganizing schedules to allow for attending presence at sign-outs, residents can be observed and taught appropriate behaviors that should take place during this time and adapt such practices from the start of their training. This will work to enhance both the clinical working environment and patient care

50 Storytelling: A Novel Wellness Initiative for Emergency Medicine Residents

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Background: Storytelling (ST) can help physicians reflect on their practice, cultivate a sense of empathy, and develop a support network of trusted colleagues. Additionally, sharing experiences through ST or narratives can decrease emotional exhaustion, an important component of burnout. Despite these benefits of ST for resident wellness, Emergency Medicine (EM) residents rarely get an opportunity to share their experiences with others in structured residency supported settings.

Educational Objectives: We sought to create a forum for EM residents to share stories about the human side of medicine, in order to promote empathy, reflection, and develop a greater sense of community.

Curricular Design: We planned an off-campus, 2 hour "open microphone" night for residents and faculty to share their experiences at two separate EM residency programs.