



EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM

How to Screen and Audit Return Visit Cases

Step-by-Step Instructions for Using Data
Reports and the Audit Template

NOVEMBER 2024

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Purpose of This Document



This document replaces
How to Conduct an Audit (November 2022)

This guide is for hospital team members who are involved in screening and auditing return visit cases for their hospital's participation in the Emergency Department Return Visit Quality program (EDRVQP). This document provides step-by-step instructions for completing the audit template.

This document is a companion to:

- Information for Hospital Sites: Guidance Document

Overview

The Emergency Department Return Visit Quality Program (EDRVQP) is an initiative that aims to build a culture of quality in Ontario emergency departments. The goal of participation in this program is to identify areas for quality improvement.

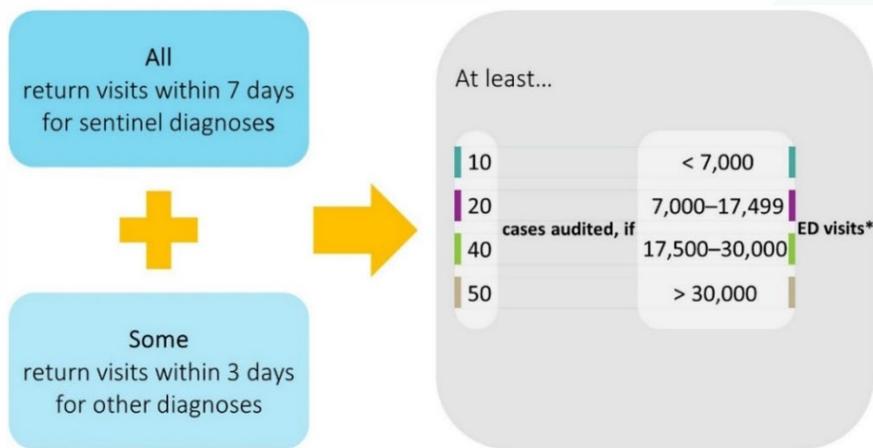
Process

As part of the program, hospitals receive access to quarterly data reports summarizing emergency department return visits and must conduct audits of cases that meet specific criteria. The process (see Figure 1) consists of regularly reviewing the data reports, identifying which cases to audit throughout the year, and conducting in-depth multistep analysis of a minimum number of cases; the minimum number of cases for each site depends on hospital emergency department patient volumes (i.e., the hospital site’s Pay For Results tier).

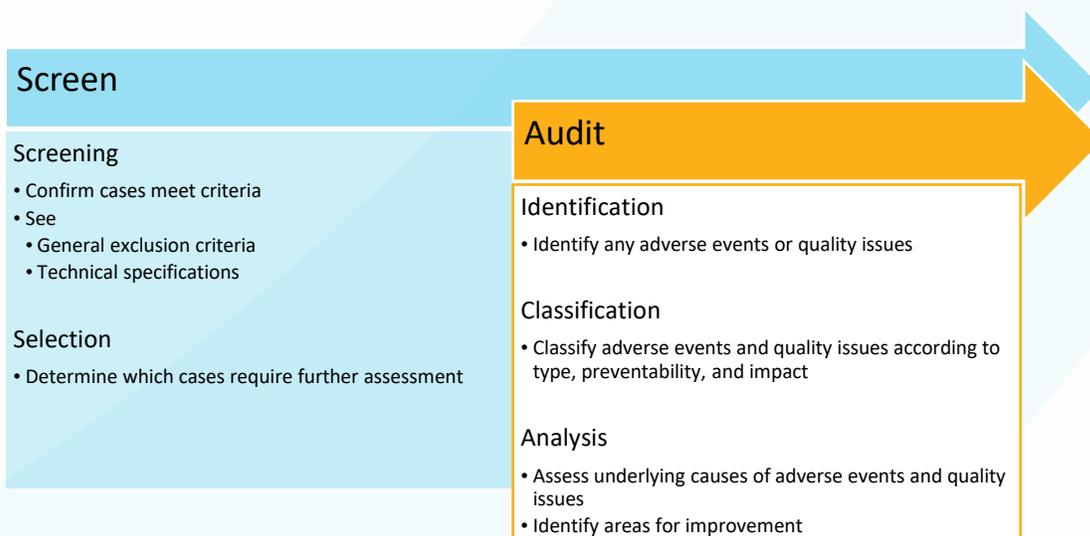
Figure 1. Screening and Auditing Overview.

(A) Minimum case auditing requirements and (B) analysis steps. *Annual emergency department visits.

A



B



Site EDRVQP Team

Each hospital site should have an EDRVQP team that consists of a site lead and, ideally, an interprofessional team with a minimum of 1 emergency department physician.

Screening

A qualified health care professional (e.g., nurse, physician assistant) can complete the screening process. This person should be familiar with the purpose and details of the program.

Auditing

Cases that have been identified as requiring further analysis during the screening process are to be audited by the team. The analysis team should discuss the case until consensus is achieved.

Templates and Documents

Data reports can be accessed through *iPort Access* data portal.

Templates and documents can be downloaded from the [EDRVQP website](#):

- [Audit template](#)
- Narrative questions

For more information, please see *Information for Hospital Sites: Guidance Document* or contact EDQuality@ontariohealth.ca.

Screening and Selection

1. Selecting Cases

Cases With Sentinel Diagnoses

All cases with return visits involving sentinel diagnoses must be included in the spreadsheet.

- Determine how many return visits involved sentinel diagnoses in the **aggregated site-level data report**
 - Locate the cell in the column labelled “Volume Admitted with Sentinel Diagnosis within 7 Days of Non-Admit ED Visit” in the row corresponding to your hospital site
- Identify these cases in the **patient-level data report**
 - In the column labelled “ED Return within 7 days, sentinel diagnosis only,” search for cases with “Yes”
- Find these cases in your hospital’s patient record system
 - Use the medical record number from the **patient-level data report** as the case identifier

Cases With Non-Sentinel (Other) Diagnoses

When including additional cases in the audit:

- In the **patient-level data report**, in the column labelled “ED Return within 7 Days, sentinel diagnosis only,” search for cases with “No”; these cases should fit the definition for all-cause 72-hour return visits



COLUMNS A, B, AND C

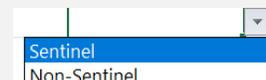
Column A: Case #

Number each case

Column B: Sentinel vs Non-Sentinel

For each case, select “Sentinel” or “Non-Sentinel” from the dropdown option

- *Sentinel*, if a case is identified as meeting the definition for a return visit involving a sentinel diagnosis
- *Non-Sentinel*, when the case meets the definition for an all-cause 72-hour return visit



Column C: Sentinel Diagnosis

Select 1 of the 3 sentinel diagnoses from the dropdown options:

- *AMI*, for acute myocardial infarction
- *SAH*, for subarachnoid hemorrhage
- *Pediatric sepsis*, for pediatric sepsis

Leave the cell blank if the case involves a non-sentinel diagnosis.

2. Describe the Visits



Please ensure that no personal health information is included anywhere in the audit spreadsheet.

- Summarize each case after reviewing the emergency department record of treatment
 - Refer to the hypothetical case example at the top of the template for guidance on the scope of information to include; the diagnostic code alone, a single-word as the diagnosis, or text such as “case reviewed” is insufficient

Approximately 80% of return visits with a sentinel diagnosis flagged in the data reports involve the same hospital site; therefore, information on the second visit can be accessed for the majority of cases in data reports. To obtain more information or access the medical records of a return visit to a different hospital, the patient or their representative must be contacted in order to either obtain the information from them directly or obtain their consent to contact the other hospital.

If contacting patients, first consult your department head who will help you coordinate with the Patient Relations department to ensure that it is carried out in a sensitive manner.



COLUMNS D AND E

Column D: Summary of Visit 1

For each case, please enter text that briefly summarizes what happened in the index visit (symptoms, tests ordered, discharge plan, etc.).

Column E: Summary of Visit 2

For each case, please enter text that briefly summarizes what happened in the return visit (symptoms, tests ordered, discharge plan, etc.).

3. Eliminate Cases That Do Not Meet Criteria

Most ineligible cases will have been discarded during the data report generation process and will not appear in the data reports, but some may still be present.

Note: Cases do not need to be excluded if the second visit was to a different hospital, because the focus of analysis is the first visit. These cases may still reflect underlying quality issues that warrant further investigation.

Cases With Sentinel Diagnoses

- Using the **patient-level data report** and the record of treatment, apply the general exclusion criteria (Appendix A) and technical specifications (Appendix B) to eliminate cases involving sentinel diagnoses that are not suitable for analysis. Almost all cases with sentinel diagnoses will be suitable for auditing, because the diagnoses on the index and return visits have been paired.

Cases With Non-Sentinel (Other) Diagnoses

When including additional cases:

- Using the **patient-level data report** and the record of treatment, apply the general exclusion criteria (Appendix A) to eliminate cases that are not suitable for analysis.

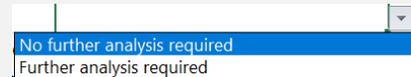


COLUMN F

Column F: Screening Result

Select “Further analysis required” or “No further analysis required” from the dropdown menu:

- *Further analysis required*, if a case is not screened out and is suitable for further auditing.
- *No further analysis required*, if a case is not suitable for analysis (i.e., doesn’t meet defined criteria or meets exclusion criteria); **no additional fields in the spreadsheet need to be completed for these cases.**

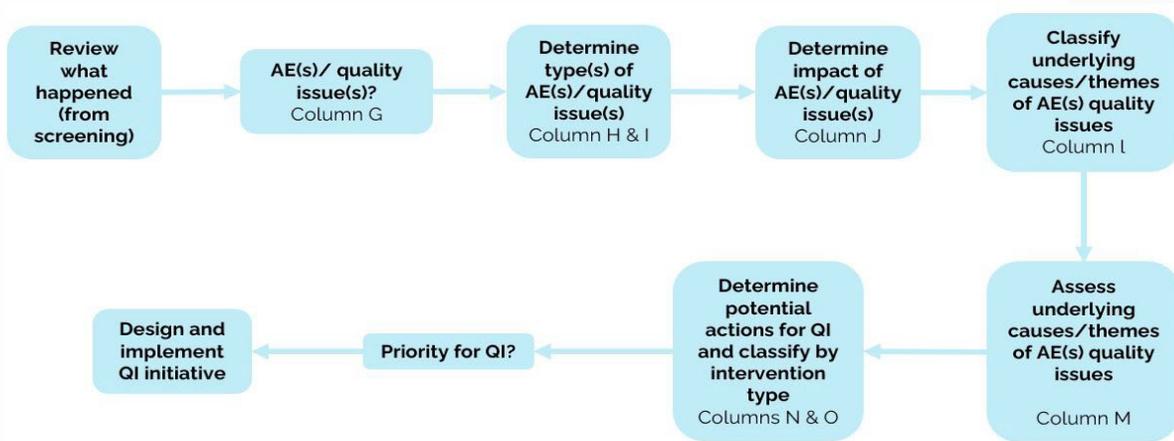


Completing columns A through F represents the screening process. Only cases where further analysis is required and conducted count towards audit requirements (i.e., the minimum number of cases specified).

Auditing

During auditing, the results of the screening process, medical records, and clinical judgment are used to identify and classify adverse events or quality issues by type and impact, uncover underlying causes, and develop potential actions for quality improvement (see Figure 2).

Figure 2. Case Review Process.



Abbreviation: AE, adverse event.

1. Identify Adverse Event or Quality Issue as Factor

Adverse events or quality issues are adverse outcomes related to care received during a visit. The focus of analysis should be on the initial visit, because this is when adverse events and quality issues are more likely to have occurred.

- Review summaries of the visits and medical records and, when possible, involve the clinical team that provided care during the index visit:
 - Use clinical judgment to identify whether any adverse events or quality issues were at play (i.e., consider whether the outcome for this patient could have been different had they received different care during the index visit)



COLUMN G

Column G: AE(s)/Quality Issue(s)

Select “Yes” or “No” from the dropdown menu:

- Yes, if adverse events or quality issues are likely contributing factors.
- No, if adverse events or quality issues are not likely contributing factors (for example, if a return visit is due to natural disease progression); **no additional fields in the spreadsheet need to be completed for these cases.**

	▼
Yes	
No	

2. Classify Adverse Events and Quality Issues

Classify the Type

- Classify each adverse event or quality issue by referring to the definitions in Table 1:

Table 1. Quality Issue Types and Definitions.

Type	Definition
Diagnosis	Not acting on documented signs, symptoms, laboratory tests or imaging, or not ordering an indicated diagnostic test
Management issue	Suboptimal management plan despite accurate diagnosis or based on an inaccurate diagnosis
Medication adverse effect	Occurring when a patient experiences a symptom related to a medication regardless of whether the medication was appropriately prescribed or taken
Procedural complication	Occurring when a patient experiences adverse consequences of a procedure.
Suboptimal discharge follow-up	Problems with follow-up arrangements that led to the development of new symptoms or unnecessary prolongation of symptoms. This could be due to inadequate availability of a follow-up appointment or due to inappropriate follow-up arrangements.
Unsafe discharge disposition or decision	When a patient is placed at an unnecessary risk of experiencing death or major disability by being sent home
Access/service not available	When a service (e.g., ultrasound) is unavailable at the time

Adapted from Calder et al.²

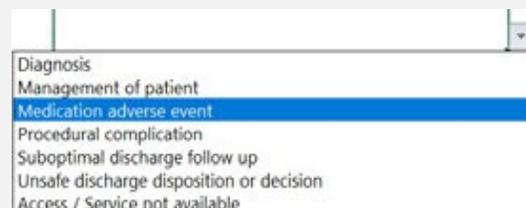


COLUMNS H and I

Column H: Type(s) of AE(s)/Quality Issue(s) – Primary response

If Yes was selected for the corresponding cell in column G, this response is required. Select 1 type from the dropdown options:

- Diagnosis
- Management issue
- Medication adverse effect
- Procedural complication
- Suboptimal discharge follow-up
- Unsafe discharge disposition or decision
- Access/service not available



If none appear to fit, enter text directly in the cell to describe a type that you think better captures the issue.

Column I: Type(s) of AE(s)/Quality Issue(s) – Secondary response

This response is optional. At times, more than 1 type of quality issue may contribute to a return visit. If applicable, select 1 type of quality issue from the dropdown options or enter text directly in the cell to describe a secondary adverse event or type of quality issue.

Classify the Impact or Severity of Harm

Determine the severity of harm for adverse events or quality issues by referring to Table 2:

Table 2. Severity of Harm Definitions.

Severity	Definition
None	Patient outcome is not symptomatic or no symptoms detected, and no treatment is required
Mild	Patient outcome is symptomatic, symptoms are mild, loss of function or harm is minimal or intermediate but short term, and no or minimal intervention (e.g., extra observation, investigation, review, or minor treatment) is required
Moderate	Patient outcome is symptomatic, requiring intervention (e.g., additional operative procedure; additional therapeutic treatment), an increased length of stay, or causing permanent or long-term harm or loss of function
Severe	Patient outcome is symptomatic, requiring life-saving intervention or major surgical/medical intervention, shortening life expectancy, or causing major permanent or long-term harm or loss of function
Death	On balance of probabilities, death was caused or brought forward in the short term by the incident
Unable to determine	Insufficient information

Source: World Health Organization⁷



COLUMN J

Column J: Impact of AE(s)/Quality Issue(s)

Select from the dropdown options:

- None
- Mild
- Moderate
- Severe
- Death
- Unable to determine

3. Assess Causes and Identify Actions for Improvement

Underlying causes are defined as the deepest yet still potentially modifiable factors that contribute to an adverse event or quality issue.⁸ Analysis of these causes can reveal opportunities for improvement for which achievable projects can be designed.⁸ Remember that these assessments should be blame free and promote a just culture, as the goal of this program is systemic improvement and learning.

Identify and Assess Causes

Guiding questions from the [Canadian Incident Analysis Framework](#) (pp. 89–91)¹¹ can be used to uncover underlying causes.

- Consult the team involved in treating the patient for this portion of the audit. Although it can be difficult for people to recall a case that occurred months prior, it is important that individuals try to understand their thought process and the environment that existed during the index visit in order to understand why actions that appear inappropriate in retrospect made sense at the time.⁹
- When appropriate, consider involving patients and their families in the analysis as well. Before doing so, first contact your department head to help you coordinate with the Patient Relations department to ensure that this is carried out in a sensitive manner¹⁰

Assess the causes and determine which themes are present in the case in question (see Appendix C or the worksheet named “Underlying Cause Themes” in the audit template).



COLUMNS K, L, and M

Column K: Underlying Cause(s)

- For each case, enter text that briefly summarizes the underlying cause

Column L: Theme – Primary response

This response is required.

- *Patient risk profile/patient factors*
- *Elder care*
- *LAMA or LWBS, for left against medical advice or left without being seen, respectively*
- *Documentation*
- *Physician cognitive lapses*
- *High-risk medications or medication interactions*
- *Vital signs abnormal or not documented*
- *Handovers/communication between providers*
- *Radiology*
- *Imaging/testing availability*
- *Discharge planning/community follow-up*

If none of the those listed appear to fit, type “Other” in this cell.

Column M: Theme – Secondary response

This response is optional. At times, more than 1 underlying cause (or theme) may contribute to the return visit. If applicable, select 1 theme from the dropdown options or type “Other” in this cell.

Prioritize

An intervention does not need to be proposed for every adverse event and quality issue uncovered. Not all quality problems can be tackled at once and some should be monitored for trends. Hospitals often don’t have the resources available to address every underlying cause of every preventable quality issue; it is therefore recommended that hospitals prioritize a few underlying causes. Hospitals may wish to prioritize by focusing on underlying causes that are common across multiple adverse events or

quality issues and are associated with the greatest harm or align with other strategic priorities. A useful guide can be found in the [Canadian Incident Analysis Framework](#) (pp 58–60).¹¹

- Work with the CEO, Quality Committee of the Board, and Medical Advisory Council (or other appropriate committee) when prioritizing underlying causes to ensure that chosen actions to improve quality are aligned with overall hospital strategy

Summarize Actions That Could Be Taken

The goal for this section is to identify changes that are doable, manageable, and can be monitored for future goals.

- Consult resources on how to design and implement a quality improvement initiative (e.g., [QI Essentials](#))
- Focus on identifying SMART (Specific, Measurable, Attainable, Realistic, Timely) actions¹² to be taken; avoid vague conclusions such as “we should try harder next time,” which are not likely to result in change^{10,11}
- Classify interventions (see Table 3) and consider whether it is possible to target interventions that are ranked as being more effective, based on the hierarchy of effectiveness¹³

Table 3. Intervention Types and Descriptions.

Type	Description
Forcing function	Limits a person’s ability to deviate from a prescribed process <i>For example, requiring that a sepsis screen is completed before the system will allow the triage process to be marked as complete</i>
Automation and computerization	Addresses human fallibility (e.g., reliance on memory) for simple, routine and/or repetitive tasks. <i>For example, a visual prompt on the electronic patient tracking board</i>
Simplification and standardization	Decreases variability and simplifies complex steps by bundling them into a single decision or action. <i>For example, an order set for patients with sepsis</i>
Reminders, checklists, and double-checks	Increase redundancy and include methods to remind clinicians to perform certain actions. <i>For example, conspicuous posters in the physician’s lounge that read “Have you ordered antibiotics within 3 hours for sepsis?”</i>
Rules and policies	Resolve complex issues at the organizational level. <i>For example, implement a directive that stipulates nurses should draw sepsis panel blood work, start an intravenous normal saline bolus, and administer acetaminophen before physician evaluation for all patients who meet sepsis criteria</i>
Education and training	An essential part of a comprehensive change initiative <i>For example, physician rounds, nursing huddles, monthly emails</i>

Adapted from: Chartier et al.¹⁴



COLUMNS N, O, and P

Leave cells blank for those for which you will not be designing actions for improvement.

Column N: Potential Actions for Quality Improvement

Enter text that describes (in your own words) the potential action.

Column O: Intervention Type – Primary response

Select 1 type from the dropdown options:

- *Forcing function*
- *Automation and computerization*
- *Simplification and standardization*
- *Reminders, checklists, and double-checks*
- *Rules and policies*
- *Education and training*

A screenshot of a dropdown menu with a white background and a thin border. The menu is open, showing a list of six options. The third option, "Simplification and standardization", is highlighted with a blue background. The options are: "Forcing functions", "Automation and computerization", "Simplification and standardization", "Reminders, checklists, and double-checks", "Rules and policies", and "Education and training".

Column P: Intervention Type – Secondary response

This response is optional. If applicable, select 1 type from the dropdown options.

References

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Appendix

Appendix A: General Exclusion Criteria

- Cases for which
 - The patient's chart cannot be located
- Or in which
 - The subsequent visit is clearly unrelated to the index visit
 - The subsequent visit was a repatriation
 - The subsequent visit was indicated as a transfer between emergency sites
 - The subsequent emergency department visit was scheduled (NACRS *ED Visit Indicator* = 0); a scheduled visit is one for which the visit date and time are fixed, and the appointment is recorded in a manual or electronic scheduling system

Appendix B: Technical Specifications for Sentinel Diagnoses

Return visit (DAD data element ^{a,b} and criteria [condition with ICD-10-CA diagnosis codes or variable values])	Index visit (NACRS data element ^b and criteria [condition with ICD-10-CA diagnosis codes or variable values])
Acute myocardial infarction	
<p>Most responsible <i>Diagnosis Code</i></p> <ul style="list-style-type: none"> Acute myocardial infarction (I21.0–I21.9) <p><i>Age</i></p> <ul style="list-style-type: none"> 20–95 years <p>Excludes patients with most responsible <i>Diagnosis Code</i> = I21.0–I21.9 [acute myocardial infarction] in previous year.</p>	<p><i>Main Problem diagnosis</i></p> <ul style="list-style-type: none"> Chest pain (R07.1–R07.4) Angina (I20) Shortness of breath or congestive heart failure (R06.0, R06.8, I50, or J81) Abdominal pain (R10.1, R10.3, or R10.4) Heartburn, esophagitis, or gastritis (R12, R13, K20, K21, K22.9, K23.8, K29, or K30) Syncope/malaise (R42, R53, or R55)
Subarachnoid hemorrhage	
<p>Most responsible <i>Diagnosis Code</i></p> <ul style="list-style-type: none"> Nontraumatic subarachnoid hemorrhage (I60.0–I60.9) <p><i>Age</i></p> <ul style="list-style-type: none"> ≥ 18 years <p>Excludes patients with most responsible <i>Diagnosis Code</i> = I60.0–I60.9 [nontraumatic subarachnoid hemorrhage] or I67.1 [cerebral aneurysm] in previous year.</p>	<p><i>Main Problem diagnosis</i></p> <ul style="list-style-type: none"> Migraine/headache (F454, G430–G439, G440–G442, G448, R51) Neck pain (M436, M4642, M4782, M4792, M4802, M501–M509, M530, M531, M542, S1340–S1342, S1348, S136, S168) Hypertension (I100 or I101) Sinusitis (J010–J019, J320–J329) Stroke/transient ischemic attack (G450, G459, I64, I674) Meningitis (A870–A879, G000–G009, G01, G020–G028, G030–G039, G042) Syncope and collapse (R55) Giant cell arteritis (M315 or M316)
Pediatric sepsis	
<p><i>Total Length of Stay</i></p> <ul style="list-style-type: none"> ≥ 4 days <p>or <i>Discharge Disposition</i></p> <ul style="list-style-type: none"> Died (07, 72, 73, or 74) with main <i>Diagnosis Code</i>: <ul style="list-style-type: none"> Meningitis (A390, G000, G001, G002, G003, G008, G009, G01, G030, G039, A870, A871, A878, A879, B003, B010, B021, B051, B261, B375, G020) Septicemia/sepsis (A021, A327, A392, A394, A400, A401, A402, A403, A408, A409, A410, A411, A412, A413, A414, A4150, A4151, A4152, A4158, A4159, A4180, A4188, A419, A483, R572) <p>or <i>SCU Unit Number</i> (special care unit code)</p> <ul style="list-style-type: none"> Not 90, 93, 95, or 99 With direct admission to ICU (within 30 minutes of admission) <p><i>Age</i></p> <ul style="list-style-type: none"> 30 days to 5 years <p>Excludes patients with prior acute inpatient discharge (regardless of diagnosis) in previous 14 days.</p>	<p><i>Main Problem diagnosis</i></p> <ul style="list-style-type: none"> Fever of unknown origin (R50) Cough (R05) Other general symptoms and signs (R68) Nausea and vomiting (R11) Convulsions, not elsewhere classified (R56) Abnormalities of breathing (R06) Rash and other nonspecific skin eruption (R21) Malaise and fatigue (R53) Abdominal and pelvic pain (R10) Headache (R51) Other disorders of eye and adnexa (H57) Other noninfective gastroenteritis and colitis (K52) Symptoms and signs concerning food and fluid intake (R63) Diarrhea and gastroenteritis of presumed infectious origin (A09) Acute obstructive laryngitis [croup] and epiglottitis (J05) Other functional intestinal disorders (K59) Back pain (M54) Viral infection, unspecified (B34.9)

Abbreviations: DAD, Discharge Abstract Database; ICD-10-CA, *International Statistical Classification of Diseases and Related Health Problems Tenth Revision Canada*; ICU, intensive care unit; NACRS, National Ambulatory Clinical Reporting System.

^aAcute Inpatient abstracts.

^bDischarge Abstract Database and National Ambulatory Clinical Reporting System data elements are *italicized*.

Appendix C: Themes

Theme	Description	Example
Patient risk profile/patient factors	Failure to account for high- risk characteristics of patients (e.g., age, comorbidities, psycho- social status, etc.) when determining evaluation and management	40-day-old patient presenting with inconsolable crying and irritability; no consideration given or evaluation for sepsis. Had a return visit to another hospital and found to have E. coli meningitis
Elder care	Failure to consider unique presentations and needs of elder patients	81-year-old from nursing home; had an unwitnessed fall causing fracture of patella; treated conservatively with Zimmer splint; discharged back to nursing home. Returned next day, confused. CT scan showed subdural hematoma as a result of the first fall. Patient admitted for monitoring
LAMA or LWBS	Patients who left against medical advice or who left without being seen	37-year-old presented to ED. Prolonged wait time and LWBS recorded after 4 hours. No re-triage. Patient returned with meningitis; admitted to ICU.
Documentation	Suboptimal documentation, which may have contributed to the return visit that the patient experienced	Patient’s positive troponin was not documented in the chart, and it is unclear whether the MD had seen it; patient returned 5 hours later for admission
Physician cognitive lapse	Knowledge gap or failure to act on signs and symptoms	Immunocompromised patient presents with abdominal pain after recent bowel perforation. MD failed to consider intra- abdominal abscess and performed an abdominal plain film
High-risk medications or medication interaction	Failure to account for high- risk medications in assessment and management	Xarelto prescribed to patient with increased creatinine level (this medication contraindicated with elevated creatinine levels)
Vital signs abnormal or not documented	Failure to explain abnormal vital signs or vital signs that are not repeated for many hours during stay in ED and/or prior to discharge	Patient with chronic atrial fibrillation and heart rate of 126 bpm at triage (not re- documented or re-checked during visit). Presented with lightheadedness in setting of URTI, discharged home with plan to see GP after long weekend. Patient had syncopal episode at home (heart rate on return visit of 155 bpm) and sustained head injury requiring admission.
Handovers, communication between clinicians	Suboptimal communication, especially during handovers or between physicians and nurses	Nursing documentation states patient reports this is the worst headache of their life but in MD documentation patient states similar headache in past
Radiology	Failure to diagnose correctly by the emergency physician, to communicate by the radiologist, or to appropriately note discrepancies in a timely manner	Patient visited ER with LLQ abdominal pain and had an abdominal CT scan to rule out diverticulitis. Initial radiologist read was negative. Pt was discharged home with a diagnosis of abdominal pain NYD. Next day, patient called back as the radiologist reinterpreted the CT as a query sigmoid volvulus. Pt was admitted to surgery and eventually underwent colostomy for treatment of volvulus
Imaging/testing availability	Availability of timely access to imaging or other tests (e.g., after hours)	Patient presented in evening hours with RLQ abdominal pain brought back next day for ultrasound; positive diagnosis of appendicitis
Discharge planning/community follow- up	Failing to assess baseline functioning, ability to cope, and support systems or follow-up care in the community prior to ED discharge	Patient with chest pain was discharged to follow-up with cardiologist, but cardiologist was not available for 2 months

Abbreviations: ED, emergency department; ICU, intensive care unit; LAMA, left against medical advice; LLQ, left lower quadrant; LWBS, left without being seen; NYD, not yet determined; RLQ, right lower quadrant; URTI, upper respiratory tract infection.

In the first year of this program, Health Quality Ontario (now part of Ontario Health) and a team of clinicians analyzed all audits in which adverse events or quality issues were identified. Eleven themes were identified through this analysis. To learn more about these themes and how they were identified, read the [year 1 report](#) (section 3)

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