Ontario Health

Emergency Department Return Visit Quality Program

Report on the 2023 Results

2023 Highlights

- **75** hospital sites participated in the Emergency Department (ED) Return Visit Quality Program
- **5,173** audits were submitted to Ontario Health, representing 10% of all ED return visits
- **291** sentinel diagnoses were identified, representing 5.63% of the submitted audits and 0.59% of all ED return visits
- **1,154** quality issues/adverse events were identified, representing 22.3% of the submitted audits

About the Program

The Emergency Department (ED) Return Visit Quality Program builds a continuous structure of quality improvement (QI) 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 and voluntary for other hospitals.

In the ED Return Visit Quality Program, participating hospitals are required to audit a minimum of 50 cases from 2 different types of return visits:

- 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.*

This report summarizes audit data from July 1, 2022, to June 30, 2023, that were submitted in January 2024. All references to 2023 relate to the overall program year and assume the data reporting period above. References to earlier years of the program represent similar data reporting periods.

Findings From the Audits and Narratives

Notable Results from 2023

For all audits (sentinel and nonsentinel):

- 74.3% of adverse events were mild or moderate
- The 3 most common causes that were responsible for 79% of all adverse events/quality issues:
  1. Patient management
  2. Delayed or incorrect diagnosis
  3. Unsafe discharge disposition decisions

Note: Definitions of quality issues are found in *How to Conduct an Audit*, p. 10.

Adverse events for sentinel diagnoses:

- In 2023, return visits due to a sentinel diagnosis represented 0.74% of total ED return visits; this has been consistent over the past years
- The percentage of sentinel diagnoses with underlying quality issues/adverse events is 38.3%, which is similar to last year, but an overall decrease from the start of the ED Return Visit Quality Program in 2016 (Figure 1)

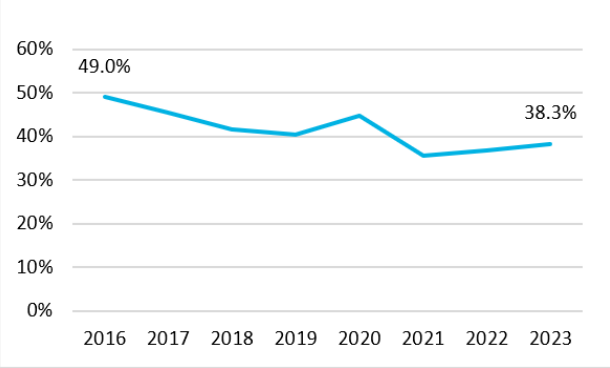

Figure 1: Annual percentage of sentinel diagnoses with adverse events or quality issues, program years 2016 to 2023.

Source: ED Return Visit Quality Program audit submissions.

Quality Themes and Improvement Initiatives

This year, we are building on the left without being seen (LWBS) analysis that we shared in last year's annual report. Changes this year include updated methodology to focus on the LWBS population, and the shift from reporting based on fiscal years to program years to align with the data timeframe of the audits. Therefore, LWBS figures should not be compared between the reports from this year and last year. Hospitalization and ED administrative data provided by the Canadian Institute for Health Information (CIHI) are helpful for observing broader trends. According to these data, the rate of ED return visits for patients who first LWBS increased from 3% in 2021 to 6% in 2023 for all-cause return visits and from 3% in 2021 to 8% in 2023 for sentinel diagnoses (Figure 2).

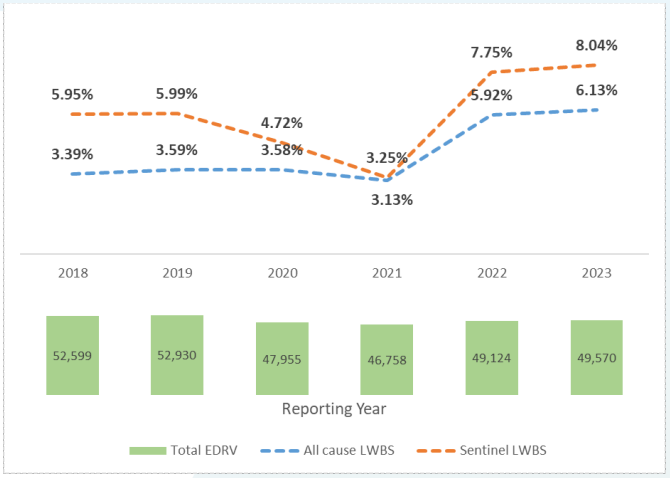

Figure 2: Proportion of LWBS for all-cause and sentinel diagnosis return visits, program years 2018 to 2023.

Note: Includes data for Emergency Room NACRS Initiative (ERNI) hospitals, with both P4R and non-P4R hospitals represented.
Data sources: Discharge Abstract Database (DAD) and National Ambulatory Care Reporting System (NACRS) (CIHI).

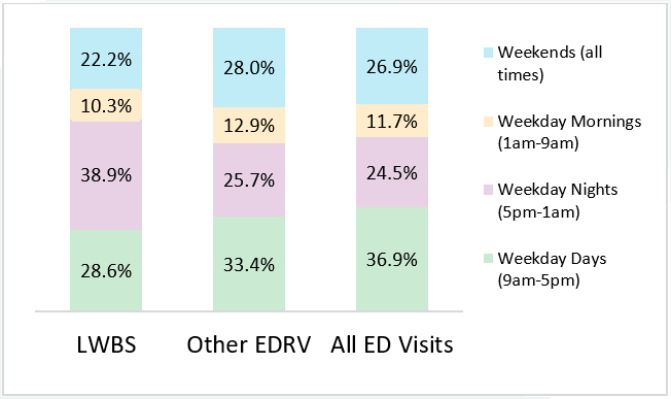

Figure 3: Time-of-day breakdown for all-cause ED return visits (EDRVs) with LWBS disposition compared with other ED return visits and with all ED visits, program year 2023.

Note: Includes data for ERNI hospitals, with both P4R and non-P4R hospitals represented.
Data sources: DAD and NACRS (CIHI).

In 2023, visits leading to LWBS occurred most often on weekday nights, at 39% of the total number of LWBS return visits (Figure 3). Only 26% of all other ED visits occur during weekday nights; this may signal that the time of day is a factor in a patient leaving the ED early. Wait times could also contribute to a patient's decision

to leave. Although patients who LWBS have not reached the point of physician initial assessment (PIA), time to PIA as a proxy for wait times for a typical ED visit in 2023 averaged 1 hour and 48 minutes. Patients who LWBS may not have the time to wait, especially during weekdays.

Early in the program, analysis of adverse events and quality issues 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 2023: left without being seen, diagnostic imaging, and abnormal vital signs and suboptimal discharge.

Left Without Being Seen

Patients who were assessed by a triage nurse but then chose to leave the ED before being assessed by a clinician or before diagnosis may return to the ED with more serious illness or more urgent needs. Patients LWBS because of overcrowding and high demand for care with long waits to see a clinician.

In the last few years, the rate of patients who leave the ED without being seen by a clinician has increased, and hospitals participating in the ED Return Visit Quality Program have made it a priority area of focus. Notably, 23 Ontario hospitals included a LWBS-related indicator in their annual Quality Improvement Plan for 2024/25.

Through the ED return visit narratives, hospitals shared their ongoing commitment to understanding the different factors contributing to LWBS rates, identifying ways to reduce the risk of patients leaving, and ensuring that patients receive the care they need.

Ross Memorial Hospital
Ross Memorial Hospital in Lindsay aims to reduce the number of patients who leave the ED without being seen. The team used QI methodology and Epic clinical information system data to understand trends, contributing factors, and root causes for their LWBS rates. Their data indicated, for example, that patients at high risk of LWBS are often ambulatory, are often assigned a Canadian Triage and Acuity Scale (CTAS) level of 3, and can be managed appropriately via the fast-track stream. To address this, additional physician and nursing support was added to the existing "See and Treat" model for evening hours.

Learn more about this initiative on Quorum.

London Health Sciences Centre
To address long wait times, overcrowding, and delays to PIA, the ED team at London Health Sciences Centre adapted their ED fast track to an intermediate zone. This zone serves patients triaged as CTAS level 2, 3, 4, or 5 who are ambulatory, is staffed by 1 dedicated physician and 2 nurses, and aims to streamline high-quality care. A protected area that includes simple chairs provides ample space to assess and treat patients, leaving acute care spaces for acute patients. Reduced time to PIA for this cohort of patients has shown some impact on decreasing LWBS rates but continues to be a work in progress with the ED team dedicated to ongoing QI initiatives.

Diagnostic Imaging

Over the past several years, ED Return Visit Quality Program analysis has revealed 2 central diagnostic imaging (DI)-related ED quality themes leading to return visits to the ED: discrepancy reporting of imaging results, and timely access to DI. Both are often integral to accurate diagnosis and treatment.

- DI performed after hours often yields preliminary reports upon which the ED physician renders a treatment plan and disposition decision. Final reports by a staff radiologist may reveal clinically relevant discrepancies from the preliminary report and may not be available until hours or days later. These interpretation discrepancies may change the diagnosis and treatment plan, potentially leading to adverse events caused by delayed or incorrect diagnosis and management.
- Timely access to DI is imperative to confirm diagnosis and inform clinical management. DI services are not always available after hours, resulting in longer wait times, prolonged ED length of stay, and overcrowding. Often, patients are discharged from the ED with a planned return visit for imaging tests the following day, which results in delayed diagnosis, higher risk of adverse events, and potentially higher ED and DI volumes during peak times.

Several hospitals described their efforts to address these DI-related quality themes. The May 2024 Provincial Emergency Services Community of Practice (PES CoP) webinar featured presentations about DI-related quality issues. The recording and slide presentation can be found in the PES CoP on Quorum.

St. Joseph's Healthcare Hamilton
St. Joseph's Healthcare Hamilton is focusing their QI efforts on reducing DI report discrepancies and reporting time through an ED/DI collaboration to develop discrepancy policies and processes to manage urgent, emergent, and incidental findings on images.

Learn more about this initiative on Quorum.

Michael Garron Hospital
Michael Garron Hospital in Toronto aims to improve access to DI and reduce time to diagnosis by using QI methodology (e.g., process mapping, root cause analysis) to refine processes for ED patients who require DI tests.

They also aim to reduce reporting discrepancies for computed tomography (CT) reports. Through process redesign efforts, after-hour DI reports to ED physicians are confirmed as final, enabling the ED physician to determine the patient's disposition and treatment plan in a timely manner.

Abnormal Vital Signs and Suboptimal Discharge

Serious adverse events and patient deterioration occurring after discharge from the ED are often preceded by abnormal vital signs and physiological markers. Identification of deterioration risk is integral to treatment and disposition decisions, preventing return visits to the ED and admission to hospital. Suboptimal discharge planning and a lack of postdischarge supports increase a person's risk of experiencing adverse events that require a return visit and potential admission to hospital.

Hospitals described their efforts to ensure safe discharges in their 2023 narratives.

Health Sciences North
Return visit data highlighted suboptimal or failed discharges as a priority for the ED team at Health Sciences North in Sudbury. With the goal of reducing the number of failed discharges, the team is developing a comprehensive discharge checklist that would be used by physicians and nurses to ensure a safe discharge from the ED. The checklist will include elements such as discharge vital signs, walk tests, transportation and mobility needs, and care plans, with written instructions provided to the patient and their family care partners. The team also identified a need to standardize processes for alerting clinicians to abnormal vital signs and acknowledgement of critical lab results to ensure safe discharge practices.

In 2024, as part of the hospital's digital transformation, computerization and automation strategies will be used to standardize care, including reminders to check vital signs, alerts for critical lab values, and prompts for medical directives.

Learn more about this initiative on Quorum.

Peterborough Regional Health Centre
The ED team at Peterborough Regional Health Centre recognized that frail elderly patients were frequently returning to the ED due, in part, to suboptimal discharge. In 2023, the team focused on discharge planning, documentation, and communication. Their patient navigator facilitates assessment and early discharge planning, geriatric emergency management (GEM) referral, community support care, and outpatient appointments for lab and DI, relevant to the person's visit to ED, and communicates the plan to the interdisciplinary team, the patient, and their family care partners. Since implementation of the patient navigator 5 days per week, there has been demonstrable improvement in early intervention and referrals, and decreases in ED length of stay and return visits. Patients and family care partners are provided with information about their ED visit with detailed post-discharge instructions to support a safe transition home.

All of this work has been done in the context of considerable strain on health care workers – both personally and professionally. We sincerely thank everyone involved in the ED Return Visit Quality Program for your immense efforts over the past year, and for taking the time to share this work with us.

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 Emergency Department Return Visit Quality Program 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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