Ontario Health

# Emergency Department Return Visit Quality Program

## Report on the 2024/25 Cycle

### Highlights

- A record **159** hospital sites (**75** larger-volume and **84** smaller-volume sites) participated in the Emergency Department Return Visit Quality Program (EDRVQP).
- **5,257** audits were submitted to Ontario Health, representing 10% of all emergency department (ED) return visits.
- **325** sentinel diagnoses were identified, representing 6.7% of the submitted audits and 0.58% of all ED return visits.
- **1,383** quality issues and adverse events were identified, representing 26.3% of the submitted audits.
- **46** sites included 1 or more ED-related indicators in their Quality Improvement Plan (QIP) and connected them to the EDRVQP, representing 31.5% of hospital organizations.

This report summarizes audit data from July 1, 2023, to September 30, 2024, submitted in April 2025. An additional quarter is included in this report to align this program's timelines with those of the QIP Program. All references to 2024 relate to the overall program year and assume the data reporting period above.

### Audit Findings – Sentinel and Nonsentinel

- 72.5% of reported adverse events were mild or moderate
- The 3 most common causes of quality issues and adverse events, accounting for 76% of those reported, were:
  - Patient management issues
  - Delayed or incorrect diagnosis
  - Unsafe discharge disposition decisions

**Note:** See *How to Conduct an Audit* (p. 10) for definitions of quality issues.

## Sentinel Diagnoses

- Return visits for a sentinel diagnosis (i.e., subarachnoid hemorrhage, acute myocardial infarction, or pediatric sepsis) represented 0.58% of total ED return visits (325 visits); this has been consistent over the past several years.
- 36.6% of sentinel diagnoses were identified as having underlying quality issues or adverse events; this percentage is marginally lower than that of last year and a decrease from the start of the EDRVQP in 2016 (Figure 1).
- Since 2021, the rate of quality issues and adverse events in sentinel audits has remained consistently below the 9-year average. Rates broke the lower confidence interval in 2021 and 2024, indicating statistically significant deviations. The downward trend and the astronomical values could indicate special cause variation and sustained improvement in the rate of adverse events for sentinel cases.

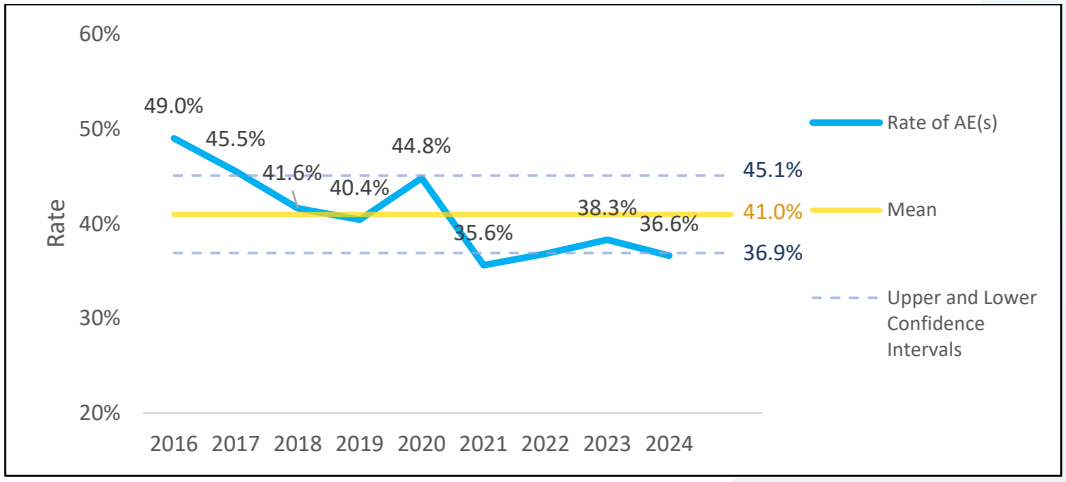


**Figure 1: Annual percentage of sentinel diagnoses with underlying quality issues or adverse events, 2016 to 2024, with statistical process control analysis.**

Abbreviation: AE, adverse event.

*Source: EDRVQP audit submissions. Note: Results are based on the assumption that internal processes for identifying, and self-reporting underlying quality issues and adverse events are stable.*

## Quality Themes and Improvement Initiatives

Key areas for quality improvement (QI) among hospital sites in 2024 included **safety** (e.g., suboptimal discharge, abnormal vital signs), **efficiency and timeliness** (e.g., access to diagnostic imaging, consultations, medical directives), **effectiveness** (e.g., elder care, stroke and cardiac care), and **equity** (e.g., marginalized populations, social determinants of health).

Sites conducted QI initiatives related to access and flow, elder care and incorporating senior-friendly principles into the ED, pediatric sepsis, appropriate discharge, trauma, obstetric and gynecological visits, and condition-specific care in the areas of acute cardiac syndromes and stroke pathways.

Early in the program, analysis of quality issues and adverse events identified in the return visit audits yielded 11 themes (as described in *How to Conduct an Audit*, pp. 13–15). This report features hospital sites focusing on 3 of these themes in 2024: **elder care**, **pediatric patient risk profile**, and **leaving without being seen (access and flow)**. Suboptimal discharge was a common quality issue influencing these themes.

## Elder Care

The ED's busy environment can be challenging for vulnerable older adults, increasing their risk of functional decline and medical complications. Compared with younger patients, older patients are more likely to arrive by ambulance, present with higher acuity and greater complexity, have more comorbidities, and be admitted to hospital. Overcrowding and long wait times often lead to under-triage, with older adults being especially at risk.[1] Under considerable pressure, EDs must balance patient complexity with hospital capacity. Identifying risk factors, conducting assessments early, and being vigilant for deterioration in the waiting room are essential to providing high-quality ED care and enhancing the experiences and outcomes of older patients. A focus in these areas may also reduce hospital admissions.[2] Aware of this, several sites are using elder risk assessment tools, including delirium assessment tools, to identify patients at higher risk of ED return visits.

Table 1 shows the volume of ED visits by age group in 2024. Adults over the age of 65 years, especially those over 85, had the highest rate of return visits within 72 hours (Figure 2).

| 0–17 years | 18–64 years | 65–84 years | ≥ 85 years |
|---|---|---|---|
| 1.38 million | 4.62 million | 1.63 million | 0.43 million |

**Table 1: Volume of ED visits by age group, 2024**

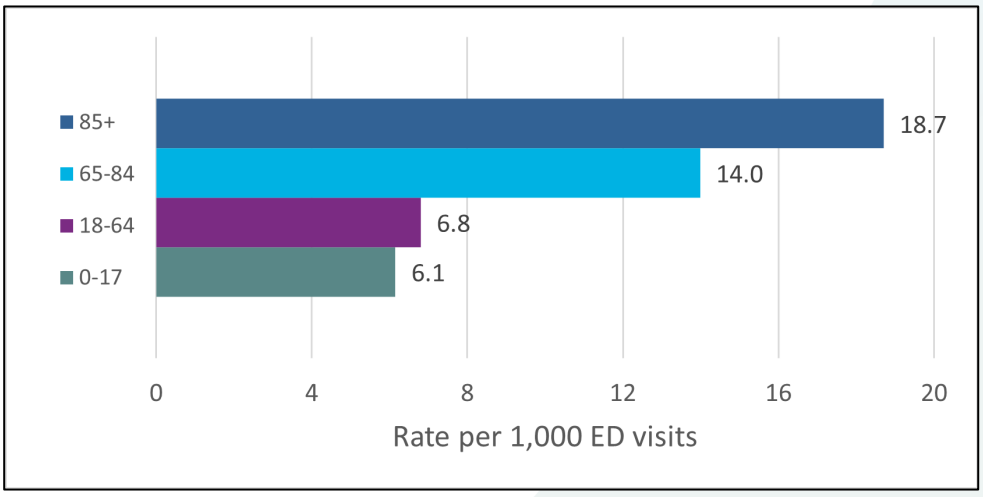


**Figure 2: Rate of ED return visits per 1,000 ED visits and volume of ED visits by age group, 2024.**

*Source: Discharge Abstract Database, National Ambulatory Care Reporting System.*

### *Cambridge Memorial Hospital: Senior-Friendly ED*

A review of return visit cases revealed that older adults were returning to the Cambridge Memorial ED frequently and with higher-acuity needs requiring hospital admission. In 2024, the ED team conducted a gap analysis of the organization's Senior-Friendly Plan to identify opportunities for improvement. The ED team, in collaboration with Grand River Hospital, is leveraging their shared electronic health information system to standardize use of the Assessment Urgency Algorithm (a tool to identify the urgency of comprehensive follow-up for older adults). The team also increased coverage for a geriatric medicine nurse in the ED to 7 days a week, and they prioritized the implementation of 3 components of the Senior-Friendly ED Checklist: promote mobility, ensure adequate hydration, and provide supportive pain management.

***Queensway Carleton Hospital: Identifying Older Adults at Risk***
The Queensway Carleton ED team is prioritizing the accurate assessment and identification of older adults with higher-risk profiles using the Identification of Seniors at Risk tool. At-risk older adults are more likely to experience significant functional decline, more frequent ED visits, and increased rates of hospitalization than those not at risk; thus, those at risk may benefit from more comprehensive assessment and intervention. The ED team is also improving transitions of older adults from acute care to retirement and long-term care homes by enhancing their discharge checklist to emphasize post-discharge follow-up care, patient safety, and communication.

***Ontario Health Initiatives Supporting QI in Elder Care***
Ontario Health supports hospitals' efforts to improve elder care through the following initiatives:

- The Delirium Aware Safer Healthcare (DASH) campaign
- The ALC Leading Practices toolkit
- The Ontario Surgical Quality Improvement Network's geriatric (≥ 65 years) outcome monitoring via the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP)

For more information, please contact ClinicalQuality@OntarioHealth.ca.

## Pediatric Patient Risk Profile

Many sites are pursuing improvements for pediatric patients presenting to the ED. Areas of focus include pediatric sepsis and abnormal vital signs, measles pathways, mental health support, equity, trauma-informed care, and team-based simulation training.

As sepsis can be life-threatening, early recognition and prompt treatment are imperative for improving patient outcomes and rates of morbidity and mortality. In children, early signs of sepsis are often subtle, nonspecific, and easily missed. Orders sets and algorithms, such as those provided by Trekk, help identify pediatric patients at risk of sepsis and early deterioration. Further, including abnormal vital sign alerts in electronic medical records can prevent unsafe discharge decisions.

***Trillium Health Partners – Pediatric Sepsis***
Early identification of pediatric sepsis and abnormal vital signs has been a focus for the Trillium Health ED team. When a pediatric patient presents to the ED with early signs of sepsis, the team uses a pediatric sepsis screening tool to ensure early recognition and initiate an appropriate response. When a patient meets the criteria for possible sepsis, a sepsis alert is initiated, and the patient is immediately provided a room and assessed by a clinician. The team's ED return visit audits also revealed that some patients were being discharged home without documentation of vital sign assessment. To remedy this, they plan to add an alert to their electronic medical record that would require the health care team to acknowledge abnormal pediatric vital signs prior to discharge.

***The Hospital for Sick Children – Language-Concordant Care***
With over 65,000 ED visits in 2024, including many by patients and families with a preferred language other than English, the Hospital for Sick Children identified an opportunity to address inequities and potentially improve outcomes by using language-concordant care. Providing care in patients' preferred languages has been shown to improve patient outcomes, improve access to health information, and build patient trust.[3] A new icon on the patient tracking board identifies patients with a non-English language preference, and the use of a "smart" phrase embedded in clinical notes identifies the interpreters used with non-English-speaking patients, thus allowing the team to monitor language-concordant care in the ED. This is also used as an equity indicator on the hospital's scorecard.

## Access and Flow – Leaving Without Being Seen by a Clinician

Over the years, the EDRVQP has highlighted several quality themes connected to the broader category of access and flow, including patients who leave without being seen by a clinician (LWBS), the availability of diagnostic imaging, timely specialist consultations, ED redesign, and alignment with Pay-for-Results (P4R) metrics. Ontario Health's new ED Leading Practices Toolkit provides many resources to support QI in emergency medicine.

The strain on EDs is largely due to overcrowding and health human resource constraints, which may result in unintended negative consequences for people seeking ED care. Too often, patients wait several hours to see a clinician, access advanced diagnostic imaging or specialist consultations, or receive care; such delays can cause patients to leave without being seen or against medical advice and lead to prolonged ED length of stay. ED teams routinely balance patient care and complexity with hospital capacity; thus, by necessity, they must often treat only the presenting condition rather than the more complex contributing factors. Similarly, because of ED overcrowding and the pressure to expedite discharge, patients may experience unsafe discharges.

This year's narratives indicated that hospitals are increasing efforts to manage wait times and patient flow while ensuring accurate diagnosis and safe discharge, particularly for older adults and children. Preliminary QIP data also show that 90% (132/146) of hospital organizations included access-and-flow indicators in their QIP, demonstrating hospital-wide support for QI initiatives to improve access and flow.

***Scarborough Health Network – Leaving Without Being Seen***

Recognizing a higher LWBS rate due to long wait times, the Scarborough Health Network implemented a front-end model of care that brings the clinician closer to triage, thereby reducing time to physician initial assessment (PIA), treatment times, and length of stay, as well as reducing the number of patients leaving without being seen or against medical advice. Trialed at their Birchmount site, where the LWBS rate dropped to 1%, the front-end model of care is now being implemented at their General Hospital site.

***London Health Sciences Centre – Ambulance Offload Time***

To improve ambulance offload time (AOT), the London Health Sciences ED team has implemented a vertical–horizontal model of care in which the team works with the Office of Capacity Management's inpatient push–pull strategy, removing the preexisting 2-tiered triage approach and supporting flow. At University Hospital, 90$^{th}$ percentile AOT dropped from 284 minutes (4.7 hours) to 42 minutes, and Victoria Hospital saw their 90$^{th}$ percentile AOT drop from 174 minutes (2.9 hours) to 40 minutes.

***Sunnybrook Health Sciences Centre – Time to Physician Initial Assessment***

With the longest times to PIA (90$^{th}$ percentile) in the Greater Toronto Area in 2024, the Sunnybrook ED team took on an ambitious QI initiative to measure, understand, and address the issues driving long wait times. ED clinicians Dr. Dan Cass and Dr. Justin Hall presented their QI initiative and findings at the Provincial Emergency Services Community of Practice webinar in May 2025. To view a recording of the session and the presentation slide deck, please visit Quorum.

## Alignment of the EDRVQP with the QIP Program

This was the first year that teams submitted their EDRVQP narratives and audits via the QIP Navigator. Several aspects of the 2024/25 QIP facilitated the connection of the 2 programs, including:

- The addition of an EDRVQP section to the QIP narrative
- A new requirement for teams to identify in the QIP workplan whether their QIP indicators are connected to their EDRVQP work

One key objective for integrating EDRVQP requirements into the QIP submission was to acknowledge that many issues facing EDs are complex, multifaceted, and due in part to broader hospital and system-level issues. Thus, linking a hospital's overall QIP to the EDRVQP demonstrates an organizational commitment to quality beyond the programmatic level.

Hospital-wide issues like patient flow and health human resources are integral to the provision of high-quality ED care. We are therefore pleased to share that a preliminary synthesis of the 2024/25 QIP and EDRVQP submissions shows that hospitals are identifying both ED and hospital-wide initiatives to support key ED QIP indicators and respond to underlying quality issues identified via return visit audits.

Overall, 46 of 146 organizations included at least 1 ED-related indicator in their QIPs, which they connected to quality improvement work identified from their EDRVQP audits. For each indicator, they also identified change ideas describing their quality improvement activities.

Figure 3 shows the distribution of 2024 QIP indicators connected to EDRVQP work. Figure 4 shows the 5 most common QIP change ideas connected to 1 or more EDRVQP indicators. The most selected change idea was "Monitoring Data: Dashboards and Analysis," with teams using dashboards and regular reports to support evidence-based decision-making and QI prioritization.

Importantly, to demonstrate their commitment to the patients and communities they serve, hospitals are to ensure their QIPs are publicly available.

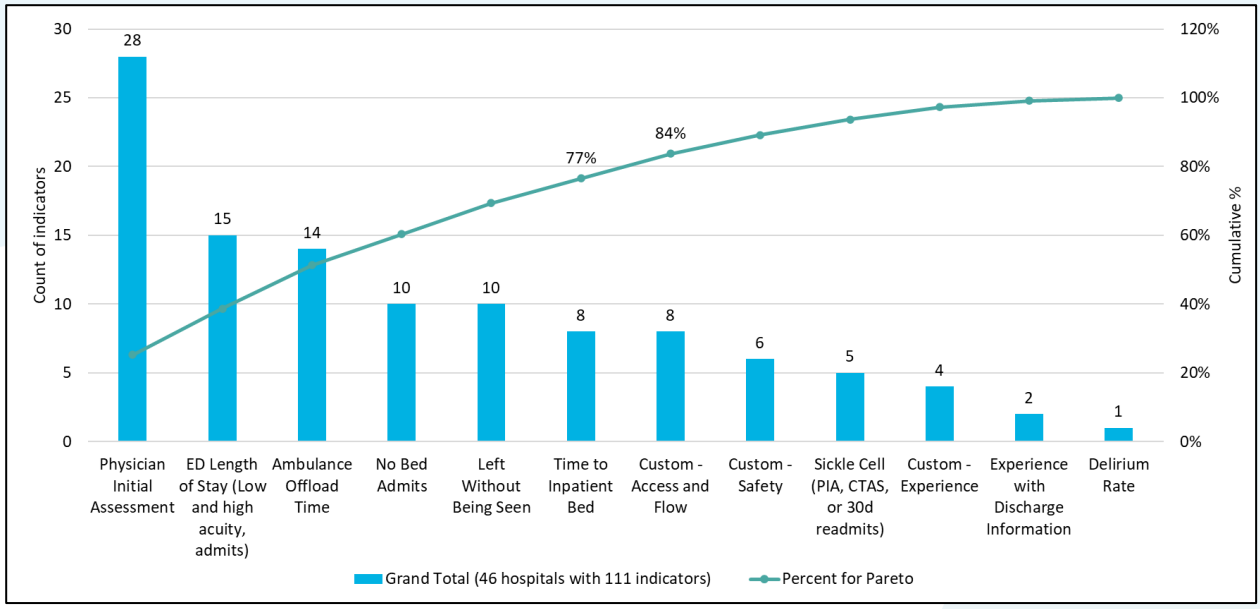


**Figure 3: Pareto chart of the ED-related indicators included in QIPs and connected to EDRVQP work.**

Abbreviations: CTAS, Canadian Triage and Acuity Scale; PIA, physician initial assessment.

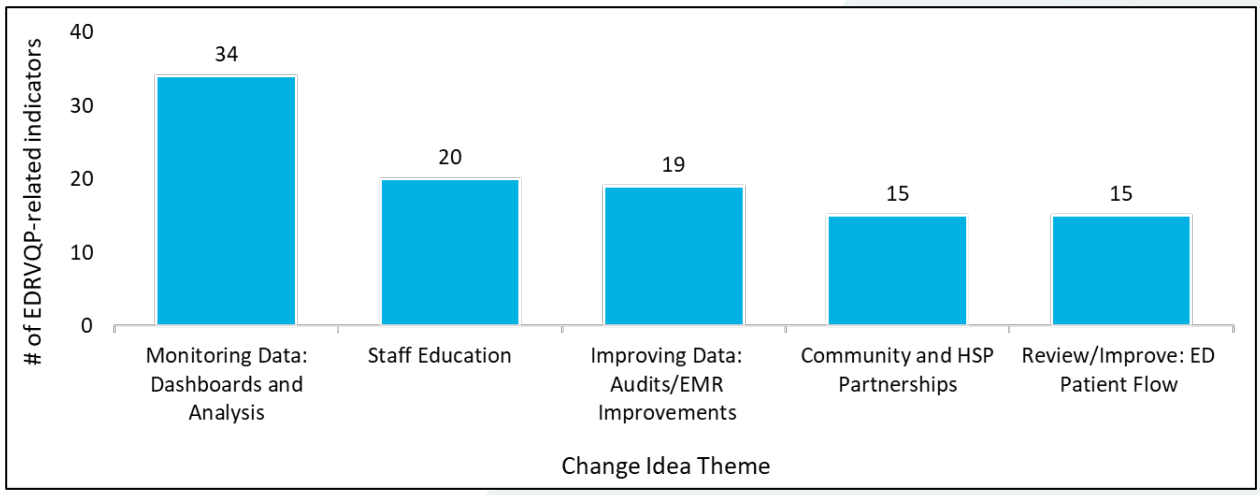


**Figure 4: The 5 most common QIP change ideas and the number of EDRVQP-related QIP indicators.**

Abbreviations: ED, emergency department; EDRVQP, Emergency Department Return Visit Quality Program; EMR, electronic medical record; HSP, health service provider.

## Thank You

All this improvement work has been done in the context of ED challenges across the province, including strains on our health care workers. We sincerely thank everyone involved in the EDRVQP for their immense efforts over the past year and for taking the time to share this work with us.

## About the Program

The EDRVQP builds a continuous structure of quality improvement in Ontario's EDs. This program is an Ontario-wide audit-and-feedback program involving routine analysis of ED return visits resulting in admission. Where quality issues are identified, hospitals take steps to address their root causes. Participation is mandatory for all hospitals participating in the Pay-for-Results (P4R) Program.

Participating large-volume hospitals (i.e., those with > 30,000 annual ED visits) are required to audit a minimum of 50 cases, while smaller-volume sites audit between 10 and 40 cases. Two types of return visits are audited:

- Return visits within 72 hours for any diagnosis resulting in admission to any hospital (termed "all-cause 72-hour return visits")
- Return visits within 7 days resulting in admission to any hospital with 1 of 3 key sentinel diagnoses (acute myocardial infarction, pediatric sepsis, and subarachnoid hemorrhage)* on the return visit, paired with a set of related diagnoses on the initial visit

**The sentinel diagnoses listed have a high likelihood of disability or death resulting from a missed or delayed diagnosis; thus, EDs that identify quality issues that have contributed to missed sentinel diagnoses may prevent significant patient harm by addressing these issues.*

### Stay in Touch

If you have questions, would like to provide feedback, or want to learn more about any of the initiatives shared in this report, please contact us at EDQuality@OntarioHealth.ca.

Please visit the EDRVQP website for all program-related materials, including past reports and webinar recordings.

Please join the Provincial Emergency Services Community of Practice on Quorum to access resources, webinar presentations, and recordings and to contribute to this vibrant community.

Need this information in an accessible format? 1-877-280-8538, TTY 1-800-855-0511, info@ontariohealth.ca
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