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Call for Research and Solutions Posters

The IHI Patient Safety Congress, is taking place both in-person and online from May 16–18, 2022. This annual meeting is the must-attend event for those who continue to shape smarter, safer care for patients wherever it's provided – from the hospital to outpatient settings to the home. It is a unique opportunity for practitioners, leaders, and experts around the world to come together and share their knowledge.

Poster Submission Deadline

The deadline to submit final posters is Friday, March 25, 2022. Please note, you will need to create a new account for this specific submission, even if you had previously submitted an abstract or poster to present at this or other IHI conferences.

Research and Solutions Posters

Posters are intended to highlight cutting edge patient safety research or the utilization of patient safety approaches, methods and tools that result in demonstrated reductions in harm or improved patient safety.

Posters describing research or patient safety projects that have been implemented in a practical setting with a discussion of the challenges and barriers to implementation are encouraged. Posters must report on findings of implemented research or patient safety projects, not descriptions of planned projects. Posters should not advertise products or services.

Submitting Your Final Poster

You are required to include the following information:

- Poster Title
- Description
 - Important: please add your name, the name of any contributors, and a preferred email address in the description
- Aim Statement
- Actions Taken
- Summary of Results

Please only submit for yourself and not for colleagues.

Important Notes

- Final poster must be uploaded as a PDF file.
- Please ensure that all the information you submit is complete and final as you will not have the opportunity to edit your information.
- IHI will upload all posters to the event website prior to the IHI Congress for electronic viewing.
- You will receive an automatic email from our system confirming that your information was uploaded successfully. If you do not receive an email from our system, please contact posters@ihi.org to confirm that your storyboard was uploaded successfully.
- You will receive further information on next steps from Lauren Cameron, IHI Event Manager, at a later date, closer to the event.

Conference Registration

All poster presenters are invited to register for the IHI Patient Safety Congress, May 16–18, 2022. Attendance is not required for those whose poster is displayed in the online gallery, as part of the virtual conference experience, but is required for those submitting for the in-person conference experience. For more information regarding registration fees, group discounts, and scholarships, please [visit our website](#).

Layout

Aim to create an attractive display that will draw IHI Congress participants to your poster and clearly communicate the main points of your display. The guidelines below may be helpful. *Please note, these are recommendations and not requirements for submission. Posters without one or more of these elements will also be considered.*

Appearance

Creative use of pictures, graphs, text blocks, color, headlines, etc., can attract others to your storyboard, prompt conversation, and enhance communication of your message. Avoid making your storyboard too “text heavy.” Focus on the highlights of your display. If it can be communicated with numbers, graphs, or other visuals, do so.

Tips for Creating a Poster

Improvement Advisors at IHI developed the following recommendations for creating posters that demonstrate quality improvement (QI) projects in health care. Your poster submission should include the following:

- A clearly defined Aim Statement with an expected change in outcome indicator and time to expected change in the outcome indicator.
- An outline of your project design/strategy for change that explains how you will reach your aim.
- An explanation of the changes made to achieve improvement in the targeted process.
- Graphical representation of improvement. The use of statistical process control (SPC) tools (especially annotated run charts or Shewhart control charts) is preferred to demonstrate the performance of data over time. Bar and pie charts should not be used when building a poster for QI projects.
- An indication that changes were tested and/or adapted to the local environment/organization prior to implementation.
- An explanation of how multiple measures were used to understand and show improvement in the target process.
- A listing of the multi-disciplinary team that was involved in achieving improvement (elements may include: content experts, patients, leadership, etc.)
- A demonstrated sustainability in improvement indicated by the data (if possible).
- A short summary of the lessons learned from the work and/or the message for readers.

Helpful Links for Run Charts

- [How to create a run chart](#)
- [Why is a run chart important?](#)

Poster Examples

Example 1

What Are You Leaving Behind? Operation Swipe & Wipe in the CT OR
 Karen Richeal, BSN RN CNOR
 Nancy W. McMann, MS MT(ASCP)
 Abington Hospital - Jefferson Health

AIM
 To develop a systematic process to perform an "information sweep" between cases in our cardiovascular operating rooms that would remove all sources of patient information.

PROBLEM
 Inappropriate point of care testing results attributed to the wrong patient were undetected for several hours until we discovered that the patient label left behind from a prior case was used in identifying the patient's blood sample. Unfortunately the patient was not harmed. This near miss situation prompted us to take a critical look at all of the possible sources of patient information that is left behind when a CT OR room is turned over between cases.

APPROACH and DEPLOYMENT
Step 1 Engaged all of the disciplines who are in the room during a case. The group was quickly on board; our CT Nurse Team Coordinator and our Chief Perfusionists agreed to lead the improvement process.
Step 2 Developed an analogy for staff to grasp what we were trying to accomplish - we described the process as being similar to the cleaning in between cases - wanted to perform a sweep of all physical information (e.g. patient labels that seemed to be stuck on every available piece of equipment).
Step 3 Made an inventory of the physical places that information was commonly found:
 • Medication infusion pump
 • Perfusion equipment
 • White boards in the room
 • Computer documentation stations - patient labels/ID bands/OR schedule
 • Any part of the patient chart left behind
Step 4 Communicated to staff what the new process will be:
 • All patient labels in the room need to be verified during timeout by nursing and perfusion
 • Location of labels need to be standardized to help with wiping room at end of case
 • No labels allowed on the bypass machine only on vials and for surgery
 • ID wipes need to take place at end of case
 • Add ID wipe to perfusion checklist
 • Will discuss with lead PCA when cleaning room to also dispose of labels if left behind
Step 5 Reported progress at the weekly CT operational meeting - interdisciplinary group of CT OR clinicians supported by representatives from Cardiovascular Service Line Administration, Scheduling and Coordination, Pharmacy and Patient Safety.
Step 6 Refined the process through several PDCA cycles. For example, it was "discovered" that there was prior case with patient information on a cardiac monitor. This led us to inventory other sources of patient information that needed to be "wiped" between cases:
 • Cardiac monitors with hemodynamic information
 • Catheterization/ echocardiogram docs
 • X-ray films
Step 7 Continued monitoring and feedback to staff

RESULTS
 Progress is evaluated in several ways:
 • Frequency of defects are counted each month and discussed at meetings with staff
 • Types of Defects are identified to learn and correct our practices
 • Progress is measured using a tool that has been successful in other Hospital areas - "The Number of Days Since..."
 This count allows staff to easily know when a defect has been found. Early efforts coincided with PDCA cycles. Day 1 was the project start, and multiple reports where "The Number of Days Since Patient Info Was Left Behind - 0" was posted. Currently, the measure reflects: "The Number of Days Since Patient Info Was Left Behind - 33". The longest interval of time between defects has been 56 days.

Frequency of Defects
 (Bar chart showing frequency of defects over months)

Defect Type
 (Pie chart showing categories: Cardiac, Medication, Patient Safety, etc.)

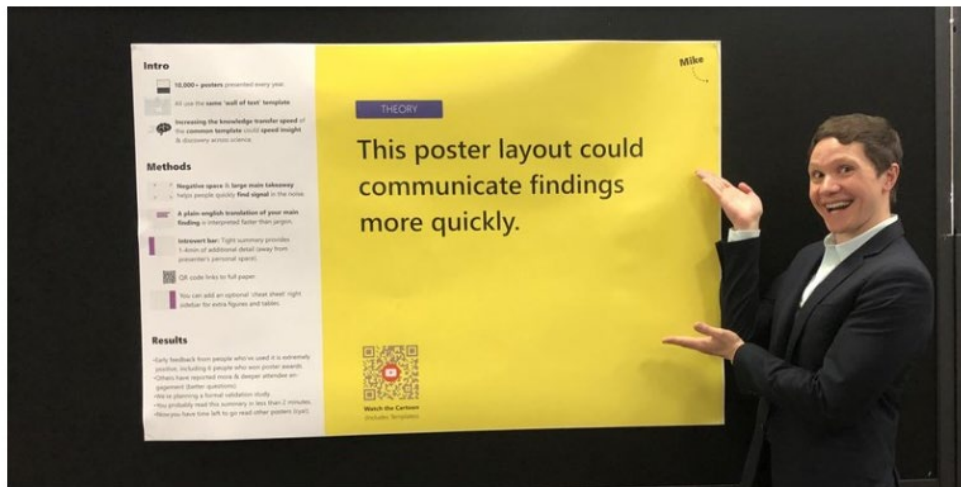
INTEGRATION
 This improvement project is integrated with our Hospital's Strategic Goals and Core Value of Patient Safety (reducing errors). Patient Experience (improving the experience) and Employee Engagement and Safety Culture (empowering staff to make changes to processes and prevent errors).

LEARNINGS
 • Complete, correct documentation coupled with crucial time management is a concern in the CT OR. Hurrying to turn over rooms between cases creates blind spots to potential sources of error that need to plan right.
 • It took several PDCA cycles, heightened awareness and required to address this issue. Opportunities were identified to reinforce processes for correct logging in and out of technology used in the OR.
 • Partnering with our perfusion team was crucial. They took an active role in ensuring that patient info is removed from the pump after each case.

It Takes a Team - Thanks To:
 Marissa Gamble MD, Cardiothoracic Surgery
 Christa Havel, Perfusion Team
 CT OR Team - Nancy, Tracy, PCA, Anesthesia Team
 Renee Adams, Patient Safety & Quality

Example 2

IHI suggests trying this new suggested layout to include a QR Code. More information about this format can be found in [this NPR article](#).



Michigan State University doctoral student Mike Morrison has a redesign for scientific posters to spell out their main point in big, easy-to-read letters.

Courtesy of Mike Morrison

[Submit your completed poster here](#)