The Emergency Department Return Visit Quality Program

Frequently Asked Questions

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The Emergency Department (ED) Return Visit Quality Program has been in operation since 2016. Each January, participating hospitals answer a set of questions as part of their annual submission of results to Ontario Health.

In the January 2020 submission, we asked hospitals whether they had any questions for other participating sites. Questions most frequently addressed the following themes: program engagement, ED Quality Committee structure, access to diagnostic imaging, and follow-up processes for outstanding test results. This document addresses these themes via examples from submissions, interviews with participants, and other sources.

We hope that this document may be a useful reference for EDs as they continue to focus on quality during and beyond the COVID-19 crisis.

1. How can hospitals effectively engage front-line staff in the program?

Create a program structure that supports engagement

- Create a dedicated committee or team to conduct or coordinate case reviews, discuss findings, and plan and execute quality improvement initiatives.
    - This could be a stand-alone committee or a sub-group of the ED Quality Committee or another committee/group focused on quality.
    - The group can be small to start, with membership open to anyone who would like to participate. Members of the group can also act as informal champions to engage others in the program.
    - A diverse membership is beneficial to reflect multiple perspectives and could include nurses, physicians, allied health, and other ED staff.
- Assign a program lead for the ED Return Visit Quality Program at your hospital.
    - This could be a clinician with expertise in quality improvement who could help to engage people in the program through personal outreach while building further credibility for the

program. This is an opportunity for the clinician to hold a leadership role where their efforts can be recognized.

- Hold open review sessions to engage participants who may not wish to commit to joining a formal team or committee.
- Train/educate participants about how to do reviews and why, as well as quality improvement/safety principles at the same time.
- Get buy-in from leadership to show commitment to the program and support engagement of staff.

Share the benefits of participating in the program

- If feasible, connect with your hospital's data team to provide individual physicians with lists of patients they have seen who experienced a return visit resulting in admission.
    - Sites that have done this have noted that physicians appreciate receiving this data. Physicians may not be aware of these cases otherwise, and they welcome the opportunity to review their cases on their own time for self-reflection and self-directed learning.
    - Sharing personalized data reports could get more people interested in joining a committee or team to conduct reviews or participate in improvement initiatives.
- Encourage participation in team or committee review meetings by ensuring that members are aware that the reviews can count toward their yearly CME requirements.

Communicate about the program and disseminate learnings from it

- Always emphasize the blame-free approach to reviewing return visit data when discussing the program. This will support staff in feeling comfortable participating in case reviews.
- Share findings from return visits or resulting quality improvements initiatives regularly – for example, by including a standing update on monthly team meetings or posting information on your departmental quality/safety board.
- Present on return visit cases during already-existing M&M rounds to share learnings with those not yet involved in the reviews.
- Present findings from the program at other venues in the hospital (e.g., councils with interdisciplinary membership).

Engaging staff is also discussed in our webinar on adverse events and approaches to conducting audits.

2. Do other hospitals have ED Quality Committees? If so, who sits on these committees? How frequently do they gather? What are their mandates?

Some hospitals mentioned ED Quality Committees in their program submissions. These committees vary based on the size of the site. Larger sites may be more likely to have formalized ED Quality Committees with larger membership, while smaller sites may have smaller teams dedicated to quality improvement.

Here are two examples of how organizations have structured their ED Quality Committees: one from an academic hospital (University Health Network) and one from a large community hospital (Woodstock Hospital).

University Health Network's ED Quality Committee

Mandate: The Committee's mandate is to monitor quality/safety of care provided in the ED and conduct projects to improve it. Academic dissemination is also part of the mandate, as University Health Network is an academic hospital.

Structure and membership:

- The Quality Committee is composed of physicians with training in quality improvement and co-chaired by a physician and a nurse educator/manager. The role of the co-chairs is to engage providers, mentor/coach project leads, structure projects/charters, and organize related activities (yearly luncheon, Quality Improvement and Patient Safety Awards, etc.).
- Anyone who is interested/willing can participate, with understanding from leaders that people have time protected to take out of their day to attend meetings.
- Leadership (the ED Chief and Nurse Manager) must be represented to show the importance of the committee.
- The following are also represented: front-line physicians, nurses, respiratory therapists, physiotherapists, occupational therapists, pharmacists, physician assistants, nurse practitioners, geriatric emergency medicine nurses, trainees, nurse educators, flow coordinators, and clerks.

Meeting frequency: The committee meets quarterly to review ongoing projects, engage stakeholders, and review incident debriefs.

Terms of reference: The ED Quality Committee has terms of reference set out that includes links to the organization's Quality of Care Committees and the Quality of Care Information Protection Act.

For more information on University Health Network's ED Quality Committee, contact Sameer Masood, Director of ED Quality and Safety at the University Health Network: sameer.masood@uhn.ca.

Woodstock Hospital's Front Line Improving Performance Team

Mandate: The Front Line Improving Performance (FLIP) team is dedicated to improving quality of care in the ED and acute inpatient units of Woodstock Hospital, a rural 162-bed facility.

Structure and membership:

- The FLIP team is co-led by the Directors of the Emergency Department and the Acute In-Patient Medicine Service, who liaise with senior management, external stakeholders, and the LHIN on ED and hospital wait times issues.
- Two full-time Performance Improvement (PI) Specialists work with front-line staff to implement improvement initiatives using "Lean thinking".

Responsibilities and workflow:

- The FLIP team compares hospital performance against quality indicators to formulate a broad Action Plan each year, consisting of targeted projects addressing key quality initiatives.
- The FLIP team's PI Specialists facilitate small workgroups of front-line staff and physicians in designing and implementing change for each specific project, typically in one to three full-day or half-day sessions away from patient care units.
- The FLIP team also conduct daily staff huddles on each unit to highlight quality indicators, infection control practice, and education pearls to help keep staff focused on key initiatives.
- The PI Specialists promote organizational Lean Knowledge capacity through Lean education sessions. Approximately 10% of hospital staff have completed Lean Yellow Belt education, while Lean White Belt and Lean Green Belt courses are offered periodically.
- The Emergency and Medicine Patient Care teams meet monthly to monitor and guide unit functions. FLIP team members are integrated into these Patient Care teams to provide progress reporting on quality issues and to strategize with the teams. Directors present unit scorecards on specific quality and safety indicators to the hospital's Quality Council on a quarterly basis.
- The FLIP team hosts an annual staff appreciation event and presentation, reporting quality improvement data to all staff and celebrating progress toward reducing wait-times and improving quality of care in the ED and across the hospital.

Meeting frequency: The FLIP team meets monthly to review data and progress toward goals.

For more information on the FLIP team, contact Heidi Dantes, Director, Emergency and Outpatient Clinic at Woodstock Hospital: hdantes@wgh.on.ca.

3. Given that access to imaging is one of the top issues identified in the ED Return Visit Quality Program, what success have other programs experienced in expanding access to imaging?

EDs noted that data from this program revealed a significant number of return visits for diagnostic imaging result in admission on the return visit. Sites that implemented expanded access to imaging often reported that they used this data as evidence to support the need for expanded access.

- **Cambridge Memorial Hospital** developed a structured return-to-ED process for patients returning for diagnostic imaging (read more here).

  ”We developed a structured return-to-ED process for patients receiving diagnostic ultrasounds. This process included a fast-track back to the ED green zone area bypassing our regular triage process. The charge nurse would do their eCTAS and ensure they were seen quickly. This helps streamline these patients’ return visits and also helps free up resources for patients waiting to be seen. The return visit audits were used as evidence to support the need for change.”

- **Southlake Regional Health Centre** expanded access to abdominal CT to 24 hours (read more here).

  “One of the changes we have made was to increase access to abdominal CT to 24 h. Previously, we had been giving these patients the option to return the next morning for their scan or be admitted overnight, but through the audits we were finding that some of these patients actually had appendicitis and required surgery as soon as possible. So our director of paramedical services has been working to train the technicians who are working overnight so that they can perform abdominal CT scans. This hasn’t been a huge investment of resources and has actually smoothed the patient flow for imaging as there is no longer a wave of patients coming in for CT scans in the mornings.”

- **Woodstock Hospital** described how they worked with their diagnostic imaging staff to expand hours for ultrasonography (read more here).

  “We worked closely with the diagnostic imaging (DI) staff to identify solutions. By looking at resource utilization, morning ultrasonography hours were reallocated to the evening to reduce the number of next-day return visit exams. Ultrasonography is now available until 8:00 pm Monday to Friday.

  In addition to extending the hours, we also challenged DI staff to improve on prioritizing imaging for ED patients. We made changes such as installing dedicated monitors to view an icon that fires when an ultrasound order is placed. We also set targets for ultrasonography time from order to start of exam and reported their progress on a weekly basis; this is a way for the staff to get recognition for the significant improvements they’ve made.”

4. How do other hospitals ensure timely follow-up of their diagnostic imaging call-backs?

Timely follow-up of results that come in after the patient has been discharged is challenging. Lucas Chartier, Co-Chair of the ED Return Visit Quality Program Working Group, has previously written about this issue in various forums:

- A two-part blog post on improving follow-up from the ED:
    - Part 1 addresses the topic of how to improve follow-up on final results (typically diagnostic imaging and microbiological results) with patients who have left the ED.
    - Part 2 addresses individual responsibilities in the follow-up process (both medico-legal and ethical).
- A systematic review of quality assurance processes ensuring appropriate follow-up of test results pending at discharge in EDs. This review includes recommendations for improving patient care.