Abstract Appendix for PPC 2014 Poster Abstracts
Document supplémentaire pour les résumés des affiches de la CPP 2014

Appendix Table 1: Summary of Quantitative parameters for Clinical Interventions

Antibiotic Stewardship Clinical Interventions	24 SEP-21 NOV 2012	22 NOV – 22 JAN 2013	23 JAN-27 FEB 2013	28 FEB-MAR 18 2013	19 MAR-APR 30 2013	01 MAY – MAY 31	01 JUNE – JUNE 30	01 JULY – JULY 31
	(58 DAYS)	(61 DAYS)	(35 DAYS)	(13 DAYS)	(42 DAYS)	(31 DAYS)	(30 DAYS)	(31 DAYS)
Total number of anti infective orders reviewed	124	253	167	83	230	162	163	182
# of orders dispensed as ordered (includes no pharmacist intervention or physician unwilling to accept recommendations)	88 (71%)	157 (62%)	111 (66%)	66 (80%)	154 (67%)	93 (57%)	90 (55%)	103 (57%)
# of orders that pharmacists intervened to make dose / frequency / duration / lab order changes (includes discontinuation of non-restricted antimicrobials)	16 (13%)	55 (22%)	39 (23%)	9 (11%)	55 (24%)	43 (27%)	44 (27%)	40 (22%)
# of orders that pharmacists intervened to change drug (broad spectrum to narrow spectrum abx change or change based on C&S or change based on indication)	9 (7.2%)	26 (10%)	10 (6%)	6 (7%)	9 (8%)	17 (11%)	13 (8%)	19 (10.4%)
# of orders where IV antibiotics changed from IV to PO (involving physician with/without pharmacist intervention)	5 (4%)	11 (4%)	6 (4%)	2 (2%)	1 (0.4%)	3 (2%)	9 (5.5%)	9 (4.9%)
# of orders where restricted IV antibiotic was discontinued after intervention from pharmacist	5 (4%)	3 (1%)	0 (0%)	0 (0%)	1 (0.4%)	5 (3.1%)	7 (4.3%)	11 (6.0%)
# of orders where restricted IV antibiotic was continued after intervention from pharmacist	1 (0.8%)	1 (0.004%)	1 (0.6%)	0 (0%)	0 (0%)	1 (0.6%)	0 (0%)	0 (0%)
% of pharmacist time in doing Stewardship	22% (22% OF 322 HRS)	21% (21% OF 585 HRS)	33% (33% OF 193 HRS)	35% (35% OF 274 HRS)	35% (34% OF 715 HRS)	38% (38% OF 414 HRS)	43% (43% OF 351 HRS)	41% (41% OF 453 HRS)

Supplementary material for Taylor M, Wist A, Radhakrishnan G, Strutchbury R, Varsava J, Oesch A. Retrospective analysis of the implementation success of an antimicrobial stewardship program in a community hospital without an infectious disease physician [abstract]. *Can J Hosp Pharm.* 2014;67(1):60.

Appendix Table 1

Survey Question to Residents (80% response rate)	Survey Responses (%)				
	Does Not Apply	Strongly Disagree	Disagree	Agree	Strongly Agree
The personalized medicine rotation increased my skills, knowledge and competency in the provision of pharmacogenomics-based pharmaceutical care.	0	0	0	75	25
The assigned readings were useful at developing a baseline of knowledge required for this rotation.	0	0	0	25	75
The online tools demonstrated were effective at allowing me to apply my knowledge of pharmacogenomics.	0	0	0	75	25
The teaching strategy of case-based learning was effective.	0	0	0	50	50
The teaching strategy of modeling (done by the preceptor) was effective.	0	0	0	50	50
The teaching strategy of coaching (done by the preceptor) when I was actively engaged in patient care was effective.	0	0	0	50	50
Overall, the teaching strategies used during the rotation were effective to accomplish learning goals and objectives.	0	0	0	75	25
The time allotted for each learning objective/activity was sufficient.	0	0	0	75	25
The total time allotted in the pharmacy residency program (i.e two weeks) is sufficient to achieve the learning goals and objectives of this rotation.	0	0	0	75	25
I agree that personalized medicine should be a mandatory rotation for pharmacy residents.	0	0	0	100	0
What I learned in this rotation about pharmacogenomics is useful for my career as a pharmacist.	0	0	0	50	50

Supplementary material for Facca NM, Jansen S, Kim RB. Personalized medicine: teaching strategies for a novel clinical pharmacy residency rotation [abstract]. *Can J Hosp Pharm*. 2014;67(1):66.

Annexe 1

Paramètres	BMA	A/NZ	GMC	ACP	AMA	ASHP	AMC	ACPM	CMPNB	CPSBC	CMQ
1. Assurer la protection des renseignements personnels des patients	X	X	X	X	X	X	X	X	X	X	X
2. Exercer une prudence quant au partage de données relatives aux cas cliniques, aux anecdotes et expériences pratiques			X			X		X		X	X
3. Échanger des renseignements et documenter ces échanges après consentement éclairé des patients et soignants				X						X	
4. Comprendre et utiliser adéquatement les paramètres de gestion de la protection des renseignements	X		X		X	X				X	
5. Respecter la frontière professionnel-patient	X	X	X	X	X	X	X			X	X
6. Éviter de communiquer des renseignements personnels sur soi			X	X	X	X	X			X	X
7. Être conscient de son image en ligne et de son influence sur la profession	X	X		X							X
8. Surveiller sa présence sur le web		X		X	X						
9. Identifier clairement son identité et déclarer ses conflits d'intérêts	X		X			X	X				X
10. Obtenir les consentements appropriés et mentionner l'origine des renseignements divulgués							X				X
11. Fournir des conseils conformes aux meilleures données disponibles et aux données probantes				X		X					X
12. Comprendre les technologies utilisées et les publics rejoints							X	X			
13. Saisir les enjeux des communications en ligne et l'ensemble du cadre juridique applicable	X		X	X	X	X	X				

Légende: BMA : British Medical Association, A/NZ-MACDT: Australian Medical Association Council of Doctors- in-Training, New Zealand Medical Association Doctors-in-Training Council, New Zealand Medical Students' Association, Australian Medical Students' Association, Australian Medical Association, GMC: General medical council, ACP-FSMB: American College of Physicians and the Federation of State Medical Board, AMA: American Medical Association, ASHP: American Society of Health-System Pharmacist, AMC: Association médicale canadienne, ACPM : Association canadienne de protection médicale, CPSBC: College of Physicians and Surgeons of British Columbia, CMPNB : Collège des médecins et pharmaciens du Nouveau Brunswick et CMQ: Collège des médecins du Québec.

Document complémentaire pour Guérin A, Lebel D, Bussières JF. Médias sociaux, comportements en ligne et pharmaciens : lignes directrices et réflexions [résumé]. *J Can Pharm Hosp*. 2014;67(1):72-3.

Appendix Table 1

Compliance (%) with Medication Reconciliation

	Preadmission		Admission		Verification of Best Possible Medication History		Transfer		Discharge	
	Site 1	Site 2	Site 1	Site 2	Site 1	Site 2	Site 1	Site 2	Site 1	Site 2
F2013 Q1	70		89.6		85.7		19.9		73.1	
F2013 Q2	88.2	56.1	92.9	73.1	93.1	69.5	66.6	35.5	81.5	55.5
F2013 Q3	90.5	51.7	94.9	72.3	94.9	68.1	65.6	39.6	82.0	53.9
F2013 Q4	93.3	64.5	96	70.6	95.7	66.9	65.8	46.6	81.1	53.9
F2014 Q1	96.5	87.5	96.7	73.7	96.3	70.1	73.2	74.9	82.9	57.1

Supplementary material for Facca NM, Ahrari S, Jansen S, Sellery C, Laman D, Bogorad I, et al. Successful medication reconciliation implementation in a multi-site acute care facility [abstract]. *Can J Hosp Pharm*. 2014;67(1):77.

Appendix Table 1

Results

	Pre-Program Implementation (June-Dec 2011)	Post-Program Implementation (June-Dec 2012)
Self or medically referred for smoking cessation	201	322
Subsequently initiated medication therapy	187	317
Champix	125 (67.2%)	222 (70.0%)
Zyban	21 (11.2%)	45 (14.2%)
NRT	40 (21.5%)	50 (15.8%)
Completed 12-wk Tx	36 (19.6%)	48 (15.4%)
Did not complete 12-wk Tx	147 (80.3%)	263 (84.6%)
Loss to Follow-up	4	6
First to last fill interval	72.1 days	25.6 days

Supplementary material for Lui K, Vodenicar L, Ma J. Impact of a multidisciplinary program on smoking cessation medication use patterns [abstract]. *Can J Hosp Pharm*. 2014;67(1):77-8.