Emergency Department Return Visit *Quality Program*

Report on the 2020 Results

80 Number of hospital sites participating in the ED Return Visit Quality Program

28 Number of hospital sites that opted to conduct audits this year

2357 Total audits conducted *(optional this year)*

527 Quality issues / adverse events identified

About the Program

The Emergency Department (ED) Return Visit Quality Program was started in April 2016 to bring focus on quality of care and build a culture of continuous 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 and voluntary for other hospitals.

In the ED Return Visit Quality Program, participating hospitals receive data reports that flag two types of return visits:

1. Return visits within 72 hours for any diagnosis resulting in admission to any hospital (termed all-cause 72-hour return visits).
2. Return visits within 7 days resulting in admission to any hospital with one of three key 'sentinel diagnoses' (acute myocardial infarction [AMI], paediatric sepsis, and subarachnoid hemorrhage) on the return visit, paired with a set of related diagnoses on the initial visit.

The ED Return Visit Quality Program during the COVID-19 pandemic

In early 2020, the requirements of the ED Return Visit Quality Program were adjusted to support participating hospitals as they focused on the demands of the COVID-19 pandemic. Participating sites were only required to complete a narrative describing their quality improvement initiatives over the year. Remarkably, 28 hospitals were able to conduct audits despite the demands of COVID-19. Read on for our observations from these submitted narratives and audits.

Findings from the Audits

Consistent with our observations in previous years, identification of quality issues and adverse events was higher among the cases involving sentinel diagnoses (approximately 45% for the three diagnoses combined) compared with all-cause 72-hour return visits (approximately 22%; see Table 1).

Table 1. Number of audits conducted and quality issues/adverse events identified

Type of return visit	# Audits	# Audits that resulted in identification of a quality issue/adverse event	%
All-cause 72-hour return visits	2192	474	21.6%
Sentinel return visits	125	56	44.8%
Acute myocardial infarction	89	37	42%
Paediatric sepsis	20	7	35%
Subarachnoid hemorrhage	15	12	80%

In the audits, program participants most commonly classified quality issues/adverse events as being due to diagnostic issues, management issues, and unsafe disposition decisions.

Focusing on sentinel events, we observed that:

- Most quality issues/adverse events related to subarachnoid hemorrhage were due to a diagnostic issue (7 of 12 [58%]).
- Most quality issues/adverse events related to paediatric sepsis were due to a management issue (5 of 7 [71%]).
- Most quality issues/adverse events related to acute myocardial infarction were due to either diagnostic or management issues (27 of 37 [73%]).

The most common quality themes identified in the audits were patient risk profile, physician cognitive lapse, and elder care.

Findings from the Narratives

Ontario's hospitals are working on a number of innovative quality improvement initiatives that will better support patients who are discharged and ensure that Ontarians continue to receive high-quality care.

Hospitals most commonly reported initiatives that focused on the themes of discharge planning and community follow-up, documentation, imaging/testing availability, and vital signs. The most common strategies hospitals used to address these themes are summarized below.

Read on for a few standout examples of initiatives described by program participants. To learn more about any of these quality improvement initiatives, contact us at EDQuality@ontariohealth.ca.

Discharge planning and community follow-up	Documentation	Imaging and testing availability	Vital signs
Discharge nurse role to support seamless transitions	Regional EMR to give clinicians access to patient's comprehensive medical history	Fast track patients discharged from ED with follow up medical imaging	Confirm vital signs at discharge
Medication review and reconciliation at discharge	Order sets (diagnosis-specific as well as regional sets)	Set 'order to start' wait time standards for ultrasound, CT	Forcing function in CIS to follow up on abnormal vitals signs
Provide patient with document outlining post-discharge follow-up, expectations	Electronic documentation, flags to ensure completeness, abnormal results, etc.	ED neuroimaging huddle to facilitate disposition planning	Routine trending of vital signs to facilitate early detection of abnormal values
Engage 'peer workers' with lived experience to support marginalized persons post-discharge	Electronic order entry, medical directives	Extend hours of operations on evenings and weekends	

Examples of quality improvement initiatives focusing on the themes of discharge planning and community follow-up, documentation, imaging and testing availability, and vital signs.

Improving discharge planning and community follow-up

St. Joseph's Healthcare Hamilton described their focus on referrals to ambulatory clinics to support patients in the community and divert admissions. In their 2019 audits, the team identified that 20% of patients returned to the ED with worsening condition before the ambulatory clinic follow-up could occur. The team's 2020 submission reported a reduction to 10%.

Their efforts included:

- Education and training for staff who book referral appointments to ensure they are booked into the earliest appointment
- Ensuring patients receive an ambulatory clinic appointment prior to discharge from the ED
- Establishing a consistent triage process with the ambulatory clinics to identify urgency

Niagara Health, in partnership with St Joseph's Health System, implemented COVID Care @ Home to support patients who are COVID-positive or suspected to be COVID-positive in their own home and avoid admission to hospital. This program provides both virtual and in-home support (personal support worker, nursing, and respiratory therapy) to help patients successfully manage at home. Patients also have access to a 24-hour line to call if support is needed.

Click here **to learn more about the COVID Care @ Home initiative.**

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Findings from the Narratives – *continued*

Improving access to diagnostic imaging and testing

St. Joseph's Healthcare Hamilton collaborated with their Diagnostic Imaging (DI) leadership team and were able to extend the hours of ultrasound from 8:00 am to 4:30 pm Monday to Friday to 8:00 am to 10:00 pm Monday to Friday. This change was implemented in November 2019 and has resulted in a positive outcome, with only 6% of patients returning for DI testing in 2020 compared to 28% in 2019.

Pembroke Regional Hospital identified the absence of a formal teaching program in point-of-care ultrasound (POCUS) as a gap. The team has since begun to provide monthly courses to their ED physician group and residents, has established a monthly journal club, and shares audited cases in which POCUS could have played a pivotal role in prompt diagnosis and management.

Northumberland Hills Hospital described a collaboration between their DI and ED teams to ensure tests are performed and reported in a timely manner. Their work included reviewing the process of patients returning for imaging next day, improving communication between the DI department and ED for planned downtimes for maintenance or upgrades (including processes to be followed during planned as well as unplanned downtimes to ensure timely access to diagnostics for ED patients), and having an ED representative participate in the DI Quality and Practice Committee.

Improving care for sentinel diagnoses

Markham Stouffville Hospital described work to address both acute myocardial infarction and paediatric sepsis. Through a two-year quality journey, the team has launched a multi-faceted project to enable better care and outcomes for the febrile neonate. This included ascertaining rectal temperatures at triage, the development of a screening tool for nursing staff, the early engagement of attending ED physicians for at-risk infants, and the initiation of a sepsis order set – both for the resuscitation of septic-appearing neonates, but also the standardization of the work-up of febrile neonates. The team has already instituted audits for the acquisition of rectal temperatures at triage and will be auditing the impact of the initiative.

The team also identified the need to improve and standardize the transition of care for acute coronary syndrome (ACS) patients awaiting medicine consultation and admission. The team recently launched a transition ACS order set to ensure care standardization during this common transition.

Click here **to access a Young Infant Fever/Sepsis order set shared by Markham Stouffville Hospital**

Addressing substance use disorder

Multiple hospitals noted that presentations to the ED related to substance use disorder had increased during the pandemic and described initiatives to address it:

Thunder Bay Regional Health Sciences Centre utilized P4R funding to hire a Process Improvement Coordinator to focus on supporting patients with addictions who present to the ED. Initiatives include a medical directive for distribution of Narcan kits, standardized order sets for alcohol withdrawal, and a streamlined referral processes for community addiction services. The coordinator has strengthened existing community partnerships, worked on collaborative initiatives, supported patients with addictions, and connected them with community services to reduce ED visits related to substance use. The team is monitoring ED visits and return visits within 30 days to evaluate this position and other targeted addictions strategies.

Click here **to access an alcohol withdrawal order set shared by Thunder Bay Regional Health Sciences Centre**

Halton Healthcare described many initiatives this year, including:

- Miichael's Rule, a new communication protocol around wait times developed in response to a return visit where a patient left before triage after an informal communication from a staff member that wait times would be long
- A new model for ensuring consistent leadership in the ED during the COVID-19 pandemic
- Training for ED staff to support models of care during the pandemic

Click here **to read more about Halton Healthcare's work this year on Quorum.**

Findings from the Narratives – *continued*

Building virtual care into the ED

This year, many hospitals have implemented different models of virtual care, including virtual visits, follow-up, and consultations.

The increase in virtual care has undoubtedly been valuable during the pandemic. Virtual care has supported patient flow in the ED and provided patients who may have been reluctant to present to the ED with a safe way of accessing needed care. However, the impact and outcome of virtual visits has not yet been fully investigated. Work is ongoing to determine which ED visits are highest value for virtual care.

The examples below are only a few of those submitted that related to virtual care.

Health Sciences North has developed an ED Virtual Care service for ED patients meeting established criteria. Following the virtual visit, the ED physician can initiate referrals to community partners/services, treat, or direct the patient to present to the ED in person. Information is faxed to the patient's primary care provider to ensure a warm handoff.

North York General Hospital developed a High-Risk Virtual Follow-Up Clinic to support patients who are discharged home but are at risk for deterioration with minimal access to family practice. ED physicians could identify those that were high risk with pending swabs to receive a follow-up call within a few days of being last seen.

Hamilton Health Sciences created a long-term care/ED virtual consultation framework for ED visit avoidance (a program called LTC-CARES or Consults And Recommendations for Emergency and Support Services).

Click here **to learn more about LTC-CARES**

Quality Improvement in the ED During the COVID-19 Pandemic

This year, we asked participating hospitals to describe their quality improvement initiatives related to the COVID-19 pandemic and/or the health system response to it. The amount and quality of work described to address the demands of the pandemic and support high-quality care for Ontarians during this time was incredible.

Over the course of the pandemic, hospitals have:

- Revamped patient flow in the ED
- Instituted new tools, policies, order sets, and training to support the safe management of COVID-19 for both patients and staff
- Established new ways of providing care
- Built incredible collaborations to support the health system, including with EMS, primary care, long-term care homes, other hospitals, and more
- Supported all of this work through via ongoing communication, education, and training

All of this work has been done in the context of considerable strain on health care workers – both personally and professionally. We sincerely thank all 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! We would love to hear from you at *EDQuality@ontariohealth.ca* if you have questions or feedback.

If you would like to learn more about any of the examples mentioned in this report, reach out to us and we will be happy to connect you with the program participants who are involved in the initiative.

You can access all materials related to the ED Return Visit Quality Program (including past reports and webinars) via *our website*.

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