Emergency Department (ED) Leading Practices Toolkit

Optimizing ED Patient Flow

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Disclaimer

The Emergency Department (ED) Leading Practices Toolkit ('Toolkit') is evidence-informed and contains the consensus opinions from a group of Ontario ED health care professionals. The information contained in this document pertains to patient flow processes and is not intended to substitute any accountability associated with the Public Hospitals Act, constitute a standard of care, nor is it intended to substitute the professional judgment of health care professionals. Processes associated with the flow of patients in Ontario EDs may vary due to a variety of factors. Health care professionals may encounter circumstances where the practices within this Toolkit may require adjustments, are not appropriate, or do not apply.

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Version History

Version	Date	Notable Change
1.3	June 2026	Updated FY 26/27 provincial targets identified for Physician Initial Assessment, Number of Patient Waiting for Inpatient Bed at 8am, High-Acuity Non-Admit Length of Stay, Low-Acuity Non-Admit Length of Stay and Admitted Length of Stay.
1.2	February 2026	Emergency Department Pay-for-Results Program Manual updated to 2026-27 version.
1.1	May 2025	Updated provincial targets identified for Ambulance Offload Time, Time to Physician Initial Assessment, ED LOS for Non-Admitted Patients and No Bed Admits.
1.0	April 2025	First publication of Emergency Department Leading Practices Toolkit.

Introduction

Emergency department (ED) overcrowding has become a critical issue in health care, driven by several factors including a rising volume of patients presenting to EDs and increasing acuity levels of these patients over the last number of years (1). More individuals are seeking emergency care due to factors such as an aging population, disparities in access to primary care and a growing burden of chronic disease (1). As a result, EDs are struggling to accommodate the influx of patients, leading to prolonged wait times to see a physician, increases in length of stay (LOS) in the ED and a higher proportion of patients leaving without being seen (LWBS) by a physician (1). In many cases, EDs have become the default destination for patients who are unable to receive care from the right provider in the right place at the right time, regardless of the fact that emergency care providers may not have the necessary expertise or resources (2).

The resultant issue of ED overcrowding contributes to a deteriorating standard of care, avoidable patient morbidity and mortality and increases in health care provider and staff burnout, which places increased pressure on an already burdened health care system (1). ED overcrowding is a complex health care issue that extends beyond the ED as patient flow is interconnected with the broader health care system (1).

The avoidable patient morbidity and mortality associated with crowded EDs is complicated and impacted by several factors, including long wait times for assessment and treatment and a chaotic environment ripe for preventable errors and omissions. These factors, in turn, alter the threshold for admission and further exacerbate the problem (3).

The input-throughput-output model of ED overcrowding (see Figure 1) has widely been used in health care settings for several years to categorize the causes of ED overcrowding (1). *Input* refers to the factors that contribute to patients arriving to the ED. *Throughput* refers to the activities that happen within the walls of the ED, and *output* refers to the factors that contribute to patients leaving the ED – back to their home, to an inpatient unit, or alternative care settings such as rehabilitative care or long-term care (LTC).

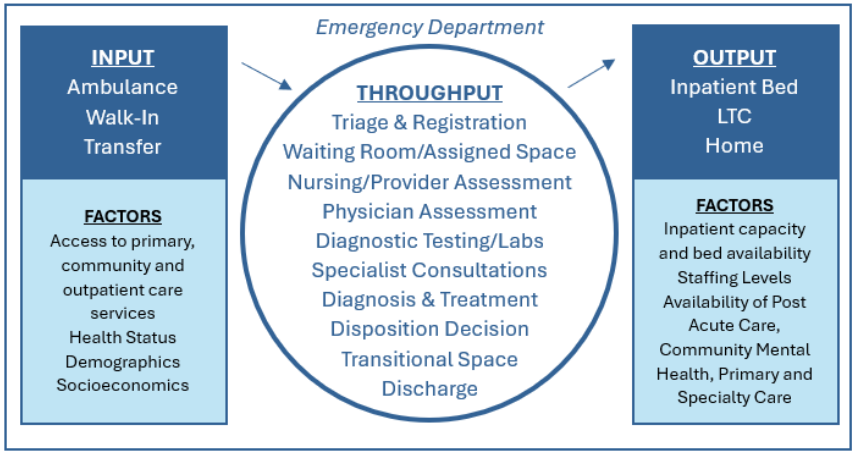

Figure 1. Input-throughput-output model of ED overcrowding

Evidence shows that improving ED overcrowding will result in fewer admitted patients remaining in the ED, shorter ED wait times and LOS, reduced ambulance offload delays, better response times, less moral injury/burnout in health care providers, less patient and family frustration and violence in ED and, finally, better coordination, access and flow across the health care system (2).

Ontario Context

ED overcrowding first emerged as an issue in Ontario in the mid 1990's due to population growth exacerbated by fiscal constraints and subsequent hospital restructuring, which resulted in fewer beds and resources to care for more patients. In the 1990's, the number of hospital beds was cut by almost 40%, rural hospitals, psychiatric hospitals and extended care facilities closed, which further contributing to the current alternate level of care (ALC) issues we face today (2). The cuts put in place during the 1990's were reversed in the early 2000's. In 2006, the Ministry of Health and Long-Term Care (at the time) established a task group to make recommendations on how to address ED overcrowding. The resulting report, *Improving Access to Emergency Care: Addressing System Issues*, called for systemic changes in EDs and the health care system at large for sustainable improvement in ED flow.

In 2008, the Ministry of Health and Long-Term Care launched the Emergency Room (ER) Information Strategy (later renamed to the ER/Alternate Level of Care Strategy) as part of Ontario's broader Wait Times Strategy to reduce time spent in the ED and improve patient satisfaction. As part of this strategy, the Pay-for-Results (P4R) Program was initially launched in 25 hospitals to address ED overcrowding at large volume sites. The program was (and continues to be) a key provincial incentive-based funding initiative designed specifically to:

- Monitor and strive to improve ED performance
- Achieve provincial wait time goals; and
- Improve patient experience and working conditions in Ontario EDs

In 2023, the P4R Program expanded to all 163 EDs to provide funding stability and remains a critical program to support improvements in provincial ED performance. P4R funding investment was, and continues to be, leveraged by large-volume EDs (≥ 30,000 annual ED visits) to support several strategies that improve wait time performance, quality of care and patient experience, including skill and capacity building; health human resources; technology, information systems, medical devices and clinical tools; physical infrastructure, as well as process improvement initiatives.

Small-volume EDs (< 30,000 annual ED visits) continue to focus on strategies that stabilize staffing to maintain access to EDs 24 hours a day, 7 days a week and support staff recruitment and retention to reduce dependency on the ED Locum Program and nurse agency staffing.

The province's continued focus on quality also saw the development of the Emergency Department Return Visit Quality Program, which provides an opportunity for clinicians, ED and hospital teams to identify, audit and investigate underlying causes of return visits and take steps to address these causes, prevent harm and future adverse events and quality issues.

Despite these investments, as well as other provincial initiatives such as the Home First Operational Direction and development of the ALC Leading Practice Guide, ED performance issues remain. Stemming from longstanding systemic problems, many issues extend beyond the ED system and have been exacerbated by the COVID-19 pandemic. These include staffing shortages, the bulge of the baby-boomer demographic (coupled with increased patient complexity), rise in substance-induced mental health disorders and addictions, along with insufficient levels of publicly funded mental health care, long-term care shortages and inadequate

infrastructure in acute care. As a result, boarded ED patients and inpatient units are often operating at exceeded capacity (2).

As the demand for emergency services continues to rise, there is a need to share successful strategies and innovations more broadly across the province to drive performance improvement. By leveraging the expertise and experience of peer hospitals, EDs can continue to assess and develop effective strategies that will drive better access to timely and safe emergency care.

ED Leading Practices Toolkit

The Toolkit was developed as an evidence-informed resource for all health care organization leaders, ED leaders, ED teams and front-line staff looking to improve ED flow and performance. The information, strategies, resources and tools found in the Toolkit and accompanying Self-Assessment Guide can assist end users to evaluate and identify actionable opportunities to improve ED patient flow within their organizations. The Toolkit was built in collaboration with EDs across Ontario with a commitment to share learnings, cultivate innovation and foster collaboration in an effort to continue to drive improved ED performance and enhance patient and provider experience.

The Toolkit includes practical information summarizing:

- International, national and provincial research evidence on leading practices in ED patient flow
- Successful strategies used by Ontario EDs to help address patient flow more effectively
- Case examples, templates and links to helpful resources

The accompanied Self-Assessment Guide is designed to help organizations determine what strategies they have in place, where are the opportunities for improvement and support action planning to address performance gaps.

It is recognized that there are factors impacting ED patient flow that reside outside of the ED and often require system-level strategies. However, the Toolkit examines key organizational leading practices to support EDs to improve patient flow, with a focus on factors that are within the ED's control. In addition, some of the strategies included are output strategies that have shown evidence in providing a direct, positive impact on ED throughput.

The Toolkit is aligned to the Home First Operational Direction and Alternate Level of Care (ALC) Leading Practices Guide. It is also aligned to priorities within the Required Organizational Practices (ROP) in the 2024 Emergency Department Accreditation Canada Standards.

Toolkit Development

The leading practices and strategies presented in the Toolkit are informed by peer-reviewed and grey literature from provincial, national and international sources. Findings were summarized and thematically organized.

In addition, a total of 25 interviews were conducted with a group of Ontario hospital organizations and their ED teams, including senior leaders, managers and front-line staff. The interviews were conducted to gather insight into site-level strategies proven to have improved ED patient flow and key performance indicators and collect tools and resources to be shared with other organizations. To validate initial findings, a group of expert Ontario ED health care professionals was consulted to finalize the leading practices and strategies and design of the final toolkit.

The Leading Practices

The leading practices and the associated strategies defined within the Toolkit are organized into two categories:

Section 1:

Foundational Leading Practices across the organization enable improvements in ED flow.

Themes include: Organizational Culture and Leadership, Building a High-Performing Culture in the ED, Data Driven Decision-Making and Continuous Quality Improvement

Section 2:

Functional Leading Practices enable key process improvement along the ED patient journey.

Themes include: Optimizing Physical Space Design and Queuing Systems, Enhanced Staffing, Resource Allocation and Models of Care, Leveraging Technology and Using Standardized Policies, Processes and Procedures

The key points and processes discussed as they relate to the ED patient journey (see Figure 2) include:

1. Ambulance Arrival and Ambulance Offload Time (AOT)
2. Triage and Registration Processes
3. Physician Initial Assessment (PIA)
4. Laboratory Testing, Diagnostic Imaging and Consult Services
5. Time Spent in the ED (or LOS)

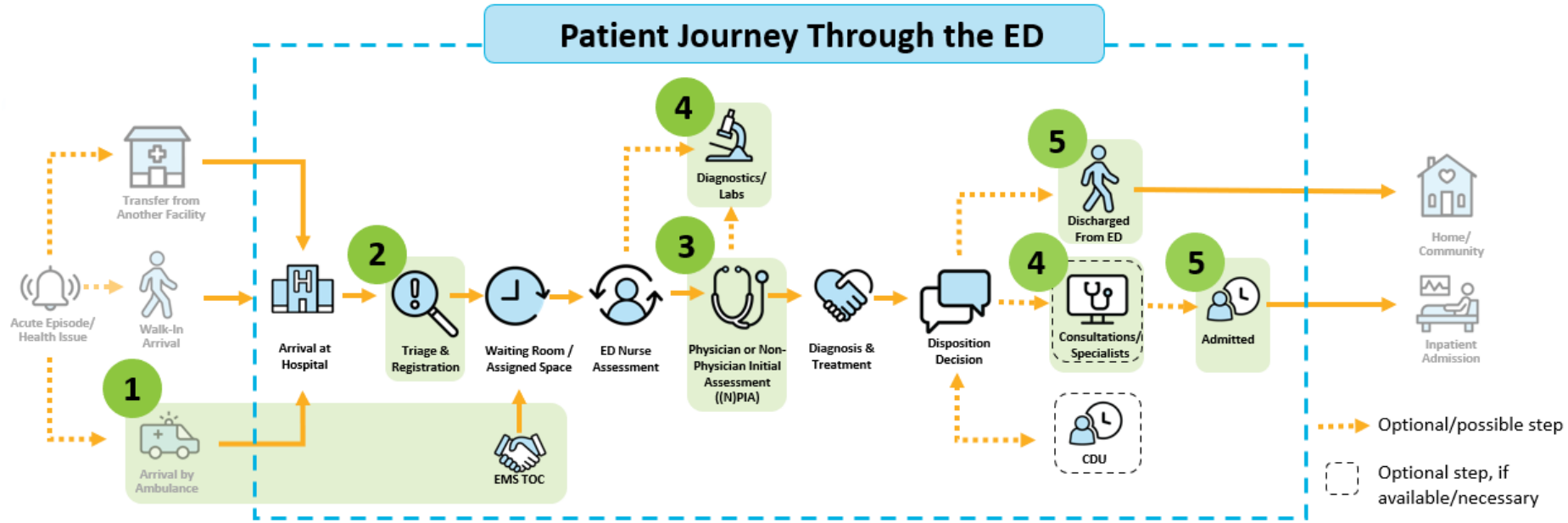

Figure 2. The patient journey through the ED

Successful strategies that are driving ED flow and improved performance identified through hospital consultations and rooted in evidence-based literature are embedded within each section. Since no two hospitals are alike, a wide range of strategies are included providing options for organizations to consider and refine for local circumstances. Organized along the ED patient journey, most strategies aim to address ED throughput; however, some output strategies such as overcapacity protocols and inpatient bedding practices are also included.

Each strategy has been categorized to help organizations understand which strategies are universally applicable across all Ontario EDs and which, based on the identified need, will add value to their organization based on the resources they have available. An additional icon and highlighted notes can be found throughout the Toolkit to draw attention to specific alignment with Accreditation Canada Standards (Table 1 below).

Table 1: Categorization of Strategies

Symbol	Description
U	**Universal**: Strategies for assessment and application at every ED in Ontario.
I	**Intermediate**: Strategies for implementation consideration, in addition to universal strategies.
A	**Advanced**: Strategies for implementation consideration when universal strategies are in place, intermediate strategies have been considered, and further innovation is being sought.
	Leading practices that are aligned to the 2024 Emergency Department **Accreditation Canada Standards** – specific standards are identified by a * throughout the document. Example: **(*2.1.1)** means this Toolkit strategy aligns with Accreditation Canada Standard 2.1.1.

All leading practices are discussed in the context of EDs as a function of the broader hospital and health care system in the current, post-COVID pandemic, overburdened landscape. Appreciating that some strategies may not be appropriate for implementation within every organization or in an ideal state, patient safety is the highest priority and should always take precedence when considering the implementation of any change.

Glossary

Term	Definition	Reference
Ambulance Offload Time (AOT)	Total time elapsed from Ambulance Arrival Date and Time to Ambulance Transfer of Care (TOC) Process Date and Time.	P4R Manual
Daily average number of patients waiting for an inpatient bed at 8AM	Admitted patients who at 8:00 am had been waiting at least 2 hours since their disposition decision was made and who left the ED after 8:00 am.	PM&M Overview Document
ED Length of Stay (LOS) for Admitted Patients	Total time elapsed from triage or registration (whichever is earlier) to patient left ED (for admitted patients only).	P4R Manual
ED LOS for Non-Admitted, High-Acuity Patients	Total time elapsed from triage or registration (whichever is earlier) to patient left ED for non-admitted high acuity (Canadian Triage and Acuity Scale (CTAS) I-III) patients.	P4R Manual
ED LOS for Non-Admitted, Low-Acuity Patients	Total time elapsed from triage or registration (whichever is earlier) to patient left ED for non-admitted low acuity (CTAS IV-V) patients.	P4R Manual
Leading Practice	"A *Leading Practice* is an innovative, people-centered, evidence-informed practice that has been implemented by teams in an organization; has demonstrated a positive change related to safe and reliable care/service, accessible and appropriate care/service, and/or integrated care/service" (4).	References
Strategy	For the purposes of this document, a strategy is a practical description of an approach identified through evidence and/or by Ontario health care professional experts and has demonstrated impact on ED patient flow. Evidence-informed approaches are identified throughout the Toolkit with a reference.	
Time to inpatient bed (IPB)	Total time elapsed from disposition decision to patient left ED (for admitted patients only).	P4R Manual
Time to Physician Initial Assessment (PIA)/Non-Physician Initial Assessment (NPIA)	Total time elapsed from triage or registration (whichever is earlier) to physician or non-physician initial assessment (whichever is earlier) for all patients. Non-physician clinicians assessing the patient may be a Nurse Practitioner (NP), Physician Assistant (PA), or Dentist.	P4R Manual

Section 1. Foundational Leading Practices Across the Organization

This section of the Toolkit focuses on leading practices and strategies under four key foundational themes. They are considered essential for every organization and set the stage for the implementation of other initiatives to drive positive change in ED patient flow:

THEME 1: Organizational Culture and Leadership
THEME 2: Building a High-Performing Culture in the ED
THEME 3: Data-Driven Decision-Making
THEME 4: Continuous Quality Improvement

THEME 1. Organizational Culture and Leadership

Ensuring all levels of leadership, especially the Chief Executive Officer (CEO), prioritize and visibly support quality improvement and patient flow is necessary to garner hospital-wide support for change (5). Although the Toolkit focuses on ED patient flow, improvement and sustainable change can only be achieved through an organization-wide understanding of the importance of patient flow. Accountability frameworks can be used to articulate ED performance as the responsibility of the organization as a whole, where it clearly identifies shared roles, responsibilities and expectations across the organization, 24 hours a day, 7 days a week, from leadership through to the bedside level (1). True cultural transformation needs to encompass a significant portion of the organization, not just the ED, to see significant results (5). Resourcing onsite support that has the advanced skills and necessary experience to lead change within an organization should be a priority in order to build a culture of accountability and continuous improvement (5, 6).

Strong organizational leadership and a senior team culture focused on supporting patient flow are crucial for several reasons, including:

- Managing Overcrowding: As strain on EDs grows across the province, strong leadership is essential in managing demand for services that often exceeds capacity (7). Overcrowding and wait times are also cited as factors influencing patient experience, which can impede efforts to create a positive, patient-centered culture (8).
- Improving Patient Outcomes and Experience: The quality of care provided to patients is directly impacted by leaders who hold accountability for their team being well-prepared to make rapid decisions and handle complex and urgent situations (9). A culture that prioritizes a patient-centered approach and factors like privacy and effective communication can positively impact patient experience (8).

- Staff Support and Retention: Accessible and engaged leaders and a positive culture in the ED both play a role in staff engagement, morale and retention (10, 11).

Improving ED patient flow should be a foundational goal and requires a clear accountability structure that encompasses all levels of hospital leadership within the organization and emphasizes removing barriers around competing priorities (such as timing of shifts or physician coverage hours) (5). Optimizing patient flow should be treated as a program with a governance structure, including, at a minimum, a vice president acting as executive sponsor, hospital directors providing support to the quality improvement teams and physician sponsors acting as liaisons with physicians in the ED (5).

Leading Practice		Strategies
1.0 *2.1	**Prioritize optimal patient flow across all levels of leadership** • Transparent accountability frameworks, identifying clear roles, responsibilities and reporting relationships with a commitment to act on data to improve performance • An organizational culture that values high ED performance and continuous improvement of patient flow	• The organizational governance structure defines the authority, responsibilities and accountabilities at all levels of leadership and front-line staff as it relates to ED performance and flow • Accountabilities and responsibilities related to ED performance and patient flow are documented for every member of the senior organizational leadership team and anyone else responsible for ED flow (e.g., in a policy, corporate strategy documents, etc.) and these documents are readily available and routinely reviewed **(*2.1.1)** • Senior organizational leaders regularly access Ontario Health's Hospital/ED Performance Scorecard and use the data to inform performance discussions and develop improvement strategies • Senior organizational leaders use additional available data related to ED flow performance daily/weekly/monthly to measure, monitor and inform decision making **(*2.1.1)** • Senior organizational leadership commits to being present and visible in the ED and makes effort to do regular walk-throughs of the ED to liaise with ED leadership and front-line staff • Senior organizational leadership establishes and chairs regular forums with leadership across the organization to discuss hospital performance through the lens of ED throughput
1.1	**Foster a culture of continuous quality improvement and innovation**	• Organizational leadership across all levels are provided the opportunity and protected time to participate in learning and development and/or educational seminars that relate to ED performance and flow and quality

Leading Practice		Strategies
	• Quality improvement education for all levels of staff • Provide leadership with the tools/resources needed to lead change and provide positive reinforcement to staff resistant to change	improvement (e.g., Ontario Health Emergency Services Program Community of Practice) • Organizational and ED leadership provides forums for ED teams to regularly socialize and review performance data, measure changes over time and share the impact of initiatives that enhance performance and ensure the team has an opportunity to provide feedback, share ideas and highlight risks • Develop a clear change management framework for performance improvement and ensure that it supports all hospital/ED leadership and ED staff to be engaged in change, manage resistance and promote success

THEME 2. Building a High-Performing Culture in ED

Fostering a cohesive and high-performing culture in the ED is essential for timely, safe and effective patient care (12). In the ED, operational efficiency and clinical excellence are linked to the culture cultivated among the interdisciplinary team. When all members of the ED team (including physicians, nurses, allied health, administrative and support services) share a sense of responsibility for patient flow and ED performance, the ED can function as a coordinated system focused on performance and quality improvement.

Health care providers are often inherently motivated to provide meaningful and impactful care and want to feel confident that their efforts are contributing to good outcomes for their patients. Creating an environment in which staff can perform to the best of their ability and experience minimal moral distress will improve provider satisfaction, which is crucial to an effective ED (12). Establishing a high-performing ED culture is a shared responsibility across the organization; however, involvement of ED leadership in building the ED culture can drive impactful changes for front-line providers.

Leading Practice		Strategies
2.0	**ED leaders create and inspire a shared vision for ED performance and flow and continuously promote this vision** • A shared vision amongst team members is essential in aligning individual team members' interests with those of the organization (12) • A shared vision creates a common understanding of organizational goals and strategies to achieve those goals (12) • A shared vision can guide team members' actions and decision and motivate them towards the organizational goals (13)	• Develop a forum for the front-line interdisciplinary team members to collaborate on defining the shared vision and/or goals related to ED performance (e.g., daily huddles, staff meetings) • Develop communication and key messages that link the vision to intrinsic motivators to improve commitment to the vision (e.g., reducing Time to PIA means the patient will get the right care faster) • Share and celebrate positive patient feedback and team successes that illustrate the shared vision in action (e.g., through team huddle, internal newsletters, bulletin boards) • Use bulletin boards in the ED to share information and data on ED flow and performance with front-line staff • Use daily huddles in the ED to reinforce the shared vision, review data on ED performance and flow, identify challenges and collaborate with the front-line staff on developing and implementing solutions • Use internal newsletters distributed to front-line staff to communicate ED performance and flow • Celebrate and highlight progress made towards the goals of the shared vision • Establish a unit-based council to provide a forum for front-line engagement and support opportunities for continuous learning and decision-making

Leading Practice		Strategies
		• Include information and messaging related to the importance of ED flow and performance and the role staff plays in performance improvement as part of onboarding and orientation programs for new ED staff and interdisciplinary team members
2.1	**ED leaders build a culture of psychological safety in the ED** • Psychological safety refers to the extent to which individuals feel their work environment supports taking interpersonal risks. This is critical to support quality improvement work as it often involves taking interpersonal risks (14) • Team members who feel psychologically safe are more likely to speak up, admit mistakes and/or offer new ideas	• ED leaders are visible and present on the frontlines, where they actively support staff, learn about real-time challenges and demonstrate a shared commitment to patient care and team success • ED leaders have the opportunity to receive training in building psychological safety to equip them with skills to support dialogue • A leadership open-door policy is in place for staff • Team members have the opportunities to provide input and feedback related to ED performance and flow and a regular forum is available to review and address those input and feedback
2.2	**Foster a culture of continuous quality improvement and innovation** • Quality improvement education available for all levels of staff • Provide leadership with the tools/resources and protected time needed to lead change and provide positive reinforcement to staff who are resistant to change	• ED staff are provided with the opportunity and protected time to attend learning and development sessions and educational programs related to quality improvement, such as Lean methodology • Front-line ED staff are included in quality improvement events (e.g., value stream mapping, Kaizen) from planning, through participation and evaluation • Forums exist for staff to share quality improvement ideas • Change management frameworks and personnel are in place to support front-line staff through all changes as a result of quality improvement initiatives

Tools and Resources	
Peterborough Regional Health Centre	LWBS/Waiting Room Committee Presentation
Mount Sinai	ED Unit-Based Council Terms of Reference

THEME 3. Data-Driven Decision-Making

To design a solution, the problem must first be defined and understood. In the case of improving ED performance, thorough review and appreciation of data on key performance metrics is the first step to finding a solution. Monitoring ED performance is a crucial activity to ensure standards in patient safety and quality are upheld, optimal resource management are designed, systemic issues are identified and understood, and an improvement plan is developed.

Using common-sourced ED performance data "[grounds] conversations about the hospital's performance in facts and helps to avoid speculation regarding the magnitude and causes of problems." (5) This allows the organization to focus on solutions that are aligned to a specific performance challenge (6). For example, data may be used to demonstrate that ED overcrowding is not just an ED problem, but one that requires hospital-wide solutions (15).

There should be clear organizational processes around ongoing data review, data quality analysis and dissemination, with all levels of staff, to inform and track process improvements. Data should be used to establish baseline performance, identify specific flow problems, inform the progress of improvement projects and select tests of change (16). Sharing performance data from process improvement initiatives regularly both internally and externally provides opportunity to sustain efforts and spread impactful initiatives to other organizations. Widely reporting results of department initiatives helps to create a culture of transparency and openness and will often foster an attitude of healthy competition to drive improvement (15).

Leading Practice		Strategies
3.0	**A balanced scorecard to provide continuous feedback to senior management on outcomes**	• Once implemented, leverage the organizations balanced scorecard to support regular review and performance discussions with relevant partners around ED key performance indicators **(*3.1.1)** • If possible, measure flow in real time and use dashboards to share live data to ensure decisions are made based on relevant data for immediate action
3.1 ***3.1**	**Processes around ongoing data review, data quality analysis and data sharing to inform process improvements** • Providers are knowledgeable in the data elements and their definitions they are responsible for, and how to record and report them • Data is validated on a regular cadence	• Ensure clinical providers and staff responsible for documenting ED data understand definitions, their relevance, how they are measured and how their daily work impacts it. Ongoing refresher training should be available to minimize variation in quality and deviation from standard process. • Ensure the organizational process for data validation is in place, which should include a regular cadence for review (including spot checks) to ensure data is being reported accurately, used appropriately for decision making and that feedback related to data capture is provided to individual providers (15)

Leading Practice		Strategies
	• Organizational team shares any data collection issues with relevant partners for accountability, transparency and solution-finding	- This may include ensuring time stamps are appropriately and accurately captured within the health record, outlier data is assessed and analyzed and strategies to improve, if needed, are identified • Review data to explore variation in performance amongst individual providers and based on this review, develop and implement improvement strategies

THEME 4. Continuous Quality Improvement

Fostering a culture of continuous quality improvement and encouraging it as part of daily work is crucial for evaluating and improving ED flow and performance. The importance of a common framework for improvement and a shared approach to training, with standardized training materials across all departments, is an important part of building quality improvement at all levels and in all areas of the organization (16). Ontario Health's Integrated Quality Framework is designed to support the Ontario health care system in improving performance as it relates to the six domains of quality (see Figure 3; 17). EDs are encouraged to develop their own quality frameworks that outline data and evidence-driven strategic objectives to improve performance (17).

Equitable	Effective	Patient-Centred	Efficient	Timely	Safe
Patient Meaning	**Patient Meaning**	**Patient Meaning**	**Patient Meaning**	**Patient Meaning**	**Patient Meaning**
No matter who I am or where I live, I can access services that benefit me. I am fairly treated by the health care system.	I receive the right treatment for my condition, and it contributes to improving my health.	My goals and preferences are respected. My family and I are treated with respect and dignity.	The care I receive from all practitioners is well coordinated and efforts are not duplicated. The value of my time is respected.	I know how long I must wait to see a doctor, for tests or treatments and why. I am confident this wait time is safe and appropriate.	I will not be harmed by the health system (physically, emotionally, or otherwise).
Health System meaning	**Health System meaning**	**Health System meaning**	**Health System meaning**	**Health System meaning**	**Health System meaning**
Every patient received high quality care that is fair and appropriate to the, no matter where they live, what they have, or who they are.	The health system delivers care based on the best available evidence and produces the desired outcome.	The system promotes patient autonomy in decision-making regarding care choices.	The health system eliminates waste and dedicates efforts toward streamlined and coordinated care for patients.	Patients receive the care they require within an acceptable wait time after the need is identified.	Policies, processes, and procedures are in place to ensure patient safety.

Figure 3. Six Domains of Health Care Quality. Image adapted, with permission, from the Quality Improvement Primer: Guide to the Science of Quality Improvement, 2024 (17)

Quality improvement can be broken down into three basic steps (see Figure 4), each step being iterative and designed to build on knowledge gained from the previous step:

Figure 4. Quality Improvement Steps. Image from the Quality Improvement Primer (17)

Planning for Change includes:

- Assembling a team including those directly involved in the delivery and receipt of care
- Understanding the problem using data analysis and Lean methodologies such as value stream mapping
- Mapping the process, both current and future state
- Measuring current performance and setting goals for future performance

Implement change by testing change ideas to address the problem and using tools like the Hierarchy of Intervention Effectiveness or a Plan-Do-Study-Act cycle.

Sustain change by identifying initiatives with positive outcomes and then formalize and standardize the changes by documenting the new process and communicating widely.

Examples of process improvements within the ED include initiatives like bedside registration and point-of-care testing, which can reduce turnaround times and increase efficiency (6). Rapid Assessment Zone (RAZ) is another example of a Lean process called single-piece flow, in which early assessment and investigation of patients, along with prompt treatment, often reduces the amount of time patients wait in between these steps (cycle time) as compared to a more traditional care model (18).

To implement any quality improvement, all levels of staff across the organization should be engaged in the process. Prioritizing staff education (and re-education) on quality improvement is also important. However, simply teaching senior leaders and front-line management about the concepts of continuous improvement is not sufficient. A teach-and-show methodology is essential to success, making the implementation of leaders dedicated to quality improvement paramount. Moreover, time and resources need to be dedicated for quality and process improvement; it cannot be made off the side of a desk (5). Site visits are another valuable tool to inform the design of ED flow solutions and foster networks across the province. Including Team Leads and other team members in site visits provides exposure to the workings of other hospitals, often encouraging creative solutions to develop (5).

Leading Practice		Strategies
4.0	**Utilize Lean principles, tools and processes to support quality and process improvement** • Value stream mapping can be used to identify what patients value and highlight unnecessary steps and waste • Create flow across the organization ensures patients are placed in the most appropriate care area • Pull patients to the most appropriate care area • Strive for perfection	• Ensure protected time is available to ED leadership and staff to assess key processes in the patient journey using Lean methodology • Review data to identify bottlenecks in patient flow, or instances where patient arrivals and staffing or resources are mismatched and share findings with staff • Engage the clinical staff and provide information and feedback to create awareness and build insight on how their performance and behaviour impact ED flow • Use Lean principles to drive improvement - Host Kaizen events to address specific issues that have been identified - Use value stream mapping to identify patient-specific processes, using data to inform decisions where applicable - Consider a real-time study where patients are followed from triage to disposition to understand the patient experience and identify gaps, challenges and successes within the process - Value stream map key processes that may impact ED LOS such as turnaround time of diagnostic imaging, lab results and time to consultation - Identify any waste in these processes and determine steps to reduce or eliminate waste where possible (e.g., documentation processes that do not add value and delay Time to PIA) and provide feedback to teams
4.1	**Educate all levels of the organization on quality improvement**	• Prioritize training staff in quality improvement to ensure quality improvement is built into the organizational culture and create common language amongst teams (5) • Develop team members within the organization to lead quality improvement projects or oversee multiple projects (16) • Ensure appropriate resources and tools are available to conduct quality improvement initiatives • Include Quality and Risk Managers and teams in ED change management events

Tools and Resources	
Institute for Healthcare Improvement	Quality Improvement Essentials Toolkit
Ontario Health	Planning for Change
Brightshores Health System	Patient Access and Flow Improvement Project
Ross Memorial Hospital	Process Mapping

Section 2. Functional Leading Practices to Improve ED Patient Flow

This section of the Toolkit provides details on leading practices under four key functional themes. These themes have been identified as core building blocks throughout the patient journey to support effective patient flow and safety.

THEME 5: Optimizing Physical Space Design and Queuing Systems
THEME 6: Enhanced Staffing, Resource Allocation and Models of Care
THEME 7: Leveraging Technology
THEME 8. Using Standardized Policies, Processes and Procedures

THEME 5. Optimizing Physical Space Design and Queuing Systems

The physical infrastructure of EDs across Ontario varies widely, but the importance of optimizing space design remains imperative for several reasons. They include to increase workflow efficiency, enhance patient and staff safety and security, improve patient privacy and experience, staff satisfaction and retention and optimize patient flow. In addition, queuing theory can be used to optimize triage by determining the ideal number of nurses and beds to manage patient flow and reduce wait times. By analyzing patient arrival rates and service times, an organization can establish optimal staffing levels and allocate resources effectively for EDs, as well as the supporting services such as diagnostic imaging, labs, and consultative services. The following are overarching strategies related to optimizing physical space design and queuing systems.

- **Workflow Efficiency**: Strategically positioned equipment and optimal room layouts to enable faster patient care, specifically in emergency situations where every second counts. This can help minimize unnecessary movement and delays and increase both staff and patient satisfaction and safety (19).
- **Enhanced Safety and Security**: Controlled entrances, unobstructed views in triage areas and effective wayfinding (e.g., signage) can increase security and satisfaction for both patients and staff and are particularly important in spaces where violence may occur (19). **(*2.2.1)**
- **Patient Privacy, Experience and Staff Satisfaction**: Privacy is essential for patient comfort, dignity, and confidentiality during their care journey.

- **Staff Satisfaction**: Staff satisfaction can be improved by designing spaces to minimize physical strain, enhancing communication through high visibility and increasing access to essential supplies (19).
- **Optimizing Patient Flow**: Designing spaces that are dedicated to care for mid- to low-acuity patients (e.g., RAZ or Fast Track Zone) can help expediate their care and decrease wait time. Using internal waiting rooms to situate patients waiting for testing, treatments and reassessment can increase the availability of care spaces. Optimizing spaces outside of the ED that are not in use (e.g., using the fracture clinic in off-hours) can provide additional capacity as well.

Use this icon throughout the document to identify specific strategies along the patient journey related to this leading practice theme. Detailed strategies are found in Section 3.

THEME 6. Enhanced Staffing, Resource Allocation and Models of Care

The ability to implement dynamic staffing structures and innovative models of care increases in an organization's flexibility to redistribute resources to where it is most needed. With continued health human resource (HHR) constraints and an increasingly complex population seeking care in EDs, the need to be flexible and adaptable is paramount. The following are strategies related to enhanced staffing, resource allocation and models of care:

- **Dynamic Staffing**: Decision support teams can review flow-related data, such as volume of patients based on arrival times, CTAS-specific arrivals and LWBS rates, to support the implementation of dynamic staffing. Predictive technology can be used to forecast patient volumes based on a multitude of factors, enabling organizations to adapt staff and physician schedules based on patient volume. This can help increase staff satisfaction and cost efficiency (6).
- **Models of Care**: The use of advanced triage protocols and fast-track units to streamline care for lower acuity patients and employing advanced care providers such as NPs can not only improve patient outcomes but also increases provider satisfaction (6). Access to Ontario Health's ED Peer-to-Peer Program at sites with single physician coverage can provide needed assistance with problem solving, clinical assessment, decision making and support.
- **Optimize Clinical Team Make-Up**: Including more alternate providers, such as NPs and PAs, as part of the ED team can improve ED flow, especially when all team members are working at their full scope of practice and capacity. These alternate providers can be assigned to specific areas in the ED to see and treat a subset of the ED patients (e.g., low acuity patients), which can help reduce wait times overall.
- **Utilize Non-Clinical Roles**: Non-clinical work can be delegated to non-clinical staff (e.g., clerks) to allow clinical staff to focus on patient care. For example, physician scribes can assist with documentation, or non-clinical staff can assist with patient flow, wayfinding and stocking of supplies.

- **Include Allied Health**: In accordance with the Ontario Health ALC/Home First Operational Direction, ED-specific Multidisciplinary Case Managers or Discharge Planners can be dedicated within the ED to support admission avoidance. Additionally, population-specific clinical and non-clinical ED staff such as Geriatric Emergency Management (GEM) Nurses for older adults or Child Life Specialists for pediatric patients can be integrated into the team to provided targeted assessments and care to these patient populations.
- **Surge planning**: Surge plans with appropriate staffing resource allocation and models of care should be in place to ensure a timely response to sudden or unexpected variations in patient volumes.
  (*1.1.5)

Use this icon throughout the document to identify specific strategies along the patient journey related to this leading practice theme. Detailed strategies are found in Section 3.

THEME 7. Leveraging Technology

Technology has been vital to providing safe and effective emergency care for the past several decades. Appropriate integration of technological advances can be especially useful when implementing changes to improve patient flow as it can help address challenges like overcrowding and long wait times and improve provider and patient experience. The benefits of implementing new technology must be accompanied by appropriate investment in robust implementation and change management strategies, training and customization to ensure optimum productivity. The following are overarching strategies related to leveraging technology:

- **Streamlined Administrative Tasks:** Technologies such as voice-to-text scribing can decrease the time it takes for providers to complete administrative tasks, allowing for more time for direct patient care.
- **Real-Time Decision Making:** Systems that offer hospital-wide dashboards to monitor patient activity in real time can help staff to identify bottlenecks and barriers to bed access for admitted patients waiting in the ED.
- **Artificial Intelligence (AI)-Enhanced Efficiency:** AI tools can be used to predict patient volumes and admissions, identify bottlenecks to flow and redistribute resources. This type of technology can also be used to manage staff and provider schedules to adjust for high-volume patient hours and assign patients to providers based on predicted outcomes to optimize flow.
- **Virtual Care Resources:** Ontario's ED Peer-to-Peer Program can be leveraged to support decision-making, and remote consultations can be facilitated via CritiCall. These resources are particularly useful for northern, rural and remote EDs with limited physician coverage and support.
- **Optimizing Electronic Health Records (EHR):** EHRs have a wide range of functionality, which can be leveraged to improve ED flow and performance. Flags can be added into EHRs to alert providers for status changes or next steps (e.g., when test results are available, when a patient needs to be reassessed, or when an inpatient bed is ready).

Use this icon throughout the document to identify specific strategies along the patient journey related to this leading practice theme. Detailed strategies are found in Section 3.

THEME 8. Using Standardized Policies, Processes and Procedures

Standardization is a cornerstone of providing high-quality patient care. Standardizing procedures reduces variability, while minimizing errors and increasing efficiency. Having well-established hospital and ED processes also allows for the identification of bottlenecks and potential areas for continuous quality improvement. Clear processes and communication that set clear expectations about an ED visit can also increase patient satisfaction and decrease complaints (20). Standard policies and procedures can support performance measurement and monitoring and accountability. The following are strategies related to using standardized policies, processes and procedures:

- **Demand-Driven Overcapacity Protocols:** These protocols are implemented to direct actions when patient demand exceeds available resources. They include clear criteria on when to activate the protocol, levels of escalation and specific roles, responsibilities and activities required by identified personnel.
  (*2.1.10, 2.1.11, 2.1.13)
- **Standardize Admission and Discharge Processes:** Using standard procedures for patient admission and discharge to create consistency, reduce variability and improve safety and efficiency across the patient journey.
  (*2.1.9, 2.7.18)
- **Pre-Printed Order Sets, Care Protocols and Pathways:** Streamlining clinical decision-making through these tools and processes can reduce variability, ensure patients are receiving up-to-date care and improves efficiency and consistency in care.
- **Standard Patient-Facing Information**: Patients should receive standard information about what they can expect in the ED, including information about length of stay and events that may occur in the care process (e.g., diagnostic imaging)
- **Medical Directives:** Used in the correct context and setting, medical directives can be a vital tool in enhancing both the patient experience and ED throughput. Medical directives can support earlier pain control and comfort for patients, faster diagnostics and reduce ED length of stay.

Use this icon throughout the document to identify specific strategies along the patient journey related to this leading practice theme. Detailed strategies are found in Section 3.

Section 3. Strategies Along the ED Patient Journey

The strategies outlined in this section follow the patient journey, beginning with arrival to the ED (see Figure 2). For each point along the patient journey, strategies are organized in a table according to the overarching strategies described in the previous section (Theme 5: Optimizing Design, Space and Queuing Systems; Theme 6: Enhancing Staffing, Resource Allocation and Models of Care; Theme 7: Leveraging Technology; and Theme 8: Using Standardized Policies, Processes and Procedures). In addition, the table will also indicate which category the strategies belong (i.e., universal, intermediate, advanced) and highlight any existing tools or case examples that may be helpful when considering the implementation of those strategies. Clicking on each tool or case example will redirect you to the appendix where details about the tool or case example are outlined.

Recognizing that each hospital and ED operates within unique context, these strategies can be adapted to meet local needs, though some may require greater capacity and resources to implement and may not be feasible for all sites. However, the layout of the strategies is designed with an appreciation of the distinct challenges faced by both large urban centers and small rural facilities.

1. Ambulance Arrival and Offload

AOT Provincial Target:
≤ 30 minutes*
**For FY 26/27, as of June 2026*

Delays in offloading patients from ambulance stretchers and transferring care result in longer wait times, which can increase the risk of morbidity and mortality (2). Additionally, paramedics who are not able to complete transfer of care are unavailable to attend to other emergency calls, reducing ambulance capacity and service and increasing risk to community safety (21). In addition, patients requesting 9-1-1 services may experience longer waits for 911 emergency response. Reducing AOT will improve patient outcomes and paramedic response time to emergencies.

Ambulance arrival is defined as the date and time when the ambulance/emergency medical services (EMS) pull into the hospital driveway and arrives at the hospital. If arrival is by air, it is defined as the date and time when the aircraft lands on the facility's heliport. *Ambulance Transfer of Care (TOC) Process* refers to the date and time when the ambulance/EMS personnel turn over care of the patient to the ED or hospital staff and no longer has responsibility for the patient. This can occur when the patient is transferred to a stretcher, bed, chair or any other care space in the ED, with the consent of the ED staff or when care of the patient has been assumed by other ambulatory care staff (e.g., day surgery, clinic).

Case Example
The Ottawa Hospital
Reducing Ambulance Offload to Improve Community Access to Emergency Services

The relevant ED key performance indicator is *Ambulance Offload Time (AOT)*, which is the total time between ambulance arrival (date and time) and transfer of care (date and time). As of 2025, the performance target for AOT in Ontario is 30 minutes or less. When AOT exceeds the performance target of 30 minutes, it is referred to as *ambulance offload delay*.

Category	#	Strategies	Tools
		Theme 5: Optimizing Design, Space and Queuing Systems	
Universal	1.1	Optimize the physical layout of the ED to enhance visibility of ambulance arrival to ED staff (e.g., triage/charge nurse) to minimize the time to triage upon arrival	
	1.2	Dedicate an area of the ED (i.e., dedicated offload area) with stretchers and/or other care spaces (e.g., reclining chair) to receive patients arriving via ambulance to support offloading	
	1.3	Use non-stretcher care spaces in addition to the dedicated offload area in the ED to offload patients, where appropriate (e.g., waiting room, internal/sub-waiting room or reclining chair)	
		Theme 6: Enhancing Staffing, Resource Allocation and Models of Care	
Universal	1.4	Use data to understand ambulance arrival patterns and support staffing for ambulance triage and ambulance offload areas accordingly (i.e., match staffing to peak ambulance arrival times)	
	1.5	Assign a nurse(s) or eligible alternate care providers to be primarily responsibility for: • Ambulance triage • Offload of patients arriving by ambulance (22) • Nursing care of patients who have been offloaded Standard work for this role to include: • Expected time to triage patients • Expected time to offload patients (target 30 minute or less) • Considerations for patients requiring advanced monitoring (e.g., cardiac monitoring) • Communication pathways	EMS Offload Nurse Role Description- Mount Sinai Ambulance Offload Nurse – Peterborough Regional Health Sciences Centre Paramedic Triage Nurse – Lakeridge Health

Category	#	Strategies	Tools
Universal		*This role may be assigned to a dedicated offload nurse (or alternate care providers) at certain sites.*	
	1.6	Protect the nurse(s) with primary responsibility for ambulance offload in the shift assignment (i.e., this nurse is not reassigned if the department is short-staffed)	
	1.7	Develop an escalation policy with a trigger and process to reallocate staffing to respond to surges in patients arriving via ambulance (e.g., additional nurse assigned to triage ambulance arrivals) (22)	Toronto Ambulance Offload Toolkit
Theme 7: Leveraging Technology			
Universal	1.8	Optimize EHR to ensure accurate capture of key data elements related to ambulance offload, including arrival date/time and transfer of care date/time	
Intermediate	1.9	Optimize EHR to flag users when ambulance offload time is approaching or exceeding the offload target (i.e., offload delays)	Using EHR flags for offload delays – Lakeridge
	1.10	Consider working with local ambulance service to share real-time data and technology, where available	
Advanced	1.11	Use the Patient Distribution System (PDS) to monitor and prepare for incoming ambulances (i.e., prepare a bed in advance for an incoming high acuity patient to allow for the immediate offload of the patient) (22)	
	1.12	Use technology to streamline the transfer of the ambulance call reports to the ED	
Theme 8: Using Standardized Policies, Processes and Procedures			
Universal	1.13	Develop a standard operating procedure that outlines the triage process and ensures consistency in the assessment and process for all patients, regardless of mode of arrival (i.e., the decision to offload patients to the waiting room should not prioritize patients arriving by ambulance) (22) **(*2.3.3)**	
	1.14	Develop and implement a process to ensure that offloading of patients prioritized within the ED	ED Flow and Offload Playbook – Peterborough Regional Health Centre

Category	#	Strategies	Tools
Universal	1.15	Develop and implement a process to ensure that registration of patients is not a bottleneck to offload (i.e., paramedics should not be required to wait for registration of patients or charts) (22)	
	1.16	Provide standardized messaging and communication to staff regarding the importance of offloading patients arriving by ambulance and reducing AOT	
	1.17	Develop and implement a process where patients are continuously flowed from the designated offload space to the next available care space in the ED to ensure ongoing availability of offload spaces	
	1.18	Establish and communicate a 30-minute target for transfer of care from paramedics to ED staff and implement a corporate escalation policy, when this target is not met (22) and the policy should include, at minimum: • Stages of escalation • Escalation criteria and triggers • Communication pathways • Accountabilities for each partner in the process (e.g., triage nurse, charge nurse, ED Manager, etc.) **(*2.2.3, 2.2.4, 3.1.2)**	Toolkit to Support Optimizing Ambulance Offload - Toronto AOT Toolkit Ambulance Hold Escalation Process in the Emergency Department - London Health Sciences Centre Offload Delay Escalation Pathway – Peterborough Regional Health Centre
	1.19	Develop a process with local paramedic services where patients, as appropriate, will be moved from a stretcher to wheelchair upon arrival at the hospital, and patient movement will be facilitated by ED staff (22)	
	1.20	Streamline the transfer of care process and consider standardized handover (i.e., using a structured handover tool) between paramedics and ED staff to minimize the need for secondary reports, where appropriate, and reduce duration of handover (23)	
	1.21	Establish a structured table and process for hospital/ED and EMS leadership to hold regular touchpoints that focus on reviewing the current state of AOT, identifying gaps and challenges and collaboratively developing solutions to improve related workflows	

Category	#	Strategies	Tools
Universal	1.22	Collaborate with EMS to establish an agreed upon process to document Transfer of Care time to ensure the same data is documented by hospital and EMS	
	1.23	Collaborate with EMS to develop an escalation policy/process when paramedic services are approaching Code Zero and have limited ambulances available in the community	
Intermediate	1.24	Collaborate with local paramedic services to develop and implement a Fit-to-Sit program where patients meeting Fit-to-Sit criteria will be offloaded to the waiting room following a brief verbal report from paramedic staff with additional triage information provided by written documentation on a Fit-to-Sit Report (22)	Fit-2-Sit Criteria – Peterborough Regional Health Centre

2. Triage and Registration

Triage is a fundamental process in the ED. It is often the first point-of-contact for patients presenting to the ED and begins their patient journey. Triage is essential for identifying patients who must be attended to immediately (24); however, "triage is often a bottleneck that can aggravate emergency access block" (2). Specifically, availability and capacity of triage nurses and inefficient workflows can cause delays in the triage process, resulting in a backlog of patients waiting to be triaged upon arrival to the ED. By assessing and optimizing this part of the patient journey, less time would be spent waiting for patients to be assigned to the right place at the right time and see a physician sooner, thus improving patient satisfaction, promoting efficiency of care and decrease the overall ED LOS (25).

Registration is also important to consider along with triage as these processes often occur in close succession. Registration is the process that officially registers the patient to emergency (or ambulatory care) services. Depending on the ED, registration may occur before, concurrently or after the triage process.

Case Example
Hamilton Health Sciences, Juravinski
Triage Assessment Team

Triage date and time and registration date and time are both data elements that are captured during a patient's ED visit and are used when measuring key performance indicators including Time to PIA and ED LOS.

Category	#	Strategies	Tools
	Theme 5: Optimizing Design, Space and Queuing Systems		
Universal	2.1	Optimize the physical layout of the triage space to enhance visibility of walk-ins and ambulance arrival to triage nurse to minimize the time to triage upon arrival	
	2.2	Optimize the triage and registration spaces so the processes can occur concurrently or as close as possible to one another	
	2.3	Centralize storage for all material required for triage and registration and ensure they are stocked and readily available to minimize the time and movement of staff to gather resources	
	2.4	Use queuing theory to understand daily patient arrival patterns and ensure walk-ins and ambulance arrival triage stations are staffed accordingly (26)	Queuing Theory Daily Visit Pattern Heat Map – Oak Valley Health

Category	#	Strategies	Tools
		Theme 6: Enhancing Staffing, Resource Allocation and Models of Care	
Universal	2.5	Ensure nurses who are assigned to triage have completed initial CTAS participant course and receive regular re-education	
	2.6	Train all nurses assigned to triage on site-specific education with respect to the triage process in relation to ED flow in the local context **(*1.1.1)**	
	2.7	Develop a process to reallocate staffing to respond to surges in patients arriving to the ED (e.g., providing additional triage nurses) **(*1.1.5)**	
Intermediate	2.8	Implement a "nurse first" approach, where patients are greeted by nursing staff immediately upon arrival (prior to waiting for triage) to identify potential high-acuity patients that should be prioritized for triage and/or to streamline patients to a specific care area in the ED (e.g., RAZ or Fast Track Zone)	Patient Allocation Nurse – Joseph Brant Hospital Pre-Triage – Peterborough Regional Health Centre
	2.9	Implement volunteers or waiting room attendants to provide information and comfort services (e.g., warm blankets) in the waiting room to offload non-clinical work from triage nurses, minimize interruptions at triage and improve patient experience (25)	
	2.10	Designate a staff member (e.g., non-triage nurse, phlebotomist), other than the triage nurse, to complete orders that have been implemented with medical directives to ensure continuous availability of triage nurses for patient arrival	
	2.11	Use other regulated health professionals (e.g., Registered Respiratory Therapists) in the ED who can support the initiation and performance of medical directives	Registered Respiratory Therapy Scope of Practice in the ED – Oak Valley Health
		Theme 7: Leveraging Technology	
Universal	2.12	Use the electronic Canadian Triage and Acuity Scale (eCTAS) tool to triage patients upon arrival to ED	

Category	#	Strategies	Tools
Universal	2.13	Ensure triage nurses have been provided education on the use of the eCTAS tool and leadership endorses the need for optimal use of eCTAS as a decision support tool	
Advanced	2.14	Consider the use a self-check-in kiosk for walk-in patients arriving at the ED to enter demographic information and presenting complaint (e.g., using a pre-populated list or free text) to support identification and prioritization of patients for triage (27)	Emergency Department Kiosk – Health Standards Organization RAPP - SickKids
	Theme 8: Using Standardized Policies, Processes and Procedures		
Universal	2.15	Develop and implement a standard operating procedure outlining the triage process in the ED, including: **(*2.2.2)** • Target audience of the procedure (i.e., triage trained nurses) • Processes to triage patients upon arrival at the ED • Considerations for the placement of patients within the department • Reassessments of patients • Standard work for triage nurses • Role and responsibilities of triage nurses	Standard Operating Procedure for Triage Process in the ED - London Health Sciences Centre Triage Nurse Roles and Responsibilities - North Bay Regional Health Centre
	2.16	Use the Canadian Triage and Acuity Scale (CTAS) guidelines to triage patients arriving to the ED **(*2.3.1)**	
	2.17	Develop and implement medical directives that can be initiated and performed following the triage assessment and prior to physician/non-physician initial assessment	Medical Directive Examples
	2.18	Balance the mandatory information and data required to determine a CTAS level (e.g., demographics, Canadian Emergency Department Information System (CEDIS) complaint) with additional screening and or/documentation (e.g., IPAC screening, medication reconciliation, domestic violence screening) and streamline the process where possible (28)	

Category	#	Strategies	Tools
Universal	2.19	Ensure clinical reference tools and materials related to the triage process are available at the triage desk including: • Vital signs ranges • Commonly used screening tools (e.g., Pediatric Respiratory Assessment Measure)	
	2.20	Develop a process for triage to occur in conjunction with registration to optimize flow (29) **(*2.3.5)**	
	2.21	Provide the patient and/or caregiver with general information regarding the ED visit, including key processes that may occur during the visit, normal wait times for tests and results, information regarding lengths of stay and who to contact if their condition changes (25) **(*2.3.6)**	Emergency Department Patient Education - North York General Hospital Video: Emergency Care - North York General Hospital

3. Physician Initial Assessment

Time to PIA Provincial Target:
≤ 3.4 hours*
**For FY 26/27 as of June 2026*

In the ED, "prolonged wait times can frustrate patients, negatively affect their perception of care, contribute to high morbidity and mortality rates…[and] reduce staff retention and satisfaction (18)". Strategies to reduce the wait time for patients to see a physician can improve patient care and outcomes and lead to a better patient experience. Time to PIA is a key performance indicator for ED performance, and the data is publicly reported in Ontario and available through Health Quality Ontario.

In Ontario, *Time to PIA* refers to the total time elapsed between triage or registration (whichever is earliest) and when the patient is first assessed by a physician in the ED. Assessment refers to a medical assessment that involves a direct interaction between the physician and the patient resulting in a doctor-patient relationship. The assessment must be a face-to-face encounter. Initial assessments that are conducted by a non-physician provider who has the capacity and authority to make treatment decisions independent of the physician is called non-physician initial assessment (NPIA). NPIA that are conducted by a NP, PA or a dentist can also be used towards the calculation of Time to PIA. When both PIA and NPIA have taken place, whichever assessment was initiated first would be used in the calculation of Time to PIA.

Case Example
Lakeridge Health
Using a systems approach to improve PIA and AOT

Category	#	Strategies	Tools
		Theme 5: Optimizing Design, Space and Queuing Systems	
Universal	3.1	Optimize all spaces in the ED (including stretchers and chairs) to create capacity for patient assessment and ensure patients are placed in the appropriate assessment space based on acuity and resources that may be required (e.g., patients who require an assessment in supine position are placed in a stretcher, patients who require an eye exam are placed in room with eye exam equipment)	
	3.2	Streamline patients to designated areas of the ED (e.g., fast track zone, RAZ) based on acuity and/or presentation, if available (20, 30)	
Intermediate	3.3	Establish a dedicated area within the waiting room that can be used and is appropriate for patient assessments (e.g., ensure screens or physical barriers can be used to provide privacy) when space within the ED is limited	

Category	#	Strategies	Tools
Intermediate	3.4	Implement transitional spaces and discharge lounges for patients who have been discharged from the ED and awaiting transport to next destination (e.g., home) to increase availability of assessment spaces for new patients	
		Theme 6: Enhancing Staffing, Resource Allocation and Models of Care	
Universal	3.5	Use queuing theory to understand daily patient arrival patterns and match physician staffing accordingly	
	3.6	Establish a structured framework for physician assignment in the ED, which clearly outlines: • Zone of coverage within the department • Hours of coverage in each zone • Specific responsibilities (e.g., call-backs, code response)	Emergency Physician Schedule - NYGH
Intermediate	3.7	Develop criteria and processes for activation of the on-call physician for sites that use an on-call model to ensure physician coverage	Emergency Physician Back Up Call In – Joseph Brant Hospital
	3.8	Place a provider (e.g., Physician, NP, PA) at triage with triage nurse 24/7 (or according to daily peak volumes if unable to staff 24/7) to promptly assess undifferentiated patients, order diagnostic procedures, diagnose, treat and even discharge directly from the waiting room and ensure workflow is documented, including: • Hours of coverage • Roles and responsibilities of provider, triage staff, charge nurse	Provider in Triage Workflow – Erie Shores Health Care
	3.9	Use a triage assessment team model, composed of a provider (e.g., MD, NP, PA) and a nurse, where the provider will assess the patient after triage and place orders, and nursing staff will complete orders and ensure workflow is documented including: • Standard work of provider • Standard work of nurse • Process for patient assessments • Communication pathways for escalation	Standard Work (Nursing) – HHS Standard Work (Physician) – HHS Triage Assessment Team – HHS

Category	#	Strategies	Tools
Intermediate	3.10	Consider the implementation NPs and/or PAs and develop organizational policies to ensure these providers have the opportunity to practice to their full scope as part of the ED team for the assessment and treatment of low acuity patients (30, 31)	
	3.11	Use a physician navigator to flow patients into the department to support physician assessment and offload non-clinical work from physicians	Physician Navigator Roles and Responsibilities – Mount Sinai
	3.12	Consider the use of scribes to offload clerical work from physicians (25)	
Advanced	3.13	Use available data to understand individual physician efficiency and capacity and use this data to optimize the physician schedule **(*3.1.3)**	Physician Scorecard – Humber River Health Physician Scorecard – Thunder Bay Regional Health Sciences Centre
	Theme 7: Leveraging Technology		
Advanced	3.14	Use preference- and performance-based scheduling software and/or statistical modelling to align physician capacity with patient arrivals (32)	
	3.15	Integrate AI such as AI scribes into workflows to reduce the time spent by physicians on documentation (33, 34)	
	3.16	Use voice-to-text or speech recognition software to reduce the time spent by physicians on documentation	
	Theme 8: Using Standardized Policies, Processes and Procedures		
Universal	3.17	Establish and implement a process to define how patients are assigned to ED physicians for care to maximize physician availability and capacity to assess new patients and provide necessary training for physicians on the process	
	3.18	Establish a standardized process for turning over assessment spaces to ensure ongoing availability	
	3.19	Implement the process of direct bedding where patients are placed into the next available bed immediately following triage (31)	

Category	#	Strategies	Tools
Universal	3.20	When direct bedding is not feasible, ensure there is a process in place to outline how and by whom patients are moved into available care spaces for physician initial assessment	
	3.21	Reduce and/or streamline documentation practices for physicians (e.g., through EMR optimization) to ensure ideal efficiency in clinical documentation and maximize time spent with patients	
	3.22	Use pre-printed order sets for select clinical conditions (e.g., hip fractures, STEMI) to increase standardization of care and reduce time spent by physicians writing orders	

4. Laboratory Testing, Diagnostic Imaging and Consult Services

Many patients visiting the ED will require laboratory testing, diagnostic imaging and/or consultation services to guide their care. For those who are more acutely ill or have complex conditions, these tests and assessments become more extensive (35). These key processes play a crucial role in determining a patient's disposition, yet research shows that ordering diagnostics or referring patients to in-house specialist consultations contribute to prolonged ED LOS (2).

While these key processes are essential and sometimes unavoidable, there are strategies that can be implemented in the ED and in collaboration with the respective services to reduce ED LOS within these workflows. For example, providers should consider whether consultations or advanced imaging is necessary in the ED or if they can be managed on an outpatient basis (2). Utilizing decision-support tools, guidelines and recommendations can help select the most appropriate imaging (36). Additionally, efforts to reduce turnaround times for laboratory tests and diagnostic imaging, as minimizing delays in specialist consultations, can significantly improve patient flow and overall efficiency in the ED (35, 37, 38).

Virtual care options such as Ontario Health's ED Peer-to-Peer Program provide opportunities to connect rural clinicians with experienced emergency medicine peers through a 24/7 virtual platform. Specifically, the Peer-to- Peer Program helps bridge gaps in resources, enhance decision-making and improved patient care in critical moments by reducing processional isolation and giving providers confidence in the care they are providing. This program empowers ED physicians and NPs to engage in conversations and develop a collaborative network across isolated communities to ensure equitable, high-quality care is available to patients across the province.

	#	Strategies	Tools
	Theme 5: Optimizing Design, Space and Queuing Systems		
Universal	4.1	Optimize the layout and location of resources within the ED related to laboratory testing (e.g., blood tubes, blood draw equipment) to ensure resources are readily available in the areas where blood draws occur (e.g., at the patient's bedside, designated blood draw station)	
	4.2	Optimize wayfinding in the ED to ensure ambulatory patients can self-porter to diagnostic imaging services, where appropriate	
	4.3	Dedicate space in the ED for consulting services to review charts, document and complete order-entry	

	#	Strategies	Tools
		Theme 6: Enhancing Staffing, Resource Allocation and Models of Care	
Universal	4.4	Provide education to medicine trainees who are responsible for consults in the ED on the rationale for reducing ED wait times and the related concerns for patient safety due to ED overcrowding in order to encourage prioritization of consult completion (39)	
Intermediate	4.5	Implement dedicated phlebotomists in the ED to reduce the time from lab order to draw, thereby decreasing result turnaround time	
	4.6	Optimize ED radiologist hours to match patterns in diagnostic imaging requests (29)	
	4.7	Optimize laboratory service hours (for sites without 24/7 laboratory capacity) to match peak volumes and reduce delays in laboratory result turnaround times **(*2.5.12)**	
	4.8	Collaborate with diagnostic imaging to optimize availability and hours to match availability to patterns in diagnostic imaging requests and reduce delays in access to imaging	
Advanced	4.9	Implement a dedicated radiologist for ED studies to decrease delays in results and reduce time to disposition (29)	
	4.10	For sites that are able, consider dedicated consultation staffing in the ED for services with high rates of consultation requests (e.g., general medicine) to decrease response times (38)	
		Theme 7: Leveraging Technology	
Universal	4.11	Use virtual services for clinical consultations and support when services are unavailable in-house (e.g., Ontario Health's ED Peer-to-Peer Program)	
Intermediate	4.12	Consider the implementation of point-of-care testing to decrease turnaround time for selected tests and reduce the time to disposition (29)	
	4.13	Consider the use of secure short messaging service (SMS) technology to liaise with consulting services (38)	

	#	Strategies	Tools
		Theme 8: Using Standardized Policies, Processes and Procedures	
Universal	4.14	For all lab and diagnostic imaging processes: • Conduct value stream mapping from the point of order entry to results available to identify bottlenecks within the processes that are impacting turnaround times • Collaborate with all involved partners to reduce bottlenecks, where possible	
	4.15	Develop and implement standard work for dedicated ED phlebotomists outlining roles and responsibilities in the ED related to laboratory testing and reduction of turnaround time	
	4.16	Develop a protocol detailing the procedures for accessing laboratory services at sites without 24/7 or on-site lab availability and consider including direction for: • Point-of-care testing • When to contact/call in laboratory services • When and how to facilitate transport of labs to external location	Markdale Laboratory Guide – Brightshores Health System
	4.17	Use clinical decision support tools and other guidance/recommendations (e.g., Choosing Wisely), where appropriate, to determine the need for diagnostic imaging and select the most applicable imaging	
	4.18	Develop and implement a protocol with diagnostic imaging services to streamline the process from imaging request to imaging completion • Consider surge protocols to address rapid influxes of imaging requests • Consider huddles at pre-determined times throughout the day for ED and diagnostic imaging to discuss current state (e.g., ED census, number of requests in queue, barriers to imaging completion) (30)	
	4.19	Establish a target time for consultation request and admission order entry and provide personalized performance feedback for individuals with respect to the target (39)	
	4.20	Establish a policy related to consultation services, which includes: **(*1.1.4, 2.5.15)** • Information required to initiate a consultation • Criteria for who can initiate a consult	Inpatient and Emergency Department Consultation – SickKids

	#	Strategies	Tools
Universal		• Steps related to initiating the consult (e.g., who needs to be notified) • Expected response times • Consultants' role in disposition • Assuming responsibility for the patient • Conflict resolution/escalation pathways	Standard Work: Acute Medicine and Academic Hospitalists - HHS Standard Work: Multispecialty Service Hospitalists - HHS Standard Work: Nocturnist - HHS
	4.21	Develop and implement standard admission order sets for selected diagnoses to reduce the time consultants spend writing admission orders	
	4.22	Evaluate the time to admission decisions at sites where residents are responsible for admission decisions in the ED and implement targeted processes and strategies to reduce delays • Involvement of residents and medical trainees in the admission process has been associated with longer ED LOS and delayed admission decisions compared to attending-only workflows (40, 41) • Data should be used to evaluate the impact of residents and medical trainees on time to admission decisions, guiding the development of streamlined processes that reduce delays, while preserving educational opportunities • An example of a process may be protocols where attending providers directly admit clearly eligible patients to expedite ED flow and avoid delays from resident and medical trainee evaluations	

5. Time Spent in ED For Non-Admitted Patients

ED LOS for Non-Admitted High-Acuity Patients Target: ≤ 7 hours*
**For FY 26/27 as of June 2026*

ED LOS for Non-Admitted Low-Acuity Patients Target: ≤ 5 hours*
**For FY 26/27 as of June 2026*

Time spent in the ED for patients who are not admitted to the hospital is an important indicator for patient experience, and it is a performance measure that is publicly reported in Ontario. It reflects many key processes that are occurring throughout the patient journey. Improvements in those processes, with strategies discussed in earlier sections above, will result in overall reductions in ED LOS for non-admitted patients. The strategies outlined below are those that may have a more direct impact on ED LOS as a key performance indicator.

Key processes that are measured in EDs in Ontario are ED LOS for non-admitted high acuity patients (CTAS 1-3) and ED LOS for non-admitted low acuity patients (CTAS 4-5). Both metrics are defined by the total time elapsed from triage or registration (whichever is earlier) to the time the patient left the ED.

Category	#	Strategies	Tools
		Theme 5: Optimizing Physical Space Design and Queuing Systems	
Universal	5.1	Use non-stretcher care spaces (e.g., reclining chairs) to provide care for patients, where appropriate	
	5.2	Designate a zone in the ED for lower acuity patients who are likely to remain ambulatory and are unlikely to require more acute care in the ED, inpatient or other health care services (e.g., RAZ or Fast Track Systems) and ensure that this zone has: • Dedicated provider(s) to staff the zone and exclusively attend to patients within the zone • Dedicated nursing staff to provide care and ensure continuous flow of patients through the zone • Dedicated non-clinical staff to assist with non-clinical duties and flow • Internal waiting rooms for patients to wait for initial assessment, testing and reassessments	ED Fast Track Area Guideline – Humber River Health ED Rapid Assessment Zone Guidelines – Humber River Health ED Ambulatory Zone: Standard Work (Secretary) – Mackenzie Health

Category	#	Strategies	Tools
Universal		• Shared stretcher spaces (i.e., patients are placed in a stretcher for assessment and moved out once assessment is complete so the next patient can be placed for assessment; no patient "owns" a stretcher) • Chairs used for patient care and treatments, as appropriate • Clear pathways/protocols and standard work exclusive to the zone outlining, at minimum: - Appropriate patients to be cared for in the zone (e.g., based on CTAS level, patient presentation, etc.) - Documented processes that describe how staff move patients through the zone - Roles and responsibilities for each team member in the zone	
	5.3	Use spaces in the ED as internal waiting rooms where patients can wait for results and/or reassessment as opposed to waiting in a designated care space	
	5.4	Organize care spaces and workspaces with appropriate stock and ergonomic structures to minimize time spent between steps for patient care, including: • Stock all commonly required supplies in patient rooms/care spaces as opposed to central equipment stations (42) • Organize stock carts with most commonly used items • Footprint or mark the ED floor with designated locations for necessary equipment so that equipment can always be located easily • Anticipate necessary equipment for certain procedures and aim to have equipment prepared in advance, where possible	
Intermediate	5.5	Implement transitional spaces and discharge lounges for patients discharged from the ED awaiting transport to their next destination (e.g., home), to increase availability of assessment and care spaces for new patients	
	5.6	Utilize areas outside and/or adjacent to the ED for patient care when those spaces are not being used for their intended purpose (e.g., use fracture clinic space in off-hours to care for ED patients)	

Category	#	Strategies	Tools
		Theme 6: Enhancing Staffing, Resource Allocation and Models of Care	
Universal	5.7	Use patient arrival and volume data to match all staffing levels (e.g., providers, nursing, registration) to reduce staff-related bottlenecks at all possible points during the time the patient spends in the ED	
	5.8	Develop team skills and capacity to function in all areas of the ED to ensure as patient volume and acuity fluctuates, staffing resources can be reallocated seamlessly to support continuous flow and reduce wait times	
	5.9	Designate a staff member per shift to act as resource person/team lead/charge nurse and document: • Standard work • Roles and responsibilities • ED flow-related duties • Competencies related to the role • Communication pathways • Escalation protocols	Task Checklist: Emergency Department Resource Person/Team Leader Duties – Humber River Health Emergency Department Team Leader Competencies – Joseph Brant Hospital Charge Nurse Duties – Peterborough Regional Health Centre
	5.10	Designate a staff member on the ED team to be responsible for ensuring the continuous flow of patients through the ED (this may be team leader/charge nurse or another dedicated staff member) • Develop standard work for this role including key responsibilities such as: - Follow up on laboratory and diagnostic imaging results - Identify and address bottlenecks and challenges with flow in the moment - Maintain flow through the ED - Escalating through the appropriate pathways when challenges with flow cannot be resolved	

Category	#	Strategies	Tools
Intermediate	5.11	Implement a dedicated porter for ED patients to move patients through and out of the ED	
	5.12	Implement dedicated facilities services to prepare care spaces in the ED for incoming patients	
	5.13	Integrate allied health providers in the ED to support discharges home and into the community, where appropriate (e.g., GEM nurse, home and community care, Hospital at Home coordinator, crisis support workers) **(*2.8.5)** • Consider processes and pathways for allied health providers to be consulted early in the patient journey through the ED (e.g., medical directives for nursing to initiate consult)	EFORT- Emergency Facilitated Outreach Team – Joseph Brant Hospital Social Worker Mental Health Navigator – Muskoka Algonquin Healthcare ED Mobility Team – Health Sciences North Geriatric Emergency Management Nurse Practitioner Standard Work – Lakeridge Health Transition to Home – Lakeridge Health
	Theme 7: Leveraging Technology		
Intermediate	5.14	Implement an ED tracking board to monitor in real-time: • Number of patients in the department • Status of each patient (e.g., waiting to be seen, admitted, etc.) • Outstanding tests/orders to be completed • Number of patients awaiting reassessment • Number of patients awaiting discharge	Status Dashboard – Lakeridge Health

Category	#	Strategies	Tools
Advanced	5.15	Use technology that monitors, in real-time, flow through the ED and notifies staff of bottlenecks to flow	Hero AI - SickKids
		Theme 8: Using Standardized Policies, Processes and Procedures	
Universal	5.16	Develop an ED-specific surge policy that outlines the processes to efficiently manage and support patient care and safety and throughput in the ED • This is different than a hospital-wide surge policy in that all aspects of the policy are related to processes within the ED **(*2.1.12, 2.1.13)**	Emergency Department Surge Plan for Mental Health Patients – Humber River Health Emergency Internal Surge Guidelines – Lakeridge Health
	5.17	Establish a hospital-wide surge policy to be activated in the event of ED surge, overcrowding and/or gridlock, which includes: **(*2.1.4, 2.1.5, 2.1.6)** • Processes to initiate the escalation • Hospital personnel to be notified • Roles and responsibilities for key personnel • Communication pathways • Escalation triggers (e.g., ED occupancy projection, number of beds blocked by admissions and/or consults, ambulance offload, etc.) • Levels of escalation • Actions for each level of escalation (which may include notifying external partners such as local Ontario Health Teams) • Recovery from surge/overcrowding/gridlock	Escalation and Code Gridlock – London Health Sciences Centre Bed Management Surge Alert Guideline – Humber River Health Patient Flow Escalation Protocol - SickKids
	5.18	Reduce and/or streamline documentation practices to ensure ideal efficiency in the time it takes to complete clinical documentation and maximize time spent with patients	

Category	#	Strategies	Tools
Universal	5.19	Develop a process to alert providers of patients that have had all tests completed, results are available and are ready for reassessment (e.g., a flag on the patient's chart or within the EHR)	
	5.20	Use standard discharge checklists to streamline the discharge process	
	5.21	Ensure the team has a standard process to continuously reassess stable patients and reallocate space and staffing resources to maintain continuous flow through the department	Flexing Standards - SickKids
	5.22	Develop a policy and/or process in collaboration with paramedic services for interfacility transport of patients requiring urgent/emergent transportation to reduce the time patients spend waiting for transport and optimize the use of nursing staff who are required for escort in these processes **(*2.1.7, 2.1.8)**	
Intermediate	5.23	Develop processes where specific patient populations with a defined presentation are streamlined to specialist consultations within the hospital (e.g., patients presenting with early pregnancy complications)	Obstetrical Patient Triage and Assessment – Peterborough RHC ED Oncology Pathway – Peterborough RHC
	5.24	Develop a process to rapidly refer patients to a rapid access clinic and/or outpatient specialist consultation to reduce the amount of time waiting to see in-house specialists and avoid admissions for appropriate clinical presentations (43)	Ambulatory Care Referral Forms – North York General Hospital
	5.25	Establish partnerships with non-urgent transportation services to streamline the transport of patients who are returning home/community/long-term care etc. to reduce the time patients spend waiting for transport services	

For Admitted Patients, Time to Inpatient Bed and No Bed Admits

Daily Average Number of Patients Waiting for Inpatient Bed at 8am: 25% reduction from FY25/26 avg*

**For FY 27/28 as of June 2026*

ED LOS Admitted Patients: ≤ 33 hours*

**For FY 26/27 as of June 2026*

Often, after the decision is made to admit a patient to an inpatient bed, the patient remains in the ED until an inpatient bed becomes available. Unfortunately, patients can end up waiting for their inpatient bed for hours or even days. These patients endure long waits in the ED with limited privacy and inadvertently occupy stretchers that are often needed for acute ED patients (2). This results in a lack of physical space in the ED, less capacity for providers to care for incoming ED patients and, ultimately, diminishes the ability of the ED to provide emergency care (2).

Although there are many factors that contribute to long stays for admitted ED patients, the solution to these problems is often not within direct control the ED and requires collaboration across services within the hospital, the broader community and at the greater health care system level. Outlined below are strategies that require communication, teamwork and collaboration across the hospital to support the flow of admitted patients out of the ED.

Category	#	Strategies	Tools
	Theme 5: Optimizing Physical Space Design and Queuing Systems		
Intermediate	5.26	Implement transitional spaces and discharge lounges for patients that are discharged from inpatient units and awaiting transport to next destination (e.g., home), to increase availability of assessment spaces for new patients	
	5.27	Use short-stay units to transfer admitted patients to until a traditional inpatient bed becomes available	
	Theme 6: Enhancing Staffing, Resource Allocation and Models of Care		
Universal	5.28	Implement a hospital patient flow team that consists, at a minimum, of (15): • Team Leader (day-to-day lead) • Senior Hospital Leader • Technical leader or an expert in quality improvement • Physician(s) • Nurse(s)	

Category	#	Strategies	Tools
Universal		• Support Staff (e.g., clerks) • Coding and data experts The hospital patient flow team should have: • Defined roles and responsibilities of each member • Accountabilities related to hospital and ED flow • Standard work as it relates to monitoring and addressing hospital and ED flow	
	5.29	Designate a member of the ED team to be the point-of-contact with the hospital patient flow team to liaise with the team 24/7	
Intermediate	5.30	Implement dedicated portering services whose responsibility is transporting admitted patients in the ED to inpatient units	
	5.31	Implement dedicated facilities services whose responsibility is preparing inpatient rooms for the next admission	
	Theme 7: Leveraging Technology		
Universal	5.32	Develop a hospital-wide bed management dashboard to ensure constant awareness and up-to-date information of current and upcoming available beds within the hospital	
	Theme 8: Using Standardized Policies, Processes and Procedures		
Universal	5.33	Establish a process for hospital-wide bed meeting, which should: • Include the following members: - Hospital patient flow team - Senior-level leadership (e.g., VP, CEO) - Director-level leaders from each clinical program - Front-line leaders from ED and inpatient units (44) • Occur at least daily (16) and ad hoc • Use real-time data to support discussion and decision-making • Review current state in ED and inpatient units related to capacity and flow	

Category	#	Strategies	Tools
Universal		• Conclude with individual action items to address discharging of patients, bottlenecks to flow and volume surges (44)	
	5.34	Establish a patient flow standard operating procedure for the ED to ensure that bottlenecks are identified and flow through and out of the ED is being measured, monitored and escalated in real-time	
	5.35	Ensure clear pathways and processes for escalation are in place to address situations in which hospital and ED flow is impacted in the moment	Internal Flow and Triggers – Lakeridge Health
	5.36	Establish a clear and timely process where ED and/or admitting providers notify central bed management of a new admission in the ED (44)	
	5.37	Establish processes and standard work for the transfer of care (e.g., nurse-to-nurse report) and transport for patients from the ED to inpatient units **(*2.5.22)**	Patient Transfer from ED to Inpatient Unit Procedure – Humber River Health
	5.38	Develop service-related surge protocols (e.g., a specific surge protocol each for medicine admissions, surgical admissions, pediatric admissions, etc.) to address surge in defined areas of the hospital	Over-Capacity Protocol – Lakeridge Health
	5.39	Use screening tools (e.g., I-SAR) in the ED to identify patients at risk of prolonged hospitalization, functional decline, etc. for early intervention	ISAR Tool – Health Sciences North
Intermediate	5.40	Develop admission pathways for patients with selected diagnoses, whereby ED physicians can make the disposition decisions and admit the patient without the need for a consult service (29, 38)	
	5.41	Develop admission pathways, where patients can be admitted prior to completion of ED investigations and/or where admitting providers can complete patient consults on the inpatient units (29)	

Section 4. Medical Directives

Medical directives are orders written by physicians to other health care providers that may be implemented prior to the direct assessment of the patient for a number of patients when certain conditions and circumstances are met (45). Medical directives may authorize a health care provider (an implementer) to implement or activate the order and an additional health care provider (a co-implementer) to carry out the order. In the ED, medical directives are designed to be implemented by nursing or other non-physician staff to initiate certain treatments and diagnostic tests in advance of the physician assessment to expedite care, improve flow and enhance the patient experience through symptom management.

Medical directives are grounded in evidence and should reflect current best practices in emergency care. With that, a number of key partners must be involved in the development and subsequent implementation of medical directives. At a minimum, those involved should include:

- All the physicians whose patients would receive the treatment or testing outlined in the directive (e.g., ED physicians) (46)
- Representatives from those who would implement the directive (e.g., nursing staff) (46)
- Those with administrative responsibility for ED practice (e.g., Manager and/or Director of ED, Chief of ED) (46)
- Representatives from those who would be affected by the implementation of the medical directive (e.g., laboratory and diagnostic imaging staff) (46)
- Local corporate committees, as applicable (e.g., Professional Practice, Medical Advisory Committee, Pharmacy and Therapeutics) (46)

A medical directive must also contain a number of specific components, including (46):

- The authorizing prescriber(s)
- Provisions for consent
- Those to which the medical directive is authorized (i.e., the implementers and relevant co-implementers)
- The name and description of the procedure, treatment, drug or intervention that is being ordered
- The specific indications (i.e., clinical condition of the patient) and the circumstances that must be met for the directive to be implemented
- The specific contraindications for which the medical directive can not be implemented
- The names, dates and signatures of the authorizer prescriber(s) and those with administrative authority for approving the directive (e.g., Medical Advisory Committee)

Organizational policies should also be in place to outline and support the use of medical directives in the ED. These policies should include:

- The types of procedures that may be ordered through a medical directive (47)
- Identification of whom may implement a medical directive and any specific educational requirements, designations or competencies (47)
- Clearly stated documentation requirements for the health care professionals implementing the directive (47)
- Frequency of routine review and renewal of medical directives (46)
- Education and training requirements for those who will be implementing the medical directive, including documented signoffs and a process for continuous education (e.g., re-sign off every 2 years)

Medical directives, used in the correct context and setting, can be a vital tool in enhancing both patient experience and ED throughput. They can support earlier pain control and comfort care for patients, faster diagnostics and reduce ED LOS. When implemented with proper training, oversight and policies, medical directives can support safe, timely and patient-centred care.

While it is understood that every ED operates within unique workflows and staffing models and there are variations in how medical directives are implemented at the organizational level, through hospital ED interviews it was learned that there are a core set of medical directives that have proven to enhance the patient experience and improve ED flow. The following links will provide examples of both symptom-based medical directives and test-/procedure-based medical directives.

Please note that the medical directives below are examples that are kindly provided to Ontario Health by health service partners. These are intended to provide an overview of the standard information in a particular symptom- or test/procedure-based medical directive; the specific images below may not contain all the details necessary to constitute a fulsome medical directive. Click here to view the following medical directives: Medical Directive Examples.

Symptom-Based Medical Directives	Test- and Procedure-Based Medical Directives
• Chest Pain • Abdominal Pain • Sepsis (Adults) • Early Pregnancy Complications/Obstetrical Emergencies/Vaginal Bleeding • Extremity X-Rays • Inhalation Therapy (Adult and Pediatric) • Pain and Fever Management (Adult and Pediatric) • Oral Rehydration Therapy • Acutely Presenting Older Adult	• Laboratory Testing - Blood and Urine • Capillary Blood Glucose Testing • Electrocardiogram • Vascular Access • Oxygen Administration

Left Without Being Seen

In Ontario, the volume of patients leaving the ED without being seen (LWBS) by a physician remains a persistent challenge and is often considered to be an indicator of ED overcrowding (48) and long wait times (49). Patients who leave without being seen are at risk of becoming increasingly ill and may experience adverse outcomes due to delayed or missed treatments (50). In fact, between 2020 to 2022, for patients that initially left without being seen and then returned to the ED within 72 hours, 50% more visits were triaged higher (CTAS level 1 or 2) during the return visit, indicating that patients who leave without being seen are returning sicker and require more urgent care than if they were seen during their first visit (51).

Ideally, the strategies described in the Toolkit will drive ED flow and performance, reducing the impact of overcrowding on the ED, decrease wait times, and subsequently, reduce the rates of patients who leave without being seen. However, organizations must remain cognizant of the current state in the department with respect to patients who leave without being seen by utilizing data to track, benchmark and improve upon (accreditation standards). Additionally, organizations should have a policy in place to address situations in which a patient does leave without been seen by a physician. This is particularly important for patients that have received treatment, diagnostic/laboratory testing through medical directives as it is essential that these results, especially abnormal findings, are reviewed with the patient and addressed accordingly. Policies related to patients who leave without being seen should include:

- Language to support the staff to actively discourage patients from leaving without being seen
- Responsibilities of the physician on shift related to LWBS
- Guidance for notification of results to the patient (e.g., what warrants notification)
- Identify roles, responsibility and accountabilities for staff that may be involved (e.g., triage nurse) including:
    - Contacting the physician and providing the physician with test results
    - Participate in notifying the patient, as required
- Documentation requirements
- Additional personnel that may require notification of the event within the organization (e.g., ED Manager)

Section 5. Sustainability

Sustainability is often discussed at the end of a change initiative but is one of the most important considerations of any project or change (52). Sustainability is defined as "when new ways of working and improved outcomes become the norm," meaning the implemented change that ultimately led to improved performance is now embedded in the culture and workflow and no longer requires ongoing support to continue (52). Quality improvement experts believe that as difficult as improving outcomes is, sustaining improvements is even harder, and in fact, one of the most notable learnings from the Ontario ED Process Improvement Program (PIP) (2008 to 2012) was the inability of organizations to sustain any changes made after the "coach" assigned to the organization had left (5, 52).

Some reasons identified as challenges in sustainability are: "the waning enthusiasm or turnover of front-line providers as newer, more exciting projects are rolled out; the competing personal or professional interests of managers; the shifting priorities of leaders who support the project through their time and resources; and the tendency of [quality improvement] teams to declare victory too soon that leads to a shift in focus away from an improvement that may not have been as stable and ingrained as was thought" (52).

Methods for Increasing Sustainability	Tools and Resources	
Ensure the change is ready to be sustained: • Evaluations demonstrate improved performance that has been maintained for a reasonable period of time • The change has been tested with various combinations of staff, at different times and in different locations (if applicable) • There is infrastructure in place to support the change in the long run; not in dedicated project resources, but rather in equipment, supplies and personnel • There is a mechanism in place to continue monitoring the performance **Ensure the change offers:** • A clear advantage when compared to previous work • Compatibility with the system and with providers values • Simple and easy steps	IHI Video and Sustainability white paper	https://www.ihi.org/resources/white-papers/sustaining-improvement
	IHI white paper - spread	https://www.ihi.org/resources/white-papers/framework-spread-local-improvements-system-wide-change
	NHS sustainability guide for leaders	https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/ILG-1.7-Sustainability-and-its-Relationship-with-Spread-and-Adoption.pdf
	IHI sustainability planning worksheet	https://www.ihi.org/resources/tools/sustainability-planning-worksheet#downloads

Methods for Increasing Sustainability	Tools and Resources	
• Demonstratable and observable positive impact on staff **Ensure the change can be practically and easily maintained by:** • Using visual management tools like a performance board • Creating standard work documents that are simple and easy to follow • Reviewing improvements at regular huddles	Ontario Health sustainability primer	https://quorum.hqontario.ca/Portals/0/QI-Tools-and-Resources/Implementing-and-Sustaining-Change-Guide.pdf
	Ontario Health sustainability tool	https://quorum.hqontario.ca/Portals/0/QI-Tools-and-Resources/Sustainability-Planner-Tool.pdf

Section 6. Specialized Populations

There are certain cohorts of the population that require special consideration, specifically in the context of ED patient flow. Some of these specialized populations include frail and older adults, paediatric patients and patients experiencing mental health and substance use disorders. Below are resources related to the flow of ED patients from these specialized populations, as certain considerations may be needed to ensure patient safety is prioritized and patient experience is considered. Specific clinical education as it relates to the populations below should be maintained by care providers, as determined by their professional bodies, which may lead to better outcomes.

Older Adults

The Alternate Level of Care (ALC) Leading Practices Guide: Preventing Hospitalization and Extended Stays for Older Adults. September 2021. ALC Leading Practices Guide v1 2021 (2).pdf

Ontario Health Operational Direction: Home First. August 14, 2024. Ontario Health Home First Operational Direction

Please see the appendix for a detailed crosswalk of the Leading Practices indicated in the Toolkit and those identified in the ALC Leading Practices Guide and Home First Operational Direction.

Tools and Resources	
Regional Geriatric Programs of Ontario	A Competency Framework for Interprofessional Comprehensive Geriatric Assessment
Health Sciences North	Clinical Frailty Scale
St. Joseph's Healthcare London	Self Reliance Indicator
North East Specialized Geriatric Centre	Geriatric Care Pathways
North East Specialised Geriatric Centre	Implementation Playbook
Lakeridge Health	Medical Directive: Acutely Presenting Older Adult
Lakeridge Health	ALC Quality Improvement Project

Paediatrics

(* 1.1.3, 2.3.2)

Official Journal of the American Academy of Pediatrics. **Best Practices for Improving Flow and Care of Pediatric Patients in the Emergency Department.** Best Practices for Improving Flow and Care of Pediatric Patients in the Emergency Department | Pediatrics | American Academy of Pediatrics

Case Example: Hamilton health Sciences, McMaster Children's Hospital - Role of the Child Life Specialist in Improving Flow in a Pediatric Emergency Department

Case Example: Hamilton Health Sciences, McMaster Children's Hospital - Pediatric Emergency Department Low Acuity Diversion - Rapid Assessment Service

Tools and Resources	
SickKids	Inpatient & Emergency Department Consultations – Medical and Dental
SickKids	Patient Flow Escalation Protocol
SickKids	Who can be flexed?
Children's Hospital of Eastern Ontario	Overnight Psychiatry Admissions Process
Children's Hospital of Eastern Ontario	Pathway for Mental Health Patients in the CHEO ED
Children's Hospital of Eastern Ontario	ED MH Model of Care

Mental Health and Addictions

(*1.1.2)

Canadian Mental Health Association: Addressing Emergency Department Wait Times and Enhancing Access to Community Mental Health and Addictions Services and Supports. https://ontario.cmha.ca/documents/addressing-emergency-department-wait-times-and-enhancing-access-to-community-mental-health-and-addictions-services-and-supports/

Tools and Resources	
Humber River Health	Surge Plan for Mental Health Patients
Humber River Health	Notifying Toronto Policy Dispatch regarding Mental Health capacity within the ED

Section 7. Case Examples

Thank you to our health system partners for providing the following case examples to illustrate successful initiatives from their organizations.

Hamilton Health Sciences, McMaster Children's Hospital - Role of the Child Life Specialist in Improving Flow in a Pediatric Emergency Department

Hospital
McMaster Children's Hospital is a tertiary care pediatric hospital, specializing in pediatric trauma and mental health, with an annual ED volume of approximately 50,000 patients.
Description
The role of the Child Life Specialist (CLS) in the pediatric emergency department (ED) traditionally revolves around emotional support for children and families. However, the initiative sought to expand this role by addressing patient flow management. The main benefit was reducing the wait time for patients by ensuring that available rooms in the ED were consistently filled as soon as possible, even during busy periods. By engaging Child Life Specialists in maintaining room availability, we aimed to avoid unnecessary delays in patient care and improve overall ED efficiency. This project aimed to address the efficiency and timeliness of patient care, as well as improving patient experience through management of the ED flow.
Introduction and context – what was the aim?
The rationale for this initiative was to improve ED flow and reduce waiting room times, especially during periods of high patient volume. One of the major challenges identified was that rooms often remained empty while patients waited in the ED waiting room. Nursing staff were often unavailable to immediately manage the flow of patients in and out of rooms due to other responsibilities. This led to inefficiency and prolonged wait times for incoming patients. Aims and Objectives: - Streamline patient flow by ensuring that rooms are filled promptly. - Move stable patients out of rooms to waiting spaces while awaiting results, enabling new patients to be assessed in available spaces. - Utilize the Child Life role to assist in maintaining room occupancy and ensuring rooms are filled as quickly as possible.
Method – what did you do?
Child Life Specialists were trained and given the responsibility to monitor available patient rooms and advocate for filling those rooms promptly. Child Life Specialists communicated with nursing and triage staff to coordinate the timing of room usage, making sure the ED was operating at full capacity.

Outcomes – what difference did you make?
While this role has been in place for several years, the main impact has been on improving ED staff visibility and providing a point of contact for families. The inclusion of Child Life Specialists in the room management process has helped maintain better flow in the ED, reducing unnecessary delays and improving overall patient care. P4R Metrics Rankings Dec 2024 changes from previous P4R year • Overall P4R ranking improved by 4 • Time to PIA improved by 11 • ED LOS Admitted improved by 5 • ED LOS non admit CTAS 1-3 improved by 6 • ED LOS non admit CTAS 4 &5 improved by 8 • Ambulance offload improved by 2
Key learnings
The key takeaway from this initiative is that Child Life Specialists can contribute significantly to operational flow, not only by offering emotional support but also by optimizing room management. What worked well: The collaboration between Child Life Specialists, nursing, and triage staff enabled smoother room transitions, enhancing overall efficiency. Subjective feedback from families through patient experience surveys about ED experience validate the benefit of the child life specialist role in supporting them and their child

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The Ottawa Hospital – Reducing Ambulance Offload to Improve Community Access to Emergency Services

Hospital
The Ottawa Hospital is a multi site quaternary academic hospital. We have an adult emergency department at two of our main sites, the Civic and General that see a combined annual volume of approx. 180,000 ED visits (250-275 daily per site and 60-80 ambulances daily per site). The Civic site is also the regional trauma center as well as the regional site for neurosurgery, vascular Surgery and stroke. The General site is the regional cancer center as well as the main site for nephrology, thoracis and ENT.
Description
The focus of our initiative was to reduce ambulance offload times to ensure there was adequate EMS coverage for our community. AOT is an identified area of focus from Ontario Health and aligns with P4R and our internal QI programs focus on improved access.
Introduction and context – what was the aim?
In summer 2024, both of our EDs were struggling with AOT times often >200mins and our EMS partners were facing regular level zero as a result. The primary objective was to reduce our AOT and return paramedics back to the community. At the same time, we were challenged with high volumes of boarded patients in our departments making it challenging to offload patients into the appropriate beds in the ED. Our goal was to reprioritize our ED beds for ED patients and shift our teams focus to caring for the ED patients in the appropriate spaces.
Method – what did you do?
We started the initiative by looking at our peers across the province, specifically at peers who had made recent sustained improvement in AOT. Once we had identified these peers, we reached out and arranged site visits to learn from their progress. We strategically selected members of our team at all levels to participate in the visits to ensure role specific knowledge translation and generate buy in across all levels and roles within our team. Following the site visits, we formed internal working groups that included members who participated in the site visits as well as unit change champions to develop an action plan for change implementation. Beyond the unit level working groups, there was discussion at the organizational level to ensure awareness and commitment beyond the ED to support the improvement initiatives. We then implemented process and physical space changes unique to both sites including - Creating unconventional space within the ED to move boarded patients out of ED beds - Reallocation of existing clinical resources to support horizontal waiting space for patients who could not be offloaded to the main waiting room (key was to maintain the same standard of care for both waiting areas) - Proactive flow initiatives to push admitted patients to inpatient units when a bed was known rather than ready

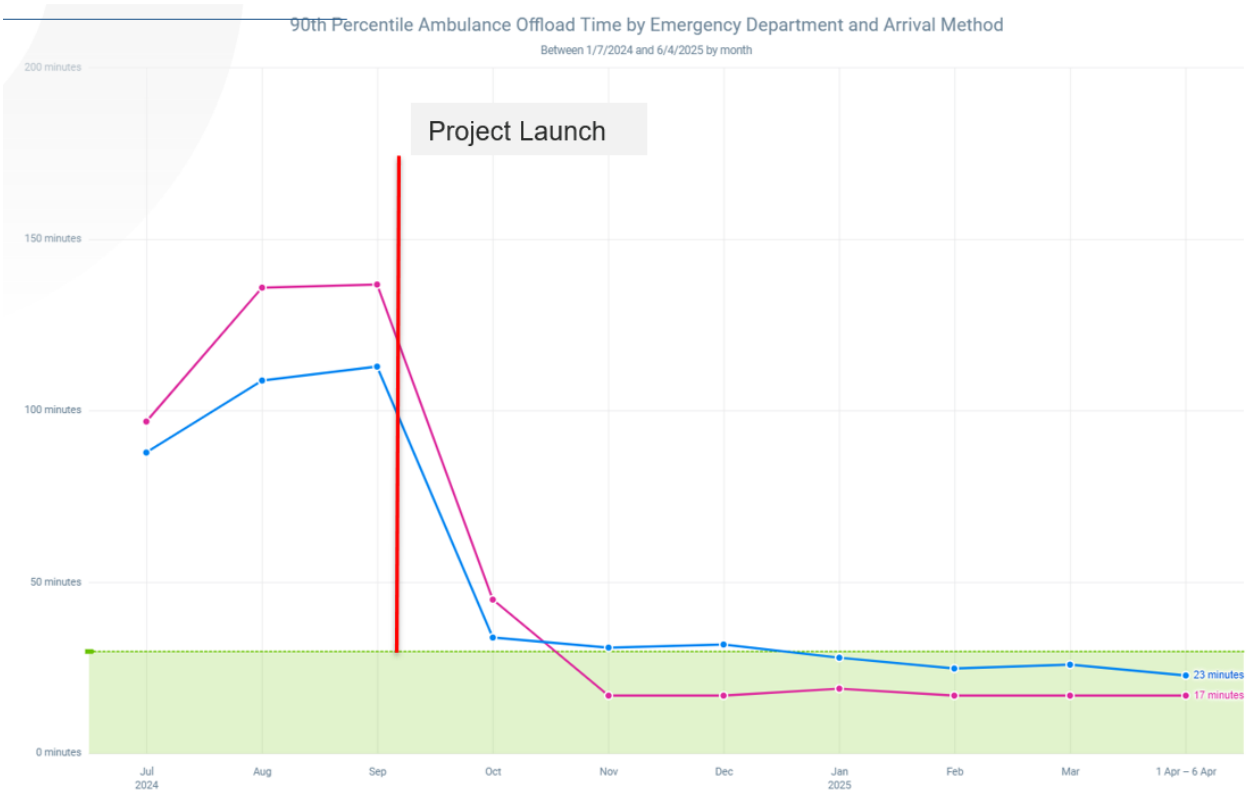
- Focused flow role to ensure patients who could be moved out of the care area to maintain internal ED capacity

Engagement with key stakeholders within the ED and the organization was key as well as continued communication with community partners (EMS, other Eds in the city).

We did not increase our resources in order to support these changes; they were accomplished through reallocation of our existing staffing and improved role clarity.

Outcomes – what difference did you make?

We have achieved a significant and sustained reduction in AOT at both sites since implementation in Oct 2024. Both campuses have sustained monthly AOT below 30mins (see visual)



Anecdotal feedback from EMS partners that level zero has significantly reduced and ability to respond in a timely way to all call categories has improved.

Key learnings

The key learning for us has been the importance of engagement from team members at all levels. Additionally, for these changes to be sustainable, there needs to be organizational engagement, and singular solutions within the ED in isolation will not sustain in the same way. Certainly, we faced barriers initially with building engagement outside of ED as on the surface ambulance offload can be perceived as an ED only challenge. Communication and education around the challenge beyond the ED was key to working through those barriers. Going forward, we are paying more

attention to early signal data on balancing measures to respond early to unintended downstream impacts. As far as advice, we would say early engagement with the whole team is key. Be clear on what the goal is and then allow the people who do the work every day to generate ideas and develop the change. Pay attention to the data and communicate the outcomes regularly.
Tools & Resources
Our most important tool was the relationships and communication with our peers across the province.

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Hamilton Health Sciences Juravinski Site – Triage Assessment Team to rapidly assess patients on ED presentation and initiate early tailored patient care

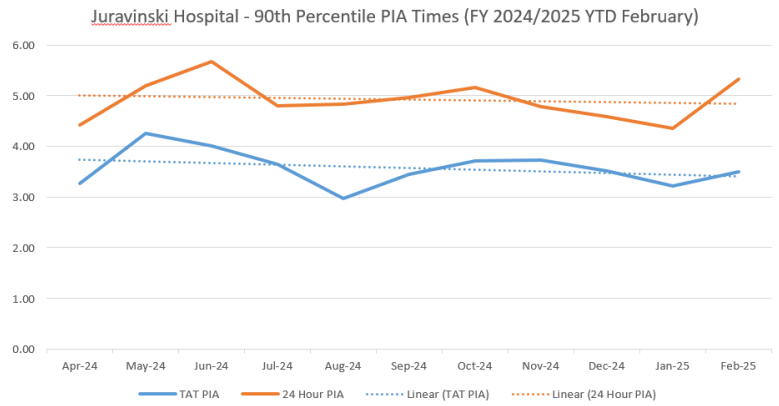
Hospital
Juravinski Hospital and Cancer Centre- Hamilton Health Sciences, is a 400-bed urban tertiary acute care hospital located within the city of Hamilton, with a population of 600,000 people. The hospital particularly specialises in cancer care, geriatric care and joint arthroplasty. Annual ED census is approx. 40,000 visits.
Description
A multidisciplinary team- termed the Triage Assessment Team (TAT), composed of Advanced Care Providers (Nurse Practitioner and Physician Assistants) and a Registered Nurse was formed to provide expedited patient initial assessments and care at the Juravinski Hospital Emergency Department. This aligned well with Ontario Health related priorities of reducing Provider Initial Assessment (PIA) time, reducing Left Without Being Seen (LWBS) rates and improving overall patient safety.
Introduction and context – what was the aim?
Prolonged patient wait times result in increased morbidity and even mortality. Nursing medical directives are one strategy to initiate early investigations for ED patients but generally have strict criteria on included patients. These also generally exclude advanced investigations such as advanced imaging, and various therapies. As a result, patients presenting to the ED would often have to wait for a physician to assess them to enact patient tailored investigations and therapies. As such, in a vast proportion of ED visits, care was generally not tailored to their individual injury/illness until seen by the ED physician, resulting in unaddressed symptom and illness management for prolonged periods, and further prolonged ED length of stay as that care and investigations were being completed. An opportunity existed in the period between patient arrival and ED physician assessment which could be better utilised to better address symptoms, treat illness and initiate advanced investigations.
Method – what did you do?
The TAT team provided early assessment and treatment for patients soon after triage and registration for all patient arrivals (ambulatory and ambulance arrivals). Patients were assessed and patient tailored investigation and therapy was initiated. The patient would then wait (waiting room or ambulance offload area) until their assessment by the ER physician. During much of this waiting time, labs would have been resulted and even advanced imaging performed and resulted. Further, therapy started early would have taken effect e.g. analgesia, antipyretics, iv fluids. On ED physician assessment, most tests would be available for disposition decisions. Occasionally, a second round of investigations would be ordered by the ER physician. Some key resources include:

1. Clinical space: One ED stretcher was utilized for patient assessments from the front waiting room. Occasionally, a second assessment space was used in the ambulatory zone if ambulatory volume was high.
2. Equipment: 2 workstations were required for Provider and RN at the front assessment area.

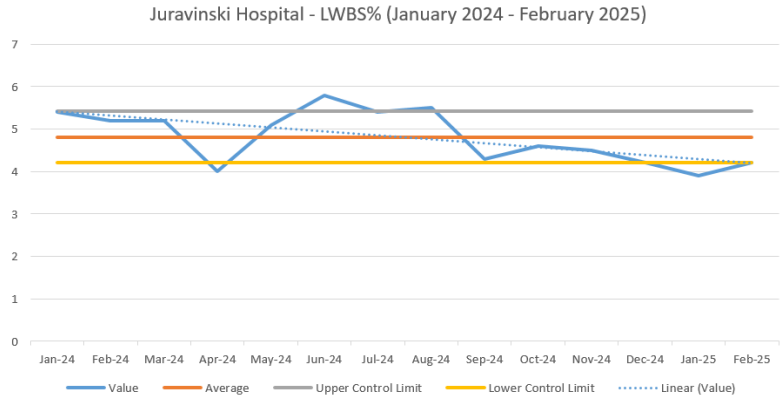
Outcomes – what difference did you make?

1. Patient tailored care was expedited, as the Provider in the TAT team could initiate investigations and therapy not included in nursing medical directives, such as iv fluids, advanced imaging. Patient feedback has been very positive on early assessment.
2. PIA times during the hours of coverage of TAT were significantly lowered compared to outside TAT hours (3.5 hrs vs 4.8 hrs, Sept 2024 – Feb 2025).
3. LWBS rates have fallen to 4.7% (compared to 7.3% prior to TAT coverage).

Juravinski Hospital – 90th Percentile PIA



Juravinski Hospital – Left Without Being Seen Rate (LWBS%)



Key learnings
Significant impact on patient flow during TAT hours. Pt investigations often completed by the time of ER physician assessment facilitating patient disposition: discharge or referral. Slight improvement in ED LOS for non-admitted patients, but not significant. This is likely due to continued patient waits for ED physician assessment and disposition, and for the completion of advanced investigations/imaging. TAT team hours of coverage limited to Monday to Friday 8am to 10pm due to staffing and funding. Clear evidence of PIA times quickly rising when TAT team hours of coverage end. Ideal coverage would be longer hours of coverage to midnight to catch up with the evening influx of patients. Clinical space for TAT team sometimes a challenge when ED gridlocked. Agreement from ED leadership and Charge RN to designate protected TAT assessment space. Entire ED team engagement important as flow changes affect all aspects of the ED. Patient education important as to the role of the TAT team. Patients may assume their assessment is complete but understanding that an ED physician assessment is needed to ensure thoroughness/second assessment.

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Hamilton Health Sciences, McMaster Children's Hospital - Pediatric Emergency Department Low Acuity Diversion - Rapid Assessment Service

Hospital
Tertiary care pediatric hospital, pediatric trauma and mental health centre, with our pediatric ED seeing approx. 50,000 patients annually.
Description
Rapid Assessment Service is an ED initiative where low-acuity patients are seen outside of the ED footprint in an afterhours clinic space, to maintain department capacity to treat high acuity patients, decrease waiting room volumes, improve PIA time and patient experience. It provides more privacy and confidentiality in comparison to hallway medicine, and improves ED flow.
Introduction and context – what was the aim?
Volumes of ANB patients impacting patient flow, leading to large volumes of waiting room patients in the evenings, inability to perform follow-up assessments, repeat VS etc. Long wait times meant CTAS 2 and 3s were waiting extended periods of time, sometimes decompensating in the waiting room. Higher LWBS rates during high volume and long wait times, leading to ED return visits with CTAS 1 on return, or requiring PICU, OR, or resulting in a sentinel diagnosis. Objective: Improve PIA time, ED LOS, decrease LWBS rate, decrease number of concerning return visits by redirecting low acuity volume to a space outside of the ED.
Method – what did you do?
Developed a diversion strategy to address high-volume hours in the Pediatric Emergency Department including: - Identified clinic space with 5 rooms that could be utilized after-hours and on weekends to see patients - Staffing model with an ED Physician, ED RPN, and ED Child Life Specialist or Clinical Extern, and Environmental Aide (room cleaning). - Additional bed spaces created in Epic for patient tracking - Process map for flow of ED patients including criteria of appropriate patients, hours of operation, patient flow, and roles and responsibilities - Equipment and supply availability addressed using pharmacy medication carts, supply carts, and existing IT supports in clinic space - Emergency processes outlined for escalation of care needs
Outcomes – what difference did you make?
<u>Dec 2024 P4R Ranking</u> 1. ED LOS Non-admitted CTAS 4&5 rank improved by 8 points from previous P4R Year 2. Time to PIA rank improved by 11 points from previous P4R Year
Key learnings

Learning points:

Model is most efficient when a dedicated physician is available

Worked well: use of rooms outside of ED footprint but in close proximity, multidisciplinary staffing model, more privacy for patients in comparison to hallway beds

Barriers: Emergency equipment (i.e. oxygen, suction, monitors, code blue bells) not available in clinic spaces, filling physician shifts can be a challenge during winter months

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Lakeridge Health – Using a systems approach to improve PIA and AOT

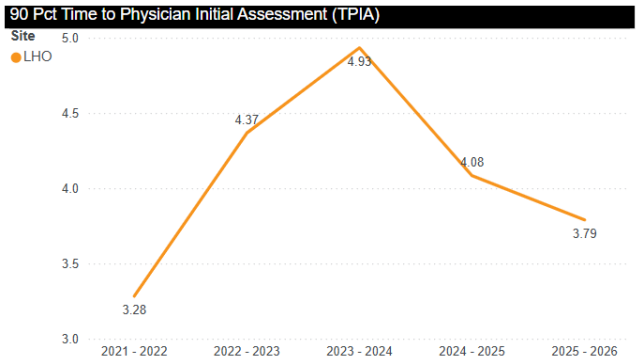
Hospital
Lakeridge Health offers some of the broadest and most comprehensive acute care, ambulatory care and long-term care services in Ontario, with four emergency departments. In 2024/25, the EDs saw a combined total of 209654 visits with Oshawa being a very-high volume site, Ajax-Pickering a high-volume site and Bowmanville a medium volume site.
Description
The focus of the initiative was to improve the flow of patients through the Lakeridge Health Oshawa ED. This multi-phased project aligns with the goal of improving site performance and Pay-for-Results ranking as well as improving staff retention, patient and family experience and patient safety.
Introduction and context – what was the aim?
The driving forces for this work included patient complaints, critical patient safety events, increasing ED visit volumes with concurrent Durham region population growth, increasing patient acuity and complexity and increasing no bed admit pressures. Staff also unsatisfied with workload and no standard work established. The work aimed to look at the current process to identify opportunities to improve efficiency, safety and effectiveness. The projects aimed to improved PIA, AOT and ED LOS.
Method – what did you do?
Oshawa's continuous improvement journey

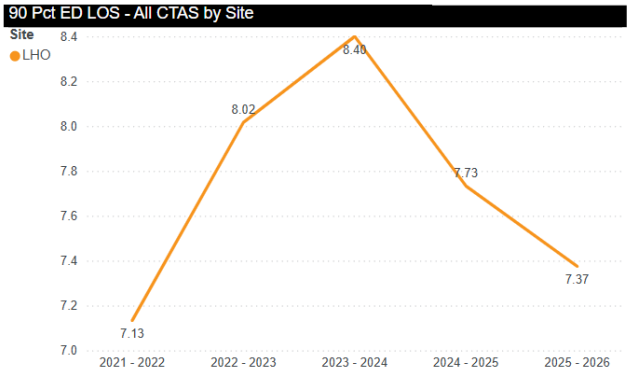
Date	*Initiative*	*Activities/Stakeholders/Resources*
Feb 2023	*Flow optimization Kaizen*	*Gathered leaders and front-line team members to identify current barriers and future opportunities. Recommendations included 1) segmentation of lower acuity patients, 2) developing standard work and staffing to support quick assessment/treatment/discharge and 3) creating "surge" care locations*
Apr 2023	*Fit2Sit*	*Partnership with EMS to implement fit2sit criteria*
Dec 2023	*Supertrack implementation*	*Initiative coming out of the Kaizen in Feb requiring re-design of physical space, workflow and staffing.*
Apr 2024	*Additional physician assistant shifts*	*Reviewing AOT weekly heat map, identifying opportunities to support PIA and ED LOS.*
Jun 2024	*Zone 5 Kaizen*	*Gathered leaders and front-line team members to identify current barriers and future opportunities.*
Sep 2024	*Community provider partnerships to*	*Developing relationships with Lighthouse and CCD to offer additional, more robust services in addition to Ontario Health*

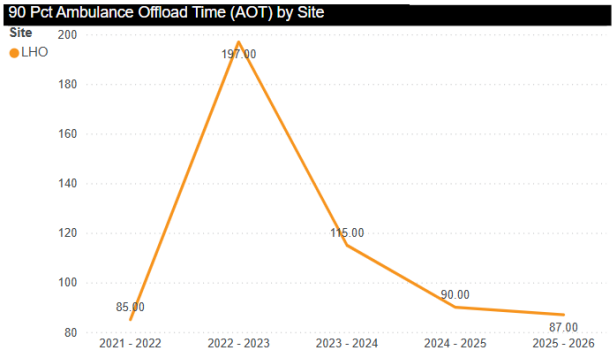
		avoid admissions and support discharges from ED	*atHome services to patients to avoid an admission and support discharge directly from ED.*
	Nov 2024	*Deployment of Corporate Overcapacity Protocol*	*Involved all programs with inpatient units, with emphasis on Medicine as those patients contribute to the highest number of no bed admits. This protocol established specific triggers to activate the pull of patients into unconventional spaces on inpatient units.*
	Dec 2024	*Internal ED surge plan implementation* *Daily Management System huddles* *Additional MD and nursing shift*	*The internal surge plan provides an additional layer of measures when no bed admit pressures are high to surge patients into additional unconventional care locations.* *The Daily Management System provides a touchpoint between leaders and team members to reflect on the previous day, identify current barriers and constraints to plan for the current day and support continuous improvement.* *The additional shift need was identified through review of the PIA heat map, supporting a need for an evening shift.*

Outcomes – what difference did you make?

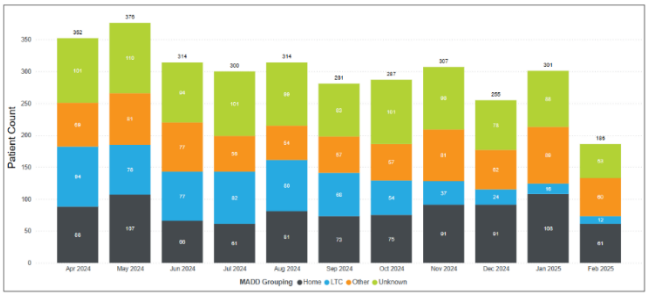
See below the outcome of specific KPIs.
% Left Without Being Seen has improved steadily year over year.
Staff engagement has increased with improvements to workflow and participating in the change.



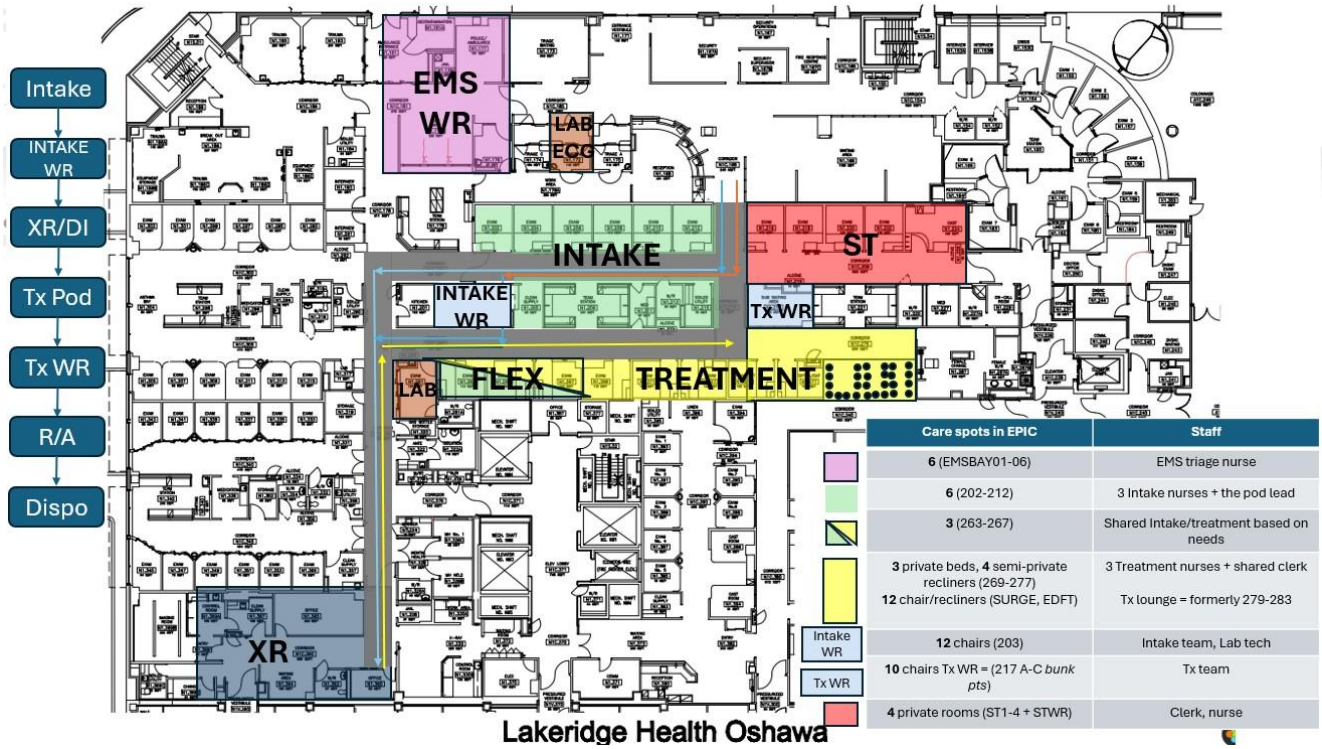




Outcome of ALC initiative



LHO ED Physical Changes



Care spots in EPIC	Staff
6 (EMSBAY01-06)	EMS triage nurse
6 (202-212)	3 Intake nurses + the pod lead
3 (263-267)	Shared Intake/treatment based on needs
3 private beds, **4** semi-private recliners (269-277) **12** chair/recliners (SURGE, EDFT)	3 Treatment nurses + shared clerk Tx lounge = formerly 279-283
12 chairs (203)	Intake team, Lab tech
10 chairs Tx WR = (217 A-C *bunk pts*)	Tx team
4 private rooms (ST1-4 + STWR)	Clerk, nurse

Key learnings

Optimizing and addressing issues within the ED span of control is key to improving performance in the context of system constraints

Increasing PIA is a symptom of a system problem – Kaizens can help to support rapid improvement. It is essential a Kaizen is led by front-line staff and facilitated by content experts

Listen to your front-line staff, they already have the answers, help implement their solutions

Strong executive sponsorship and leadership is important to focus the work and remove barriers. There needs to be strategies to improve hospital throughput, only focusing on ED is limiting.

Looking at the big picture is key, corporate access and flow directly impact ED metrics. Therefore, there needs to be shared accountability when ED is not able to meet their targets, it should not only fall on the ED (this is a culture shift)

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Appendix

Hospital Interview Participants

Brightshores Health System
Children's Hospital of Eastern Ontario (CHEO)
Erie Shores HealthCare
Hamilton Heath Sciences
Health Sciences North
Humber River Hospital
Joseph Brant Hospital
Lake of the Woods District Hospital
Lakeridge Health
London Health Sciences
Mackenzie Health
Michael Garron Hospital
Muskoka Algonquin Healthcare
North Bay Regional Health Centre
North York General Hospital
Oak Valley Health
The Ottawa Hospital
Peterborough Regional Health Centre
Ross Memorial Hospital
Royal Victoria Regional Health Centre
The Hospital for Sick Children (SickKids)
Sinai Health
Stevenson Memorial Hospital
Thunder Bay Health Science Centre
University Health Network

Contact Us

Please contact us at EmergencyServices@ontariohealth.ca if you:

- ❑ would like to suggest an update to the content in the current version of the Toolkit
- ❑ have an update to make to your contact information
- ❑ would like to submit content for consideration in the next version of the Toolkit

If you would like to submit a case study for consideration in the next version of the Toolkit, please email: EmergencyServices@ontariohealth.ca

ALC and Home First Crosswalk

sf = Senior Friendly Care

ED Leading Practices Toolkit		ALC Leading Practices		Home First OD	
		A. Leading Practices across the organization	B. Leading Practices in the ED	A. Direction for Acute Care Hospitals	Components for Implementation
1. Foundational Leading Practices across the Organization	**THEME 1. Organizational Culture and Leadership** Ensuring all levels of leadership, especially the CEO, prioritize and visibly support quality improvement and patient flow is necessary to garner hospital-wide support (5). Accountability frameworks that clearly identify shared roles, responsibilities and expectations across the organization, 24 hours a day, 7 days a week, through to the bedside level, ensures performance results do not lie solely within the ED (1). Although this Toolkit focuses on ED patient flow, improvement and sustainable change can only be achieved through an organizational-wide understanding of the importance of patient flow. True cultural transformation is difficult and needs to encompass a significant portion of the organization, not just the ED, to see significant results (5). Resourcing onsite support, with the advanced skill and necessary experience to lead change within an organization, to build a culture of accountability	1.A member of the Senior Leadership team (such as a vice president) is designated as accountable for sfCare (8). sf			1. Governance and Accountability: a. All organizations to designate an executive lead to oversee and drive implementation of the Home First operational direction. b. Hospitals to identify an engaged physician champion to support implementation, messaging, and monitoring of Home First. c. Designate an implementation team – ideally, an interdisciplinary team (which should include clinical leaders with geriatric expertise, quality improvement staff and individuals focusing on transitions and flow as part of their core portfolios) would take the lead in championing the operational direction by working across the organization.
		2.Commitments to sfCare are included in the organization's strategic plan, operating plan, and/or corporate goals and objectives (11,37). sf			
		9. Training is provided to hospital staff and physicians to ensure clarity about: a. How early transition planning is incorporated into the admission process and monitored (9); b. when to recommend an ALC designation (9).			2. Implementation Structures and Supports: b. Consider the inclusion of Home First in the organizational strategic plan, operating plan, corporate goals/objectives, and/or Quality Improvement Plan (QIP). c. Implement a comprehensive internal communication and education plan (both broad and targeted) to ensure staff

ED Leading Practices Toolkit	ALC Leading Practices		Home First OD	
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and continuous improvement culture, should be a priority (5,6).				understanding of the Home First approach and rationale, including: i. At onset of launch. ii. During new staff (incl. physicians for hospitals) on-boarding, hospitals to consider utilizing the Medical Advisory Committee (MAC), or similar structure for physician engagement, education and reinforcement. iii. Annual refresher training. d. Provide educational tools/resources to staff (incl. physicians), and patients/families outlining the Home First approach, including but not limited to, Home First Launch event, scripts (terminology, consistent messaging), print material (i.e., pamphlets, booklets, newsletters, fact sheets, frequently asked questions, etc.), screen savers, posters (including in the ED), webinars, and information and resources on organizational website.
THEME 2. Building a High-Performing Culture in ED Fostering a cohesive and high-performing culture in the ED is essential for timely, safe and effective patient care (11). In the ED, operational efficiency and clinical excellence are linked to the culture	1.A member of the Senior Leadership team (such as a vice president) is designated as accountable for sfCare (8). Sf 2.Commitments to sfCare are included in the organization's strategic plan, operating plan, and/or corporate goals and objectives (11,37). Sf			1. Governance and Accountability: a. All organizations to designate an executive lead to oversee and drive implementation of the Home First operational direction. b. Hospitals to identify an engaged physician champion to support implementation, messaging, and monitoring of Home First.

ED Leading Practices Toolkit		ALC Leading Practices		Home First OD	
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	cultivated among the interdisciplinary team. When all members of the ED team, physicians, nurses, allied health, and administrative and support services share a sense of responsibility for patient flow and ED performance, the ED will function as a coordinated system focused on performance and quality improvement. Healthcare providers are often inherently motivated to provide meaningful and impactful care and want to feel confident that their efforts contribute to good outcomes for their patients. Creating an	5. Functional decline and delirium are recognized as preventable harms and risk to the safety of older adults (8). sf 8. A training plan is in place for all staff, physicians, and volunteers so that they are proficient in the provision of sfCare, including (8,11,14,37): a. Seniors' sensitivity - i.e., communication, general awareness on aging and the special needs of older adults with frailty, and recognizing and addressing ageism; sf b. Delirium prevention and management* sf; and c. Mobilization* sf			c. Designate an implementation team – ideally, an interdisciplinary team (which should include clinical leaders with geriatric expertise, quality improvement staff and individuals focusing on transitions and flow as part of their core portfolios) would take the lead in championing the operational direction by working across the organization.

ED Leading Practices Toolkit		ALC Leading Practices		Home First OD	
		A. Leading Practices across the organization	B. Leading Practices in the ED	A. Direction for Acute Care Hospitals	Components for Implementation
	environment in which staff can perform to the best of their ability and experience less moral distress will create satisfied providers which are crucial to operating an effective ED (11). Establishing a high-performing ED culture is a shared responsibility of the organization, however ED leadership can be especially impactful in building the ED culture in such a way that ED performance and flow is at the forefront for front-line providers.	9. Training is provided to hospital staff and physicians to ensure clarity about: a. How early transition planning is incorporated into the admission process and monitored (9); b. when to recommend an ALC designation (9).			2. Implementation Structures and Supports: b. Consider the inclusion of Home First in the organizational strategic plan, operating plan, corporate goals/objectives, and/or Quality Improvement Plan (QIP). c. Implement a comprehensive internal communication and education plan (both broad and targeted) to ensure staff understanding of the Home First approach and rationale, including: i. At onset of launch. ii. During new staff (incl. physicians for hospitals) on-boarding, hospitals to consider utilizing the Medical Advisory Committee (MAC), or similar structure for physician engagement, education and reinforcement. iii. Annual refresher training. d. Provide educational tools/resources to staff (incl. physicians), and patients/families outlining the Home First approach, including but not limited to, Home First Launch event, scripts (terminology, consistent messaging), print material (i.e., pamphlets, booklets, newsletters, fact sheets, frequently asked questions, etc.), screen savers, posters (including in the ED), webinars, and information and resources on organizational website.

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THEME 3. Data-Driven Decision-Making To design a solution, the problem must first be understood. In the case of improving ED performance metrics, an assessment of current data is the first step to finding a solution. Monitoring emergency department performance is crucial to ensure standards in patient safety and quality are upheld, designing optimal resource management, understanding systemic issues and planning for improvement. Shared ED performance data helps "to ground conversations about the hospital's performance in facts and helps to avoid speculation regarding the magnitude and causes of problems" (5) allowing the organization to focus on solutions aligned with the context in which the issue is occurring (6). Data can also be used to demonstrate that ED crowding is not just an ED problem, but one that requires hospital-wide solutions (14).	4. A set of ALC-related process and outcome measures are collected, monitored and regularly reviewed by senior leaders, managers, physicians and staff.* sf 17. A system is in place to measure the experience and outcomes of older adults and their designated caregivers /SDMs and make improvements based on the results (9,11,37). Sf			1. Governance and Accountability: d. Outline an evaluation framework in partnership with your Ontario Health region. - Develop and implement a process for monitoring and measuring Home First in your organization, in alignment with the provincial performance monitoring framework (in development). e. Embed the Home First approach, measurement and monitoring in organizational committees (e.g., division meetings, steering committees, staff meetings, etc.).

ED Leading Practices Toolkit	ALC Leading Practices		Home First OD	
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THEME 4. Continuous Quality Improvement Fostering a culture of continuous quality improvement is crucial for evaluating and improving emergency department flow and performance. The importance of a common framework for improvement and a shared approach to training, with specific training materials across all departments, is an important part of building quality improvement at all levels of the organization [l]. Our Integrated Quality Framework is designed to support the Ontario health care system in improving performance as it relates to the 6 domains of quality [m]. EDs are encouraged to develop their own quality frameworks that outline data and evidence driven strategic objectives to improve performance (16).				1. Governance and Accountability: a. All organizations to designate an executive lead to oversee and drive implementation of the Home First operational direction. b. Hospitals to identify an engaged physician champion to support implementation, messaging, and monitoring of Home First. c. Designate an implementation team – ideally, an interdisciplinary team (which should include clinical leaders with geriatric expertise, quality improvement staff and individuals focusing on transitions and flow as part of their core portfolios) would take the lead in championing the operational direction by working across the organization.

ED Leading Practices Toolkit		ALC Leading Practices		Home First OD	
		A. Leading Practices across the organization	B. Leading Practices in the ED	A. Direction for Acute Care Hospitals	Components for Implementation
2. Functional Leading Practices to Improve ED Patient Flow	**THEME 5. Optimizing Physical Space Design and Queuing Processes** The physical infrastructure of EDs across Ontario varies widely, but the importance of optimizing space design remains imperative for several reasons, including workflow efficiency, enhanced patient and staff safety and security, patient privacy and experience, staff satisfaction and retention and optimal patient flow. Queuing theory can optimize triage by determining the ideal number of nurses and beds to manage patient flow and reduce wait times. By analyzing patient arrival rates and service times, one can establish optimal staffing levels and allocate resources effectively for EDs, as well as support processes such as diagnostic imaging, labs, and consultative services.	6. The structures, spaces, equipment, and furnishings provide an environment that minimizes the vulnerabilities of older adults and promotes safety, comfort, functional independence and well-being (37). sf	8. Where appropriate, a clinical decision unit/short stay unit has been considered to support the development of a more comprehensive plan for their transition to the next best level of care or place for care. A protocol is developed and in-place (e.g. pre-printed order set) (24,43).		

ED Leading Practices Toolkit	ALC Leading Practices		Home First OD	
	A. Leading Practices across the organization	**B. Leading Practices in the ED**	**A. Direction for Acute Care Hospitals**	**Components for Implementation**
THEME 6. Enhanced Staffing, Resource Allocation and Models of Care The ability to implement dynamic staffing structures and innovative models of care offers an increase in an organization's agility to redistribute resources when needed. With continued health human resource (HHR) constraints and an increasingly complex population seeking care in emergency departments, the need to be flexible is paramount.	7. Clinicians who specialize in geriatric care are available 7 days a week to support a comprehensive assessment and care of older adults (38). Sf	2. An interprofessional team who has skills and expertise in the assessment and management of older adults with frailty is available to support assessment and care of the older adult including (45):* sf a. Geriatric Emergency Management Nurse (GEM); b. Social Worker; c. Home and Community Care case manager; d. Physiotherapist, Occupational Therapist, Pharmacist, Behavioural Support clinicians, and other health professionals as needed; and e. Consultation with geriatric physician specialists (geriatric medicine, geriatric psychiatry, Care of the Elderly) as indicated.	2. Patients are assessed by an inter-professional team to inform admission decisions and identify appropriate community services for patients not requiring an acute care admission. Work to ensure after hour/weekend coverage. Admissions should be considered only after all community resources to ensure a safe return home have been exhausted. For patients in the ED that are already enrolled in a Hospital to Home (H2H) program, or clients that are already receiving home care from Ontario Health atHome, connect with the appropriate care coordinator (i.e., H2H coordinator or Ontario Health atHome care coordinator) to confirm additional supports can be arranged to support the patient to return home.	

ED Leading Practices Toolkit	ALC Leading Practices		Home First OD	
	A. Leading Practices across the organization	B. Leading Practices in the ED	A. Direction for Acute Care Hospitals	Components for Implementation
	8. A training plan is in place for all staff, physicians, and volunteers so that they are proficient in the provision of sfCare, including (8,11,14,37): a. Seniors' sensitivity - i.e., communication, general awareness on aging and the special needs of older adults with frailty, and recognizing and addressing ageism; sf b. Delirium prevention and management* sf; and c. Mobilization* sf	3. A comprehensive assessment is initiated, which accounts for physical, cognitive, functional, and psychosocial domains, and includes:(45,46).* sf a. A collateral history from a designated caregiver / SDM, or primary care provider (47). b. Identification of baseline functional status (e.g. two weeks prior to illness onset). This is essential to determining the nature of the presenting complaint c. Identification of goals of care, outstanding care needs, and what matters most to the older adult and designated caregiver / SDM (e.g., what are they most concerned about in the short term and long-term?) (14,48,49).		
		4. A plan of care is developed by all members of the care team with the older adult and their designated caregiver / SDM and relevant community partners to address care needs with a focus on transition to the pre-admission destination (11,22,48).* **sf**		
		5. Frequent re-assessment of an older adult's status is an essential part of the care process so that changes and resulting support needs are identified as early as possible,		

ED Leading Practices Toolkit	ALC Leading Practices		Home First OD	
	A. Leading Practices across the organization	B. Leading Practices in the ED	A. Direction for Acute Care Hospitals	Components for Implementation
		and the care plan and goals of care are adjusted accordingly (23). Sf		
		6. A senior friendly care approach is implemented and includes: a. Processes for screening, prevention, management, and monitoring of functional decline (8). * sf b. Processes for screening, prevention, management, and monitoring of delirium (37,44). * sf		
		8. Where appropriate, a clinical decision unit/short stay unit has been considered to support the development of a more comprehensive plan for their transition to the next best level of care or place for care. A protocol is developed and in-place (e.g. pre-printed order set) (24,43).		
THEME 7. Leveraging Technology Technology has been vital to providing safe and effective emergency care for the past several decades. Using technology is increasingly important when implementing change for the		1. A screening process/tool is used for early identification of "at risk" older adults presenting to the ED, regardless of presenting issue and inclusive of social factors, (24,43,44). The risk screen should tie directly into the comprehensive assessment (45).* sf		

ED Leading Practices Toolkit	ALC Leading Practices		Home First OD	
	A. Leading Practices across the organization	B. Leading Practices in the ED	A. Direction for Acute Care Hospitals	Components for Implementation
improvement of patient flow. From the simple streamlining of administrative tasks to up and coming artificial intelligence (AI), integrating technological advances can help address challenges like overcrowding and long wait times and enhance provider and patient experience. The benefits of implementing new technology should be balanced with the need to invest appropriate in robust implementation strategies, training and customization to ensure optimum productivity.		7. Transition protocols are in place that facilitate the timely communication of clinically relevant information to the older adult and their designated caregiver / SDM and primary care providers, including long term care homes (43). **sf**		
THEME 8. Using Standardized Policies, Processes and Procedures Standardization is a cornerstone of providing high quality patient care. Standardizing procedures reduces variability while improving patient outcomes by minimizing errors and increasing efficiency. Having well established hospital and ED processes allows for the identification of bottlenecks and potential areas for advancement,	11. Formal partnerships are in place with care delivery partners to support smooth and timely transitions from the ED, acute and post-acute care (e.g., pre-arrangements negotiated through Memoranda of Understanding and/or Purchase of Service Agreements) (10).* sf	1. A screening process/tool is used for early identification of "at risk" older adults presenting to the ED, regardless of presenting issue and inclusive of social factors, (24,43,44). The risk screen should tie directly into the comprehensive assessment (45).* sf	1. All older adults (i.e., 65 years or older) in the emergency department (ED) are screened for early identification of "at-risk" adverse outcomes and ALC designation, and a follow-up plan is developed as needed. Tools such as The Identification of Seniors at Risk (ISAR), Blaylock, Clinical Frailty Score (CFS), etc. can be leveraged. Compliance with the use of screening tools is audited quarterly by the ED management team and/or patient experience/quality team.	2. Implementation Structures and Supports: a. Conduct organizational assessment against operational direction and set priorities and develop an action plan to address gaps moving forward for ongoing implementation, monitoring and assessment. b. Consider the inclusion of Home First in the organizational strategic plan, operating plan, corporate goals/objectives, and/or Quality Improvement Plans

ED Leading Practices Toolkit		ALC Leading Practices		Home First OD	
		A. Leading Practices across the organization	B. Leading Practices in the ED	A. Direction for Acute Care Hospitals	Components for Implementation
	enabling continuous quality improvement. Clear processes and communication can also increase patient satisfaction and decrease complaints by setting clear expectations about an emergency department visit [q]. Standard policies and procedures also provide a basis for performance measurement and accountability.	12. Policies and procedures are in place to ensure ongoing reassessment occurs over the course of an older adult's admission. This includes intensive assessment of older adults who are long-stay ALC (22).	7. Transition protocols are in place that facilitate the timely communication of clinically relevant information to the older adult and their designated caregiver / SDM and primary care providers, including long term care homes (43). **sf**		c. Implement a comprehensive internal communication and education plan (both broad and targeted) to ensure staff understanding of the Home First approach and rationale, including: At onset of launch. During new staff (incl. physicians for hospitals) on-boarding, hospitals to consider utilizing the Medical Advisory Committee (MAC), or similar structure for physician engagement, education and reinforcement. Annual refresher training. d. Provide educational tools/resources to staff (incl. physicians), and patients/families outlining the Home First approach, including but not limited to, Home First Launch event, scripts (terminology, consistent messaging), print material (i.e., pamphlets, booklets, newsletters, fact sheets, frequently asked questions, etc.), screen savers, posters (including in the ED), webinars, and information and resources on organizational website. e. Ensure guiding documents (e.g., policies, standards, procedures, guidelines, care pathways, etc.) reflect the Home First approach.
		13. An escalation process is in place which provides clear direction about when and how to engage leadership in discussions around challenging barriers to transition for older adults at risk of an avoidable admission or potential ALC designation. (9). This includes non-punitive audit and feedback as part of an overall performance and quality improvement evaluation.	9. In partnership with the older adult and their designated caregiver / SDM, the medication reconciliation process is initiated for older adults with a decision to admit, and can be completed on the receiving unit (18).* **sf**		
		14. A process is in place to ensure that the older adult and their designated caregiver / Substitute Decision Maker (SDM) are included as part of the care team (11). * sf	10. Processes are in place to transition individuals directly to the next best level of care to meet their presenting needs e.g., bedded rehabilitative care.* sf		

Pay-for-Results (P4R) Manual

EMERGENCY DEPARTMENT (ED) PAY-FOR-RESULTS (P4R) PROGRAM MANUAL

2026/27 Program Year

Last updated: December 2025

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

Document disponible en français en contactant info@ontariohealth.ca.

Version History

Version	Notable Changes
2026/27	• Explicitly identified information relevant to large- and small-volume hospitals using icons • Updates to the action plan template including how hospitals provide site name information and the addition of several elements, including increased details associated with the identification of new or existing health human resources, confirmation of initiatives based on EDRVQP audit findings, ED Leading Practices Toolkit and/or Self-Assessment Guide, and the attestation of continued participation in all P4R Program components. • Examples of eligible uses of funds have been added to provide clarity
2025/26	• Action plan template updated with more targeted questions on initiatives, and linkage to performance metrics. This additional information aimed to improve the Program's ability to understand how hospitals are using their P4R funds and monitor how effective the funded initiatives are toward achieving program improvements over time. • The roles and responsibilities of Program partners were updated to provide more clarity.
2024/25	• First formal program manual that consolidated information on P4R Program policies, requirements and accountabilities, processes and methodology.

1 Purpose of Document

This manual is intended to provide information, guidance and direction on the Pay-for-Results (P4R) Program ('the Program') components and requirements of participating hospitals and other program partners.

Three types of text boxes can be found throughout this manual to highlight important information:

- Background information (e.g., rationale, for your information)
- Program notes (e.g., key dates, process information, instructions)
- Technical/methodology notes (e.g., formulas)

In addition, the following icons will denote sections where the information is pertinent to large- or small-volume P4R-participating emergency departments (EDs):

- Information relevant for **large-volume EDs**
- Information relevant for **small-volume EDs**

> Hospitals with questions regarding their Program participation should be directed to their **Ontario Health Regional P4R Program Lead** (main regional contact for the P4R Program) **and their Regional ED Clinical Lead(s)**.
>
> General questions about the P4R Program, or this manual, should be directed to atc@ontariohealth.ca. For frequently asked questions, please see
>
> **Appendix A: Frequently Asked Questions**

2 Background

There is overwhelming research that shows a crowded ED can contribute to greater risks of adverse outcomes for both admitted and discharged patients, regardless of their personal wait time. Crowded EDs with long wait times are also major causes of poor patient experience and reduced staff morale, the latter which impacts staff recruitment and retention.

ED overcrowding emerged as an issue in the mid 1990's due to population growth and exacerbated by fiscal restraints and subsequent hospital restructuring, resulting in fewer beds and resources to care for more patients. In 2006, the Ministry of Health ('ministry') established a task group to make recommendations on how to address ED overcrowding. The resulting report, *Improving Access to Emergency Care: Addressing System Issues*, called for systemic changes in the EDs and health care system at large for sustainable improvement in ED flow.

The P4R Program was launched in 2008 as part of Ontario's broader Wait Times Strategy to reduce time spent in the ED and improve patient satisfaction. It is an incentive-based funding program designed specifically to:

- Monitor and strive to improve ED performance
- Achieve provincial wait time goals
- Improve patient experience and working conditions in Ontario EDs

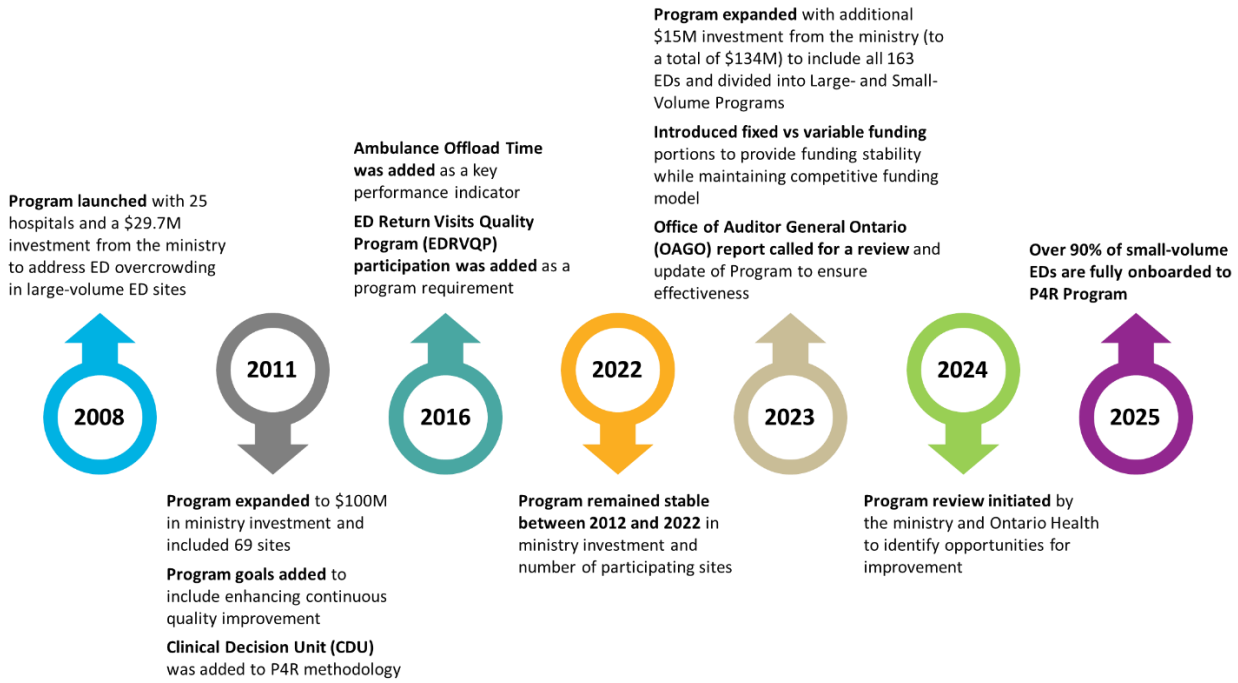
Initial participation included the 25 largest EDs and then expanded to all 76 large-volume EDs (EDs with ≥ 30,000 annual visits) in Ontario. In fiscal year (FY) 2023/24, the ministry invested an additional $15 million (to a total of $134 million annually) to extend the Program to include the 87 small-volume EDs (< 30,000 annual visits). As of the end of 2025, over 90% of small-volume EDs have been fully onboarded to the P4R Program.

> Historically, the P4R Program targeted large-volume EDs because data showed ED overcrowding was more likely found in busier EDs. However, small-volume EDs with single or limited physician coverage also often face challenges such as staffing shortages. Supporting smaller EDs is an important strategy to help ensure equitable access to health care across Ontario, as they act as important access points to health care services for Northern and rural patients. As such, the ministry expanded the P4R Program to include the small-volume EDs in FY 2023/24.

In recognition of the continued critical role emergency care plays in Ontario's heath care system, the ministry and OH initiated a review of the P4R Program in 2024. The review includes evaluating priorities, processes, key performance indicators (KPIs) and formula for ranking with system partners to identify opportunities to update and amend the program. Approaches to integrate the Program with other Ontario Health-led initiatives like the Hospital/ED Performance Measurement and Monitoring (PM&M) Initiative, as well as the Quality Improvement Program and Hospital Services Accountability Agreements are being explored to ensure their goals, performance targets and incentives are aligned. This review is also in

response to the 2023 Office of Auditor General of Ontario (OAGO) report, *Value-for-Money Audit: Emergency Departments*, in which it recommended efforts be made to ensure the Program's priorities, processes and incentives are effective in achieving its objectives. This work is currently underway, and updates to the program will be implemented as opportunities are identified. See Figure 1 for highlights from the Program history.

Figure 1. Highlights of Program History



3 Program Goals

The Program aims to bring all Ontario EDs to a common platform, with priority focus on:

- Making quality improvement an underpinning of ED culture
- Improving ED performance and patient experience
- Ensuring consistent and rigorous standards by using Canadian Triage and Acuity Scale (CTAS)
- Being transparent through public reporting of wait time performance

4 Program Participation

Large- and small-volume EDs face different challenges. Therefore, they are divided into their own unique P4R Programs and focus on different strategies to achieve Program goals. Program assignment depends on a hospitals' annual ED visit volume (see Table 1).

Table 1. Categorization and Distribution of EDs* for 2026/27 P4R Program Year

P4R Program	Funding Category	Definition	# Hospitals
Small-Volume Program (< 30,000 annual visits)	Under 7,000 ED Visits	Treat less than 7,000 annual ED visits.	17* (18)
	Very Low Volume Hospitals	Treat between 7,000 and 17,499 annual ED visits.	43
	Low Volume Hospitals	Treat between 17,500 and 29,999 annual ED visits.	27
Large-Volume Program (≥ 30,000 annual visits)	Medium Volume Hospitals	Treat between 30,000 and 49,999 annual ED visits.	24
	High Volume Hospitals	Treat between 50,000 and 85,000 annual ED visits.	18
	Very High Volume Hospitals	Treat more than 85,000 annual ED visits.	14
	Teaching Hospitals	Provide acute and complex patient care and have membership in the Council of Academic Hospitals of Ontario. They are affiliated with a medical or health sciences school, are involved in significant research activity and provide training for interns/ residents.	17
	Paediatric Hospitals	Treat only patients 18 years of age or less. Generally, they provide all types of paediatric services.	3

** Currently one small-volume hospital does not participate in the P4R Program, meaning only 18 of the 19 Under 7,000 Visit ED sites are listed as participating sites.*

4.1 Large-Volume Program

4.1.1 Program Focus and Strategies

As the Large-Volume Program is a competitive program, hospitals in this Program are incentivized to improve their ED flow, performance, and quality (see Section 0). Strategies to achieve these goals have been identified as:

- **Increasing skills and capacity within ED and hospital teams** to develop and execute strategies to improve ED flow
- Supporting **investments in health human resources** to:
- Provide **additional physician and nursing roles to support strategies** that improve wait time performance, quality of care and patient experience
- **Incorporate alternate providers within the ED** that optimize the capacity of ED physicians and nurses to focus on patient care
- **Investing in**:
    - **Technology, information systems, medical devices and clinical tools** to improve performance, quality of care and patient experience
    - **Local ED physical plant and clinical spaces close to the ED** to optimize ED efficiency and capacity to improve flow
    - **Process improvement initiatives** to improve inpatient flow such as through creating capacity by addressing alternate level-of-care performance and operationalizing best practices

4.1.2 Program Requirements

Each hospital in the Large-Volume Program is accountable for the following:

- Completing and submitting an annual P4R action plan (see Section 0) and expenditure report (see Section 0)
- Submitting ED data as part of Emergency Room National Ambulatory Care Reporting System Initiative (ERNI) (see Section 0)
- Utilizing the electronic CTAS (eCTAS) decision support tool to triage ED patients
- Participating in Ontario Health's ED Return Visit Quality Program (EDRVQP) to build a culture of continuous quality improvement in their ED and hospital (refer to the Health Quality program website for details)

- Collecting patient experience data using questions from Ontario Hospital Association's Emergency Department Patient Experience of Care (EDPEC) Survey or the Ontario Emergency Department Short-Form (OED-SF) Patient Experience Survey

> In 2009, ERNI was established to ensure timely data collection on ED wait times and other ED visit-related data. It leverages existing National Ambulatory Care Reporting System (NACRS) data collection and submission processes to allow for monthly reporting. See Appendix B for more details.

> NACRS is the national metadata for hospital- and community-based ambulatory care, which includes day surgeries, outpatient and community-based clinics and emergency department visits. See the NACRS website for more details.

4.2 Small-Volume Program

4.2.1 Program Focus and Strategies

Recognizing some of the unique challenges faced by small-volume EDs, the focus for the Small-Volume P4R Program is to support EDs to operate 24 hours a day, 7 days a week. Small-volume EDs should focus on strategies that:

- **Stabilize staffing and reduce dependency** on ED Locum Program and agency nurses
- Drive **improvements in ED staffing strategies**
- **Develop local leadership** and seek opportunities for improvement in quality of care and patient experience

4.2.2 Program Requirements

Each hospital in the Small-Volume Program is accountable for the following:

- Completing and submitting an annual P4R action plan (see Section 0) and expenditure report (see Section 0)
- Submitting ED data as part of Emergency Room National Ambulatory Care Reporting System Initiative (ERNI) (see Section 0)
- Utilizing the electronic CTAS (eCTAS) decision support tool to triage ED patients
- Participating in Ontario Health's ED Return Visit Quality Program (EDRVQP) to build a culture of continuous quality improvement in their ED and hospital (refer to Health Quality Ontario's program website for details)
- Collecting patient experience data using questions from Ontario Hospital Association's Emergency Department Patient Experience of Care (EDPEC) Survey or the Ontario Emergency Department Short-Form (OED-SF) Patient Experience Survey

In 2009, ERNI was established to ensure timely data collection on ED wait times and other ED visit-related data. It leverages existing NACRS data collection and submission processes to allow for monthly reporting. See Appendix B for more

NACRS is the national metadata for hospital- and community-based ambulatory care, which includes day surgeries, outpatient and community-based clinics and emergency department visits. See the NACRS website for more details.

4.3 Transition Between and Within Programs

The decision to move a hospital from one P4R Program to the other is based on the annual ED visit volume data submitted to NACRS. Each summer, the Canadian Institute of Health Information (CIHI) confirms annual ED visit volume data from the previous fiscal year. Those data are used to inform each hospital's P4R Program participation (see Section 0 for more details on the funding cycle).

The movement of a hospital into a new volume grouping category, or from one P4R Program to the other is based on two consecutive fiscal years (April 1-March 31) of ED visits volume data submitted to NACRS.

4.3.1 Transition between Programs

TRANSITION FROM LARGE- TO SMALL-VOLUME PROGRAM

Hospitals in the Large-Volume Program that experience a volume decrease to less than 29,000 annual ED visits for two consecutive fiscal years (April 1-March 31) should be moved to the Small-Volume Program. If hospitals meet this criteria, Ontario Health makes a recommendation for transition to the ministry. If the transition is confirmed by the ministry, hospitals are notified before the beginning of the next P4R Program year.

TRANSITION FROM SMALL- TO LARGE-VOLUME PROGRAM

P4R-participating small-volume hospitals that experience a volume increase to 30,000 or more annual ED visits for two consecutive fiscal years (April 1-March 31) should be moved to the Large-Volume Program. If hospitals meet this criteria, Ontario Health will make a recommendation for transition to the Large-Volume Program to the ministry. If the transition is confirmed by the ministry, hospitals are notified before the beginning of the next P4R Program year.

During the first year of the Small-Volume Program, volume data from FY 2022/23 were used to categorize all small-volume hospitals for funding purposes. This initial year of data is not used for consideration for transition into a new volume-based funding category. The first two consecutive years of data for consideration are FYs 2023/24 and 2024/25 (see Section 7.1 for details on program timeline).

4.3.2 Transition between Funding Categories within the Small-Volume Program

As the current funding structure for the Small-Volume Program is based on annual ED volume, there is opportunity for small-volume hospitals to transition between funding categories within the Program as their ED volume changes over time.

If a small-volume hospital experiences a change in volume, where their annual ED visit volume falls in a different funding category for two consecutive fiscal years (April 1-March 31), Ontario Health makes a recommendation to the ministry on transitioning the hospital to the new funding category. If the transition is confirmed by the ministry, these hospitals are notified before the beginning of the next P4R program year.

For reference, the annual ED volume that informs P4R funding categories for Small-Volume Program are as follows:

- **Under 7,000 Visits:** Treat less than 7,000 annual ED visits.
- **Very Low Volume Hospitals:** Treat between 7,000 and 17,499 annual ED visits.
- **Low Volume Hospitals:** Treat between 17,500 and 29,999 annual ED visits.

While hospitals in the Large-Volume Program may move between hospital group categories based on changes in their annual ED volume, their funding is not impacted by this movement. Large-Volume Program funding allocation is primarily determined by performance in key metrics, and adjustment based on annual ED volume is included in the calculation of the P4R funding ranking, which informs the yearly notional allocation (see Section 0 for methodology details). As such, Section 0 only applies to Small-Volume Program.

5 Program Overview

5.1 Roles and Responsibilities

The following table (Table 2) outlines the roles and responsibilities of P4R Program partners.

Table 2. Roles and Responsibilities of P4R Program Partners

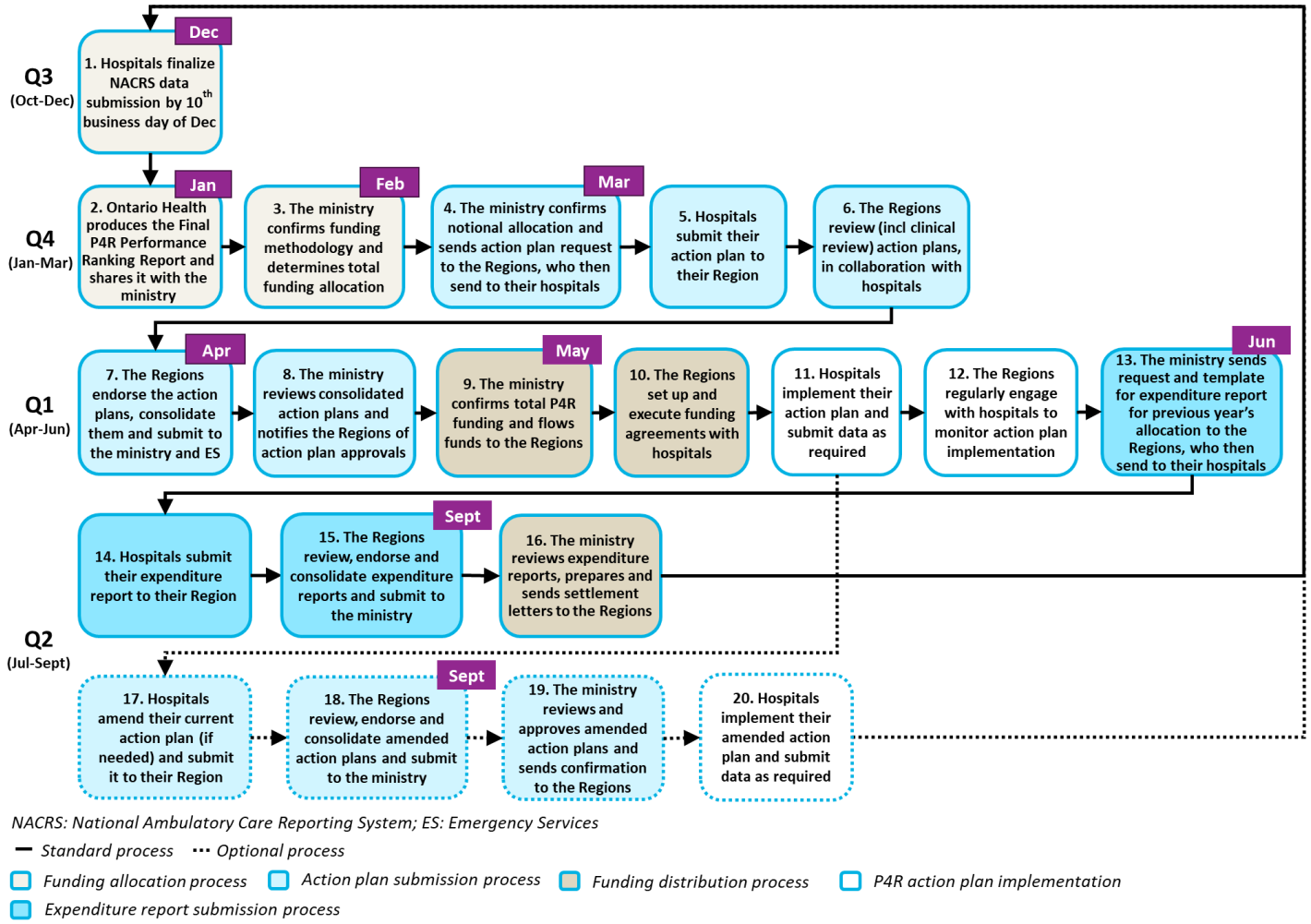
Partner	Roles and Responsibilities
Ministry of Health (Hospitals Branch)	• Direct program policy and funding methodology • Distribute requests and templates for annual action plan and expenditure reports to Ontario Health Regions • Review and approve submitted action plans and expenditure reports • Determine notional allocation, approve and distribute P4R funding to Ontario Health Regions
Ontario Health Emergency Services (in collaboration with other Ontario Health programs e.g. Sector Support – Emergency Services, Health System Analytics, Data Compliance, etc.)	• Provide advice to and take guidance from the ministry on program policies and funding methodology • Monitor and manage hospital data submissions, compliance and quality • Produce monthly and annual P4R performance reports • Support sharing lessons learned and leading practices regionally and provincially • Onboard any eligible hospitals to the P4R Program • Manage P4R operational process and co-design program improvements, in collaboration with Ontario Health Regions and the ministry • Analyze submitted action plans to understand funding utilization patterns
Ontario Health Regions	• Ensure hospitals comply with program requirements • Distribute action plan and expenditure report templates to hospitals and receive completed action plans and expenditure reports from the hospitals in their region • Review and endorse action plans from fiscal, clinical and regional system perspectives to ensure initiatives are of high quality,

Partner	Roles and Responsibilities
	relevant and appropriate to P4R Program goals, as well as coordinate action plans to meet regional priorities • Lead initial and ongoing discussions with hospitals during submission, implementation and monitoring of action plan initiatives during the P4R cycle and as part of the PM&M process • Review and submit expenditure reports to the ministry • Develop and execute funding agreements with hospitals • Support hospitals that have questions about the P4R Program • Continue to collaborate and co-design P4R Program improvements with other Ontario Health programs
Hospitals	• Comply with program requirements and follow program processes • Participate in initial and ongoing discussions with Ontario Health Regions during the development, implementation and monitoring of their action plans during the P4R cycle and as part of the PM&M process • Monitor expenditures and submit annual expenditure reports to their Ontario Health Region

5.2 Overall Program Process

Figure 2 outlines the key steps for the P4R annual program process. Note the timing of certain steps may vary slightly each year.

Figure 2. P4R Program Process Map



NACRS: National Ambulatory Care Reporting System; ES: Emergency Services

Standard process *Optional process*

Funding allocation process *Action plan submission process* *Funding distribution process* *P4R action plan implementation*

Expenditure report submission process

5.3 Action Plan Submission

5.3.1 Action Plan Template Overview

Changes to the P4R action plan template for 2026/27 P4R Program:

- Updated how hospitals provide site name information
- Added the following elements for hospitals confirm:
  - Identify if initiatives involve new or existing health human resources (HHR); if so, provide details on role, staff category and full-time equivalent (FTE)
  - Confirm if initiatives are based on the ED Leading Practices Toolkit and/or Self-Assessment Guide
  - Identify if initiatives target specific CTAS population(s)
  - Indicate if initiatives were informed through a finding from an ED Return Visit Quality Program audit
  - Attest to continued participation in all P4R Program components

An action plan must be submitted for each hospital site. For multi-site organizations, please ensure to submit a separate action plan for each hospital site; do not submit one action plan for the entire organization.

The action plan template consists of five tabs:

- **Tab A**. Instructions
- **Tab B**. Action Plans
- **Tab C**. Category Definitions (Column J)
- **Tab D**. Initiative Titles (Column K)

The Action Plans (Tab B) includes seven sections. The following provides a high-level description of each section; detailed instructions for each section can be found under Tab A.

SECTION A. HOSPITAL IDENTIFICATION

- Information on the hospitals submitting the action plan. Once the hospital site name is selected, other identification information is filled in automatically.

SECTION B. INITIATIVE IDENTIFICATION

- Each initiative in both Large- and Small-Volume P4R action plans need to be categorized into one of the categories, listed in Table 3. Information on eligible use of P4R funds is outlined in Section 0 of this manual.
- Hospitals are encouraged to select an option from a list of initiative titles (see Tab E) that matches the initiative being described. In some instances, certain organizations may have a specific term that is used, particularly for human resource-related positions. In these cases, consider selecting a title from the list that is most aligned with the term used at the organization. If there is no existing term that describes the initiative, select "Other" and include a title under Initiative Description (Tab B, Column U). Using standardized titles will improve Ontario Health's ability to analyze action plans and better understand funding utilization patterns and identify effective initiatives for knowledge sharing.
- Hospitals are also asked to indicate if an initiative is new P4R initiative or a continuation of an existing P4R initiative, and whether any health human resources (HHR) roles are involved (Tab B, Columns M and O, respectively). This will support further understanding of funding utilization patterns.

Table 3. P4R Action Plan Initiative Categories

P4R Initiative Category	Category Description	Details to Include in Initiative Description (Column U)
1. Education and Skills Training	Funding to support education and training for ED staff, such as educational conferences or specialty training courses, where there are no other sources of funds (e.g., base funding, Ontario Health's ED Nursing Education, Retention and Workforce Program or other grants) to support such educational opportunity.	• Program/course/consultant details • Nature of the course (e.g., ACLS) • Details on how funding is used (e.g., tuition, fees, materials, staffing remuneration for attendance) • Length of course/program duration (e.g., 8 hours) • Category of staff expected to complete course/program (e.g., physicians, flow leads, ED leadership, front-line nursing etc.)

P4R Initiative Category	Category Description	Details to Include in Initiative Description (Column U)
2. Health Human Resources	Staff to expand the ED team beyond base-funded positions. These roles can be leveraged to provide ED direct patient care or support ED leadership, performance measurement and monitoring, quality improvement initiatives, or EDRVQP support.	• Category of staff (e.g., nursing, additional physician hours, social worker, etc.) • FTE • Additional hours of coverage (if applicable)
3. Hospital Inpatient Flow Initiatives	Process improvement initiatives, resources or roles to improve the flow of ED patients to inpatient care within the hospital. This may include initiatives directed at reducing time to inpatient bed, reducing the number of no bed admits at 0800, etc.	If initiatives include HHR roles, include information on category of staff, FTE and additional hours of coverage (if appropriate)
4. Investment in Resources for ED Innovation and Quality Improvement Initiatives	Funding can be allocated to initiatives, programs, courses, and/or consultants that aim to coach, train and develop ED team members on skills related to ED processes, flow and quality improvement.	• Program/course/consultant details • Nature of the course (e.g., describe type of quality improvement education) • Details on how funding is used (e.g., tuition, fees, materials, staffing remuneration for attendance) • Length of course/program duration (e.g., 8 hours) • Category of staff expected to complete course/program (e.g., physicians, flow leads, ED leadership, front-line nursing etc.)

P4R Initiative Category	Category Description	Details to Include in Initiative Description (Column U)
5. Minor Renovations and Modifications to ED Environment	Minor physical renovations or modifications to the ED and/or adjacent spaces to expand ED capacity, improve flow and performance.	• Description of limitation(s) of current ED space • Description of the renovation or modification • Expected impact of the renovation or modification
6. Technology/ Equipment	Investments in technology, equipment or automation to improve ED patient care, flow, experience and/or quality.	• Details of the specific technology/equipment (e.g., additional ECG machine) and how it will be implemented • Expected impact of the new technology/equipment
7. Other	This category should be used when the initiative does not match any of the categories listed above. Describe this category when completing Section E. Initiative Information in the action plan template.	

SECTION C. KEY PERFORMANCE INDICATOR (KPI)

- Only hospitals in the Large-Volume P4R Program are required to complete the section related to KPIs; this section is not applicable for the Small-Volume Program.

- Hospitals are asked to identify a primary KPI that each initiative aims to address, provide a desired target for the identified KPI and describe how the initiative is expected to improve the KPI. This will help identify the expected impact of the initiative on specific performance indicators. See Section 0 for details on the KPIs.
- While initiatives often aim to impact more than one KPI, the identification of a primary KPI in the action plan will facilitate improved assessment of impact for each initiative. Expected impact on additional KPIs can be described under Initiative Description (Tab B, Column U).

There are no specific performance improvement targets associated with the P4R Program although hospitals can set specific KPI goals for their P4R initiatives, if desired.

However, as some of the P4R KPIs overlap with the provincial priority performance indicators, hospitals may wish to support efforts to achieve provincial performance targets through P4R initiatives.

SECTION D. ALIGNMENTS

- Part of the approach to modernizing the P4R Program includes greater alignment with other ED-related programs and concurrent planning with the overall hospital quality improvement plan (e.g., Quality Improvement Program (QIP) Workplan). The P4R action plan template is set up to support this process. Specifically, hospitals are asked to indicate whether each initiative was also part of the hospital QIP Workplan for that year, was identified as part of an EDRVQP audit, or was informed by the ED Leading Practices Toolkit or Self-Assessment Guide (click here for details). This will provide a snapshot of how workplans/action plans are aligned across each hospital's P4R, EDRVQP and QIP efforts, as well as the effectiveness of the Leading Practices Toolkit/Self-Assessment Guide in supporting ED initiatives.

SECTION E. INITIATIVE INFORMATION

- Hospitals are asked to describe the initiative using a series of open-ended questions, which includes a description of the initiative (and if it is HHR-related, including specific information on staff category, FTE or hours of coverage) and whether it targets a specific CTAS population. These questions aim to ensure key information about the initiative is captured and support a more fulsome review of the initiative, its expected impact and the methods with which it will be implemented and monitored.
- In the initiative description (Column U), specific details must be included, depending on the initiative category (Column J). Refer to Tab D for instructions.

Hospitals should endeavour to provide sufficient and explicit details in the Initiative Description (Column U) for new and existing initiatives to ensure Ontario Health and the ministry have a clear picture of how P4R funding is intended to be used.

If insufficient information is provided, Ontario Health and the ministry will seek further clarification from hospitals, which risks delaying the P4R action plan approval, and execution of funding agreements.

For questions on how best to prepare an action plan, reach out to your Ontario Health Regional P4R Program Lead and Regional ED Clinical Lead.

SECTION F. P4R PROGRAM REQUIREMENT ATTESTATION

- In addition to the initiatives, hospitals are asked to confirm their continued participation in the other components of the P4R Program (i.e., ERNI, EDRVQP, eCTAS and patient experience survey).

SECTION G. HOSPITAL SITE SIGNATORIES

- Before submitting the action plan to Ontario Health Regions, a signature from the following hospital leaders must be included:
  - Chief Executive Officer (or equivalent)
  - Emergency Department Medical Lead (or equivalent)
  - Emergency Department Nursing Lead (or equivalent)

5.3.2 Eligible Use of P4R Funds

As hospitals prepare their action plan, it is critical to keep in mind the following eligible uses of P4R funding. Funding should be used to implement initiatives aligned to one of the following initiative categories, as listed above in Table 3.

If you have questions about eligible use of funds, please contact your Regional P4R Program Lead and Regional ED Clinical Leads.

> In an effort to ensure action plans include a clear rationale and direct purpose to drive improvements in flow and performance, the necessity for a more critical review of the plans was identified. As a result, 2024/25 P4R Program was updated (see Section 2 for details) to clarify and elaborate on the process, led by Ontario Health Regions, for action plan review and endorsement.
>
> With a more critical assessment of action plans, some existing initiatives may be examined using this updated approach and continued eligibility may be reassessed for alignment with P4R Program goals.

> Funding cannot be used in a way that contravenes existing provincial agreements or laws and must not be used for initiatives that do not contribute to P4R Program goals (e.g., capital improvement outside of the ED, offsets to overall hospital budget deficit, etc.).

The following provides general guidance on the eligible uses of P4R funds, based on initiative category, which applies to both Large- and Small-Volume Programs (unless indicated).

EDUCATION AND SKILLS TRAINING

P4R funds can be used to support training and skills development opportunities for ED staff such as educational conferences and specialty training courses e.g., Pediatric Advanced Life Support (PALS) and Advanced Cardiovascular Life Support (ACLS). However, P4R funds should only be used when no alternative source (e.g., base finding, other grants) is available to support the training opportunity.

For example, while the cost of training staff to use the eCTAS application is eligible for P4R funding, the cost associated with taking the CTAS Participant course (owned/created by the National Emergency Nurses Association (NENA) and delivered by NENA-approved trainers) is not eligible. This is because the former is related to the implementation and ongoing use of the eCTAS triage support platform, and the latter is related to triage skills training, the cost of which can be covered by other funding sources like Ontario Health's ED Nursing Education, Retention and Workforce Program.

If hospitals wish to use P4R funds to support training opportunities that are funded through other sources, rationale must be provided in the P4R action plan. These P4R initiatives will be assessed on a case-by-case basis.

When describing this type of initiative in the action plan, the following information must be included: a) program/course/consultant details; b) nature of the course (e.g., ACLS); c) details on how the funding is used (e.g., tuition, fees, materials, staffing remuneration for attendance); d) length of course/program duration (e.g., 8 hours) and e) staff category expected to complete course/program (e.g., physicians, flow leads, ED leadership, front-line nursing, etc.).

HEALTH HUMAN RESOURCES (HHR)

P4R funds can be used for staffing to expand the ED team beyond base-funded positions to support P4R Program goals—improving ED flow, performance and patient experience. These roles can be leveraged to provide ED direct patient care or support ED leadership, performance measurement and monitoring, quality improvement initiatives and EDRVQP participation. The following is a non-exhaustive list of examples of eligible HHR-related uses:

- **Additional ED RN/RPNs to augment direct care hours with dedicated resources** (e.g., resource/charge nurse, additional triage nurse, ambulance offload nurse, staff to support surge plans or address bottlenecks in flow, etc.)
- **Indirect nursing care hours** (e.g., roles that support triage audits, chart audits, critical results review, patient follow-up, etc.)
- **Additional ED physician hours above funded services**, which may be used to extend the number of physician hours per day or to provide physician resource for process and quality improvement initiatives (e.g., lead flow improvement projects or support chart reviews associated with EDRVQP)

- **Allied health roles** (e.g., social work, physiotherapy, physiotherapy assistants and occupational therapy) **to reduce admissions and enhance clinical care**
- **New and novel roles that enhance care, reduce length of stay and improve patient experience** (e.g., patient navigators, geriatric emergency management (GEM) staff, dedicated ED pharmacist)
- **Roles to extend clinical staff** (e.g., physician assistants, nurse practitioners, personal support workers, clerical staff, additional patient transport, unit stocking/supply management and housekeeping)
- **Roles to extend clinical resources** (e.g., additional medical imaging hours, lab services, phlebotomists, ECG technicians)

When describing HHR-related initiatives, be sure to include information related to staff category (e.g., nursing, additional physician hours, social worker, etc.), number of roles and FTEs required. If applicable, indicate the additional hours of coverage.

P4R funds can be used to develop leadership, quality and process improvement through **physician education**. This is especially valuable and a good use of P4R funds for small-volume hospitals because it creates capacity within the ED team to further drive quality improvement initiatives in the organization. Education and leadership training within small-volume hospitals should be primarily directed to staff recruitment and retention.

While requests for additional physician hours may be an eligible use for P4R funds, this decision must take existing physician renumeration structures into consideration.

For Alternative Funding Agreement (AFA) sites, P4R funds may be used for additional clinical hours of coverage not already paid by AFA contract (i.e., above the AFA workload maximum hours of coverage). For example, AFA sites must provide information in their P4R action plan that outlines the current and requested additional physician hours and the maximum workload hours in the contract to help determine whether the request falls within the confines of the AFA.

For ED physicians paid by a fee-for-service (FFS) model, they cannot be paid a premium above and beyond the amount paid by the ministry for doing the same work. For FFS sites requesting additional physician hours, hospitals must provide, as part of their action plan, a physician schedule at baseline to demonstrate that the request is for additional hours.
In addition, P4R funds cannot be used for top-up of physician renumeration or incentives.

Hospitals in the Small-Volume Program must align their use of funding to the Program goals, which includes reducing ED closures and dependency on agency nurses and locum physicians. Some examples include:

- Support for hospitals to keep ED services open and available 24 hours a day, 7 days a week. While hospitals work to reduce their reliance on agency nurses, they can continue to utilize P4R funding for agency nurses, as a short-term solution.
- Direct clinical care by physicians that is in addition to the hours of coverage required by existing contracts. Premiums to support coverage challenges may be eligible upon case-by-case review.
- Supporting ED/hospital leadership's time to develop and implement quality improvement and flow improvement process in the ED

As the Small-Volume Program aims to support the stabilization of EDs, initiatives that help ensure EDs stays open are appropriate and may include the use of the ED Locum Program (EDLP).

While hospitals in Ontario Health North East and North West Regions can access a program that reimburses travel costs for EDLP locums (where the costs are much higher due to geography that often requires flights, car rentals, etc.), hospitals in other Ontario Health Regions are responsible for reimbursing EDLP locums for "reasonable travel expenses," according to hospital specific policies. This typically involves mileage and either a hospital call room or hotel stay. The use of P4R funds for travel expenses, including physician time compensation, is only allowed where it is not covered by EDLP or Rural and Northern Physician Group Agreement (RNGPA) contract, and documentation to support this is required as part of P4R action plan submission.

This is an appropriate use of funds for small-volume hospitals that are not covered by the above reimbursement programs.

HOSPITAL INPATIENT FLOW INITIATIVES

ED flow is often a symptom of system-wide flow challenges, and a known primary contributor to ED flow challenges is delay in inpatient admissions. Any process improvement initiative, resource, or role designed to improve flow of ED patients, including to inpatient care units within the hospital, are eligible for use of P4R funds.

Examples include establishing a discharge planning team that focuses on patients with complex social and/or mental health and/or addictions needs, expanding physiotherapy and occupational therapy services on weekends to support ED admission avoidance and early mobilization of inpatients to support early discharge or adding roles to support discharges 7 days per week.

Funding that supports the operation of inpatient beds is not an eligible use of P4R funds. However, funding to support flow-related resources for ED admission and inpatient discharge that directly impacts ED flow is an appropriate use.

INVESTMENT IN RESOURCES FOR ED INNOVATION AND QUALITY IMPROVEMENT INITIATIVES

P4R funds can be used for initiatives, programs, courses, and/or consultants that aim to coach, train and develop skills of ED team members related to ED processes, flow and quality improvement. Examples may include utilizing funds for expert consultants to provide coaching and direction on flow, quality, safety and performance improvement or education in quality improvement for ED staff.

Some examples include creating and deploying simulations for ED teams to develop and improve skills in responding to emergency codes or adding dedicated ED quality improvement resources to identify opportunities and lead projects to drive improvements in quality, safety and performance.

Be sure to include all pertinent details described in the Education and Skill Training section in the action plan.

MINOR RENOVATIONS AND MODIFICATIONS TO ED ENVIRONMENT

P4R funds can be used to support minor physical renovations/modifications to the ED and/or adjacent spaces to expand ED capacity, improve ED flow and performance. This can include funding for consultants to assist with planning.

Examples include re-designing an ED space to create areas appropriate for the care of patients experiencing a mental health crisis or behavioural escalation or adding cardiac monitoring capabilities to non-cardiac monitoring rooms.

For this type of initiatives, hospitals must provide details outlining the limitation(s) of the current ED physical space and provide details on the renovation, the goal and the expected impact to performance or quality improvement.

TECHNOLOGY/EQUIPMENT

Investments in technology, equipment or automation to improve ED patient care, flow, experience and/or quality are eligible uses of P4R funds. These can also include procurement and ongoing operating costs of the technology (e.g., licensing fees, subscription fees).

For example, software/applications that support physician scheduling based on ED flow patterns or provide real-time information on ED flow.

For this type of initiative, details about the specific technology/equipment (e.g., additional ECG machine) should be described in the action plan.

> Resources available to assist in developing P4R initiatives include:
>
> - *ED Leading Practices Toolkit*
> - *Hospital/ED Performance Scorecard* (via HSI)
> - ES Community of Practice and Quorum Site (via Quorum)
> - Regional P4R Program and ED Clinical Leads

5.3.3 Action Plan Submission Process

Once the ministry has confirmed the funding allocation for the new P4R Program year, they send a request for P4R action plans to Ontario Health Regions, which includes the action plan templates (in Excel format) and the *Final P4R Ranking Report* (includes funding allocation per site). The templates are specific to the Large- and Small-Volume Programs. Ontario Health Regions then send the corresponding template to their hospitals based on their program participation (Large or Small). Hospitals must submit their completed templates to their Ontario Health Region for review and endorsement.

> Some hospital corporations have hospital sites in both the Large- and Small-Volume Programs. In this scenario, the hospital corporation needs to submit two different action plans, one for the hospital(s) in the Large-Volume Program and another for hospital(s) in the Small-Volume Program.
>
> Each hospital site must be included in the action plan, even if they are part of a multi-site organization belongs to the same (Large- or Small-Volume) Program.

ONTARIO HEALTH REGIONAL REVIEW AND ENDORSEMENT OF ACTION PLANS

Ontario Health Regions review action plans for consistency with the P4R notional allocation from the ministry and for expected clinical and regional impact (see Table 4 for specific regional roles and responsibilities). Ontario Health Regions should work with hospitals to ensure the final submitted action plans are of high quality, clinically relevant and appropriate in meeting P4R Program goals. In addition, Ontario Health Regions can help identify opportunities to align action plans that would support coordinated improvements or meet regional priorities.

Ontario Health Regions consolidate action plans from hospitals across their region into a single file. The consolidated action plan needs to be endorsed by the leadership at Ontario Health

Region prior to its submission to the ministry. While this endorsement process (e.g., cc'ing leadership on the submission email to the ministry) may vary across Ontario Health Regions, at minimum, the following regional leaders need to acknowledge their endorsement of the consolidated action plan:

- Vice President, Clinical Program (or equivalent) and/or Vice President, Capacity, Access and Flow (or equivalent)
- Vice President, Performance Accountability and Funding Allocation (or equivalent)

See Figure 3 for a high-level summary of this process.

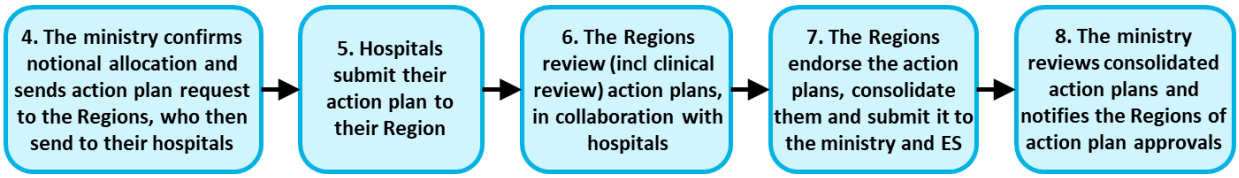
Table 4. Regional Roles and Responsibilities in P4R Action Plan Submission Process

Roles and Responsibilities of Regional ED Clinical Leads	Roles and Responsibilities of Regional P4R Program Leads
• Provide clinical guidance and support to hospitals as they develop their P4R action plan • Share any lessons learned or successful initiatives from across the region with hospitals • Review and endorse P4R action plans to ensure they are of high quality, clinically relevant and in alignment with P4R Program goals, as well as coordinate action plans to meet regional priorities	• Act as the first point of contact for P4R action plan submission • Ensure submitted P4R action plans are fully completed and include sufficient information to allow for appropriate review and aligned with regional priorities, and if necessary, follow up with the hospital • Consolidate action plans and ensure they are endorsed by regional leadership before submitting to the ministry • Inform Ontario ES team when the P4R action plans have been approved by the ministry

Ontario Health Regions are to send the endorsed consolidated action plan to the ministry (Hospitals.Branch-HSQFD@ontario.ca) and Ontario Health Emergency Services (emergencyservices@ontariohealth.ca).

For submission deadlines, refer to the email communication from the ministry.

Figure 3. P4R Action Plan Submission Process High-Level Summary



5.3.4 Amendment to Submitted Action Plans

Hospitals are expected to implement their P4R action plan as submitted and use the allocated P4R funds for initiatives approved in their action plan. However, there may be instances where a hospital needs to make changes to their submitted action plan (e.g., replace a proposed initiative with a new one) during the Program year. In this case, hospitals must submit amendments to their action plans to the ministry for formal review and approval before implementation.

> Changes to primary KPIs and targets cannot be the sole purpose for an action plan amendment. Any changes to primary KPIs and/or targets must be in relation to a change in the initiative being proposed to address performance.

> Changes to the distribution of allocated funds across initiatives within a hospital site or corporation do not require an amendment submission. However, the ministry's approval is required prior to moving any P4R funding from one hospital corporation to another. See Section 0 for more details.

ACTION PLAN AMENDMENT PROCESS

To initiate this optional process, a hospital is to notify their Ontario Health Region as soon as possible. The hospital submits the amended action plan to their Ontario Health Region for review and endorsement using the same process as described in Section 0. Ontario Health Regions, along with the Regional ED Clinical Leads, should work collaboratively with the hospital to ensure the proposed amendment is reasonable and aligns with the hospital's opportunities to address gaps in performance (see Table 5 for specific regional roles and responsibilities).

> Inquiries about eligible changes to an action plan should be sent from Ontario Health Region to the ministry (Hospitals.Branch-HSQFD@ontario.ca) and cc Ontario Health Emergency Services (emergencyservices@ontariohealth.ca)

Amendments to an action plan should be made directly in the original action plan and the amended cells highlighted for ease of identification (refer to the action plan template, Tab A, for instructions). Amended action plans can be submitted up to the end of the sixth month in

the Program year. This will allow hospitals sufficient time to implement the amended action plan once approved.

> For the 2026/27 P4R Program year, hospitals can submit action plan amendments for consideration up to **September 30, 2026**.

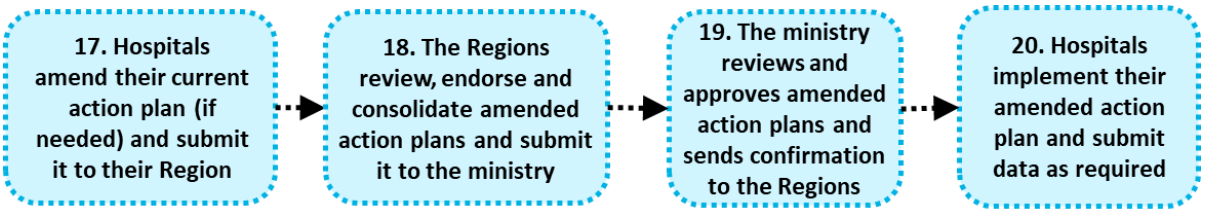
Once the amended action plan is endorsed, the Ontario Health Region is to update the consolidated regional action plan (noting the changes) and submit it to the ministry (Hospitals.Branch-HSQFD@ontario.ca) and cc Ontario Health Emergency Services (emergencyservices@ontariohealth.ca). In the submission email, a summary of the changes and how (if any) P4R funds were redistributed should be detailed.

The ministry notifies the Ontario Health Region if the revised action plan is approved. The Ontario Health Region then informs the hospital of the approval and continues to monitor implementation, in collaboration with the hospital. See Figure 4 for a high-level summary of this process.

Table 5. Regional Roles and Responsibilities in P4R Action Plan Amendment Process

Roles and Responsibilities of Regional ED Clinical Leads	Roles and Responsibilities of Regional P4R Program Leads
• Provide clinical guidance and support to hospitals as they amend their P4R action plan • Review and endorse the amended P4R action plans to ensure the amendments are of high quality, clinically relevant and in alignment with P4R Program goals, as well as coordinate action plans to meet regional priorities	• Act as the first point of contact for P4R action plan amendment • Ensure amended P4R action plans are fully completed (and appropriate cells highlighted to identify changes) with sufficient information to allow for appropriate review and alignment with regional priorities, and if necessary, follow up with the hospital • Consolidate action plans and ensure they are endorsed by regional leadership before submitting to the ministry • Include summary of changes in the email submission • Notify Ontario ES team when the amended P4R action plans have been approved by the ministry

Figure 4. P4R Action Plan Amendment Process High-Level Summary



5.4 Expenditure Report Submission Process

Every year (around June), the ministry sends a request (and an Excel template) for P4R expenditure reports to Ontario Health Regions, whom in turn forward to their hospitals to complete. Each P4R hospital must report on the spending associated with each initiative in their action plan from the previous P4R Program year. Spending on operations, staffing, equipment, training, education and others are to be reported separately for each initiative.

The completed expenditure report from each hospital is to be submitted to their Ontario Health Region for review, endorsement and consolidation. While the review and endorsement process (e.g., cc'ing leadership on submission email to the ministry) may vary across Ontario Health Regions, at minimum, the following leaders need to acknowledge their endorsement of the consolidated expenditure report:

- Vice President, Clinical Program (or equivalent) and/or Vice President, Capacity, Access and Flow (or equivalent)
- Vice President, Performance Accountability and Funding Allocation (or equivalent)

See Table 6 for regional roles and responsibilities and Figure 5 for a high-level summary of this process.

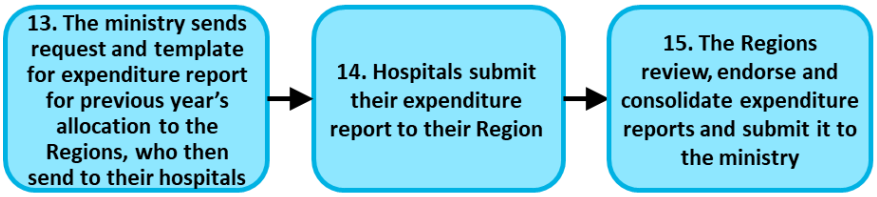
> Ontario Health Regions are to send the endorsed consolidated expenditure report to the ministry (Hospitals.Branch-HSQFD@ontario.ca).
>
> For submission deadlines, refer to the email communication from the ministry.

Table 6. Regional Roles and Responsibilities in P4R Expenditure Report Submission Process

Roles and Responsibilities of Regional ED Clinical Leads	Roles and Responsibilities of Regional P4R Program Leads
• Are informed of the expenditure report submission	• Act as the first point of contact for P4R expenditure report submission

Roles and Responsibilities of Regional ED Clinical Leads	Roles and Responsibilities of Regional P4R Program Leads
	• Ensure P4R expenditure reports are fully completed, and necessary signoffs are included, and if needed, follow up with the hospital • Consolidate expenditure reports and ensure they are reviewed endorsed by regional leadership before submitting to the ministry • Notify Ontario ES team when the P4R expenditure reports have been submitted to the ministry

Figure 5. P4R Expenditure Report Process High-Level Summary



5.5 P4R Funding Flowthrough Process

Once the ministry confirms total P4R funding and approves the submitted P4R action plans, allocated P4R funding flows from the ministry directly to Ontario Health Regions. Ontario Health Regions then prepare and execute the funding agreements with the hospitals to distribute the allocated amount.

If a hospital does not use all of their allotted P4R funding by the end of the fiscal year, designated hospitals are subjected to recovery for any unspent funds, as well as funds not used for the intended and approved purposes.

Ontario Health Regions are responsible for working with funded recipients to identify unspent funds for each initiative at the end of each fiscal year, consolidate this information using the expenditure report provided by the ministry and submit it directly to the ministry to initiate the recovery/settlement process.

6 Program Accountability

Ontario Health Regions are responsible for ensuing their P4R hospitals comply with all program requirements and engage with them on a regular basis to monitor P4R Program performance

through existing regional performance monitoring processes, or as part of broader ED performance initiatives such as PM&M.

6.1 Data Submission for P4R Hospitals

As ERNI sites, all P4R hospitals must submit data based on established processes and timelines. The P4R Program uses data collected through NACRS to monitor participating hospitals' performance and inform funding allocation. As such, the data periods selected for the P4R Program must align with the CIHI's report production timeline. See Appendix B for details on data collection methodology.

Collection of ED data elements is mandatory in Ontario as part of NACRS submission.

Notable time periods for P4R Program:

Performance Period (December 1 to November 30 of the following year): The period where performance data are captured and used to determine funding allocation for the following funding period (applicable only to the Large-Volume Program).

Funding Period (April 1 to March 31 of the following year): The period in which the P4R funding is allocated to and spent by participating hospitals. This is also the period in which the annual ED visit volume is captured and used to inform funding allocations for the Small-Volume Program and volume adjustment in the funding methodology for the Large-Volume Program.

6.1.1 NACRS Data Submission

To support timely reporting of provincial ED wait times and other KPIs, P4R hospitals are required to report NACRS Level 1 data monthly, with submission of the previous month's data due by the 10th business day of each month.

Annual funding calculations for the Large-Volume Program is based on the *Final P4R Performance Ranking Report* produced each January using Level 3 data from the previous performance period (except for November data, where Level 1 data would be used). As such, final data submissions by all P4R hospitals to CIHI for P4R funding purposes must be completed by the 10th business day in December (see Section 0 for details on the data and funding cycle).

NACRS supports multiple levels of ED data submission. Level 1 data is of a subset of administrative data that can be submitted quickly to meet the deadline of the 10th business day of each month and is considered preliminary data. Level 3 data encompass the full "coded" NACRS ED dataset, in which some of the data elements take longer to collect and submit (see CIHI website for more details). Therefore, hospitals are given until the 10th business day of each December to submit their Level 3 data for December to October.

A hospital's failure to submit data to NACRS by the 10th business day of the month, following the ED visit, will result in the hospital being designated as having a reporting issue (RI) on the public website (Time Spent In Emergency Departments). If hospitals are identified as being non-compliant for any of the compliance indicators (as applicable), they will be addressed through Ontario Health's Critical Communication Pathway (see Appendix E).

The NACRS data submission deadline for the 2025/26 P4R performance period is **December 12, 2025**. These data are to be used to inform the P4R funding ranking for 2026/27 Large-Volume P4R program year.

6.1.2 Data Correction

Any data corrections submitted after the 10th business day in December will not be reflected in the *Final P4R Performance Ranking Report*. As such, it is critical that hospitals ensure there are no reporting issues for November's data submissions, as there will not be an opportunity to resubmit November data after the 10th business day in December.

NACRS data correction deadline for the 2025/26 P4R performance year is **December 12, 2025**.

CIHI data submission requirements for all other reporting purposes are not affected by the P4R Program.

6.2 Large-Volume Program Accountabilities

6.2.1 Performance Measurement

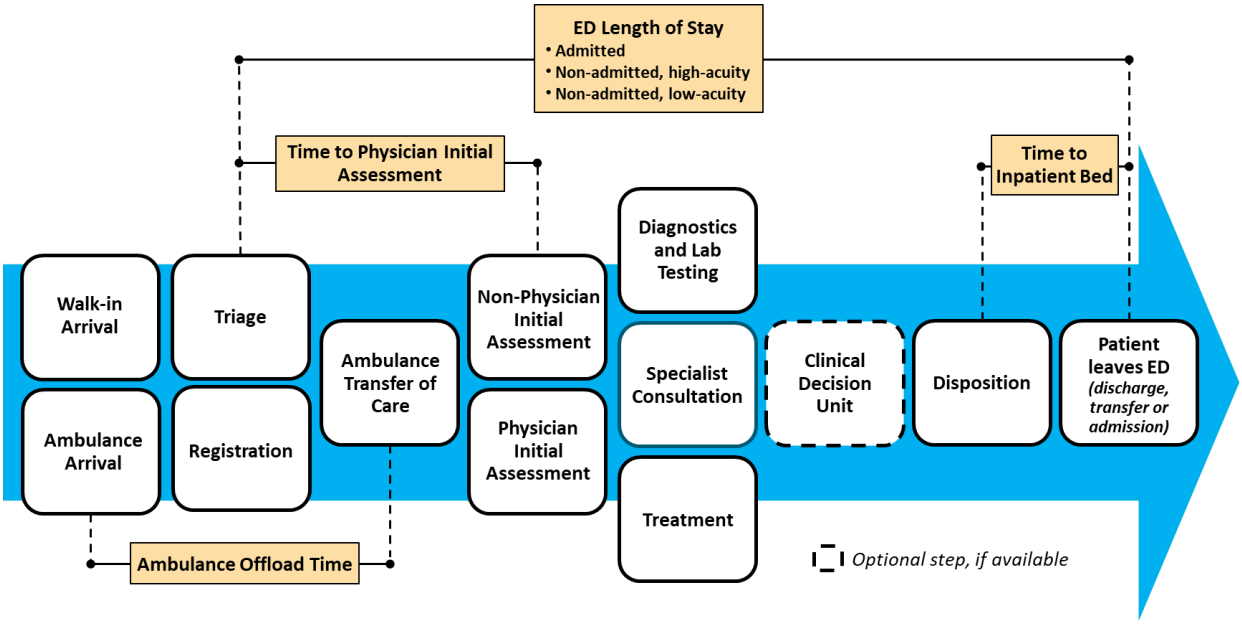
For the Large-Volume Program, six KPIs are used for performance monitoring, assessment of performance ranking and calculation of P4R funding allocation. KPI data are presented at the 90th percentile for P4R reporting and performance rank calculation.

Table 7 lists the KPI descriptions (see Appendix C for detailed KPI methodology) and Figure 6 illustrates these time-based indicators based on the ED patient journey.

Table 7. List of P4R KPIs for Large-Volume Program

Performance indicator	Description
Ambulance Offload Time (AOT)	Total time elapsed from ambulance arrival to transfer of care process (for all patients arriving via ambulance).
Time to Physician Initial Assessment (PIA) OR Time to Non-Physician Initial Assessment (NPIA)	Total time elapsed from triage or registration (whichever is earlier) to physician or non-physician initial assessment (whichever is earlier) for all patients.
Time to Inpatient Bed (for admitted patients)	Total time elapsed from disposition decision to patient left ED (for admitted patients only).
ED Length of Stay (LOS) for Admitted Patients	Total time elapsed from triage or registration (whichever is earlier) to patient left ED for admitted patients.
ED LOS for Non-Admitted, High-Acuity Patients	Total time elapsed from triage or registration (whichever is earlier) to patient left ED for non-admitted, high-acuity patients.
ED LOS for Non-Admitted, Low-Acuity Patients	Total time elapsed from triage or registration (whichever is earlier) to patient left ED for non-admitted, low-acuity patients.

Figure 6. Time-Based P4R Indicators as They Relate to ED Patient Journey



ED LOS is measured separately for three patient cohorts: Admitted, non-admitted high acuity and non-admitted low acuity. This distinction is important because the needs of and care for these cohorts differ significantly from each other (e.g., admitted patients require more intensive investigation and treatment in the ED leading to their admission, while low acuity patients often require more basic care and management and can be discharged). Separate LOS's allows more accurate comparisons between similar ED visits across hospitals.

Other KPIs (i.e., Time to PIA and Time to Inpatient Beds) were selected because they are pure wait times (i.e., no direct patient care involved). Improvements in these metrics would enhance patient experience without compromising the quality of care.

AOT was added later because it not only reflects a pure wait time but also helps identify sites that may have process bottlenecks, preventing paramedic services from leaving the ED limiting their ability to respond to other calls.

The **90th percentile** is used in performance measurement, instead of an average or the median value. It is considered the preferred metric to describe a skewed database of human experience because it represents a value below which 90% of the data falls. This means it provides insight into the experience of the majority of patients, while excluding extreme outliers. While not as well understood as average or median, it is a robust measure that provides a better reflection of changes in performance over time.

6.2.2 Performance Monitoring

To support ongoing performance monitoring, data on these KPIs (and others) are available on the ***Hospital/ED Performance Scorecard*** monthly and quarterly. The Scorecard is available to all ERNI hospitals.

> Details about the *Hospital/ED Performance Scorecard* can be found here.
> To access the scorecard, please visit Health System Insights (HSI) and sign in using your Ontario Health account or ONE ID. Information on how to gain access can be found on the HSI Online Help website.

Ontario Health also continues to provide a monthly *ED P4R Ranking Report* to hospitals via the ATC Information Site and is emailed to specific individuals via a user mailing list. This report provides data on KPIs (relevant to P4R Program performance and funding rankings) and can be requested from the designated Ontario Health ED Coordinator at your facility (e.g., your primary ED contact for Ontario Health outreach).

6.3 Small-Volume Program Accountabilities

As of fall 2025, the majority of hospitals in the Small-Volume Program have completed onboarding for all P4R Program requirements (see Section 0). Hospitals that are still in process of onboarding to specific components of the P4R Program are expected to complete onboarding as soon as possible.

Onboarded hospitals are expected to continue to participate in all P4R Program components (i.e., ERNI, EDRVQP, use of eCTAS and collect data using OHA ED Patient Experience of Care Survey) during 2026/27 P4R Program Year. They are also required to complete and submit an annual action plan and expenditure report, as outlined in Section 0. Small-volume hospitals are encouraged review their EDRVQP audits, the *EDRVQP Year-End Report* and/or the results of their *ED Leading Practices Self-Assessment* to support P4R initiative planning.

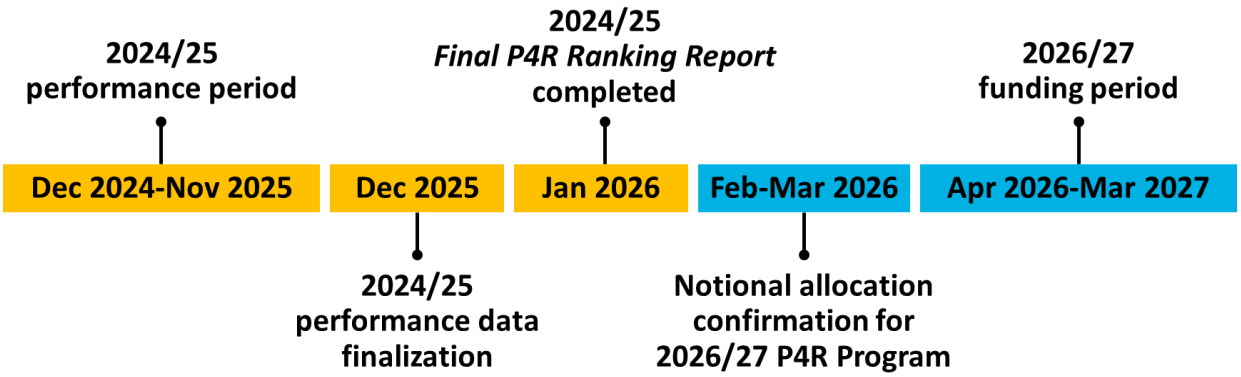
The Small-Volume Program is not a competitive program. Its focus remains on supporting ED operations 24 hours a day, 7 days a week, achieving staffing stabilization and reducing dependency on ED Locum Program and nurse agency staffing. As such, they are not required to identify which KPI their initiatives aim to impact in their 2026/27 P4R action plan. However, they are encouraged to internally monitor their ED performance as it relates to the six P4R KPIs (see Section 0). As indicated earlier, Small-Volume EDs can now review their data on the *Hospital/ED Performance Scorecard*, available via HSI and are encouraged to connect with their Regional ED Clinical Leads when reviewing their performance.

7 Funding Allocation

7.1 Data and Funding Cycle

For the 2026/27 P4R Program, the notional allocation of funding for each Large-Volume hospital is to be based on their funding ranking in the *Final P4R Ranking Report*, which uses the 2024/25 performance data (see Figure 7). Data quality issues (if any) will not be addressed in the ranking report released in January—it will only report on submitted data. The *Final P4R Ranking Report* will only be re-released if there are major data quality issues that required addressing.

Figure 7. Data and Funding Timeline for 2026/27 P4R Program



Due to established provincial reporting cycles, fiscal year data (April 1-March 31) is not finalized until May. As such, P4R funding amounts are calculated based on the data from previous years' performance period (December 1-November 30). This approach allows hospitals to receive P4R funding sooner than if the performance period was aligned with the fiscal year.

To enable timely P4R funding notification, the *Final P4R Ranking Report* uses Level 3 data for all months except for November, where Level 1 data are used.

7.2 Funding Methodology

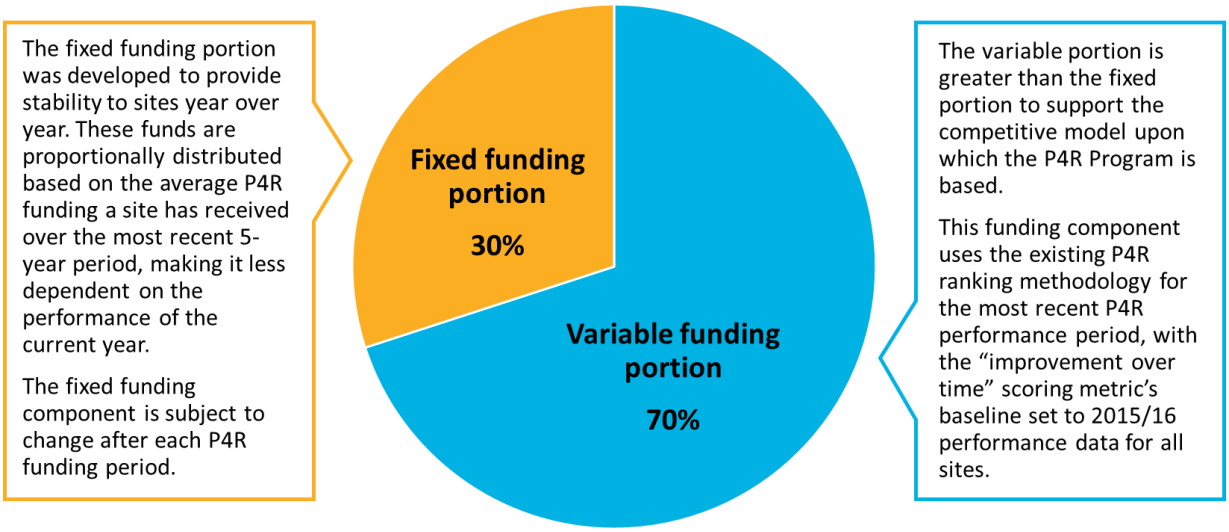
7.2.1 Large-Volume Program Funding Structure

As a competitive program, hospitals in the Large-Volume Program are ranked comparatively against one another, where the higher a hospital's ranking (1 being the highest rank), the more funding they would be allocated. Detailed methodology can be found in Appendix D.

To ensure greater funding stability for hospitals, while maintaining a competitive funding model, the funding pool is split into fixed and variable portions (see Figure 8).

> A competitive approach was used for the Large-Volume Program as it helps isolate how individual hospitals are performing, independent of system-wide changes, and ensures all available funds are distributed and utilized to enhance access to care.

Figure 8. Funding Breakdown for the 2026/27 P4R Program



The use of "current" and "improvement over time" is intended to adjust for some of the baseline characteristics associated with hospitals that they are unable to change, such as hospital type, local patient population or other circumstances creating flow challenges. In recognition of these characteristics, a site's ability to improve over time, despite the relative difficulty associated with doing so, is measured and rewarded.

Improvement in ED performance would result in a higher score for both the "current" and "improvement over time" performance measures used to calculate P4R funding allocation. Thus, a hospital's improved P4R performance could result in a higher funding allocation in the subsequent P4R funding period.

7.2.2 Small-Volume Program Funding Structure

Total available funding for the Small-Volume Program is divided between the three hospital groups within this program: Under 7,000 Visits, Very Low Volume Hospitals and Low Volume Hospitals. Hospitals within each group receive a designated funding amount.

Funding allocation to hospitals in the Small-Volume Program is based on annual ED patient volume data collected for the previous two fiscal years (i.e., April 1-March 31). Funding received by each of the three volume-based groups has the potential to change, based on the volume-

driven movement of hospitals between Small-Volume groups and the movement of any hospital into the Large-Volume Program (see Section 0).

For Small-Volume P4R hospitals: In the 2026/27 P4R Program, any ED shift closures (with the exception of closures caused by local/community disasters e.g., wildfire, flooding) are to be closely monitored and reviewed by the ministry to identify the reason(s) for, and length of, each closure. The ministry may assess a financial disincentive on the next year's P4R funding as a result of a closure.

For P4R funding consideration, an ED shift closure is a defined period of time during which the ED is temporarily closed to any new patients during posted operating hours, regardless of how they arrive (by ambulance, police escort, or walk-in). Each event is tracked in Ontario Health's ED Closure Master Tracker. All ED shift closures are tracked including, but not limited to, those caused by staffing shortages, insufficient blood supply and Code Gray.

The ministry is currently reviewing a different approach for EDs who historically experienced ongoing, longer-term partial or full closures to address closure issues for these sites.

7.3 Movement of P4R Funds Within and Between Hospital Corporations

Every effort should be made to ensure P4R funds are spent at the designated site to support P4R Program goals. In exceptional circumstances, Ontario Health Regions have the authority to adjust individual hospital allocations, as needed, to re-focus funding regionally for the greatest impact on patient experience (e.g., targeted reduction of Ontario's overall ED length of stay).

During action planning, when necessary, funding can be shared or moved within a hospital corporation between P4R-participating ED sites to optimize impact, regardless of the site's annual ED patient volume.

A discussion with the Ontario Health Regional P4R Program Lead and Regional ED Clinical Lead is required prior to movement of funds within a hospital corporation to ensure appropriateness. However, this internal move does not require the ministry's approval to implement.

However, the ministry's approval is required prior to moving any P4R funding from one hospital corporation to another. In this case, both transferring and receiving hospital corporations are required to detail their request of inter-corporation funding reallocation within their P4R action plans and submit it to the ministry for consideration. If approved, Ontario Health Region is to notify the approval of each hospital's P4R action plans, after which the Allocation Payment Tracking System (APTS) request can proceed from Ontario Health Region to the ministry's Financial Management Branch, based on the hospital funding letters and approved P4R action plans.

> P4R action plans require signed approval from specific members of hospital leadership prior to submission, which include inter-corporation P4R funding transfer requests. See Section 0 for list of required signatories for P4R action plans.

Appendix A: Frequently Asked Questions

Q1. Why were updates made to the 2026-27 Pay-for-Results Program?

The P4R Program is reviewed on a regular basis to ensure it continues to function as intended. As such, after each Program year, a review of the Program is carried out to identify opportunities for improvement and inform changes in the subsequent program year. This is also in response to the 2023 Office of Auditor General of Ontario (OAGO) report, *Value-for-Money Audit: Emergency Departments*, in which it recommended efforts be made to ensure the Program's priorities, processes and incentives are effective in achieving its objectives.

Q2. What are the updates to the Pay-for Results Program?

Specifically, the following changes were made to the 2026/27 P4R Program:

- Action plan template was updated to improve the Program's ability to analyze and understand how participating hospitals are using P4R funds and monitor how effective initiatives are in meeting Program goals and performance improvement over time. An attestation to participate in ongoing program requirements is also added to the template.
- Roles and responsibilities of Program partners and timelines for Program operations were updated, the latter including the measurement and monitoring for both performance and use of funds.
- Small-Volume Program clarifications were made to reflect the completed onboarding of small-volume sites to the P4R Program. Details related to the movement of P4R hospitals within the Small-Volume Program and into the Large-Volume Program were also clarified.

Please refer to Section 0 for more information.

Q.3 Are there any changes to the CDU component of the Program?

The CDU Manual and associated templates were updated in 2025 to provide clarity on roles and responsibilities and processes associated with program operations, but no changes to the methodology were made. Ontario Health will continue to accept and review applications for new CDUs (refer to the *CDU Manual* for details).

Q.4 In the action plan template, there is a column to select a primary key performance indicator (KPI). What if the initiative aims to address more than one KPI?

While it is likely some initiatives will impact more than one KPI, the focus on a primary KPI in the action plan will facilitate the improved assessment of impact of each

initiative. Expected impact on additional KPIs can be described under Initiative Description (Tab B, Column U). Please refer to Section 0 for more information.

Q.5 There is no title in Tab E that exactly matches the initiative. What should be entered for this column?

While it is encouraged to select the most appropriate term from the list provided, if there is no existing term that describes the initiative, select "Other" and include a title under Initiative Description (see Tab B, Column U). Using standardized titles will improve Ontario Health's ability to analyze action plans and better understand funding utilization patterns and identify effective initiatives for knowledge sharing.

Q.6 In the action plan template, hospitals are asked to enter a desired target for the selected primary KPI. What are the implications of not meeting this target at the completion of the P4R cycle?

The P4R Program does not have set KPI targets. Some of the P4R KPIs (PIA, AOT and ED LOS for non-admitted patients) have provincial targets that are monitored and reported on through the Performance Measurement and Monitoring (PM&M) program and the Hospital/ED Performance Scorecard. The implications associated with these targets are managed collaboratively between the hospital and the respective Ontario Health Region. There are no implications associated with a hospital setting local target for the remaining KPIs. Please refer to Section 0 for more information.

Q.7 In the action plan template, hospitals are asked to indicate if the P4R initiative is also part of their QIP Workplan, informed by their EDRVQP audits and/or ED Leading Practices Toolkit. Is this alignment required for P4R initiatives?

Part of the modernization efforts of the P4R Program, which started in 2024/25, is to create greater alignment with other ED-related programs and concurrent planning with overall hospital quality improvement plans (e.g., QIP). The P4R action plan template is designed to support this process. Specifically, hospitals are asked to indicate if each initiative is part of their hospital's QIP Workplan for that year, informed by their EDRVQP audits and/or a strategy identified in the ED Leading Practices Toolkit. This will provide a snapshot of how the hospital's efforts are aligned across workplans/action plans. Please refer to Section 0 for more information.

Q.8 Why is the 90th percentile used in performance measurement and monitoring?

The 90th percentile is used in performance measurement, instead of an average or the median value. It is considered the preferred metric to describe a skewed database of human experience because it represents a value below which 90% of the data falls. This means it provides insight into the experience of the majority of patients, while excluding extreme outliers. While it is not as well understood as average or median, it

is a robust measure that provides a better reflection of changes in performance over time.

Q.9 What is the process for performance monitoring and management and escalation?

Participating hospitals will align to Ontario Health on processes related to ED performance monitoring and escalation.

Q.10 I still have questions about the Pay-for-Results Program. Who should I contact?

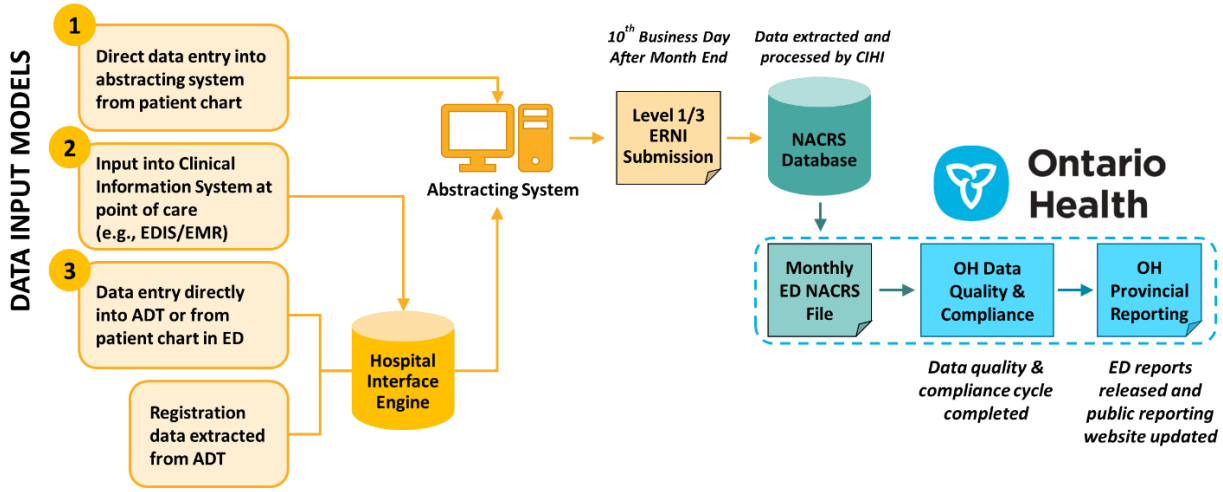
Please contact atc@ontariohealth.ca if you have any additional questions.

Appendix B: P4R Data Collection and Reporting Methodology

ED Data Collection

Ontario Health manages all aspects of data collected by CIHI through NACRS (see Figure 9) and its monitoring and analysis. These data elements are submitted to CIHI/NACRS and are reported by Ontario Health monthly.

Figure 9. Hospital Data Input Models and Submission Process



The accurate collection of ED data is dependent upon timely and high-quality documentation practices that meet ministry reporting requirements. It is recognized that the collection of some of the ED data elements is challenging. It is important that all partners such as Emergency Medical Services (EMS) and Health Records and Information Technology collaborate to work towards the collection of quality ED data.

Reporting Schedule

The number of clinical scenarios differs significantly across the province, and there are many variations in clinical practice. It is the goal of Ontario Health to support all hospitals in their efforts to collect and report quality ED data. On a monthly basis, hospital data completeness and fit-for-use is being assessed through the ED Data Quality and Compliance process.

Interim Monthly ED NACRS File Submission	Final ED NACRS File Submission
Sites can make an interim data submission to NACRS by the 3rd business day following the end of the reporting month following the ED visit.	Sites must make a final data submission to NACRS by the 10th business day following the end of the reporting month following the ED visit.

Reporting Tools and Solutions

Ontario Health drives performance improvement through data collected by hospitals. Reporting and analytics ensure transparency, consistency, and accountability within healthcare organizations across Ontario, and stimulate discussion and strategy sharing between sites.

Ontario Health Performance Reports and Analytics

Reports that are designed to support decision making, performance monitoring and strategic planning are made available on the ATC Information Site (for hospital ERNI/eCTAS Coordinators) on the 5th business day of each month. These reports provide performance management solutions at a local, regional and provincial level, and support ongoing planning, evaluation and decision making.

ED Performance Reports

ED performance reports can be accessed through Health System Insights or ATC Information Site (Figure 10). Ontario Health's ED performance reports present intuitive, customizable, high quality and timely ED information to meet specific audience needs and support decision making, performance monitoring and strategic planning. This information is shared with the ministry, hospitals, regional partners and other key health system stakeholders. Ontario Health enables the performance management approach that is used by the ministry to achieve positive health system change.

Figure 10. ED Performance Reports and Their Location

Type	Power BI	Excel Reports
Location	Health System Insights	ATC Information site
List of available reports	• **Hospital/ED Performance Scorecard** • **ED Fiscal Year Trending** – Monthly & Quarterly • **ED Fiscal Year Trending** – Annual • **ED Equity Report** (Coming soon)	• **ED eCTAS Informational Indicator Report** (QTR) • **ED eCTAS Data Quality Report** • **ED Data Quality Notes Report** • **ED Final Compliance Report & Feedback Tool** • **Ambulance Offload Time Report** • **ED P4R Ranking Report** • **ED CDU Compliance Report**

To access Health System Insights:

Prepare your ONE® ID account

- Contact your facility ONE® ID Local Registration Authority (LRA) to register for a ONE ID account and/or enroll account to the HSI service

Register in HSI

- Navigate to https://hsi.ontariohealth.ca
- Click ONE® ID and login with ONE® ID credentials
- Complete the Welcome Wizard:
  - Acknowledge the End User License Agreement
  - Complete profile details
  - Select dashboards

Request Access to Reports

- New and existing HSI users must contact the facility HSI Facility Role Administrator (HSI FRA) to approve access to **Emergency Department – Performance Reports**
- Existing HSI Users can skip directly to this step

Note: For contact information on your facility's ONE ID LRA or HSI FRA, please email itservicedesk@ontariohealth.ca

Excel Reports Technical Compatibility

For optimal compatibility, some ED performance reports require Excel version 2010 or higher to use all enhanced functions. For older versions of Excel, users can install a file from Microsoft that will allow them to open reports with enhanced features.

Users will need to enable macros by going into File > Options > Trust Center > Trust Center Settings > Macro Settings > "Enable all macros" or "Disable all macros with notification".

Public Reporting

Public reporting of ED wait times is made available through Ontario Health's Health Quality Ontario (HQO)'s public reporting website: Time Spent in Emergency Departments. The HQO website offers public access to current and accurate information on wait times for all ERNI-reporting Ontario EDs and affiliated urgent care centres. Both the public and health care professionals can easily find the most recent information on ED LOS and wait times indicators for each hospital site and the province, and further details on ED volumes and performance with respect to achieving the targets set out by the province. The information on this website is updated monthly and includes 13 months of time-trend data. Ontario publicly reports the following ED metrics:

- Average ED LOS (or Service Time), Percentage Within Target, and Volume, provincially and at the hospital site level for the following patient groups:
  - High-Urgency Patients Not Admitted to Hospital (CTAS 1, 2, 3)
  - Low-Urgency Patients Not Admitted to Hospital (CTAS 4, 5)
  - All Patients Admitted to Hospital (CTAS 1-5)

- Average Wait Time to First Assessment by a Doctor in Emergency and Volume, provincially and at the hospital site level for All Patients

Reporting the time spent in the ED on the public website allows health care providers to track and assess:

- The time patients spent in the ED
- Ontario's progress in reducing wait times and improving ED performance

NACRS Data Submission Methodology

The following section describes the details and notes on specific data elements that are relevant to NACRS data submission[1], some of which are used for P4R KPI calculations.

> This section provides information to act as a quick reference for NACRS data elements. For details on NACRS data submission, please refer to *NACRS Abstracting Manual, 2025-2026*[1].

Click on each to jump to that section:

- ED Visit
- Patient Arrival for Non-Ambulance Patients
- Referral Source Prior to Ambulatory Care Visit
- Ambulance Arrival and Transfer of Care Process
- Triage
- Presenting Complaint
- Registration
- Initial Assessment
- Main Intervention
- Clinical Decision Unit (CDU)
- Visit Disposition and Patient Left ED
- Discharge Diagnosis

[1] Canadian Institute for Health Information. National Ambulatory Care Reporting System Abstracting Manual, 2025-2026. Ottawa, ON: CIHI; 2025.

ED Visit

All metrics associated with the P4R Program are measured using unscheduled ED visit volumes only.

> Cases where ED visit indicator is = “0” are excluded from P4R calculations.

NACRS Data Element Name	NACRS Description
ED Visit Indicator	Indicates whether a visit reported under the emergency MIS functional centre account code is an arranged day surgery or clinic visit taking place in the ED or an ED visit.
Valid Data Legend	
Code	**Description**
0	**Not an ED visit:** Scheduled visits to the emergency department where the visit date and time are fixed and the appointment is recorded in a scheduling system (electronic or manual).
1	**ED Visit:** Visits to the emergency department where the presentation does not fall into category 0 (Not an ED visit).
Note	
When organized clinic or day surgery areas are unavailable (occurs more often in rural facilities and occasionally after regular clinic/day surgery hours in urban facilities), patients may receive treatment or consultations in the emergency department. This indicator differentiates these two types of ED visits to ensure that each ED record is correctly grouped and reported on.	

Patient Arrival for Non-Ambulance Patients

Hospitals can submit Arrival Date and Time data elements. The completion of these fields is optional for the Province of Ontario.

NACRS Data Element Name	NACRS Description
Arrival Date and Time	Arrival Date and Time indicates the arrival of a patient at the emergency department for services.

The calculation of 90th percentile ED LOS is measured by the time between Triage Date and Time or Registration Date and Time (whichever occurs first) and Patient Left ED Date and Time. Neither arrival times nor ambulance arrival times are used for these calculations, even when those data elements are complete.

Referral Source Prior to Ambulatory Care Visit

Hospitals can also submit Referral Source data elements. The completion of these fields is optional in Level 1, but mandatory in level 3 for Ontario hospitals.

NACRS Data Element Name	NACRS Description
Referral Source	Referral Source Prior to Ambulatory Care Visit identifies the person or agency that referred the patient for emergency or ambulatory care service in the reporting facility.

When referral source 08 (Legal Service) is recorded and the patient is referred to the ED by drug court or by law enforcement under the Mental Health Act, it is mandatory to complete Special Project 270 (Ministry Other Referral Source). For more information on Project 270, see the NACRS Abstracting Manual.

Ambulance Arrival and Transfer of Care Process

EMS refers to the treatment and transport of people in crisis health situations that may be life-threatening. There are over 50 recognized regional EMS providers in Ontario.

NACRS Data Element Name	NACRS Description
Admit Via Ambulance	Identifies whether a patient arrives at the reporting facility via ambulance and the type of ambulance that was used.
Ambulance Arrival Date and Time	The date and time when the ambulance/EMS pulls into the hospital driveway and arrives at the hospital. If arrival is by air ambulance (for sites with a helipad), it is the date and time when the aircraft lands on the facility's helipad.
Ambulance Transfer of Care Process Date and Time	Date and time when the ambulance personnel turn over care of the patient to the ED/hospital staff and no longer have responsibility for the patient.

Note
The term, ambulance, includes all licensed ambulances (and other ambulances only if they are part of a recognized program within a province), inter-facility transfer service units and air ambulances having the capability of providing medical intervention to a service recipient on route to the destination.

Triage

The patient then moves into triage where the process of determining the priority of the patient's treatment based on their symptoms and severity of condition begins. The goals of triage are to:

- Rapidly identify patients with urgent, life-threatening conditions
- Determine most appropriate treatment area for patients presenting to the ED
- Decrease congestion in emergency treatment areas
- Provide ongoing assessment of patients
- Provide information to patients and families regarding expected care and waiting times
- Contribute information that helps to define departmental acuity
- Assess and assign a CTAS value

NACRS Data Element Name	NACRS Description
Triage Date and Time	Date and time when the patient is triaged in the ED.
Triage Level (CTAS)	Categorizes the patient according to the type and severity of the patient's initial presenting signs and symptoms.

Note
The Canadian Triage Acuity Scale (CTAS) is used to determine the triage level. This scale was developed by the Canadian Association of Emergency Physicians (CAEP), and it is applicable to all patients seen in an ED. CTAS is a five-point scale used to more accurately define patient needs and allow for timely care. As per Canada Association of Emergency Physicians (CAEP) guidelines, the time from patient arrival to triage should be less than 15 minutes. Following this standard helps to reduce medical and legal risk and, most importantly, improves patient safety; hospitals are responsible for monitoring their performance and ensuring compliance with this standard. In general, sites will need to plan for both predictable variations in patient arrivals, as well as unexpected surges. As per CAEP, the triage date and time should coincide with the assignment of a triage level, as well as the collection of the following key assessment items: • Chief complaint or presenting concerns

- Subjective history (onset of injury/symptoms)
- Allergies and medications, if applicable
- Diagnostic, first aid measures, therapeutic interventions, if applicable

Presenting Complaint

Hospitals can also submit Presenting Complaint data elements. The completion of these fields is optional in Level 1, but mandatory in Level 3 for Ontario hospitals. Hospitals can submit up to three occurrences.

NACRS Data Element Name	NACRS Description
Presenting Complaint	The symptom, complaint, problem or reason for seeking emergency medical care as identified by the patient, expressed in terms as close as possible to those used by the patient or responsible informant.
Note	
The CEDIS Presenting Complaint List was developed by the Canadian Emergency Department Information System (CEDIS) Working Group with CAEP.	

Registration

Typically, the patient chart, medical record and electronic medical record (EMR) visit (if applicable) are created during registration.

NACRS Data Element Name	NACRS Description
Registration Date and Time	Date and Time when the patient is officially registered for emergency or ambulatory care services.
Health Care Number	Patient's unique health care coverage number s assigned to the patient by the provincial/territorial or federal government.
Province/Territory Issuing Health Care Number	Province/territory or federal government from which the health care number was issued.
Responsibility for Payment	Identifies the primary source responsible for payment of service(s) rendered.

NACRS Data Element Name	NACRS Description
Postal Code	The six-digit alphanumeric code assigned by Canada Post to identify the patient's place of residence.
Recorded Sex or Gender	One alpha character describing the sex of the patient.
Birthdate	The date the patient was born.

Initial Assessment

During initial assessment, sites collect data on the time a patient is first seen by a clinician. Depending on the clinician, there are two ways to document the initial assessment:

Physician Initial Assessment (PIA)

For the purposes of P4R Program, an "assessment" refers to a medical assessment, which involves a direct interaction between a doctor and a patient, resulting in a doctor-patient relationship with its attendant obligations and implications. The physician must document the results of this assessment in the medical record and sign their name to it. As the only physician associated with the patient at this time, they become the most responsible physician (MRP) for the patient until care is assumed by another physician.

Non-Physician Initial Assessment (NPIA)

An initial assessment can be conducted by a non-physician provider who has the capacity and authority to make treatment decisions independent of the physician.

Only initial assessments completed by physician assistants (PA), nurse practitioners (NP) or dentists can be used in the calculation of the Time to NPIA indicator.

NACRS Data Element Name	NACRS Description	Notes
Date and Time of Physician Initial Assessment	Date and time when patient was first assessed by a physician in the ED.	In Ontario, this must be a face-to-face encounter between the physician and patient (or significant other acting on behalf of the patient).
Date and Time of Non-Physician Initial Assessment	Date and time when a patient is first assessed or evaluated by a non-physician provider.	Eligible NPIA includes NPs, PAs and dentists.

NACRS Data Element Name	NACRS Description	Notes
Non-Physician Initial Assessment Provider Service	The specialty of the non-physician provider who performed the initial assessment of the patient.	A non-physician provider is defined by a Provider Service Number (data element 41).

> The initiation of medical directives, the review of ECG's, X-rays or blood work and telephone consultations with the ED physician do not constitute as initial assessment and must not be documented in those fields.

Main Intervention

Hospitals can also submit Main Intervention data elements. The completion of these fields is optional in Level 1 but mandatory in Level 3 for Ontario Hospitals.

NACRS Data Element Name	NACRS Description
Main Intervention	Main Intervention is the one intervention considered by the health care provider(s) to be the most clinically significant for the improvement of health, alteration or diagnosis of the course of a disease (health condition) to promote wellness.
Note	
The intervention is captured in a CCI code that describes the service (procedure/intervention) performed for or on behalf of a patient.	

Clinical Decision Unit (CDU)

The CDU Program serves an important role in enabling Ontario hospitals to manage a hospital-specific subset of ED patients. The CDU is an area or section to which emergency department patients may be formally assigned following their initial ED assessment and care. The purpose of clinical decision units is to provide facilities for short term (<24 hours) monitoring, investigation and treatment to support disposition decisions.

Please refer to the *CDU Manual* for further information.

NACRS Data Element Name	NACRS Description
Clinical Decision Unit Flag	Indicates if the patient was placed in a clinical decision unit during their emergency visit.

NACRS Data Element Name	NACRS Description
Clinical Decision Unit Date In and Time In	Date and time when the patient arrived in the clinical decision unit.
Disposition Date and Time	Date and time when a decision is made by a service provider about the patient's disposition.
Clinical Decision Unit Date Out and Time Out	Date and time when the patient leaves the CDU. *Only use when Disposition Date and Time is unknown (9999) or blank*
Note	
The best available marker for the Disposition Date and Time is typically the date and time when the service provider issues the disposition order or request.	

Visit Disposition and Patient Left ED

Disposition refers to a point at which a physician or consultant makes a decision about what treatment the patient should receive, or whether to admit or discharge a patient. The last step of the patient journey refers to the point at which the patient leaves the ED (admission, discharge or transfer to another facility).

NACRS Data Element Name	NACRS Description
Visit Disposition	Patient's type of separation from the ambulatory care service after registration.
Disposition Date and Time	Date and time when a decision is made by a service provider about the patient's disposition.
Date and Time Patient Left ED	Date and time the patient physically leaves the ED and does not return during that encounter.
Note	
The best available marker for the Disposition Date and Time is typically the date and time when the service provider issues the disposition order or request.	

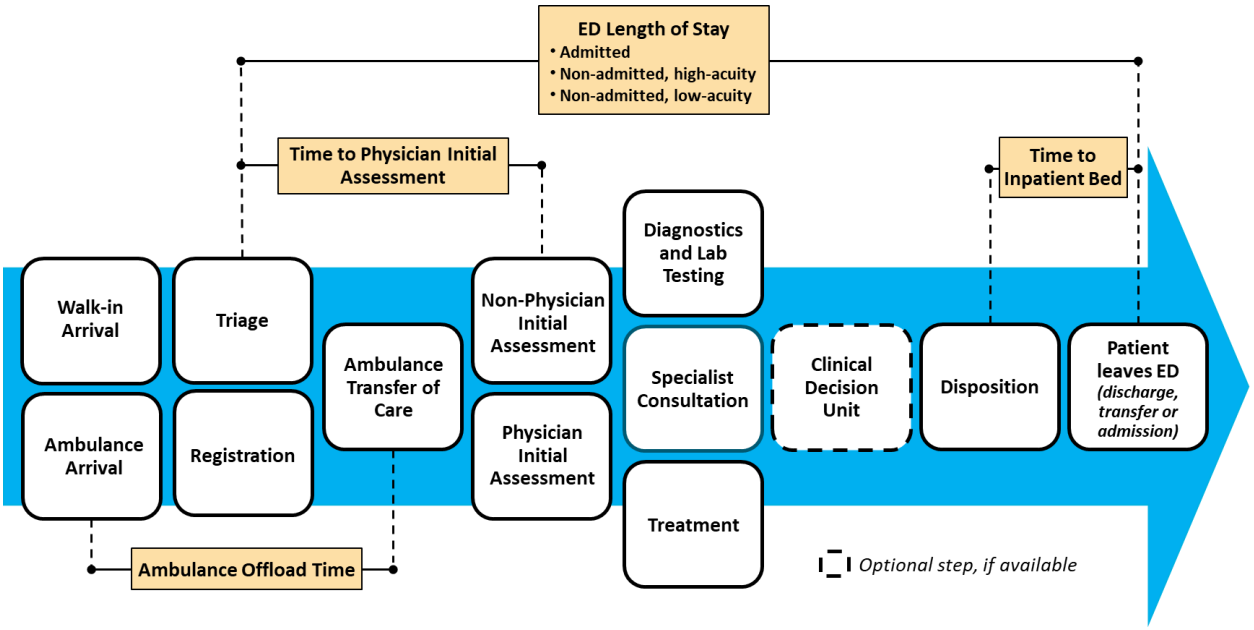
Appendix C: P4R KPI Descriptions and Methodology

There are six KPIs used to measure ED performance in the P4R Program (see Figure 11):

- Ambulance Offload Time (AOT)
- Time to Physician Initial Assessment (PIA)
- Time to Inpatient Bed (IPB)
- ED Length of Stay (LOS) for admitted patients
- ED LOS for non-admitted, high-acuity patients
- ED LOS for non-admitted, low-acuity patients

The sections below provide the indicator descriptions, their calculation using specific NACRS data elements and any additional guidance and clarification on their clinical application and interpretation.

Figure 11. P4R KPIs in Relations to Points in Patient Journey Through the ED



Ambulance Offload Time (AOT)

Indicator Description: Total time elapsed from **ambulance arrival** to **transfer of care process** (for all patients arriving via ambulance).

> **AOT formula using NACRS data elements**:
> AOT = (Ambulance TOC Process Date and Time) - (Ambulance Arrival Date and Time)

NACRS Data Element Name	NACRS Description	Note
Ambulance Arrival Date and Time	The date and time when the ambulance/Emergency Medical Services (EMS) pulls into the hospital driveway and arrives at the hospital.	If arrival is by air ambulance (for sites with a helipad), it is the date and time when the aircraft lands on the facility's helipad.
Ambulance Transfer of Care Process Date and Time	Date and time when the ambulance personnel turn over care of the patient to the ED/hospital staff and no longer have responsibility for the patient.	The transfer of care process can occur when the patient is transferred to an ED stretcher, bed, chair, or any other area in the ED, with the consent of the ED staff or when care of the patient has been assumed by other ambulatory care staff (for example, day surgery or clinic).

Additional Guidance and Clarification

To ensure the AOT process is measured and documented accurately and consistently hospitals should:

- Assess ED operations, develop standard operating procedures, in collaboration with local paramedic services, and provide standardized messaging and communication to all staff

Collaboratively review EMS data related to AOT performance and establish structures, whereby both hospital and EMS leadership regularly review processes to ensure consistent clinical processes and accurate data collection.

Time to Physician Initial Assessment (PIA)

Indicator Description: Total time elapsed from **triage** or **registration** (whichever is earlier) to **physician** or non-physician **initial assessment** (whichever is earlier) for all patients.

> As of April 2010, a blended methodology is used to determine Time to PIA. Specifically, Time to PIA can be determine using initial assessment by a physician or by a non-physician health care provider—nurse practitioners, physician assistants or dentists (whichever is earlier). The latter is referred to as Time to Non-Physician Initial Assessment (NPIA).

> **Time to PIA formula using NACRS data elements**:
>
> Time to PIA = (PIA Date and Time) - (Triage/Registration Date and Time)
> or
> (NPIA Date and Time) - (Triage/Registration Date and Time)
>
> } Whichever is earlier is used

NACRS Data Element Name	NACRS Description	Note
Triage Date and Time	Date and time when the patient is triaged in the ED.	As per hospital process
Registration Date and Time	Date and Time when the patient is officially registered for emergency or ambulatory care services.	As per hospital process
Date and Time of Physician Initial Assessment	Date and time when patient was first assessed by a physician in the ED.	In Ontario, an assessment must be a direct, face-to-face encounter between the provider and patient or significant other acting on behalf of the patient resulting in a provider-patient relationship with its attendant obligations and implications.
Date and Time of Non-Physician Initial Assessment	Date and time when a patient is first assessed or evaluated by a non-physician provider.	For the purposes of the PIA indicator, only the following NPIA service types are used: nurse practitioners, dentists and physician assistants.

Additional Guidance and Clarification
The initiation of medical directives, the review of ECG's, X-rays or blood work, and telephone consultations with the ED physician or non-physician provider do not constitute "initial assessment". In March 2023, the following was clarified regarding **Physician at Triage** model of care: • If a physician is performing triage alone and did not completing an initial assessment, this does not count as PIA, and as a result, a PIA should not be flagged as completed/ triggered. A physician should not trigger a PIA and document an assessment, unless they met the standard of care in doing so.

Time to Inpatient Bed (IPB)

Indicator Description: Total time elapsed from **disposition decision** to **patient left ED** (for admitted patients only).

Time to IPB formula using NACRS data elements:

Time to IPB = (Date and Time Patient Left ED) - (Disposition Date and Time)

NACRS Data Element Name	NACRS Description	Note
Disposition Date and Time	Date and time the decision was made about the patient's disposition	The date and time the main service provider **(Physician, Nurse Practitioner)** makes the decision about the patient's disposition. The best available marker for the Disposition Date is the date when the service provider issues the disposition order or request **(admission or discharge order)**. It is the end point for an ED visit.

NACRS Data Element Name	NACRS Description	Note
Date and Time Patient Left ED	Date and time the patient physically leaves the ED	For admitted patients, this is the time of transfer to an inpatient bed, when the patient physically leaves the ED. If patient is going to the operating room (OR) first for an inpatient surgical procedure, the documented time when the patient went to the OR (Time to OR) should be used as the Time Patient Left ED.

ED Length of Stay (LOS)

> For hospitals with a CDU, see next section for ED LOS calculation for patients assigned to CDU.

Indicator Description: Total time elapsed from **triage** or **registration** (whichever is earlier) to **patient left ED**.

This indicator is calculated for three patient populations:

- Admitted patients
- Non-admitted, high-acuity patients (i.e., CTAS 1-3)
- Non-admitted, low-acuity patients (i.e., CTAS 4-5)

> **ED LOS formula using NACRS data elements**:
>
> ED LOS = (Date and Time Patient Left ED) - (Triage/Registration Date and Time)

NACRS Data Element	NACRS Description
Triage Date and Time	Date and time when the patient is triaged in the ED.
Registration Date and Time	Date and time when the patient is officially registered for emergency or ambulatory care services.
Date and Time Patient Left ED	Date and time the patient physically leaves the ED and does not return during that encounter.

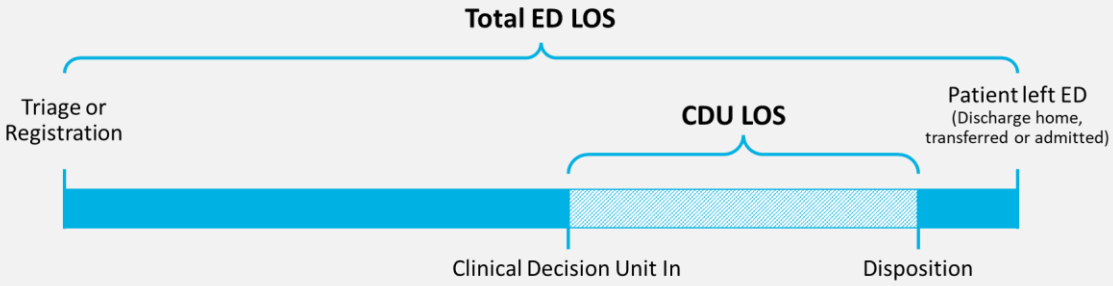
ED LOS with CDU Status

A CDU is a care pathway in which patients in the ED may be formally assigned following their initial assessment and care. Specifically:

- It should be used for patients in the ED who require additional short-term (i.e., less than 24 hours) observation, investigation, consultation and/or treatment to support a disposition decision and avoid hospital admission.
- A CDU can be a physical space (e.g., separate area in the ED) or a virtual assignment (e.g., CDU status for a patient in the ED on the medical chart).

Currently only large volume sites operate CDUs within the P4R Program. Refer to the *CDU Manual* for more details.

The **CDU Length of Stay (LOS)** is a subsection of the total ED LOS. When an eligible patient (at an approved CDU Site) is assigned to a CDU, their time spent in the CDU (or CDU LOS) is excluded from their total ED LOS calculation.



CDU LOS formula using NACRS data elements:

CDU LOS = Disposition Date and Time - Clinical Decision Unit Date In and Time In

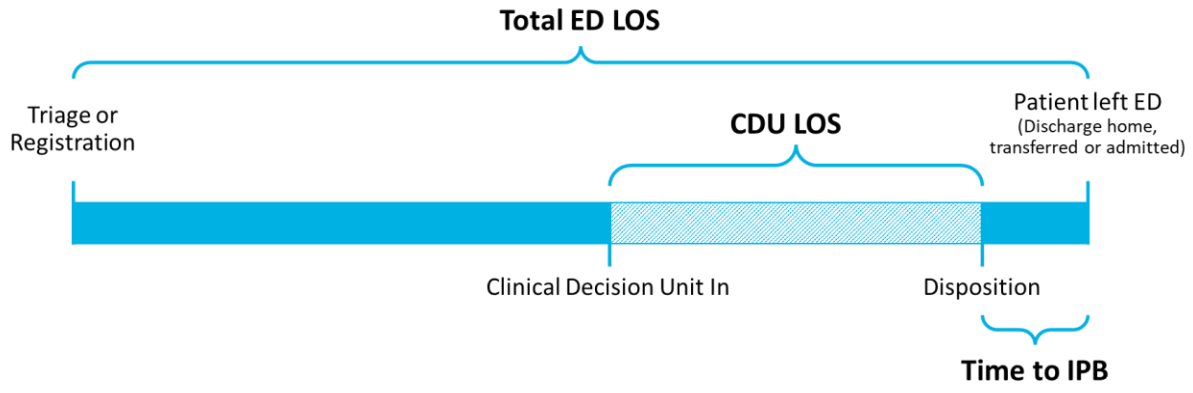
ED LOS formula (for those with CDU status) using NACRS data elements:

ED LOS = [(Date and Time Patient Left ED) - (Triage/Registration Date and Time)] - CDU LOS

NACRS Data Element Name	NACRS Description	Note
Clinical Decision Unit Date In and Time In	Date and time when the patient arrived in the clinical decision unit.	
Disposition Date and Time	Date and time the decision was made about the patient's disposition	The date and time the main service provider (physician, nurse practitioner) makes the decision about the patient's disposition. The best available marker for the Disposition Date is the date when the service provider issues the disposition order or request (admission or discharge order). It is the end point for an ED visit.

Additional Guidance and Clarification

For admitted patients: The time interval between disposition decision and when the patient leaves the ED is used to calculate another P4R KPI, **Time to Inpatient Bed (IPB)**. That interval is not included in the CDU LOS calculation.

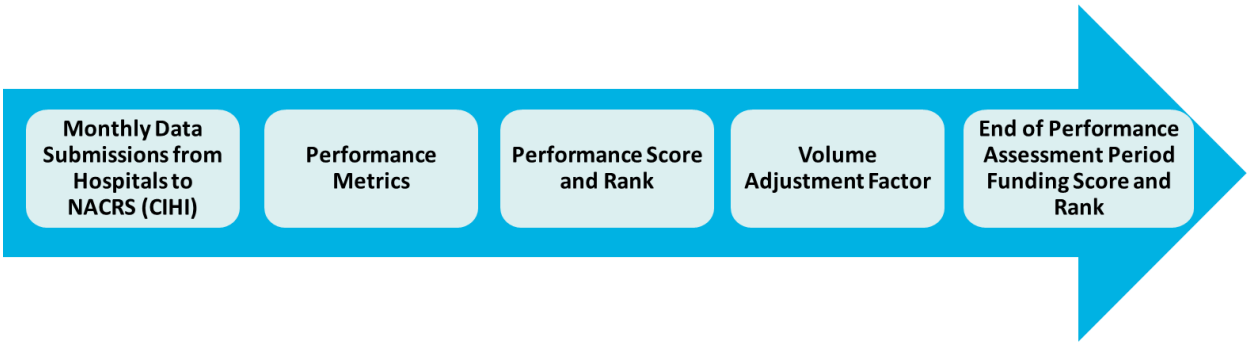


Appendix D: Funding Methodology

Variable P4R Funding Calculation

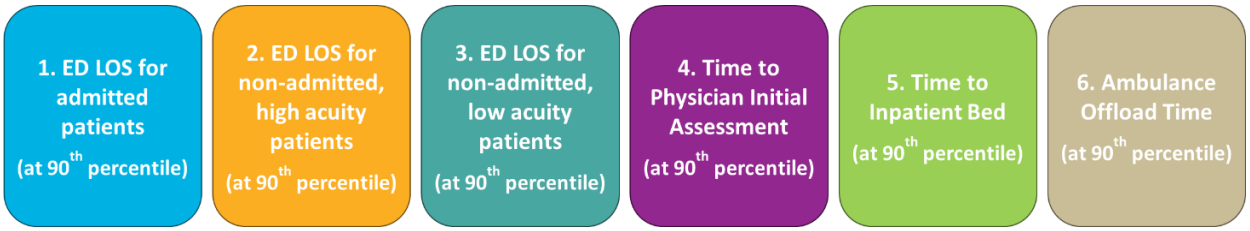
The P4R methodology evaluates performance based on overall performance and sustained improvement over time for Large-Volume Program. Additionally, P4R rewards performance and improvement in Large-Volume hospitals using an overall volume-adjustment factor (see Figure 12Figure 12.). Funding is based on each hospital's funding score relative to all other hospitals in the Large-Volume Program. Six indicators are used to assess performance (see Figure 13).

Figure 12. P4R Assessment Overview



While the ministry supports the exploration of virtual care as a novel opportunity in the provision of emergency/urgent care services (and wishes to capture that data), virtual visits will be excluded from ED patient volumes at this time for the purposes of public reporting, P4R performance and other funding formulas that include ED patient volume within their funding methodology.

Figure 13. P4R Funding Methodology Indicators



Funding Methodology for Large-Volume Program

Funding is determined using the following methodology (Table 8).

Table 8. P4R Funding Methodology

Step	P4R Funding Methodology Indicators (#1 to #5)	Ambulance Offload Time (AOT) Indicator
1: Current Score	The performance period, December 1-November 30, is used to measure P4R-participating hospitals' performance for the first five P4R indicators (see Section 0) for each funding year. Each hospital is ranked per indicator and assigned a score of 1-76 (with the #1 ranked site for that indicator receiving a score of 76 and the #76 ranked site for that indicator receiving a score of 1).	The performance period, December 1-November 30, is used to measure performance for each of the 76 participating hospitals for each funding year. Each site is ranked based on their AOT at the 90th percentile and assigned a score of 1-76 (with the #1 ranked site receiving a score of 76, and the #76 ranked site receiving a score of 1). Note: Current performance is weighted at a full 100%. An improvement-over-time adjustment is not used to determine funding for the AOT indicator.
2: Improvement Score	For the first five indicators, the average monthly difference in performance for each P4R-participating hospital since April 2016 is measured against that site's baseline FY 2015/16 performance data. If a hospital joined the P4R Program subsequent to FY 2015/16, their baseline performance will be derived from the December-November performance data collected prior to that site's first P4R funding period. The same ranking and scoring process is followed as noted in Step (1),	

Step	P4R Funding Methodology Indicators (#1 to #5)	Ambulance Offload Time (AOT) Indicator
	resulting in an “improvement over time” score for each site.	
3: Weighted Score	For each of the first five indicators, the current score is multiplied by 70% and the improvement score is multiplied by 30%.	
4: Volume Adjustment	The patient volumes for each of the first five indicators are used to determine each hospital’s share of the total provincial ED patient volume for the indicator (i.e., the volume distribution per site). A volume-adjustment factor of 100 is then applied to the volume distribution for each of the five indicators, which is multiplied by the weighted scores for each indicator from Step (3) to give a volume-adjusted score for each site.	Each hospital’s share of the total provincial ambulance volume is calculated to give the volume distribution per site. A volume-adjustment factor of 100 is then applied to the hospital’s ambulance volume distribution which is multiplied by the current AOT score from Step (5) to give a volume-adjusted score for each hospital. Note: Patients arriving via ambulance are counted in both the ambulance volumes and the associated ED volumes in Step (4).
5: Total Volume-Adjusted Score for all 6 indicators	After volume-adjustment factors from Step (4) have been applied for the first five P4R indicators and AOT, they are combined to determine each hospital’s final volume-adjusted score and P4R funding rank.	
6: Variable Funding Calculation	The volume-adjusted scores for all hospitals are combined to form a provincial sum. The total variable P4R budget is divided by the provincial sum to calculate a dollar amount per point of each hospital’s final volume-adjusted score. Each hospital’s score is multiplied by this per-point dollar amount to determine their earned share of the overall variable P4R budget.	

Step	P4R Funding Methodology Indicators (#1 to #5)	Ambulance Offload Time (AOT) Indicator
Final Funding Calculation	The final funding value is the sum of fixed funding and the calculated earned share of the total variable P4R budget from Step (6).	

"Improvement over time" is not included as part of the funding methodology for the AOT indicator, as the indicator was introduced at a different point in time relative to the five original P4R indicators.
P4R funding formula only compares hospitals by performance and volume, not by type of hospital.

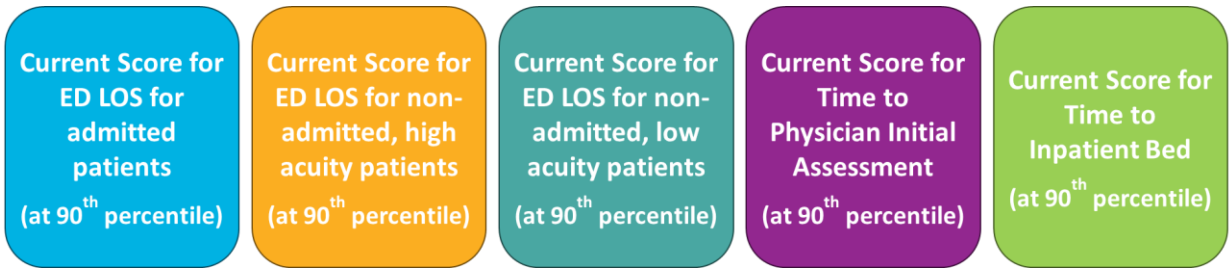
Volume adjustments are made in an effort to align strategy costs with impact on patient flow.
For example, the costs associated with initiatives to improve flow in a 35,000 visit/year ED (e.g., implementing one new Flow Navigator) are likely smaller than those associated with initiatives to improve flow in a 100,000 visit/year ED (e.g., it may require three new Flow Navigators to decrease ED LOS).

Detailed Methodology for Variable Funding

First 5 Indicators

CURRENT SCORE

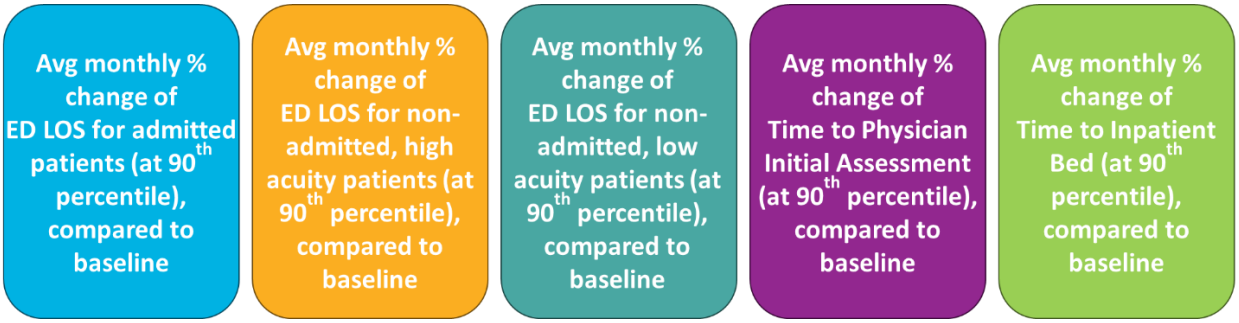
The current score ranks the best performing hospital compared to other participating hospitals in the Program based on the NACRS data for the P4R performance assessment period (December 1–November 30). Each site is ranked for each of the indicators and assigned a score of 1-76 (with the #1 ranked site for each indicator receiving a score of 76, and the #76 ranked site receiving a score of 1). The scores for the first five indicators are then combined to determine a current score for each site.



IMPROVEMENT OVER TIME

The Improvement-Over-Time score rewards improvement in performance compared to the hospital's own performance in the baseline year of FY 2015/16. Improvement-Over-Time score is determined by taking the average monthly improvement over the hospital's own baseline performance for all the months since April 2015 to November of the current performance period. Each hospital is then given a score based on how they rank for each indicator relative to all other sites in the Program.

As some of the underlying factors evolve with time, the Program periodically adjust the baseline year. The Improvement-Over-Time score also tends to dampen the funding impact of short-terms swings in performance and rewards sustained improvements or their converse.



WEIGHTED SCORE

For each of the first five indicators, the current score is multiplied by 70%, and the Improvement-Over-Time score is multiplied by 30%.

VOLUME ADJUSTMENT

The volume adjustment is included to recognize that higher volume EDs may require more resources to achieve performance improvement. The first five indicators are associated with specific patient cohorts (i.e., admitted, non-admitted, etc.). Each indicator's score is individually adjusted for the proportion of the hospital's share of the total provincial ED volume for the associated patient cohort. For example, ED LOS for admitted patients and Time to Inpatient Bed indicators are both adjusted individually for the hospital's volume contribution to the total provincial admitted ED volume. This volume adjustment reflects the hospital's impact to the provincial performance. Each indicator's weighted score, as described in the above section, is multiplied by the hospital's share of the provincial visits for the associated patient cohort and a volume-adjustment factor of 100.

Volume-Adjusted Score = Weighted Score x (Site's Share of Provincial Visits) x 100

To place more emphasis on ED inpatient indicators, the LOS for admitted patients and Time to Inpatient Bed indicators have been grouped together by patient cohort (see Table 9) for the volume distribution calculation.

Table 9. P4R Indicators Grouped by Patient Cohort

P4R Indicator	Patient Cohort
• 90th percentile ED LOS for admitted patients • 90th percentile Time to Inpatient Bed	Admitted ED patients
• 90th percentile ED LOS for non-admitted, high acuity patients	Non-admitted high-acuity ED patients
• 90th percentile ED LOS for non-admitted, low acuity patients	Non-admitted low-acuity ED patients
• 90th percentile Time to Physician Initial Assessment	All ED patients

Ambulance Offload Time (AOT) Indicator

CURRENT SCORE

Current score is determined using the NACRS data for the P4R performance period (December 1–November 30). Each site is ranked based on their 90th percentile AOT and is assigned a score of 1-76 (with the #1 ranked site for the AOT indicator receiving a score of 76, and the #76 ranked site receiving a score of 1).

> Current AOT performance is weighted at 100%. Improvement Over Time is not used to determine funding for AOT.

AMBULANCE VOLUME-ADJUSTMENT FACTOR

The volume adjustment reflects the hospital's impact to the provincial AOT performance. Each hospital's current AOT score, as described in the above section, is multiplied by the hospital's share of the provincial ambulance volume and a volume-adjustment factor of 100.

Combined 6 Indicators

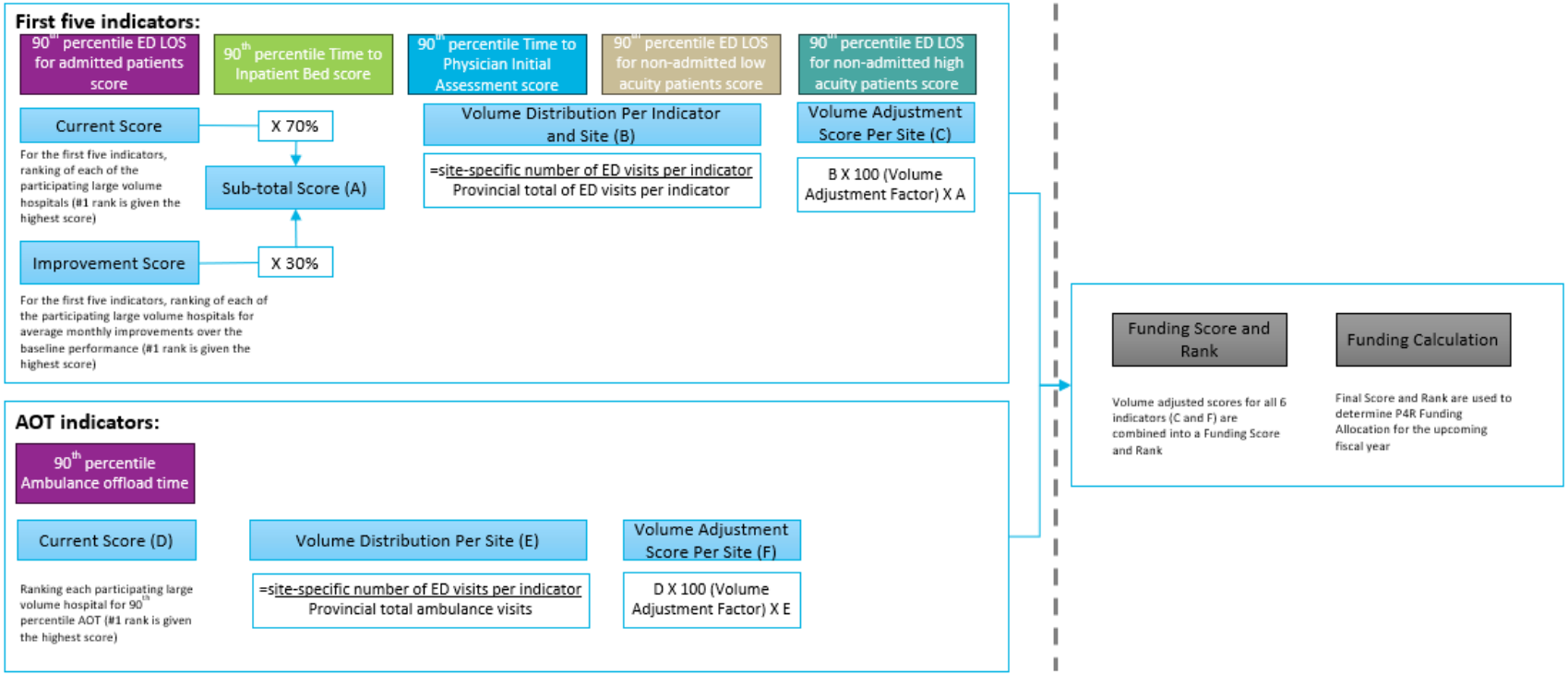
TOTAL VOLUME-ADJUSTED SCORE FOR ALL 6 INDICATORS

After the respective volume-adjustment factors have been applied for the first five P4R indicators and AOT, they are combined to determine each hospital's final volume-adjusted score and P4R funding rank.

FUNDING CALCULATION

The volume-adjusted scores across all P4R sites are combined to form a provincial sum (see Figure 14). The provincial P4R funding allocation for the year will be divided by the provincial sum to calculate a dollar amount 'per point' for each hospital's final adjusted score. The 'per point' dollar amount is multiplied by each hospital's score to determine individual hospital's final dollar amount from the provincial P4R funding allocation. This competitive approach to funding allocation is used to ensure the full budgeted amount is allocated to hospitals each year to maximize benefit from the Program's investments.

Figure 14. Detailed P4R Methodology Process Flow



Appendix E: Data Quality and Compliance

Compliance and data quality is a shared responsibility between P4R hospitals and Ontario Health. Ontario Health reviews and analyzes the feedback provided by hospitals and assigns compliance designations. The compliance process is designed to allow hospitals to proactively manage submissions and operational performance. Ontario Health is available to help hospitals identify issues and develop a resolution plan based on best practices and lessons learned from other hospitals.

Monitoring Data Quality

Ontario Health monitors ED data quality through four dimensions (see Figure 15). Data is evaluated monthly to ensure that it is usable for its intended purposes of planning and decision making for all Program partners.

Figure 15. Data Quality Matrix

Timeliness	Validity	Reliability	Usability
Freshness • Change in refreshed data **Currency** • Data submissions	**Accuracy** • Clinical logic of events • Rate of defaulting or "proxy" data **Completeness** • Usable KPI records	**Consistency** • Performance trends for KPI • Distribution of volumes compared to historical data	**Relevance** • Meeting stakeholder needs • Exclusion criteria **Accessibility** • Presentation of data

Ontario Health's Data Quality Team generates an ED Data Quality Report monthly, which includes the following indicators:

- **18 compliance indicators** that measures a hospital's ability to meet data submission requirements, including completeness and variation in performance and volumes, compared to historical data
- **12 data usability indicators** to measure the number of records usable based on the submitted data to calculate KPIs
- **11 information indicators** to gain additional insights on data trends and variation such as defaulting values and demographic data

Data Quality Designations

The Data Quality team is also responsible for informing the accuracy and usability of data. Using a combination of the 12 usability indicators and feedback received from hospitals, the Data Quality team determines whether a hospital's data is suppressed from all reporting on a month-to-month

basis (see Table 10). Depending on the data quality issues identified and the severity, the following scenarios could occur:

- All data is reported, accompanied by a Data Quality note explaining the specific data issue. This data should be interpreted with caution.
- Data is suppressed. Data is only reported where usable for a specific site (with a Data Quality note) and otherwise suppressed with a Reporting Issue (RI) designation.
- No data is usable for a specific site. All data is suppressed, and an "RI" designation is applied for all indicators.

> Data Quality team will make every effort to work with hospitals to resolve any data quality issues and ensure data is reportable. Data suppression is evaluated on a case-by-case basis.

Table 10. Data Quality Designation Definitions

Data Quality Designation	Definition
Reporting Issue (RI)	Hospital did not meet the data quality requirements for reporting purposes and/or did not participate in the compliance process
Not Required to Report (NS)	Not required to report or no service offered
No Volume (NV)	Hospital did not perform this service or did not have any ED visits during the reporting period
Low Volume (LV)	Volume of cases reported is too low for reporting

Monitoring Compliance

Ontario Health conducts monthly compliance processes to:

- Support hospitals in meeting the ED operational requirements for data submission and data quality
- Mitigate ED data collection issues
- Maintain and improve data quality
- Provide hospitals with an understanding of their operational performance

When the ED Data Quality Report identifies potential issues in a hospital's data based on the compliance indicators, Ontario Health's Compliance Team follows up with the hospitals accordingly to identify if the data is suitable for reporting (see Table 11).

Hospitals are asked to submit their feedback monthly and action plans (when required) using the *Interim/Final Compliance Report and Feedback Tool* for any indicators flagged for potential non-compliance. After the feedback deadline has passed and feedback is reviewed, the final compliance designations are published monthly on the *ED Compliance Designation Report*.

For each compliance indicator, a hospital will be designated compliant if the submission requirement has been achieved. A hospital will be designated non-compliant if the submission requirement has not been met and/or the data has been confirmed inaccurate.

> Facilities have until the end of the **15th business day of each month** to submit their feedback.

Table 11. List of Compliance Indicators

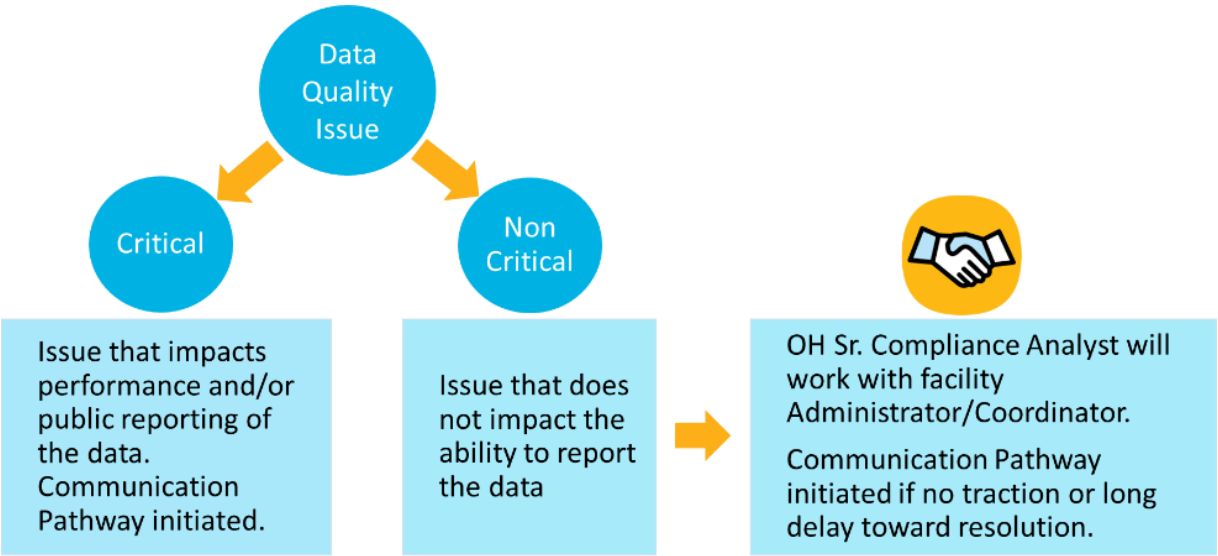
Dimension	Indicator
Comprehensiveness	• Percent variance in ED Level 1 reported volumes compared against ED Level 3 reported volumes in the same month of the previous fiscal year • Percent variance in ED Level 1 reported ambulance volumes compared against ED Level 3 reported ambulance volumes in the same month of the previous fiscal year

Dimension	Indicator
Completeness	• Percent of records with complete Ambulance Arrival date and time • Percent of records with complete Ambulance Transfer of Care Process date and time • Percent of records with complete Triage date and time • Percent of records with complete Triage Level • Percent of records with complete PIA or NPIA date and time • Percent of records with complete Disposition date and time • Percent of records with complete Patient Left ED date and time
Accuracy	• 90th percentile ED LOS for admitted patients compared to historical performance • 90th percentile ED LOS for non-admitted complex patients compared to historical performance • 90th percentile ED LOS for non-admitted minor patients compared to historical performance • 90th percentile Time to Inpatient Bed compared to historical performance • 90th percentile Time to PIA compared to historical performance • 90th percentile AOT compared to historical performance
Consistency	• In one or more months of the open fiscal year, ED volumes for the most recently submitted data have changed by 5% or more compared to the initial volumes submitted by the 10th business day

Critical Communication Pathway

The Critical Communication Pathway may be initiated to ensure senior leadership awareness for major data quality issues or to obtain support when data quality issues are not resolved in a timely manner. Ontario Health may be required to proceed along the pathway when the hospital is not engaged or there is limited activity toward resolving the issue (see Figure 16). Data quality issues are typically classified as either critical issues that impact reportability or non-critical issues.

Figure 16. Critical Communication Pathway



A facility's Chief Information Officer (CIO) is notified at the onset of a critical issue that the data will be suppressed and unavailable for both public and performance reporting. Ontario Health will continue to work with the Facility Coordinator to resolve the issue. The CIO is informed again after three months if the issue is ongoing and has not been resolved. The CIO is further engaged if the issue persists with no action plan provided. If there is still no traction on the issue, the hospital's Chief Executive Officer may be engaged and subsequently the Board Chair.

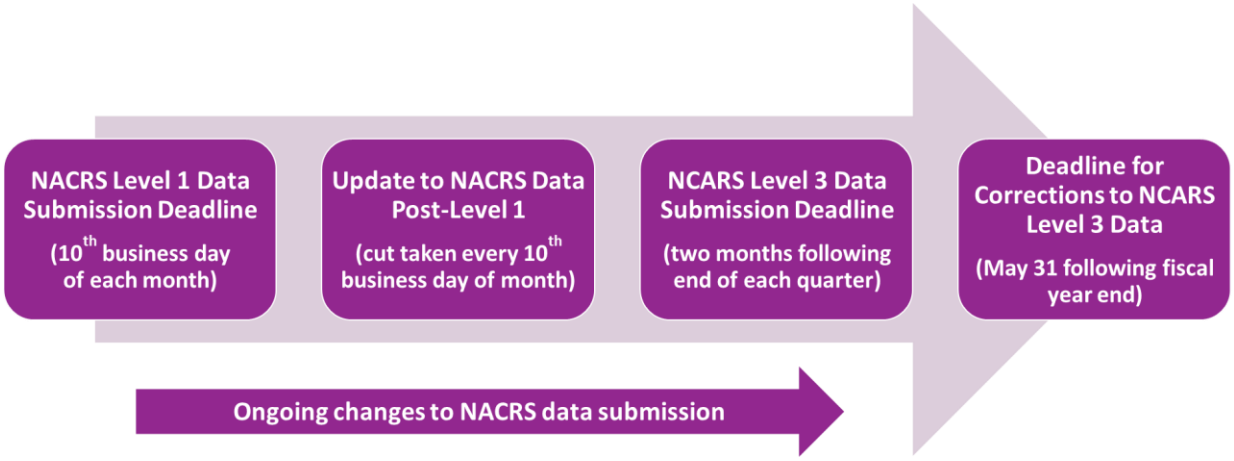
The Critical Communication Pathway combined with the robust data quality framework ensures that the highest level of data quality is available for funding, performance and public reporting purposes.

Refreshed Historical Data

The historical months in the open fiscal year are refreshed in Ontario Health reports with the most recent data available in NACRS. Refreshed data will include all data corrections submitted by sites to CIHI each month (see Figure 17). Hospitals can submit Level 3 data for any month within the fiscal year up until May 31 following that fiscal year.

> The public wait times website is not refreshed with Level 3 submissions.

Figure 17. Refreshed Historic Data Process



While the performance reports containing historical data are refreshed using NACRS Level 3, it is crucial that hospitals strive for the highest data quality in their Level 1 submissions by the ED NACRS deadlines, as mandated by the ministry. Level 1 data in these reports are used to evaluate the impact of investments and support ongoing decision-making for health care organizations across Ontario.

> Hospitals that opt to submit only Level 3 data must still meet Level 1 timelines to ensure high-quality performance monitoring and reporting.

Common Compliance Questions

Why is there an Interim Compliance Report (ICR) and Final Compliance Report (FCR)?

There are two submission monthly deadlines for ED Level 1 data: the interim deadline on the 3rd business day, and the final deadline on the 10th business day. The ICR is released by the end of the 6th business day. It provides hospitals an opportunity to review and address potential compliance issues prior to the final submission deadline (10th business day). The FCR is released by the end of the 14th business day. The FCR offers a final opportunity to review potential compliance issues and provide feedback.

Why do we only have one business day to provide feedback to the Final Compliance Report (FCR)?

The FCR is released by the end of the 14th business day, and feedback is due by 5pm on the 15th business day. The reason for this short turnaround is that the feedback is needed to understand potential issues with the data prior to creating performance reports and public reporting. For this reason, we highly recommend that hospitals submit interim data by the 3rd business day and review the Interim Compliance Report (ICR) if flagged for potential non-compliance. The ICR provides hospitals with an opportunity to investigate potential issues prior to the FCR.

If our facility submits a weekly opioid overdose file to CIHI as a Level 3, will we still be able to submit Level 1 files?

If your hospital submits a Level 3 file, an archiving process for Level 1 files will be initiated at CIHI. CIHI will no longer accept a Level 1 file for that month. For hospitals that have multiple sites, this process is site specific. It is important that your hospital put in place safeguards to prevent the accidental submission of a Level 3 file

Hospital Tools & Resources

Foundational Theme Strategies

ED UNIT-BASED COUNCIL TERMS OF REFERENCE

Sinai Health | Mount Sinai Hospital
Joseph & Wolf Lebovic Health Complex

UNIT-BASED COUNCIL
Terms of Reference

Purpose & Function

The purpose of the Unit-Based Council is to provide an open forum which creates opportunities for continuous learning, decision-making and frontline staff engagement at the level where service/ care is provided. The primary function of the council is to empower and engage the staff in decisions related to standards of practice, quality and clinical outcomes, professional development, inter-professional activities/relationships, evidence based practice, research, peer reviews and resource allocation.
Staff work as partners to problem-solve and implement change to enhance patient care, clinical practice, and the quality of the work environment, congruent with the organization's mission, vision, and strategic directions. The core of the Unit-Based Council is teamwork, with the goal of achieving a shared purpose.

Decision Making

- This council is a decision-making body.
- Decisions are made by a majority vote of the members.
- Unit-Based Councils, in collaboration with unit and/or program leadership, provide direction over decisions impacting care and patient outcomes.

Council Mandate

1) All members of the Unit-Based Council carry equal weight in the consensus and decision-making process.
2) Members ensure that work done is communicated to all staff on the unit.
3) Unit-based goals and objectives will act as a guide to council work. Objectives will be developed on an annual basis and will be revisited as needed. These objectives will form the basis for council activities.

Council Objectives

- To promote autonomy, partnership, shared accountability and ownership for unit operations.
- To examine and evaluate patient outcomes on an ongoing basis as a means of identifying strategies for continuous quality improvement.
- To assess and participate in the development of unit-based initiatives (e.g., education and mentorship, research and evidence-based practice, monitoring of safety and practice issues) aimed at addressing the needs of staff and patients.

Reporting Relationship

- Unit-Based Councils are accountable to the unit's staff and to the Leadership Team for shared decision making.
- Councils are accountable for reporting initiatives across units and/or disciplines to the relevant council as applicable.
- All Unit-Based Council Co-Chairs sit on the Unit Council Advisory and are responsible for sharing information between Unit Council Advisory and their respective Unit-Based Councils.

October 2021 1

Membership/ Composition

- Council membership is assumed by nursing and health discipline staff from the Unit/ Department.
- Membership is reflective of the needs, size and demographics of the unit. A minimum of 50% of the council membership is direct care (frontline) nurses and health discipline staff.
- Membership may be voluntary and/or selected (i.e. voted) by staff of the unit with the goal of providing a consistent leadership group.
- Two council members will co-facilitate (co-chair) meetings.
- Council co-chairs will be nominated by council members and will ideally function in the Leader role for a minimum period of 1 year. Co-leaders will not be replaced simultaneously to ensure a consistent leadership group, and to allow mentoring opportunities for new Council leaders.
- When necessary, the Unit-Based Council may be co-facilitated by a direct care staff with a member from leadership of that unit.
- Members will attend each session or have another peer attend in their place if unable to do so. A minimum of 75% of all meetings will be attended annually.

Council Format

- The Unit-Based Council will meet on a scheduled basis upon the call of the Council Co-Chairs.
- Ground rules/ group norms will be established by Council members and revisited on an as needed basis.
- Goal setting sessions will be done as required (minimum annually).
- Agenda and meeting minutes will serve to provide organization and communication to unit staff members. Council members will submit and share items for the agenda.
- Magnet updates, review of clinical indicators and unit celebrations will be a standing agenda item.
- Meeting minutes will be shared with all members of the unit to which the Council belongs and should be saved for a period of no less than 4 years.
- Council members will have the authority to make final decisions on unit-specific issues congruent with Hospital policies, procedures and the corporate agenda/ strategies.
- Shared Work Teams will be created as needed to accomplish the Council goals and objectives.
- All meetings are open attendance.

Responsibilities of Unit-Based Council Leaders (Co-Chairs)

- Set and communicate the agenda, date, time and location of the meetings based on staff input.
- Facilitate discussion at meetings and encourage consensus building.
- Ensure that minutes are kept and distributed to all staff members, and to the Magnet Program Director, in a timely fashion.
- Coordinate the assignment of Shared Work Teams as required.

Responsibilities of Unit-Based Council Members

- Review the agenda and previous minutes and come to Council prepared to participate.
- Bring forward and share any relevant issues from the unit to the Council Leaders and membership.
- Share and discuss information from the Council to colleagues, seeking input and feedback in a proactive manner.
- Participate in the fulfillment of the Council's purpose and objectives.

COMMITTEE IDEAS FOR IMPROVING FLOW AND DECREASING LWBS – PETERBOROUGH REGIONAL HEALTH CENTRE

LWBS/WR Committee Presents:

Ideas for improving flow and decreasing LWBS times in the main waiting room

PRE-TRIAGE/SWIPER ROLE

- Consider pulling patients to the booth or the area beside the booth to reassess or do repeat VS
- When reassessing patients, a quick way to document is using the *Quick Updates* function in EPIC, and system specific assessments as required
- If time permits, can assist the triage nurse with entering medical directives, obtaining verbal orders for things that fall outside of directives, and carrying out these orders
- Circulating through WR q1-2 hours for reassessments is encouraged

FLOW FROM WR TO GREEN ZONE

- Limit visitors as appropriate in order to have enough GZ chairs for patients, and have visitors join the patients when they have been placed in a room
- Swiper can communicate with GZ to facilitate flow back to GZ
- Consider using the reassessment chairs outside of G3 or G9 as additional space to carry out treatments
- Communication between swiper/triage/clerks and GZ nurses when patients are returning for IV abx, rabies vaccine, IV re-starts, imaging results to ensure these patients are brought back sooner

FLOW TO BZ

- Communication between triage nurses and BZ nurses to ensure true 2's are getting sent back and assessed in a timely manner
- Limit number of visitors to ensure there is seating for patients in BZ WR (visitors can come in when patient is in a room)
- Consider pulling CTAS 2's aside (reassess room or another hallway space) to assess prior to placing in room when wait times are long

PATIENT COMFORT

- Consider offering comfort items (blankets, pillows, a space to lie down, medication as per medical directives) as discomfort is a major reason for LWBS
- Communicate with Charge Nurse if a patient is very uncomfortable and is not tolerating being seated in the main WR
- Consider obtaining orders for pain/symptom management from a physician

PHYSICAL ENVIRONMENT IMPROVMENTS: COMING SOON!

- Information on alternate care options to be more readily available in WR for those who might be able to seek care elsewhere
- Addition of wait times to website, as well as link to alternate care options
- Improved signage and way-finding in WR

Any further ideas to decrease LWBS times, improve patient comfort, or improve on role of pre-triage or triage nurses?
Please email Maddie at
mdimacakos@prhc.on.ca

Patient Access and Flow Improvement Project – OS Emerg Dept.

Owen Sound Emergency Department

- 16 bed emergency department
- 2 secure rooms that are also used as regular assessment rooms
- Roughly 100 ED visits/day
- Average 10-12 admissions/day
- Holding 6 – 12 admissions/day
- Consults 4 -10/day
- Code Stroke Volume = 281 YTD
- Fully Staffed = 16 new hires

Current State

- The OS Emerg Dept. has been struggling for years to provide in-patient care for patients awaiting beds on other units
- This in turn has caused increased wait times and delay in care for our Emerg patients as no space to assess and treat
- Also negatively impacted our "Pay 4 Results" funding over the last few years, which is driven on assessment and admission times

Brightshores Health System

Owen Sound Emerg Dept. P4R Stats

December 2023 – December 2024

Metric (all at 90P)	Current Performance	Ranking
ED LOS Admitted	43.3 hrs.	51
Time to In-Pt bed	33.2	52
PIA	5.8	52
ED LOS Non Admitted High Acuity	8.2 hrs.	35
ED LOS Non Admitted Low Acuity	6.8 hrs.	37
EMS Offload	22 mins	14

**Currently sitting mid-pack around 67/76 for P4R funding*

Brightshores Health System

Project Goals

- The goal of the project was to reprioritize the ED waiting room over stabilized admitted patients.
- Improve patient flow, which will increase the number of interactions a patient has with a health care provider allowing more timely reassessments and the ability to capture changes in conditions in a more timely manner.
- Improve our P4R metric, which will have positive impacts on our funding next fiscal year.
- Change the culture of the corporation and implement the "push-pull" of admitted patients to enable the Emerg Dept. to continue patient flow.

Brightshores Health System

Objective: Change in Mindset

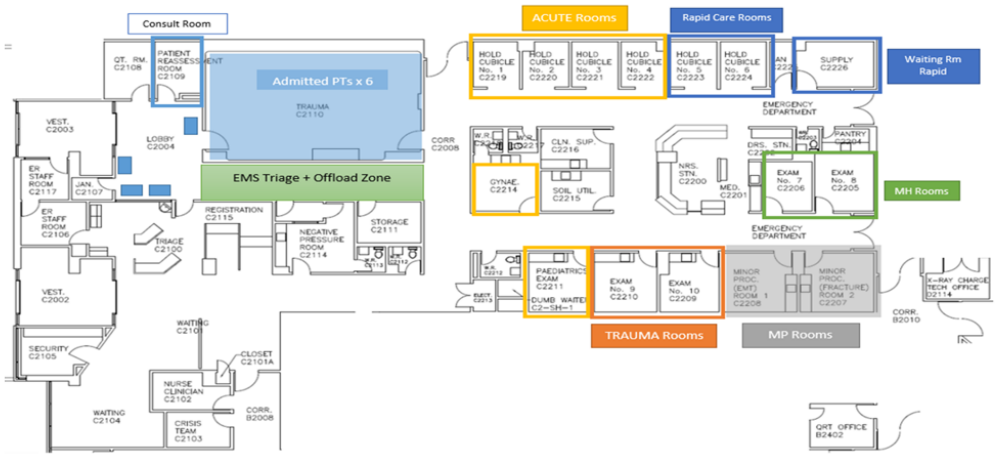
- All ED patients do not require stretchers – they can remain in chairs until further diagnosing
- Our sickest patients needs to be our priority and focus, which means they need to be in the allocated ED rooms
- Admitted patients have been assessed and treated – can be placed in a separate area to await in- patient bed
- The more ED patients move throughout their visit should result in positive patient experience and satisfaction
- If we start making these changes and pushes the goal is that the other units will follow
- Admitted patient number (6 in-patients) – when reached escalation to halls and surge plan begins

Brightshores Health System

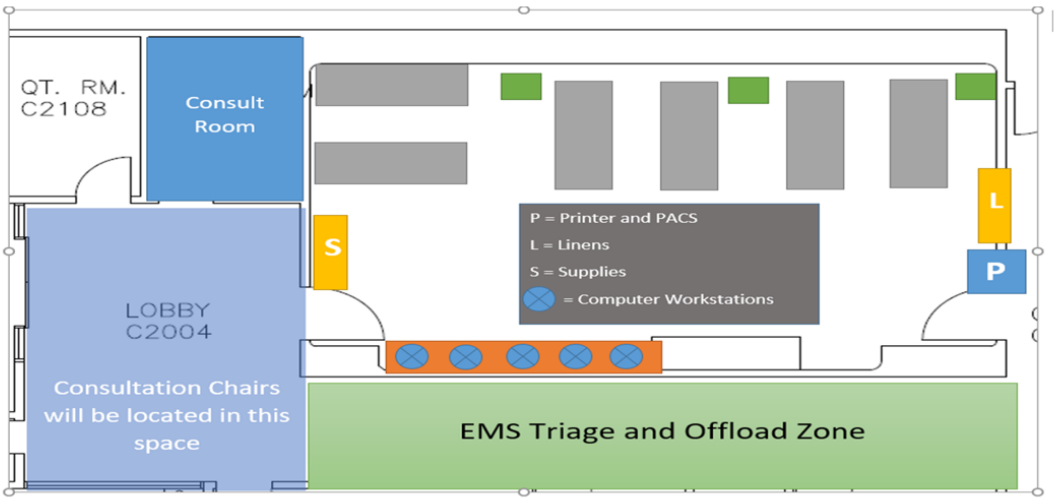
Project Outline

- On Oct 2nd & 3rd Andrea Ennis – Director of Emergency Services at North York General and Dr Kevin Wasko visited the OS ED to provide suggestions on patient flow and how to improve our P4R times and funding.
- North York ED sees over 300 patients/day and went from bottom 10 to top 10 in P4R ranking and are sharing their ideas to other EDs that are striving to meet P4R goals.
- Developed a plan which included revamping patient flow throughout the department and a change in staff mindset
- Frontline staff involved in creating plan
- Stakeholder meeting held on Oct 3rd with our North York partners sharing the plan
- OS ED Staff meeting held on October 22nd - Plan finalized
- Staff Meeting held on January 13th – touch base – process review

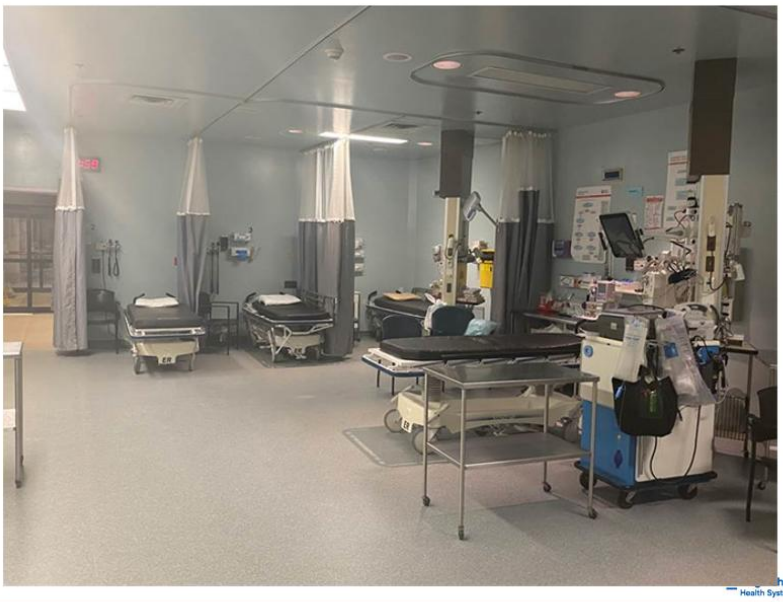
New Floor Plan (3 Stages)



Trauma Room = New Clinical Decision Area (CDA)



Trauma Room - BEFORE

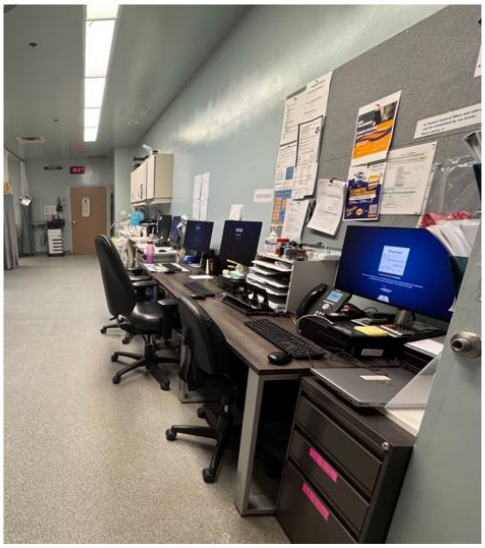


Trauma Room - AFTER

Brightshores Health System

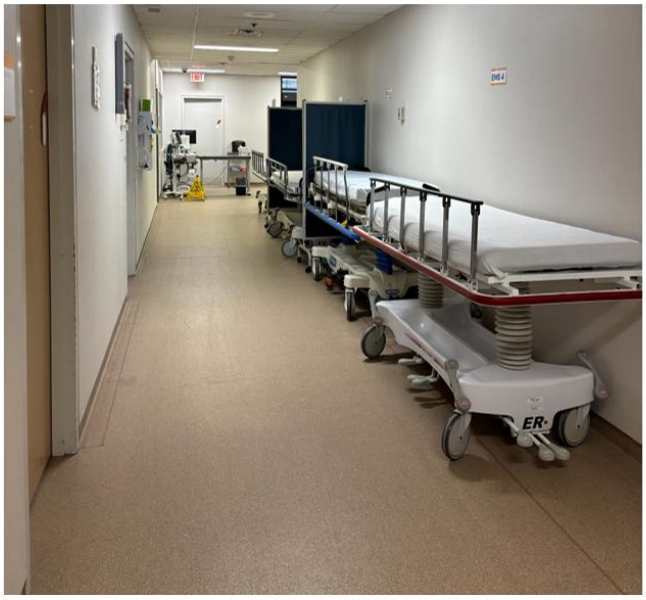
Before

After



Brightshores Health System

EMS Triage/Offload Area



Consult Room

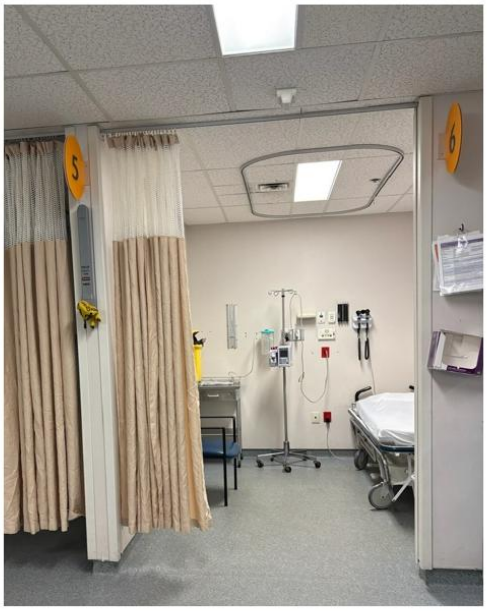
Fast Track Area

- Closer to the physicians and ED staff
- Lower CTAS patients do not always require a bed as increases their length of stay.
- Two assessment rooms (5 & 6) utilized as fast track rooms i.e. paper on stretchers, quick assessments
- Patients will be assessed and sent back to the Fast Track waiting room to await lab and/or ambulate to the DI hallway to await x-ray and than walk back to the waiting room.

Supply/Dictation Room Before

Brightshores Health System

Fast Track Treatment Rooms + Waiting Area

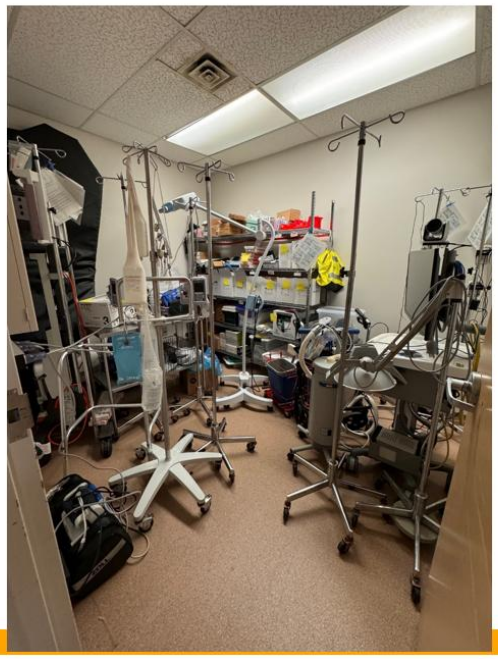


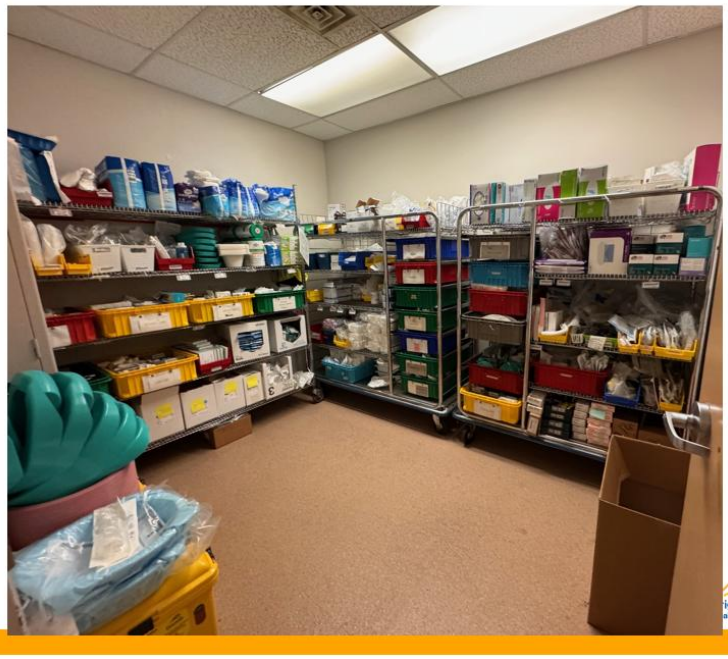
Brightshores Health System

Designated Waiting Area for ED Patients in Medical Imaging

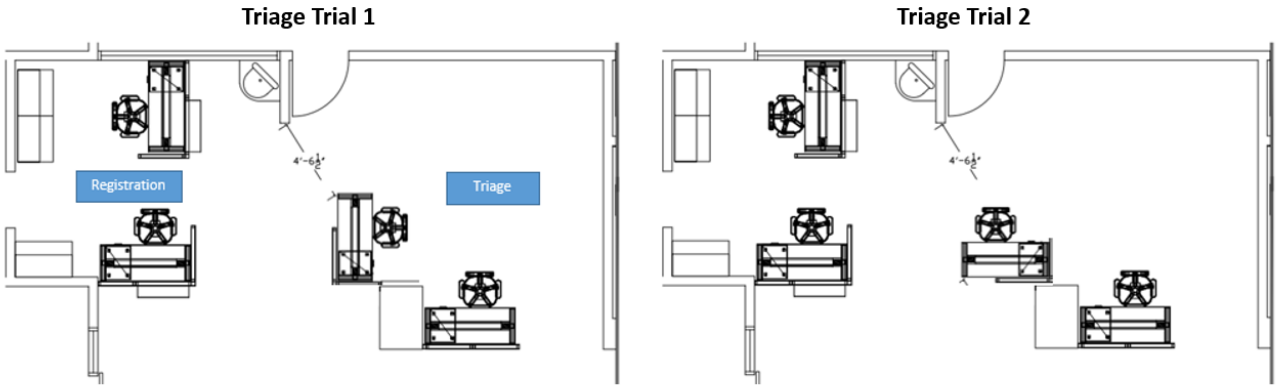
Brightshores Health System

Supply Room – Before and After



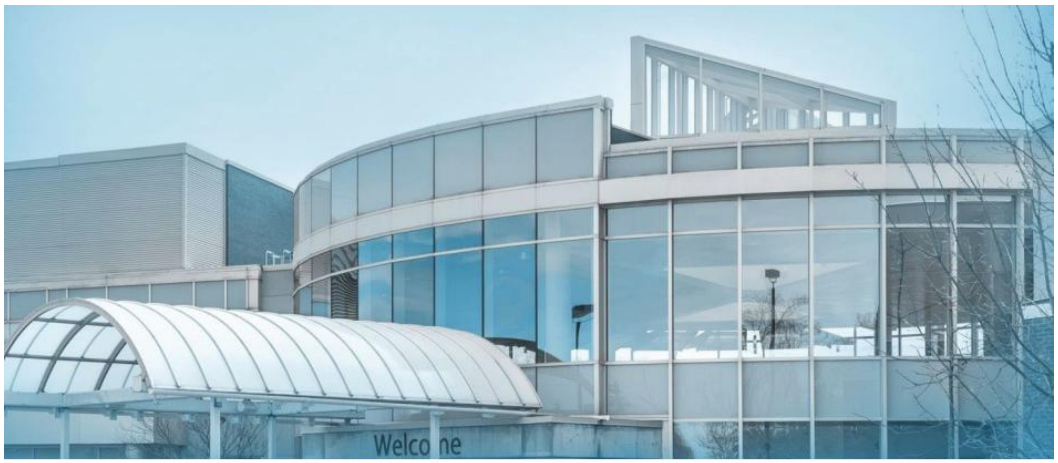


Registration and Triage Modifications



Next Steps

- Stage 3 – Triage/Registration area
  - Modifications were made to the Registration and Triage furniture
  - Triage staff are going to trial 2 options for the 2nd triage desk
  - Electronic Documentation CDA In-Patients – RPNs and PCAs – training started Feb 3rd with IT and Learning
  - Implement 2nd triage nurse (1100-2300) – Quick Reg training all RNs
  - Implement "push-pull" strategy across all units to increase ED flow
    - Corporation creating unconventional bed spaces



Process Mapping

2025

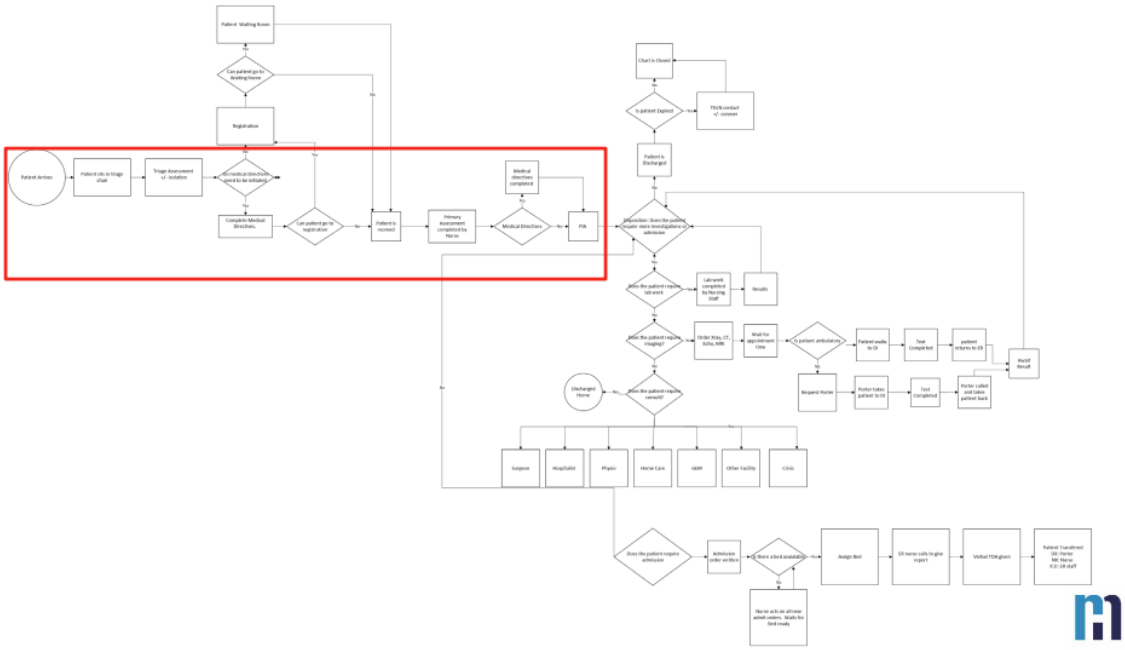
ROSS MEMORIAL HOSPITAL
Kawartha Lakes

Improvements to Patient Flow

- Current state process mapped for Emergency Department (ED) and Inpatient (IP) Acute Units
- Areas of improvement identified during exercise
  - Pull to Full in the ED
  - Ambulance Offload (AOL)
  - Asynchronous Transfer of Accountability (A.TOA) between ED and IP units,
  - Prioritization of patients with High Braden and Falls Risk scores

Emergency Department Process

Pull to Full

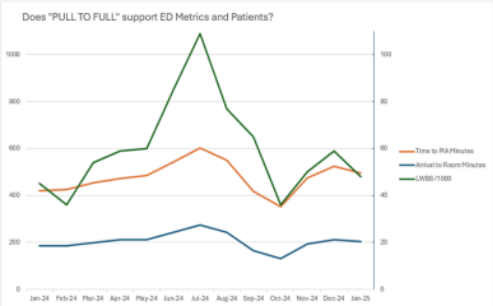


Pull to Full in ER: Direct Bedding

PULL 'TILL FULL

STRATEGY OF DIRECT BEDDING

TOWARDS ED QUALITY, EFFICIENCY, AND PATIENT SAFETY



- Started in September 2024
- Taking patients from the waiting room into available bed spaces
- Aim was to increases patient satisfaction, reduces Left without Being Seen (LWBS) rates and improve patient safety of clinical deterioration while in waiting room

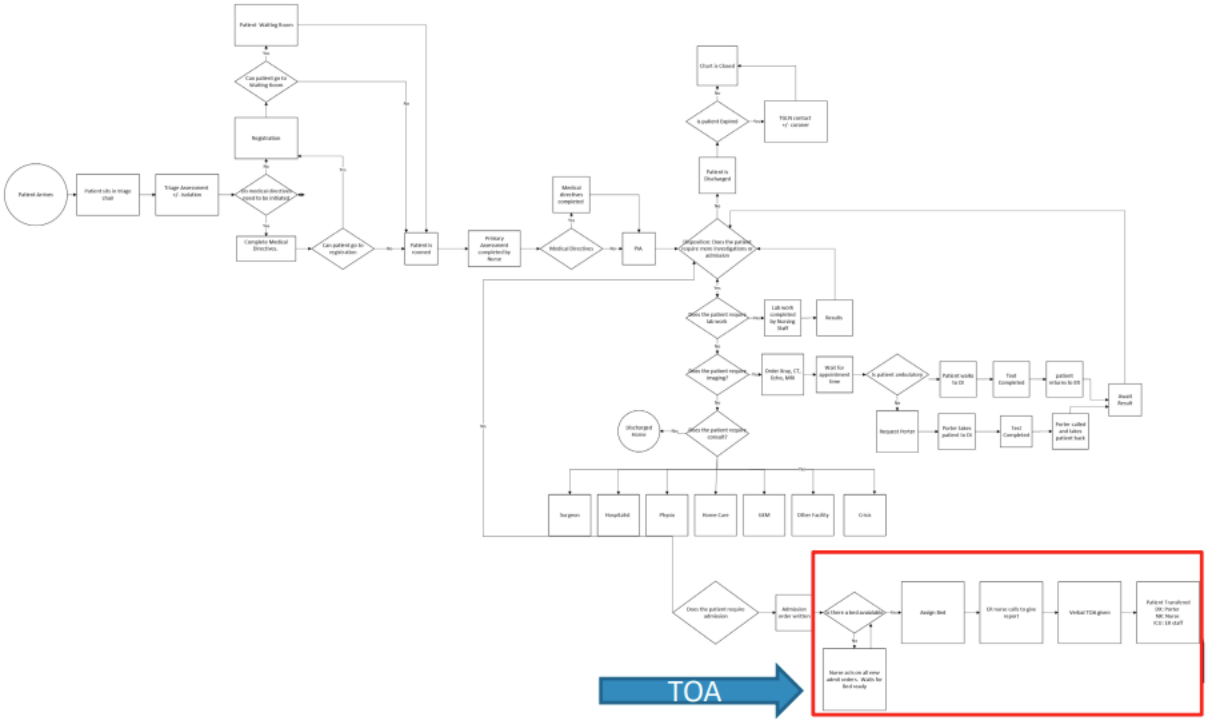
Ambulance Offload

Stage	Paramedic Staff	Escalation Information	Hospital Contact
1	Superintendent	Volume surge or >1 unit in OLD >30 min	ED Charge Nurse
2	Superintendent	Any OLDs >1hour <2.5 hrs *(with no apparent movement from Stage 1 request)*	ED Manager Mon-Fri 7am – 4pm **Escalate to Manager on call outside of these hours*
3	Superintendent	Any OLDs > 2.5 hours or multiple OLDs with no movement *(with no apparent movement from Stage 2 request)*	ED Director Mon-Fri 7am-4pm **Re-escalate to Manager on call outside of these hours*
4	Senior Management on Call (SMOC)	Any OLDs >3.5 hrs and 3 or more OLDs >2.5 hrs with no movement from previous escalations	Hospital VP Mon-Fri 7am-4pm **Escalate to Senior Admin on call outside of these hours by contacting RMH switchboard*

- Implementation of Dedicated Offload Nurse Program (DONP)
- Promoted timely offload and transfer of care to all patients arriving via ambulance to the ED
- As AOL is an important quality indicator for the ED, RMH developed a policy for Ambulance offloading and escalation of delays January 2025
- To provide timely assessment, triage and flow of patients arriving by ambulance
- Goal: To have all ambulances offloaded within 30 minutes of arrival to RMH ED.
- Number of "Code Zero's" (no available ambulances) has reduced by 50% since implemented

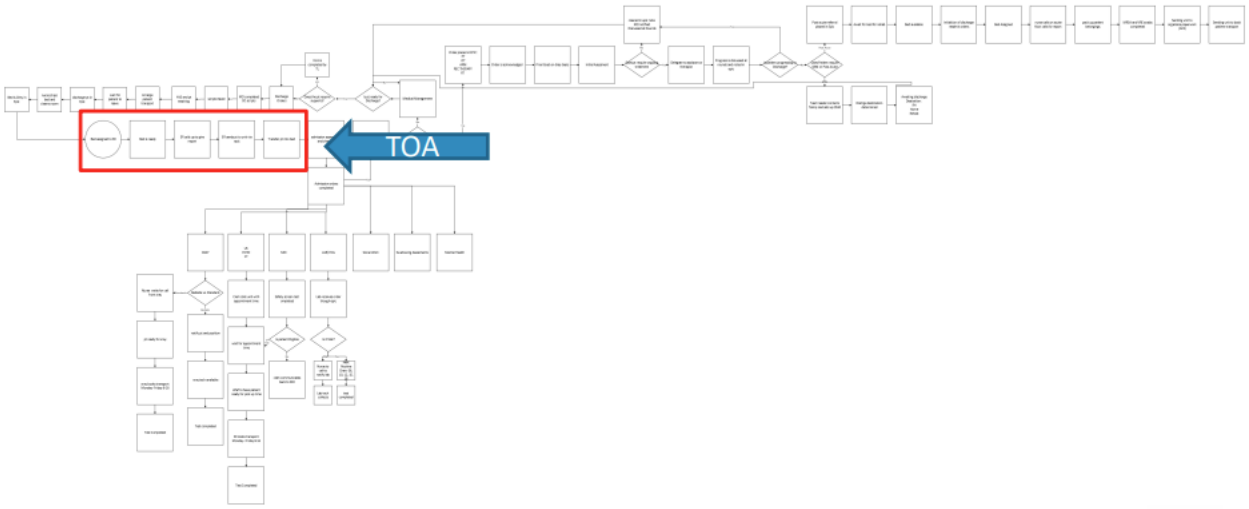
Emergency Department Process

A.TOA



Inpatient Current Process

A.TOA



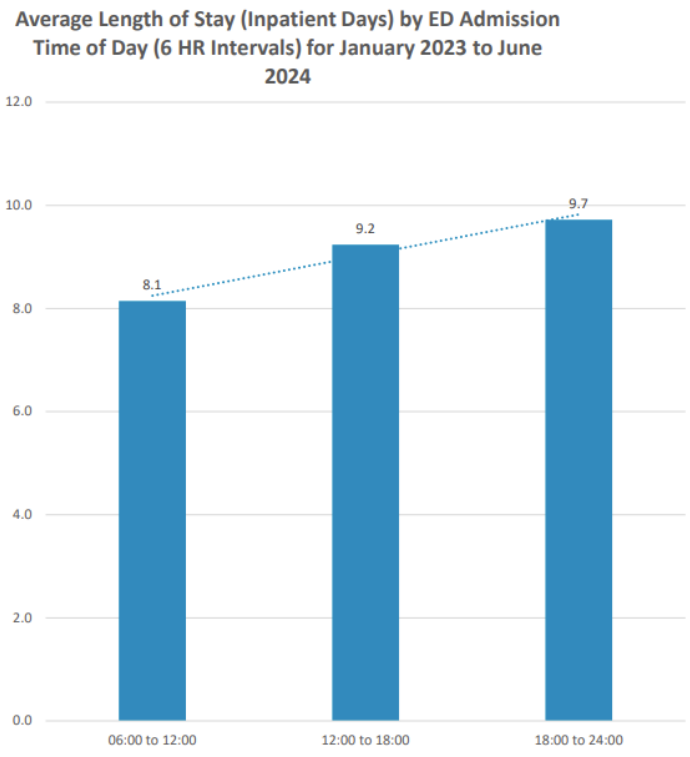
Overall Impact of TOA Delays

Average Time Bed Ready to Bed Occupied ED to IP = **77 min**
Average Time Bed Ready to Bed Occupied Acute IP to Post Acute IP = **110 min**

Average ED to IP transfers per month = **300 patients (16 days idle bed time/month)**
Average Acute IP to Post Acute IP per month = **26 patients (2 days idle bed time)**

77 min TOA = 16 idle bed days/month
45 min TOA = 9 idle bed days/month
30 min TOA = 6 idle bed days/month

Timely Patient Flow Supports Everyone!



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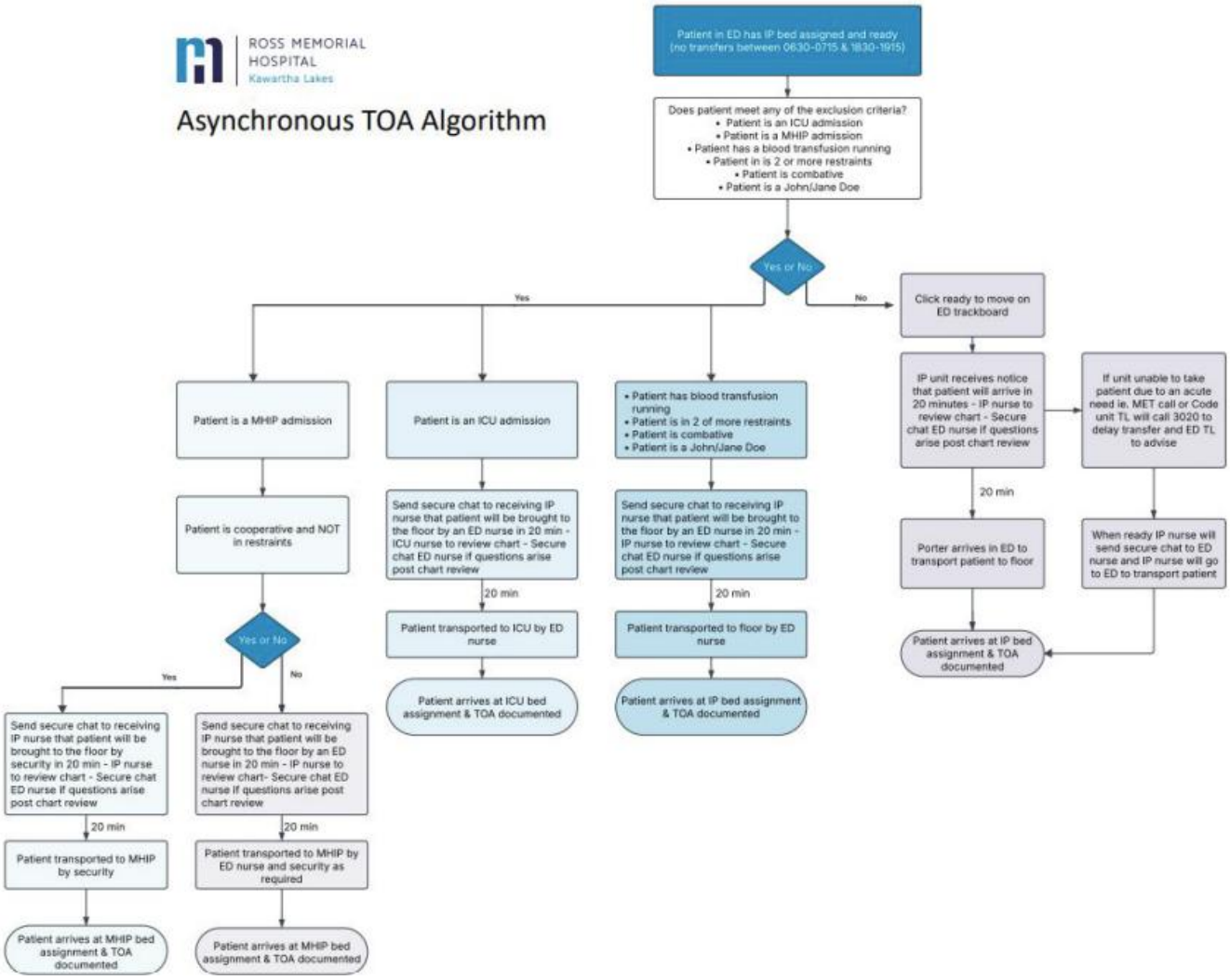
Proposed Future Workflow

1. MRP Places Admission Order
2. Bed assigned
3. When bed clean, ED nurse clicks "Ready to Move"
4. Notification to all ROVERS on Receiving Unit
5. IP Unit Reviews Patient Chart during 20 min built in delay
6. Patient Arrives on IP Unit

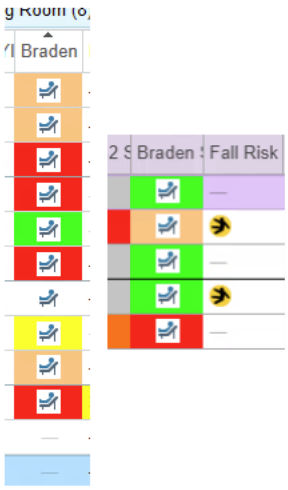
10

ROSS MEMORIAL HOSPITAL
Kawartha Lakes

Asynchronous TOA Algorithm



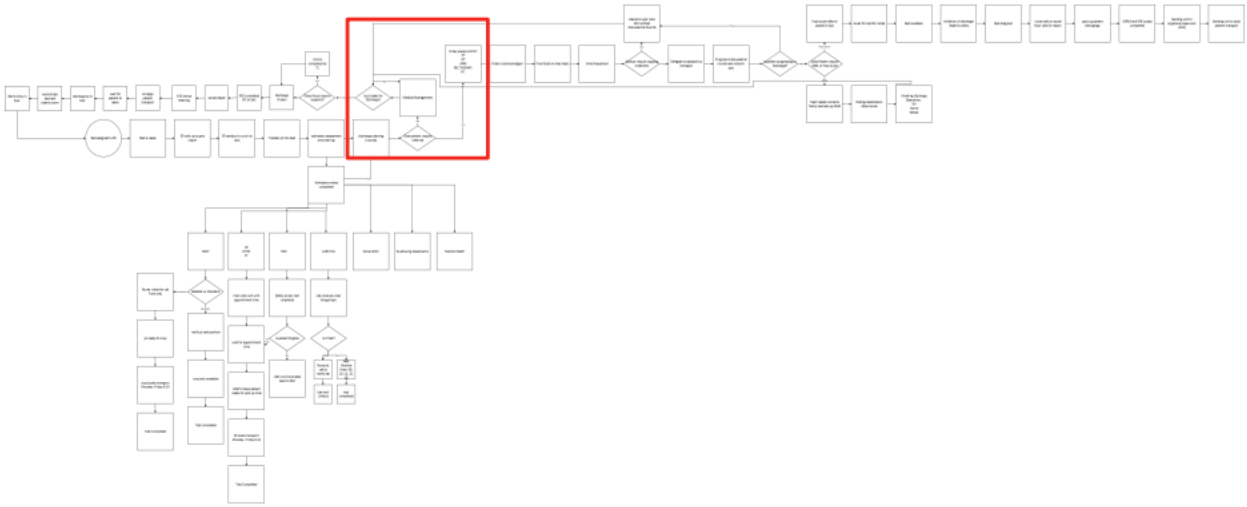
Prioritization of Patients



- Aims to prioritize patients for inpatient bed status based on RMH QIP and reductions of pressure ulcers
- Track board column wrenched in for patients Braden scores, colour coded based on score
- Track board for falls, identifying those who are 'high risk' based on the Morse Fall Risk Scale
- Mores Falls Risk and Braden are now essential documentation in ER for inpatient units

Next Steps

Standardization of Process between Units



Ambulance Arrival & Offload

EMS OFFLOAD NURSE ROLE DESCRIPTION – SINAI HEALTH

Last revised September 2024

Sinai Health

EMS Offload Nurse Role Description

1. EMS Offload Nurses will function in the triage/waiting room area, primarily in the EMS Offload Room, of the Emergency Department (ED). EMS patients are to be triaged within 15 minutes of arrival. They are to be offloaded by the nurse within 30 minutes, when eligible and if a bed is available. EMS patients that cannot go directly into a room will be moved from paramedic stretchers to either a chair in the waiting room, onto an Offload stretcher or left on Offload Delay.

2. The EMS Offload Nurses' primary role is to offload EMS patients and care for them in chairs/stretchers. If the Offload Nurse is triage trained, they will prioritize triaging ambulances. If not, triage will be performed by the triage nurses and report will be given to the Offload Nurse.

3. Fit2Sit patients are also a priority of the EMS Offload Nurse. Medical Directives & treatments can be initiated in the waiting room if a patient is eligible.

4. It is a shared responsibility of the triage and Offload Nurse to update the patient's location: "EMS" to "EDWR" or "OLSTR1-4". This action captures the TOC time.

5. When offload appropriate, the patient is to be offloaded whether full registration has been completed or not. Full patient registration is not to delay offload.

6. The Offload Nurse will provide care for up to 4 EMS patients on stretchers simultaneously. They will also provide care to Fit-2-Sit patients, when eligible for medical directives or orders are received from a physician.

7. EMS patients who arrive with **cardiac monitoring** in place will be assessed by a triage-trained nurse to determine if the patient can be safely removed from the monitor. Patients who cannot be safely removed from the monitor will remain under the care of the paramedic team until an assessment space becomes available. In the event of disagreement, the emergency physician will assess the patient. The ED staff will endeavour to move monitored patients into the department on a priority basis.

8. Paramedics will assist with managing violent, intoxicated patients until Hospital security staff arrives to ensure both staff and patient safety. The triage/EMS Offload Nurse will endeavour to ensure this happens in a timely manner.

9. When there is a disagreement about patient care between an EMS crew and the triage/Offload Nurse, the Team Leader and the ED physician will be engaged. If the issue is not able to be resolved it will be escalated to an EMS Duty Supervisor and ED Leadership/NCM.

10. While the patient is in the waiting room the EMS Offload Nurse will initiate relevant medical directives that can be reasonably performed in that space.

11. The EMS Offload nurse will document on the relevant Nursing Record that correlates to the area that the patient is assigned at the time of triage.

12. The EMS Offload Nurse will ensure the Team Leader is kept up to date on changes in patient status and acuity.

13. The Offload Nurse will assist the triage nurses with initiating medical directives/providing care for patients in the waiting room when there are no outstanding tasks for EMS patients. If the Offload Nurse is triage-trained, they will assist with triaging walk-ins.

Patient CTAS Level and Disposition

CTAS 1:

Patient goes directly into the ED.

CTAS 2:

Attempt to move CTAS 2 patients into the department as soon as possible. While waiting for a space the patient may need to be transferred to a stretcher or chair depending on the CEDIS Presenting Complaint. Patients who require continuous cardiac monitoring are to be assessed by a triage-trained nurse for safety in offloading and removing the cardiac monitor. Patients deemed to require continuous cardiac monitoring will remain with the EMS crew and will not be offloaded. When there is disagreement between the nurse and the EMS staff the ED physician will determine the monitoring and resources the patient requires. Every effort is to be made to move patients requiring monitoring into the department as quickly as possible.

CTAS 3:

Offload to a chair in the Waiting Room when patient is:

Alert, ambulatory, can follow directions, symptoms/injury can be managed in WR.

Offload to Stretcher in the Waiting Room when the patient is:

Unable to ambulate, has pain/symptoms that can't be managed in a seated position.

CTAS 4 & 5:

When possible, offload directly to the waiting room. If patient is unable to sit in a chair, transfer to an offload stretcher, if available.

Special Considerations:

Patients arriving on a backboard will be triaged, assessed for mechanism of injury and the medical directive for backboard removal will be initiated in the waiting room. If the patient does not qualify for removal from backboard they are to be moved into the department and are to be assessed by the ED physician.

AMBULANCE OFFLOAD NURSE POLICY – PETERBOROUGH REGIONAL HEALTH CENTRE

PRHC
Peterborough Regional Health Centre

EMERGENCY DEPARTMENT UNIT MANUAL

Title	Ambulance Offload Nurse
Number	#1. A.9
Policy Area	Patient Care
Policy Statement	To ensure quality and safe patient care, reduce ambulance offload times and optimize EMS vehicles returning to the community. The ambulance offload nurse is responsible for the triage of ambulances arriving at PRHC, facilitating transfer of care within the Emergency Department as well as assuming the care of ambulance patients as appropriate and according to below criteria.
Definitions:	**Ambulance Offload Nurse (AON)**: a registered nurse (RN) in the ED with successful completion of the CTAS Provider Course **CIS**: Clinical Information System (Epic) **CTAS**: Canadian Triage and Acuity Scale **ED**: Emergency Department **EMS**: Emergency Medical Services **PCCP** – Peterborough County-City Paramedics
Background:	The Ontario Ministry of Health dedicated offload nurse initiative focuses on transferring ambulance patients to hospital care and thereby reducing ambulance offload times by providing funding for dedicated AONs. Ambulance offload delay is a long-standing issue that negatively impacts both EDs and ambulance responses to life-threatening calls in the community. The goal is to offload patients into the ED, supporting paramedics in their timely response to emergency calls in the community. This funding is provided by PCCP on an annual basis and is subject to change.
Implementation (Procedure):	1. AON is responsible for pre-hospital communication with EMS via the patch phone. a. AON will inform charge nurse and charge physician of incoming patients as appropriate. 2. The AON will be accountable for triaging all patients arriving by ambulance in a timely manner in accordance with the CTAS guidelines and ED Unit Manual Policy 1.A.6 Triage Assessment and Documentation.

3. The time of arrival, means of arrival, and transfer of care date/time within ED will be documented in the CIS.
    a. Documentation of patient's condition will follow ED documentation and triage policies, and CTAS guidelines.

4. The AON who completes triage will be accountable to ensure the patients receive an PRHC patient armband.

5. In the event of a CIS downtime, the AON will defer to the downtime triage record (Form # 1726) for documentation and follow the Epic downtime policy.

6. The AON will offload the patients to an appropriate bedspace in the ED.

7. If no available bedspaces within the ED, the AON will assume care of up to a maximum of 4 patients until an appropriate area within the ED is available.

8. Unstable patients with unpredictable outcomes are not to be placed in an offload bed. They will remain under the direct care of EMS until the time that an appropriate bed can be facilitated for the patient at the discretion of the charge nurse, in collaboration with EMS and ED leadership.
    a. The AON will work with EMS staff to facilitate a bed assignment in a timely manner.
    b. Patients that remain with EMS on offload delay will be assigned to the EMS Offload Delay care area on the ED Manager in the CIS.
    c. If the patient is not appropriate for an offload bed and there are no available bedspaces in the ED, it is expected that a patient be moved from an existing bedspace in the ED into an available offload spot to create space to facilitate EMS transfer of care.

9. Patients may also be triaged and offloaded to the waiting room until an appropriate area within the ED is available.
    a. Patient will be offloaded to the waiting room based on the inclusion and exclusion criteria of the Fit2Sit program with PCCP (see Appendix A).
    b. If the patient is offloaded to the waiting room, this will be communicated with the triage nurses.
    c. If patients are sent to the waiting room the AON can conduct reassessments as outlined in CTAS guidelines in conjunction with the triage nurses when they have the capacity to do so.

10. The AON will endeavour to complete medical directives as appropriate to expedite patient care.
    a. Bloodwork & other diagnostic medical directives should not be used as a decision-making tool to aid in determining the most appropriate clinical area with the exception of immediate identification of STEMI criteria on ECG.

11. The AON will exercise leadership and work collaboratively with EMS services, management, the charge nurse, charge physician and other emergency service staff members to promote and facilitate rapid access to in-hospital emergency care.
    a. The AON will communicate to the charge nurse and EMS regularly the status of offload patients and collaboratively promote patient flow within the ED (refer to Appendix B for the Offload Escalation Pathway)

12. The AON be responsible for providing patient care in the department when offload duties are not required during the shift. This includes duties such as reassessing patients in the waiting room and/or all areas within the ED.

13. The roles and responsibilities of the AON are subject to change/re-evaluation by the ED leadership as required.

Related Documents

The following policies found in the ED Unit Manual:

- 1.A.5.20, Nursing Documentation in the ED
- 1.A.5.40, Nursing Assessments in the ED
- 1.A.6, Triage Assessment and Documentation
- 1.A.6.20, Obstetrical Patient Triage and Assessment

Form #1726, ED Downtime Triage Record

Central East EPIC Downtime Business Continuity Access (BCA) Procedures and Policy

References

Ontario Health Toolkit for Hospitals and Paramedic Services to Support Optimizing Ambulance Offload in Toronto.

Responsibility for Monitoring:

ED Manager
ED Clinical Nurse Educator

Responsibility for Review/Update:

ED Manager
ED Clinical Nurse Educator
ED Steering Committee

Effective Date:

July 10, 2024

PARAMEDIC TRIAGE NURSE – LAKERIDGE HEALTH

Paramedic Triage Nurse

Standard of Work

Revision Date:		Document Owner:	LHO ED Manager
Revision version:	1		

Purpose:

Standardized Process Steps	
	Receive TOA from previous shift nurse for all patients on delay or in the police bay.
	Visualize all patients who arrive to the department with Paramedics or Police.
	Prioritize the triage of all patients who arrive to the department with Paramedics of Police.
	While triaging, completed a focused primary assessment on all patients (with the exception of patients requiring immediate resuscitation care) including: • A full set of vital signs and pain assessment score • IPAC Screening • Medical History • Applicable Home Medication • Allergies • Suicide/Violence Risk Screening Assign the most appropriate CEDIS Complaint and CTAS using applicable modifiers.
	Enter appropriate medical directive. • If initiating Cardiac Medical Directive, complete 12-Lead ECG prior to triaging next patient (unless a patient present who requires immediate intervention/medical care) **Target for door-to-ECG time is < 10 Minutes**
	Determine if patient can be safely offloaded to the main waiting room.
	If patient is appropriate to be transferred to the main waiting room, complete "Transfer of Care" in Epic.
	If patient is not appropriate to offload to the main waiting room, determine the most appropriate level of care. Review the Epic Tracker to identify appropriate placement and collaborate with the ED Unit Coordinator/Charge Nurse.
	If available, make use of the transitional beds in Paramedic Bay for patients that do not require higher level of monitoring.
	If no appropriate rooms are available, update the paramedics with care plan (medical directive, reassessment, arrival of family, improvement of presentation, etc.) and direct crew and patient to delay location.

	If the patient is with paramedics and/or police for mental health complaints, flag to Mental Health Unit Coordinator for direction. If there is no MH UC on shift, flag to ED UC.
	The Paramedic Triage Nurse should aim to offload patients arriving with paramedics within 30 minutes (?regional standard). If unable to offload in a timely fashion, document ongoing assessments in Epic as per Emergency Department Policy and Procedures.
	Relieve the ED Unit Coordinator/Charge Nurse when possible.
	Part of the Code Blue Team.
	When able and if required: • Assist in Resus/Trauma • Restock and declutter Paramedic Bay and ECG Room

ED FLOW AND OFFLOAD PLAYBOOK – PETERBOROUGH REGIONAL HEALTH CENTRE

ED Flow and Offload Playbook

1 - Charge Nurse Expectations

- Charge Nurse Duties/Expectations document (attached)

2 – Ambulance Offload Nurse Role/Expectations/Support Plan

- ED Policy #1.A.9 (draft phase currently - attached)
- ED Offload Expectations (draft currently - attached)

3 – Criteria for Offload Hallway (AONH) Patients

- Any patient who arrives via EMS who is not a CTAS 1/2 or does not meet Fit2Sit criteria
- Clinically stable patients arriving with EMS on cardiac monitors can be reviewed with the charge doc to clarify if the monitor can be removed while they wait for a spot in the department.
- Admitted patients waiting for inpatient pick up who have been pulled out to create capacity for EMS in Yellow/Orange
- Patients pulled out of Red Zone post sedation/observation not requiring cardiac monitoring to create capacity in Red
- If patient needs are higher than the Offload Nurse is able to provide (i.e. toileting, medical directives, etc.) the Offload Nurse can request support from the CN, R/O float RN, Float/Resource RNs and/or assign a float RN/RPN to the AONH patients as needed.

4 – Offload Delay Criteria and Escalation Pathway

- PRHC Goal for AOT is Less Than 30 minutes for all EMS patients
    - At 30 minutes the CN must have a plan in place for where the patient is to go.
- ***Default is Offload NOT Delay***
- Considerations for offload delay include:
    - Unstable patient requiring Red or Orange monitoring and no spots currently available – the Offload Nurse and CN will be directly communicating with the Charge Doc to develop a plan to downgrade a patient in one of these areas to make room as soon as possible (i.e. have Red and Orange flex beds/code beds available at all times).
    - All 4 AONH beds are occupied by patients and the current EMS patient is clinically deemed inappropriate to be removed from EMS stretcher (i.e. monitoring, non-ambulatory, medically unstable and waiting for Red/Orange bed). All efforts will be made between Offload Nurse, CN and Charge Doc to make appropriate moves to create capacity for this patient as soon as possible.
    - AONH patients and Delay patients will be continuously reassessed for who would be most appropriate to move into a zone first. These patients will also be placed in queue according to CTAS scores with patients in the Main Waiting Area. If patients in the AONH stabilize while waiting, they can be reassessed for BZ or Fit2Sit criteria to encourage pulling patients from Offload Delay.
    - There always needs to be a plan in place for fast accommodation of unstable patients in the department.

5 – Orange Zone Decanting Pathway i.e. OZ Flex Bed using YZ monitors for stable patients

- The CN and Charge Doc will discuss several times/shift the best plan for decanting OZ of up to 2 stable patients who are hospitalist admits and/or tele admits who can be supported in the YZ by an ACLS/CC1 RN on a monitor. Break coverage for the YZ monitored patients will have to be

planned for with an ACLS/CC1 RN who can safely manage this type of patient (R/O float, Float/Resource RN, Clinical Mentor, Modified staff).

- The idea will be to always maintain capacity in the OZ similar to how we reserve a RZ bed for a Code/Trauma. OZ and YZ are the most highly sought after spaces for patients arriving via EMS. Patients waiting for OZ are at a much higher risk of deterioration than the patients who have been admitted and are waiting for inpatient beds in the OZ. Every effort will be made to maintain capacity and create plans to ensure that patients are not waiting longer than 30 minutes for an OZ spot.

TOOLKIT FOR HOSPITALS AND PARAMEDIC SERVICES TO SUPPORT OPTIMIZING AMBULANCE OFFLOAD IN TORONTO – TORONTO REGION HOSPITALS AND TORONTO PARAMEDIC SERVICES WORKING GROUP

Toolkit for Hospitals and Paramedic Services to Support Optimizing Ambulance Offload in Toronto

Prepared by: Toronto Region Hospitals & Toronto Paramedic Services Working Group

Version Date: May 2022

PURPOSE:

Ontario Health coordinated a collaboration between Toronto area hospitals and Toronto Paramedic Services (TPS) to create a best practices document for the reduction of ambulance offload times (AOTs), based on the practices of hospitals with low AOT.

This document outlines a set of practices and operational approaches that have been implemented in hospital emergency departments (EDs) across the region with good success in supporting ambulance offload and hospital flow. While not exhaustive, this list of practices and approaches can be leveraged collaboratively by hospitals and TPS in reviewing internal practices and further opportunities to support local improvement.

BACKGROUND:

Ambulance offload delay is a long-standing issue that negatively impacts both EDs and ambulance responses to life-threatening calls in the community, and it has been exacerbated by recent pressures of the COVID-19 pandemic. There are a number of contributors to healthcare system pressures leading to long offload times; however, ambulance offload delay can be minimized. Ensuring the timely offload of ambulance patients improves patient and staff experiences in both prehospital and in-hospital environments.

1. Supporting the Right Culture

Create a culture of NO offload delay:

- Promote an understanding among hospital and paramedic staff of the impact of offload delay to 911 medical emergency calls in the community.
- Develop specific hospital procedures to avoid offload delays; consider how to support timely offloads.

Create a culture that patients do not require a paramedic to stay with them once in the hospital:

- Promote the belief that all patients should be rapidly offloaded to the general or horizontal waiting room (i.e. a hospital bed in the waiting room); only patients that require immediate intervention should remain on a stretcher with paramedics, while staff are taking immediate actions to place the patient in the department.
- Develop communication training for nurses and paramedics for difficult conversations (e.g., moving patients off stretcher to chair, etc.).

Hospital-wide education:

- Promote enhanced awareness among members of hospital leadership regarding the culture and operations to support timely ambulance offload.
- Promote broad awareness of corporate escalation process for patient flow delays, including ambulance offload delays.
- Partner and collaborate with hospitals with low AOTs to understand processes and procedures that help improve flow, and help share those internally.

2. Operations

Improve triage practices:

- Assign a nurse with primary responsibility for ambulance triage that can assist in the timely triage and offload of ambulance patients.
- Develop a trigger for rapid additional triage response (e.g., float staff) to address surges of incoming ambulance patients.

Standardize practice for patients regardless of method of arrival:

- The decision to offload patients to the waiting room should not be influenced by their method of arrival. For example, a patient experiencing chest pain without cardiac features and a normal electrocardiogram should not remain on an ambulance stretcher.

  NOTE: The arrival of an ambulance patient on a cardiac monitor does not require the patient to remain on telemetry.
- Physician assessment on ambulance stretchers should only be initiated in support of rapid offload of ambulance patients and in collaborative agreement with the triage nurses.

Implement strong escalation plans:

- Develop a target for hospital patient transfer of care (offload) – recommend 30* minutes – then escalate when that target is not met. For example, each successive escalation (to charge nurse -> to ED management/on call management -> to hospital senior management) is given a 30-minute window to support resolution before being further escalated.

  **Targets can be adjusted to reflect change of baseline – but should be continuously working* towards a 30-minute goal.
- Establish a 24/7 hospital corporate escalation process for patient flow delays, including ambulance offload delays, as an indicator of gridlock.
- TPS uses a four-stage escalating communication plan to ensure regular communication with hospitals when transfer of care delays begin to impact ambulance availability:

Stage	TPS Staff	Escalation Information	Hospital Contact
1	Deputy Commander	**Volume surge or >1 unit in OLD**	Charge Nurse
2	Deputy Commander	**Any OLDs >1 hour <2.5 hours** (No apparent movement from Stage 1 request)	ED Manager
3	Deputy Commander	**Any OLDs >2.5 hours or multiple OLDs with no movement** (No apparent movement from Stage 2 request)	ED Director
4	On-Call Commander	**Extensive OLDs with no movement from previous escalations**	Hospital VP

Integrate Patient Distribution System (PDS) information into processes:

- Use PDS information to support the 30-minute target:
  - Monitor and interact with PDS in real-time and prepare for incoming ambulances (e.g., high acuity patients, specialty services, surges, etc.);
  - Review data for trends to inform process improvement.
- 24/7 system performance and PDS monitoring by the TPS Deputy Commander.
- Hospitals are encouraged to regularly provide TPS with relevant data for consideration with regards to destination selection procedures (e.g., hospital capacity and occupancy).
- Reporting
  - Weekly and monthly offload performance reports are generated and distributed to identified staff at each hospital (plans are currently underway to produce and distribute daily reports).

- Performance reports are regularly presented to and reviewed at the Toronto PDS Working Group.
- Performance reports are available to each hospital regarding their own (recent) performance through PDS and can be accessed by the hospital at any time.

Additional reporting:

- Regular system update and key performance indicator (KPI) reports, including hospital status reports, are provided to the TPS on-call and senior leadership team.

3. Existing Programs

Initiatives in place to promote improved ambulance offload performance:

- Triage nurses may accept paramedic-provided vital signs and a current 12-lead ECG.
- Secondary reports by paramedics are no longer required for CTAS 3, 4, and 5 patients.
- Registration is now concurrent with triage or completed after transfer of care to eliminate delays (paramedics are not expected to register or wait for charts).
- Paramedics are expected to encourage the accompaniment of a family member/friend to assist the patient while in hospital where possible (respecting hospital essential care partner policies).
- Where appropriate, patients will be moved from a stretcher to a wheelchair upon arrival at the hospital and patient movement will be facilitated by ED staff.

Fit2Sit Pilot Program:

- Phase 1 (in place) – Paramedics and hospital staff have been provided with criteria to identify patients who will be offloaded to the waiting room following a full triage report.
- Phase 2 (implementation Spring 2022) – Patients meeting Fit2Sit criteria will be offloaded to the waiting room following a brief verbal report from Paramedic staff. Additional information required for triage will be provided via documentation (Fit2Sit Report) from the paramedics with additional information coming from the patient. Transfer of care occurs when the appropriate hospital staff (e.g., triage nurse) has received the brief verbal report and Fit2Sit Report.

Additional mitigation strategies when unresolved offload delay occurs:

- A TPS Superintendent is assigned to attend hospital site by the TPS Deputy Commander, to assist with identifying patients that can be safely offloaded to the waiting room.
- If hospital gridlock has occurred and has been internally escalated (see *Implement a strong internal escalation plan* above), hospitals should consider contacting the TPS Deputy Commander for assistance. In these cases, a TPS Superintendent may attend to direct paramedics to "double up" care of ambulance patients on hospital stretchers to release ambulances into the community. Hospitals should ensure additional stretchers are available in these circumstances.

APPENDIX 1 – PATIENT DISTRIBUTION SYSTEM (PDS)

The Patient Distribution System

The Patient Distribution System (PDS) software was developed in the early 2000's through a collaborative effort between the Toronto Emergency Access Committee (TEAC) and Toronto EMS, and was implemented in September 2004. The PDS system is a destination software that assists with distribution of patients to the most appropriate hospital based on patient acuity (CTAS), services required, hospital proximity and recent distributions.

PDS is built on the principle of equitability, rather than equality. The nature of paramedic service delivery in a large urban environment is such that demand patterns are neither geographically nor chronologically distributed equally. The unpredictable nature of the 911 system will inevitably cause some instances where the distribution will appear to not be equitable. The *predictable* nature of PDS rules helps to even out those inequities and has produced an extremely stable 'market share' of patients received by each hospital, as envisioned by the TEAC/TPDS WG.

Toronto Patient Distribution Working Group

The TEAC later became the TPDS WG – which continues to be a collaborative effort between Toronto Paramedic Services and Toronto ED Physician leads.

The objectives of The Toronto Patient Destination Working Group are to:

1. Review the ambulance destination processes/rules through the regular review of data,
2. Identify gaps and opportunities, and
3. Reach consensus on the underlying principles that guide any current or future revisions to PDS rules, and the process to be followed.

The ultimate goal is to enhance the quality of patient care, while maintaining trust in the fairness and transparency of the system to its major stakeholders.

How PDS works

PDS utilizes the Time to Next Patient (TNP) metric to assess the workload assigned to each facility. When an ambulance is assigned to a hospital, the hospital's TNP will be credited with a set amount of time based on the CTAS level of the patient. The times allotted were arrived at in consultation with the TPDS WG and are based on the perceived resources that the patient may require for care.

- CTAS 1 – 60 minutes
- CTAS 2A/2B – 45 minutes
- CTAS 3, 4 & 5 – 30 minutes
- CTAS 4 & 5 ambulatory – 15 minutes

TNP is credited to a hospital immediately once PDS assigns a destination for a patient transport. TNP starts to decrease (count down) once the patient arrives at the facility. TNP is the primary factor governing which hospitals are recommended, however there are additional location-based rules to ensure patients are transported appropriate distances. (Note: TNP does not represent the actual amount of time that will pass until the *next* patient arrives).

Process:

1. Paramedics contact the destination coordinator from the scene of the emergency call, prior to transport;
2. The destination coordinator enters the CTAS assigned by the paramedics to the patient, along with any specialty service required (e.g., pediatric, ortho, psych, trauma, STEMI);
3. PDS considers the location of the patient (i.e., the scene of the emergency call) and recommends the closest hospital(s) that:

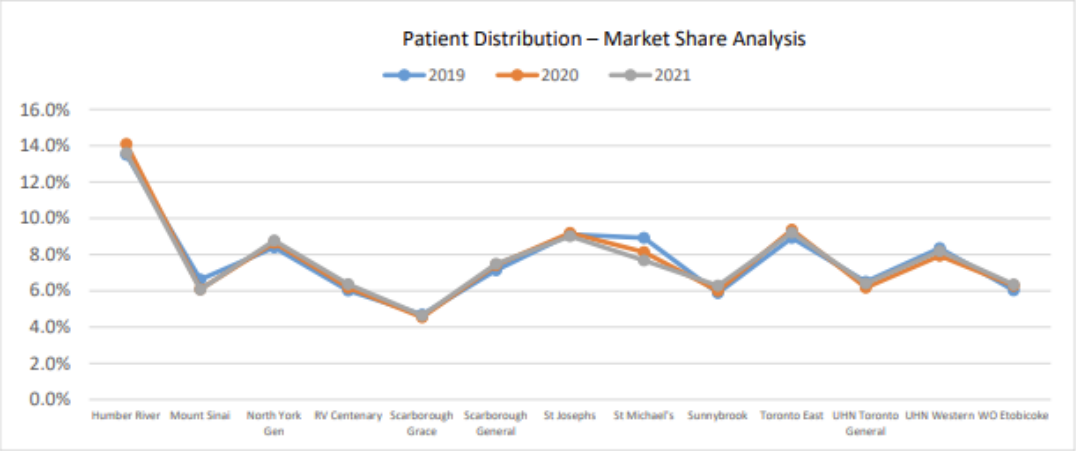
a. Offers the required service, and
b. Has a relatively low TNP.

There are a few situations where the TNP of a hospital will not influence the hospital destination:

- CTAS 1 & 2A patients (must legislatively be transported to the closest appropriate hospital).
- Code STEMI, Code Stroke and Trauma patients (standing agreements for transport to definitive care)
- Accepted Repatriations (as agreed on by the TPDS WG).

On occasion, circumstances may warrant a PDS recommendation not be followed (e.g., adamant patient, ongoing cancer treatment). In these situations an override must be discussed and approved/documented by the on-duty Deputy Commander.

The relative "market" share for each hospital is extremely stable using this method and is closely tracked and reported on at all TPDS WG meetings.



TORONTO REGION HOSPITALS & TORONTO PARAMEDIC SERVICES WORKING GROUP

Organization	Name	Title
Humber River Hospital	Jane Casey	Program Director, Emergency Program and Command Centre
Mount Sinai Hospital	David Dushenski Gillian Wilde-Friel	Chief of Emergency Medicine Patient Care Manager, Emergency Department
North York General	Karyn Popovich Andrea Ennis	President & CEO Clinical Team Manager, Emergency Services Program
Scarborough Health Network	Dr. Bert Lauwers Nancy Veloso	Executive VP, Medical & Clinical Director, Emergency Care & Medicine
Unity Health Toronto	Orla Smith	Senior Clinical Program Director, Emergency Department & Medicine
Sunnybrook Health Sciences Centre	Aikta Verma Steffanye Michaelson	Chief of Emergency Medicine Patient Care Manager, Emergency Department
Toronto East Health Partners	Jennifer Sampson	Manager, Emergency Department
University Health Network	Dr. Lucas Chartier Debra Davies	Toronto Region Emergency Medicine Lead Nurse Manager, Toronto General Emergency Department
William Osler – Etobicoke	Melissa Mann	Manager, Emergency Department
Toronto Paramedic Services	Paul Raftis Mark Toman Jennifer Chung	Chief Deputy Chief Commander
Ontario Health (Toronto)	Rose Cook Waleed Mohammad	VP, Clinical Programs Lead, Clinical Programs
MOH	Steven Haddad	Director

USING EHR FLAGS TO IDENTIFY AMBULANCE OFFLOAD DELAYS – LAKERIDGE HEALTH

As per Lakeridge Health, Epic sites can utilize their ED tracker to create a customized EMS offload Delay waiting room tracker. This captures the TT (total time) used as a trigger to offload before the 30 min target is reached.

A screenshot of this customized "waiting room" (EMS offload delay) tracker is below:

EMS Offload Delay (2)

	Bed	Patient	Age	A	Complaint	TT	Comments	Req	Prio	Tea	Lab S	Rad S	EC	EC	Wt Fil	Ten	BP	HR	Res	SpO
				3	Vomiting and / or N...	00:10	—	—	—	—	...	—		—	—	(...	18...	90	18	98

AMBULANCE HOLD ESCALATION PROCESS – LONDON HEALTH SCIENCES CENTRE

London Health Sciences Centre

DEPARTMENTAL

Standard Operating Procedure:		Ambulance Hold Escalation Process in the Emergency Department			
Owner:		Manager, Emergency Services			
Department:		Emergency Services			
Approval By:		Director Emergency Services		**Approval Date:**	2025-03-06
Original Effective Date:	2025-03-26	**Reviewed Date:**		**Revised Date:**	

PURPOSE

The purpose of this Standard Operating Procedure (SOP) is to outline the internal escalation process when ambulances are held on offload delay in the Emergency Department (ED) due to impeding department flow. This SOP will outline and support the escalation pathway and accountability of the Triage trained Registered Nurse, ED Charge nurse, Manager, Director, and Executive.

LHSC duty of care considerations include arrival triage and exist ahead of transfer of care. Ambulance offload delays remove Emergency Medical Services (EMS) crews from community services and compromise care delivery.

PROCEDURE

1. All patients that arrive in the ED via Emergency Medical Services (EMS) will be assessed and triaged by a Triage trained Registered Nurse (RN) and assigned a Canadian Triage Acuity Scale (CTAS) designation.

2. Patients will be directed to 1 of 3 areas within the department:
   2.1. Waiting room,

   2.2. Hallway stretcher, offload nurse (OLN) Stretcher,

   2.3. Care space (in pod or resuscitation room).

3. If the patient is inappropriate to assign to the waiting room and all stretchers are occupied, the Triage Nurse will review with the assigned departmental flow Triage RN/Reassessment RN and discuss the opportunity for push/pull of patients within the ED to create an available stretcher to offload the patient.

4. At 30 minutes, if the Triage RN remains unable to assign the EMS patient to an appropriate care space, the Triage RN will escalate to the ED Charge Nurse (CN).

5. The ED CN will reassess and assist in creating an appropriate care space for the EMS patient and if unable to accommodate the ED CN will escalate to the Patient Flow Office, Capacity Manager.

6. At 45 minutes, if the Triage RN/CN remains unable to assign the EMS patient to a care space, the CN will escalate to the ED Manager or Afterhours Capacity Manager.
   6.1. During weekday hours, the ED Manager will follow up and request an update from the Capacity Manager.

7. The ED Manager/Capacity Manager will review the situation and collaborate with inpatient units to explore opportunities to support flow and aid in decanting the ED.

8. At 60 minutes, if the Triage RN/ED CN remains unable to assign the EMS patient to a care space, the ED Manager/Afterhours Capacity Manager will escalate to the ED Director/Director on-call.

9. The ED CN/ED Manager will communicate this escalation to the EMS crew/supervisor.

10. At 90 minutes, if there is no resolvable plan, the ED Director/Afterhours Capacity Manager will escalate to the Executive/Executive on-call.

11. The ED Director/Executive/Director on-call/Executive on-call will communicate with EMS leadership as needed.

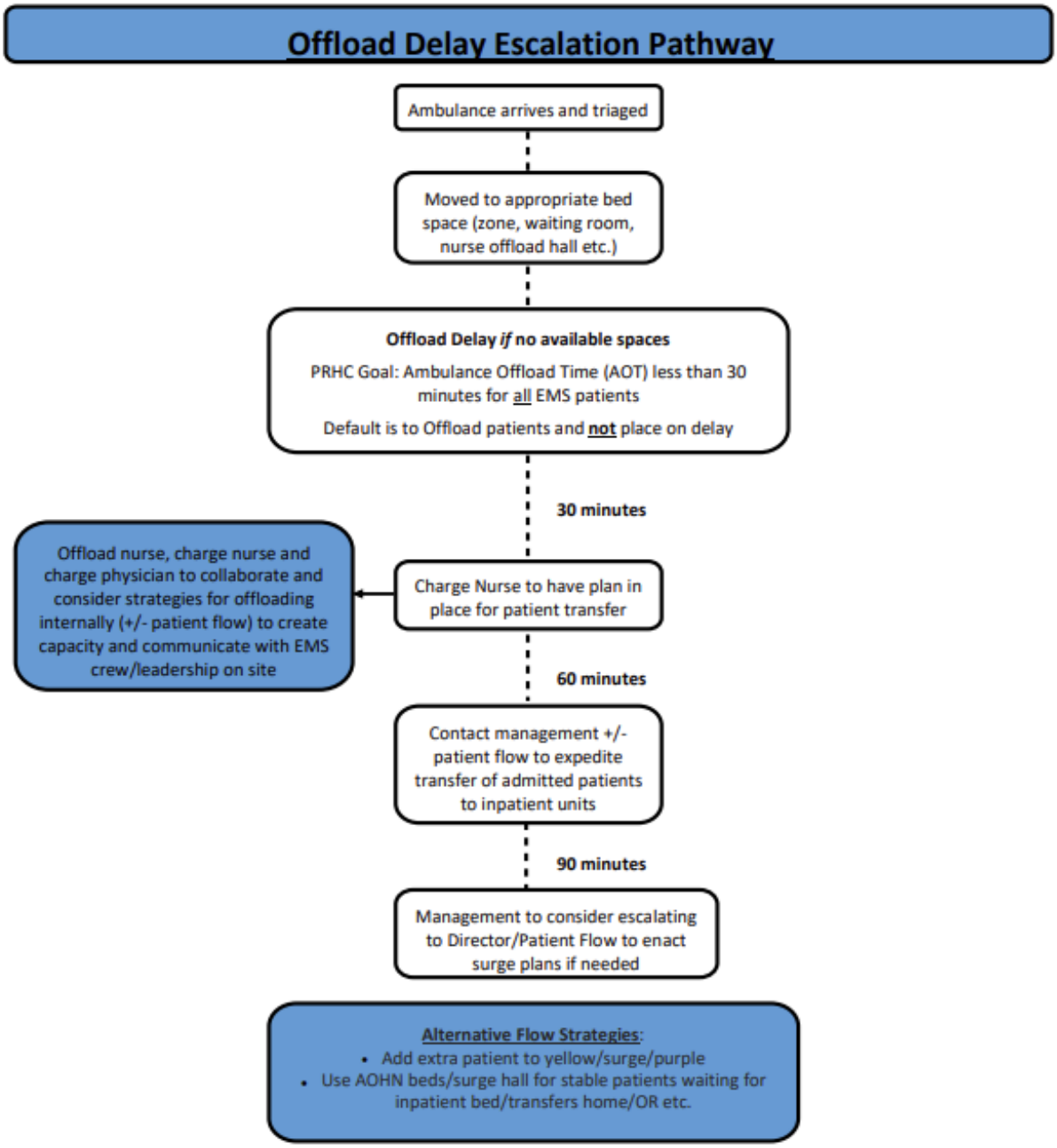
Note: Any adverse event or near miss directly resulting from the implementation of the policy/procedure shall be reported through the LHSC online safety system as per LHSC procedure Incident Reporting and Management.

OFFLOAD DELAY ESCALATION PATHWAY – PETERBOROUGH REGIONAL HEALTH CENTRE

PRHC
Peterborough Regional Health Centre

Policy #1. A.9
Page 6 of 6

Appendix B: Offload Escalation Pathway



July 2024

FIT-2-SIT CRITERIA – PETERBOROUGH REGIONAL HEALTH CENTRE

PRHC
Peterborough Regional Health Centre

Policy #1. A.9
Page 5 of 6

Appendix A: Fit2Sit Inclusion and Exclusion Criteria

Fit-2-Sit

When the following criteria are met, the ambulance offload nurse should consider implementing the Fit2Sit process:

Fit2Sit Inclusion Criteria:

- Patient has a GCS of 15
- Patient is physically able to sit in a chair and is appropriately dressed
- Patient has vital signs that fall into the following parameters:
  - SBP > 100mmHg
  - HR 50-100 BPM
  - RR 12-20 RPM
  - Temp <40°C
  - SpO2 >92% on RA
  - Blood Sugar between 4-20 mmol (if obtained)

Fit2Sit Exclusion Criteria:

- CTAS 1
- Unaccompanied patient deemed frail or vulnerable
- Unaccompanied minor under 16 years of age
- Any patient unable to communicate health care needs
- Any patient at risk of active self-harm or risk of elopement
- Any patient under spinal motion restriction

PETERBOROUGH PARAMEDICS

PRHC
Peterborough Regional Health Centre

Triage & Registration

PATIENT ARRIVAL PATTERN HEAT MAP – OAK VALLEY HEALTH UXBRIDGE

Uxbridge Emergency Daily Visit Patterns FY2325 YTD Nov

Data Source: NACRS

Last Updated Date: : Jan 29, 2025

Table 1: Uxbridge Emergency Heat Map by Registration Day of Week and Registration Hour

	Average by Day of Week and Registration Hour							
Reg Hour	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Weekly Average
12 midnight	1	1	1	1	1	1	1	6
1 a.m.	1	0	1	0	1	1	1	5
2 a.m.	1	1	0	1	0	0	1	4
3 a.m.	1	1	0	0	0	0	1	3
4 a.m.	1	0	1	0	1	1	1	4
5 a.m.	1	1	1	0	0	0	1	4
6 a.m.	1	1	1	1	1	1	1	7
7 a.m.	2	2	1	2	2	1	2	12
8 a.m.	3	3	2	2	3	3	3	18
9 a.m.	4	3	3	3	3	2	3	22
10 a.m.	4	3	3	3	3	3	4	24
11 a.m.	3	3	3	3	3	3	3	23
12 noon	3	3	3	3	3	3	3	20
1 p.m.	3	3	3	3	3	3	3	20
2 p.m.	3	2	3	3	2	3	3	19
3 p.m.	3	2	2	2	3	3	3	18
4 p.m.	3	3	2	3	2	2	3	18
5 p.m.	3	3	2	3	3	2	3	18
6 p.m.	3	2	3	2	3	2	3	18
7 p.m.	3	2	3	2	3	2	3	18
8 p.m.	2	3	3	3	2	2	2	16
9 p.m.	2	2	2	2	2	2	2	13
10 p.m.	1	1	1	1	2	1	1	8
11 p.m.	1	1	1	1	1	1	1	7
Average by Day	50	47	45	46	45	44	49	325

PATIENT ALLOCATION NURSE – JOSEPH BRANT HOSPITAL

STANDARD WORK: ARM Process Flow

JOSEPH BRANT HOSPITAL

Role: Patient Allocation Nurse (PAN)	**Area(s):** ARM	**Date:**
Process: PAN is stationed at front of ARM and manages intake processes	**Rev No.** 1	**Page:** of 1
Process Trigger: Patient is triaged and assigned to ARM 1 or directly to a room for assessment and management.	**Process Done: Pt awaits for assessment in ARM room by ERP OR Pt awaits for allocation in ARM 16 by nurse.**	

Step	Time	Description	Equipment/Supplies	Additional Information
1.	1-5 min.	**ASSESSMENT (ARM 1)** PAN identifies pt by reviewing triage note. Identifies need by critical look/assessment. (i.e. acuity, need for medical directives, one-touch etc.) Pt's requiring indepth assessment or higher acuity should be placed in a private ARM room for assessment/management. Pt's may require additional resources that are better suited in other areas of the department - discuss with CN or TL Assign/Advise ERP	Computer- Meditech System	The PAN role is primarily responsible for patient flow and management of patients in the ARM area for the ambulatory patient population The PAN will; 1. Deligate tasks to colleagues assigned in ARM to complete rapid assessments and application of medical directives if applicable 2. Relocate pt's that are waiting for results, reassessments or diagnostics tests into ARM1 OR ARM 16 3. Provide brief TOA to colleagues in ARM regarding plan of flow and care for the next pt who enters into the ARM area. 4. May assist by performing Medical Directives and perform brief primary when flow is at risk of compromise for Pt's in ARM 1 and utilize ARM 2-3 for private assessments/ tasks. NOTE: The ARM area is subject for flux depending on the volume of patients and the acuity of care in the department. Standards of practice should be met and managed based on pt's stated complaint and presentation. For further assistance please advise to Charge Nurse or TL When assisting in nursing tasks primary assessment includes the critical look and ABC's. The Priamry assessment is NOT a head to toe.
2	5-10 mins.	**ASSESSMENT (ARM ROOMS)** PAN moves patients waiting for reassessment or diagnostic results to ARM16 or to ARM1 In cases of grid lock, utilize a private ARM room (i.e. ARM17) for low acuity pt's just needing reuslts explained or d/c instructions Identify high acute pt's requiring transfer to CC/CAM/PES to the Charge Nurse or TL Assign/Advise ERP		
3.	15 min.	**PAN (POSSIBLE ASSIGNMENT)** One-touch pt's (i.e. soft tissue, request for Rx etc.) should be managed infront of ARM (i.e. ARM 2-4) and discharged promptly. If experiencing any delay, continue this pt to ARM16 to await reassessment/DI/DC. Assign/Advise ERP		

PRE-TRIAGE – PETERBOROUGH REGIONAL HEALTH CENTRE

WHAT IS PRE-TRIAGE?

Pre-triage is the ability to simultaneously (and rapidly) collect patient presenting complaints, health card number and determine who needs to be subsequently triaged next. It takes us away from a more first-come-first-seen model. When long lines form prior to triage, it is an effective method to determine who is going to be triaged next, determine more accurate arrival times, provide the identity of who is in the waiting room and mitigate some risk around patients who leave before being triaged.

WHY ARE WE REINTRODUCING THIS PROCESS?

- Pre-triage times have reached an all time high along with our LWBS times being consistently >10%
- The risk of having patients in our department for unknown reasons is decreased when we can collect a chief complaint and interact with patients soon after they arrive
- We have secured funding for an 11-19 nursing shift through P4R dollars and are committed to using this resource to increase safety and decrease risk in the department
- As the ramp-down of Pandemic Support continues, the screeners (pandemic support workers) will no longer be present at the Emergency Department entrance. We are working with volunteer services to advocate for assistance in the WR with visitors/etc. but initially will lean on WR staff (clerks/nurses/pre-triage RN) to identify how much non-clinical work is present in the WR.
- This is an expectation of the triage role and ultimately decreases overall risk to the nurses working at triage when all patients have chief complaints identified as soon as possible. We have spoken with the Risk department and can confirm that we are equally responsible for patients in our WR who both have and have not yet been triaged. Faster swipe times will eliminate the unknown and help us organize acuity for triage.

WHY IT MATTERS

STAFF AND PATIENT SAFETY:

- We have identified serious safety concerns with non-clinical people being in the screening role – potentially giving people the wrong information, being told more health information about people than they necessarily should have been privy to, ‘clinically’ prioritizing who goes to see triage next. The screeners’ role evolved to be much more than they were hired and trained for, which was solely screening people for COVID-19 symptoms. They were initially funded from the province that funding ended in July and again its sole purpose was COVID-19 management, not WR management as it evolved into.
- Pre-Triage RN or RPN can visually see all patients walking in and seated in the main waiting room
- Rapid collection of health card numbers lets us know who is in the waiting room and also decreases time required with the triage nurse
- Collection of chief complaint and “first-look” lets the pre-triage nurse identify who needs to be triaged next as opposed to first come first seen

MORE EFFICIENT WORKFLOWS:

- Minimize disruptions to the Triage Nurses work
- complete initial IPAC screening so Triage doesn’t have to

- Opportunity to provide re-assessment to patients sent back to the waiting room

WHO WILL BE TRAINED IN THIS ROLE?

- All RN's and RPN's will be able to work in the pre-triage role and will be trained in the role and supported by Tammy during the initial roll out and evaluation of the role
- This may turn into an expression of interest similar to float/resource where we will rotate staff through this role schedule by schedule.

HOW ARE WE MEASURING EFFECTIVENESS?

- Tracking average wait times to triage for 1100-1900
- Capturing real-time collection of patient arrivals
- Decreasing LWBS/LWBT %
- # of waiting-room re-assessments
- Triage times

REGISTERED RESPIRATORY THERAPISTS: MEDICAL DIRECTIVE AND DELEGATION IN THE ED – OAK VALLEY HEALTH UXBRIDGE

MAR 2025

Uxbridge ED RRT Medical Directive & Delegation Updates

NEW:

Electrocardiogram (ECG) Medical Directive

May request and/or complete an ECG

- see list of indications and contraindications

Note: Once ECG obtained, the RRT will notify an ED physician of completion and request further guidance if necessary.

Chest X-Ray (CXR) Medical Directive

May request a CXR posteroanterior/ lateral views (CXR PA/LAT) OR a portable CXR (one view)

- see list of indications and contraindications

Note: The ED physician is responsible for reading the CXR or acting on the results associated with the implementation of this medical directiv^

Oak Valley Health

Point of Care Testing for Glucose Monitoring Delegation

- see list of indications and contraindications
- delegation required for non-cardiorespiratory patients as it is a prescribed procedure below the dermis
- follow Glucose Testing - Critical Results and Confirmation policy

Note: Must have successful completion of glucometer learning module.

Bladder Scan Delegation

- see list of indications and contraindications
- delegation required as it is an application of energy

Note: Must have demonstrated competence in the use of the bladder scanner through successful completion of orientation. Existing staff will be provided with training.

Key Changes - Addition of:

- Chest X-Ray Medical Directive
- Electrocardiogram Medical Directive
- Point of Care Glucose Testing Delegation
- Bladder Scan Delegation

https://mshdms.labqms.com/sthlabframe.asp?MeReLoad=F&DID=26950&FromW=

Algorithm for RRTs Working in UXB ED

TASKS SHOULD ONLY BE COMPLETED WHEN YOU HAVE THE REQUISITE KNOWLEDGE, SKILL AND JUDGEMENT

Cardio/Respiratory Patient

Y

- Controlled Act
  - Authorized Controlled Act
    - Order (medical directive/direct order)
    - Examples:
      - Intubation (direct order),
      - ABGs (medical directive),
      - Ultrasound for ABGs (direct order),
      - POCT BG (direct order),
      - Administration of bronchodilators (medical directive)
  - Non-Authorized Controlled Act
    - Delegation & Order (medical directive/direct order)
    - None currently in place
- Non-Controlled Act
  - Personal Knowledge & Order (medical directive/direct order)
  - Examples:
    - ECG (medical directive),
    - Ordering chest XRay (medical directive)

N

- Controlled Act
  - Needs Delegation & Order (medical directive/direct order)
  - Examples:
    - Routine bloodwork (medical directive / delegation),
    - Insertion of saline lock (medical directive / delegation)
- Non-Controlled Act
  - Personal Knowledge & Order (medical directive/direct order)
  - Examples:
    - Urinalysis (medical directive / direct order),
    - ECG/CXR for non-cardioresp patients (medical directive / direct order),
    - Oral medication (direct order),
    - Simple wound care (direct order)

Controlled Acts Authorized to RRT:

Note: Authorized for Cardio/Respiratory Patients Only

•Performing a prescribed procedure below the dermis
•Intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx
•Suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx
•Administering a substance by injection or inhalation
•Administering a prescribed substance by inhalation

ED Relevant Controlled Acts NOT Authorized to RRT:

- **Controlled acts in the list on the left for non-cardio/respiratory patients**
- Communicating to the individual a diagnosis identifying a disease or disorder as the cause of symptoms of the individual
- Putting an instrument, hand or finger beyond the external ear canal, point in the nasal passages where they normally narrow, larynx, opening of urethra, labia majora, anal verge, or an artificial opening of body
- Setting or casting a fracture of a bone or a dislocation of a joint
- Applying or ordering the application of a form of energy prescribed by the regulations under this Act
- Prescribing, dispensing, selling or compounding a drug

Updated: April 11, 2025

RRT Scope of Practice for Uxbridge ED Tasks

With the creation of the RRT role in the Uxbridge ED, many questions have arisen about the types of assessments and interventions that RRTs can provide. Much of this decision-making is context specific and up to each individual RRT to determine using their clinical judgment. The RRT will consider their professional scope of practice (cardio-respiratory patients), personal scope of practice (presence of the knowledge, skill, and judgment to safely perform the task), and the patient's presentation to determine if they are competent to perform an identified assessment or intervention.

Despite this, there are some tasks that are currently not within the scope of the RRTs working in the Uxbridge ED. This is primarily due to lack of exposure and education for these specific tasks. The majority of these tasks are not traditionally performed by RRTs, as they are outside of the scope and controlled acts authorized for RRTs. As the role continues, and the expertise within the RRT team grows, there is opportunity for expansion of some of the tasks that RRTs can perform when supported with additional education.

To support transparency and role clarity for all members of the Uxbridge ED team, the tasks in the table below are **not currently within the professional or personal scope of practice for Uxbridge RRTs working in the ED**.

Identified Task/Skill	Rationale for NOT Including
Dispensing Oral Medications on Discharge	RRTs require a delegation to dispense medications, which is not currently in place. In addition, RRTs do not have baseline knowledge about non-cardiorespiratory medications.
Wound Care below the Dermis	Performing a procedure below the dermis is a controlled act. If the patient is not a cardio-respiratory patient, RRTs require a delegation, which does not currently exist. *****Note:*** *Simple wound care and/or assisting with suturing or suture removal is not a controlled act and could be completed by the RRT if this task is within their personal scope of practice.*
BPMH	RRTs do not have baseline knowledge about non-cardiorespiratory medications.
Applying Slings OR Fitting Air Casts, Splints, or Crutches	RRTs do not have baseline knowledge about the musculoskeletal system, safe patient handling with or without weight bearing restrictions, or about how to apply and use slings, casts, splints, or crutches.
Visual Acuity Testing Eye flushing	RRTs do not have baseline knowledge about sensory systems, including the visual system.

RAPID ASSESSMENT OF PAEDIATRIC PATIENTS - SICKKIDS

RAPP targets very low acuity patients who are unlikely to require any ED testing/consultations and are likely to be discharged home. A QR code is available for them to scan and answer questions to see if they qualify for being diverted away from the ED to a rapid access outpatient clinic. This is using a custom-built deterministic logic-based questionnaire that was created by SickKids (i.e. SickKids IP) and operationalized by Hero AI. Nurses at triage also have an ability to manually direct patients up to RAPP. Through the Hero AI app, nurses can open and close the clinic on demand or at set times. Patients access the form via a simple web-based interface that works on any mobile phone. Questionnaire takes less than 90 seconds to complete (typically 3-5 “yes/no” questions). We have been running this for a few years now safely and look to expand on it.

TRIAGE PROCESS IN THE EMERGENCY DEPARTMENT – LONDON HEALTH SCIENCES

DEPARTMENTAL

Standard Operating Procedure:	Triage Process in the Emergency Department	
Owner:	Managers, Emergency Services	
Department:	Emergency Services	
Approval By:	Directors, Emergency Services	**Approval Date:** 2023-12-19
Original Effective Date: 2023-12-20	**Reviewed Date:**	**Revised Date:**

PURPOSE

The Ministry of Health has raised concerns regarding the length of time ambulances are being held in London Health Sciences Centre (LHSC) Emergency Departments. This concern has created a catalyst for change to ensure the Emergency Department staff are providing consistency in care, regardless of the patients' mode of arrival. The purpose of this Standard Operating Procedure (SOP) is to support the flow of patients arriving at the emergency department regardless of mode of arrival. This SOP will also support the accountability of the Triage Nurse, including reassessment of patients and patient flow of the emergency department resulting in removing the 2-tiered system triage approach.

AUDIENCE

Registered Nurses in the Emergency Department who are triage trained.

PROCEDURE

1. All patients that arrive in the Emergency Department (regardless of mode of arrival) will be assessed and triaged by a Triage trained Registered Nurse (RN).

2. Appropriate Canadian Triage Acuity Scale (CTAS) designation will be applied based on assessment by Triage RN.

3. Based on assessment by nurse and following triage patients will be directed to 1 of 3 areas: Waiting room, Hallway stretcher, Care space within the department.

4. Should the patient require immediate interventions the patient will be moved to the most appropriate and available care space, regardless of mode of arrival to the Emergency Department. Completion of triage can be completed in the care space. The Charge Nurse/In charge Person must be made aware of this patient immediately.

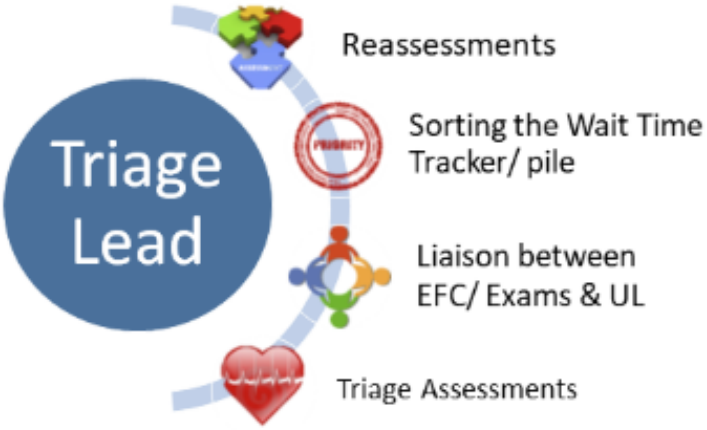
5. Reassessments will occur for all patients not in a care space, including patients that request reassessment. All reassessments need to be documented. Reassessment of CTAS scale may require further alteration if there is a change in the patient's condition.

6. Triage Nurse and Reassessment Nurse will work closely with the Charge Nurse to ensure departmental flow.

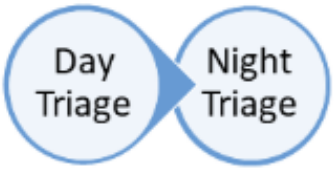
REFERENCES

Canadian Triage Acuity Scale (CTAS)

Triage Lead (TL)



Who will cover this role?



What is My Role?

- REASSESSMENT: Complete R/A for CTAS 2 & 3 Pts waiting longer than 2 hours
- INITIAL TRIAGE ASSESSMENT: Support Initial Triage Assessments/ Medical Directives
- SORTING: Assuming patients are stable, our threshold for moving a lower acuity patient in front of a higher acuity is **2 hours**.
  For example:
  - Move ahead a CTAS 3 that has waited 2 hours longer than a CTAS 2
  - Move ahead a CTAS 4 that has waited 2 hours longer than a CTAS 3

Draft 1 durocp December 9 2022

Clinical Judgement/ Concern Trumps Everything!

- LIAISON/COMMUNICATION:
  - Receive report from Triage nurse who are concerned about patient going to Exams
  - Attempt to alleviate bottleneck at Triage and/or Exams, by requesting help as available
  - Escalate challenges from Triage/ EFC/ Exams to UL

** Please provide report to oncoming Triage nurse on the status of the Waiting Room, R/A, and flow**

I am a Nurse at Triage but Not Lead. What is My Role?

- Continue to report to UL when concerned about a patient you want to bring in to CDU/ACU.
- Report to Triage Lead when concerned about a patient tracking to Exams, i.e. If wanting to bump ahead of their CTAS/Time.
- Due to patient condition / clinical judgement inform EFC of need for room.
- Responsible for doing primary Triage assessment/ Medical Directives.
- Report to TL if need support to complete backlog initial Triage assessments of CTAS 2 & 3.
- Support TL to complete reassessments when caught up with initial Triage assessment and there are many patients that require reassessment.

What is the UL Role?

- Consider re-directing D8/E8, F9, and E12 as needed to balance workload in heaviest area (i.e. If Triage initial assessment times are long for high acuity patients, and there is capacity in the department).
- Attempt to problem solve, and continue to escalate unresolved concerns to Management.

Be mindful that this change may result in less capacity for initial Triage assessments. Some LOWER acuity patients may wait longer to have their initial Triage assessment completed.

If there are long waits for initial assessments, you are encouraged to ask prompting questions at Triage window to ensure there their presentation isn't more complicated than their initial story

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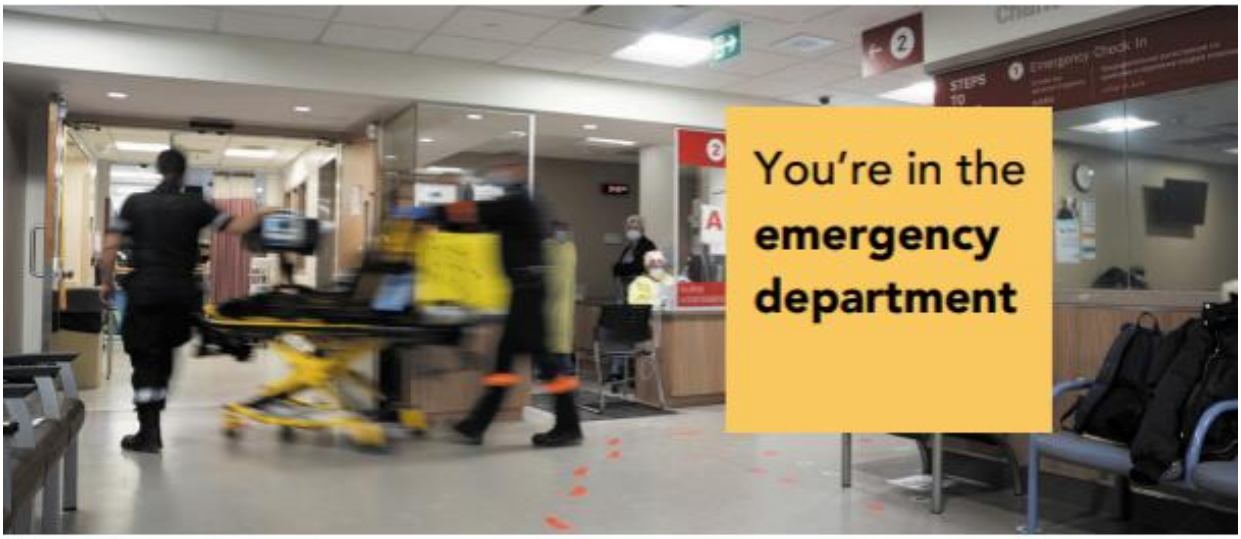
EMERGENCY DEPARTMENT PATIENT INFORMATION – NORTH YORK GENERAL HOSPITAL

NORTH YORK GENERAL



What happens next?

STEP 1 **Show health card to the nurse at the entrance**

This allows us to identify you. Some tests and basic first aid are done here.

STEP 2 **Triage**

This means sorting patients by how life-threatening their health concerns are. The nurse will ask questions about your symptoms and measure your pulse, oxygen level, blood pressure, respiratory rate, and temperature.

STEP 3 **Registration**

The registration clerk will confirm your name, contact information, and health card information.

STEP 4 **Go to the colour "zone" you are assigned to**

Zones are different areas of the Emergency Department, based on how sick a patient is and their type of health problem. For some zones, you will be directed to walk there and for others a nurse will accompany you.

STEP 5 **Wait to see an emergency doctor.**

The average wait time after triage is 2-4 hours. Your wait may be less or more depending on the number ofother patients.

STEP 6

You may get blood tests, a urine test, or x-rays before seeing the emergency doctor.

Please flip the page

STEP 7 **See the emergency doctor**

The emergency doctor will ask you some questions, examine you, and order additional tests or treatment as needed.

STEP 8 **Wait until the test results are back, sitting in the waiting room of your "zone"**

This can take several hours since many other patients are in line for the same tests as you. Some tests, such as CT scans, ultrasounds, and X-rays, need to be read by another doctor (called a radiologist). Please let the nurses know if you need pain or nausea medication or if your symptoms have changed.

We recommend that you stay in the waiting room so that we can help if your condition worsens. However, please let the nurse know if you wish to walk around the hospital or buy some food. Please do not leave the hospital grounds.

STEP 9 **The doctor tells you your test results.**

The emergency doctor will tell you the next steps. These may include going home, taking medications, and possibly getting an appointment to see a specialist later. Alternatively, you may be advised to stay in the hospital.

So.. when will I get seen?

We aim to see patients in the order they arrive. However, patients who are sicker than you will need to be seen first. In addition, if the emergency doctor is treating a very ill patient, he or she will not be available to speak with you yet, even though your test results are ready. We greatly appreciate your understanding of this.

Physician Initial Assessment

PHYSICIAN NAVIGATOR ROLES AND RESPONSIBILITIES – MOUNT SINAI

Physician Navigator Responsibilities and Duties:

Physician Interaction:

- Obtain past medical history, medication lists, and old charts for patients from the EMR.
- Keep track of the patients the physician has seen, flagging critical results and ensuring timely reassessment of patients.
- Assist clerical staff in following up on delays in results with Diagnostic Imaging and Labs.
- Notify physicians of completed investigations or pending reassessments.
- Prior to reassessing the patient, print off Lab and DI results, and load patients into rooms.
- Place and answer phone calls on behalf of the physician to support patient referral processes/discharges.
- Assist with making patient follow-up arrangements and provide printouts and instruction sheets, copying materials on behalf of physicians.

Patient Interaction:

- Move patients in and out of assessment rooms.
- Wipe chairs and high-touch surfaces in rooms between each patient.
- Change bed sheets/bed sheet rolls between each patient.
- Ensure equipment relevant to the patient examination or necessary procedures is present and clean in the room (e.g., ophthalmoscope, point-of-care ultrasound).
- Instruct patients on preparing for exams (e.g., asking them to change into gowns).
- Direct patients to appropriate areas to wait for tests (e.g., DI or bloodwork)
- Organize and gather supplies needed for procedures (e.g., I&D, suturing, casting).
- Provide items of comfort to patients, including blankets, tissues, and water (with physician/nursing approval).
- Assist in managing patient expectations while waiting.
- Answer non-clinical patient questions about the next steps in their progress (refer clinical questions to the MRP or nursing team).
- Conduct environmental scans of waiting areas and relay any concerns to nursing leadership or the MRP.

Miscellaneous:

- Help with stocking items, including clean bedsheets, warm towels, gowns, gloves, tongue depressors, and otoscope specula tips.

PROVIDER IN TRIAGE WORKFLOW – ERIE SHORES HEALTH CARE

Erie Shores HealthCare
Care Happens Here

Erie Shores Health Care

Provider in Triage "PIT" - Workflow

Goal

- An overall goal is a reduction in physician initial assessment (PIA) patients left without being seen (LWBS) and total length of stay (LOS). These are quality metrics along with P4R metrics that have seen a great reduction in institutions that have implemented the provide in triage (PIT) process

Process

- The provider will start their shift at 1700 working out of the secondary triage area to review patients in the waiting room with the longest wait to be seen. The provider will be able to assess the patients, order further diagnostics (labs or imaging) that may not be part of the medical directive. Once the patients with the longest wait or those with minor complaints that are not RAZ appropriate are assessed the provider can work to review the current triages that are arriving and assess those patients, provider further orders and review potential for discharge from waiting room (when appropriate).

Provider

- Review with the triage nurse will be done at start of PIT shift for appropriate patients.
- Review of the patients with the longest wait times and assessment for further diagnostics (labs or imaging) to be started. This will be completed as a physician initial encounter record (PIER) and can be handed over to the subacute or acute physician.

- **Treat and Release Patients**
  - Patients that present with simple complaints that do not require extensive medical management can be seen in the secondary triage by the PIT physician and discharged from triage as a treat and release

- **Standard Treatments**
  - Patients that present with simple complaints that require medical management and intervention can be seen in secondary triage by PIT physician and liaison with the charge nurse for support and placement if requiring IV Therapy (medications or antibiotics) but are anticipated to be discharged after (Ex; cellulitis, repeat antibiotic therapy, gastro – antiemetic's and fluids)

- **Primary Treatment**
  - Patients that present with extensive medical history- or ones that require a complex workup, that are in the waiting room can be seen in secondary triage by the PIT physician and have investigations started that would be beneficial for the primary ERP to have completed to guide further assessment or admission. These patients will be handed over to the subacute or acute physician after the PIER assessment.

*** Unless a patient needs IMMEDIATE intervention after the PIER assessment the medical management should be left for the ERP to allow PIT physician to continue work flow***

Triage Nurse

- Review of patients at start of PIT physician shift to assess wait times for patients in the waiting room and assess patients that are; treat and release, standard treatment or primary treatment criteria.
- Medical Directive initiation to be continued within PIT physician hours, however further labs that are requested can be reviewed with Triage RN for add on eligibility after PIER assessment completed.

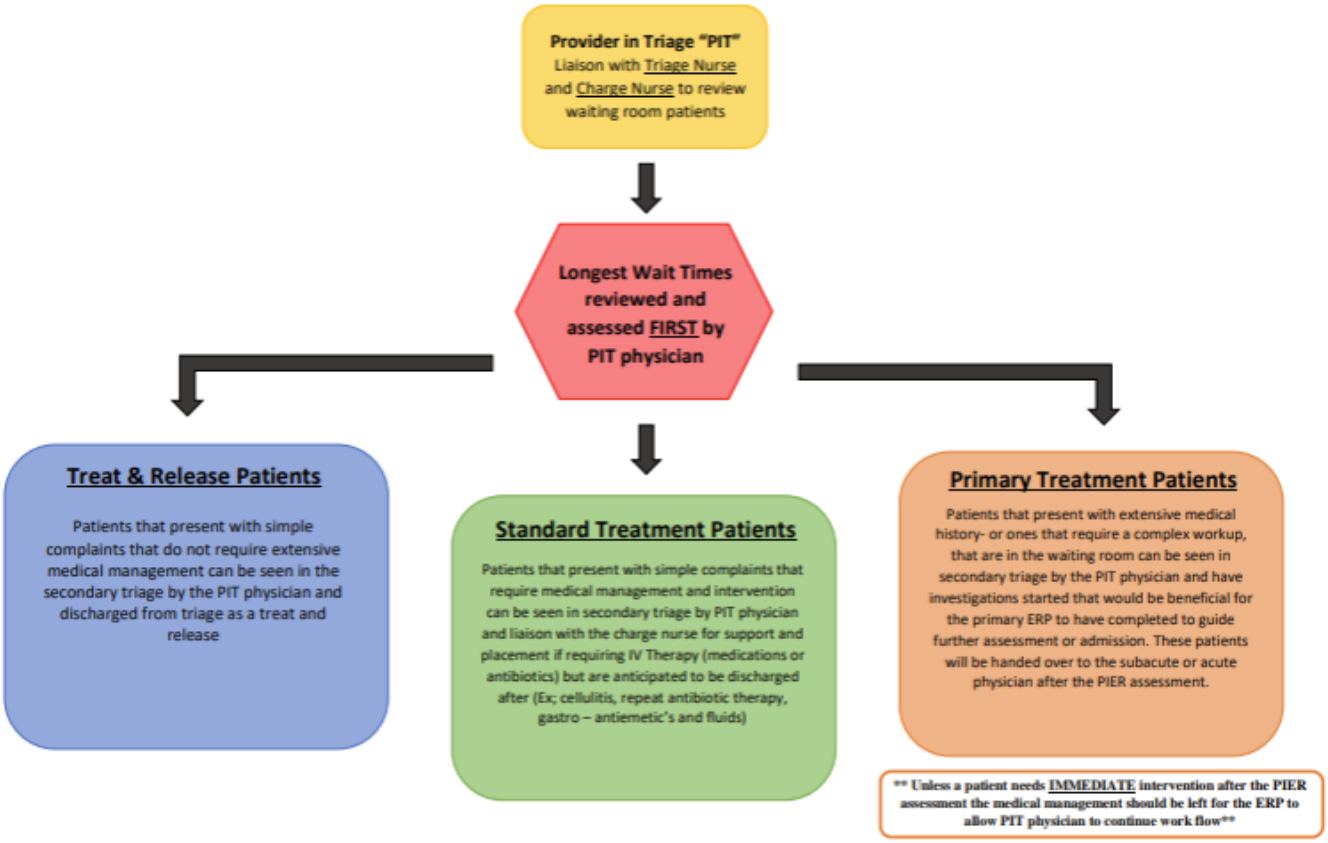
Charge Nurse

- Charge nurse to liaison with physician and triage nurse at start of shift when reviewing patients to be assessed by PIT physician. Patients

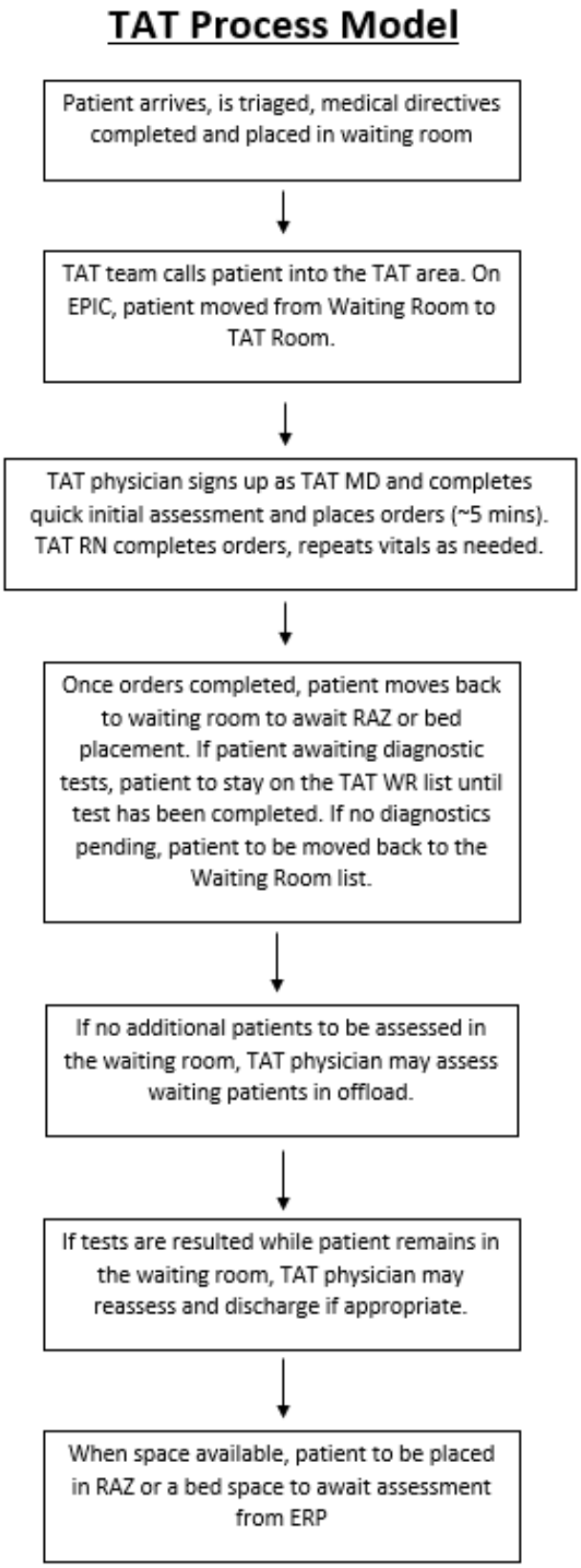
Erie Shores HealthCare
Care Happens Here

Erie Shores Health Care

Provider in Triage "PIT" - Workflow



TRIAGE ASSESSMENT TEAM – HAMILTON HEALTH SCIENCES



STANDARD WORK FOR INITIAL ASSESSMENT NURSE – HAMILTON HEALTH SCIENCES

Standard Work (Initial Assessment Nurse)	Hamilton Health Sciences
Last Update: __August 29, 2024_____ Created by: __Sarah Hayhow, Kendra Carrington-Greco __	

Time	Major Steps	Details	√	Comments
0700 – 1000	• Ensure IAN/IAP space is stocked and set up for the shift • Assist throughout the department to support as needed • Ensure first break happens prior to the 1000 IAP start time	• Ensure needed equipment is within the room ie. ECG machine, vitals machine, IAN and IAP computers • Re-stock blood draw equipment, IV supplies, dressing supplies etc.		
1000 - 1800	• IAP to determine and call in which patients are to be seen by the TAT team • IAP to sign up and move patient to the Treatment at Triage (TAT) WR within EPIC • IAP to assess patient and place initial orders • IAN to acknowledge appropriate IAN orders (no IV fluids or medication infusions). **Leave any additional orders that will not be completed by the IAN unacknowledged.** • Complete labs and provide appropriate ordered medications (including any IV push medications) and complete documentation • IAN to complete repeated vitals if greater than 30 minutes since last vitals (for CTAS 2) or 60 minutes since last vitals (for CTAS 3, 4, 5) • IAN to move the patient back to the general waiting room once orders have been completed (this includes	• Break when the IAP physician takes a break • Patients who are just ordered medications and lab work may be moved back to the general waiting room as soon orders have been completed • Patients who have imaging ordered must remain in the Treatment at Triage WR until imaging has been completed (but not resulted) to ensure imaging appears correctly in the chart. Once patient has returned from DI, the patient may be moved back to the general waiting room on the tracker • If there are no patients in the waiting room to be assessed, and there are patients in the offload area, the IAP may assess offload patients. IAN to finish up on any existing orders for waiting room patients, re-stock etc. Offload nurses to complete orders on offload patients.		• If patient leaves after being assessed by the IAP/IAN team but prior to ERP assessment, please notify the IAP and discharge patient as LABS • If patient leaves after being assessed by the IAP/IAN team but prior to ERP assessment and the IAP has left, please let the Minor (RAZ) Side doctor know and discharge patient as LABS. If Minor Side doctor unavailable, please notify Major Side doctor

Time	Major Steps	Details	√	Comments
	the completion of any imaging) to await placement as well as moving their location within EPIC • Change destination status if indicated by the IAP (i.e. can now go to RAZ instead of OBS bed) • Liaise with Charge Nurse if patient now needs a higher level of care after assessment • Reassess any patients who have received treatment and liaise with triage and charge to assist with reassessments as needed • Complete discharge process in EPIC if patient can be discharged post IAP assessment			
1800 - 1900	• Take third break • Clean and prep the IAN/IAP room for the next day			

STANDARD WORK FOR INITIAL ASSESSMENT PHYSICIAN – HAMILTON HEALTH SCIENCES

Standard Work (Initial Assessment Physician)				
Last Update: July 26th, 2024				
Time	**Major Steps**	**Details**	**√**	**Comments**
0945-1000	• Arrive to shift and meet with IAN to prepare for the day • Check in with charge RN to review any concerns in patients WTBS and to plan initial assessments	• Work with IAN to ensure needed equipment is within the room ie. ECG machine, vitals machine, IAN and IAP computers		
1000 - 1800	• If many patients WTBS on arrival, review triage notes and eCTAS to determine initial order of assessment • After TAT patient assessment, determine pathway as follows: (1) flow directly to ED bed (for most acute patients and where bed is available), (2) return to WR to await bed availability and/or test results, (3) discharge home after assessment • For any patients that IAP/IAN are concerned about, speak to charge RN to arrange for bed as soon as possible • IAP to liase with major side ERP for any patient they are concerned about, usually those flowing directly to bed in resus/cardiac • For patients returned to WR, IAP should R/A investigations ordered as results return and determine if current TAT pathway is still appropriate, or if destination can be different (i.e. can now go to RAZ instead of OBS bed, discharge home)	• For all patients assessed by TAT, IAP responsible for the following: - Must click Treatment at Triage button before signing up for patient - Right click and "assign me" as normal for seeing a patient - Right click and ROOM patient to TAT WR - Use the TAT WR to manage patient list - Complete focused assessment of CC, including brief history and physical, ordering of initial investigations including bloodwork and imaging - Document TAT note - Communicate to patient and/or NOK the purpose of TAT, noting that it does not constitute full workup and that full ERP assessment to be completed if patient to be placed in a bed • For any patient seen in ambulance offload, communicate directly with		

Time	Major Steps	Details	√	Comments
	• For patients that can be referred to a service directly after TAT assessment and/or results, IAP to call that service to make consult and complete disposition tab (referred) • For patients that can be discharged directly home, IAP to complete ED provider note, AVS +/- any prescriptions • If there are no patients to be assessed, IAP may go to ambulance offload to start assessment and orders on patients there, but this must not supersede primary role of seeing ambulatory patients at front of ED • For patients LABS, IAP will be required to complete ED provider note – see LABS workflow*	RN in offload about any investigations ordered - Click on Treatment at Triage button and sign up as above, but do not ROOM patient to TAT WR • Generally, the IAP should not be involved in resuscitations, procedural sedation, or other tasks that detract from the primary role and standard work here. There is a 2nd ERP that can assist in department during 1000-1800 that TAT operates • Workflow for ER discrepancies, phone calls from outside physicians, and base hospital calls will remain unchanged and are not the responsibility of the IAP		
1700 - 1800	• Review TAT patient tracker for outstanding results • Ensure all documentation for patients is complete • Liase with major side ERP any patients awaiting results who IAP is concerned about			

DRAFT

ED PHYSICIAN SCORECARD – HUMBER RIVER HEALTH

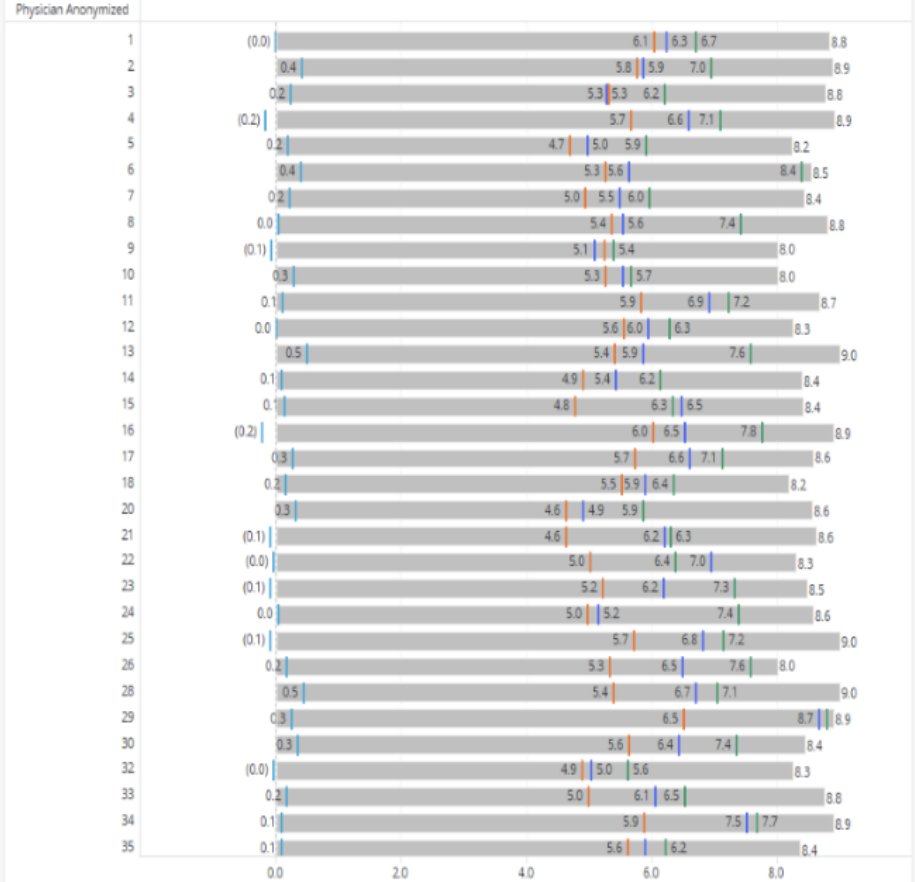
ED Physician Scorecard by Month

Month

(All)
2023-04
2023-05
2023-06
2023-07
2023-08
2023-09
2023-10
2023-11
2023-12
2024-01
2024-02
2024-03
2024-04
2024-05
2024-06
2024-07
2024-08
2024-09
2024-10
2024-11
2024-12
2025-01

Avg Shift Length | First MDSEEN | Last MDSEEN | Last Documentation | Last Order

Monthly Shift Review



# of Physicians

65

Physician Statistics

Anonymized Physician	Total Shifts	Avg Shift Length (hrs)	Avg pts per shift	Avg PIA to Dispo (min)	Avg ED LOS (min)	Total Pts	Consults	Consult Rate	CDU	CDU Rate	DI	DI Rate
Total	583	8.6	1,202.9	11,385	370	11,927	1,157	9.7%	845	7.1%	5,589	46.9%
1	24	8.8	17.5	120	335	402	62	15.4%	27	6.7%	234	58.2%
2	16	8.9	34.0	198	436	534	65	12.2%	13	2.4%	204	38.2%
3	13	8.8	22.6	156	307	296	24	8.1%	44	14.9%	129	43.6%
4	21	8.9	23.3	149	324	511	55	10.8%	70	13.7%	253	49.5%
5	9	8.2	17.8	178	297	183	4	2.2%	16	8.7%	84	45.9%
6	13	8.5	14.5	288	620	195	41	21.0%	28	14.4%	110	56.4%
7	14	8.4	16.9	213	452	254	26	10.2%	26	10.2%	146	57.5%
8	15	8.8	16.3	193	380	250	27	10.8%	26	10.4%	109	43.6%
9	10	8.0	13.9	126	446	120	27	22.5%	3	2.5%	48	40.0%
10	15	8.0	21.9	116	358	345	38	11.0%	19	5.5%	136	39.4%
11	3	8.7	15.0	177	390	50	6	12.0%	3	6.0%	23	46.0%
12	8	8.3	23.0	162	377	200	14	7.0%	14	7.0%	96	48.0%
13	1	9.0	14.0	144	256	13	3	23.1%	–	0.0%	7	53.8%
14	13	8.4	20.2	162	355	258	15	5.8%	16	6.2%	160	62.0%
15	12	8.4	16.3	202	437	204	28	13.7%	8	3.9%	109	53.4%
16	10	8.9	15.5	204	400	156	32	20.5%	12	7.7%	84	53.8%
17	14	8.6	15.9	138	342	216	23	10.6%	18	8.3%	116	53.7%
18	11	8.2	19.3	152	347	191	11	5.8%	14	7.3%	93	48.7%
20	9	8.6	12.1	196	354	111	10	9.0%	17	15.3%	45	40.5%
21	13	8.6	20.1	141	318	276	26	9.4%	19	6.9%	144	52.2%
22	10	8.3	18.6	134	392	181	15	8.3%	19	10.5%	83	45.9%
23	15	8.5	22.6	238	372	332	33	9.9%	48	14.5%	188	56.6%
24	14	8.6	15.4	201	388	221	26	11.8%	17	7.7%	123	55.7%
25	8	9.0	23.9	145	281	191	21	11.0%	13	6.8%	97	50.8%
26	7	8.0	21.9	159	387	153	19	12.4%	1	0.7%	94	61.4%
28	8	9.0	19.9	208	390	161	19	11.8%	8	5.0%	56	34.8%
29	10	8.9	16.5	282	474	182	20	11.0%	8	4.4%	79	43.4%
30	9	8.4	15.7	220	397	130	26	20.0%	9	6.9%	74	56.9%
32	8	8.3	27.3	118	315	253	13	5.1%	19	7.5%	136	53.8%

ED PHYSICIAN SCORECARD – THUNDER BAY REGIONAL HEALTH SCIENCES CENTRE

ED Physician Report for Dr. XXXXX

created as of: *October 15, 2024*

table 1 | table 2 | table 3 | table 4

Physician	Avg. Patient Admissions per Shifts				ED LOS (ER Start to Decision to Admit)				ED 72 hour bounce back by physician					DI - Average % of Physician ordered tests per patient							
														23-24 Q3		23-24 Q4		24-25 Q1		24-25 Q2	
	23-24 Q3	23-24 Q4	24-25 Q1	24-25 Q2	23-24 Q3	23-24 Q4	24-25 Q1	24-25 Q2	23-24 Q3	23-24 Q4	24-25 Q1	24-25 Q2	Readmit by ED Visits %	CT	Ultrasound	CT	Ultrasound	CT	Ultrasound	CT	Ultrasound
Physician #106	2.5	2.9	2.1	2.0	9.1	7.9	8.0	8.7	17	13	11	10	1.4%	25.5%	11.7%	23.9%	10.6%	23.9%	13.4%	25.5%	11.5%
Physician #159	2.9	3.6	3.2	2.5	8.2	7.6	7.1	8.1	18	20	18	21	2.0%	27.1%	14.1%	37.7%	13.5%	27.6%	13.2%	20.9%	10.2%
Physician #190	3.4	3.1	3.2	2.9	7.6	7.2	7.1	7.9	17	15	12	8	1.4%	27.0%	11.6%	23.8%	11.2%	21.0%	12.4%	21.4%	13.2%
Physician #209	2.5	2.3	2.8	2.3	7.9	7.4	7.6	7.9	15	16	16	10	1.0%	28.3%	9.9%	23.5%	8.8%	30.7%	9.9%	24.9%	9.6%
Physician #238	2.0	2.4			8.5	7.7			17	18				37.4%	10.6%	32.3%	13.4%				
Physician #258	2.0	1.5	1.9	1.8	7.9	6.2	7.2	8.8	13	13	12	11	1.4%	24.3%	9.7%	19.1%	6.6%	23.8%	10.4%	18.4%	10.4%
Physician #273	2.6	2.6	3.2	2.5	7.6	8.0	7.9	7.8	12	12	17	5	1.0%	26.7%	12.7%	26.8%	16.4%	29.8%	12.3%	25.6%	11.6%
Physician #277	0.2	0.3	0.3	0.2	8.0	4.8	5.3	5.2	2	5	3	5	0.6%	1.7%	4.4%	1.0%	4.9%	1.0%	3.8%	1.0%	3.6%
Physician #282	2.9	2.5	2.7	2.6	7.4	6.9	8.2	7.6	12	11	16	13	1.7%	28.9%	10.4%	27.7%	7.8%	23.1%	12.2%	25.4%	14.4%
Physician #313	2.8	2.0	2.4	2.8	7.4	7.2	7.6	7.8	9	8	16	7	1.0%	22.0%	13.7%	22.5%	13.7%	20.8%	13.5%	21.9%	8.9%
Physician #36	1.8	2.8	2.7	2.9	7.7	7.0	7.6	7.3	3	12	7	9	2.3%	14.7%	8.7%	26.1%	9.4%	25.0%	7.5%	22.0%	9.9%
Physician #376	2.4	2.4	2.1	2.1	7.9	6.9	8.5	8.3	14	15	11	11	1.6%	16.5%	9.7%	16.0%	11.1%	10.2%	6.1%	16.1%	13.3%
Physician #381	2.4				9.7				6					17.5%	5.3%						
Physician #410	2.9	2.5	2.2	2.3	7.4	7.9	7.2	8.3	15	11	23	17	2.0%	28.4%	10.5%	23.6%	10.0%	25.1%	10.7%	26.0%	8.5%
Physician #468	2.1	1.4	2.2	1.6	7.1	6.4	7.0	6.5	9	3	9	7	1.4%	14.2%	4.6%	15.3%	6.3%	11.1%	5.2%	9.6%	6.4%
Physician #484	1.7	1.7	1.8	1.5	8.4	7.1	7.4	9.7	16	17	25	11	1.5%	14.9%	6.1%	14.2%	7.3%	13.3%	5.5%	13.2%	7.5%
Physician #493			3.2	2.6			8.1	8.2			17	11	1.2%					32.4%	14.0%	25.7%	11.3%
Physician #538	1.9	2.2	1.7	1.9	7.1	6.9	7.2	9.4	10	10	13	9	1.6%	19.6%	13.1%	17.3%	12.4%	14.6%	13.7%	16.8%	10.8%
Physician #58	4.7	3.7	3.5	2.7	9.6	8.4	8.8	8.3	3	5	6	4	0.9%	30.6%	11.3%	28.4%	11.8%	24.4%	11.3%	30.3%	15.3%
Physician #607	2.3	2.5	2.5	2.1	8.6	6.9	7.8	8.9	17	23	18	27	4.5%	11.5%	4.3%	14.1%	6.5%	16.0%	6.6%	18.0%	5.7%
Physician #620	2.2	2.9	2.0	2.1	7.5	7.7	7.9	7.3	9	17	14	14	1.8%	21.7%	11.8%	29.4%	12.0%	19.0%	7.8%	24.5%	8.4%
Physician #631	2.6	2.9	2.7	2.2	8.4	7.7	8.0	8.4	16	21	18	19	2.0%	22.8%	9.3%	23.5%	10.4%	26.8%	9.3%	26.8%	7.8%
Physician #687	2.6	3.1	3.3	2.9	9.3	9.5	9.6	9.7	10	21	19	16	1.9%	21.4%	3.7%	23.8%	5.3%	24.2%	6.4%	26.1%	5.2%
Physician #705	1.9	2.1	1.7	1.9	8.2	6.5	7.1	8.3	8	19	14	25	2.5%	17.6%	9.6%	17.1%	8.7%	19.2%	8.3%	20.2%	11.4%
Physician #735	2.8	2.6	2.1	2.6	7.7	7.3	7.9	7.8	14	15	13	17	1.8%	23.6%	13.2%	28.5%	13.1%	18.7%	10.0%	24.0%	10.8%
Physician #743	2.0	2.0	1.7		7.7	7.5	7.6		16	13	3			16.8%	8.4%	18.2%	7.2%	22.9%	9.2%		
Physician #748	1.5	1.6	1.6	1.4	7.2	6.0	7.3	8.2	22	21	19	18	2.1%	17.2%	4.3%	16.8%	4.6%	23.8%	4.7%	18.6%	7.4%
Physician #757	2.6	2.5	2.0	2.4	8.1	7.9	8.5	8.6	15	15	14	11	1.5%	25.3%	13.0%	26.4%	11.1%	22.0%	8.1%	29.6%	12.3%
Physician #804	2.7				8.0				5					25.6%	12.6%						
Physician #81	2.6	2.4	3.4	2.4	9.2	8.3	7.8	9.0	7	13	3	7	1.1%	15.0%	11.5%	15.8%	10.8%	20.7%	13.9%	19.5%	10.3%
Physician #873	2.8	4.2	4.1	3.1	8.1	8.6	8.3	8.5	11	9	11	6	0.7%	33.8%	17.6%	42.5%	22.8%	42.7%	17.8%	36.2%	13.2%
Physician #911	2.1	1.9	2.4	1.9	7.5	8.6	7.3	8.5	6	9	14	12	1.5%	19.7%	6.4%	15.7%	7.2%	17.9%	11.1%	20.1%	11.2%
Physician #915	3.0	2.4	2.7	2.8	8.6	7.3	8.0	8.3	13	16	15	11	1.3%	25.2%	11.2%	21.2%	13.1%	21.4%	12.4%	21.6%	9.6%
Average \ Total	**2.4**	**2.5**	**2.5**	**2.2**	**8.1**	**7.6**	**7.8**	**8.3**	**377**	**416**	**407**	**352**	**1.5%**	**22.0%**	**9.8%**	**22.4%**	**10.3%**	**21.1%**	**9.7%**	**21.7%**	**10.0%**
Median	**2.5**	**2.5**	**2.4**	**2.3**	**7.9**	**7.4**	**7.7**	**8.3**	**12.5**	**14.0**	**14.0**	**11.0**	**1.4%**	**22.4%**	**10.4%**	**23.5%**	**10.5%**	**22.0%**	**10.0%**	**21.9%**	**10.3%**
Standard Deviation	**0.7**	**0.7**	**0.8**	**0.6**	**0.7**	**0.9**	**0.7**	**0.9**	**5.0**	**5.1**	**5.5**	**5.8**	**0.9%**	**7.1%**	**3.4%**	**7.9%**	**3.8%**	**8.4%**	**3.8%**	**6.7%**	**2.8%**

EMERGENCY PHYSICIAN SCHEDULE – NORTH YORK GENERAL HOSPITAL

NYGH Emergency Physician's Schedule February 2025

Shift Name	Pink/Blue/Orange	Red Zone*	Reassessments	Green Zone	Cleanup
4 AM	0400-0700	Longest Waits		0700-1000	1000-1400
6 AM	0600-0900	Longest Waits	0900-1000	1000-1300	1300-1600
8 AM	0800-1000	1000-1200	1200-1300	1300-1500	1500-1800
10 AM	1000-1200	1200-1400	1400-1500	1500-1700	1700-1900
10 AM YZ	1000-1500 YZ		1500-1800	Responsible for callbacks	1800-2100
11 AM 2nd YZ Doc	1100-1700		1700-1800	Sedations, MHA, Code Response	1800-1900
12 PM	1200-1400	1400-1600	1600-1700	1700-1900	1900-2100
2 PM	1400-1600	1600-1800	1800-1900	1900-2100	2100-2300
3 PM YZ	1500-2100 YZ		2100-2200		2200-0000
4 PM	1600-1800	1800-2000	2000-2100	2100-2300	2300-0100
5 PM 2nd YZ Doc	1700-2300		2300-2400	Sedations, MHA, Code Response	2400-0100
6 PM	1800-2000	2000-2200	2200-2300	2300-0200	0200-0300
7 PM (Mon&Tue)	1900-0100			Respond to Area of Greatest Need	0100-0200
8 PM	2000-2200	2200-0100 (RZ/YZ)	0100-0200	0200-0300	0300-0600
9 PM	2100-0300 YZ		0300-0400		0400-0500
10 PM	2200-0400		0400-0600		0600-0800

2nd On-Call	0400-0400	24hrs

***Respond to Longest Wait times if Red Zone volume has been managed**

EMERGENCY PHYSICIAN BACK UP CALL IN – JOSEPH BRANT HOSPITAL

Emergency Department Manual: Physician Backup Call in	Policy No. C-2
Applies to: Emergency Department Staff	
Document Sponsor: Chief Nursing Executive/ EVP, Patient Care Services	Document Owner: Director of Critical Care and Emergency Services
Approving Body: Emergency Department Quality Committee	Approval Date: 2023/04/20
Revision Dates: 11/89, 05/07R, 03/11 R, 01/12R	Renewal Date: 2026/04/20
Key Words: Backup, Emergency Department	
****CRITICAL CONSIDERATIONS****	

A. Purpose
To outline the process for requesting the back up Emergency Department (ED) physician to come support the ED.

B. Definitions
Backup Physician: The ED physician who is scheduled on-call.

C. Acronyms

Acronym	Meaning
ED	Emergency Department
JBH	Joseph Brant Hospital

D. Policy Statements
The flow of the ED department is dynamic and fluid. Operational status can change quickly and may require support in addition to the current resources.

Initiation of this procedure is a collaborative process between the ED Physician and ED Charge Nurse (or Team Leader) based on the current state of the ED.

Joseph Brant Hospital (JBH) follows the CARE+ commitment to patient-centered care and each patient interaction will follow the values of Compassion, Accountability, Respect, Excellence and Service as outlined by JBH.

E. Resources/Supplies
ED Physician call list
ED Physician schedule
Phone

F. Procedure

1. The calling in of the ED backup physician is a process of collaboration between the ED Charge Nurse (or Team Leader) and ED Physician based on the following criteria;
    a. Number of patients waiting for assessment by the ED physician.
    b. Number and type of patients waiting to register.
    c. Number and type of patients waiting to be triaged.
    d. Number of patients triaged and not currently assigned to a care area.
    e. The availability of ED resources to support the workload of an additional physician on shift, including available bed space, nursing staff and support staff.
2. Depending on the time of day, the next physician scheduled to begin a shift will be called first, before the backup physician, as determined by the ED Physician and ED Charge Nurse.
3. Once the determination has been made that the backup physician is to be called in, the ED Charge Nurse or delegate, will confirm which physician is scheduled for backup.
4. The Charge Nurse or delegate calls the backup physician and advises them of the state of the ED and that they are being called into assist.
5. If, for any reason, the ED physician and ED Charge Nurse (or Team Leader) can not come to an agreement OR the backup physician is not available, the Chief of ED will be called to assist.

G. Related Documents

Emergency Department Standards of Care

H. References

N/A

Brightshores Health System

Markdale Laboratory Guide
When an MLA is Working Alone or On Call

Document ID: MISC 0066
Edition Date: March 7, ,2025

POC Test List (Nursing perform):

I-Stat: Troponin, BUN, Glucose, Lytes, derived Hgb, Blood Gases, Lactate, TC02, Creatinine

Clinitek: Urinalysis, hCG urine

Glucometer: Glucose

Rapid Strep

Lab Hours:

Monday to Friday 7:30 –1900

Sat and Sun 07:30 – 15:30

NOTE: Please be mindful of lab hours and place collection orders *1 hour prior* to closing when possible.

On Site Tests that are available with Auto/ Remote Verification:

AST, Alk Phos, ALT, Bilirubin conjugated, Bilirubin unconjugated, BUN, Calcium, Chloride, CK, Creatinine, Ethanol, LDH, Magnesium, Phosphorus, Potassium, Sodium, Uric Acid, Urine Drug Screen, Lipase, Lipids (Cholesterol, Trig, HDL), Albumin, GGT, Total Protein, CBC, Hemoglobin, Hematocrit, D-Dimers, PT/INR, PTT.

Transfusion Medicine:

Emergency Dispense Blood products available for urgent/critical situations (Red cells and PCC's)

Group & Screen and Crossmatch testing available next day if required and patient is stable (On Site If MLT available or will be sent to Owen Sound for testing)

*Ketone- MLA records/performs result and MLT on next shift confirms/reports result

Tests that will not be available:

Mono, Occult Blood, Serum pregnancy, and manual CBC differential (tested the next shift an MLT is on site)

Page 2 of 2	Issued On March 7, 2025

POC Test List (Nursing perform):

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SickKids®

Scope: Hospital-wide Patient Care
Document Type: Policy, Procedure
Approved on: 2025-03-25
Next Review Date: 2028-03-25

Inpatient & Emergency Department Consultations Medical and Dental

Version: 3

This is a CONTROLLED document for internal use only, valid only if accessed from the Policies and Procedures site.

1.0 Definitions

Consultation: The responsible physician seeks advice or assistance from a staff physician or dentist with privileges at SickKids (consultant) on specific issues related to a patient's diagnosis or management.
Consulting Service: Any Consulting Service Staff Physician, Resident, Fellow, Dentist, Medical Student or Advanced Practice Provider (APP, Nurse Practitioner or Physician Assistant (PA)) delegated by a Consulting Service Staff Physician.
Responsible Service: Any Staff Physician, Resident, Fellow, Dentist, PA, Medical Student or APP delegated by a Staff Physician who requests a consultation.

2.0 Policy

Only the Responsible Physician can initiate a consultation. The Responsible Physician can delegate this act to members of the health care team working under them at the time. Unless special arrangements are made through the Medical Advisory Committee, a consultant must be a Hospital for Sick Children Staff Physician, Physician Assistant, Dentist, Resident, Fellow, Medical Student or APP delegated by a Consulting Service Staff Physician.

3.0 Essential Information for Initiating Consultations

- Name of Responsible Physician
- Time and date of request
- Name of the service consulted (or of a specific consultant only if the request is directed to a particular physician or APP)
- Question to be asked
- Whether the consultant is invited to discuss their opinions with the family of the patient

4.0 Inpatient Consultations

4.1 Inpatient: Initiating the Consultation

Step	Responsible	Key Notes
1. Notify the parent or guardian of the request for consultation.	Responsible Service	• Address Questions
2. Initiate contact with Consulting Service.	Responsible Service	• Discuss appropriate plan for communication with the patient/family
3. Acknowledge consultation request, set expectations for completion & discuss the patient's case.	Consulting Service **AND** Responsible Service	• History, question, urgency • Nature of communication between Consulting Service and patient/family

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4. Confirm whether a consult is needed.	Consulting Service **AND** Responsible Service	• If there is a disagreement, proceed to section 6.0 Conflict Resolution

4.2 Inpatient Consultation (does not apply to encounters by the CCRT)

Step	Responsible	Key Notes
1. Proceed with consultation.	Consulting Service	
2. Complete preliminary consultation notes including recommendations.	Consulting Service	• Notes should include clear indication of who has seen the patient, who is the consulting staff and how best to contact the consulting team
3. See patient and review recommendations with Consulting Team.	Consulting Staff Physician	• If not already involved in case
4. Countersign, update and clarify impression and recommendations noted in the team's note **within 24 hours** of consultation request.	Consulting Staff Physician	
5. If no further testing is recommended or there is no new diagnosis, continue with care plan.	Responsible Service	

4.3 Consultant Recommendation Testing or New Diagnosis

Step	Responsible	Key Notes
1. Discuss recommendations for testing or new diagnosis with Consultant Staff Physician.	Consulting Service	• If the Consultant Staff Physician is not already involved
2. Discuss recommendations for testing or new diagnosis with Responsible Service.	Consulting Service	• Verbal communication of recommendations with Responsible Service should occur prior to discussion with patient and family if there is a change in proposed plan
3. Discuss appropriate recommendations for testing or new diagnosis with patient and family.	Responsible Service AND/OR Consulting Service	• Discussion between Responsible and Consulting Services re: most appropriate team to discuss recommendations with patient and family

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4. Determine whether Consulting or Responsible Service will be responsible for ordering tests	Consulting Service **AND** Responsible Service	• Consulting services must use "suggest" orders in Epic for any atypical or unique requests • Consulting Service should not order tests unless explicitly agreed upon with Responsible Service

4.4 Option A: Responsible Service is Responsible for Ordering Tests

- If the Responsible Service is responsible for ordering tests, they arrange for tests to be conducted and continue with the care plan.

4.5 Option B: Consulting Service is Responsible for Ordering Tests

Step	Responsible	Key Notes
1. Conduct and review tests and make treatment recommendations.	Consulting Service	
2. If no further testing is needed, but findings include changes in management/ diagnosis of patient, communicate this with Responsible Service.	Consulting Service	
3. Continue with Care Plan	Responsible Service	

4.6 Further Involvement of Consulting Service

- Based on the consultation, Consulting Service and Responsible Service decide who will be the most responsible physician during hospitalization or post discharge. If there is disagreement, escalate as per section 6.0.

4.7 Consultant Assumes Responsibility for Patient

- Consulting Service becomes the Responsible Service and continues with care during hospitalization, **OR**
- Consulting Service takes responsibility for arranging follow-up post discharge. Follow-up plans must be communicated to parents/guardian and responsible team, documented in the chart, and ordered in Epic.

4.8 Responsible Service Retains Responsibility for Patient

- If further involvement by the Consulting Service is required for treatment, the Consulting Service continues to advise the Responsible Service on care during hospitalization, **OR**
- If no further involvement by the Consulting Service is required for treatment, the Consulting Service signs off on consultation.

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5.0 Emergency Department Consultations

5.1 Initiating the Consultation

Step	Responsible	Key Notes
1. Notify the parent or guardian of the request for consultation.	EM MD	• Note that EM is either requesting consultation for admission or patient management under the Consulting Service because: 1. the patient is known to the Consulting Service, or 2. the problem requiring management relates or is most likely to relate to the Consulting Service
2. Place Consult order in electronic health record and Page Consulting Service.	EM MD	
3. Respond to page in person or by telephone **within 10 minutes.**	Consulting Service	• If Consulting trainee does not respond, EM MD makes 2 more attempts 10 minutes apart (may escalate to Fellow on 2nd or 3rd call) before calling the Consulting Staff Physician. **Total time before Consulting Staff MD is paged = 30 minutes**
4. Decide whether Consulting Service should proceed with consultation.	EM MD **AND** Consulting	• If there is a disagreement, proceed to section 6.0, Conflict Resolution

5.2 Patient Consultation

Step	Responsible	Key Notes
1. Proceed with ED patient consultation **within 1 hour of consultation request**.	Consulting Service	• If involved in critical or emergent clinical care that will delay consultation, then notify the Responsible Service of situation through staff-to-staff communication and proceed with consultation as soon as possible • If routine clinical care (example, operating room case) is expected to delay consultation then alternative coverage plan needs to be put in place by dept/div leadership wherever possible
2. Complete preliminary consultation notes, including recommendations .as discussed with Consulting Staff Physician.	Consulting Service	Notes should: • Be communicated verbally within 3 hours of the consultation request; be documented in Epic within 4 hours of the consultation request • Include clear indication of who has seen the patient, who is the consulting staff and how best to contact the consulting team • If the patient has been accepted for admission to Ped Med, then an abridged note may be

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		placed until the full admission has been performed
3. Decide who will be the most Responsible Physician.	ED MD **AND** Consulting Service	• All tests and treatment recommendations to be ordered by the most responsible physician (or delegate from their team) • If Consulting Service to admit patient, then admission orders and a change of MRP status required • If Consulting Service and EM MD **disagree** about who should be responsible for the patient, see section 6.0 Conflict Resolution
4a. Consultant Role in Disposition		
1. Responsible for disposition of patient **within 4 hours of consultation.**	Consulting Service	Disposition may be to: • Admit the patient and continue with care during hospitalization as the responsible service. • Notify EM MD and then in conjunction with EM arrange for admission to another service. • Notify EM MD and then arrange for consultation by another service. • Recommend transfer to another health care facility in discussion with the EM MD (for example transfer of Ped Med patients to community partner hospitals), or • Collaborate with EM MD to discharge the patient home. If initial Consulting Service, and any subsequent Consulting Services, disagree about who should be responsible for the patient, see section 6.0 Conflict Resolution.

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6.0 Conflict Resolution

6.1 Initiation of Inpatient Consultation

- If the Responsible Service and Consulting Service disagree as to whether or not a consult is needed, they escalate the issue to the Responsible and Consulting Service Staff Physicians for discussion (if not already involved).
- If the Staff Physicians decide a consultation is required, the Consulting Service proceeds with the consultation.
- If the Staff Physicians disagree as to whether or not a consult is needed, then the consultation proceeds, and both staff notify their respective Division Heads to organize a debrief at a later date.

6.2 Initiation of ED Consultation

- If the Responsible Service and Consulting Service disagree as to whether a consult or a telephone consult is needed, they escalate the issue to the Responsible EM and Consulting Service Staff Physicians for discussion (if not already involved).
- If the Staff Physicians decide a consultation or a telephone consult is required, the Consulting Service proceeds with the consultation.
- If the Staff Physicians disagree as to whether a consult or telephone consult is needed, then the consultation proceeds, and both staff notify their respective Division Head to organize a debrief at a later date.

6.3 Transition of Responsible Service for ED Consultations

- If after the consultation, the EM MD and Consulting Service disagree about which service should be responsible for the patient, they escalate the issue to the Responsible EM Staff Physician and Consulting Service Staff Physician for discussion, if Staff Physician(s) not already involved.
- If Staff Physicians disagree about which service should be responsible for the patient or the 4-hour threshold for disposition has been breached, then the Responsible EM Staff Physician determines which Consulting Service will become the Responsible Service, including cases in which the diagnosis remains undetermined (example, a patient awaiting neuroimaging).
- All escalations requiring conflict resolution by the Responsible EM Staff will be subsequently reviewed by appropriate Division Heads, the Paediatrician-in-Chief and/or the Surgeon-in- Chief.

6.4 Non-urgent Inpatient Consultation

- Where the consultation cannot be completed within twenty-four (24) hours and can safely be delayed for an outpatient visit subsequent to the hospitalization, this is communicated to the Responsible Service within twenty-four (24) hours of the request for consultation.
- When it is desirable to expedite a non-urgent consultation for social reasons (to facilitate discharge), or to reduce bed utilization, the consultant considers the best interests of the patient and the Hospital in deciding whether to see the patient during this hospitalization, or as an out-patient subsequently. If agreement cannot be reached, escalate in the same way as 6.1 Conflict Resolution: Consultation.

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7.0 Timelines

7.1 Inpatient Consultations

As outlined in the procedure, the following response times are expected for inpatient consultations:

- Consulting Service responds to pages for consultation in person or by telephone within 10 minutes. If they do not respond to 2 pages 10 minutes apart (20 minutes total), the Consulting Fellow (if appropriate) is paged. If the Consulting Fellow does not respond within 10 minutes then the Consulting Staff Physician is paged
- Consulting Service **sets expectations for completion of consult.**
- The standard for routine consults is within twenty-four (24) hours upon receipt of the consultation request (expectation for critically ill patients would be very much shorter, usually within minutes to a few hours). The response may be made by a delegate, in which case it will be countersigned by the consultant within twenty-four (24) hours of the time of the receipt of request. The response may take the form of an appointment in the Outpatient Clinic.
- Non-urgent consultations: Consultations that cannot be completed within 24 hours and can safely be delayed for an outpatient visit after hospitalization will be indicated within **24 hours** of the consultation request.

7.2 ED Consultations

As outlined in the procedure, the following response times are expected for ED consultations:

- Consulting Service responds to pages for consultation in person or by telephone within 10 minutes. If they do not respond to 2 pages 10 minutes apart (20 minutes total), the Consulting Fellow (if appropriate) is paged. If the Consulting Fellow does not respond within 10 minutes, then the Consulting Staff Physician is paged. For any emergent or critical care patient needs, the ED MD can always escalate sooner to the Consulting Staff MD as deemed necessary.
- Consulting Service decides on a patient disposition within 4 hours of the consultation.
- If the EM MD retains responsibility for the patient following the consultation, the care plan is documented and discussed with the EM Staff physician within 4 hours of the consultation.
- If the initial Consulting Service requires a subsequent consultation, that consultation is initiated within 4 hours of the initial consultation.

If Consulting Services are unable to consistently adhere to expected timelines, then this data will be tracked in order to ensure timely follow-up of these issues.

8.0 Consultant's Responsibility

8.1 Availability

- Each service is responsible for making a consultant available within:
  1. a maximum of **24 hours** for inpatients, and within a reasonable time in the case of emergencies.
  2. **10 minutes** to respond to pages from the ED and within **1 hour** of a request to provide consultation for ED patients.
- Availability implies that the Consulting Service provides a reliable mechanism for receiving calls for consultation and that the mechanism is accessible to Staff Physicians and their delegates.
- Each service will adhere to the same standard of receiving a consultation.
- When appropriate, telephone consultations may be completed without a patient encounter, but the recommendations must be documented by the Consulting Service in the EMR. If a Consulting Service and EM MD **disagree** about whether a telephone consult is appropriate, see section 6.0 Conflict Resolution.

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8.2 Signatures and Documentation

- Initial Note by the Consulting Service must be signed with or without additional notations by the responsible Consultant within 12 hours (or at least indicated that the assessment and plan have been reviewed and agreed upon by the responsible Consultant).
- Minimal notation by the responsible Consultant includes:
  a. agreement with the Consulting Service's note,
  b. the Consultant's signature together with the date and time.
- The Consulting Staff Physician is encouraged to add their own impressions to the consult note on the chart.
- The suspended orders must be activated by the Responsible Service prior to implementation by nursing staff.
- If the electronic health record system is used by a consultant or delegate in the ED, then either:
  - the EM MD is responsible, and the consultant orders need to be entered or cosigned by the EM MD,
  - **OR** the Consultant assumes responsibility before the patient is admitted and enters the orders directly
- Exceptions may be established for special situations, when two divisions/departments have a defined policy of cooperation with regard to a particular group of patients,

  e.g. Medical Orders

- Where changes in treatment are indicated urgently, a verbal order by the Responsible Physician's delegate will suffice, conditional on the implementation of policies relating to verbal orders.

  See Medical Orders.

8.3 Unexpected findings

- Where a finding is unexpected and may require an immediate change in patient management, the Consulting Service informs the Responsible Service verbally and without delay.

8.4 Consultant follow-up

- If a follow-up visit is required, the Consulting Service makes the necessary arrangements. Follow-up plans must be communicated to parents/guardians and responsible team, documented in the chart, and ordered in the Epic discharge navigator.

8.5 Communication with parents

- Patients/families should generally be made aware that a consultation has been requested (eg oncology, psychiatry etc). Self-introduction, explanation of role, obtaining a history and performing a physical examination are part of the consultative process.
- The Consulting Service only communicates their opinion about diagnosis, management and prognosis of the patient directly with patient and/or parents if agreed upon by the Responsible Service.

8.6 Communication with Responsible Staff

A direct verbal communication between the Consulting Service and the Responsible Service to discuss the outcome of the consultation is expected in addition to timely documentation.

9.0 Responsible Physician's Responsibility

- At a minimum, the Responsible Service indicates that they have read the Consulting Service's note.
- Where the Consulting Service has recommended any actions, the Responsible Service indicates in writing a response to these recommendations.

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STANDARD WORK: ACUTE MEDICINE AND ACADEMIC HOSPITALISTS – HAMILTON HEALTH SCIENCES

Standard Work– Acute Medicine and Academic Hospitalists				
Time	**Major Steps**	**Details**	**√**	**Comments**
Morning 8:00 to 12:00	1. Receive handover from Nocturnist/Admissionist on any overnight ward issues	Check in with Navigator		Phone/verbal handover is expected for patients whose clinical status has deteriorated/changed & RACE patients & CCU admissions & ICU signouts
	2. See sickest patients			Phone/verbal handover is expected for sickest patients
	3. Attend Multidisciplinary Discharge Rounds*	Attend Zoom rounds scheduled at 09:15 Non-urgent concerns – use EPIC secure chat Follow-up from Zoom rounds – use EPIC secure chat Attend CQI Huddles, if possible F3 – 8:00 E3 – 8:45 B3 – 11:15 F5 – 11:30		If unable to attend Rounds, update EPIC EDD and touch base with Charge Nurse
	4. See any ED patients	Aim to see all assigned ED patients before 9-10am		
	5. See patients who are or could be discharged	Identify discharge barriers and let Charge Nurse, Clinical Leader or Manager know		
Afternoon	6. Round on Medicine patients off-service			
	7. Everything else	Charting Discussion with consulting service Discussion with allied health Family meetings Teaching		

Time	Major Steps	Details	√	Comments
13:00 to 17:00	8. Provide Handover to Nocturnist	Including list of expected next day discharges for Navigator for geographic cohorting		Phone/verbal handover is encouraged for patients whose clinical status will potentially deteriorate or are clinically unstable

*On weekends, there are no Multidisciplinary Discharge Rounds; Navigator can help with weekend discharges

STANDARD WORK: MULTISPECIALTY SERVICE HOSPITALISTS – HAMILTON HEALTH SCIENCES

Standard Work - Multispecialty Service Hospitalists				
Time	**Major Steps**	**Details**	**√**	**Comments**
Morning 8:00 to 12:00	1. Receive handover from Nocturnist on any overnight ward issues	Check patient distribution assignment email Physician contact information will be found in Pedal scheduling software Review Transfer Note		Phone/verbal handover is expected for patients whose clinical status has deteriorated/changed & RACE patients & CCU admissions & ICU signouts
	2. See sickest patients			Phone/verbal handover is expected for sickest patients
	3. Attend Multidisciplinary Discharge Rounds*	Attend Zoom rounds (schedule to be shared in advance) Attend off service rounds and touch base with Charge Nurse Non-urgent concerns – use EPIC secure chat Follow-up from Zoom rounds – use EPIC secure chat Attend CQI Huddles, if possible F3 – 8:00 E3 – 8:45 B3 – 11:15 F5 – 11:30		If unable to attend Rounds, update EPIC EDD and touch base with Charge Nurse Check in with Navigator
	4. See any ED admit-to-no-bed patients	Aim to see all assigned ED patients before 9-10am		08:00 to 16:00 On-Call Hospitalist
	5. See patients who are or could be discharged	Identify discharge barriers and let Charge Nurse, Clinical Leader, or Manager know		
	6. Everything else	Charting Discussion with consulting service Discussion with allied health Family meetings		

Time	Major Steps	Details	√	Comments
		Teaching		
	7. Provide Handover to Nocturnist	Including list of expected next day discharges for Navigator for geographic cohorting		Phone/verbal handover is encouraged for patients whose clinical status will potentially deteriorate or are clinically unstable

*On weekends, there are no Multidisciplinary Discharge Rounds; Navigator can help with weekend discharges

STANDARD WORK: NOCTURNIST – HAMILTON HEALTH SCIENCES

Standard Work -Nocturnist				
Time	**Major Steps**	**Details**	**√**	**Comments**
1700-0800	Start of Shift: Receive handover from Academic/Acute Medicine/MSS/CCU MRPs			Phone/verbal handover is expected for patients whose clinical status has deteriorated/changed & RACE patients & CCU admissions
	See sickest patients			Phone/verbal handover is expected for sickest patients
	Check-in with Medicine Wards (3x) Hem ward (2x)	Approx. window for ward check-ins 2000-2200 Med 0000-0200 Med & Hem 0400-0600 Med & Hem		Nurses will collect Non-Urgent *3 issues for Nocturnist to review at check-in Review 'issue/problem list' on wards Hem Staff on-call until 20:00
	Respond to any CODE BLUE (carry CODE BLUE pager 1700-0800)	Nocturnist is **NOT** responsible for airway		Discuss with ICU team at time of code who will be code captain (CODE captain must be PGY2 or greater)
	Respond to CCU (can page at any time)			
	End of shift: Provide Handover to MRPs			Phone/verbal handover is encouraged for patients whose clinical status will potentially deteriorate or are clinically unstable

Time Spent in the ED

EMERGENCY DEPARTMENT FAST TRACK AREA GUIDELINE – HUMBER RIVER HEALTH

Humber River Health

Manual	Emergency Services Manual	GUIDELINE
Section	Patient Flow	
Author	MANAGER, EMERGENCY SERVICES	
Approved by	**PROGRAM DIRECTOR, EMERGENCY SERVICES**	
Date	O: 09/24/2009	**Version Number:** 5
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EMERGENCY DEPARTMENT FAST TRACK AREA - GUIDELINE

Guideline Statement

Fast track (FT) is an area within the emergency department (ED) that facilitates the care of ambulatory ***Canadian Triage Acuity Scale*** (CTAS) 2 - 5 patients with the goal of providing timely care, improved patient flow and facilitate increased patient satisfaction. This is accomplished by ensuring that appropriate patients are triaged to FT, and are assessed by a physician in a timely manner according to CTAS level.

This guideline outlines the FT patient criteria and patient flow strategies. The principle of flow for patients in FT is to ensure that the patients only occupy a stretcher during assessment and the initiation of treatments. Patients shall remain in the internal wait area while awaiting for further treatments and reassessment.

Guideline

Inclusion criteria

FT is for CTAS 2 - 5 patients who:

- are normally ambulatory and/or able to sit in a chair and get up and down to an examination table or stretcher,
- have simple single system complaints (includes but is not limited to sore throat, simple prescription renewal, extremity injuries, lacerations, minor injuries, corneal abrasions/foreign bodies),
- have stable vital signs,
- are ambulatory with the exception of lower extremity injuries (but can still manage a wheelchair or crutches),
- do not need long and complex investigations and treatments,
- have an expected length of stay of less than 4 hours from the time of arrival,
- request for test results with resolved symptoms,
- request for simple prescription renewal, or
- obtain medical advice.

Exclusion Criteria

- Hemodynamic compromise (e.g., tachypnea, oxygen saturation < 90%, tachycardia with hypotension)
- Chest pain – non traumatic
- Pre-syncope/Syncope
- Vaginal bleeding – with or without known pregnancy
- High risk mental health with primary mental health complaint
- Isolation – Airborne
- Infant (less than 1 month of age)
- Any high risk mechanism of injury (see below for definition)
    - Motor vehicle collision (MVC) causing the vehicle(s):
        - rollover,
        - significant intrusion into passenger's space, or
        - impact greater than 40 km/hr (unrestrained) or impact greater than 60 km/hr (restrained).
    - MVC causing the passenger(s):
        - ejection from vehicle,
        - extrication time greater than 20 minutes, or
        - death in the same passenger compartment.
    - Motor Cycle Collision (MCC) – where impact with a car greater than 30 km/hr, especially if rider is separated from motorcycle.
    - Fall – greater than 18 feet (6m) or onto the head from greater than 3 feet (1m)
    - Pedestrian or bicyclist – run over or struck by a vehicle at greater than 10 km/hr
    - Any significant trauma with abdominal pain, CNS involvement, needing IV resuscitation or unstable vital signs
    - Penetrating torso or neck trauma
- Non-ambulatory patients with no prospect of ambulation post-treatment – i.e., patients from long-term care facilities unable to ambulate
- Cognitively impaired without escort (e.g., dementia)

Patient Flow

1. ED triage nurse will assess patients based on the above criteria to determine if a patient is appropriate for FT area. If the criteria is met, the triage nurse will assign the patient to the ***Wait Fast Track Lounge (FT waiting room)*** in Meditech. The patient will then be directed to the FT waiting room for registered and treatment.
    a) If the patient meets the criteria for the initiation of a medical directive, the triage nurse will initiate appropriate medical directives to be implemented within the FT area.

2. ED FT registration clerk will:
    a) Complete the registration at FT.
    b) Direct the patient to the FT waiting room. If an assessment room is available, the patient will be brought directly into the room in collaboration with the FT nurse.
    c) Assign the patient to the room in Meditech.
    d) Place the patient's chart in the ***MD2C*** slot on the chart rack.

3. The FT nurse will:
    1) Direct the patient in an assessment room in order of CTAS and then time of arrival if the patient has not already been assigned to a room.
    2) Direct the patient to remove clothing and change into a gown. FT patients do not receive a decreased quality of examination or care.
    3) Complete a focused assessment of the patient in the room and implement medical directives as appropriate
    4) Sign up for the patient in EDM by clicking the ***sign up*** button to assume the primary nurse position for this patient.
    Note: Signing up for the patients ensures increased clarity, safety and communication amongst physicians and nursing teams in FT. Not using the sign up function does not eliminate the accountability or responsibility of the primary nursing duties.
    5) Document the nursing assessment and intervention(s) in Meditech as outlined in the ***ED Standard of Care***.

4. The FT physician will:
    1) Sign up for the patient in Meditech, this will change the status event to ***MD Seen***
    2) Direct the patient in an assessment room in order of CTAS and then time of arrival if the patient has not assigned to a room.
    3) Direct the patient to remove clothing and change into a gown if not already done.
    4) Assess the patient and document in Meditech.
    5) Leave the patient in the assessment room, or move the patient to the treatment area, ***FT waiting room***, if there are no orders to be carried out in a private setting.
    6) Enters orders as appropriate in Meditech.

5. The FT nurse, after physician assessment and receiving order(s), will:
    1) Initiate orders in the assessment room, such as; intravenous access, specimen collection, or initial treatment.
    2) Move the patient to the treatment area, ***FT waiting room*** and complete all additional treatments.
    3) Assign or delegate a clerk to assign the patient to ***Fast Track Wait*** in EDM. Update the patient's status event to ***Tx In Prog***.

6. The FT nurse, once all orders are carried out and reported, will:
    1) Advance the status event to ***MDRA*** on the EDM tracker.
    Note: MDRA status event is also to be used if there is a change in patient condition that requires a physician reassessment.
    2) Verbally communicate to the primary physician when the patient has significant changes in condition or significant diagnostic results, and document the communication with the physician and any subsequent orders in the ***Physician Communication Screen*** on the EDM ***worklist***.

7. The physician will reassesses the patient and may write additional orders, consult a specialty or discharge the patient home.

8. If discharge occurs, the physician and nurse will provide the patient with discharge instructions, health teaching, outpatient appointments and written patient education material.

Special Circumstances

- In situations where the patient's acuity increases or the patient is admitted, the FT nurse will inform the ambulatory area TL. The TL may contact the RP/TL to move the patient to the most appropriate zone.

- If a physician requests that the patient be transferred to a different zone, the ambulatory area TL in consultation with the RP/TL in Sub-Acute will facilitate the transfer. Physician to physician transfer of accountability will occur to ensure a safe continuity of care.

Accountability / Responsibility

Refer to the *Guideline* for accountability / responsibility.

Definitions

Status Event
Status Event is a function on the Meditech program tracker to allow health care professional to enter and communicate a patient's event of most current status.

High Risk Mechanism of Injury

- Motor vehicle collision (MVC) causing the vehicle(s):
  - rollover,
  - significant intrusion into passenger's space, or
  - impact greater than 40 km/hr (unrestrained) or impact greater than 60 km/hr (restrained).
- MVC causing the passenger(s):
  - ejection from vehicle,
  - extrication time greater than 20 minutes, or
  - death in the same passenger compartment.
- Motor Cycle Collision (MCC) – where impact with a car greater than 30 km/hr, especially if rider is separated from motorcycle.
- Fall – greater than 18 feet (6m) or onto the head from greater than 3 feet (1m)
- Pedestrian or bicyclist – run over or struck by a vehicle at greater than 10 km/hr
- Any significant trauma with abdominal pain, CNS involvement, needing IV resuscitation or unstable vital signs
- Penetrating torso or neck trauma

Documentation

Refer to the *Guideline* for documentation.

Infection Prevention and Control Considerations

All patients will be cared for using Infection Prevention and Control Routine Practices and Additional Precautions as outlined in **Provincial Infectious Diseases Advisory Committee (PIDAC):** Routine Practices and Additional Precautions, Ministry of Health and Long-term Care, as per HRH policy. All staff will perform Hand Hygiene as per HRH guideline.

References
Ontario Hospital Association (2008). *Triage in Ontario Emergency Departments: Triage Training Resources for Educators and Facilitators*.
Sudbury Regional Hospital. (2008). *Non-Urgent Care Guidelines: Exclusion Criteria*
Southlake Regional Health Centre. (2008). *Southlake Regional Health Centre Emergency Department: Patients Suitable for Fast Track*

Humber River Health

Manual	Emergency Services Manual	GUIDELINE
Section		
Author	MANAGER, EMERGENCY SERVICES	
Approved by	**PROGRAM DIRECTOR, EMERGENCY SERVICES**	
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EMERGENCY DEPARTMENT RAPID ASSESSMENT AREA (OZONE) - GUIDELINE

Guideline Statement

The rapid assessment area, also referred as orange zone (ozone), is an area within the emergency department (ED) to facilitate the care of ambulatory ***Canadian Triage Acuity Scale*** (CTAS) 2 - 5 patients with the goal of improving patient flow and facilitating increased patient satisfaction. This is accomplished by ensuring that appropriate patients are triaged to ozone, and are assessed by physician in a timely manner according to CTAS level.

This guideline outlines the ozone patient criteria and patient flow strategies. The principle of flow for patients in ozone is to ensure that patients only occupy a stretcher during assessment and the initiation of treatments. Patients shall remain in the internal wait area while awaiting for further treatments and reassessment.

Guideline

Inclusion Criteria

CTAS 2 - 5 patients who are normally ambulatory and/or able to sit in a chair and get up and down to an examination stretcher. These patients will have conditions that could potentially progress to a serious problem requiring emergency intervention. May be associated with significant discomfort or affecting ability to function at work or activities of daily living. Vital signs are usually normal or at the upper and lower ends of the normal range.

Exclusion Criteria

Patients with the following conditions:

- Hemodynamic compromise (e.g., tachypnea, oxygen saturation < 90%, tachycardia with hypotension)
- Chest pain with suspicion of cardiac origin (abnormal ECG such as ST elevation, ST depression, T wave inversion, peaked T wave, and/or new left bundle branch block) needing cardiac monitoring and immediate intervention
- Trauma
- High risk mental health with primary mental health complaint
- Isolation – Airborne

- Bedridden

Patient Flow

1. The Triage Nurse will:
    - Complete a triage assessment and initiate appropriate medical directives to be implemented within the department.
    - Determine if a patient is appropriate for Ozone based on the above criteria. The triage nurse will assign appropriate patients to the *OZ Wait North in Meditech Emergency Department Management (EDM) tracker.

2. The Registration Clerk will:
    - Complete the registration, enter the medical directives into EDM, and direct the patient to the *OZ Wait North. The ED chart will be placed on the Ozone desk by the Team Leader.

3. The Ozone TL will:
    - Direct the patient to an assessment room in order of Canadian Triage Acuity Scale (CTAS) first and then time of arrival while balancing the workload between the ozone nursing teams.
    - Direct the patient to remove clothing and change into a gown. Ozone patients do not receive a decreased quality of examination or care.
    - Assign or delegate a clerk to assign the patient to the room in EDM. The patient's status event will be changed to MD2C automatically.
    - Delegate a nurse to initiate or initiate ED medical directives as appropriate. The Laboratory Technician can be ~~utilized~~ used to assist.
    - Place the patient's chart in the MD2C slot on the chart rack.

    If a Physician assessment room is not available, the Laboratory Technician will work with the Ozone TL/TE Nurse to complete ECGs and venipuncture.

4. The Flow Clerk, or Unit Clerk in the absence of a Flow Clerk, in collaboration with the TL will:
    - Review the tracker to identify available beds and ensure rooms are full at all times.
    - Direct the patient into a physician assessment room in order of CTAS, then time in department, ensuring a balanced workload between the two teams.
    - Direct the patient to remove clothing and change into a gown.
    - Assign the patient to the room in EDM.
    - Place the patient's chart in the MD2C slot on the chart rack.
    - Monitor Ozone TBS tracker and "Reg to Tower" time to ensure it is less than 30 minutes.

5. The Ozone Nurse will:
    - Assess the patient in the room.
    - Sign up for the patient in EDM by clicking the sign-up button to assume the primary nurse position for this patient.
        - Note: Signing up for the patient ensures increased clarity, safety, and communication amongst physicians and nursing teams in ozone. Not using the sign-up function does not eliminate the accountability or responsibility of the primary nursing duties.
    - Initiate and/or implement medical directives as appropriate.

- Document the nursing assessment and intervention findings in EDM as outlined in the ED Standard of Care.
- Ensure the patient's chart is in the MD2C slot on the chart rack.

6. The Physician will:
   - Sign up for the patient in EDM, automatically changing the status event to MD Seen.
   - Assess the patient, place orders, and document in the EMR.
   - Move the patient to the internal waiting area *OZ Wait South depending on the type of orders placed. If privacy is needed for orders, the nurse will place the patient in *OZ Wait South.
   - Communicate to the nurses/clerk if the patient is discharged or sent to Medical Imaging.

7. The Ozone Nurse, after physician assessment and receiving order(s), will:
   - Initiate orders in the assessment room that require privacy.
   - Move the patient to the treatment area, ozone waiting room south, and complete all additional treatments.
   - Assign or delegate a clerk to assign the patient to OZ Wait South in EDM. Change the patient's status event to Tx In Prog.
   - Verbally communicate to the primary physician when the patient has significant changes in condition or significant diagnostic results and document the communication with the physician and any subsequent orders in the Physician Communication Screen on the EDM worklist.

8. The Ozone Nurse, once all orders are carried out and reported, will:
   - Advance the status event to MDRA on the EDM tracker.
   - Place the patient's chart in the MDRA slot in the chart rack.
   - This process can be done by the ozone flow clerk with consultation from ozone TL/nurses to facilitate patient flow. Refer to the role description of the ozone flow clerk.

9. The Flow Clerk, or Unit Clerk in the absence of a Flow Clerk, will:
   - Review the tracker to identify patients ready for reassessment and discharge-ready patients.
   - Monitor patient care delay status indicators on the tracker or command center tile and report to TL when thresholds are reached.
   - Make hourly rounds and report to TL the number of patients waiting and flow interrupters for immediate follow-up.
   - Monitor patients' movement from patient rooms to *OZ Wait South and update the tracker frequently.
   - Liaison with the Medical Imaging department to follow up on results and/or delays.
   - Liaison with the Laboratory department to follow up on results and/or delays.
   - Monitor and follow up with consult order and consultant arrival time.

10. The physician will reassess the patient and may write additional orders, consult a specialty, or discharge the patient home.

11. If discharge occurs, the physician and nurse will provide the patient with discharge instructions.

12. The Unit Clerk will:
    - Monitor the EDM tracker and schedule patient follow-up appointments.

- Prepare the patient follow-up appointment package and provide it to the discharge nurse or patient directly.
- Change the appointment order status to "completed" in EDM.
- Document a clerical note including the appointment booking completion status.
- Answer patient inquiries and telephone inquiries.
- Discharge appropriate patients from the discharge tracker, this includes FT patients discharged between (11:30pm and 07:30 am)
- Act as a liaison amongst all healthcare providers.

13. The Discharge Nurse will:
    - Review the EDM tracker for the last time an assessment and vital signs were documented as outlined in the ED Standard of Care.
    - Ensure all follow-up appointments are scheduled and the patient is aware of the details.
    - Provide health teaching and appropriate discharge instructions sheet.
    - Complete a discharge assessment in EDM, including a new set of vital signs.
    - Communicate any concerns to the MD prior to discharge.

14. If the patient is consulted or admitted, the patient will be cared for by the POD specific nurses until a bed is available on the inpatient unit or until the number of admissions triggers the ED surge protocol.

Special Circumstances

- In situations where the patient's acuity changes or the patient is admitted, the Ozone nurse will inform the Ozone TL. The Ozone TL will contact the Resource Nurse to determine and move the patient to the most appropriate ED area.

- If a physician orders a patient be placed in a different ED area, the Ozone TL will contact the Resource Nurse to facilitate the transfer. Physician-to-physician transfer of accountability will occur to ensure a safe continuity of care.

Ambulatory Area Team Leader Roles and Responsibilities

The ambulatory area TL is responsible for the following but not limited to:

- Facilitate a smooth patient flow in Ambulatory Area.
- Maintain appropriate communication with the Patient Flow Manager (PFM), Flow Clerk, Resource Nurse, Triage Nurses, and other ambulatory area nursing and clerical staff to ensure optimal patient care, including coordinating the movement of patients requiring a higher level of monitoring and patients who are consulted for potential admission
- At the beginning of each shift and hourly, connecting with nursing teams to confirm staffing, answer any questions regarding patient stability, flow etc. and provide support to staff (i.e. novice nurses, nurses on orientation)
- Collaborating with laboratory technician to monitor implementation of medical directives and reassign staff as necessary to assist with patient care, discharge, and flow.
- Reassess and rearrange assignments according to needs of the team.
- Ensure patients are reassessed in a timely manner.
- Ensures nursing break coverage occurs.

- Liaison with triage and ozone RNs to prioritize patients with vital signs at the upper/lower ranges or who are identified as higher risk
- Arrange charts to reflect patients to be seen in highest priority
- Facilitates transfers to Subacute and Acute as required

Accountability / Responsibility

Refer to the *Guideline* for accountability / responsibility.

Definitions

Status Event
Status Event is a function on the Meditech program tracker to allow health care professional to enter and communicate a patient's event of most current status.

Documentation

Refer to the *Guideline* for documentation.

Infection Prevention and Control Considerations

All patients will be cared for using Infection Prevention and Control Routine Practices and Additional Precautions as outlined in **Provincial Infectious Diseases Advisory Committee (PIDAC):** Routine Practices and Additional Precautions, Ministry of Health and Long-term Care, as per HRH policy. All staff will perform Hand Hygiene as per HRH guideline.

References

Accreditation Standard/Criteria:

ED Ambulatory Zone Standard Work Secretary

Ambulatory Secretary – Day and Night

Standard Work

Within the Assessment Area

- ❑ Upon arrival, log into Epic and ensure all empty rooms are clean and ready for use
  - ❑ Check Assessment Room 8 for used scopes, if dirty call Service Assistant
- ❑ In between patients, prepare the assessment room/stretchers
- ❑ Check urine sample and dispose the ones of discharged patients (not if it has a barcode label on it)
- ❑ Check tracking board to ensure patient has registered
- ❑ Check reason for patient's visit to determine if need to be placed in a specialized Assessment Room (ex. If they need Assessment Room 8)
- ❑ Monitor the PIA time on the tracking board, if wait is more than two hours talk to the resource MD and MRN to activate escalation process
- ❑ Place patient in a room according to time (unless if the triage nurse indicates to Bump the patient), and work in collaboration with the assessment Nurse
- ❑ As the patient waits for Physician Assessment, in the Assessment Room or waiting area, visually monitor and update patients on their status
  - ❑ Escalate the patient to the Assessment Nurse if the patient's condition appears to change
  - ❑ Be visible to the patient to answer any questions they may have
  - ❑ Expected time to see the physician

When Patient Moves to Treatment Area

- ❑ Ask patient to go to treatment and wait for nurse to call their name for treatment
- ❑ If Xray ordered, patient may be directed to Xray waiting room and advised to return to treatment area
- ❑ Move patient's name on tracking board from assessment to treatment
- ❑ Clean room after patient moves to Treatment, if it requires a deep clean call EVS

Sending Patient to Diagnostic Imaging (Ultrasound or CT)

- ❑ Diagnostic Imaging (DI) will contact Unit Secretary when they are ready for patient to be sent for imaging
- ❑ Unit secretary will identify patient, and check with nurse that patient is ready to be sent
- ❑ Unit secretary will confirm any pre imaging requirements, example, presence of IV, full bladder

When Patient is Discharged

- ❑ Unit secretaries will be responsible for printing AVS, and follow up appointment information if not completed by MD
- ❑ Give AVS, prescription, and follow-up appointment information to the primary nurse, or assessment nurse if no nurse assigned, for discharge

When Patient is for Re-Assessment

- ❑ Place patient in re-assessment room based on length of stay, or MD request, once they have been marked for ready for re-assessment by nursing staff
- ❑ Monitor the patient's re-assessment waiting time on the tracking board, collaborate with MRN &MD if increasing number of patients waiting for re-assessment, or increasing length of stay times
- ❑ After MD re-assesses the patient move the patient to the treatment area

Transferring Patient to a Bed

- ❑ For a Bed placement, collect information regarding patient status and bed requirements
- ❑ Call MRN to advise/request a bed for admitted patients

Patient status communication

- ❑ Leave a note in the comments section on the tracking board when: Patient is sent to DI or MRN has been called to request a bed

TASK CHECKLIST: EMERGENCY DEPARTMENT RESOURCE PERSON/TEAM LEADER DUTIES – HUMBER RIVER HEALTH

Task Checklist: Emergency Department Resource Person/Team Leader Duties

The following tasks and duties of the RP/TL were reviewed and/or demonstrated to staff:

✓	Task/duty
	Initial Tasks ☐ Receive verbal report from the TL and review EDM tracker – EMS, TBS, F1, SI, admissions etc ☐ Spectralinx Application sign in ☐ Complete round of the department ensuring all staff have arrived/report is being taken. ☐ Conduct shift Spectralink audit to ensure staff have their phones and are logged in for alerts ☐ Review nurse assignment & break coverage, make potential changes based on acuity and volumes
	Review ED Expediter Tile • **Metrics** ✓ **Total Census**: Total number of patients in the ED ✓ **Census by CTAS**: # of patients in the ED by CTAS, how many arrived in the prior hour (rolling 60 min) ✓ **Queue**: Patients waiting to be registered ✓ **EPU Pts**: Patients in the EPU ✓ **MH Wait**: Patients with a violence-related Chief Complaint or "Behaviour Risk Alert" that are waiting for a bay ✓ **Boarders**: Admitted patients in the ED ✓ **EPU Wait**: CTAS 9 patients not in EPU ✓ **CDU**: Patients in the CDU • **Alerts** ✓ **MH Wait**: Patients with a violence-related Chief Complaint or "Behaviour Risk Alert" that are not in a bay in the desired timeframe ✓ **Imaging Alerts - CR, US, CT, MR:** Imaging exam ordered, but not taken ✓ within specified timeframe ✓ **PIA**: Physician initial assessment is delayed more than specified timeframe ✓ **Readmit:** Patient discharged from hospital in the past 30 days ✓ **High Utilization:** Patient visited ED 4 or more times in the past 30 days ✓ **Sepsis Risk**: Patient meets SIRS criteria and no Physician Communication SIRS Alert Action documented ✓ **LOS Admit/CTAS:** Patient ED LOS greater than specified threshold ✓ **EMS Offload**: Patient ED arrival via EMS ETOC in ED ▪ Ensure patients pending simple interventions or discharge are pulled out fo the rooms in Acute and Subacute and placed in the SA hall to ensure capacity for new patients TBS ▪ Move medically clear MH patients to EPU. Coordinate call to the psychiatrist if not arrived by 1000 with PFM ▪ Connect with GEM, SW, PSY regarding consults and pending discharges ▪ Coordinate with other departments (e.g., radiology, laboratory) to ensure timely completion of tests and procedures. ▪ Place patients in room in the Subacute area while overseeing Acute and the Ambulatory area
	Review Boarders Tile ✓ Hold Time: Time elapsed since admission for ED and Direct Admit patients. ✓ Patient: Patient name and account number ✓ Bed Type: Level of care and unit type requested

Humber River Health Lighting New Ways in Healthcare

✓	Task/duty
	✓ LOC: Boarding patient's current location ✓ Status: Assigned bed location ✓ Bed Status: Details of matching or assigned beds ✓ Boarding Flags: Patient boarding flags ☐ Ensure that ETRs are completed promptly, and report provided as soon as beds become available. If ED nurse is unable to give report, the RP/TL will call the respective unit's RP/TL to facilitate the report. If this is not possible, escalate the PFM. ☐ Collaborate with the PFM to open the CDU for admissions when there are more than 15 patients waiting without beds. Ensure that NRT staff are booked accordingly.
	Morning Huddle ☐ Co-facilitate morning huddle with Managers/CPLs to identify/communicate patient care needs. ☐ Conduct **Daily Quality & Safety Huddles** (Binder located at the RP desk) o Patient Quality and Safety Huddle checklist o One form to fill out each shift by the RP
	Attend ED Bed Rounds @ 0915 (ED PFM Office) ☐ Follow up with issues identified in rounds i.e. Tests, consults, barriers to discharges, outstanding allied referrals, family concerns → escalate to PFM as needed
	RP/TL rounds: ☐ Safety Check in Patient's room: o Check that patients are undressed and bed is at the lowest level o Appropriate signage infront of room (IPAC, Violence, falls risk) ☐ Monitor and adjust staffing levels based on patient volume, acuity, and department needs throughout the shift. ☐ Complete hourly rounding in department o Round with the TL in Acute and Ozone/FT o Review ETOC offload status and PDS for offload delays o Review F1/F42 patients and patients TBS with Police o Readjust staffing if more than 30 min wait at front triage ☐ Conduct shift audits as directed by Manager/Clinical Practice Leader
	OMNICELL responsibilities: ☐ End of shift Discrepancies assessment (before 1930 for days, and 0730 for nights) ☐ Ensure 0600 full Omnicell touched/untouched is completed
	Leadership Demonstration throughout shift ✓ Ongoing communication with ED MD and PFM to discuss plan of care and discharges ✓ Address family concerns, if unable to resolve, escalate to PFM ✓ Promoting team building ie. Purposeful rounding, buddy support ✓ Follow up on department call-backs
	Coaching/Mentoring ✓ Check In with staff ie. Novice staff, NRT staff, student externs ✓ Follow up with staff regarding SIRS
	Ensure the following checks are completed ☐ Crash Cart Checks (for all areas, check in with each assigned staff) ☐ Monthly Code Cart Expiration Checks ☐ Glucometer

TRIAGE/TEAM LEADER EMERGENCY DEPARTMENT COMPETENCIES – JOSEPH BRANT HOSPITAL

Name: Signature: Date:

JOSEPH BRANT HOSPITAL

Emergency Department Competencies

Triage/ Team Leader

Competency Level

- **0- I have NO EXPERIENCE with this**
- **1- I have MINIMAL EXPERIENCE with this. I will need to review and be supervised. I have done this at least once**
- **2- I am COMFORTABLE performing this with the resources available, which may include my colleagues, charge nurse or educator**
- **3- I am COMPETENT to perform this independently and safely**
- **4- I am an EXPERT in this and can be a resource for others**

General Knowledge/ Equipment	0	1	2	3	4
All competencies from ARM/CAM/PES and CC competency checklists					

Triage Specific	0	1	2	3	4
Completion of the NENA Triage Course					
Knowledge of ED flow					
Able to perform focused triage assessments for; • **Adults** • **Pediatrics** • **Mental Health** • **Geriatrics**					
Knowledge of eCTAS program					
Knowledge of Triage downtime procedures					
Knowledge of documentation standards for Triage					
Knowledge of Team Leader competencies					

Team Leader Specific 4	0	1	2	3	
Knowledge of how to call CRITICAL					
Knowledge of how to call TELESTROKE					
Knowledge of how to page MOC					
Knowledge of how to book an ambulance for transport					
Knowledge of how to obtain PTAC number					
Knowledge of how to check and record fridge temperatures					
Knowledge of how to receive and follow up on critical microbiology results.					
Knowledge of Hospital Policy and Procedures and how to find relevant resources for patient care					
Knowledge of Hospital Flow					
Knowledge of ED Flow and troubleshooting for high patient volume, gridlock and EMS offload situations					
Knowledge of methods to support ED staff, including debrief tools					
Ability to support patients and families afterhours and resources available (i.e. patient concerns, Patient Experience, etc)					
Knowledge of how to page Nina's place nurse afterhours					

EMERGENCY DEPARTMENT CHARGE NURSE DUTIES – PETERBOROUGH REGIONAL HEALTH CENTRE

ED Charge Nurse Duties/Expectations

Days

0700

- get report on department, including scheduling breakdown for current and next shift.
- During report consider
  - Who would be good for purple/offservice/hallway admits?
  - Who can come off isolation if swabs negative?
- Communicate with pt flow about beds (2139)
- Round on all zones and crews on offload with WOW for updates/concerns (continue to round on all zones throughout shift)
- consider laying eyes on patients and/or introducing yourself to patients
- check in with staff to see if any concerns about patients, questions about procedure/workload
- Consider patients that can move to purple/hallway beds to create capacity in Red/Orange/Yellow

0900

- Emerg rounds at main desk (M-F)

0930

- bed meeting with all charge nurses and management (every day including weekends)

Throughout the shift (1000-1700)

- touch base with float nurses throughout the day to deploy them where needed most
- Review staffing for next shift, request float staff or calls to be put out with LRA (x5062)
- Communicate with Patient Flow (x2139) regarding beds/flow
- Communicate with IPAC regarding isolations (who can come off with a negative swab, reassessments)
- Encourage staff to take breaks/ensure coverage if extra staff (consider break schedule)
- Communicate with inpatient floors after 1hr mark of Bed Ready
- Involve Patient Flow and/or management for support
- If crews on offload increase, involve charge doc in making internal flow plan for offloading patients.
- Check in with any EMS crews at ***30min*** Offload Delay times and consider strategies for offloading internally and/or with Patient Flow; at ***60min*** consider involving management to expedite inpatient units in collecting patients
- Consider alternative flow strategies including:
  - adding extra patient to yellow/surge/purple hallway
  - using AOHN beds for stable pt waiting for inpatient bed/transfers home/OR

1700-1900

- Get report from all zones, rounding with WOW and writing in comments

Nights

1900

- Receive report on department, including scheduling breakdown for current and next shift.
- During report consider
  - Who would be good for purple/offservice/hallway admits?
  - Who can come off isolation if swabs negative?
- Communicate with pt flow about beds (2139)

- Round on all zones and crews on offload with WOW for updates/concerns (continue to round on all zones throughout shift)
- Consider laying eyes on patients and/or introducing yourself to patients
- check in with staff to see if any concerns about patients, questions about procedure/workload
- Consider who may be a possible discharge the next day and make a list for the Patient Navigator to assess in am. Ensure that SW/OT/PT/GEM referrals are in EPIC
- Consider patients that can move to purple/hallway beds to create capacity in Red/Orange/Yellow.

1945-0500

- Round on all zones and crews on offload with WOW for updates/concerns continue to round on all zones throughout shift
- consider introducing yourself to patients, lay eyes on patients
- check in with staff to see if any concerns about patients, questions about procedure/workload
- Encourage staff to take breaks/ensure coverage if extra staff (consider break schedule)

0500-0700

- Work on schedule from for coming day/night
- Get report from all zones, round with WOW and enter comments

Sick Calls

- When taking a sick call from staff look at breakdown for next shift prior to requesting replacement (RN base 14 on D/13 on N; RPN base + WLI 5 on D/3 on N + GZ staffing); assess for number of ACLS nurses (minimum 9)
- Pass the staff member on to management or LRA to report sick call – no questions asked regarding reason for calling in.

Where Staff Can Work

- Go to the intranet home page ->sites->departments->ER-> top of page “areas staff qualified to work’ (not up to date)
- Refer to this when replacing vacancies, main breakdown should be completed by management- try not to change assignments unless required for sick calls/resource allocation
- When new staff trained in new area, email Emily to update spreadsheet
- If changing assignment, the goal is always to buddy a more senior staff with those newer to a zone for support and learning

Lab/Micro results

- Lab will call throughout the day/night with critical results,
- Take the K# and name of patient and result
- Give results to primary nurse if pt is admitted for them to notify MRP
- If ED pt notify the MRP or charge doc if pt not seen yet
- Morning calls will often include results for patients no longer in dept, these results should be in the call back basket, verify this with the call back doc after 1000 or charge doc if critical result.

Charge Doc Calls

- Accepting patients from other facilities- docs make an expected chart and write a note
- Notify Triage depending on mode of arrival
- Notify Doc on arrival

Booking transfer with EMS/ORNG

- Get interfacility patient transfer order set from file box and have physician complete

- Ask ward clerk to generate MT #
- Will need sending/receiving doc and facility
- Pt weight required
- Escorts going with patient?? MT will require their weight as well.
- Diagnosis
- CritiCall will sometimes arrange transfer for you if Code Stroke for EVT or trauma patient
- CN or patients nurse will need to speak with dispatch, then ORNG MD – give report to medics on arrival
- Call receiving facility when pt leaves with ETA
- If transfer is for consult only- e.g. EVT, consider local land with nurse
- If accepted by receiving facility as inpatient, consider ORNG first by calling number beside charge desk
- Have pt info available, VS, weight, escort and their weight, equipment needed for transport, IPAC concerns
- If nurse is going on transfer- get $$ from Business Office (W4 registration near main entrance) during the day (0800-2100) or from switchboard (main ED waiting room) on nights (2100-0800)

Transfer back to Retirement/Nursing Home

- MT # required
- can book local transfer service through ward clerks
- PRHC dedicated truck 09-21(process)
- Be sure to ***call the home first*** to inform them that patient will be returning and the ETA.

Deaths

- Call Trillium Gift of Life (1 800) for all deaths that occur in ED. Call Trillium before extubating anyone or removing BiPap if death is expected.
- Use the donation tab in EPIC once disposition changed to expired

CDU (Clinical Decision Making Unit)

- Virtual space for patients while waiting dispo if likely for discharge
- Department receives funding based on these metrics
- CTAS 1/2/3 require dispo within 6 hrs
- CTAS 4/ 5 require dispo within 3 hours
- Patients to consider
    - hold overnights (GEM/crisis/sobriety)
    - entering pt into CDU stops the clock on LOS
    - If CRU patients remain in CDU, please remove them once decision is made to hold under Psych (patients can not be held in CRU under the CDU pending a Psych decision to admit)

EFORT (EMERGENCY FACILITATED OUTREACH TEAM) – JOSEPH BRANT HOSPITAL

JOSEPH BRANT HOSPITAL

EFORT (EMERGENCY FACILITATED OUTREACH TEAM) DESCRIPTION

PROGRAM TITLE: EFORT

REPORTS TO: Clinical Manager

DIVISION/ DEPARTMENT: Patient Care Services

DATE: April 2021

PROGRAM SUMMARY: The Emergency Facilitated Outreach Team (EFORT) is a transformative initiative that enhances emergency care by the assessment of a referred patient to the team for a thorough assessment to achieve optimal functioning, admission avoidance, reduce Alternate Level of Care (ALC) days, and emergency visits. Modeled after the highly successful program at St. Joseph's Hospital in Hamilton, EFORT incorporates a best-practice approach that pairs the complementary skills of a Registered Nurse (RN) and an Occupational Therapist (OT). As explained by the leadership at St. Joseph's, the dynamic partnership between these two roles is the key to the program's success, as it ensures a well-rounded, holistic evaluation of each patient.

Unlike many traditional programs that operate with strict inclusion and exclusion criteria, EFORT was deliberately designed with no limitations on eligibility, ensuring that all individuals who may benefit from its services can access support. While there are no age restrictions, a significant portion of the patients seen by the team are geriatric, often presenting with challenges such as caregiver burnout, failure to cope, generalized weakness, or mobility concerns.

EFORT operates through a collaborative, patient-centered approach, providing individuals with a comprehensive assessment conducted by both an experienced Emergency Department Registered Nurse (RN) and an Occupational Therapist (OT). This effective pairing allows for a more inclusive evaluation of a patient's medical, functional, and social needs. By combining clinical expertise with occupational focused insights, the team provides valuable, real-time information to the emergency physician, enabling them to make a more informed and well-rounded disposition decision regarding the patient's care.

A key strength of EFORT is its emphasis on integrating family, community resources, and Ontario Health at Home services into the patient's discharge plan. Rather than defaulting to hospital admission, the team actively explores safe and supportive alternatives that prioritize a "Home First" philosophy—an approach that focuses on keeping individuals in their familiar environment whenever possible while ensuring they have the necessary resources for a safe recovery. This process not only supports better patient outcomes and quality of life but also reduces unnecessary hospital admissions, helping to alleviate emergency department overcrowding.

By fostering collaboration between hospital staff, community partners, and family caregivers, EFORT plays a crucial role in bridging the gap between acute emergency care and long-term support systems. This innovative model not only enhances patient safety and independence but also contributes to a more efficient and sustainable healthcare system. The team's ability to provide immediate, tailored interventions ensures that patients receive the right care, in the right place, at the right time, ultimately improving healthcare experiences for both patients and providers.

JOSEPH BRANT HOSPITAL

ROLE DESCRIPTION

POSITION TITLE: EFORT Nurse-Emergency Department

REPORTS TO: Clinical Manager

DIVISION/ DEPARTMENT: Patient Care Services

DATE: April 2021

ROLE SUMMARY:
Reporting to the Manager of the Emergency Department, the Emergency Facilitated Outreach Team (EFORT) Nurse is part of a multidisciplinary team that provides expert clinical resource in an effort to assist elderly and complex patients to achieve optimal independent functioning, reduce Alternate Level of Care (ALC) days, and ED visits. general coordination and flow within the Emergency Department under the support and direction of the Emergency Department Leadership team. As part of the team the nurse will assess, plan, implement and evaluate care options in collaboration with patients, family, inter-professional teams, and with community partners.

RESPONSIBILITIES:

- In tandem with Allied Health partners, completes comprehensive assessments and identify the needs of elderly and complex patients in the ED, with the goal of avoiding unnecessary hospitalizations and to safely discharge patients to the community
- Act as a resource/coach to ED staff in the care and management of elderly patients with complex medical and social issues
- Facilitate timely and safe discharge of elderly patients from the ED and to link them to community resources
- Promote a model of best practice in Elder Care nursing and an elder friendly philosophy of care within the ED
- Enhance relationships with the local Long Term Care and Retirement Homes within the community to build capacity and collaboration to foster ED avoidance.
- Communicate plan and strategy for those admitted patients to members of the receiving unit's interdisciplinary team
- Upholds and supports the utilization of clinical policies, procedures, standards of care and practice.
- Assists in the department, up to and including a patient assignment when required.

QUALIFICATIONS:

- Registered Nurse in good standing with the College of Nurses of Ontario
- Minimum of three to five years of current clinical experience within the Emergency Department required
- Demonstrated excellence in oral and written communication
- Excellent interpersonal, problem solving and teaching skills
- Ability to function both independently and collaboratively within the inter-professional team;
- Excellent knowledge of community supports for the patient population;
- Additional training and experience in Gerontological Nursing an asset
- Solid understanding of P4R metrics and admission rates and contributors
- Demonstrated critical thinking, organizational skills, decision – making and problem – solving skills
- Ability to demonstrate team effectiveness through current metrics including length of stay, ALC rate and other P4R tracking
- Demonstrated commitment to continuous education and learning for self and others
- Ability and knowledge to access hospital resources
- Demonstrated commitment to the Mission, Vision, Values, and the Care Commitment of JBH
- Demonstrated reliable attendance and punctuality

JOSEPH BRANT HOSPITAL

ROLE DESCRIPTION

POSITION TITLE: EFORT Occupational Therapist-Emergency Department

REPORTS TO: Clinical Managers

DIVISION/ DEPARTMENT: Patient Care Services / Allied Health

DATE: April 2021

STATUS: TPT 0.4 (Alternating Sat & Sun 0800-1600) 1-year contract with potential to extend

UNION: OPSEU

ROLE SUMMARY:

Reporting to the Managers of the Emergency Department & Allied Health, the Emergency Facilitated Outreach Team (EFORT) Occupational Therapist is part of a multidisciplinary team that provides expert clinical resource in an effort to assist elderly and complex patients to achieve optimal independent functioning, reduce Alternate Level of Care (ALC) days, and ED visits. As part of the team the occupational therapist will assess, plan, implement and evaluate care options in collaboration with patients, family, inter-professional teams, and with community partners.

RESPONSIBILITIES:

- In tandem with Nursing & Allied Health partners, completes comprehensive assessments and identify the needs of elderly and complex patients in the ED, with the goal of avoiding unnecessary hospitalizations and to safely discharge patients to the community
- Act as a resource/coach to ED staff in the care and management of elderly patients with complex medical and social issues
- Facilitate timely and safe discharge of elderly patients from the ED and to link them to community resources (Home and Community, volunteer organizations, day programs, individual services, caregiver support services, equipment & funding sources)
- Promote a model of best practice in Elder Care and an elder friendly philosophy of care within the ED
- Enhance relationships with the local Long Term Care and Retirement Homes within the community to build capacity and collaboration to foster ED avoidance.

- Communicate plan and strategy for those admitted patients to members of the receiving unit's interdisciplinary team
- Upholds and supports the utilization of clinical policies, procedures, standards of care and practice.
- Assists in the department, up to and including providing assessment and treatment for additional patient populations when required.

QUALIFICATIONS:

- Registered Occupational Therapist in good standing with the College of Occupational Therapists of Ontario
- Preferred clinical experience within the Emergency Department
- Demonstrated excellence in oral and written communication
- Excellent interpersonal, problem solving and teaching skills
- Ability to function both independently and collaboratively within the inter-professional team;
- Excellent knowledge of community supports for the patient population;
- Additional training and experience in Geriatrics an asset
- Understanding of P4R metrics, admission rates and contributors
- Demonstrated critical thinking, organizational skills, decision – making and problem – solving skills
- Ability to demonstrate team effectiveness through current metrics including length of stay, ALC rate and other P4R tracking
- Demonstrated commitment to continuous education and learning for self and others
- Ability and knowledge to access hospital resources
- Demonstrated commitment to the Mission, Vision, Values, and the Care Commitment of JBH
- Demonstrated reliable attendance and punctuality

SOCIAL WORKER MENTAL HEALTH NAVIGATOR – MUSKOKA ALGONQUIN HEALTHCARE

JOB PROFILE

JOB TITLE: Social Worker Mental Health Navigator, Emergency Department

JOB CLASSIFICATION: OPSEU Para-Medical

DEPARTMENT: Emergency Services

REPORTING RELATIONSHIP: Manager of Emergency Services

MAJOR RESPONSIBILITIES:

- To provide clinical social work assessment and management for hospital emergency department patients or other areas as assigned
- To develop future potential programming if needed related to mental health patient population at MAHC
- To develop and implement a plan of care with clients and teams which may include individual or family counselling, facilitating financial supports and assistance through resource applications. Psychosocial support with discharge transitioning in collaboration with other members of the healthcare team, patient and family.
- Ability to develop and implement plan of care for those suffering from substance use concerns
- A strong understanding of intimate partner violence (IPV)
- To maintain charting standards according to institutional and College standards
- To maintain records of workload and service statistics and submit to administration in a timely manner
- To participate as a member of an interdisciplinary team in the provision of patient care
- To participate in quality assurance programs
- To maintain continuing professional development and ongoing learning by attendance at professional seminars, courses and conferences
- To maintain patient safety and infection control precautions at all times
- To provide educational in-services to staff, patients/families and volunteers as needed
- To establish and maintain liaisons with hospital and community groups through project and committee work as required
- To provide appropriate referrals and consultation to other professionals and/or agencies as required
- To maintain confidentiality of patient information and ensure security of patient records.
- To provide student placement experiences as caseload and resources permit
- To attend and participate in Rehabilitation Service staff meetings and other professional practice related activities
- To perform other duties as assigned by the Manager, Emergency Services

DUTIES LIST AVAILABLE FOR THIS POSITION: ☐ **YES** ☒ **NO**

EDUCATIONAL PREPARATION:

- Master of Social Work from an accredited learning institution

REQUIRED EXPERIENCE:

- Minimum Masters of Social Work (MSW) 2-3 years' experience in an interdisciplinary hospital setting
- 2-3 Years experience working with mental health population
- Experience conducting locus and crisis assessments
- Experience working with paediatric mental health population
- Experience working with crisis programs with OPP
- Experience working with indigenous populations
- Experience or certification in addiction treatments and medicine
- Experience in leading debriefs
- Familiarity with adult education, patient counselling
- Proficient in computer skills including electronic health record, Microsoft Office
- Effective communication skills (oral, written) and ability to work collaboratively in a team setting
- Effective critical thinking, problem solving, organization and leadership skills
- Demonstrated conflict resolution skills and front line leadership skills
- Demonstrated skills in managing complex inter-personal relationships in a confidential, caring and compassionate manner
- Familiarity with community resources and supports

REQUIRED CERTIFICATIONS:

- Registration with the Ontario College of Social Workers and Social Service Workers

DESIRABLE EDUCATION/CERTIFICATION(S):

- Courses or certifications relevant to mental health population, crisis assessments, trauma, resilience, violence and debriefing.

PATIENT SAFETY RESPONSIBILITIES:

- Participating in and compliance with hospital safety and infection control programs
- Reporting unsafe conditions
- Assisting in the reporting and investigation of incidents
- Reviewing related policies and procedures on a regular basis
- Maintaining patient and hospital confidentiality
- Responding appropriately to codes
- Participating in quality activities as required

DEMANDS OF POSITION:

•	**Physical Demands**	•	**Biological**
	Patient Transfers		Exposure to blood borne pathogens
	Patient Lifts	X	Exposure to bacteria, viruses
	Patient Lifts with Mechanical Assist.		Exposure to disinfectants/sterilization agents
	Transporting Carts (laundry, dietary, supply, etc.)	•	**Ergonomic**
	Material Handling (supplies, IV solutions, paper, etc.)		Workplace design
X	Lifting less than 22.7kg/50lbs		Equipment design
	Lifting more than of 22.7kg/50lbs	X	Work organization
	Exposure to excessive heat, noise or vibration		Work environment
X	Exposure to violence/aggression		Repetitive work due to computer use
	Prolonged Standing		Repetitive work due to equipment use
X	Prolonged Sitting		Repetitive work due to task performance
	Shift Work (days, nights, 8 hour, 12 hour, etc.)	•	**Safety**
	Exposure to radiation		Work with or operate equipment, moving parts, blades, pinch points, etc.
•	**Chemical**		Electricity
X	Exposure to controlled products, designated substances		Steam, heat, chemical energy
	Exposure to solids, liquids, gasses		
	Exposure to anaesthetic agents		
	Exposure to medications		

JOB IS REGULATED UNDER THE REGULATED HEALTH PROFESSIONS ACT: [X] **YES** [ ] **NO**

If yes, copy of STANDARDS attached: [ ] **YES** [ ] **NO**

PREPARED BY:
Melissa Bilodeau **July 2022**
Signature Date

REVIEWED BY HUMAN RESOURCES:

ED MOBILITY TEAM – HEALTH SCIENCES NORTH

OVERVIEW OF THE TEAM			
ED TEAM			
ED Mobility Team: **Physiotherapist (PT),** **Physiotherapy Assistant (PTA)**	**High Risk Assessors (HRA)**	**ED Social Worker** Newly filled	**ED Community Transitions Supervisor**
ROLE			
Collaborate with care team to identify ED admitted patients at risk of prolonged stay and initiate early mobilization and functional assessments to support discharge planning and prevent deconditioning	Collaborate with care team to identify ED admitted patients at risk of prolonged stay, address barriers to discharge, and initiate early interventions, such as admission avoidance to inpatient units, and early discharge planning to reduce length of stay and enhance ED flow	Collaborate with the care team and triage with the HRA to prioritize ED-admitted patients with social risks and discharge barriers, facilitating safe and timely transitions back to community	Collaborate with the care team to identify outpatients at risk of admission due to social concerns and coordinate appropriate supports
RESPONSIBILITY			
PT/PTA mobilize patients as required with the priority and focus on ED admitted patients	HRAs Assess high risk ED admitted patients (over age 65) using Blaylock and Barthel tools to assess baseline and current -Can enter Social Work referral if required Barthel: assesses ADLs and functional independence for both baseline and current (at the time of assessment) Blaylock: assesses risk for complex discharge needs and prolonged hospital stays (baseline and current) to guide early interventions	Prioritize patients at high risk of social admission to inpatient unit who are at risk of becoming ALC, or prolonged length of stay by addressing family concerns, coordinating community resources, and facilitating referrals to prevent unnecessary admission Also provides coverage at our Alternate Health Facility (Amberwood) to assist ALC patients with discharge planning, service coordination and transitions to appropriate care settings	Liaise with patients/families, community partners for opportunities for ED diversion, and admission avoidance - Will hand off to HRA and/or SW if patient is going to be admitted - Provide discharge support to outpatients Identify pathways in community or in hospital if admitted
AVAILABILITY			
PT: Monday-Friday 8am – 4pm **PTA:** 8:30am – 4:30pm	7 days per week, 8am to 8pm M-F, 8am-4pm on weekends	2 Week rotation in ED: Wk 1: Mon/Tues/Fri Wk 2: Wed/Thurs *At Amberwood when not in ED	Dedicated M-F: 8-4 *2/3 positions hired for 12 hour Day/Night support. When fully staffed 24/7 support to be provided

OVERVIEW OF THE TEAM						
Bed Allocation Associates	**Organizational Patient Flow Supervisors**	**Inpatient Flow Supervisors**	**Home First Liaisons / Care Transitions Associate**	**Hospital to Home Coordinator**	**Clinical Operations Managers**	**Clinical Manager at Alternate Healthcare Facility (Amberwood)**
ROLE						
Work Closely with Patient Flow to apply Bed Management policies and optimize patient placement	Oversee daily patient flow into and out of HSN beds as well as collaborate with internal and external stakeholders to improve patient flow, identify and resolve delays in flow and ensure optimal patient placement and timely transfers	Facilitate early identification of discharge barriers, ensure resource optimization and coordinate with interdisciplinary teams to reduce length of stay and support safe, timely discharges	Support Alternate Level of Care (ALC) patient pathways, manage ALC data and report to the Wait Time Information System (WTIS)	Acts as the primary liaison between HSN, patients and Bayshore Integrated Care Solutions (ICS), overseeing the identification of appropriate patients, coordinating patient referrals and transitions to the Hospital to Home Program (H2H)	Oversee hospital operations after hours and on weekends to provide support for leaders on call and front-line staff	Oversees daily operations, staffing, managing resources (47 bed capacity)
RESPONSIBILITY						
Participate in Capacity Management Rounds to allocate beds, track inpatients, coordinate with units and external hospitals, arrange non-urgent transportation and patient repatriation, and manage care transitions following death	Send daily Morning Occupancy Report to the organization and external stakeholders Capacity Management Rounds (am and pm): Collaborative assessment of occupancy, prioritization of patient movements, identification of bottlenecks, and coordination of discharges, transfers, waitlist patients, and repatriations	Support efficient patient transitions to and from the unit, early identification and resolution of discharge barriers, collaboration with interdisciplinary teams to optimize patient care and support ALC reduction strategies	Plan and oversee complex discharges for ALC patients, coordinate with community partners and interdisciplinary teams using the Home First Philosophy, track and communicate bed offers to inpatient units, maintaining transparency with all stakeholders	Ensures the timely identification and enrollment of eligible patients in the H2H program, enabling seamless coordination between hospital and community services to support safe transitions home while reducing the risk of deconditioning, frequent ED visits, and readmissions	Manage patient care activities and support efficient flow, resource allocation, and address hospital-wide issues and challenges (clinical and non-clinical)	Manages daily operations for ALC-designated patients awaiting LTC, coordinating allied health services and ensuring quality patient care to support efficient, effective facility operations
AVAILABILITY						
24/7 coverage	7 days per week, 7am-7pm	Monday–Friday 8am – 4pm	Monday–Friday 8am – 4pm	M-F 8am-4pm	7 days per week, after hours and weekends	Monday–Friday 8am – 4pm

GERIATRIC EMERGENCY MANAGEMENT NURSE PRACTITIONER STANDARD WORK – LAKERIDGE HEALTH

Geriatric Emergency Management Nurse Practitioner
Standard Work

Revision Date:	**September 10th, 2024**	Document Owner:	**Emergency Department**

Purpose: The Geriatric Emergency Management (GEM) service provides geriatric focused assessment with the goal of preventing unnecessary hospital admission.
It is within the NP scope of practice to:

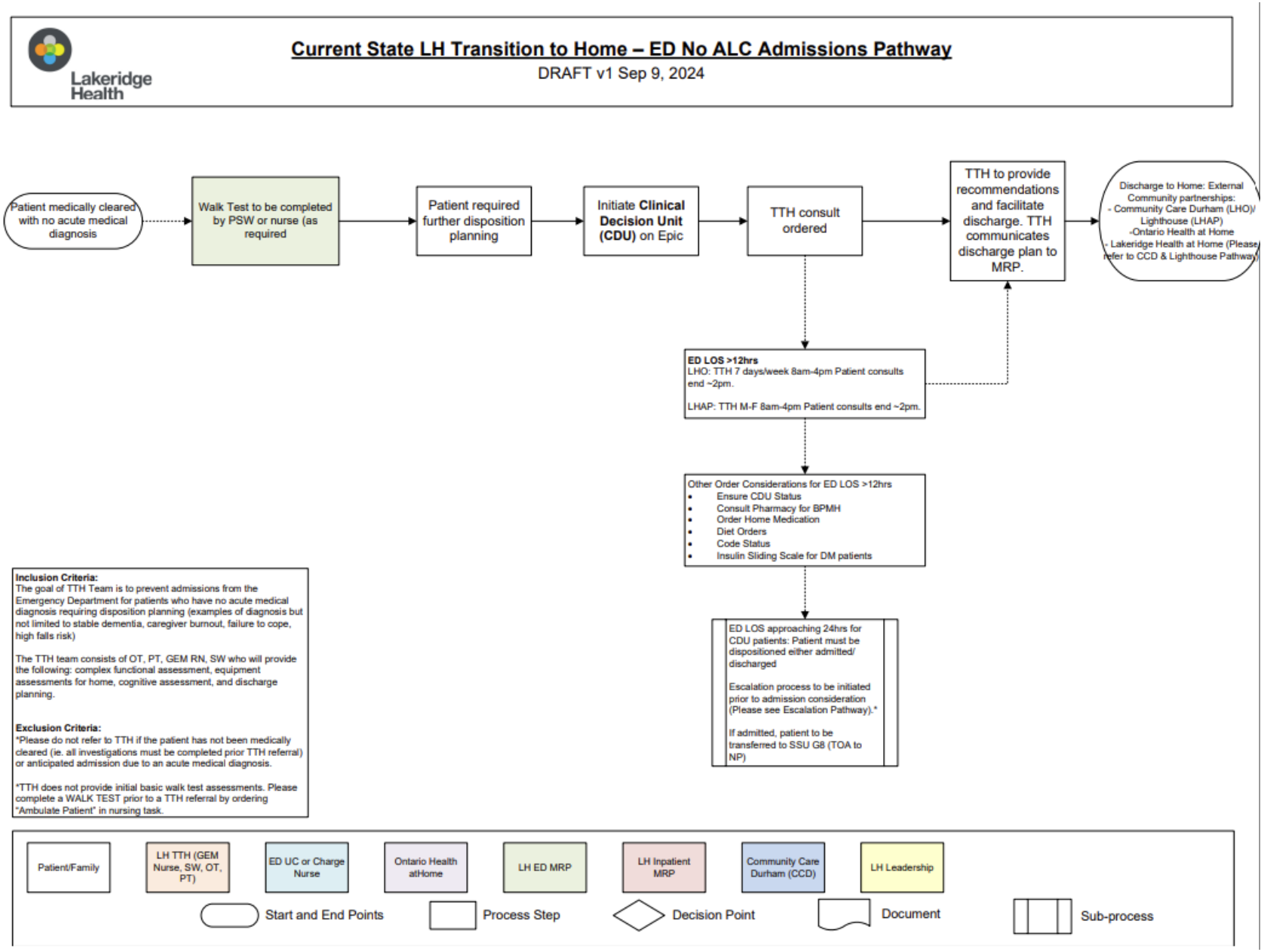
- Perform history-taking and a comprehensive physical exam
- Formulate and communicate diagnoses
- Develop and document plan of care
- Order/interpret diagnostic tests
- Prescribe medications and treatments

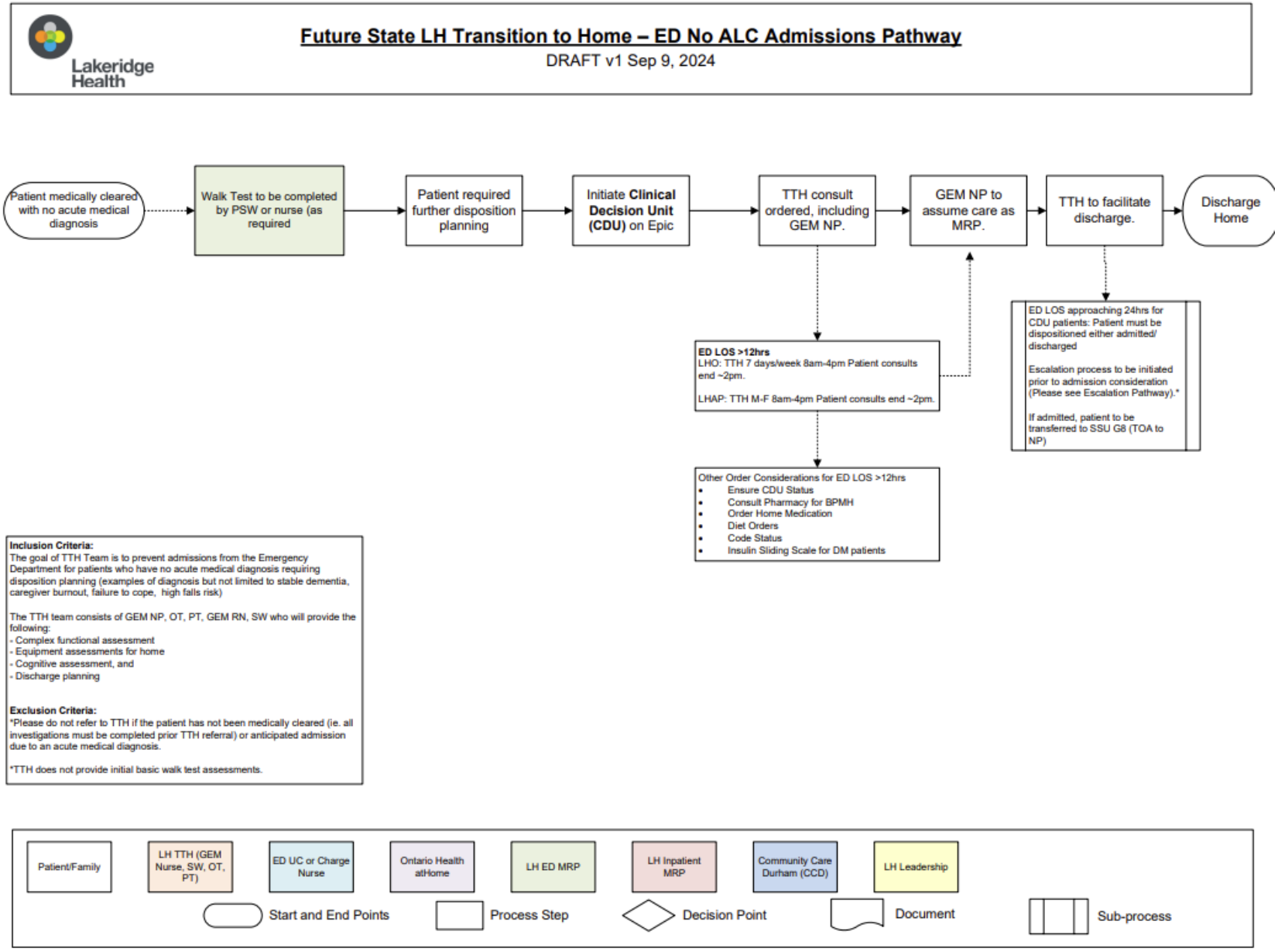
Standardized Process	
1	Patient Population for GEM NP Consults: Frail elderly (> 65 years old) ED non- admitted patients with one or more of the following challenges: 1. Cognitive changes / History of cognitive impairment 2. Falls or impaired mobility 3. ED use in previous month or hospitalization in previous 3 months 4. Polypharmacy (5 or more medications) 5. Decrease in overall function 6. Malnutrition / weight loss 7. Caregiver strain; Lives alone / no caregiver 8. Pain 9. Incontinence
2	GEM NP Expectation Consultive and/or MRP role for medically stable frail elderly ED patients to optimize quality of life and functional ability and prevent hospitalization and readmissions. Improve communication and transitions in care by: 10. To assume care as MRP over CDU patients waiting for TTH assessment. 11. To be clinical lead and point of contact for TTH consults 12. Liasing with MD, nursing and interprofessional team to optimize outcomes for ED elderly patients in a consultive role. 13. Working with community services and primary care providers to keep seniors safe in the community
2	Daily Duties Collaborate with the ED team and TTH Team in identifying those patients who meet GEM criteria for further geriatric nursing assessment. NP will work within scope of practice to: 14. Perform history-taking and a comprehensive physical exam 15. Formulate and communicate diagnoses 16. Develop and document plan of care 17. Order / interpret diagnostic tests 18. Prescribe medications and treatments 19. Order consultation / referral to allied-health professionals with the goal of facilitating earlier discharge and preventing admissions.

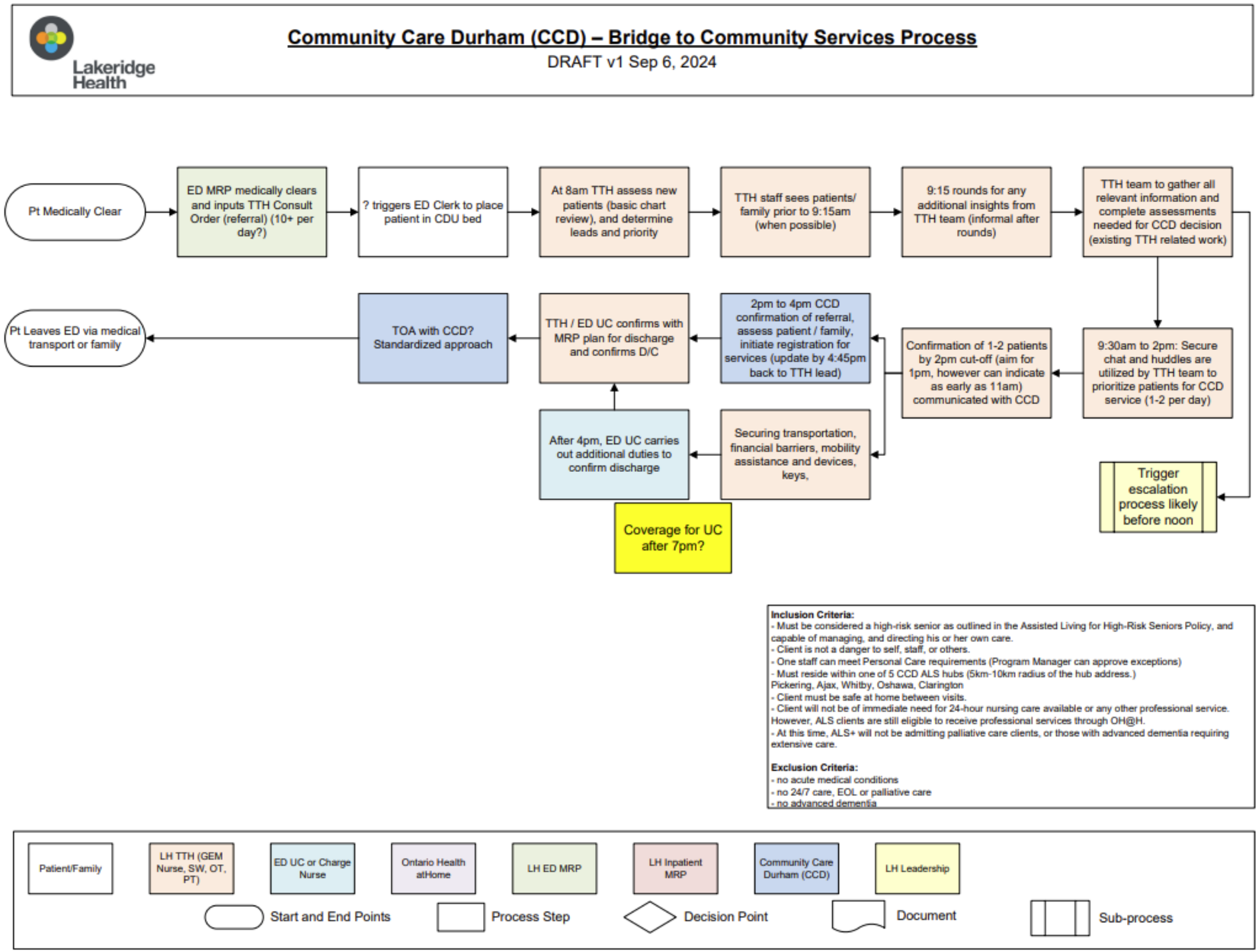
	Additional Responsibilities 20. Conduct virtual follow ups on ED patients who were seen during off hours and met GEM criteria 21. Support best practices related to transitional care 22. Collaborate with MD, nursing and interprofessional team in ED 23. Provide patient and family education and updates 24. Non-clinical duties include policy development, education and capacity building on geriatric best practices
3	Hours of Operation TBD
4	How to send referrals TBD- working on GEM NP EPIC builds with regional Off Hours-

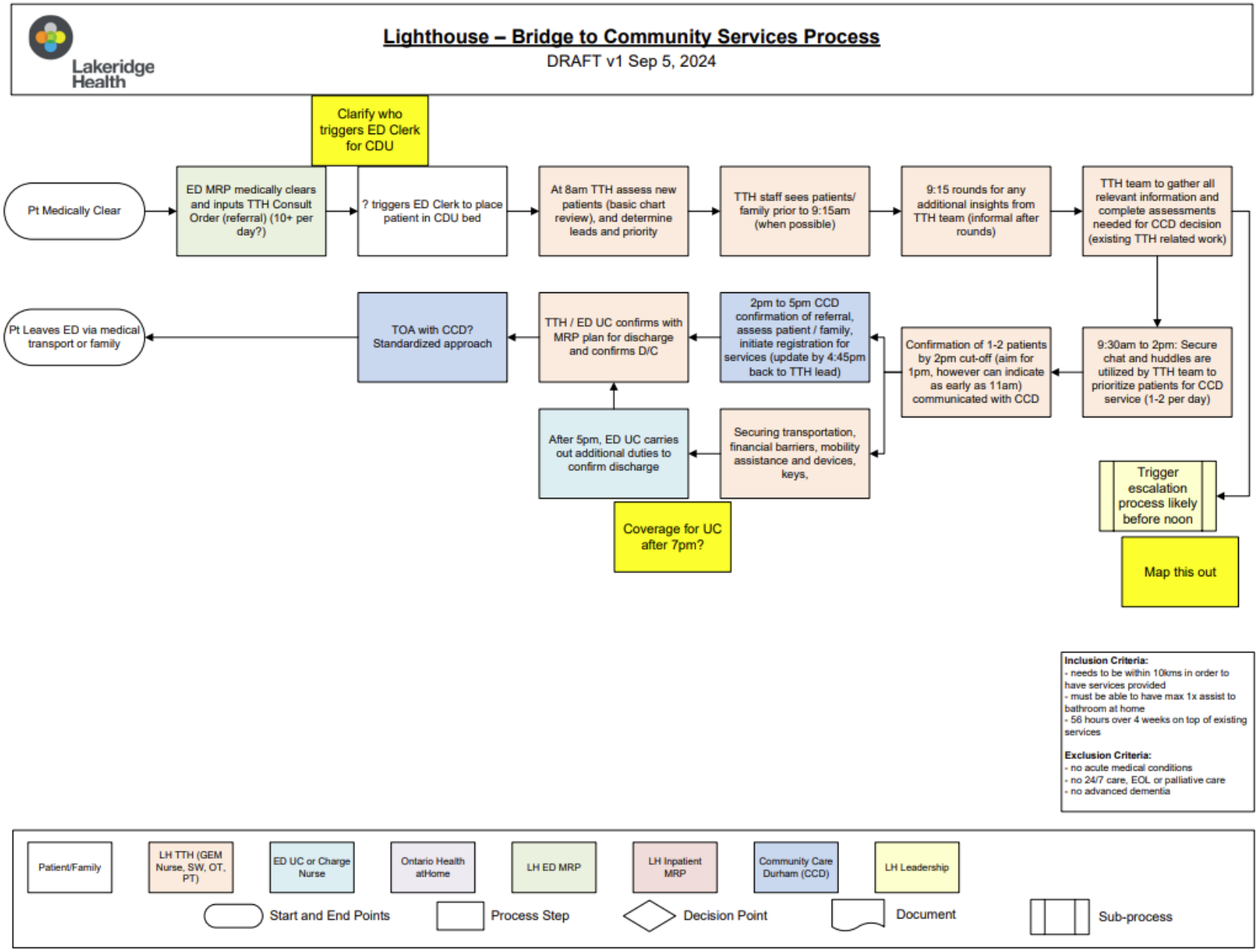
Other Notes:

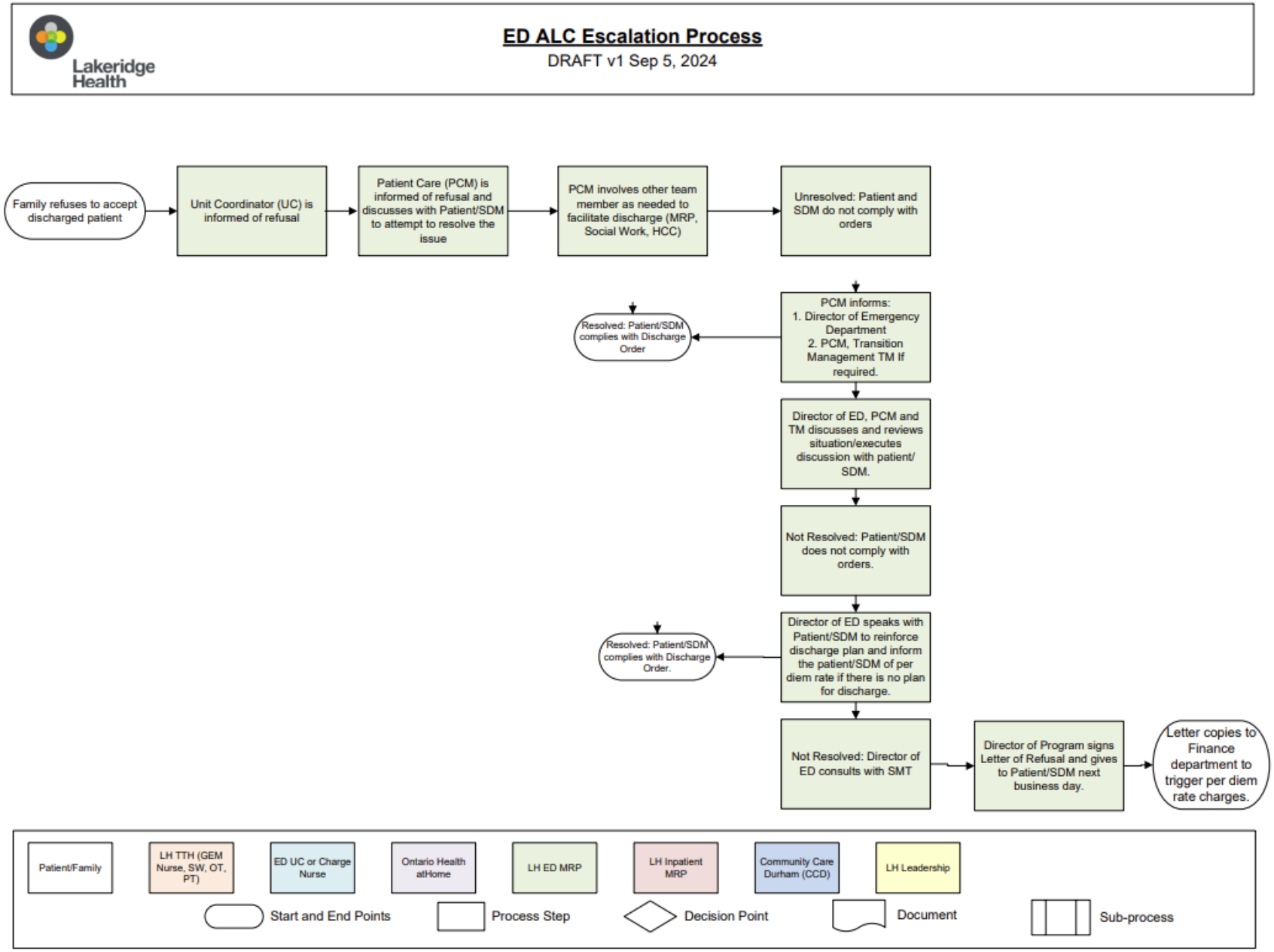
TRANSITION TO HOME PATHWAY – LAKERIDGE HEALTH




Lakeridge Health
Future State LH Transition to Home – ED No ALC Admissions Pathway
DRAFT v1 Sep 9, 2024
Patient medically cleared with no acute medical diagnosis
Walk Test to be completed by PSW or nurse (as required
Patient required further disposition planning
Initiate Clinical Decision Unit (CDU) on Epic
TTH consult ordered, including GEM NP.
GEM NP to assume care as MRP.
TTH to facilitate discharge.
Discharge Home
ED LOS >12hrs
LHO: TTH 7 days/week 8am-4pm Patient consults end ~2pm.
LHAP: TTH M-F 8am-4pm Patient consults end ~2pm.
ED LOS approaching 24hrs for CDU patients: Patient must be dispositioned either admitted/ discharged
Escalation process to be initiated prior to admission consideration (Please see Escalation Pathway).*
If admitted, patient to be transferred to SSU G8 (TOA to NP)
Other Order Considerations for ED LOS >12hrs
Ensure CDU Status
Consult Pharmacy for BPMH
Order Home Medication
Diet Orders
Code Status
Insulin Sliding Scale for DM patients
Inclusion Criteria:
The goal of TTH Team is to prevent admissions from the Emergency Department for patients who have no acute medical diagnosis requiring disposition planning (examples of diagnosis but not limited to stable dementia, caregiver burnout, failure to cope, high falls risk)
The TTH team consists of GEM NP, OT, PT, GEM RN, SW who will provide the following:
- Complex functional assessment
- Equipment assessments for home
- Cognitive assessment, and
- Discharge planning
Exclusion Criteria:
*Please do not refer to TTH if the patient has not been medically cleared (ie. all investigations must be completed prior TTH referral) or anticipated admission due to an acute medical diagnosis.
*TTH does not provide initial basic walk test assessments.
Patient/Family
LH TTH (GEM Nurse, SW, OT, PT)
ED UC or Charge Nurse
Ontario Health atHome
LH ED MRP
LH Inpatient MRP
Community Care Durham (CCD)
LH Leadership
Start and End Points
Process Step
Decision Point
Document
Sub-process


Lakeridge Health
Community Care Durham (CCD) – Bridge to Community Services Process
DRAFT v1 Sep 6, 2024
Pt Medically Clear
ED MRP medically clears and inputs TTH Consult Order (referral) (10+ per day?)
? triggers ED Clerk to place patient in CDU bed
At 8am TTH assess new patients (basic chart review), and determine leads and priority
TTH staff sees patients/ family prior to 9:15am (when possible)
9:15 rounds for any additional insights from TTH team (informal after rounds)
TTH team to gather all relevant information and complete assessments needed for CCD decision (existing TTH related work)
9:30am to 2pm: Secure chat and huddles are utilized by TTH team to prioritize patients for CCD service (1-2 per day)
Confirmation of 1-2 patients by 2pm cut-off (aim for 1pm, however can indicate as early as 11am) communicated with CCD
2pm to 4pm CCD confirmation of referral, assess patient / family, initiate registration for services (update by 4:45pm back to TTH lead)
Securing transportation, financial barriers, mobility assistance and devices, keys,
After 4pm, ED UC carries out additional duties to confirm discharge
TTH / ED UC confirms with MRP plan for discharge and confirms D/C
TOA with CCD? Standardized approach
Pt Leaves ED via medical transport or family
Trigger escalation process likely before noon
Coverage for UC after 7pm?
Inclusion Criteria:
- Must be considered a high-risk senior as outlined in the Assisted Living for High-Risk Seniors Policy, and capable of managing, and directing his or her own care.
- Client is not a danger to self, staff, or others.
- One staff can meet Personal Care requirements (Program Manager can approve exceptions)
- Must reside within one of 5 CCD ALS hubs (5km-10km radius of the hub address.)
Pickering, Ajax, Whitby, Oshawa, Clarington
- Client must be safe at home between visits.
- Client will not be of immediate need for 24-hour nursing care available or any other professional service. However, ALS clients are still eligible to receive professional services through OH@H.
- At this time, ALS+ will not be admitting palliative care clients, or those with advanced dementia requiring extensive care.
Exclusion Criteria:
- no acute medical conditions
- no 24/7 care, EOL or palliative care
- no advanced dementia
Patient/Family
LH TTH (GEM Nurse, SW, OT, PT)
ED UC or Charge Nurse
Ontario Health atHome
LH ED MRP
LH Inpatient MRP
Community Care Durham (CCD)
LH Leadership
Start and End Points
Process Step
Decision Point
Document
Sub-process


Lakeridge Health
Lighthouse – Bridge to Community Services Process
DRAFT v1 Sep 5, 2024
Clarify who triggers ED Clerk for CDU
Pt Medically Clear
ED MRP medically clears and inputs TTH Consult Order (referral) (10+ per day?)
? triggers ED Clerk to place patient in CDU bed
At 8am TTH assess new patients (basic chart review), and determine leads and priority
TTH staff sees patients/ family prior to 9:15am (when possible)
9:15 rounds for any additional insights from TTH team (informal after rounds)
TTH team to gather all relevant information and complete assessments needed for CCD decision (existing TTH related work)
9:30am to 2pm: Secure chat and huddles are utilized by TTH team to prioritize patients for CCD service (1-2 per day)
Confirmation of 1-2 patients by 2pm cut-off (aim for 1pm, however can indicate as early as 11am) communicated with CCD
2pm to 5pm CCD confirmation of referral, assess patient / family, initiate registration for services (update by 4:45pm back to TTH lead)
Securing transportation, financial barriers, mobility assistance and devices, keys,
After 5pm, ED UC carries out additional duties to confirm discharge
Coverage for UC after 7pm?
TTH / ED UC confirms with MRP plan for discharge and confirms D/C
TOA with CCD? Standardized approach
Pt Leaves ED via medical transport or family
Trigger escalation process likely before noon
Map this out
Inclusion Criteria:
- needs to be within 10kms in order to have services provided
- must be able to have max 1x assist to bathroom at home
- 56 hours over 4 weeks on top of existing services
Exclusion Criteria:
- no acute medical conditions
- no 24/7 care, EOL or palliative care
- no advanced dementia
Patient/Family
LH TTH (GEM Nurse, SW, OT, PT)
ED UC or Charge Nurse
Ontario Health atHome
LH ED MRP
LH Inpatient MRP
Community Care Durham (CCD)
LH Leadership
Start and End Points
Process Step
Decision Point
Document
Sub-process


Lakeridge Health
ED ALC Escalation Process
DRAFT v1 Sep 5, 2024
Family refuses to accept discharged patient
Unit Coordinator (UC) is informed of refusal
Patient Care (PCM) is informed of refusal and discusses with Patient/SDM to attempt to resolve the issue
PCM involves other team member as needed to facilitate discharge (MRP, Social Work, HCC)
Unresolved: Patient and SDM do not comply with orders
PCM informs:
1. Director of Emergency Department
2. PCM, Transition Management TM If required.
Resolved: Patient/SDM complies with Discharge Order
Director of ED, PCM and TM discusses and reviews situation/executes discussion with patient/ SDM.
Not Resolved: Patient/SDM does not comply with orders.
Director of ED speaks with Patient/SDM to reinforce discharge plan and inform the patient/SDM of per diem rate if there is no plan for discharge.
Resolved: Patient/SDM complies with Discharge Order.
Not Resolved: Director of ED consults with SMT
Director of Program signs Letter of Refusal and gives to Patient/SDM next business day.
Letter copies to Finance department to trigger per diem rate charges.
Patient/Family
LH TTH (GEM Nurse, SW, OT, PT)
ED UC or Charge Nurse
Ontario Health atHome
LH ED MRP
LH Inpatient MRP
Community Care Durham (CCD)
LH Leadership
Start and End Points
Process Step
Decision Point
Document
Sub-process

STATUS DASHBOARD – LAKERIDGE HEALTH

Zone 5 - Harnessing Data

Lakeridge Health

LHO ER "LIVE" STATUS DASHBOARD

Instructions: Edit the BLUE boxes ONLY
The rest will autocalculate

If zone 5 Status shows ANY RED discuss w UC/Charge to escalate
May still show green for bed status but Tx/admits/consults hits our trigger

Updated	16/10/2024
Time	2:00PM
By:	CHRIS

2	Monitored Beds (**DO NOT TOUCH** # here it auto calculates)
61	admits/consults
	Escalation Status
0:00	Escalation initiated at

Zone 5 Status	
Room Available	11
Intake Admits	1
Intake Consults	0
Intake Blocked	0
Tx Admit/Consults	11
Triggers	
9	>9
Alloted Beds	*12*
Longest stay	85:45

RESUS BAY Status	
Beds Available	1
Admits	3
Consults	0
Blocked	1
Triggers	
2	3>
Alloted Beds	*5*
Longest stay	28:23

ACUTE Status	
Beds Available	1
Admits	8
Consults	3
Blocked	2
Triggers	
4	4>
Alloted Beds	*14*
LONGEST STAY	50:01:00
Tele Ordered	2

EMS BAY Status	
Beds Available	1
Admits	0
Consults	0
Blocked	4
Triggers	
3	3>
Alloted Beds	*5*
Longest stay	23:21:00

Tx admit/consult = an Tx or admit in unconventional space - eg Tx lounge, 217, 203, 275,277/279-283(FAST TRACK TAB), INPROC (includes vol admits, crisis consults)

HERO AI – SICKKIDS

Hero AI: Your ED's AI Sidekick for Flow, Safety & Performance

Hero AI
TRANSFORM CARE. SAVE LIVES

Overview:
Hero AI is a clinical automation platform that acts as *your* **AI Sidekick**—working alongside your frontline teams to enhance patient safety, reduce wait-times, and decrease lengths of stay. First launched at SickKids Hospital, this system leverages real-time EHR data to identify issues *before* they escalate. It also automates routine clinical tasks *without adding* additional burden to staff or requiring an EHR overhaul.

What does your Sidekick do?
Think of it as a **digital team member** that understands *your* **specific workflows, working 24/7**, analyzing patient data in **real-time** to:

- **Accelerate Care** – Coordinate care to improve **quality**, **outcomes**, and **P4R metrics**
- **Automate Safety Monitoring** – Detects and flags high-risk patients in *real-time* to automate advocacy
- **Mobile Alerts for Clinicians** – Secure, trackable, high-precision alerts drive timely care
- **Patient Messaging & Wait-Time Tools** – Keep patients informed & reduce staff interruptions through a secure patient-facing mobile app
- **AI-Driven Dashboards** – Visualize bottlenecks at the patient, department, or even hospital network level & provide recommendations in real-time to improve flow, including patient movement and resource allocation

Sidekicks **add capacity**, reduces cognitive load, and improves care—especially during surge conditions.

Real-World Impact at SickKids:
Hero AI supports real-time clinical decisions and resource coordination with *measurable results* including:

- **Improved P4R metrics** for targeted patients, including length of stay, PIA, and LWBS
  - **60 min reduction in PIA** for high-risk patients (e.g. oncology, cardiac, transplant, etc.)
  - Automated Psychiatry consults from triage:
    - **60-120 min** reduction in LOS per acute mental health patient
    - **55% reduction** in time to consultation
  - Testicular torsion detection:
    - **104 min** reduction in PIA
    - **30% reduction** in time to US
- 5,000+ provider sessions in Beacon app in 2024, up to **97% acknowledgment rate** for significant alerts
- **1,800+** patient research candidates identified through automated screening workflows

Responsible AI, Privacy:
Hero AI adheres to **industry-leading standards** in data governance, cybersecurity, and privacy. All data is encrypted in transit and at rest, with role-based and field level access controls and audit logs.

Hospital-Owned Models:
To enhance customization, hospitals can also build their **own machine learning models** in collaboration with Hero AI using real-time clinical data. All models trained on hospital data are **100% hospital-owned** even if Hero AI builds them for you, with an option to license them back through Hero AI for scale-up and commercialization.

Reach out today to learn more about how Hero AI can collaborate with your ED.

WWW.HEROAI.CA DEVIN@HEROAI.CA

Humber River Health

Manual	Emergency Services Manual	GUIDELINE
Section		
Author	MANAGER, EMERGENCY SERVICES	
Approved by	**PROGRAM DIRECTOR, EMERGENCY SERVICES**	
Date	O: 09/05/2023	**Version Number:** 4
	R: 09/05/2023	**Reference #:** 9286
This is a CONTROLLED document. Any documents appearing in PAPER FORM should be checked against the electronic document in Policy & Procedure Manager (PPM).		

EMERGENCY DEPARTMENT SURGE PLAN FOR MENTAL HEALTH PATIENTS

Guideline Statement

Patients arriving to the Emergency Department (ED) who have a primary mental health disorder and who are experiencing psychiatric symptoms or are in a crisis will be managed in a collaborative manner by the crisis and emergency staff, Nursing Resource Team, emergency physician, psychiatrist, and security.

Emergency Psychiatric Unit (EPU) is the first choice for patients with mental health disorders and patient flow to EPU should be facilitated by both Mental Health and Emergency Services.

Surge capacity management incorporates standardized guidelines to manage surges. Access to mental health services cannot be ensured if patient volumes exceed the mental health bed capacity in both EPU and mental health in-patient units. This surge plan will ensure mental health patients will gain access to safe and timely meatal health services when they need it.

This guideline outlines the processes to efficiently manage and support the mental health patient's safety and throughput in the ED. The ED Manager/Patient Flow Manager (PFM) and ED Resource Person (RP) in collaboration will identify the need to initiate this surge plan by utilizing the ED CDU space.

Guideline

Inclusion Criteria

- Patients on a Form 1
- Mental health patients does not meet any of the exclusion criteria

Exclusion Criteria

- Patients with a history of violent behaviours or threatening violence towards others
- Patients with unpredictable response to substance and alcohol withdrawal with risk of agitation, seizures, delirium tremens
- Patients that present with active suicidality with current intent/plan identified
  - Active suicidality – attempt to or expressing intent to act on urges while in hospital
- Patients who are exhibiting exit seeking behaviours
- Patients under restraints

Guideline

1. The ED Manager/PFM and ED RP, in collaboration will identify when mental health patient volumes exceed the mental health bed capacity and are impacting ED patient flow. The mental health surge plan can be initiated when (a) there are fifteen or more admitted mental health patients waiting in the ED and EPU, or (b) at the ED Manager/PFM's discretion.

2. ED Manager/PFM will initiate the *Emergency Department Surge Plan for Mental Health Patient*.

3. ED Manager/PFM or delegates will ensure an appropriate staffing level is available to meet the needs the surge plan (*see Human Resource section below*).

4. ED Manager/PFM or delegates will notify ED Unit Aid and/or house keeping staff to ensure the CDU area is ready to be used.

5. In collaboration with patient's primary nurses and ED Psychiatric Nurse (1000 to 2200 hours), ED Manager/PFM and/or RP will identify the appropriate patients to be transferred to the CDU area based on the inclusion and exclusion criteria.

6. ED Manager/PFM or RP will advise both the patient's primary nurse and receiving nurse to complete the transfer of accountability (TOA).

7. Receiving nurse will complete a safety assessment of the room to ensure there are no items that can be used to harm themselves or anyone else.

8. ED Manager/PFM or RP will advise ED Unit Aide to transfer the identified patient to the CDU area.

Human Resource

The goal of this surge plan is to utilize six CDU rooms at once for six appropriate mental health patients. Hence, the following staffing resources are necessary to ensure safety of patients and staff.

- Two ED Registered Nurse (RN), OR one ED RN and one Mental Health RN
- One Security Guard

For break coverage, the ED nurses assigned to the six mental health surge patients will provide coverage for one another, with security present at all times. Upon assessment of assigned RNs in CDU if two ED nurses are needed at all times, the ED nurses will escalate to PFM to assign a nurse from existing staff compliment to cover breaks.

Logistical Resources

- The following CDU rooms will be utilized to execute this surge plan: OZ room 28, 29, 30, 31, 32, and 33.
- The equipment and supplies in room should be removed from the room to ensure the safety of mental health patients. This include, but not limited to monitor cables, suction and oxygen tubing, bedside server, and any potentially hazardous materials.

- TAT room door and the CDU area entrance door should be closed at all times.

Special Consideration

- The receiving nurses will continue to follow the ED Standard of Care when providing nursing care.
- Should the condition of a patient change, the ED Team Leader/Manager/PFM should be notified and to discuss the plan of care, which may involve transferring the patient to an appropriate ED care location.
- If a patient starts to demonstrate violent and/or homicidal behaviours, the primary nurse should continue to follow the Code White procedure to ensure the safety of self and others.
- For remaining patients with a primary mental health disorder in sub acute, the ED Resource Person will assign all mental health patient to one assignment when possible to facilitate patient monitoring and observation.

Accountability / Responsibility

Refer to the guideline

Infection Prevention and Control Considerations

All patients will be cared for using Infection Prevention and Control Routine Practices and Additional Precautions as outlined in **Provincial Infectious Diseases Advisory Committee (PIDAC):** Routine Practices and Additional Precautions, Ministry of Health and Long-term Care, as per HRH policy. All staff will perform Hand Hygiene as per HRH guideline.

References

Accreditation Standard/Criteria:

Lakeridge Health Oshawa Emergency Internal Surge Guidelines

Additional 5-10 Surge Beds

** To be initiated if Admits >45 and it is expected that floor are also Surge to 2 or 3 beds each.
(If Unsure please call Operational Supervisor.)

** As soon as this protocol is activated please call OPS Supervisor and communicate to ED Manager, ED Supervisor and LHO ED chief via Email or Phone call.

Please keep the protected zones *(Zone 5 Intake and Ems bay) as NO Admit zones***.

**Also consider Up- staffing request to support department needs. (OT may be approved by ED PCM)

This process ensures a structured and efficient allocation of resources while prioritizing the treatment and transfer of patients awaiting disposition.

Summary flow:

1. **Zone 2-** Open 2 Surge beds as needed
2. **Zone 3-** Open 3 Surge beds as needed
3. **DI Runway-** Reserved for patients with pending disposition (up to 5 beds)

The internal surge process for patient allocation and bed management, based on the provided details, would unfold as follows:

1. **Zone 2 Surge activation (+2 beds).**
   - 2 beds on Zone 2: Once all the mitigation strategies are followed and admits remain at >45.

2. **Zone 3 Surge activation (+3 beds).**
   - 3 hallway Beds: if additional; capacity is needed, Zone 3 will open 3 hallway beds (Window A-2, B-2, B-3 hallways)

3. **DI Runway Management (Pending Disposition). (up to 5 Beds)**

   **Call 34199 communicate to Diagnostic tech Runway will be utilize.

   - If this area needed to be open, relocation of evening nurse from zone 5 or the third trauma Nurse should be utilized. **this could be change depending on the department needs and patient acuity.

   - The DI Runway is reserved for patients who are waiting/ pending disposition:
     - Admitted STABLE patients with assigned beds.
     - Discharge patients who have confirmed pick- ups times.
     - Exception as Follows:
       - Isolated patients and patients with continuous Oxygen Therapy.
       - Violent patients (Form 1)
       - UNSTABLE patients

On-Call MD Triggers for LHO ED:

The On-Call MD in the Emergency Department is responsible for coming in when called to support patient flow and care. Key triggers for activation include:

1. **Extended Wait Times:** If the wait time exceeds 3-4 hours or there are more than 30 to 40 patients waiting for a provider.

2. **High Acuity:** If there are more than 3 CTAS Level 1 patients (critical cases) that need to be seen within 90 minutes, the Charge RN may consider calling the On-Call MD.

Responsibilities of the Charge RN:

- The Charge RN must communicate with the doctors on shift to determine if the On-Call MD needs to be called in.
- If the MD on shift is confident that the acuity and volume will be resolved within 30-60 mins; it is fair to not call the On-call MD. Situation can be reassessed in 30-60 mins.
- It is also the Charge RN's responsibility to ensure adequate staff support is available for the On-Call MD once activated.
- **__POD lead__ should accommodate and reserve at least 2-3 assessment rooms for the On-call MD.

In these situations, the On-Call MD is expected to assist with patient assessments, treatment, and overall management to ensure timely care.

Zone 5 (Intake/ Treatment) with Super-track (3 MD on shift)

	Rooms	Nurse
ER MD 1	202, 204, 206, 208	Intake Nurse 1
ER MD 2	210, 212, 267, 269	Intake Nurse 2
ER MD 3	ST Rooms	ST Nurse
	263, 265	Overflow/ Consult

Zone 5 (Intake/ Treatment) with Super-track (3 MD on shift + On-CALL)

	Rooms	Nurse
ER MD 1	202, 204, 206,	Intake Nurse 1
ER MD 2	208, 210, 212	Intake Nurse 2
ER MD 3	265, 267, 269	Float Nurse/ Evening Intake
ER MD 4	ST Rooms	ST Nurse
	263	Overflow/ Consult

Zone 5 (Intake/ Treatment) with Super-track (3 MD + On-CALL + Casino MD)

** ST can be utilized and continued to be open through-out the night as long as there is MD and Staff to support ST.

	Rooms	Nurse
ER MD 1	206, 208	Intake Nurse 1
ER MD 2	210, 212	Intake Nurse 2
ER MD 3	204, 267, 269	Float Nurse/ Evening Intake
ER MD 4	ST Rooms	ST Nurse
Casino MD	202, 263, 265	Casino Nurse (N12)
		Overflow/ Consult

ESCALATION AND CODE GRIDLOCK – LONDON HEALTH SCIENCES CENTRE

CORPORATE

Procedure	Escalation and Code Gridlock		
Owner:	VP Cancer, Renal, Mental Health and Patient Flow		
Endorsed By:	VP Cancer, Renal, Mental Health and Patient Flow ELC	**Endorsement Date:**	2024-12-12 2024-11-26
Original Effective Date:	2018-09-20	**Reviewed Date:**	2024-11-22
Corporate Associated Policy/Procedure	Internal Admissions & Transfers, Bed Capacity Management		
Key Search Words:	Regional Restrict, Code Gridlock, Escalation Levels		

PURPOSE

The purpose of this procedure is to ensure that during times when occupancy exceeds normal state there are clear accountabilities regarding processes and resources to optimize patient flow. London Health Sciences Centre (LHSC) is committed to ensuring the safety of patients through timely access to inpatient care. This procedure is in accordance with Accreditation Canada Required Organizational Practices – Client Flow. This procedure has four components: Initiation of Escalation, Triggers, Actions and Bed/Patient Assignment Protocols

AUDIENCE

This procedure applies to all clinical and non-clinical hospital staff and affiliates (including those working on site or remotely) 24 hours a day, 7 days per week.

PROCEDURE

1. **Initiation of Escalation**
   1.1. Upon the direction of the Vice President – Patient Flow, the escalation actions will be used proactively with lower capacity thresholds if there are anticipated surges in volumes (i.e., Homecoming, St. Patrick's Day) or significant staffing concerns.

   1.2. The Director, Patient Access and Flow, or delegate, will continuously assess and determine if the triggers for Escalation Level 1 or 2 are met. If so, the Actions and Communication (see Appendix A) are put into effect.

   1.3. Code Gridlock
      1.3.1. During regular business hours (0800 – 1600) Monday through Friday, excluding weekends and statutory holidays, the Vice President – Patient Flow or delegate will declare the implementation of Code Gridlock. See Appendix A for Accountabilities and Communication Plan.
      1.3.2. When Code Gridlock is declared, the Capacity Manager(s) will initiate the Situation-Background-Assessment-Recommendation (SBAR) (Appendix D) and send this to the Director Patient Access and Flow.
      1.3.3. During regular business hours (0800 – 1600), the Vice President – Patient Flow will convene an emergency conference (in person or virtual) with the following individuals to implement the Code Gridlock Protocol: Physician Department Heads and Site Chiefs - Medicine, Surgery, Critical Care, Emergency Department (ED) and Mental Health, all Clinical Directors inclusive of Health Disciplines, Director – Support Services, Corporate Communications, Director – IPAC, Director – Patient Access and Flow and Capacity Managers – Patient Access and Flow. Outside of regular

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business hours, on weekends and statutory holidays, a Code Gridlock will be declared by the Executive on Call (EOC). The decision to declare Code Gridlock will be guided by the triggers and any additional factors deemed relevant.

2. **Escalation Triggers**

2.1. The Director, Access & Flow or delegate will use the following assessment tool to guide determination of the Escalation Level at any point in time. If the Escalation threshold exceeds Level 2, the Vice President – Patient Flow (or delegate) will be immediately notified.

2.2. The Occupancy Trigger is calculated based on a site's overall performance against budget. Any program that is running over budget should be taking action to return to budget levels. The Level 1 and 2 Census are primary drivers of flow.

Occupancy Projection = (Current Census + Patients In – Patients Out) / Total # of Beds

Patients In = Scheduled OR's, ICU Decants, ED admitted Patients, Known Direct Admits
Patients Out = Discharges, Confirmed Transfers with Transportation booked

Escalation Trigger (ADULTS)	**1 Point**	**2 Point**	**3 Point**
Occupancy Projection	95-100%	100.1-104%	>104%
# of ED beds blocked by admissions and/or consults *	35%	50%	65%
Resuscitation / Trauma Beds avail	2	1	0
Ambulance off load	2, each with > 30 mins delay **and** EMS reporting Code Normal	2, each with >1 hour delay, **or** EMS reporting Code Critical	>2, **or** EMS reporting code Zero
Canadian Triage and Acuity Scale (CTAS) 2's in ED waiting room	≤5, with at least 2 waiting less than 1 hour	>5, with at least 2 waiting greater than 2 hours	>5, with at least 1 waiting greater than 3 hours
Critical Care Level 3 Occupancy	>70%	>85%	100% or greater **or** patient acuity ratio to staffing levels are maximized
Inpatient Bed Availability as per Capacity Management	Full, with no ability to assign ED admissions or transfers from Critical Care or PACU.	Full and all unconventional spaces are utilized with no ability to assign ED admissions or transfers from Critical Care or PACU.	Unable to staff unconventional locations for more than 12 hours.
Patient to Nurse Ratio in PACU	x	x	>2:1
PACU Beds Occupied by Overnighters	1-2	3-4	≥5

***Ensure any ED assessment spot closures are reflected in the denominator of this calculation**

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Individual or Combined Site Status	Site Escalation Level Thresholds (Sum of all Triggers)
Escalation Level 1	2-4
Escalation Level 2	5-8
Code Gridlock	9 or more

Escalation Trigger (PEDIATRICS)	Escalation Level 1	Escalation Level 2	Code Gridlock
	B6 at 85% capacity, or PCCU >70% (>8 patients), or CED>50% of beds available for turnover and flow AND <4 admit-to-no-bed in ED and >12 in Waiting Room, or any (4) patients awaiting transfer to or within CH. or >5 SDAs or >1 post-op to PCCU	B6 at 90% capacity, and PCCU >70% (>8 patients), CED 5-7 beds available for turnover Staffing constraints 10-25% AND <5 admit-to-no-bed in ED>4hrs and No capacity for CTAS 2 to be placed, >20 in Waiting room, Wait time > 4 hr. transfer to or within CH, or >5 SDAs or >1 post-op to PCCU The total number of patients requiring beds is equal to or greater than the number of expected discharges.	B6 at 100% capacity, and PCCU >80% (>=10 patients), CED at 100% plus ED diversion, trauma, and hallway chairs at capacity Staffing shortages >25% AND >=8 admit-to-no-bed in ED>4 hrs., or any patients awaiting transfer to or within CH, or No capacity for CTAS 1 to be placed. Wait time CTAS 2 > 2 hrs. Wait time CTAS 3> 4 hrs. >5 SDAs or >1 post-op to PCCU

***Pediatric Leadership Consulted to determine priorities based on Escalation Level using Escalation Actions**

3. Escalation Actions

Escalation Level 1:	Escalation Level 2:	Code Gridlock:
• Team and Clinical Manager aware of needs / barriers required to confirm discharge. • Discharge limiting tests and treatment limiting tests escalated – email to Patient Flow Manager looking 48-72 hours out. • Patient Flow Manager to escalate to appropriate areas to prioritize testing and treatment hindering Patient Flow. • Teams at bullet rounds alerted of escalation status with plans to focus on discharges. • Urgent Care Centre referrals directed to site with most capacity to admit. • Consider load levelling patients to unaffected site. • Initiate Level 3 bed spacing for Level 2 shortages (See Appendix B). • Utilize all overflow beds in alignment with the Patient Cohorting Principles Protocol (See Appendix C). • Plan for staffing needs both in overflow spaces and potential hallways • Attend 1400 bed huddles.	• Review all external admissions/ transfers; hold admissions if feasible and required. • Escalate regional repatriation movement barriers to Ontario Health West Access and Flow Director. • PACU utilized for unplaced surgical admissions. Ensure staffing is secured for 24 hours. • Review scheduled activity requiring Same Day Admission for conversion to One Day Care for the next 48 hours. • Prioritize ED Surgical patients who may be a day surgery or short stay. • Community partners alerted to review ALC patients for transfer. • Flag to OHaH to expedite any discharges a day early. • Assess if additional Health Disciplines, Pharmacy, Capacity Managers, OHaH staff would be required.	• IMT meeting called. • Division Lead's to reach out to attending physicians to assist and escalate any treatment delays to expedite discharges. • Review ALC for decant to partners, ask to surge. • Cancel scheduled activity as needed and consider future cancellation. • Redirect Critical only if required.

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4. Patient Assignment Protocols
   4.1 Utilize Patient Cohorting Principles to guide patient placement.

Escalation Level 1		
Regional Programs	Surgical Floors	Medical Floors
L3 or L2 Cases in ED		
At least one patient transfer / unit before 1000 from ED or ICU (flow to prioritize)		
All Scheduled or emergent cases	All scheduled or emergent cases	Decant ED and ICU based on site need (flow to prioritize)
ICU / L2 Decant	ICU Decant / ED Admit No Bed (flow to prioritize)	Regional Admissions
Regional Admissions	Regional Admissions	
ED Admit No Bed		

Escalation Level 2		
Regional Programs	Surgical Floors	Medical Floors
L3 or L2 Cases in ED		
At least one patient transfers / unit before 1000 from ED or ICU (flow to prioritize)		
All Scheduled or emergent cases within capacity	1st and 2nd cases	Decant ED and ICU based on site need (flow to prioritize)
ICU / L2 Decant needed to accommodate OR's	ICU Decant	Regional Admissions
ICU decant / ED cases	On service ED Admit No Bed	
Regional Admissions	Remaining cases +	
Off-service ED patients if required	Regional Admissions	
	ED Admit No Bed – may be off-service patients	

Code Gridlock		
Regional Programs	Surgical Floors	Medical Floors
** Prioritization may be adjusted based on the needs of the system		
L3 or L2 Cases in ED		
At least one patient transfers / unit before 1000 from ED or ICU (flow to prioritize)		
All deceased donor (TX), 1st and 2nd cases	All 1st cases	Decant ED and ICU based on site need (flow to prioritize)
ICU / L2 Decant needed to accommodate OR's	ICU Decant	Regional Admissions
On-service ED Admit No Bed	On service ED Admit No Bed	
Living Donor (Tx), remaining cases	2nd cases	
Regional Admissions	Regional Admissions based on acuity	
	ED Admit No Bed	
	3rd cases +	

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DEFINITIONS

Affiliates – Individuals who are not employed by the organization but perform specific tasks at or for the organization, including:

- Credentialed Professional Staff with a hospital appointment (I.e., Physicians, Dentists, Midwives and Registered Nurses in the Extended Class who are appointed by the Board and who are granted specific privileges to practice medicine, dentistry, midwifery, or nursing, respectively.)
- Clinical Fellows
- Students
- Volunteers
- Contractors or contracted workers who may be members of a third-party contract or under direct contract with the organization.
- Individuals working at the organization but funded through an external source.

Regional Alerts – Notice to the Region that LHSC is experiencing capacity issues which impact on safe and effective patient care.

REFERENCES

Legislation
Accreditation Canada Required Organizational Practices – Client Flow

Corporate
Intra-Hospital Transfers
Patient Cohorting Principles

Other Resources
Regional Patient Access Pre-Alert Response Protocol
Critical Care Program Transferable Patient Flow Algorithms – Critical Care Trauma Centre, Medical/Surgical Intensive Care Unit, Cardiac Surgery Recovery Unit

APPENDICES

Appendix A – Escalation Accountabilities and Communication
Appendix B – Level 3 Bed Sharing
Appendix C – Unit Census and Overflow Spaces
Appendix D – Situation-Background-Assessment-Recommendation (SBAR)

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Humber River Health

Manual	Patient Care Manual, Command Centre , Emergency Services Manual	GUIDELINE
Section	Command Centre	
Author	MANAGER, PATIENT FLOW	
Approved by	PROGRAM DIRECTOR - MENTAL HEALTH PROGRAM	
Date	O: 03/11/2015	Version Number: 5
	R: 06/09/2023	Reference #: 6121
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BED MANAGEMENT SURGE ALERT - GUIDELINE

Guideline Statement

- To enable decision making and enact an action plan for the management of beds in a Surge situation.
- To outline a framework to guide a response to Bed Surge demand and capacity fluctuations within the organization; from Emergency Department (ED) to inpatient units.
- To maintain the principle of "No Wait ED" and minimize ambulance offload delays.

Guideline

Objective:

- Identify a flexible and scalable framework to ensure a timely and effective response to Bed Surge demand.
- Identify a shared understanding of surge and escalation responses, and its variability under Surge guidelines, across the Organization.
- Identify the sources from which a risk can occur.
- Identify the triggers for this action plan.
- Identify the role of all stakeholders involved in Surge Plan.
- Outlines a response to any Bed Surge demand and capacity fluctuations using Surge Guidelines.
- Outlines any added responsibilities for those roles where actions required differ from the everyday role expectations.
- Outlines an internal response to ensure the organization is able to effectively assist in maintaining patient care and safety.

Surge Guidelines

- All hospital beds are corporate resources.
- To facilitate capacity management.
- Decisions will be made within appropriate timescales and will support organizational needs.
- The clinical priority of patients will be the key determinant of when and where patients are placed.

- No action made will undermine or question the clinical judgment of practitioners but will signpost patients to appropriate less congested services, which can provide acceptable clinical alternatives.

Level	Criteria for Declaration	Activation Plan
Normal Operation	Awareness:	Actions:
	Organization level: • Bed Management policy is managing with patient flow. • Patient flow is been maintained. • Critical Care capacity is available. • Adequate beds available to maintain elective and no-elective activity. Emergency Department: • Stretchers available for admitted and not admitted patients. • Admitted Patient Length of Stay (LOS) in ED is less than 12.5 hours • Number of admitted patients in ED is less than 12.	• Monitor workload to identify any potential for escalation. • Continue Patient flow as per Bed Management Policy.
Minor Surge	Preparedness:	Actions:
	• Bed Management policy is assisting with patient flow but added intervention is needed to maintain flow. Emergency: • Target times are met but added intervention need it to maintain patient flow. • No stretcher capacity to respond to ED volumes. • EHA-ICU greater than 3 pts. • Increase number of consults • Number of admitted patient in ED is greater than 12. • Ambulance offload delays longer than 30mins or more than 5 pts. Organization Level: • No acute adult bed immediately available. • No inpatient beds available within a	Emergency: • ED PFM will explore options to facilitate flow to accommodate the department needs. • Collaborate with CPFM and discuss the courses of action. • ED PFM will collaborate with the On-call internist to reassess admitted patients that could be discharged, downgraded or followed up as outpatient. • ED PFM will collaborate with disciplines (PT, GEM, SW, and CCAC) to assist with discharge plans. • Diagnostic Imaging Tech (DI) to assist and prioritize ED cases to help facilitate discharges. CPFM: • Assess Hospital bed situation, send

PPPPG Print Date: 2/19/2024

	2-3h period.	surge report from Bed Meeting Tool • Will assess all units for bed capacity. Will use the Analytics Tiles data in Command Centre, CPOE, iPLAN to assess D/Cs. • Will liaise with Supervisor of Housekeeping to facilitate bed cleaning and patient transfer if/when bed becomes vacated. • Second bed meeting will take place at the discretion of CPFM or senior management. • Temporary increase of census will be considered for units waiting for discharges. Organization: • Critical Care will activate their Minor Surge plan. • All clinical programs will respond immediately to facilitate movement of admit/ no bed patients from ED by expediting patient discharge and transfer process as quickly as possible, including discontinuing telemetry and cardiac monitoring where appropriate. • Clinical expeditor will address any Delays in Care and facilitate early discharges
Moderate Surge	Activation:	Actions:
	Organization: • Bed Management policy is not able to manage current patient flow. • All actions outline for Minor Surge were unsuccessful, all budgeted bed are in use and several units has flex beds open. ED: • Volumes exceed capacity. • Offload delays are greater than 30 min or 5-10 patients.	ED: • ED PFM will reallocate available resources based on departmental needs (Staffing assignments, CDU etc.) • Hallway stretcher might be considered. CPFM: • In collaboration with EDPFM, the CPFM will notify senior leadership and Chief of medicine with a Surge

	• No Critical Care bed available. • Admitted patients may be placed in hallway stretchers if acuity permit. • Request for Consideration for Central Ambulance is imminent.	Alert Report from Bed meeting tool • Will develop and activate Surge Management plan • Units will be expected to surge up to their flex bed, staffing will be increased at the discretion of the manager or the PFM and in accordance with the acuity of the patient of the unit. • "Off service" placement of Medicine admitted patients in ED may be considered. (to Surgery, Gynecology) • If no other bed available Collaboration with Admin and Staffing Resources Office (SRO) to open Short Stay Unit for medical admissions (4 West). • Critical Care will escalate their Surge Plan. • Will facilitate second bed meeting.
Major Surge	**Interruption of service**	**Actions:**
	• Inability to provide safe patient care • Insufficient capacity despite all prior measures • All actions outline for Moderate Surge were unsuccessful or all unbudgeted capacity is been utilized.	If all attempts to relieve the situation continued to be unsuccessful: ED: • EDTL, EDPFM and ED manager during working hours, will determinate need to request consideration from Central Ambulance communication Centre for all CTAS level.(York and EMS) • If the decision is made, ED PFM/TL will communicate with Ambulance Communication Centre to confirm request for consideration. Organization: • All Program Directors and VP of clinical program will be informed and be involved in decision process.

PPPPG Print Date: 2/19/2024

		CPFM • In the situation of no beds available, reserve surgical beds will be utilized and cancelling of surgeries for next day may be considered. Cancelation will take place as per Surgical Beds Management guidelines. • Multiple bed meetings or teleconference will take place to maintain open communication. • Send Surge Alert Report

Recovery phase:

- For Normal Operations to be reestablished, the impact of capacity demand should no longer be a pressure on resource commitments. Consideration from Central Ambulance has been eliminated.
- There are 2 ways in which resources can recover:
  - **Immediate:** This is where the organization would immediately withdraw all resources from the response and resume normal business.
  - **Phased:** This is where the organization would withdraw resources from the response in a phased manner. The phasing will be assessed against the need for resources to still be providing a service until normal level is achieve. Send *Surge Status Update*

Accountability / Responsibility

As described in this document and attached guidelines.

Definitions

Surge Situation: When Humber River Hospital has limited bed capacity. When a program is unable to meet the demands for their beds and service despite efforts to discharge appropriate patients.

Normal Operation Business as usual.
Minor Surge - Some concern over capacity, service provision and waiting times within the ED.
Moderate Surge - Demand is causing severe pressures concerning capacity, service provision and waiting times within ED. One or more service area may be affected.

Documentation

None applicable.

Infection Prevention and Control Considerations

All patients will be cared for using Infection Prevention and Control Routine Practices and Additional Precautions as outlined in **Provincial Infectious Diseases Advisory Committee (PIDAC):** Routine Practices and Additional Precautions, Ministry of Health and Long-term Care, as per HRH policy. All staff will perform Hand Hygiene as per HRH guideline.

References

PATIENT FLOW ESCALATION PROTOCOL – SICKKIDS

Scope: Hospital-wide Patient Care
Document Type: Policy, Procedure
Approved on: 2024-07-16
Next Review Date: 2025-07-16

Patient Flow Escalation Protocol - Revised for use during the COVID-19 Pandemic

Version: 3

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Revision History - Patient Flow Escalation Protocol - Revised for use...

2.0 Escalation Protocol

Note: for a definition of terms please see section 3.0

2.1 Considerations to Trigger Escalation – Revised for Covid-19 Pandemic

Services/Programs	Pre-escalation (Normal state)	Escalation Level 1	Escalation Level 2	Escalation Level 3
Emergency Department	• ED Census during business hours ≤ 60patients • ED Census after business hours ≤70 patients • 2nd Longest PIA = 3 hours • Admitted patient exceeding the 4 hours bed wait = 0	• ED Census during business hours = 61 to 69 patients • ED Census after business hours = 71 to 81 patients • 2nd Longest PIA = 4 hours • Admitted patient exceeding the 4 hours bed wait = 1 to 2	• ED Census during business hours = 70 to 78 patients • ED Census after business hours = 82 to 92 patients • 2nd Longest PIA = 5 hours • Admitted patient exceeding the 4 hours bed wait = 3 to 4	• ED Census during business hours ≥79 patients • ED Census after business hours ≥ 93 patients • 2nd Longest PIA = 6 hours • Admitted patient exceeding the 4 hours bed wait >5
Critical Care	• Combined PICU/CCCU census <32 beds	• Combined PICU/CCCU census 32 to 37 beds	• Combined PICU/CCCU census 38 to 42 beds	• Combined PICU/CCCU census >42
Total Census	• ≤ 266	• 267 to 305	• 306 to 332	• ≥ 333
Acute Care Census	• ≤200	• 200 to 230	• 231 to 249	• ≥250
Critical Care Census (PICU + CCCU + NICU)	• ≤66	• 67 to 75	• 76 to 83	• ≥83
Critical Care Isolation Room Capacity	• <50% (6 rooms available)	• 58-75% (3 to 5 rooms available)	• 83% (2 rooms available)	• >92% (1 room available)
Inpatient Physical Bed Occupancy	• <68%	• 68 to 78%%	• 79 to 85%	• >85%
Inpatient/ED Nursing Absenteeism	• < 5% (approx. 10 calls/shift)	• 6 to 10% (approx. 10-20 calls/shift)	• 11 to 20% (approx. 20-35 calls/shift)	• > 20% (more than 35 calls/shift

2.2 Overview of Strategies to Be Implemented – Revised for Covid-19 Context

The following provides a high-level overview of strategies to be implemented within each escalation level for the Covid-19 context. Additional detail is provided in the next section.

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Trigger/ Response	Action/Response									
	Capacity Management					HR/Staffing Strategies		Enablers		
	Bed Management	Inter-hospital transfers and ALC	Discharge Planning	Defer/Re-schedule pre-planned activity	Space Optimization	Augmented Staffing Strategies	Team-Based Clinical Care Model	Redeployment Centre	Clinical Operations Command Centre	Communication
Pre-Escalation (Normal State)	Standard	Standard	Standard	No	Standard	Standard	No	No	No	Standard
Escalation Level 1				Plan/Prepare	Off-service + full capacity multi-bed room use	Boost with OT, contracted staff, relief staffing, reduce non-clinical time	Upskilling and preparation	No	No	Standard
Escalation Level 2	Escalated	Escalate + Non-tertiary and ALC from all catchments	Escalated	Minor/temporary ramp-down	Open surge spaces and off unit cohort	Boost + Redeploy from non-clinical activities	Unit Level Implementation, Prepare for full system implementation	Prepare for Activation	Prepare for Activation	Hospital wide
Escalation Level 3	Centralized Resource Allocation	Escalate + Out of region deferrals considered	Escalate + Regional Situational Awareness	Broad Ramp down	Non-standard patient care spaces	Boost teams with novel HR strategies	Implement system wide	Activate	Activate	Regional/ Provincial

Printable version: Overview of Strategies to Be Implemented – Revised for Covid-19 Context

2.1 Strategies to Be Implemented – Revised for Covid-19 Context

Strategies	Pre-escalation (Normal state)	Escalation Level 1	Escalation Level 2	Escalation Level 3
Bed Management	• Status update on Daily Safety Call • Clinical Managers, Director on Call and Bed Flow Coordinator meet at 9 am • Clinical Support Nurses/ In-Charge nurses from each unit meet with Clinical Manager-on-call/Clinical Administrator and bed flow coordinator at 1:15 pm • Local Program	As per Pre-escalation AND: • Clinical managers of impacted areas attend 1:15 pm meeting with teams and initiate/support local program and unit patient flow huddles as required	As per Escalation Level 1 AND: • Director-On-Call attends all bed management meetings • Consider additional meeting with one representative from each unit/program between 4-5 pm and as required until de-escalation achieved	• Clinical Operations Command Centre activated until plan executed and de-escalation achieved • Centralized resource allocation

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Strategies	Pre-escalation (Normal state)	Escalation Level 1	Escalation Level 2	Escalation Level 3
	and Unit patient flow huddles as per usual			
Interhospital transfers Align with: *"Guideline for Transfer of Patients from SickKids to Community Hospitals for Inpatient Care"*	• Transfers to community facilities considered as appropriate • Review "Daily Bed Board" sent by the TC LHIN that provides the transfer status of each community hospital and approximate number of beds available.	As per Pre-escalation AND: • Clinical support nurses/ In-charge nurses review all patients with medical team for potential discharge/ transfer status • Transitional care coordinators and unit leads link with community partners (community hospitals, TCLHIN Care Coordinators, HBKR) to facilitate transfers as needed	As per Escalation Level 1 AND: • Most Responsible Physicians notified of escalation level and asked to review all patients for potential discharge status • Refer to "Guideline for Transfer of Patients from SK to Community Hospitals for Inpatient Care" during Escalation Level 2 or higher • Consider transfer of all patients requiring non-tertiary level care regardless of catchment • All planned transfer activity reviewed by unit and physician leads for potential deferral • Manager/ Director engagement with community partners	• Consider deferral of transfer activity beyond GTA

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Strategies	Pre-escalation (Normal state)	Escalation Level 1	Escalation Level 2	Escalation Level 3
Discharge Planning	• Usual patient flow strategies are employed	• Usual patient flow strategies are employed	• If barriers to discharge, engage manager/director level to negotiate with discharge location	• Regional situational awareness
Defer/Reschedule pre-planned activity	• No	• Assess planned activity and plan/prepare if cancellation(s) are required	• Minor/temporary ramp-down of pre-planned activity • Refer to Perioperative/ Ambulatory ORRACLE Framework	• Broad ramp down of pre-planned activity (see role of Clinical Operations Command Centre below) • Refer to Perioperative/ Ambulatory ORRACLE Framework
Space Optimization	• Standard space optimization strategies are employed	• Off-service bed capacity and available staffing resources across hospital identified and prioritized • Full capacity multibed room use (see: *Non-critical Care Multibed Use Algorithm)* • Assessment of need to open up surge spaces	• Open surge spaces and off unit cohort	• Utilize non-standard patient care spaces (Consult with IPAC)
Augmented Staffing Strategies	• Standard staffing strategies are employed • Utilize unit and program level strategies to address staffing pressures: see	As per Pre-escalation AND: • Boost with OT, contracted staff, relief staff, reduce non-clinical time • RN staffing is assessed to plan	As per Escalation 1 and: • Redeploy from non-clinical activities	As per Escalation 2 and: • Boost teams with novel HR strategies

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Strategies	Pre-escalation (Normal state)	Escalation Level 1	Escalation Level 2	Escalation Level 3
	unit *Health Human Resources Escalation Frameworks*	for increased capacity (NRG, extra shifts, OT)		
Team-Based Clinical Care Model	• No	• Upskilling and preparation for implementation of TBCM	• Consider short term <12 hour) period implementation of unit level implementation • Prepare for system-level implementation (align with Clinical Operations Command Centre)	• Consider system implementation (multiple units) of TBCM, supported by Clinical Operations Command Centre (see below)
Redeployment Centre	• No	• No	• Prepare for Activation	• Activate
Clinical Operations Command Centre	• No	• No	• Prepare for activation • Recommend activation of Redeployment Centre as needed (or if expected to escalate to Level 3)	• Clinical Operations Command Centre activated until plan executed and de-escalation achieved • Replaces morning and afternoon bed meetings • Oversees activation of Level 3 mitigation strategies, including TBCM • Oversees centralized redeployment for equitable allocation of

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Strategies	Pre-escalation (Normal state)	Escalation Level 1	Escalation Level 2	Escalation Level 3
				resources • Prioritize ramp down streams of activity (i.e. surgical, ambulatory • Internal and external communications (local, regional, provincial) to support situational awareness • Facilitate dialogue with system partners to facilitate access for tertiary/ quaternary patients • Active 7 days week, 24 hours a day while in Escalation Level 3 – daily virtual huddles at 6am, 9am, 1pm, 11pm
Allied Health and Professional Practice	Monitor & Access situation and implement internal escalation plans based on escalation level			
Diagnostic Services				
Laboratory Services				
Communication Services				

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2.2 Leader Accountabilities

Leader Role	Pre-escalation (Normal state)	Escalation Level 1	Escalation Level 2	Escalation Level 3
Decision to Escalate	N/A	Manager-on-call/Clinical Administrator	Manager/ Clinical Administrator/ Director-on-call	Director-on-call/VP
Manager-on-call/Clinical Administrators	• Leads 9 am and 1:15 pm patient flow meetings • Liaises with unit leaders to align local planning with hospital-wide flow	As per pre-escalation AND: • Consults with managers/unit leads of impacted areas re action planning • Facilitates decision-making regarding re-allocation of staff and resources	As per Level 1 AND: • Consults with physician and leadership peers	• Assumes role of primary liaison for clinical areas and provides patient flow status updates to the Clinical Operations Command Center as required. • Outside of regular business hours, Clinical Administrator assumes role of incident manager until Director on call is available
Director-on-call	• Remains abreast of hospital-wide capacity and provides status update on daily safety briefing (DSB) call • Provides overview of capacity status, escalation level and potential organizational risks/safety concerns at 9am meeting	As per pre-escalation AND: • Remains available to Manager-on-call/Clinical Administrator to provide coaching and support as required	As per Level 1 AND: • Attends all bed management meetings • Provides status updates to VP/executive-on-call and hospital level physician leadership • Prepares to activate the Clinical Operations Command Centre	• Assumes role of incident manager in Clinical Operations Command Center until situation resolved.

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Leader Role	Pre-escalation (Normal state)	Escalation Level 1	Escalation Level 2	Escalation Level 3
Clinical Support/Charge Nurses	• Reviews unit capacity and optimizes nursing staffing to meet anticipated patient volumes • Understands and anticipates pressures of the day and communicates these to local team • Updates unit manager on patient flow status prior to 9 am meeting and as needed throughout the day	As per pre-escalation AND: • Notifies local team of escalation status and reviews all patients with medical team for potential discharge/ transfer status	As per Level 1	• Provides patient census updates to Clinical Operations Command Centre as requested • Attempts to call in any available staff for hospital-wide resourcing as requested by the Clinical Operations Command Center
Clinical Managers (Inpatient, Ambulatory, ED and Critical Care areas)	• Coaches and supports team to facilitate nursing staffing and optimize patient flow within local program • Attends 9am meeting, reports on local status, and partners with peers to optimize hospital-wide patient flow • Approves overtime nursing as required	As per pre-escalation AND: • If area significantly impacted, attends 1:15 pm bed meeting with team • Works with Transitional Care Coordinators to engage community partners and facilitate transfers if required • Keeps program Director informed of status as required	As per Level 1 AND: • Notifies Most Responsible Physicians of escalation level and requests that all patients be reviewed for potential discharge/ transfer status • Reviews all planned activity with physician leads and clinical teams for potential deferral • Works with team to identify and implement discharge/ transition area as required	• Reports to clinical area and provides leadership to team as directed by Clinical Operations Command Centre. Communicates updates to program Director and Clinical Operations Command Centre as required.

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Leader Role	Pre-escalation (Normal state)	Escalation Level 1	Escalation Level 2	Escalation Level 3
Clinical Directors (Inpatient, ED and Critical Care Areas)	• Remains abreast of program capacity and is available to unit managers to provide support and coaching as required.	As per pre-escalation	As per Level 1 AND: • Consults/liaises with team, physician leadership, peers and community partners to facilitate patient flow as required.	• Reports to Clinical Operations Command Centre to represent clinical program as required. Communicates directly with portfolio managers in clinical areas (e.g. via text/phone) to provide accurate/timely updates as required.
Physicians/NPs	• Engages in unit-based patient flow procedures, rounding and patient review processes as per usual. • Understands and anticipates pressures of the day	• Residents and teams prioritize discharges and review patient lists with nursing and clinical team for potential discharge/ transfer status • Prepare for Level 2 Escalation	• Most Responsible Physician reviews all patients for potential discharge/ transfer status, reviews all planned activity for potential deferral with unit manager and works with team to identify and implement discharge/ transition plans as required. • Division Heads of all inpatient, ED and Critical Care areas notified of escalation status and briefed on patient flow pressures of the day and program capacity status.	• Physician Leadership report to Clinical Operations Command Centre.

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2.3 Communication Structures

Communication Type	Pre-escalation (Normal state)	Escalation Level 1	Escalation Level 2	Escalation Level 3
Internal	• Status update sent to clinical operations distribution list via e-mail daily between 6-8am by Clinical Administrator. • Bed capacity status available as per usual via Dashboard, Access and Flow link on internal website	As per pre-escalation AND: "Patient Flow Escalation Level 1 in place" notification on daily safety brief and at patient flow meetings	As per Level 1 AND: "Patient Flow Escalation Level 2 in place" notification by DOC via email to VPs, CMO, Department Heads, Clinical Managers & Clinical Directors, for distribution within clinical teams to support awareness and action.	"Patient Flow Escalation Level 3 in place, all required participants please report to Clinical Operations Command Centre" notification by overhead page.
External			Prepare for Escalation Level 3 (Dear parent letters, social media and press notifications ready)	Communication specialist reports to Clinical Operations Command Centre and executes communication strategies as directed.

3.0 Definitions

ACTS: Acute Care Transport Team

Acute Care Census: Combined number of patients admitted to inpatient areas outside of the critical care units (PICU, CCCU and NICU)

Admin-on-call: In the Emergency Department (ED), refers to the scheduled physician administrator on-call

CCCU: Cardiac Critical Care Unit

CCRT: Critical Care Response Team

CCU: Critical Care Unit (combined PICU + CCCU)

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CDIU: Cardiac Diagnostic Imaging Unit

Code Gridlock: An internal emergency response that is activated when all other routine bed management strategies have been exhausted, no additional bed management plans are in place over the next 4-8 hours, and patient flow throughout the hospital is completely blocked. Code Gridlock may be a short event or may be extended for hours. If deployed strategies do not resolve the gridlock, the situation may escalate leading to the activation of a Code Orange.

Clinical Administrator: also known as the CHS Administrator

Clinical Manager on-call: Clinical Manager or Senior Manager, primarily responsible for facilitating plans for patient access and flow.

Clinical Support Nurse (CSN): The Registered Nurse who is assigned in charge of the unit and responsible for on-shift management of resources.

Critical Care Census: Combined number of patients admitted to the designated Critical Care Units (PICU, CCCU and NICU)

Critical rooms: In the ED, rooms that are designated for patients presenting with higher acuity and in need of immediate assessment, and close monitoring during on-going care.

CTAS: Canadian Triage & Acuity Scale is a standardized tool used in the emergency department (ED) to triage patients and prioritize patient care requirements. It is also used to examine patient care processes, workload, and resource requirements relative to case mix and community needs. CTAS is a 5-point scale, CTAS 1 assigned to the most acute patient and CTAS 5 assigned to least acute.

Director-on-call (DOC): The Director-on-Call is the Clinical Program Director on stand-by for the designated period of time who assumes the role of Incident Manager during a Patient Flow Escalation Level 3 Clinical Operations Command Centre activation.

ED LOS: Emergency Department length of stay. The total time a patient is treated in the ED, starting from their arrival to the time they leave the ED

Form 1: Application for Psychiatric Assessment used to bring someone to a psychiatry facility for an assessment that lasts up to 72 hours.

Gridlock: A situation whereby the hospital system is overwhelmed by demand (i.e. patients, patient care needs) and the capacity to respond to the demand (i.e. resources, scheduling, physical and/ or staffed beds etc.) is completely exhausted resulting in a complete lack of patient flow and restricted access to care.

HBKR: Holland-Bloorview Kids Rehabilitation Hospital

Incident Management System (IMS): A standardized system used by health care facilities that allows existing roles within an organization to transition into key roles required to manage emergency situations. Based on the concepts of delegating predefined areas of responsibility, a clear chain of command and regular communication

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via consistent routes, the Incident Management System allows for activation of only the roles required to manage each emergency situation. See also Incident Management System on the Emergency Measures website.

IGT: Image Guided Therapy

Incident Manager: The Incident Manager is the individual in charge during the Patient Flow Escalation Level 3 Clinical Operations command Centre activation. This individual provides overall direction for hospital operations during the Level 3 escalation to manage patient flow strategies and ensure capacity for patient access to care.

Inpatient Physical Bed Occupancy: Percentage of total available physical beds occupied by admitted patients. Total available beds include all physical beds listed as inpatient beds in Epic that have not been blocked due to maintenance or other reasons that compromise their viable usage.

MRP (most responsible provider): The healthcare provider who is responsible and accountable for making care plan decisions for the patient at the moment.

NRG (Nursing Resource Group): Nurses whom hold a casual component in addition to their assigned full-time equivalent (FTE). These casual hours are booked in the event of nursing resource needs on the unit, but can be cancelled in the absence of nursing resource needs.

PACU: Post-Anaesthetic Care Unit

Patient flow meeting: planned or ad-hoc meetings to discuss variables that are impacting flow of patients into the hospital, and to create a plan for enabling patient access. May also known as the Bed Board meetings.

PICU: Paediatric Intensive Care Unit

Primary Physician: The physician who is most involved in the patient's care plan, or protocol. This physician will follow a patient over a longer period of time, and may not be the MRP while the patient is admitted.

Provider Initial Assessment (PIA): The time interval between patient arrival until the first assessment by a physician, Nurse Practitioner (NP), or Physician Assistant (PA) in the ED.

Schedule 1: A facility given the designation to complete psychiatric assessments for patients held on a Schedule 1 form under the Mental Health Act

Step-down Room: Room that is designated for close observation of acute patients

Resus/Trauma Room: In the ED, rooms that are designated for care of the most acute patient requiring active resuscitation efforts or immediate post-trauma stabilization

RRT: Registered Respiratory Therapist

TBCM: Team Based Care Model, is a novel staffing strategy to address significantly high levels of clinical staff absenteeism and/or patient activity.

TCLHIN Coordinators: Toronto Central Local Health Integration community access coordinators

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Total Census: Combined number of all patients admitted to SickKids, including all inpatient and critical care areas

VCS: Vocera Collaboration Suite
Attachments:

Overview of Patient Flow Escalation Strategies to be Implemented - Revised for Covid19.docx

Patient Flow Escalation Protocol Appendix Script.docx

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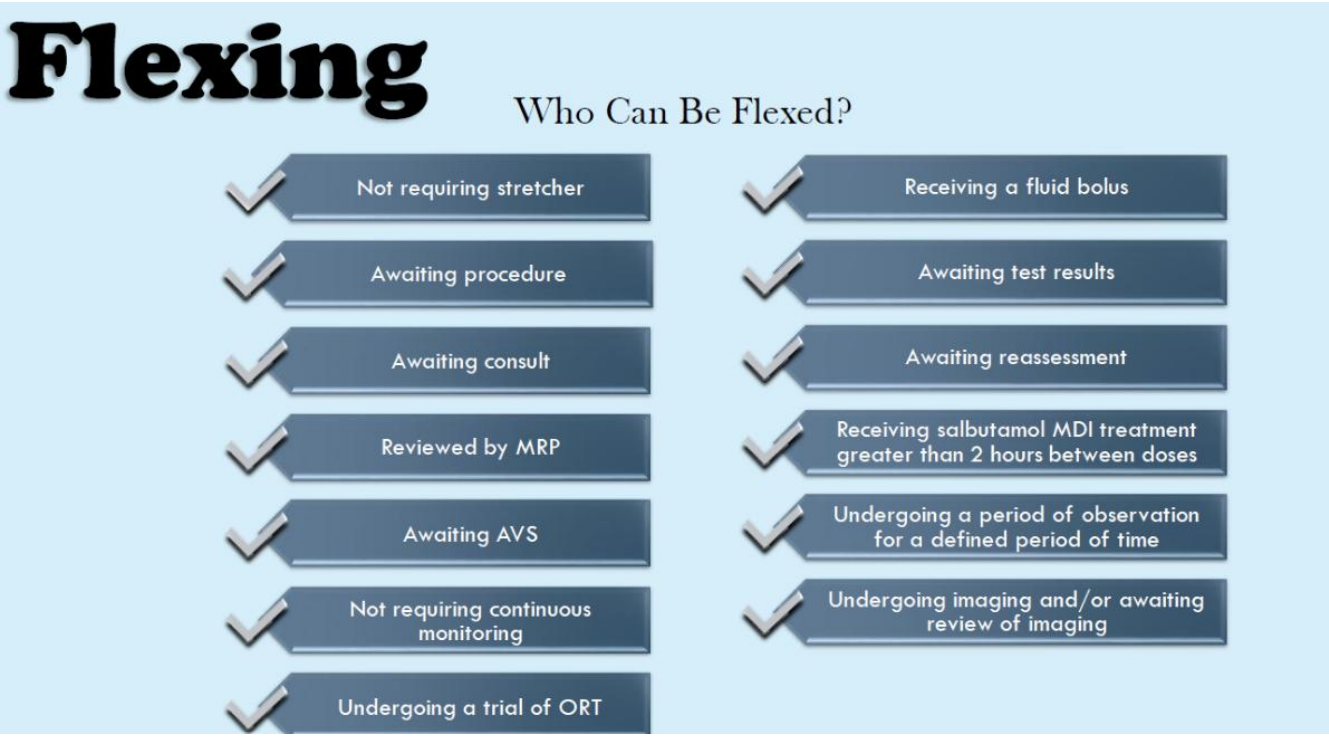
FLEXING STANDARDS – SICKKIDS



PRHC
Peterborough Regional Health Centre

EMERGENCY DEPARTMENT UNIT MANUAL

Title	Obstetrical Patient Triage and Assessment
Number	1.A.6.20
Policy Area	Emergency Department, Labour and Delivery
Policy Statement	To maintain the safety of obstetrical patients at Peterborough Regional Health Centre, timely access to expert assistance and skilled personnel for obstetrical and non-obstetrical situations is essential.
Definitions:	**CIS:** Clinical Information System used for electronic documentation **ED**: Emergency Department **FHS:** Fetal Heart Surveillance **L&D**: Labour and Delivery **MRP**: Most Responsible Provider **NToA**: Nursing Transfer of Accountability, refer to Nursing Professional Practice Manual Policy 2.F.2 Nursing Transfer of Accountability and 2.F.2.A Nursing Transfer of Accountability Bedside Shift Report. **OB/GYN**: Obstetrics and Gynecology **Preeclamptic Features**: Rapid weight gain caused by significant increase in bodily fluid, abdominal pain, severe headaches, change in reflexes, reduced urine or no urine output, dizziness, excessive vomiting and nausea or vision changes. **SA/DV**: Sexual Assault/Domestic Violence Nurse
Background	The purpose of this policy is to clearly outline the process for ensuring all obstetrical patients are directed to the most appropriate care area regardless of gestational age in the Emergency Department and Labour and Delivery.
Implementation (Procedure) :	**1.0 Pregnant Patient greater than or equal to 12 weeks** 1.1 All pregnant patients that arrive to the PRHC ED, including patients via EMS, greater than or equal to 12 weeks gestation presenting to triage with an <u>exclusive</u> pregnancy related concern will not be triaged and will go directly to L&D if they are exhibiting one or more of the following symptoms: a) Vaginal bleeding b) Leaking amniotic fluid

c) Query labour or abdominal pain/cramping
d) Nausea and/or vomiting

1.2 All pregnant patients greater than or equal to 12 weeks gestation presenting to the ED, including patients that arrive via EMS with minor non-obstetrical complaints unrelated to pregnancy (i.e. lacerations or extremity injuries) will be triaged, registered as an ED patient and assessed by their primary ED nurse and the ED physician in the ED.

1.3 All pregnant patients greater than or equal to 12 weeks gestation presenting to the ED, including patients that arrive via EMS, with one or more of the following complaints will be triaged, registered as an ED patient and assessed by their primary ED nurse and the ED physician in the ED:

Threat to maternal wellbeing which includes the following:

a) Decreased level of consciousness
b) Chest pain with cardiac features in absence of preeclamptic features
c) Severe shortness of breath or respiratory complaints
d) Trauma
e) Imminent delivery with presenting part visible
f) Syncope
g) Active seizure
h) Palpitations

1.4 L&D should be made aware of all patients meeting the criteria in 1.3 in the event imminent delivery should occur. Notification from the ED Charge nurse or designate to the L&D Charge Nurse should occur via telephone.

1.5 An L&D nurse, when requested by the ED, will come to the ED to assess fetal wellbeing by completing a FHS for patients greater than or equal to 12 weeks that are deemed CTAS 1 or 2 by the triage nurse.

1.6 A pregnant patient greater than or equal to 12 weeks gestation that has been assessed in L&D and cleared by MRP of obstetrical concerns may be discharged home directly from L&D or transferred to the ED for further assessment and treatment. If transfer to the ED is required the patient will be accompanied by the L&D nurse to accomplish NToA.

1.7 If a patient is transferred from L&D to ED, the L&D nurse will notify the ED charge nurse at ext. 5694 prior to the transfer. The patient will be accompanied by the L&D nurse to triage, where NToA will be given to the ED nurse accepting the patient.

a. If the patient had already been triaged prior to L&D and is returning to the ED for further assessment, patient may return to a bed or zone in the ED determined by ED Charge Nurse and NToA will be given to primary ED nurse. See Appendix B for process of transferring patient electronically.

1.8 If the patient is transferred from the ED after ED physician assessment to L&D, the ED nurse will notify L&D via phone prior to the transfer. The ED nurse will transport the patient to L&D to give the primary L&D nurse NToA and document the NToA in the electronic health record.

1.9 If FHS is required in the ED, the ED physician or ED charge nurse will notify L&D. Arrangements will be made to assess fetal wellbeing. An L&D nurse will bring the necessary equipment to the ED and assess the patient in the ED. The L&D nurse will document normal and abnormal/atypical findings in the electronic health record using the Intellispace Perinatal (ISP program).

a. The L&D nurse will report all FHS findings (normal, abnormal or atypical) to the ED physician and the OB/GYN on call. The ED physician will be responsible for coordinating a plan of care with the OB/GYN
b. All FHS must be reviewed by the OB/GYN.
c. If the ISP program is down, FHS tracings will be stored by health records

1.10 Pregnant patients greater than 12 weeks gestation presenting with chief complaint of sexual assault and/or domestic violence should be sent to L&D and referred to the SA/DV nurse as soon as possible. SA/DV nurse will be notified by the triage nurse.

2.0 Pregnant Patients less than 12 weeks gestation

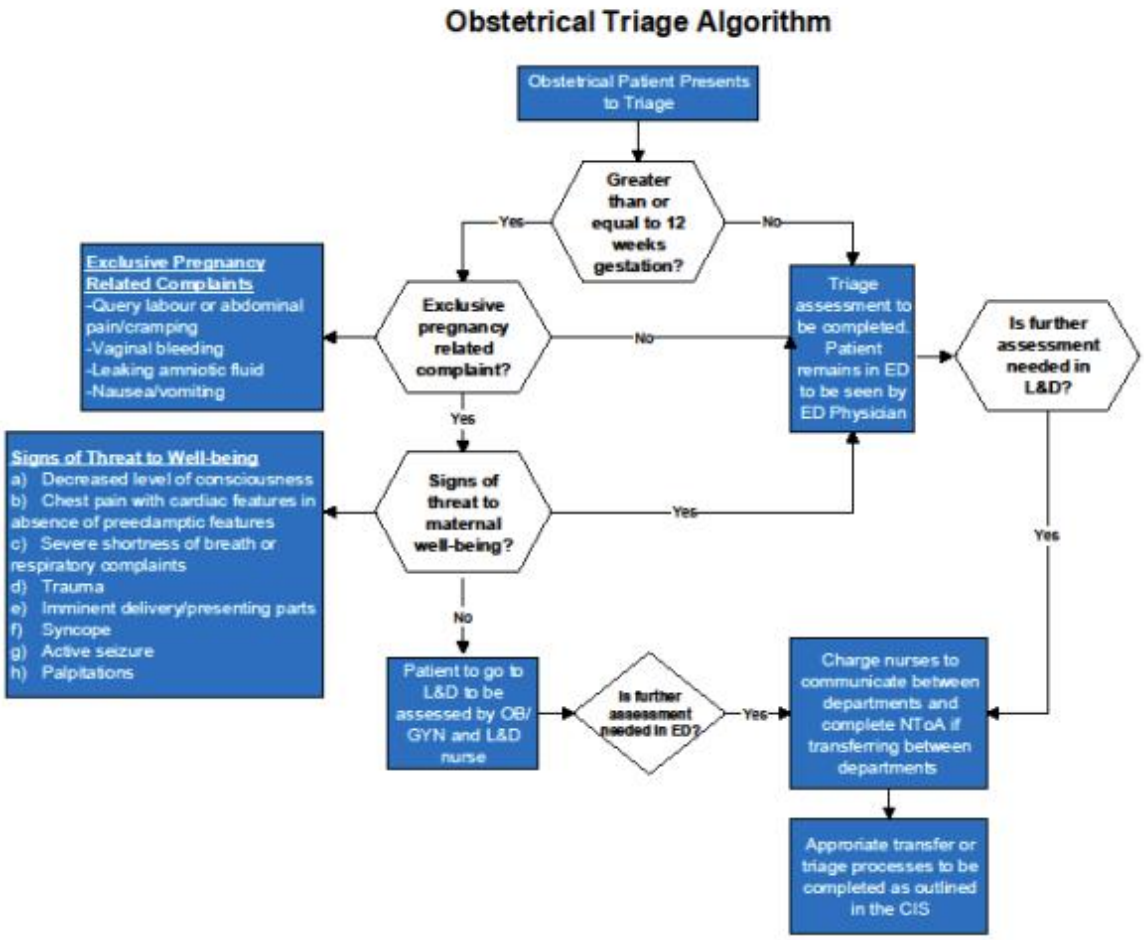
2.1 All pregnant patients less than or equal to 12 weeks gestation who present to the ED will be triaged, assessed by an ED nurse and the ED physician. The patient will be treated in the ED. If an immediate consult by OB/GYN is required, the on call OB/GYN will be notified by the ED physician.

References:

1. Emergency Nurses Association (2011). The Obstetrical Patient in the Emergency Department. Retrieved June 30, 2017.
2. Mackenzie Health (York Central Hospital) 2011 Obstetrical Patients Arriving in the Emergency Department. Policies and Procedures Manual
3. Ontario Hospital Association (2013) The Canadian Triage and Acuity Scale, Version 2.5b

Responsibility for Monitoring:	Emergency Department Steering Committee Emergency Department Quality Committee
Responsibility for Review/Update:	
Effective Date:	November 26, 2018
Original Date:	November 26, 2018
Date Reviewed:	October 10, 2024
Date Revised: *most recent date first in line*	October 10, 2024; February 28, 2022
Approval Pathway:	Department of Obstetrics and Gynecology Emergency Department Steering Committee Emergency Department Quality Committee
Appendices:	Appendix A: Obstetrical Patient Triage and Assessment Algorithm Appendix B: Electronic Transfer of Patient

Appendix A: Obstetrical Patient Triage and Assessment Algorithm



Appendix B: Electronic Transfer of Patient

See below for the process of transferring the patient electronically between units. Always defer to the Patient Movement Guide in the CIS for the most up to date information.

L&D to ED: *if* the patient has already been a triaged and registered ED patient prior to L&D assessment. Otherwise patient will triage as per usual protocol.

Who	Does What
Follow the steps listed under the appropriate scenario	
Only applicable for patients with an ADT L&D Status of L&D Assessment	
1. L&D Nurse/Clerk	**Calls ED Charge Nurse** to inform them that the patient is returning to the ED
2. L&D Nurse/Clerk	Selects the patient on the L&D Manager or Greaseboard and **clicks Transfer**
3. L&D Nurse/Clerk	Select the room and bed **of "OTF" in** the ED department and completes Transfer
4. ED Nurse	**Moves patient from OTF** care area into appropriate bed

ED to L&D

If Patient has Been Roomed in the ED (OB GYN decides patient needs to be assessed in L&D prior to admission)	
1. ED Physician	Contacts Obstetrician to inform them of incoming patient.
2. ED Physician	Places disposition to **"Send to L&D"** and order "**ED send to L&D for Triage**"
3. ED Nurse	**Places the patient in an Off the Floor (OTF)** upon patient's physical departure
4. L&D Nurse/Clerk	Arrives patient in the L&D from the L&D Manager/Grease Board using encounter started in the ED
If Patient has Been Roomed in the ED (OB GYN decides patient needs to be admitted in L&D as Inpatient)	
1. ED Physician	Place **a Consult order** and **contacts Obstetrician** to inform them of incoming patient.
2. OB/GYN/ED (if Physician have admitting privileges)	Places **Admit to L&D IP (ADT13)Order**
3. ED Nurse	Places the patient in an **Off the Floor** care area upon patient's physical departure
4. L&D Nurse/Clerk	Arrives patient in the L&D from the L&D Manager/Grease Board using encounter started in the ED

ED ONCOLOGY PATHWAY – PETERBOROUGH REGIONAL HEALTH CENTRE

PRHC
Peterborough Regional Health Centre

Oncology Pathway

- Bypass waiting room: prioritize bedspace with door whenever possible
- Triage nurse to notify charge nurse and charge MD of oncology patient and determine best location for patient to begin their care (i.e. Blue/Green zone, lab room, BCV etc.)
- Triage nurse to enter comment into Epic (i.e. "Oncology patient, directives ordered" or "fever/chemo")

Step 1: Pre-Triage nurse to identify active oncology patients:

1. Oncology flag in Epic on waiting room trackboard *or*
2. Active treatment plan in chart review *or*
3. Active treatment plan on storyboard

Step 2: Triage nurse to ask oncology related questions:

1. Do you have your fever/cancer tx card?
2. Are you on any active treatment (i.e. chemo, radiation, immunotherapy) or recent cancer related surgery?

→ **Immunocompromised Modifier = CTAS 2**

Step 3: Chief Complaint

Is the ED visit likely related to cancer diagnosis or treatment? See examples

Possible Cancer Related ED Visits

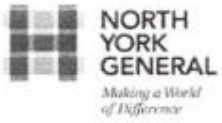
- PICC/Port-a-Cath complication (i.e. infection, DVT)
- Fever
- Chest pain or SOB
- Fatigue/Weakness
- Pain Crisis
- Nausea/Vomiting/Diarrhea
- New Rash
- Surgical site infection or complication
- Acute incidental finding on imaging

Step 4: Oncology Directives

Order and implement oncology directives and ensure charge nurse and/or charge MD aware

NOTE:
FEBRILE NEUTROPENIA TIME TO ANTIBIOTICS GOAL: LESS THAN 60 MINUTES.
PLEASE NOTIFY MD IF NEUTROPHILS ARE LOW (<1.0)

AMBULATORY CARE REFERRAL FORM – NORTH YORK GENERAL HOSPITAL



Baruch/Weisz Outpatient Care Clinic
REFERRAL FORM
AMBULATORY CARE PROGRAM

FORM MSC1 **Page 1 of 1** **Rev. 11/2020**

MRN: FIN:

PATIENT NAME:

DOB: Age: Sex:

Arrival:

HEALTH CARD NO: –

Home Phone: – –

Patient Name (first/last):

Telephone Extension: 6577 Fax: (416) 756-6567 Hours of Operation: Monday-Friday: 0700 to 1800

- ***The Clinic will call the patient within 24 hours of receiving a completed referral to book an appointment***
- ***Please check appropriate boxes below:***

PRIMARY CLINIC GOALS (MANDATORY):		Phone Messages
☐ ED ADMISSION AVOIDANCE ☐ ED VISIT AVOIDANCE ☐ FACILITATING AN EARLY DISCHARGE ****Patients will NOT be provided with ongoing longitudinal care at the clinic*** ****Fax Referral, ED Face Sheet, External DI Reports AND Nursing Triage notes to: 416-756-6567***	☐ **General Medical Consult** (within 24–72 hours) ☐ **Acute Care Surgical Consult** (within 24 hours–1 week) ☐ **Acute Care Gyne Consult** (within 1–2 weeks) ☐ **Geriatric Consult** (within 1–4 weeks) ☐ **Acute Care Urology Consult** (within 24 hours–1 week)	☐ Patient consents to phone messages ☐ Patient does **not** consent to phone messages **Best number to reach patient/leave message if applicable:**

Reason for referral and brief clinical history:

Orders/tests prior to appointment (Please fax all requisition forms. Clinic will fax to departments unless booked through ED booking slots):

Hospital discharge/ED visit date: _____
DD/MM/YY

Requested date/time for appointment:
☐ First available appointment
☐ Other (specific date): _____

Specific physician: _____
Date requested: _____ **Time:** _____
DD/MM/YY

DATE TIME (24 h)	Referring Physician Signature:	Referring Physician (Print Name)
07–APR–2025 10:18	Referring Physician Phone Number:	

NORTH YORK GENERAL
Making a World of Difference

Baruch/Weisz Outpatient Care Clinic
Telephone 416-756-6577
Fax:416-756-6567
North York General Hospital – General Site
4001 Leslie Street, Toronto, Ontario M2K 1E1

Patient Referral Information Sheet

You have been referred to:

- ☐ Adult General Medical Consult (runs Mon-Fri 8-4 pm)
  Endeavour to see within 48-72 hours
- ☐ Adult Acute Care Surgical Consult (runs Tue/Wed/Fri 1-3 pm)
  Endeavour to see within 24 hours to 1 week
- ☐ Adult Acute Care Gynecology Consult (runs Fri 1-4pm) ** Please see special note below
  Endeavour to see within 3-4 weeks)
- ☐ Geriatric Consult (runs Thurs. 1-4 pm)
  Endeavour to see within 2-4 weeks
- ☐ Adult Acute Care Urology (runs Mon/Wed/Fri half days – OR days Tue &Thu full day) – ***Please see special note below
  Endeavour to see within 24 hours to 2 weeks
- ☐ Stroke Prevention Clinic (runs Mon & Thurs. noon to 3 pm, Tue 0830 to 3pm, Wed 08:30-noon)
  Endeavour to see within 1-2 weeks

Baruch/Weisz Outpatient Care Clinic
The Baruch/Weisz Outpatient Care Clinic provides follow-up care for patients with acute medical and surgical needs.

THE CLINIC DOES NOT REPLACE THE ONGOING CARE PROVIDED BY YOUR FAMILY PHYSICIAN. MOST PATIENTS ARE SEEN ONCE BEFORE BEING REFERRED BACK TO THEIR FAMILY PHYSICIAN

What to bring to the clinic:

- ✓ Your Health Card
- ✓ All medications you are currently taking
- ✓ If you require assistance communicating in English, please bring someone to help translate

Appointment Information
You will receive a phone call with an appointment date and time.

Date: _____ Time: _____

***For Acute Gynecology Referrals Only* - You will be assessed by the Chief Gynecology Resident Physician who is under the supervision of a Staff Gynecologist. You do not need to cancel your appointment if you are vaginally bleeding and you do not need to fast for your appointment.

****For Acute Urology Patients Only* – If referral was made to Home and Community Care by ED Physician, please contact them at 416-222-2241 (You will be asked for your health card number). Removal of catheter date requested:_____

Medical Imaging Booking: Date: _____ Time_____ US, CT, MRI

NORTH YORK GENERAL
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Baruch/Weisz Outpatient Care Clinic
MEDICINE REFERRAL FORM
AMBULATORY CARE PROGRAM

FORM SF0372 **Page 1 of 1** **Rev. 12/2023**

Patient LABEL / Identification Area

Patient Name (first/last):

ADULT ACUTE GENERAL INTERNAL MEDICINE

(Endeavor to see within 48–72 hours)
Hours of Operation: Monday-Friday: 0800 to 1600

Telephone Extension: 6577 Fax: (416) 756-6567

- ***The Clinic will call the patient within 24-48 hours of receiving a completed referral to book an appointment***

PRIMARY CLINIC GOALS (MANDATORY):	REASON FOR REFERRAL ACCORDING TO CLINIC CRITERIA	Contact Information (Mandatory)
☐ ED ADMISSION AVOIDANCE ☐ ED VISIT AVOIDANCE ☐ FACILITATING AN EARLY DISCHARGE ***Patients will NOT be provided with ongoing longitudinal care at the clinic**	☐ **Acute Medical Condition (non-gynecological/non-surgical/non-urological).** **Indicate Reason for Referral:**	Best number to reach patient: _____ Email: _____
☐ **F/U GIM – Stroke Prevention (For Stroke Inpatients ONLY)** ☐ **F/U GIM (Inpatients ONLY)** **Hospital discharge:** _____ DD/MM/YY **Appointment request for follow up with specific physician:** **Physician's Name**_____ **Date requested:** _____ DD/MM/YY **Time:** _____	**EXCLUSION CRITERIA:** - <18 years old - Airborne isolation requirements - For chronic conditions being followed by a specialist, please refer back to specialist.	**Phone Messages** ☐ Patient consents for clinic to leave phone messages regarding appointments ☐ Patient does **not** consent for clinic to leave phone messages regarding appointments ☐ Referral also sent to_____

Brief Clinical History/Dictated Note:

Orders/tests prior to appointment (Please fax all requisition forms- Inpatient Discharges Only)

DATE	TIME (24 h)	Referring Physician Signature:	Referring Physician (Print Name)
		Referring Physician Phone Number:	

Approved by: Clinical Team Manager. Approval Date: 11/2023 (archive:07/2011; 06/2016)

NORTH YORK GENERAL
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Baruch/Weisz Outpatient Care Clinic
UROLOGY REFERRAL FORM
AMBULATORY CARE PROGRAM

FORM SF0371 **Page 1 of 1** **Rev. 12/2023**

Patient LABEL / Identification Area

Patient Name (first/last):

ADULT ACUTE CARE UROLOGY

(Endeavor to see within 24 hours – 2 weeks)

Hours of Operation: Mon/Wed/Fri: Half Day

Telephone Extension: 6577 Fax: (416) 756-6567

- ***The Clinic will call the patient within 24-48 hours of receiving a completed referral to book an appointment***

PRIMARY CLINIC GOALS (MANDATORY):

- ☐ ED ADMISSION AVOIDANCE
- ☐ ED VISIT AVOIDANCE
- ☐ FACILITATING AN EARLY DISCHARGE

Patients will NOT be provided with ongoing longitudinal care at the clinic

☐ **F/U with Urologist (Inpatient ONLY)**

F/U Date/Time Requested: _____ **DD/MM/YY**

Hospital discharge: _____ **DD/MM/YY**

EXCLUSION CRITERIA:
-Patient has a Urologist they can see

REASON FOR REFERRAL ACCORDING TO CLINIC CRITERIA
(Select all that apply)

☐ Infections (epididymo-orchitis, prostatitis)
☐ Hematuria
Renal Colic/Kidney Stones
☐ Other _____

Imaging done:
- ☐ **CT**
- ☐ **U/S**
- ☐ **Size & location of stone**_____

☐ Urinary Retention
- ☐ Post Void Residual (PVR)_____
- ☐ Trial of Void arranged via CCAC in 7-10 (CCAC form attached). Date: _____

Started on:
- ☐ **Flomax**
- ☐ **Antibiotics ((Urine C&S sent) YES/NO**

If patient does not meet the above urgent criteria please consider referring to the NYGH on call Urologist's office

Contact Information
(Mandatory)

Best number to reach patient: _____

Email: _____

Phone Messages

☐ Patient consents for clinic to leave phone messages regarding appointments

☐ Patient does **not** consent for clinic to leave phone messages regarding appointments

☐ Referral also sent to_____

Brief Clinical History/Dictated Note:

Orders/tests prior to appointment (Please fax all requisition forms)

DATE	TIME (24 h)	Referring Physician Signature:	Referring Physician (Print Name)
		Referring Physician Phone Number:	

NORTH YORK GENERAL
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Baruch/Weisz Outpatient Care Clinic
GYNECOLOGY REFERRAL FORM
AMBULATORY CARE PROGRAM

FORM SF0370 **Page 1 of 1** **Rev. 12/2023**

Patient LABEL / Identification Area

Patient Name (first/last):

ACUTE CARE GYNECOLOGY

(Endeavor to see within 3-4 weeks)

Hours of Operation: Friday: 1300 to 1600

Telephone Extension: 6577 Fax: (416) 756-6567

- ***The Clinic will call the patient within 1 week of receiving a completed referral to book an appointment***

PRIMARY CLINIC GOALS (MANDATORY):	REASON FOR REFERRAL ACCORDING TO CLINIC CRITERIA (Select all that apply)	Contact Information (Mandatory)
☐ ED ADMISSION AVOIDANCE ☐ ED VISIT AVOIDANCE ☐ FACILITATING AN EARLY DISCHARGE ***Patients will NOT be provided with ongoing longitudinal care at the clinic*** **Hospital discharge:** _____ DD/MM/YY	☐ Abnormal uterine bleeding (Hb<100) (NOTE: If the patient presented with a Hgb below 80, please consider concurrent GIM referral for management of anemia) ☐ Post-menopausal bleeding ☐ Ovarian cyst (>6cm or ORADS 3-4) ☐ Complex Pelvic Inflammatory Disease ☐ Bartholin's Abscess follow up **EXCLUSION CRITERIA:** -Pregnant patients - <14 years of age **If patient does not meet the above urgent criteria please consider referring to the NYGH on call Gynecologist's office**	Best number to reach patient: _____ Email: _____ **Phone Messages** ☐ Patient consents for clinic to leave phone messages regarding appointments ☐ Patient does **not** consent for clinic to leave phone messages regarding appointments ☐ Referral also sent to_____

Brief Clinical History/Dictated Note:

Orders/tests prior to appointment (Please fax all requisition forms- Inpatient Discharges Only)

DATE	TIME (24 h)	Referring Physician Signature:	Referring Physician (Print Name)
		Referring Physician Phone Number:	

Approved by: Clinical Team Manager. Approval Date: 11/2023 (archive:07/2011; 06/2016; 11/2020)

NORTH YORK GENERAL
Making a World of Difference

Baruch/Weisz Outpatient Care Clinic
GERIATRIC REFERRAL FORM
AMBULATORY CARE PROGRAM

FORM SF0369 **Page 1 of 1** **Rev. 12/2023**

Patient LABEL / Identification Area

Patient Name (first/last):

GERIATRICS

(Endeavor to see within 2-4 weeks)

Hours of Operation: Thursday: 1300 to 1600

Telephone Extension: 6577 Fax: (416) 756-6567

- ***The Clinic will call the patient within 24-48 hours of receiving a completed referral to book an appointment***

PRIMARY CLINIC GOALS (MANDATORY):	REASON FOR REFERRAL ACCORDING TO CLINIC CRITERIA (Select all that apply)	Contact Information (Mandatory)
☐ ED ADMISSION AVOIDANCE ☐ ED VISIT AVOIDANCE ☐ FACILITATING AN EARLY DISCHARGE ***Patients will NOT be provided with ongoing longitudinal care at the clinic*** **Hospital discharge:** _____ DD/MM/YY **EXCLUSION CRITERIA:** -Patients <65 years of age	☐ Age 65 years and over with at least one geriatric issue ☐ Cognitive Impairment ☐ Behavioural and Psychological Issues related to Cognitive Impairment ☐ Delirium ☐ Falls	Best number to reach patient: _____ Email: _____ **Phone Messages** ☐ Patient consents for clinic to leave phone messages regarding appointments ☐ Patient does **not** consent for clinic to leave phone messages regarding appointments ☐ Referral also sent to_____

Brief Clinical History/Dictated Note:

Orders/tests prior to appointment (Please fax all requisition forms)

DATE	TIME (24 h)	Referring Physician Signature:	Referring Physician (Print Name)
		Referring Physician Phone Number:	

Approved by: Clinical Team Manager. Approval Date: 11/2023 (archive:07/2011; 06/2016)

NORTH YORK GENERAL
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Baruch/Weisz Outpatient Care Clinic
SURGERY REFERRAL FORM
AMBULATORY CARE PROGRAM

FORM SF0368 **Page 1 of 1** **Rev. 12/2023**

Patient LABEL / Identification Area

Patient Name (first/last):

ADULT ACUTE CARE GENERAL SURGERY

(Endeavor to see within 24 hours - 1 week)

Hours of Operation: Tuesday/Wednesday/Friday: 1300 to 1500

Telephone Extension: 6577 Fax: (416) 756-6567

- ***The Clinic will call the patient within 24-48 hours of receiving a completed referral to book an appointment***

PRIMARY CLINIC GOALS (MANDATORY):

- ☐ ED ADMISSION AVOIDANCE
- ☐ ED VISIT AVOIDANCE
- ☐ FACILITATING AN EARLY DISCHARGE

Patients will NOT be provided with ongoing longitudinal care at the clinic

☐ **F/U Surgeon (Inpatients ONLY)**

Physician's Name: _____

F/U Date/Time Requested:_____ **DD/MM/YY**

New Ostomy: 2 week F/U: _____ **DD/MM/YY**

EXCLUSION CRITERIA:
-Patient has urgent/serious condition requiring surgical assessment/intervention during ED visit
-Patients <14 years of age
-Patient is presently under the care of a surgeon including post-op problems

REASON FOR REFERRAL ACCORDING TO CLINIC CRITERIA
(Select all that apply)

- ☐ Symptomatic hernia with resolution of symptoms
- ☐ Symptomatic cholelithiasis with resolution of symptoms and positive imaging investigation for gallstones
- ☐ Diverticulitis
- ☐ Breast abscess after DI drainage (Patients who do not have a GP or breastfeeding specialist)
- ☐ Other _____

If patient does not meet the above urgent criteria please consider contacting the surgeon on call OR referring to the NYGH on call General Surgeon's office

Contact Information
(Mandatory)

Best number to reach patient: _____

Email: _____

Phone Messages

- ☐ Patient consents for clinic to leave phone messages regarding appointments
- ☐ Patient does **not** consent for clinic to leave phone messages regarding appointments
- ☐ Referral also sent to_____

Clinical History/Dictated Note:

Orders/tests prior to appointment (Please fax all requisition forms – Inpatient Discharges Only)

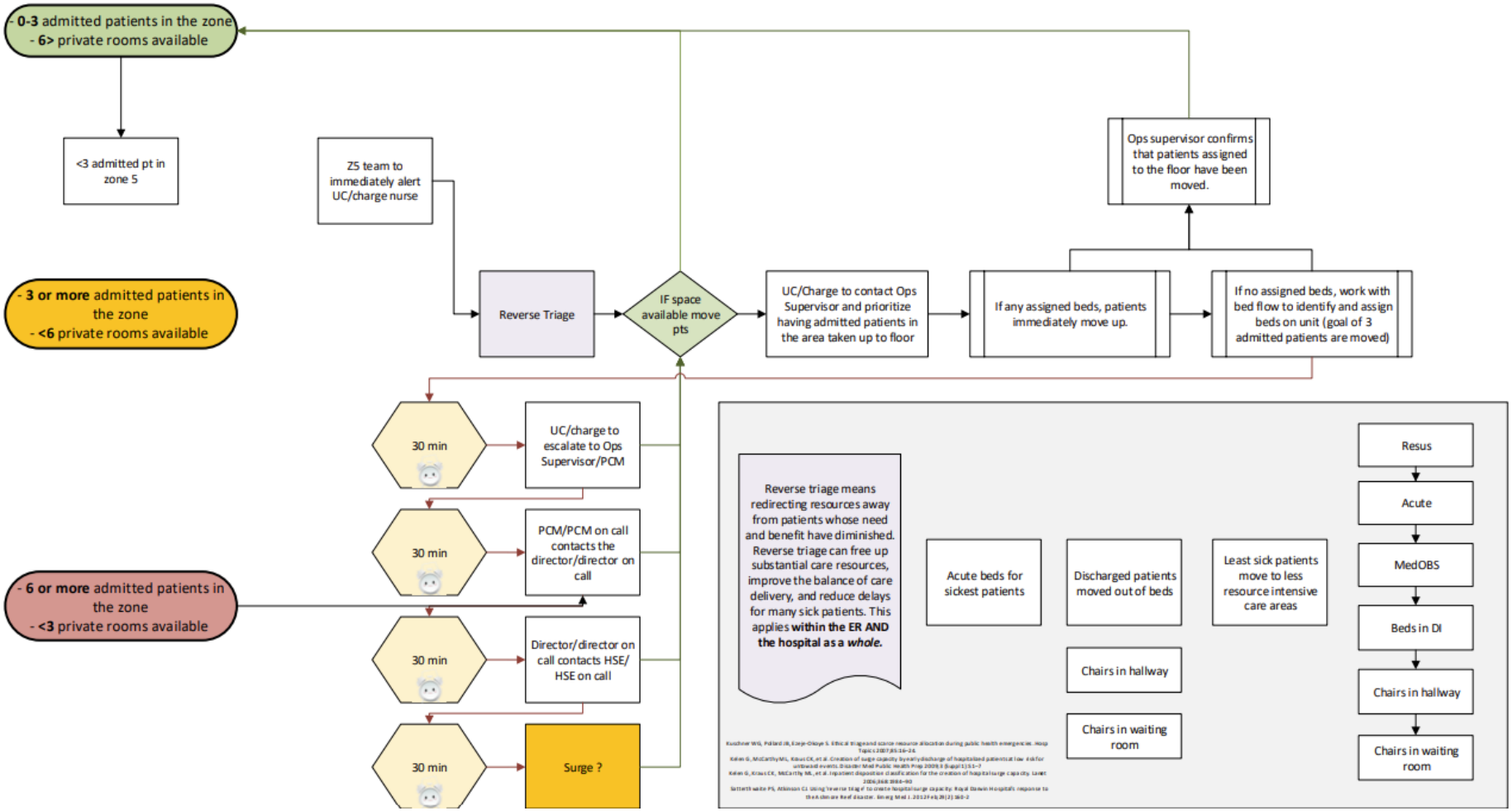
DATE	TIME (24 h)	Referring Physician Signature:	Referring Physician (Print Name)
		Referring Physician Phone Number:	

Approved by: Clinical Team Manager. Approval Date: 11/2023 (archive:07/2011; 06/2016)

INTERNAL FLOW & TRIGGERS
MOBILE ASSESSMENT - ZONE 5 (11 beds)

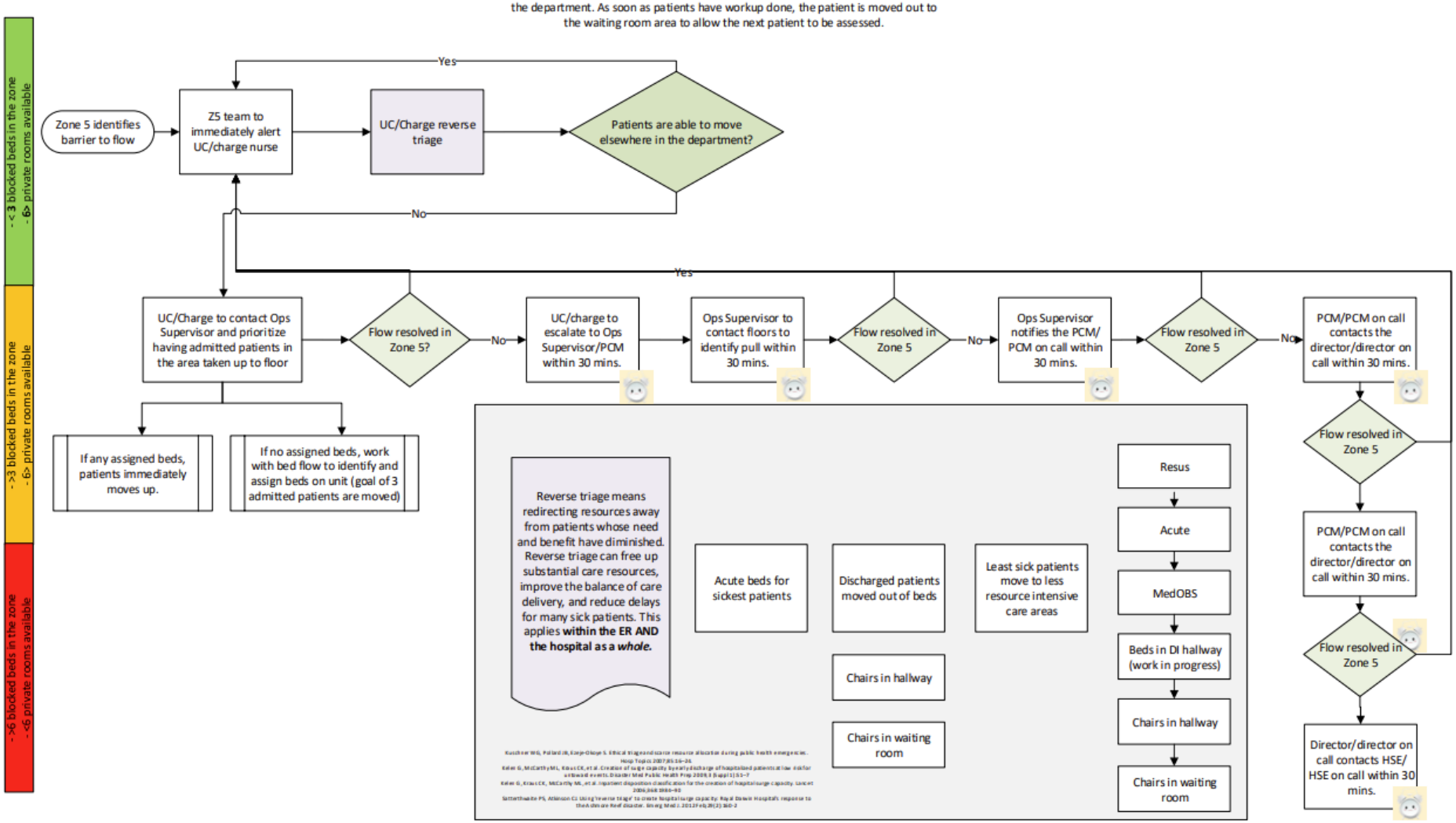
Patients **must** be able to flow through the zone regardless of the number of patients in the department. As soon as patients have workup done, the patient is moved out to the waiting room area to allow the next patient to be assessed.

NO EMS, NO BED BLOCKING PTS in Zone 5



MOBILE ASSESSMENT - ZONE 5
(11 beds)

Patients must be able to flow through the zone regardless of the number of patients in the department. As soon as patients have workup done, the patient is moved out to the waiting room area to allow the next patient to be assessed.



PATIENT TRANSFER FROM THE EMERGENCY DEPARTMENT TO AN INPATIENT UNIT PROCEDURE – HUMBER RIVER HEALTH

Manual	Patient Care Manual, Emergency Services Manual	PROCEDURE
Section	Discharge - Discharge Planning – Transfers; Emergency Services	
Author	PATIENT FLOW MANAGER	
Approved by	**PROGRAM DIRECTOR,** EMERGENCY SERVICES	
Date	O: 09/09/2010	Version Number: 6
	R: 06/24/2022	Reference #: 2454

This is a CONTROLLED document. Any documents appearing in PAPER FORM should be checked against the electronic document in Policy and Procedure Manager (PPM).

PATIENT TRANSFER FROM THE EMERGENCY DEPARTMENT TO AN INPATIENT UNIT - PROCEDURE

Policy Statement

Once the emergency patient is admitted to an inpatient area it is targeted time frame of 60 minutes from admission to inpatient area

Procedure Statement

This procedure describes how information relevant to the safe care of the patient is communicated at the time of transfer of the patient from the Emergency Department (ED) to inpatient (IP) units at Humber River Hospital. The information is communicated in writing using the Emergency Transfer Report (ETR), with verbal communication between nursing staff sending and receiving the patient.

The process goal is to create and support a system in which the inpatient unit pulls the patient from the ED to the IP unit, with the right patient, in the right bed, at the right time. Smooth communication and cooperation are the keys to a pull system for patient transfers. Using this system, it is expected that all patients have a porter requested to transfer them from the ED within 30 minutes of the bed being ready.

The goal for the patient and family is to be prepared for the transition from ED to IP care. This is accomplished, in part, through the exchange of accurate information, delivered in a timely manner between ED and inpatient staff, and by minimizing the need for the patient and family to repeat known information.

Procedure Highlights

- **Pull based:** IP nurse to initiate the transfer of accountability (TOA) by calling the ED nurse. Verbal TOA report is to be completed while room clean is in progress.
- **Direct communication between IP & ED nurse:** ED primary nurse will identify their assigned ASCOM number in the ETR form to facilitate direct communication between the ED and IP primary nurse.

- **IP nurse makes only one attempt at phone call:** If ED primary nurse is unavailable to give verbal report, IP nurse provides their personal ASCOM number to the ED Resource Person (RP) or ED Patient Flow Manager (PFM), who will ensure the IP nurse receives a call back to receive report.
- **Monitored timeframes and escalation procedures:** The verbal TOA call is to be completed within the clearly defined and monitored timeframe, with triggers and escalation procedures to manage breached timeframes:

    - At Bed Ready = 15 min., ED primary nurse will call IP unit RN to provide verbal TOA. If the IP nurse or designate is unavailable to receive report, the ED PFM will be informed.
    - At Bed Ready = 30 min., ED primary nurse will escalated to ED PFM who, if unable to contact the IP unit RP for report, will initiate a portering request and physically go up to notify the receiving unit of a pending patient transfer.
    - ED RN will call unit. One attempt is made. If unsuccessful patient sent to inpatient unit. Inpatient nurse may call EDRN, EDRP or EDPFM at any time.

Procedure Description

The full procedure for transferring a patient from the ED to an IP unit is shown in **Appendix A - Patient Transfer from ED to IP Unit Process Map.**

Bed Assignment

1. As per Bed Management Policy, 2016, the Bed Allocation Clerk will call the IP Resource Person (RP)/Team Leader or designated Unit Clerk to notify that the bed is being assigned and will update the EDM Tracker. The person receiving the call will notify the IP primary nurse that they will be receiving a new patient.
2. Once the bed is assigned, the ED primary nurse will update the ETR electronically in Meditech or using the ED Transfer Report Downtime form (see Appendix A), including their personal ASCOM number next to their name in the form.
3. Semi private rooms are to be filled from emergency. For a patient to be placed in a semi private room following criteria must be met:
    - Patient is from home
    - No recent travel to specific areas
    - Patient is COVID negative
    - Patient is on routine practice
    - IPAC is consulted on all potential SP placement
4. Criteria for Cohorting Patients in Semi Private Rooms (in order)
    - COVID positive and COVID positive
    - COVID recovered and COVID recovered
    - Routine practices on 24/48 hours
    - COVID positive patient requires private room

Transfer of Accountability

5. If the assigned bed requires cleaning, the EVS Attendant will inform the Unit Clerk (during the day) or IP RP (at night) that the cleaning of the discharged room is to be initiated. The Unit Clerk or RP will also monitor the TDSS EVS Tracker for newly initiated discharge room cleans.
6. The Unit Clerk or RP will inform the IP primary nurse assigned to the room when the room clean has been initiated. The expectation is the IP primary nurse will initiate the verbal TOA while the room clean is in progress and prior to the bed being ready. If the bed is clean at the time of assignment, the IP primary nurse will initiate the verbal reporting process once notified of the assignment in Step 1 above.
7. The IP nurse will review the ETR form in PCI under Emergency Department Data – Emergency Transfer Report (ETR). The IP nurse will then call the ED primary nurse directly, via the ASCOM number included in the ETR form, to receive verbal report. During or immediately after the call, the ED primary nurse will update the ETR form as needed, including the name of the nurse receiving report, to ensure that it is reflective of the patient's condition at the time of transfer, including vital signs to be completed within 30 minutes of patient's transfer from ED to IP unit.
8. **Escalation 1:**
    a If the ED primary nurse does not answer the call to give report, the IP nurse will call the ED RP (ASCOM number 70375). The ED RP will record the IP nurse's ASCOM number and notify the ED primary nurse to call the IP nurse back directly within 15 minutes to provide verbal report.
    b If unable to connect with the ED RP, the IP nurse will call the ED PFM (ASCOM number 70340). The ED PFM will record the IP nurse's ASCOM number and notify the ED primary nurse to call the IP nurse back directly within 15 minutes to provide verbal report.
9. Once the bed assigned has been changed to "Bed Ready" in EDM Tracker by the Bed Allocation Clerk, and the verbal report is complete, the ED nurse will instruct the ED clerk to request a porter for the transfer and immediately update the EDM Tracker status to "WAITPORTER". Prior to porter arrival, the ED nurse will prepare the patient, any necessary equipment required during the transfer (IV pump, cardiac monitor), their belongings, medications and patient record.
10. An ED nurse will accompany all telemetry and ICU patients. Cardiac monitoring must continue during transfer. A face to face report between nurses is completed for all ICU patients. Other patients including those receiving blood products during transfer or some paediatric patients will be accompanied by a nurse as clinically indicated. Refer to Transfer of Patients Between Patient Care Units - Procedure v.4
11. **Escalation 2:**
    a Upon completion of a room being cleaned and "cleared" on the TDSS EVS Tracker by the EVS Attendant, the Bed Allocation Clerk will update the EDM Tracker status event to "Bed Ready". If there is no change to the status event after 15 minutes, it will turn **yellow** triggering an escalation procedure.
    b When the "Bed Ready" status event is **yellow**, the Bed Allocation Clerk (during the day/evening) or ED PFM (overnight) will inform the ED primary nurse to initiate the verbal TOA to the IP nurse. Once verbal report is complete, the ED nurse will update the ETR form, instruct the ED clerk to request a porter for the transfer and immediately update the EDM Tracker status to "WAITPORTER".
    c If there is still no change to the status event after 30 minutes, it will turn **red**, triggering a further escalation procedure.

12. When the "Bed Ready" status event is **red**, the Bed Allocation Clerk will inform the ED PFM, who will call the IP RP to initiate verbal report. If the IP RP is unreachable, the ED PFM will instruct the

ED clerk to request a porter for the transfer and update the EDM Tracker status to "WAITPORTER". The ED PFM will then go to the inpatient unit to inform them of the impending patient move.

Nursing shift change on the inpatient units

To allow for safe and effective transfer of accountability during nursing shift change on the inpatient units, no escalations will occur between 07:15 – 07:45 and 19:15 – 19:45. At 7:45 and 19:45, if there are any patients where the EDM Tracker status has been "Bed Ready" for 15 minutes (as indicated by a **yellow** or **red** status event), they will be escalated per the procedure outlined above (Steps 9 & 10).

Crisis situation

If a crisis situation (e.g., cardiac arrest, patient fall) occurs at the time of the telephone call for the verbal report, the ED or IP unit may request a transfer delay of no longer than 1 hour. The IP unit RP will immediately notify their manager during business hours or Corporate Patient Flow Manager (CPFM) after hours, of the delay. The ED RP will notify the ED PFM of the delay. No escalations will occur during the delay. If the delay continues, the manager or CPFM will reallocate resources to ensure the transfer occurs

Downtime

If the ED Transfer Report Downtime form is used, it is faxed to the receiving unit followed by a phone call to notify the receiving unit that the report has been faxed. The information is reviewed in the report during the phone call (Step 5) and patient care information as needed is clarified with the sending ED nurse. This report is a permanent part of the health record.

Patients in Medical Imaging during verbal report or Dialysis

If a patient is in Medical Imaging (MI) when the IP nurse calls for verbal report, the ED nurse will provide verbal report, identifying the patient's current location. The patient will return to the ED before transfer to the IP unit, to allow for the ED nurse to prepare the patient, any necessary equipment required during the transfer (IV pump, cardiac monitor), the patient belongings, medications and patient record. If the patient's condition has not materially changed, the ED nurse will proceed with the transfer as outlined in Step 7 above.

ED Admits that goes to HD Clinic

→ Report should be given to floor and Patient goes directly to inpatient Unit post HD TX.

Accountability / Responsibility

The specific responsibilities of each role involved in the process of transferring a patient from the ED to an inpatient unit are outlined below:

Inpatient Nurse

The IP nurse will:

- When a patient has been assigned to an occupied/dirty bed, the IP nurse will wait until the room clean has been started (with notification to be provided by the Unit Clerk or RP) and review the ETR form. The IP nurse will call the ED nurse directly on their ASCOM as identified in the ETR to receive verbal report before the bed is ready.
- When a patient has been assigned to a clean bed, the IP nurse will initiate the verbal reporting process as soon as they are notified of the assignment by reviewing the ETR form and calling the ED primary nurse directly on their ASCOM as identified in the ETR to receive verbal report.
- If the ED nurse does not answer the call to give report, the IP nurse will call the ED RP at ASCOM number 70375, or, if the ED RP is also unreachable, the ED PFM at ASCOM number 70340 and request a call back on their ASCOM from the ED nurse within 15 minutes. The IP nurse will make every effort to be available for the call back.

ED Nurse

The ED nurse will:

- Initiate the ETR electronically in Meditech or using the ED Transfer Report Downtime form (see Appendix A) within 30 minutes of the admission order being written, with consideration for competing clinical priorities in the ED setting.
- Ensure their name and personal ASCOM number is identified in the ETR. If the ETR is initiated on a previous shift or the patient is moved from one care zone to another, the ETR will be updated with the new ED nurse's name and ASCOM, if applicable.
- Complete STAT orders. Other orders are completed as able.
- Complete the MRSA swabs as able. If unable to obtain, this will be communicated to the IP nurse in the written ETR. If unable to obtain, this will be communicated to the IP nurse in the written ETR and communicated in the verbal report.
- The ED nurse will complete the ETR and provide a verbal report when transferring the care of a patient to the NRT Medical/Surgical nurses assigned to the ED for the shift. This is considered the same as a TOA from ED to IP units.
- Ensure the ETR form is updated upon completion of verbal report to include the name of the person accepting report and to be reflective of the patient's condition at the time of transfer.
- Carry their assigned ASCOM at all times to be reachable by the IP nurse when the latter calls to receive verbal report.
    - If unavailable when the IP nurse calls to receive verbal report, the ED nurse will return the
      IP nurse's call on the latter's personal ASCOM number within 15 minutes of being notified.
- Once EDM Tracker status is "Bed Ready":
    - If verbal report has been given: the ED nurse will instruct the ED clerk to request a porter, or request one themselves, and update the EDM Tracker status to "WAITPORTER". Prior to porter arrival, the ED nurse will prepare the patient, any necessary equipment required during the transfer (IV pump, cardiac monitor), the patient's belongings, medications and patient record.
    - If verbal report has not yet been given: the ED nurse will call the receiving IP unit to give report.

- If a patient is in MI when the IP nurse calls for verbal report, the ED nurse will provide verbal report, identifying the patient's current location. The patient will return to the ED before transfer to the IP unit, to allow for the ED nurse to prepare the patient, any necessary equipment required during the transfer (IV pump, cardiac monitor), the patient's belongings, medications and patient record.

Inpatient RP

- Notify the IP primary nurse that they will be receiving a new patient when alerted of the new bed assignment. The IP nurse is to initiate the verbal report process as soon as possible if the room is already clean.
- When informed by the EVS Attendant that they are starting to clean a discharged room, notify the IP primary nurse to initiate the verbal report process while the room is being cleaned.
    - When there is no Unit Clerk coverage, periodically monitor the TDSS EVS Tracker in order to be aware of when discharged rooms are being cleaned (in the event no notification is provided by the EVS Attendant).
- In the event of an escalation, where "Bed Ready" status event is yellow or **red**, receive verbal report from ED nurse when called and convey to the IP nurse.

ED RP

The ED RP will:

- When receiving a call from the IP nurse attempting to get verbal report from the ED primary nurse who is unreachable, the ED RP will take the IP nurse's ASCOM number and notify the ED primary nurse to call the IP nurse back directly within 15 minutes to give verbal report.

Inpatient Unit Clerk

The IP Unit Clerk will:

- When informed of a new bed assignment, notify the IP primary nurse that they will be receiving a new patient (and to initiate the hand-off process as soon as possible if the room is already clean).
- When informed by the EVS Attendant that they are starting to clean a discharged room, notify the IP primary nurse to initiate the hand-off process while the room is being cleaned.
    - Periodically monitor the TDSS EVS Tracker in order to be aware of when discharged rooms are being cleaned, in the event no notification is provided by the EVS Attendant.

Bed Allocation Clerk

The Bed Allocation Clerk will:

- Once a bed has been assigned to an ED patient, call the receiving unit's designated Unit Clerk or RP to inform them of the bed assignment and update the EDM Tracker.
- Monitor the status of the assigned bed on the TDSS EVS Tracker and update the EDM Tracker status to "Bed Ready" once the bed has been "cleared" on TDSS EVS Tracker. ▯

Regularly monitor the EDM Tracker in order to trigger the appropriate escalation procedure should the "Bed Ready" status event change colour:

- When the "Bed Ready" status event is yellow, the Bed Allocation Clerk will inform the ED primary nurse to either:

- initiate the TOA by calling the receiving unit's RP to give report, or, if report has already been given;
- request a porter to transport the patient.

- When the "Bed Ready" status event is **red**, the Bed Allocation Clerk will inform the ED Flow Manager (during the day/evening) or PSC (overnight).

ED Patient Flow Manager (PFM)

The ED PFM will:

- When receiving a call from the IP nurse attempting to get verbal report from the ED primary nurse who is unreachable, the ED PFM will take the IP nurse's ASCOM number and notify the ED nurse to call the IP nurse back directly within 15 minutes to give verbal report.
- In the event of an escalation, where "Bed Ready" status event is **red**, the ED PFM will be notified by the Bed Allocation Clerk and will call the IP RP to initiate verbal report. If the IP RP is unreachable, the ED PFM will instruct the ED clerk to request a porter for the transfer and update the EDM Tracker status to "WAITPORTER". The ED PFM will then go to the inpatient unit to inform them of the impending patient move.

Corporate Patient Flow Manager (CPFM)

The CPFM will:

- If a crisis situation (e.g., cardiac arrest, patient fall) occurs at the time of the telephone call for the verbal report, the IP unit may request a transfer delay of no longer than 1 hour.
- The IP unit RP will immediately notify their manager during business hours or CPFM after hours, about the delay. No escalations will occur during the delay. If the delay continues, the manager or CPFM will reallocate resources to ensure the transfer occurs.

EVS Attendant

The responsibilities of the EVS Attendant are:

- Inform the Unit Clerk (during the day) or IP RP (at night) as they are about to start cleaning a discharged room.

Definitions

Emergency Transfer Report or Emergency Transfer Downtime Report – Document containing the patient name and other identifiers, reason for transition, safety concerns, infection prevention and control considerations, assessment and personal belongings. This report is communicated both in writing and verbally between the sending ED nurse and receiving IP nurse for all admissions.

Pull System – A process by which patients are pulled from the ED onto the IP units as soon as the bed is ready by having the IP nurse initiate the transfer of accountability process once the room clean has been initiated.

Documentation

The ED nurse completes the Emergency Transfer Report in Meditech or using the downtime form and faxing it to the receiving unit. **See Appendix B – Emergency Transfer Downtime Report**

Infection Prevention and Control Considerations

All patients will be cared for using Infection Prevention and Control Routine Practices and Additional Precautions as outlined in **Provincial Infectious Diseases Advisory Committee (PIDAC):** Routine Practices and Additional Precautions, Ministry of Health and Long-term Care, as per HRH policy. All staff will perform Hand Hygiene as per HRH guideline.

References

Accreditation Standard/Criteria:

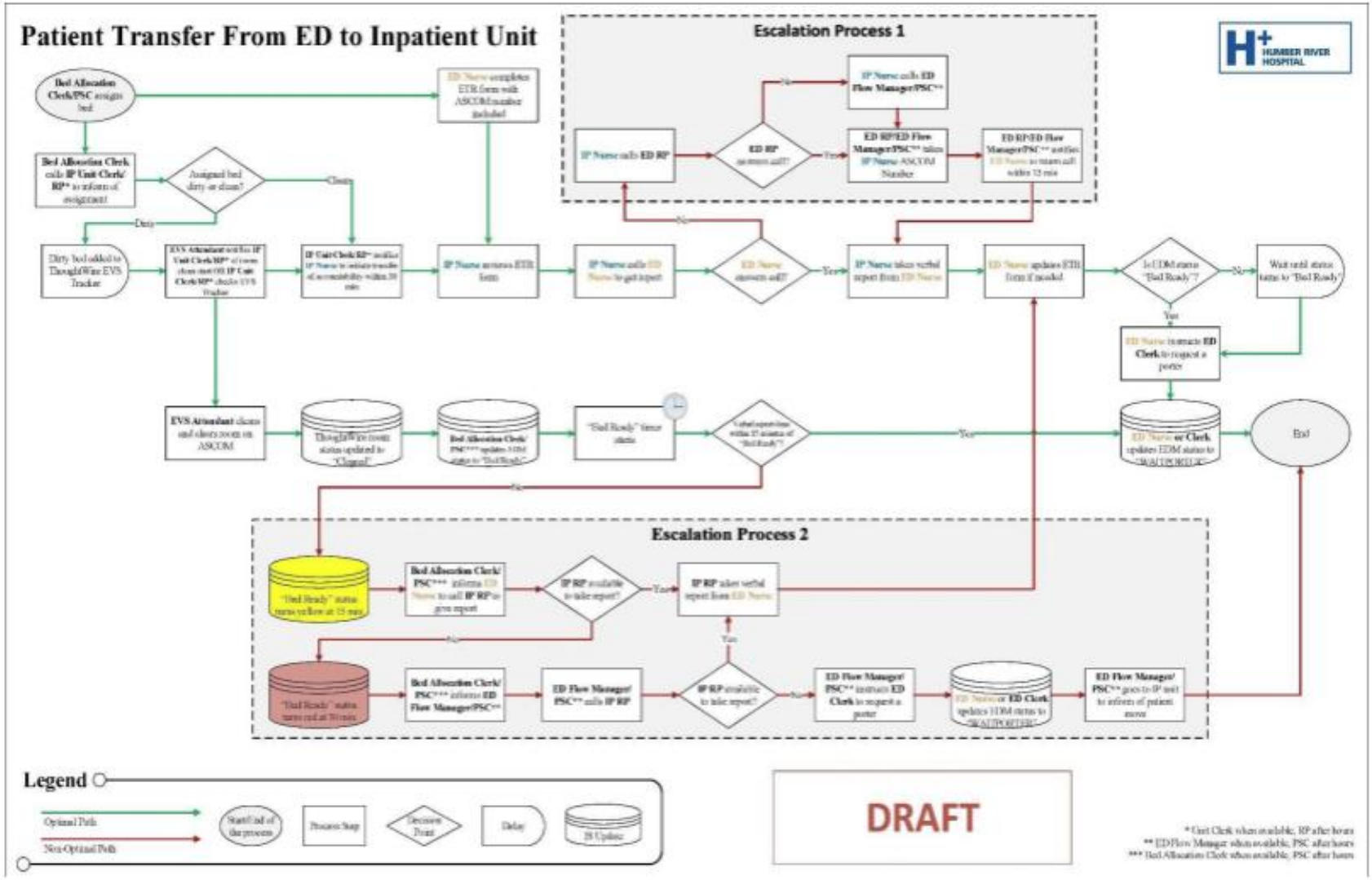
Accreditation Canada (2016). Information transfer at care transitions. In Accreditation Canada, Required organizational practices: Handbook 2017. Ottawa, ON: Author. Retrieved from http://www.gov.pe.ca/photos/original/src_rophandbook.pdf

HRH (2015). Bed management. Toronto, ON: Author.

HRH (2017). Transfer of patients between patient care units – Procedure. Toronto, ON: Author.

Registered Nurses' Association of Ontario (2014). Care Transitions. Toronto, ON: Registered Nurses' Association of Ontario.

APPENDIX A: Patient Transfer from ED to IP Unit Process Map



Patient Name: _____

Unit Number: _____

Account Number: _____

Date of Birth: _____ *Sex:* ____

Emergency Transfer Report

IDENTIFY: **RECEIVING UNIT:** _____

Patient ID in place and confirmed correct: ☐ Medication Allergies: _____

Food Allergies: _____ Other Allergies: _____

_____

Allergy Band in place: ☐ Green Arm Band in place: ☐ Resuscitation Status: ☐ Weight (Kg) _____

SITUATION:

Admitting Diagnosis: _____ MRP: _____

Secondary Medical Conditions: _____

History of stated complaint: _____

_____

SAFETY:

Therefore, falls risk is moderate to high: ☐ Falls risk sign at bedside? ☐

Pressure Ulcer(s) present on arrival to ER? ☐
Location and description of pressure ulcer: _____

Therefore, pressure ulcer development risk is high? ☐ Pressure ulcer risk sign at bedside? ☐
Is patient in restraints? ☐ Specify: _____

BPMH complete as possible at this time: Complete ☐ Partial ☐ Unable to Initiate ☐

Identified barrier in getting information: _____

Medications transferred to unit with patient? Yes ☐ No ☐ If no, why? _____

BACKGROUND:

INFECTION PREVENTION AND CONTROL

Precautions> _____ MRSA/VRE

Swabs Sent? Yes ☐ No ☐

REVIEW OF LAB VALUES

Critical results: _____ Date: _____ MD (name) notified: _____

Describe any abnormal results and/or tests not yet completed or pending? _____

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ASSESSMENT:

VITAL SIGNS:

Date and Time of Last set of vital signs (within 30 minutes of transfer to unit)

Date: _____ **Time:** _____

Temperature _ Pulse _ Respirations _ B/P SaO2:_ R/A?_____ Fi02 %: _ Oxygen delivery> _____

CARDIOVASCULAR: Include Intake and Output and IV's

Cardiac Rhythm Interpretation: _____NPO: ☐ Input/Output status: _____

IV site #1: _____ IV therapy solution #1: _____ IV Rate:_____mL/hr

IV Site #1 TBA: _____ Additional IV's: (free text): _____

Does the patient have a CVAD?: Yes ☐ No ☐ If yes, specify: _____

PAIN

Is the patient experiencing pain? Yes ☐ No ☐ Location? _____

Time last analgesic given?: _____

RESPIRATORY

PPPPG Print Date: 10/28/2023 Page 11 of 12

Chest auscultation: _____ Tracheostomy: ☐

NEUROLOGICAL: Level of alertness, behaviour	**INTEGUMENTARY:** Wound, Dressings
GI: BM's, Ostomy & Nutritional status	**MUSCULOSKELETAL AND ADL:** Mobility, Hygiene
GU: Urinary catheter, Voiding, dialysis	**PSYCHOSOCIAL:** Family & Emotional status

RECOMMENDATION: Transfer to Inpatient area

OTHER: Urgent issues requiring follow up, Consults, Referrals

---

PATIENT BELONGINGS ACCOMPANYING PATIENT ON TRANSFER

Patient belongings/clothes bag ☐ Dentures ☐ Glasses ☐ Purse/Wallet

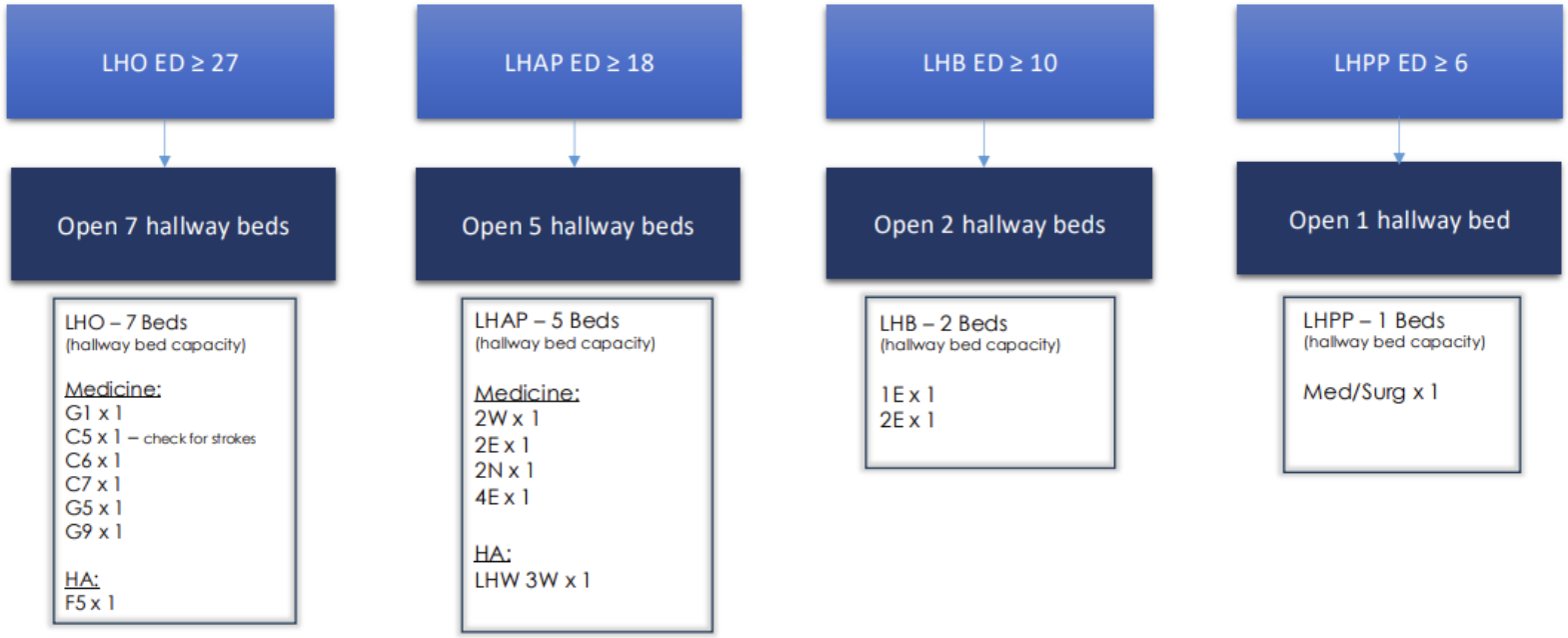
Transferring nurse (Print Name):	Designation	Date/Time:
Signature:	Agency (if applicable):	

Push Strategy

-enacted when not in overcapacity protocol

	Steps	Details
1	Assigning to confirmed discharges	When the discharge comes through on a unit, an ED patient will be assigned to the hallway on that unit so that the bed is immediately "ready" and there is not a wait time for the patient to go home. Subsequent patients will be assigned as normal to the bed where the patients are being discharged. Once the patient of the bed that the hallway patient was assigned to goes home, the hallway patient will go to their bed and another ED patient waiting for a bed on that unit will go to the hallway space.

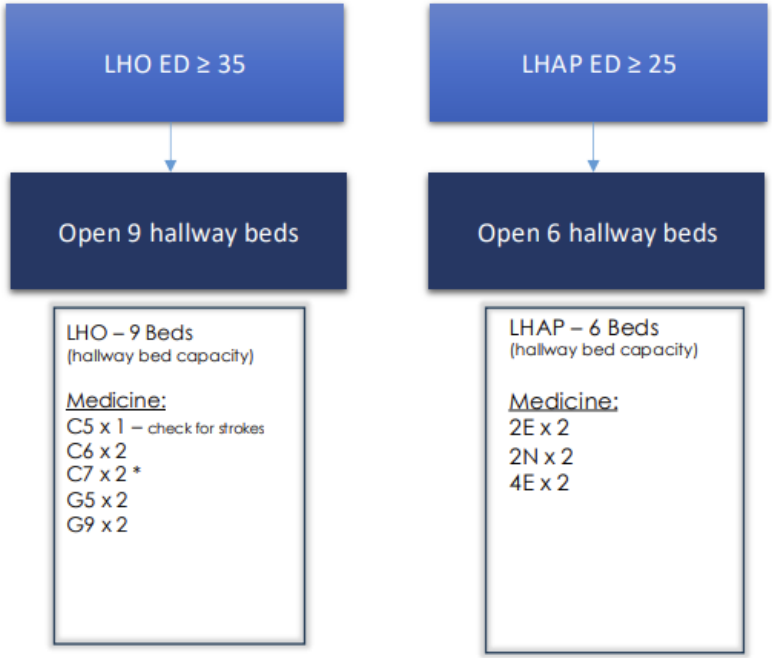
Overcapacity Protocol: Stage 1



Note that when volumes exceed trigger points, this will be verbally flagged in daily Bed Meeting for organizational awareness that overcapacity hallway beds are being utilized.
Specialty Medicine will further support overcapacity planning by delineating plan to pull 1-2 palliative patients from acute units to LHO 4F.
Healthy Aging will further support overcapacity planning by delineating plan to pull 1 hallway patient from acute unit on LHO F5 and LHW 3W.
MHA, Surgery, and W&C will continue to support flow and will work with flow to utilize hallway spaces when needed.
If units identified to pull have critical staffing levels and no ability to mitigate staffing concerns, they should notify the Operations Supervisor asap to avoid hallway assignment.

01-13-25

Overcapacity Protocol: Stage 2



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MHA, Surgery, and W&C will continue to support flow and will work with flow to utilize hallway spaces when needed.
If units identified to pull have critical staffing levels and no ability to mitigate staffing concerns, they should notify the Operations Supervisor asap to avoid hallway assignment.
*C7 – on Thursdays when cardioversions are completed, this stage 2 bed will not be utilized. Once the cardioversions leave, this bed can be utilized

01-13-25

Changes

- For push strategy

- Removed assigning to potentials since overcapacity triggers have been decreased

- For Stage 1:

- Changed LHO to 27 from 35
- Changed C5, C6, C7, G5, G9 to 1 hallway bed vs 2
- Now there is a total of 6 medicine and 1 HA hallway bed vs 11 medicine and 1 HA for Stage 1
- Changed LHAP to 18 from 25
- Changed 2E, 2N and 4E to 1 hallway vs 2
- Now there is a total of 4 medicine and 1 HA hallway bed vs 7 medicine and 1 HA bed for Stage 1

- For Stage 2:

- Changed LHO to 35 from 45
- Changed C6, C7, G5, G9 to 2 hallway bed vs 1.
- Now there is a total of 9 hallway beds at stage 2 vs 5
- C5 going to keep 1 hallway vacant to ensure access for a stroke admission
- Changed LHAP to 25 from 30
- Changed 2E, 2N, 4E to 2 hallway beds from 1.
- Now there is a total of 6 hallway beds in medicine vs 3

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Implementation of the ISAR tool

Why is this important?

"ALC Patient"

The Person

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2 | April 9, 2025

ISAR Tool

Identification of Seniors At Risk

PLEASE ANSWER YES OR NO TO EACH OF THESE QUESTIONS

		Hospital use only
1. Before the illness or injury that brought you to the Emergency, did you need someone to help you on a regular basis?	☐ YES ☐ NO	1 0
2. Since the illness or injury that brought you to the Emergency, have you needed more help than usual to take care of yourself?	☐ YES ☐ NO	1 0
3. Have you been hospitalized for one or more nights during the past 6 months (excluding a stay in the Emergency Department)?	☐ YES ☐ NO	1 0
4. In general, do you see well?	☐ YES ☐ NO	0 1
5. In general, do you have serious problems with your memory?	☐ YES ☐ NO	1 0
6. Do you take more than three different medications every day?	☐ YES ☐ NO	1 0
	TOTAL:	_____

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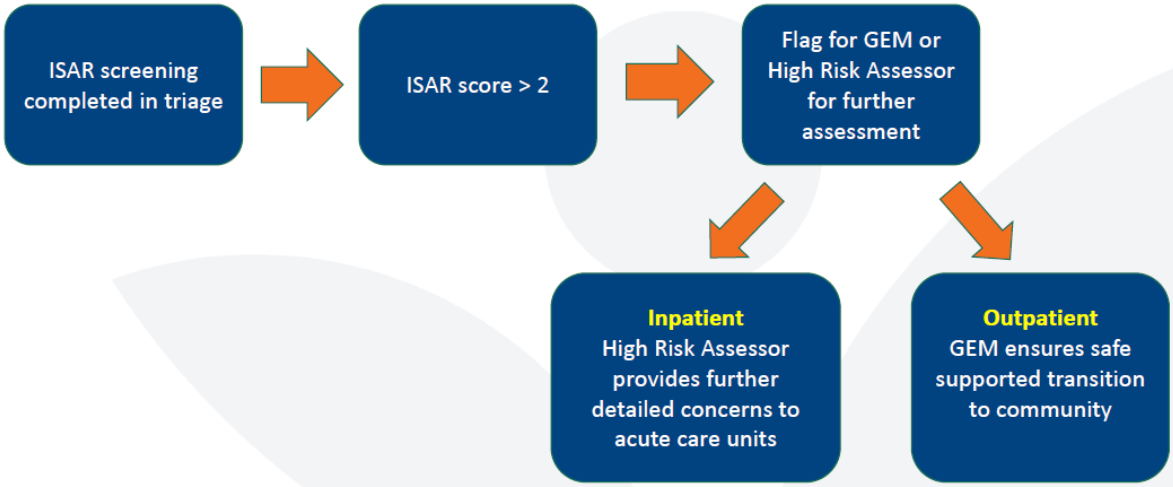
Score results



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4 | April 9, 2025

Specialized Populations

A COMPETENCY FRAMEWORK FOR INTERPROFESSIONAL COMPREHENSIVE GERIATRIC ASSESSMENT

A Competency Framework for Interprofessional Comprehensive Geriatric Assessment

Final Report

Revised October 25, 2017

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Introduction

According to the Regional Geriatric Programs (RGPs) of Ontario,

> **Comprehensive Geriatric Assessment (CGA) guides a multidimensional specialized geriatric team approach to care that determines a frail older person's biomedical, psychosocial, functional, and environmental needs, and initiates an appropriate treatment and follow-up plan... There is evidence demonstrating that CGA improves diagnostic accuracy, optimizes care plans, improves patient and system outcomes, and assists clinicians in identifying the need for treatment.** [1]

The purpose of this competency framework is to describe detailed practice expectations of health professionals participating in the CGA. This Framework will help health professionals to adequately prepare themselves to deliver interprofessional comprehensive geriatric assessments and interventions and work effectively in a specialized geriatrics environment.

[1] RGP of Ontario (2016, p 1).

Background

This Framework draws on the definition of specialized geriatric services (SGS) and CGA developed by the RGPs of Ontario [2]. The Framework development was facilitated by Seniors Care Network, the North East Specialized Geriatric Centre, and the Regional Geriatric Program of Toronto, who oversaw the project through a Joint CGA Task Group, in collaboration with the RGPs of Ontario. The development of this Framework began with the Phase 1 Development Panel who conducted a review of existing relevant competency frameworks (see Appendix B) and undertook the iterative development of initial behavioural statements. A Phase 2 Expert Review Committee later focused on confirming the domains of the CGA (see Appendix A) laying the foundation for the revision of the initial behavioural statements. In Phase 3, a Provincial Expert Delphi Panel, a group of geriatric experts from a variety of health professional disciplines who were identified by their local RGP, completed three rounds of rigorous review, rating and revision, culminating in this final Framework. A list of all Expert Panel members is found at Appendix C.

Benefits to SGS Practice

The implications for practice resulting from this framework are expected to include: (1) improved quality of assessments; (2) improved goal-based care planning; (3) better tailoring of appropriate interventions; (4) appropriate follow-up and follow through; and (5) improved consistency in assessment practices across SGS providers. It is anticipated that this framework will support training needs assessment (TNA) approaches in SGS. This may include the critical appraisal of existing educational/training resources to identify most appropriate methods to support competency development across each domain, or the development of new strategies to support capacity development/education for practitioners related to interprofessional CGA.

[2] Ibid

Comprehensive Geriatric Assessment

A Philosophy Statement

CGA is the standard of care for specialized geriatric services for frail seniors [3]. The CGA is a multi-dimensional process used to manage care for frail seniors, and employs an interprofessional, patient-focused approach to comprehensive assessment and intervention [4,5]. The CGA is supported by a highly skilled interprofessional team that uses expert clinical judgment, evidence-informed practices, technology and tools, in order to gather, synthesize, and interpret information required to understand the patient's [6] story and biopsychosocial needs. The outcome of the CGA is an integrated clinical profile and an individualized care plan. The resulting care plan addresses patient goals, enables choice and includes practical interventions that support function, independence, restoration/rehabilitation and/or palliation. The team supports the patient and their identified support networks to implement their individualized care plans and interventions.

The CGA can be initiated by any member of the interprofessional team who has received appropriate training [7]. This means that all team members function as geriatric assessors, sharing a common set of competencies. Geriatric assessors are supported by an expert clinician whose scope includes diagnostic and prescriptive authority (e.g. geriatricians, non-specialist physicians or specialist nurse practitioners). Team members contribute additional information using the lens of profession-specific geriatric knowledge and skills, and together the team creates a comprehensive plan of care in collaboration with the patient. It is the combination of interprofessional geriatric assessment data, physical assessment findings, analysis and synthesis of the clinical profile and development of a collaborative plan of care and follow-up plans that constitutes a complete CGA.

Strengths of the interprofessional model in SGS include the leveraging of common geriatric competencies and profession-specific skills and knowledge. The integration of common geriatric competencies, profession-specific competencies, and collaborative competencies relevant to interprofessional practice, differentiates this practice model from multidisciplinary models of care.

[3] Stuck et al. (1993).
[4] Welsh et al. (2014)
[5] Ramani et al. (2014)
[6] Throughout this document the term "patient" is used and is intended to mean patient and their identified support system (e.g. caregivers, family).
[7] Grant. (2016)

The Competency Framework

Purpose

The Competency Framework for Interprofessional Comprehensive Geriatric Assessment includes practice-specific behavioural statements describing the common and overlapping requisite knowledge, skills, values, and attitudes (i.e. competencies) that are the foundational elements of competence in interprofessional geriatric team-based practice [8]. Competence is demonstrated through the application of appropriate clinical judgments and actions in the context of care for older people living with frailty.

Health professionals performing an interprofessional CGA are regulated health professionals [9] who use core geriatric knowledge to guide a multidimensional CGA. The competencies needed to enable an effective CGA are in addition to discipline specific competencies relevant to an individual's specific profession. Further, some health professions require additional role-specific professional competencies (e.g. physicians, nurse practitioners, etc.), that are not intended to be described in this work.

This competency framework is not intended to replace practice competencies required by health professional regulatory colleges, but to supplement/complement the practice of experienced clinicians who are now working in geriatrics.

[8] Frank et al. (2010)

[9] Geriatric Assessors may include, but are not limited to: Dietitians, Occupational Therapists, Pharmacists, Physiotherapists, Registered Nurses, Registered Practical Nurses, Social Workers, Speech-Language Pathologists and others. Nurse Practitioners and Physicians (Geriatricians) also possess all competencies of the geriatric assessor and additional competencies related to their roles as diagnosticians and Most Responsible Providers (MRPs). Personal Support Workers may support the work of the Geriatric Assessor and contribute to the implementation of interventions and ongoing observations.

Practice Areas and Behavioural Statements

1. Core Geriatric Knowledge

Demonstrate fundamental understanding of physiological and biopsychosocial mechanisms of the aging processes, age-related changes to functioning, and the impact of frailty.

1. a) Apply knowledge of the clinical, socio-behavioural, and fundamental biomedical sciences relevant to geriatric clinical practice, including but not limited to:

- 1. a.i) Normal aging
- 1. a.ii) Frailty
- 1. a.iii) Atypical presentation of disease or medical conditions in the older adult
- 1. a.iv) Geriatric management of the older adult with multiple, complex medical conditions
- 1. a.v) Falls and mobility
- 1. a.vi) Immobility and its complications
- 1. a.vii) Cognitive function
- 1. a.viii) Mild cognitive impairment (MCI)
- 1. a.ix) Dementias including behavioral and psychological symptoms (BPSD)
- 1. a.x) Delirium
- 1. a.xi) Mood disorders and other psychiatric manifestations
- 1. a.xii) Pain management
- 1. a.xiii) Nutrition/Malnutrition
- 1. a.xiv) Bowel and bladder management
- 1. a.xv) Bone disorders
- 1. a.xvi) Metabolic disorders

1. b) Demonstrate skill in working with older adults with significant functional deficits and communication challenges (e.g. cognitive impairment, sensory impairment, behavioral problems or ethno-cultural pluralities).

1. c) Demonstrate knowledge of medications management, including but not limited to:

- 1. c.i) Complete a detailed Best Possible Medication History and perform medication reconciliation.
- 1. c.ii) Promote adherence to a prescribed drug regimen.
- 1. c.iii) Identify potentially inappropriate medications for an older adult patient.
- 1. c.iv) Recognize polypharmacy.

1. d) Demonstrate knowledge of currently accepted recommendations for primary and secondary prevention of common geriatric syndromes.

1. e) Demonstrate an awareness of the limitations of the scientific literature with regard to generalizability and applicability to a frail older population.

2. Screening, Assessment, and Risk Identification

Gather patient medical and social history and clinical data in sufficient depth to inform care planning and effective clinical decision making.

2. a) Identify and explore issues to be addressed in a patient encounter including the patient's context and preferences.

2. b) Conduct an assessment within identified domains of the CGA using clinical acumen in conjunction with standardized, valid, reliable instruments as appropriate.

2. c) Recognize important clinical indicators to promote patient safety (e.g. signs and symptoms, laboratory tests, adverse effects).

2. d) Assess an older person with multiple physical, medical, cognitive/psychiatric, functional, and/or social problems.

2. e) Identify reliable sources of information to inform the patient history (e.g. Cumulative Patient Profile, involved family etc.).

2. f) Compile a history, drawing from reliable sources, that is relevant, clear, concise and accurate to context and preferences for the purposes of prevention and health promotion, diagnosis, treatment and/or management.

2. g) Gather information about a patient's beliefs, concerns, expectations and illness experience.

2. h) Collect a collateral history; supporting details from a close source who knows the patient's daily routines and function accurately (e.g. family member or caregiver).

2. i) Recognize the significance of behavioural observations in dementia care.

2. j) Assess an older person for their capacity to consent to treatment and make personal decisions.

2. k) Recognize and identify risk factors for and assess the presence of abuse/neglect (i.e. financial, physical, emotional, sexual).

2. l) Perform and/or interpret an environmental safety screen.

2. m) Identify specific patient vulnerabilities across the social determinants of health (e.g. lack of family support, lack of primary care, and chronic mental health issues, financial challenges etc.) that increase the risk the patient's needs will not be met.

2. n) Identify and assess caregiver burden.

3. Analysis and Interpretation

Conduct accurate analysis of assessment findings and clinical information to develop a complete understanding of the patient's story. Integrate assessment findings within and across domains to formulate a cohesive clinical impression.

3. a) **Synthesize relevant information from multiple sources including perspectives of patients and families, colleagues, and other professionals.**

3. b) **Analyze and interpret results against age-appropriate and patient-specific norms.**

3. c) **Analyze and take appropriate action related to important clinical indicators (e.g. signs and symptoms, laboratory tests, adverse effects) to promote patient safety.**

3. d) **Evaluate the reason for change from baseline pre-morbidity to current functional status.**

3. e) **Evaluate the restorative potential of the older patient.**

3. f) **Demonstrate the ability to deal effectively and efficiently with clinical complexity by prioritizing problems.**

4. Care Planning and Intervention

Demonstrate expertise in treatment, education, goal setting, future and advance planning. With patients and their identified support network, formulate comprehensive, collaborative care plans focused on optimization of function and quality of life. Demonstrate knowledge of community resources and appropriate referral sources and mechanisms to access them. Conduct iterative and ongoing review and revision of the care plan and adjust interventions and modify goals as needed.

4. a) **Engage patients, families, and relevant health professionals in shared decision-making to develop a plan of care.**

4. b) **Evaluate the level of engagement and capabilities of caregiver(s) to meet the needs of older patients.**

4. c) **Include interventions to alleviate caregiver burden in the care plan.**

4. d) **Apply evidence-informed interventions appropriate to a geriatric population.**

4. e) **Use information about behavioural observations to inform a patient centred goal-based care plan.**

4. f) **Develop care plans that include the use of preventive, adaptive and therapeutic interventions in collaboration with interprofessional team members.**

...continued on the next page

4. g) Negotiate and construct timely care plans reflecting a patient's goals, beliefs, concerns and expectations in the context of their health trajectory.

4. h) Clearly synthesize the agreed interventions and responsibilities including follow-up actions.

4. i) Assure that individual responsibilities in a specific care plan are explicit and understood.

4. j) Check for patient and family understanding, ability and willingness to follow through with recommended interventions within recommended time frames.

4. k) Encourage participation in health promotion and disease prevention activities.

4. l) Promote safety while respecting patient autonomy in care planning decisions.

4. m) Propose a safety plan in response to abuse, in conjunction with clinical team and others (e.g. police).

4. n) Mediate situations of conflict between older adults and their family members in relation to care planning.

4. o) Conduct follow-up consultation(s) to evaluate the therapeutic effectiveness of care plans.

4. p) Assess acceptance, tolerance, safety, and adherence to the care plan.

4. q) Continue to refine interventions based on patient response and goal attainment.

4. r) Demonstrate the ability to promote integrated care of older patients, especially those with complex needs, and ease transitions across the variety of settings where they may receive services.

4. s) Identify the role of specialized geriatric services in providing case management for the frail senior.

4. t) Identify and appropriately discharge patients whose specialized geriatric service goals have been met.

4. u) Reinforce the importance of advance care planning and discuss with patients and families the implications of their illness to allow patients and their families to prepare a robust advance care plan.

4. v) Support patients and their families to access timely and appropriate end-of-life care consistent with their belief systems.

5. Interprofessional Practise

Demonstrate and support interprofessional geriatric practice. Recognize and engage in inter-organizational collaboration through understanding of the roles of internal and external team members, and demonstrate the ability to identify appropriate opportunities to refer to collaborating teams/individuals.

5. a) Demonstrate both knowledge of critical concepts and the skills needed for effective functioning in multidisciplinary/interprofessional clinical teams.

5. b) Identify and describe the role and expertise of members of the interprofessional team in the care of patients.

5. c) Demonstrate insight into limits of own expertise.

5. d) Demonstrate effective, appropriate, and timely consultation of another health professional as needed for optimal patient care.

5. e) Demonstrate the skills needed to address potential differences and misunderstandings between professionals.

5. f) Regularly reflect on dynamics and productivity of self and interprofessional team.

5. g) Cooperate with and show respect for all members of the interprofessional team by:

- 5. g.i) Making expertise available to others.
- 5. g.ii) Sharing relevant information.
- 5. g.iii) Contributing to identification of shared areas of concern and strategies and priorities for patient care to address those concerns.

5. h) Participate in defining team goals and objectives.

5. i) Effectively collaborate with others, including primary health care providers and other partners:

- 5. i.i) To provide quality care.
- 5. i.ii) In research, education, program review or administrative responsibilities.
- 5. i.iii) To promote health and wellness in the community.

6. Professional Practice

Demonstrate core values, behaviours and skills required to provide comprehensive, team based geriatric care. Demonstrate confidence in evaluating and maximizing own professional scope to optimize geriatric practice.

6. a) Demonstrate compassionate and patient-centered care.

6. b) Facilitate older adults' active participation in all aspects of their own health care (e.g. access to information, right to self-determination, right to live at risk, access to information and privacy).

6. c) Respect and promote older adults' rights to dignity and self-determination.

6. d) Demonstrate leadership and accountability for providing follow-up on identified patient needs or directing follow-up as appropriate.

6. e) Discuss with the patient the ongoing responsibilities of the geriatric assessor, patient and other health care professionals.

6. f) Understand and apply the principles of capacity for decision making and informed consent.

6. g) Follow procedures for voluntary consent or proxy decision making (e.g. Substitute Decision Maker, Public Guardian and Trustee etc.) that arise from aging issues.

6. h) Obtain informed consent throughout assessment, care planning and interventions.

6. i) Evaluate the impact of family dynamics on patient's health, safety, and therapeutic goals.

6. j) Respect diversity and difference, including but not limited to the impact of gender, sexual identity, family dynamics, religion and cultural beliefs on decision-making.

6. k) Address challenging issues effectively, such as obtaining informed consent, sensitively discussing a diagnosis/prognosis, addressing emotional responses, confusion or misunderstanding.

6. l) Identify and appropriately respond to relevant ethical issues arising in the care of older adults.

6. m) Maintain the patient's health record as per organizational policy and legislated requirements.

6. n) Document and share within the circle of care, the patient goals, appropriate findings of patient assessment, recommendations made, responsibilities of involved parties and actions taken.

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6. Professional Practice

6. o) **Document communication with patient and health care professionals across the broad care team in the appropriate locations (e.g. patient record and/or care plan) including connections with inter and extra agency team members, telephone calls of a clinical nature etc.**

6. p) **Evaluate self and demonstrate an understanding of the importance of and the process of continuing professional development.**

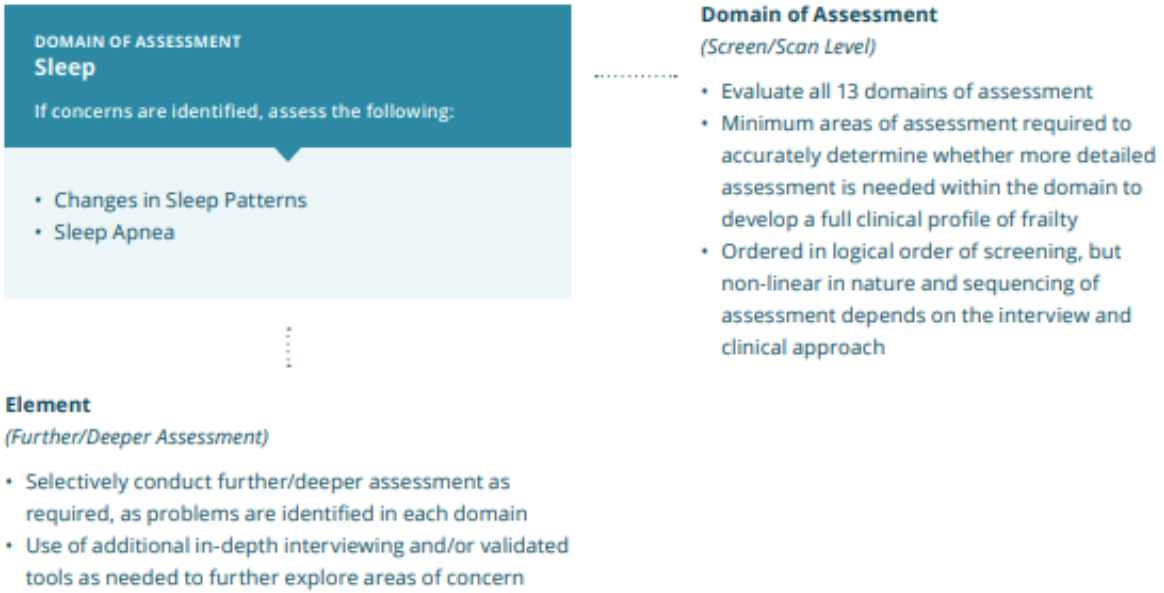
- 6. p.i) Critically reflect on own practice.
- 6. p.ii) Assess own learning needs.
- 6. p.iii) Develop a plan to meet learning needs.
- 6. p.iv) Seek and evaluate learning opportunities to enhance practice.
- 6. p.v) Incorporate learning into practice.
- 6. p.vi) Act as a preceptor/mentor for interprofessional team and students.

Appendix A: Domains of Assessment

In Fall 2014, an initial clinician panel identified an extensive list of domains and elements believed to be required for the delivery of an interprofessional comprehensive geriatric assessment and associated interventions (CGA). This list was created based on clinical experience and current evidence. Through an iterative decision making process with provincial experts, the initial domains were then consolidated into thirteen broad assessment domains and constituent elements. This list of domains and elements was approved by the Regional Geriatric Programs (RGPs) of Ontario in June 2016. This final list of domains is included in this appendix and underpins the development of the Competency Framework for Interprofessional Comprehensive Geriatric Assessment.

The approach to CGA includes the clinical review of the following thirteen core domains, and may include the use of tools and cueing questions to elicit information needed for clinical decision-making, diagnosis and the formulation of an accurate clinical impression. The selection of tools is determined by clinical judgment and may be influenced by the need for reference values to track change over time or signal the need for further assessment.

The thirteen broad assessment domains that have been endorsed by the RGPs of Ontario are described and minimum expectations for assessment are summarized. The diagram below explains how to interpret the domain list:



DOMAIN OF ASSESSMENT
Introduction

If concerns are identified, assess the following:

- Reason for Referral
- What issues would you like to address? (Patient, Family, Caregiver)
- Access to Primary Care Provider

DOMAIN OF ASSESSMENT
Medical/Surgical History

If concerns are identified, assess the following:

- Past Medical History
- Chronic Disease Management
- Preventative Health Practices
- Communication
- Family history of relevant diseases (e.g. Dementia – with age of onset)

DOMAIN OF ASSESSMENT
Medication

If concerns are identified, assess the following:

- Allergies
- Best Possible Medication History (BPMH)
- Medication Adherence
- Packaging and Administration

DOMAIN OF ASSESSMENT
Continence

If concerns are identified, assess the following:

- Bladder/Bowel

DOMAIN OF ASSESSMENT
Social History

If concerns are identified, assess the following:

- Gender/ Sexuality
- Culture/language/Religion/Place of Birth
- Family Demographic (marital status, children)
- POA/SDM
- Advance Care Directives
- Caregiver Support/ Burden/Social & Community Supports
- Current or Past Occupation
- Financial Resources
- Alcohol/Smoking/Recreational drugs (past and present)
- Abuse/Neglect (i.e. Financial/Physical/ Emotional/Sexual)
- Hobbies and interests

DOMAIN OF ASSESSMENT
Falls

If concerns are identified, assess the following:

- History of Falls/Near Falls
- Identification of Modifiable Risk Factors
- Head Injury Risk

DOMAIN OF ASSESSMENT
Function

If concerns are identified, assess the following:

- Living Environment (Safety)
- Equipment/Assistive Devices
- Mobility/Transfers/Gait/Balance
- Activities of Daily Living (ADLs)
- Instrumental Activities of Daily Living (IADLs)
- Driving/ Transportation

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DOMAIN OF ASSESSMENT
Cognition

If concerns are identified, assess the following:

- Subjective Cognitive Decline (SCD)
- Mild Cognitive Impairment
- Dementia (stage and type)
- Responsive Behaviours
- Delirium history
- Risk (potential/theoretical vs. real/actual)

Note these 10 areas of risk:

Driving, Injury (Falls), Fire, Malnutrition, Wandering, Medication non-adherence, Self-poisoning, Exposure (heat/cold), Weapons, Abuse.

DOMAIN OF ASSESSMENT
Pain

If concerns are identified, assess the following:

- Chronic/Acute
- Non-Pharmacological Treatments

DOMAIN OF ASSESSMENT
Nutrition

If concerns are identified, assess the following:

- Amount of Unintentional Weight Loss in the Past 6 Months
- Reduced Food Intake (how long?)
- Hydration
- Swallowing

DOMAIN OF ASSESSMENT
Mood/Mental Health

If concerns are identified, assess the following:

- Past/current issues with mood
- Depression
- Anxiety
- Suicide
- Grief/Loss
- Stress
- Addictions
- Apathy

DOMAIN OF ASSESSMENT
Sleep

If concerns are identified, assess the following:

- Changes in Sleep Patterns
- Sleep Apnea

DOMAIN OF ASSESSMENT
Physical Assessment

If concerns are identified, assess the following:

- Vital signs
- Orthostatic Hypotension
- Vision
- Hearing
- Oral Health
- Neurological Musculoskeletal (MSK)
- Cardiovascular
- Respiratory
- Gastroenterology
- Foot
- Skin/Nodes/ Thyroid
- Labs/ Diagnostics

Appendix B: Works Consulted

The preceding team-based competencies and behavioural practice statements reflect the expected practice of team-based interprofessional geriatric assessors. This list has been compiled following the review of existing competency documents including:

American Society of Consulting Pharmacists. (2015). Geriatric pharmacy curriculum guide.

Retrieved from https://www.ascp.com/sites/default/files/CurriculumGuide_Final_2015B.pdf

Association for Gerontology in Higher Education (2014) [10]. Gerontology competencies for gerontology in undergraduate and graduate education.

Retrieved from https://www.aghe.org/images/aghe/competencies/gerontology_competencies.pdf

Canadian Gerontological Nurses Association. (2010). Gerontological nursing competencies and standards of practice.

Retrieved from http://www.cgna.net/uploads/CGNAStandardsOfPractice_English.pdf

Canadian Interprofessional Health Collaborative. (2010). A national interprofessional competency framework.

Retrieved from http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf

College of Occupational Therapists of Ontario. (2011). Essential competencies of practice for occupational therapists in Canada, 3rd edition.

Retrieved from http://www.coto.org/resource/standards.asp

[10] With additional consultation provided by Dr. Birgit Pianosi, Chair of the Competency Task Force, AGHE, Associate Professor, Gerontology, Huntington University.

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Council on Social Work Education Gero-Ed Centre. (2008).
Advanced geri-social work practice.
Retrieved from http://www.cswe.org/File.aspx?id=25501

National Association of Pharmacy Regulatory Authorities. (2009).
Model standards of practice for Canadian pharmacists.
Retrieved from http://napra.ca/Content_Files/Files/Model_Standards_of_Prac_for_Cdn_Pharm_March09_Final_b.pdf

National Initiative for the Care of the Elderly. (n.d.).
Core interprofessional competencies for gerontology.
Retrieved from http://www.nicenet.ca/files/NICE_Competencies.pdf

Royal College of Physicians and Surgeons. (2012).
Objectives of training of the subspecialty of geriatric medicine.
Retrieved from https://www.mcgill.ca/geriatrics/files/geriatrics/geriatrics_e_objectives.pdf

Appendix C: Expert Panels

These domains and elements of the CGA, and competencies were consolidated, reviewed and edited through several iterative review cycles.

Phase 1: Development Panel

Preliminary domains and elements of the CGA and initial behavioural statements reflecting the unique context of team-based specialized geriatrics were created by an expert working group that included:

Carolee Awde-Sadler, Clinical Pharmacist,
Geriatric Assessment and Intervention Network (GAIN)

Melanie Briscoe, OT Reg. (Ont.)
Manager of Clinical Services, Northeast Specialized Geriatric Centre

Dee Craddock, RN, MN
Care Coordinator, Geriatric Assessment and Intervention Network (GAIN)

Debbie Daly RN(EC) MN, Nurse Practitioner
GAIN Regional Clinical Lead & GAIN Clinic Lead, The Scarborough and Rouge Hospital

Adam MB Day, PhD
Research and Project Coordinator NESGC

Don Doell, MD, RCPC
Geriatric Assessment and Intervention Network (GAIN)

Lynda Dus
Administrative Assistant, Geriatric Assessment and Intervention Network (GAIN)

Stacey Hawkins, MA, CPG
Director System Planning, Implementation and Evaluation, Seniors Care Network

Kelly Kay, MA (Leadership-Health Specialization)
Executive Director, Seniors Care Network

Lesley Krempulec, OT Reg. (Ont.)
Director, Geriatric Assessment and Intervention Network (GAIN) - CareFirst Seniors

Valerie Scarfone
Executive Director, Northeast Specialized Geriatric Centre

Shirin Vellani, RN(EC), NP(Adult), MN, BA, GNC(C)
Geriatric Assessment and Intervention Network (GAIN), SPLC

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Phase 2: Review Panel

Preliminary domains and elements of the CGA and initial behavioural statements were distributed to a group of expert reviewers who completed a decision matrix and provided input prior to launching the Provincial Expert Delphi Panel. The Phase 2 Review Panel Included:

Michelle Acorn, RN(EC), NP(Adult), PhD
Lakeridge Health

Nana Asomaning, RN(EC), NP(Adult), MN, BScN, GNC(C) GEM
Sinai Health System

Dee Craddock, RN, MN
Care Coordinator, GAIN

Michael Bernard, RN(EC), NP(Adult)
Peterborough Family Health Team

Barbara Liu, MD, FRCPC,
Executive Director, RGP of Toronto

Rebecca Ramsden, RN(EC), MN, GNC(C)
ACE Unit, Sinai Health System

Lesley Krempulec, OT Reg. (Ont.)
Director, GAIN - CareFirst Seniors

Kathryn Roka, RN(EC), PHCNP, MNSc
Brock Community Health Centre

David Patrick Ryan, Ph.D. C.Psych.
Director of Education & Knowledge Processes, Regional Geriatric Program of Toronto

Katherine Trip, RN(EC), NP(Adult), MN
Assistant Professor, University of Toronto

Oleg Veselskiy, MD, Geriatrician
GAIN, Peterborough Regional Health Centre

Shirin Vellani, RN(EC), NP(Adult), MN, BA, GNC(C)
GAIN SPLC

Ken Wong, BScPT, MSc
Education Consultant, RGP of Toronto

Group Reviewers
- NPSTAT Program, Central East LHIN
- RGP of Eastern Ontario
- South West RGP (Parkwood Institute)

Phase 3: Provincial Expert Delphi Panel

Revised behavioural statements were incorporated into a Delphi consensus process and underwent three rounds of review and revision by a group of expert reviewers from across Ontario. Panel members were identified and selected through the Regional Geriatric Programs of Ontario. This panel included:

Julia Borges, BSc
University of Waterloo

Jo-Anne Clarke, MD, FRCPC, Geriatrician
Clinical Lead, Northeast Specialized Geriatric Centre

Audrey Devitt
Waterloo-Wellington Geriatric Services System Coordinator
Canadian Mental Health Association AND St. Joseph's Health Centre Guelph

AnnMarie Dimillo, RN, BScN
Program Manager, Regional Geriatric Program of Eastern Ontario

Don Doell, MD, FRCPC, Geriatrician
Geriatric Assessment and Intervention Network (GAIN)

George Heckman, MD, MSc, FRCPC, Geriatrician
Associate Professor, Schlegel Research Chair in Geriatric Medicine,
University of Waterloo

Heidi Hunter, OT Reg. (Ont.)
Seniors Assessment & Support Outreach Team, Muskoka Algonquin Healthcare

Catherine Jones, MSc CHS (Nursing) & PHC-NP
Clinical Manager Aging Well Clinic, Barrie & Community Family Health Team

Barbara Liu, MD, FRCPC, Geriatrician
Executive Director, Regional Geriatric Program of Toronto,
Sunnybrook Health Sciences Centre

Heather MacLeod, MHSc (OT), OT Reg. (Ont.)
Team Leader/Senior Geriatric Assessor, Geriatric Assessment Outreach Teams
Regional Geriatric Program of Eastern Ontario

Taryn MacKenzie, RN, MN, ENC(C)
The Ottawa Hospital/Regional Geriatric Program of Eastern Ontario

Jane McKinnon Wilson, MSc. H.B.
Director, Regional Geriatric Program Central, Hamilton Health Sciences

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Andrea L Moser, MD, MSc, CCFP(COE), FCFP, CMD
Associate Medical Director,
The Jewish Home for the Aged/Apotex/Baycrest Health Sciences

Tamara Nowak-Lennard, RN, MN
Clinical Manager & Clinical Nurse Specialist,
North Simcoe Muskoka Specialized Geriatric Services Program

David Patrick Ryan, Ph.D. C.Psych.
Director of Education & Knowledge Processes, Regional Geriatric Program of Toronto

John Puxty, MB., ChB., MRCP(UK), FRCP(C), Geriatrician
Associate Professor, Division Chair, Service Chief, Program Director,
Geriatric Medicine Providence Care Hospital

Karen Truter RN(EC), MN, CHPCN(C), Nurse Practitioner
Gerontology & Post Acute Specialty Services, Northumberland Hills Hospital

Shirin Vellani, RN(EC), NP(Adult), MN, BA, GNC(C)
Geriatric Assessment and Intervention Network (GAIN), SPLC

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Frank, J., Snell, L., Cate, O., Holmboe, E., Carraccio, C., Swing, S.,....Harris, K.(2010). Competency-based medical education: Theory to practice. *Medical Teacher*, 32(8), 638-645. doi:10.3109/0142159X.2010.501190

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Stuck, A. E., Siu, A. L., Wieland, G. D., Rubenstein, L. Z., and Adams, J. (1993). Comprehensive geriatric assessment: a meta-analysis of controlled trials. *The Lancet*, 342(8878), 1032–1036. http://doi.org/10.1016/0140-6736(93)92884-V

Welsh, T. J., Gordon, A. L. and Gladman, J. R. (2014), Comprehensive geriatric assessment – a guide for the non-specialist. *International Journal of Clinical Practice*, 68, 290–293. doi:10.1111/ijcp.12313

CLINICAL FRAILTY SCALE

Clinical Frailty Scale

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (with ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill – Approaching the end of life. This category applies to people with life expectancy <6 months, who are not otherwise evidently frail.

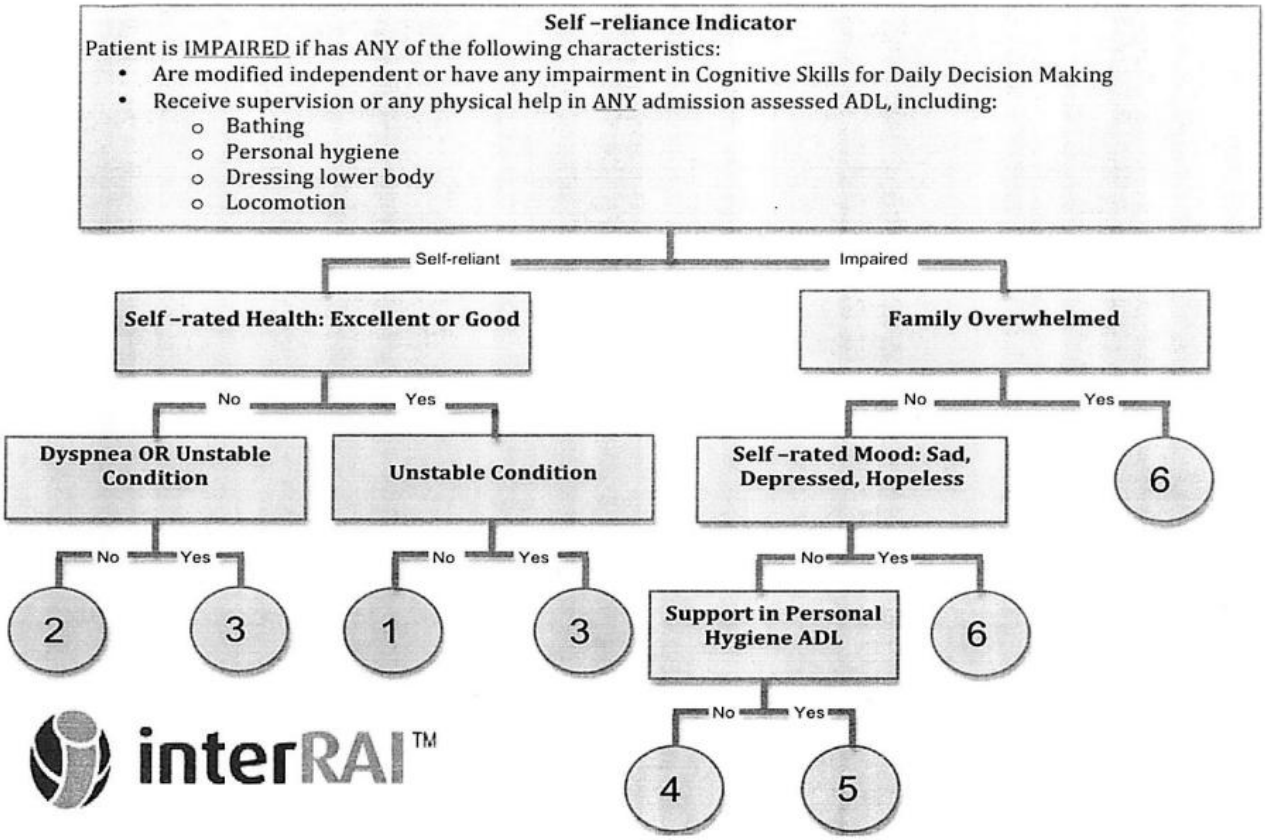
Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

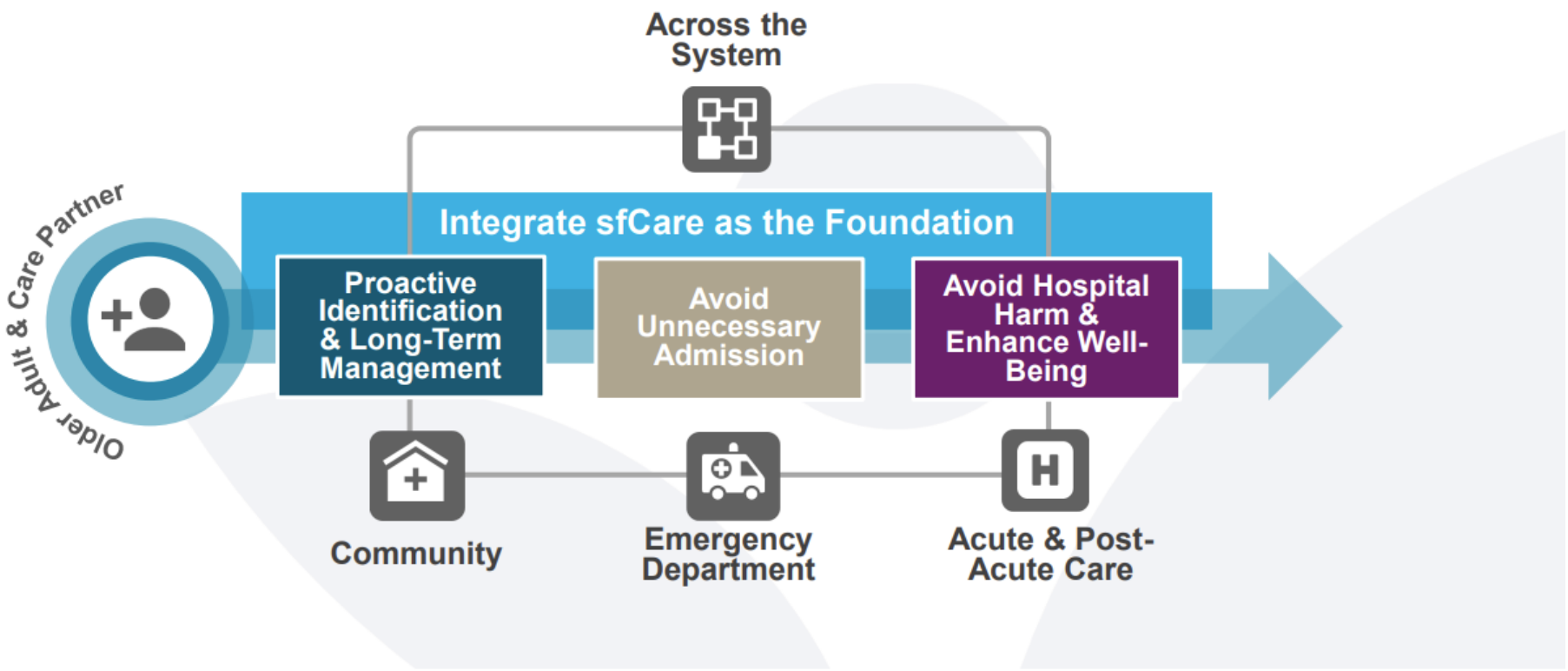
In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

SELF-RELIANCE INDICATOR



Care Trajectory



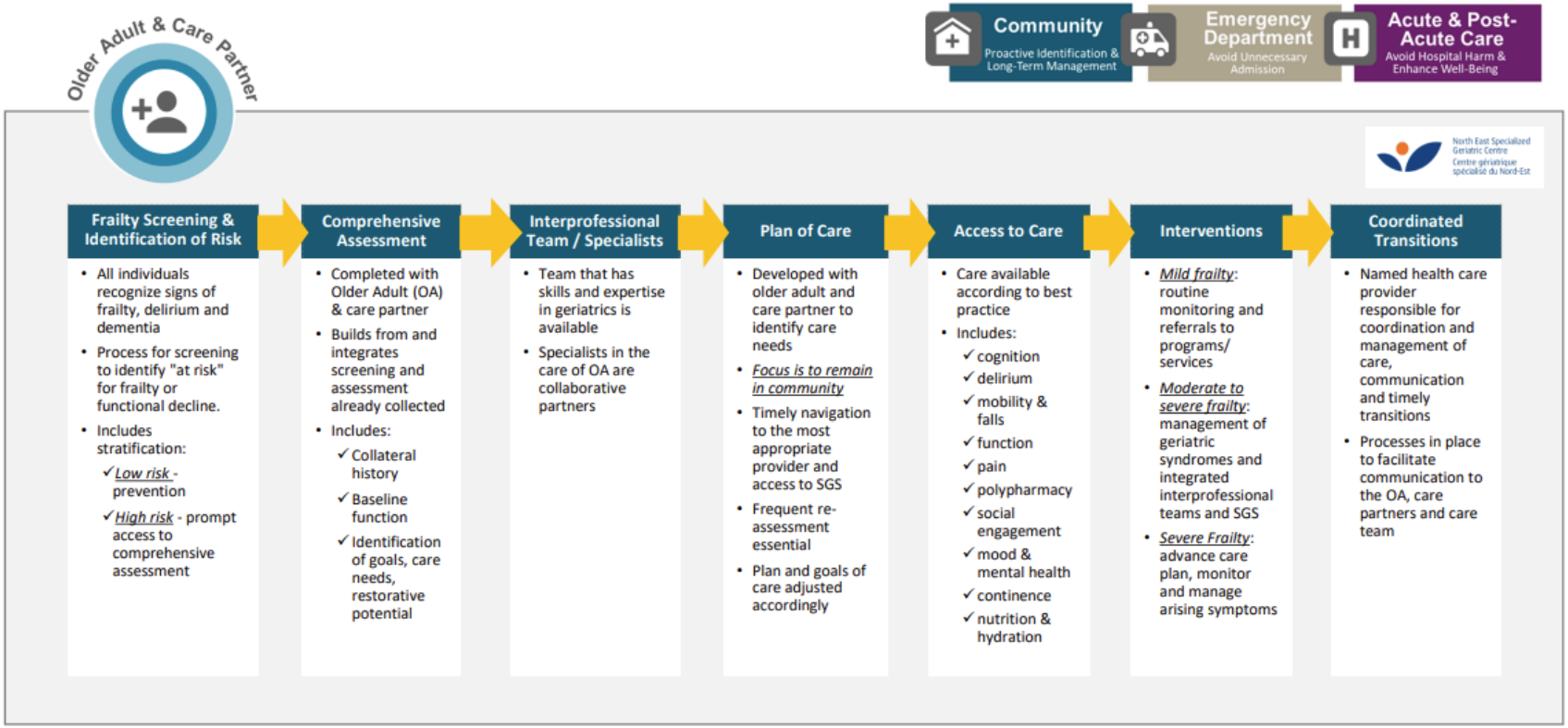
Ontario Health

North East Specialized Geriatric Centre
Centre gériatrique spécialisé du Nord-Est

Health Sciences North
Horizon Santé-Nord

https://rgps.on.ca/resources/alternate-level-of-care-leading-practices-guide-2021/

Community Geriatric Care Pathway



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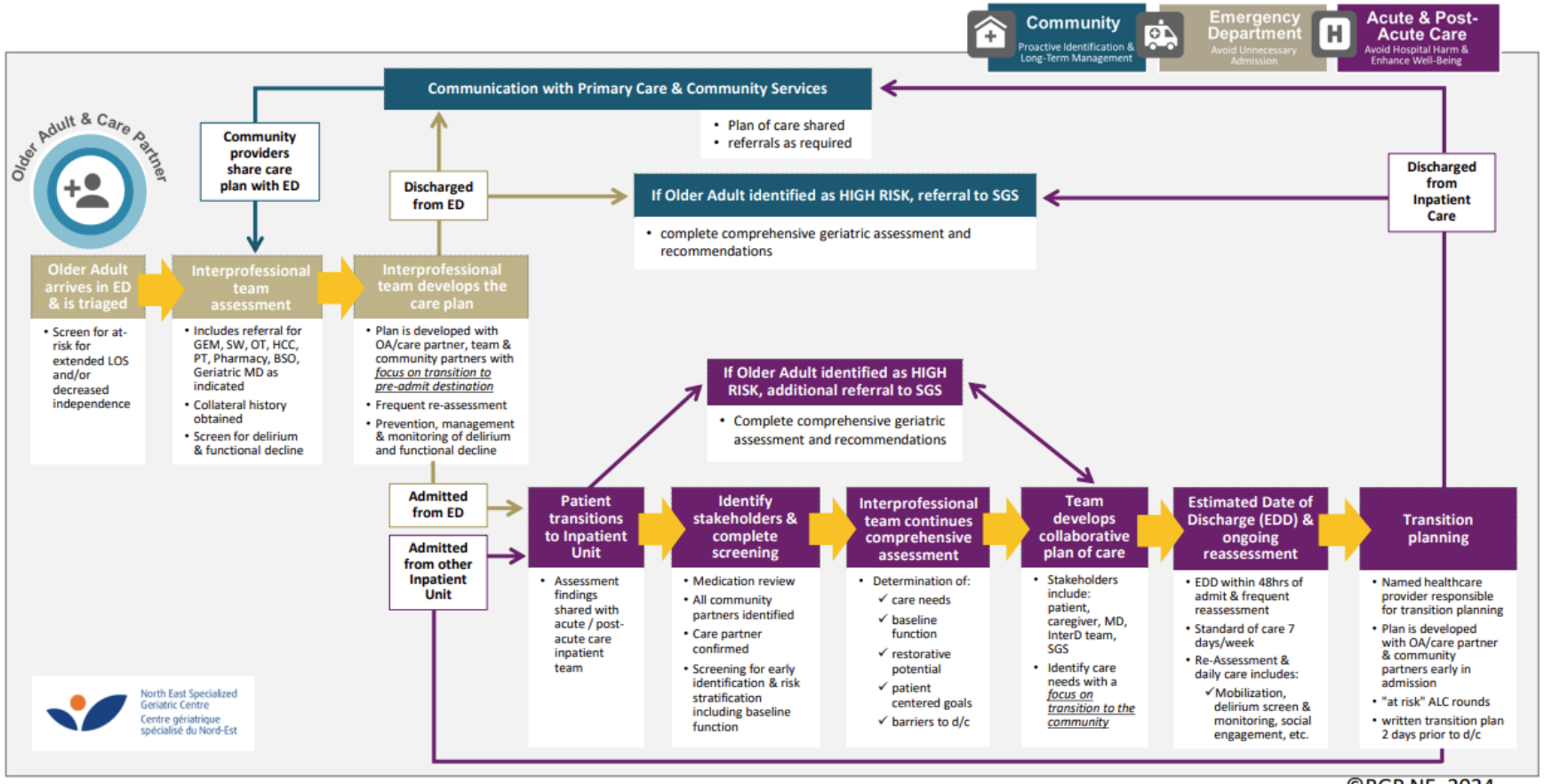
Acute & Post-Acute Geriatric Care Pathway



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ALC QUALITY IMPROVEMENT PROJECT – LAKERIDGE HEALTH

Quality Improvement Project & Sustainability Plan

ED DIVERSION

QI Lead:	Sabrina Sudhai
Project Sponsor:	Shelley Hynes (Clinical Director for the Emergency Department) Tabitha Carroll (Health System Executive, Clinical)
PES or QIS Lead:	Sabrina Sudhai; James Ibbott
Implementation Date:	July 11th, 2024
Target End Date	March 31, 2025

Problem Statement *Describe the issue and provide evidence of occurrence*

There is a variation in the ability to divert patients from Lakeridge's Health Emergency Departments (ED) prior to the patient either receiving inpatient services in the ED and being discharged or receiving an Alternative Level of Care (ALC) designation.

The problem is the ED is identifying medically stable patients at risk for admission who becomes a designation for ALC patients shortly after admission within 48 hours and to avoid social admits.

ALC Volumes: We are currently sitting at 261, with a goal and decrease of to 224 by the end of September.

ALC Throughput: Hospital strives to be higher than 1, and our goal is to decrease our ALC numbers by 10%.

Method and/or Solution Approach: *Describe what methods were used to achieve the aim*

Changes proposed	Current Progress	Recommended next steps (follow up plan)
Clarify criteria to identify a "appropriate for discharge with community resources" patient from interprofessional team.	Identified Acute, non-admitted patients (complex patients): A medically stable patient who can be discharged with less than 2 services pending to assess to devise a plan of care who requires priority further investigation. This will then be transferred for Transition to Home (TTH) to assess patients to create care to for admission avoidance. TTH includes allied health: OT PT SW GEM Future lead for TTH will be GEM NP.	N/A
Determine and optimize the role of the NP for optimization of at risk ALC patients.	Met with other Ontario Hospitals (Niagara, Trillium, Oak Valley) with leading practices of the GEM NP roles in ED for optimization of ALC risk patients and admission avoidance. Created GEM NP Standard of Work mirroring other hospitals developed programs (See attached)	GEM NP new hires (3-4 recommended) officially to be onboarded for both LHO and LHAP, and to include weekend coverage especially at LHAP site. Provide training and education as part of onboarding process: - Shadow shifts with hospitals with leading practices with

Lakeridge Health

Quality Improvement Project Sustainability Plan

ED DIVERSION		
	Created job posting for HR recruitment (See attached)	GEM NPs- Markham Stouffville, Trillium to adopt best practice. - GAIN clinic - Geriatric Consult Team - LTCs - SSU G8 - Emergency Acute Care Standard Work Developed
Develop standard work for ED and allied health staff.	TTH Pathway (See attached) Escalation Pathway (See attached) This was shared with Allied Health, Transition Management, Healthy Aging, Medicine physician group, ED physician group, HSE, ED Council.	Continue PDSA cycle assessing the TTH and Escalation Pathways Pathway Testing: Escalation pathway during after hours, weekend TTH pathway when SSU unavailable. TTH pathway when a patient fails a CDU TTH pathway with lack of resources
Optimize clinical decision unit (CDU) designation and develop our process in identifying these patients.	Work with EPIC Optimization ED lead to trigger CDU window when TTH is entered. Epic ticket entered.	To test TTH triggering CDU window when launched in EPIC and efficiency of it.
Review and communicate of consult requests/referral variation (e.g. overutilization of TTH referrals).	Standardizing TTH referrals by providing inclusion and exclusion criteria. Standardizing TTH referrals to LHAP site as they do not currently have TTH consult lists – creating an EPIC ticket to mimic LHO TTH consults	Follow up with LHAP site once TTH consult list is launched in their EPIC. Ensure LHAP that new standard practices for allied health to utilize the new TTH consult list, ensure new standard practice for providers to order TTH instead of allied health as individual order consults. Create an EPIC ticket to include inclusion and exclusion criteria as part of the TTH consult order. Create an order panel for TTH on EPIC once determine what orders is needed with ED physician group.
GEM recruitment and stabilization of roles (out of scope however work to be used as input to Manager is in scope).	GEM NP hire as roles with GEM nurses overlap and have ability to influence and make clinically informed decisions autonomously.	
Develop reporting tools for daily transparency of all stakeholders to increase	Created data collection on PowerBI and EPIC-	To collect these data weekly as pathways have been implemented

Page 2 of 3

Lakeridge Health

Quality Improvement Project Sustainability Plan

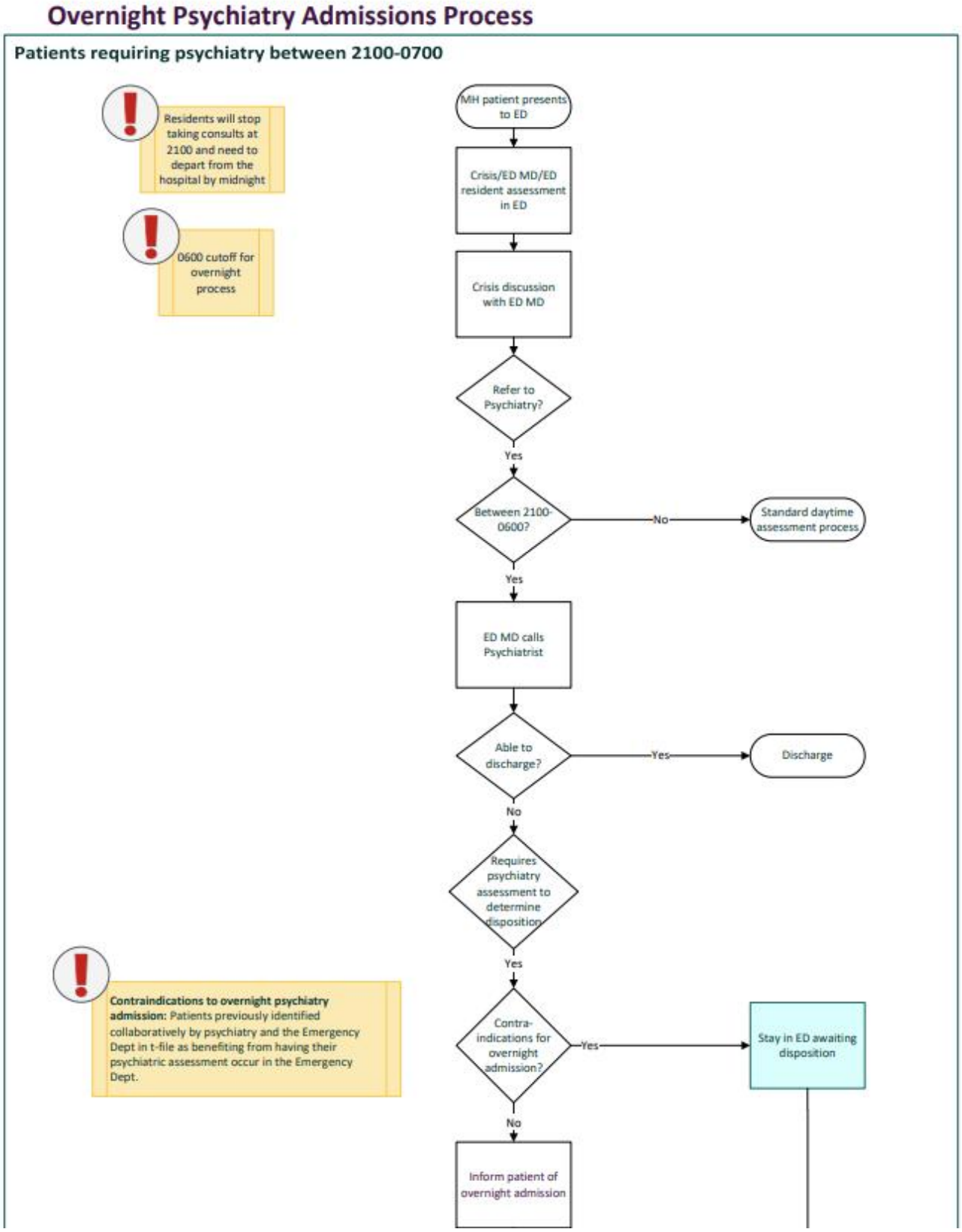
ED DIVERSION

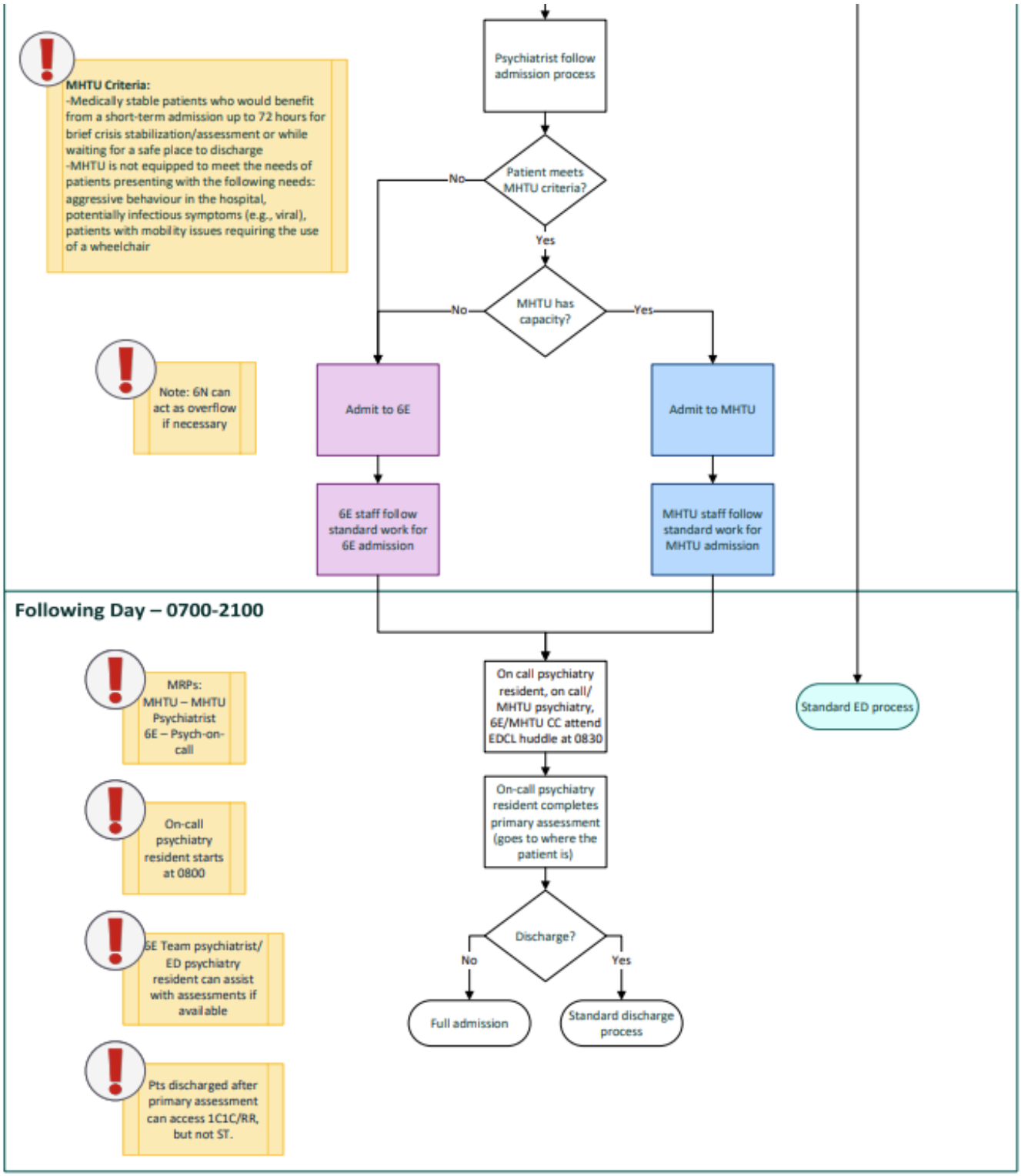
ability to divert patients from ED.	TTH referrals, admission rates, patients made ALC within 48hours within ED. CCD and Lighthouse referral tracking.	
Development of tools, training and resources for staff to better utilizing existing services.	Developed a skeleton draft- "Lakeridge ED Discharge Toolkit" (See attached)	Needs to be completed. *Can be an opportunity for nursing student project for University/College.*
Identification of community services that could support in ED Diversion.	CCD and Lighthouse Met with Durham Community Paramedicine	See below- touchpoint meetings with CCD & Lighthouse.
Explore leading practices for ALC no-admits with leading organizations.	Met with NYGH on their ALC policy Reached out to SHN and Osler for no ALC admits.	
Develop standard work process and selection criteria for expediting and transferring patients back home with Ontario Health at Home, Durham Ontario Health Teams, Light House at Ajax, Community Care Durham.	Created CCD and Lighthouse pathway (see attached)	Touchpoint meetings (weekly, then monthly with CCD and Lighthouse) to assess barriers.
Develop standard work processes for patients made ALC post acute phase in the ED	None as current focused on creating a pathway for on "No Social Admits" policy and admission avoidance.	Recommend ED Representative to be ongoing member or adhoc member for Medicine ALC working group to mirror their process within the ED.

Project Governance

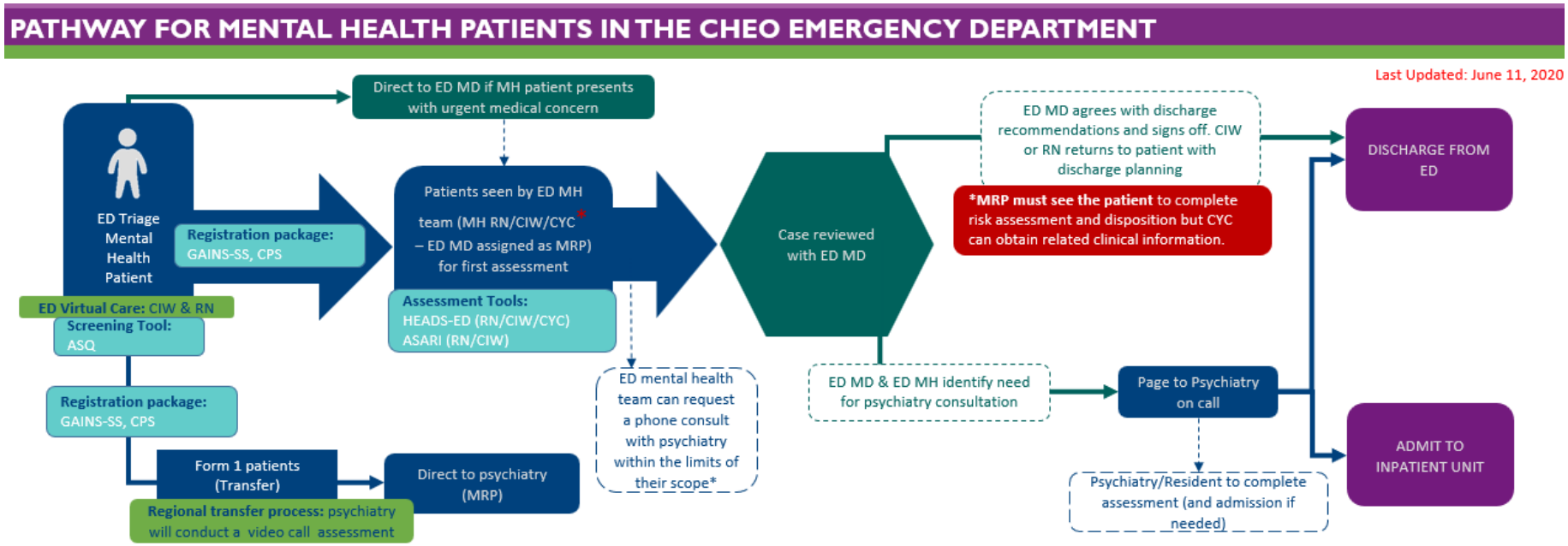
Working Group Team Members	Key Stakeholder Groups
Project Lead: Nina Siddall, NP (Aug 22, 2024 to Sept 12, 2024) Eric LeBlanc, PCM Emergency, LHAP Lynne Smart, PCM Transition Management Melissa Copps, ED Unit Coordinator Amy Dolick, ED Social Worker LHO Melissa Monardo, PCM Allied Health & Health Aging Kim Wadsworth, Unit Coordinator, LHAP	Utilization Flow Specialists, PT/OT, SW, GEM Nurses, ED Unit Coordinators, ED MRPs, Admitting MRPs/Hospitalist, ED Epic Analyst (Ad Hoc), Decision Support Unit, OHAH, OHT/Community Partners, Geriatrics/BSO Consult Teams, Patient, Patient Family Member(s)

OVERNIGHT PSYCHIATRY ADMISSION PROCESS




MHTU Criteria:
-Medically stable patients who would benefit from a short-term admission up to 72 hours for brief crisis stabilization/assessment or while waiting for a safe place to discharge
-MHTU is not equipped to meet the needs of patients presenting with the following needs: aggressive behaviour in the hospital, potentially infectious symptoms (e.g., viral), patients with mobility issues requiring the use of a wheelchair
Psychiatrist follow admission process
Patient meets MHTU criteria?
No
Yes
MHTU has capacity?
No
Yes
Note: 6N can act as overflow if necessary
Admit to 6E
Admit to MHTU
6E staff follow standard work for 6E admission
MHTU staff follow standard work for MHTU admission
Following Day – 0700-2100
MRPs:
MHTU – MHTU Psychiatrist
6E – Psych-on-call
On-call psychiatry resident, on call/ MHTU psychiatry, 6E/MHTU CC attend EDCL huddle at 0830
Standard ED process
On-call psychiatry resident starts at 0800
On-call psychiatry resident completes primary assessment (goes to where the patient is)
6E Team psychiatrist/ ED psychiatry resident can assist with assessments if available
Discharge?
No
Yes
Full admission
Standard discharge process
Pts discharged after primary assessment can access 1C1C/RR, but not ST.

PATHWAY FOR MENTAL HEALTH PATIENTS IN THE CHEO EMERGENCY DEPARTMENT



	Registered MH Nurse – RN	Crisis Intervention Workers – CIW	Child and Youth Counsellors – CYC
	Registered MH Nurses have specific training in mental health and are regulated by the College of Nurses of Ontario.	CIW are master's level clinicians (i.e. MSW, MA) belonging to a regulatory body overseeing practice.	CYCs are college level clinicians and members of the Ontario Association of Child and Youth Care.
Unique scope	• **Nursing care of medical concern** • Risk assessment • Provide recommendations of disposition to MRP • Review and/or consult with psychiatry	• Risk assessment • Provide recommendation of disposition to MRP • Review and/or consult with psychiatry	• Review case with CIW/RN or MRP • Support the work of CIW/RN/MRP/Psychiatry • Obtain background and clinical information as appropriate - MRP is responsible for risk assessment and disposition
Shared Scope	**Crisis assessment** (Information Collection) • De-escalation • Safety planning • Parental support • Liaison with community (school, MH agency, counselor, etc.) • Resource counselling		
Tools	HEADS-ED ASARI (Risk Assessment)	HEADS-ED ASARI (Risk Assessment)	HEADS-ED (MRP must complete S)
Documentation	• Select ED supervisor in EPIC • If first to see patient, complete an **ED provider note** • If second ED provider to see patient, complete an **ED note** • Can complete disposition if agreed upon/reviewed by MRP	• Select ED supervisor in EPIC • If first to see patient, complete an **ED provider note** • If second ED provider to see patient complete an **ED note** • Can complete disposition if agreed upon/reviewed by MRP	• Select ED supervisor in EPIC • ONLY documenting in ED notes • MRP must complete S (risk assessment) in HEADS-ED • Can complete disposition if agreed upon/reviewed by MRP

** Please note: As of June 4th self-administered measures are not currently being completed

ED MH MODEL OF CARE PROJECT UPDATE TO FAC

DAVID MURPHY, SHANNON WATSON

JUNE 13, 2019

CHEO uOttawa

ED Mental Health Model of Care Project Update: Agenda

Project overview:

- Background
- Project goals
- What has been done to date?
- What did we hear from our youth and families?

What are next steps?

CHEO 2

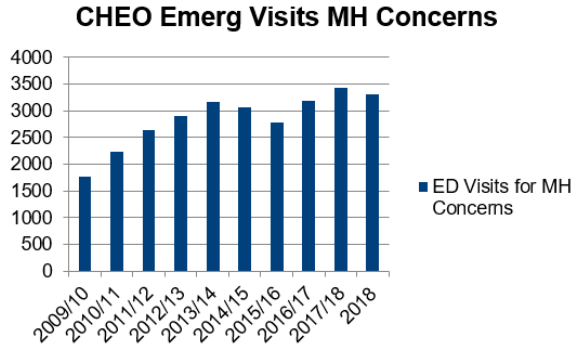
Our current model of MH support in the ED has existed for ~20 years. What has changed?

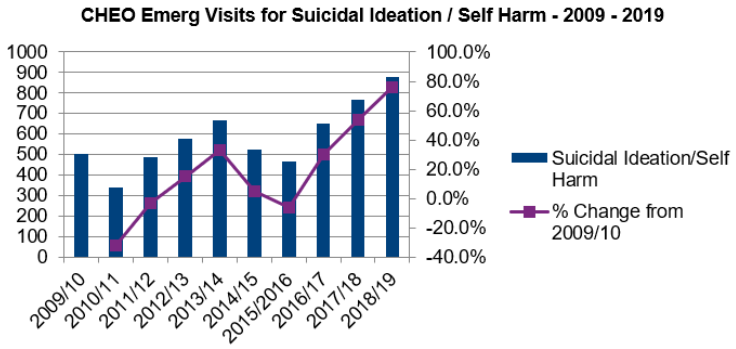
- The volume of MH patients presenting to the CHEO ED has more than doubled since the inception of the crisis program, yet our model and processes to support these patients have not changed.
- Additionally, the profile of children accessing the ED has changed depicted by a 53% increase in children/youth presenting with suicidal ideation/attempt from 2014 to 2018.
- As a result, it has been increasingly difficult for the ED MH Services to meet clinical demand due to: (1) volume of MH presentations in the ED; (2) issues with staff retention; (3) issues with back-up staffing; (4) varied expectations of role based on stakeholder group.

CHEO 3

Background

Emergency Mental Health visits have risen over 80% from 2009/10 to 2018:





CHEO 4

Background

Increasing pressures on our staff and physicians:

- Staff retention challenges with high turnover
- Inconsistent understanding of roles and responsibilities

- And most importantly, ***are we providing the right support for patients and families who come to the ED for MH services?***

CHEO 5

Project Goals

Project team developed the following project goals:

- Using input from youth, families, staff and physicians, as well as a review of data trends, environmental scan and literature review findings, develop recommendations for improved ED MH Model of Care with the following goals:
  - Providing a 24/7 standard level of MH care within the Emergency
  - Providing standardized emergency mental health support in an efficient and timely way to meet the needs of our patients and families
  - Ensuring alignment with our Emergency Wait time targets (which impacts our funding)
  - Being inclusive to all patients, including those with addictions and intoxication
- Phase 2 of the ED MH Model of Care Project will be to implement the Phase 1 recommendations.

CHEO 6

What has happened to date?

The following chunks of work were identified to assist in developing our recommendations:

CHEO 7

Survey – Youth & Families

Survey of youth and families

- Youth & Family survey developed to get feedback about their MH experience in CHEO's ED
- Survey was developed in collaboration with a parent advisor
- REDCap survey sent to ~540 individuals who visited CHEO's ED for a MH concern for the 12 month period between April 2018 – April 2019, AND who had provided an email address
- Received 83 responses
- Survey gave the option of providing additional input by interview; one interview was conducted and results are integrated with the survey
- Additional survey being administered with youth at YouthNet with support of YN staff

CHEO 8

Survey Themes – What worked well?

Survey of youth and families

1. **Feeling Heard – Triage staff & triage process**
   - Felt like they would be taken care of, and this tone was set starting at triage
   - Treated with dignity
2. **Professional, attentive and thoughtful staff**
   - Treated with respect, kindness, openness, attentiveness, thoughtfulness, concern
   - Staff were patient, understanding, supportive, professional
3. **Support provided to both youth and parents**
   - Good balance between assisting the child and supporting the parent
4. **Feeling safe**
5. **Privacy**
   - Health workers were discreet, and maintained privacy
6. **Space**
7. **Reasonable wait time**
   - Given it is the ED, expected to wait, but it was reasonable
8. **Follow up plans**
   - Supportive staff who made plans for follow-up, taking burden off family

CHEO 9

Survey Themes – What changes are needed?

Survey of youth and families

1. **More staff needed 24/7**
   - Have mental health staff available 24/7
   - Frustration finding out there is no MH support overnight
2. **Improve waiting time, especially overnight**
   - Can there be other resources (e.g. counsellor) who could check in with youth & families in the waiting room?
3. **Improve process for follow-up**
   - Lack of clarity around follow-up and next steps
   - Feeling of being left on own and not knowing what to do next
4. **Need separate waiting area / space for MH patients & families**
   - Privacy & Safety
   - Calming, soothing to reduce stress and anxiety
   - Separate triage
   - Enhance rooms so patients don't feel they are 'being locked up'

CHEO 10

Survey Themes – What changes are needed?

Survey of youth and families

5. **Need to improve communication & letting youth and families know what to expect**
   - Even if the wait is long, share what is to be expected
   - A sense of where you are in the process or assessment would be helpful
   - Being left alone for long periods is very stressful
6. **Improve staff sensitivity regarding mental health**
   - Perception that staff lack sensitivity, especially around SI / Self Harm
   - Some staff lacking compassion
7. **Youth & Families feeling they were not heard, and not helped**
   - Realize it's a busy stressful environment, but take time to listen
   - Lack of experienced staff
   - Treat each visit as a unique experience, and don't make assumptions based on health history
8. **Improve support for SI / Self Harm in the ED**
   - Feeling like self harm not addressed appropriately

CHEO 11

Survey Themes – What changes are needed?

Survey of youth and families

9. **Community Education about what MH support is provided in the ED (and what is not), and what other resources are available**
   - Provide information about what to expect when coming to the ED, for youth and families as well as family doctors in the community
10. **Ensure every patient is seen by a physician in the ED**
11. **Provide better support for children & youth with special needs**
   - Over stimulation in waiting areas can make children with special needs more agitated
   - Potential for segregated area for safety and privacy

CHEO 12

Survey Themes – FAC Feedback

As our project team looks to develop recommendations to improve many of these areas – what ideas do FAC members have? How can these be improved? What would be helpful?

- Improve process for follow-up after visit
- Need to improve communication & letting youth and families know what to expect in ED
- Community Education about what MH support is provided in the ED (and what is not), and what other resources are available

CHEO 13

Next Steps:

- Project team reviewing all materials and will make initial recommendations
- Recommendations will be reviewed by ED and MH leadership teams, and presented to Exec Team
- Phase 2 of project will oversee the implementation of the recommendations:
  - Will be engaging parents and youth to help in co-design of new model

"Youth and families in crisis need to feel like there is support around them. We need limbs to hang on to, something to lean on and to feel we are not alone" parent

CHEO 14

NOTIFYING TORONTO POLICE DISPATCH REGARDING MENTAL HEALTH CAPACITY WITHIN THE EMERGENCY DEPARTMENT – HUMBER RIVER HEALTH

Humber River Health

Manual	Emergency Services Manual	GUIDELINE
Section		
Author	MANAGER, EMERGENCY SERVICES	
Approved by	PROGRAM DIRECTOR - MENTAL HEALTH PROGRAM	
Date	O: August 14, 2023	Version Number: 1
	R: 08/22/2023	Reference #: 10695
This is a CONTROLLED document. Any documents appearing in PAPER FORM should be checked against the electronic document in Policy & Procedure Manager (PPM).		

NOTIFYING TORONTO POLICE DISPATCH REGARDING MENTAL HEALTH CAPACITY WITHIN THE EMERGENCY DEPARTMENT

Guideline Statement

The purpose of this document is to outline the process for the Humber River Health (HRH) Emergency Department (ED) Patient Flow Manager (PFM) in establishing effective communication with Toronto Police Service (TPS) Dispatch. This communication channel will be utilized when the wait time in the ED surpasses its capacity. TPS will determine whether it is necessary to accompany individuals experiencing a mental health crisis to HRH ED or to an alternative hospital. This objective of this process is to ensure that individuals who arrive with police receive prompt and appropriate care.

The PFM notification to TPS Dispatch will remain effective for a duration of 4 hours. In the event that the 4-hour timeframe elapses without any improvement in capacity, the PFM will be required to place another phone call to notify TPS Dispatch and provide an updated status.

Guideline

Identification of ED Patient Surge:

1. The ED PFM and Resource Person (RP), in collaboration, will monitor and identify instances when sub-acute volumes exceed the bed capacity and begin to impact ED patient flow.

2. Notify TPS dispatch under the following conditions:
   a) There are **twelve or more** admitted and/or consulted mental health patients waiting in the ED and Emergency Psychiatric Unit (EPU) or
   b) Overall Pressure Score >181 on Wall of Analytics
   c) The ED Manager/PFM exercises discretion in determining that a redirect is recommended based on the current situation and capacity constraints.

Notification to Toronto Police Services Dispatch:

3. When the conditions outlined are met, the ED PFM will promptly advise TPS Dispatch that they may wish to redirect individuals experiencing a mental health crisis to an alternative hospital

4. The ED PFM will obtain the name of the TPS dispatch officer receiving the notification and record it for documentation purposes.

Note: This guideline is subject to pc review to assess its effectiveness and make necessary updates based on feedback and changes in operational requirements.

Accountability / Responsibility

- The ED PFM and RP, in collaboration, will monitor and identify instances when sub-acute volumes exceed the bed capacity and begin to impact ED patient flow.
- The PFM will be responsible for placing the call to TPS Dispatch

Definitions

Refer to the guideline section of this policy

Documentation

1. The ED PFM will obtain the name of the TPS dispatch officer receiving the notification and record it for documentation purposes.
2. The ED PFM will include the details of the redirect in the PFM shift report, ensuring accurate and comprehensive information is documented.

Infection Prevention and Control Considerations

All patients will be cared for using Infection Prevention and Control Routine Practices and Additional Precautions as outlined in **Provincial Infectious Diseases Advisory Committee (PIDAC):** Routine Practices and Additional Precautions, Ministry of Health and Long-term Care, as per HRH policy. All staff will perform Hand Hygiene as per HRH guideline.

References

Accreditation Standard/Criteria:

Medical Directive Examples

Symptom-Based Medical Directives

CHEST PAIN (THUNDER BAY REGIONAL HEALTH SCIENCES CENTRE)

Medical Directive

Allergies:

_____

_____

_____

Place Patient Label with Barcode Here

Patient Presenting To The Emergency Department (ED) With Chest Pain Suggestive Of Acute Coronary Syndrome (ACS)

Procedure:

1. Initiate Cardiac Monitoring.
2. 12 Lead ECG within 10 minutes of presentation. RN to show ECG to ED physician to sign, date & time.
3. ASA 160 mg PO, chew and swallow (if not allergic and/or not already given)
4. SpO2 Monitor.
5. Titrate O2 to keep saturation greater than or equal to 92% (Notify RT if O2 requirements exceed FiO2 greater than or 40% or 6L/minute).
6. Establish one large-bore intravenous avoiding the right wrist. Second intravenous to be established if patient unstable.
7. Establish intravenous with Normal Saline to keep vein open.
8. Initiate ED Chest Pain Order Set:
   - CBC, INR/PT/PTT
   - Lytes, BUN, Creatinine, Glucose
   - Troponin I Stat
9. Vitals signs minimum every 15 minutes if patient unstable, minimum every hour if stable.
10. Obtain previous ECG from Muse web if applicable.
11. Obtain or estimate approximate patient weight
12. Notify ED Physician of medical directive implementation

*Refer to STEMI protocol: Direct PCI Option (PCS-DO-62) if applicable and/or initiate ACS clinical pathway when appropriate

SECTION 1

THIS AREA MUST BE COMPLETED BY IMPLEMENTING PROFESSIONAL:

Signature with classification _____ Date: _____ (yyyy/mm/dd)

Name (Print) _____ Time: _____ (hh:mm)

Name of most responsible physician for the patient's care related to the Directive: _____

SECTION 2

MEDICAL ADVISORY COMMITTEE:	**PATIENT CARE SERVICES:**
Signature _____	Signature _____
Date _____ (yyyy/mm/dd)	Date _____ (yyyy/mm/dd)

PCS-MD-17
Approved:Sept-2002; Rev: Nov-26-13, Feb-24-15, Oct-27-15
Review due by: Oct-27-16

White Copy: Chart Yellow Copy: Pharmacy Page 1 of 2

Place Patient Label with Barcode Here

Guidelines for Implementation of a Medical Directive

Before implementing a Medical Directive, the health professional will be responsible for:

1. Placing a patient label on the form or in the absence of a label print: the name, age, admission number, chart number and most responsible physician's name.
2. Ensuring the implementer meets the criteria as set out in Section 4.
3. Ensuring the patient meets the criteria as set out in Section 3.
4. The Medical Directive will not be implemented unless the implementing rofessional has completed Section 1 including his/her signature, health professional designation, name, the date and time and name of the most responsible physician according to the criteria in Section 5.
5. The implemented Medical Directive will be added to the patient's chart in the Physicians Order section.

This completes the implementation process. The Medical Directive is now processed as any Medical Order and is subject to all policies pertaining to a Medical Order.

Section 3 **Patient Criteria**

1. **Patient conditions that must be met:**
   Patients with the following symptoms and signs require immediate assessment by the triage nurse for the initiation of the ACS protocol
   Chief Complaint
   - Chest pain or severe epigastric pain, nontraumatic in origin, with components typical of myocardial ischemia (MI):
     - Central/substernal compression or crushing chest pain
     - Pressure, tightness, heaviness, cramping, burning aching sensation
     - Unexplained indigestion, belching, epigastric pain
     - Radiating pain in neck, jaw, shoulders, back, or 1 or both arms
     - Associated dyspnea
     - Associated nausea and/or vomiting

   Medical History
   Assessment of current or past history of:
   - Coronary artery bypass surgery (CABG), angioplasty, coronary artery disease (CAD), angina on effort, or acute myocardial ischemia (AMI)
   - Nitroglycerin use to relieve chest discomfort
   - Risk factors, including smoking, hyperlipidemia, hypertension, diabetes mellitus, family history, and cocaine use

   Reference
   **ACC/AHA Guideline 2000
2. **Specific circumstance that must exist:**
   Patients who may have atypical presentations include women, diabetic and elderly patients.
3. **Contraindications:** None

Section 4	Section 5
1. **Health professional (s) that can implement the directive:** Registered Nurse in Emergency 2. **Specific educational qualifications:** None	**Criteria for selection of the responsible physician:** Emergency physician on duty at that time

PCS-MD-17
Approved:Sept-2002; Rev: Nov-26-13, Feb-24-15, Oct-27-15
Review due by: Oct-27-15

White Copy: Chart Yellow Copy: Pharmacy Page 2 of 2

ABDOMINAL PAIN (THUNDER BAY REGIONAL HEALTH SCIENCES CENTRE)

Medical Directive

Thunder Bay Regional Health Sciences Centre

Allergies:

_____

_____

_____

Place Patient Label with Barcode Here

Adult Patient Presenting To The Emergency Department (ED) With Abdominal Pain

Procedure:

1. Initiate ED Abdominal Pain Order Set:

- CBC
- Lytes, BUN, UREA, Creatinine, Random Glucose
- Lipase, LFT
- Urinalysis (midstream sample)

2. If the patient has a temperature of 38.0 degrees or greater or if patient is age 65 years or older add:
- Lactate
- VBG

3. If patient has a history of liver disease or is on anticoagulants add:
- PTT
- INR

4. If the patient is female and age 16 to 55 add:
- Serum BHCG (Qualitative)
- Blood Group

THIS AREA MUST BE COMPLETED BY IMPLEMENTING PROFESSIONAL:

Signature with classification _____ Date: _____ (yyyy/mm/dd)

Name (Print) _____ Time: _____ (hh:mm)

Name of most responsible physician for the patient's care related to the Directive: _____

SECTION 2

MEDICAL ADVISORY COMMITTEE:	**CHIEF NURSING EXECUTIVE:**
Signature _____	Signature _____
Date _____ (yyyy/mm/dd)	Date _____ (yyyy/mm/dd)

TMEDDIRECT

WHITE COPY: CHART
YELLOW COPY: PHARMACY

PCS-MD-173
Approved: Jan-25-2022 Rev: Jun-28-2022
Review due by: Jun-28-2024

Page 1 of 2

Place Patient Label with
Barcode Here

Guidelines for Implementation of a Medical Directive

Before implementing a Medical Directive, the health professional will be responsible for:

1. Placing a patient label on the form or in the absence of a label print: the name, age, admission number, chart number and most responsible physician's name.
2. Ensuring the implementer meets the criteria as set out in Section 4.
3. Ensuring the patient meets the criteria as set out in Section 3.
4. The Medical Directive will not be implemented unless the implementing professional has completed Section 1 including his/her signature, health professional designation, name, the date and time and name of the most responsible physician according to the criteria in Section 5.
5. The implemented Medical Directive will be added to the patient's chart in the Physicians Order section.

This completes the implementation process. The Medical Directive is now processed as any Medical Order and is subject to all policies pertaining to a Medical Order.

Section 3 **Patient Criteria**

1. **Patient conditions that must be met:**
   - Primary or Chief Complaint of abdominal pain on presentation to ED
   - Patient is 16 years of age or greater
2. **Specific circumstances that must exist:**
   - Physical assessment completed by ED Nurse
3. **Contraindications:**
   - Abdominal trauma (ie: blunt or penetrating trauma to abdomen)
   - GCS 12 or less

Section 4	Section 5
1. Health professional(s) that can implement the directive: Nurse in the ED **2. Specific education qualifications:** None	**Criteria for selection of the responsible physician:** Emergency Physician on duty

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YELLOW COPY: PHARMACY

PCS-MD-173
Approved: Jan-25-2022 Rev: Jun-28-2022
Review due by: Jun-28-2024

Page 2 of 2

SEPSIS (LAKERIDGE HEALTH)

Sepsis- Adults

Order:	Indications:	Contraindications:	Notes:
1. CBC, Na, K, Cl, CO_2, Urea, Creatinine, Glucose, Ca, Mg, AST, ALT, ALP, Total Bili, Lactic Acid, Blood Culture (2 sets), Phosphate, Albumin, Lipase, Hs Troponin, INR/PTT, Venous Blood Gas **2.** Urine or Serum β HCG for People of birthing age with internal reproductive organs (9 – 55 years) **3.** Urine C+S and Urinalysis **4.** 12 Lead ECG (to be reviewed by Physician as per ED Practice Standards)	Documented, or strong clinical suspicion for sepsis Symptoms including but not limited to two or more of the following: • Temperature of greater than 38°C or less than 36°C • HR of greater than 90 beats/min • RR of greater than 20/min • SBP of less than or equal to 90 mmHg or a mean of less than 65 mmHg • Chills/rigors or headache with neck stiffness • Alterations in patient behaviour (especially in elderly)		**NOTIFY** Physician **STAT** if systolic BP less than 90 mmHg
5. Chest X-ray (PA and Lateral) OR Portable Chest X-ray for hemodynamically unstable patients	Patients presenting with symptoms suggestive of Acute Coronary Syndrome such as pain, pressure, tightness, or discomfort in the chest, shoulders, arms, neck, back, upper abdomen, or jaw, and shortness of breath	Known or suspected pregnancy.	
6. Continuous cardiac monitoring	Required in the professional judgement of the authorized HCP		
7. Initiate IV Ringer's Lactate at 30 mL/hr **OR** saline lock	IV is required in the professional judgement of the authorized HCP		
8. Ringer's Lactate 500 mL fluid bolus over 15 minutes	Patient is hypotensive with systolic BP less than 90 mmHg	If patient has history of congestive heart failure, or has signs and symptoms of congestive heart failure	

EARLY PREGNANCY COMPLICATIONS, VAGINAL BLEEDING AND OBSTETRICAL EMERGENCIES (LAKERIDGE HEALTH)

Vaginal Bleeding- Adults

Order:	Indications:	Contraindications:	Notes:
1. CBC, Na, K, Cl, CO_2, Urea, Creatinine, Glucose, Type and Screen, INR, PTT, **2.** Urine Screen	Adults with vaginal bleeding		
3. Urine or Serum β HCG	People of birthing age with internal reproductive organs (9 – 55 years)	Patients obviously pregnant or in confirmed third trimester Previous hysterectomy	
4. Administer oxygen via nasal prongs or mask	SpO2 less than or equal to 92% or SpO2 less than or equal to 88% in COPD patients		
5. Initiate IV 0.9% sodium chloride at 30 mL/hr **OR** saline lock	IV is required in the professional judgement of the authorized HCP		

Obstetrical Emergency

Order:	Indications:	Contraindications:	Notes:
Re-direct to: New Life Centre (LHPP) Birthing Suite (LHO) Labour and Delivery (LHAP) ****Does not apply at LHB****	Pregnant patient over 20 weeks of gestation presenting with a pregnancy related concern (abdominal cramping, abdominal pain, backache, vaginal leaking of fluid, decreased fetal movement, vaginal bleeding, headache, etc.)	Respiratory distress, hemodynamically unstable, imminent delivery, gestation less than 20 weeks, non-pregnancy related concerns (trauma, laceration, injury, etc.)	

EXTREMITY X-RAYS (HUMBER RIVER HEALTH)

Humber River Health

Manual	Emergency Services Manual, Medical Directives	MEDICAL DIRECTIVE
Section		
Author	CLINICAL PRACTICE LEADER	
Approved by	PROGRAM DIRECTOR, EMERGENCY SERVICES	
Date	O: 04/28/2021	Version Number: 4
	R: 08/09/2023	Reference #: 7225

This is a CONTROLLED document. Any documents appearing in PAPER FORM should be checked against the electronic document in Policy & Procedure Manager (PPM).

EMERGENCY DEPARTMENT MEDICAL DIRECTIVE FOR MEDICAL IMAGING

Purpose

When the identified patient conditions exist, and Emergency Registered Nurse (RN), employed by Humber River Hospital (HRH) in the Emergency Program (ED) who has successfully completed the competency validation process and possess the knowledge, skill and judgment may initiate the following medical imaging medical directives:

- Ankle X-Ray
- Foot X-Ray
- Knee X-Ray
- Tibia/Fibula X-Ray
- Hip/Pelvis X-Ray
- Hand X-Ray
- Finger X-Ray
- Scaphoid X-Ray
- Wrist X-Ray
- Forearm X-Ray
- Elbow X-Ray
- Shoulder X-Ray
- Chest X-Ray

Expected Outcome

To expedite care and standardize the approach to all registered patients, greater than 8 years of age with an acute injury in the ED who meet the inclusion criteria as indicated on the specific medical directive. Once the patient has been admitted, the nurse is required to call the Most Responsible Physician (MRP) for further orders.

If the patient has medical imaging under this directive but leaves before being seen by the Emergency Physician, the nurse will forward the emergency record to the ED physician for disposition (See *Emergency Department Patients – Left Without Being Seen and Against Medical Advise Policy*).

Contraindications

These medical directives must not be implemented when:

1. the patient or substitute decision maker (SDM), parent or legal guardian declines implementation of this Medical Directive.
2. the patient is from out of country
3. the patient has any of the following clinical contraindications:
   - non-traumatic or chronic condition
   - unstable patient - physician to be contacted immediately
   - signs or symptoms of neurovascular compromise in the affected limb. Physician to be contacted immediately
   - open fractures will be assessed by the emergency physician directly
   - patient is intoxicated or has other distracting injuries and is unable to follow direction, maintain motor control or is uncooperative.
   - previous imaging exams within the last 48 hours to the affected area
   - multiple injuries suspected (more than two injuries), physician to be contacted immediately.

Consent

This medical directive cannot be instituted until the patient or SDM has provided informed consent for the proposed investigation and treatment.

Obtaining and documenting informed consent includes the provision of information and the ability to answer questions about:

- the implementation of this medical directive,
- the nature of the treatment,
- expected benefits of the treatment,
- material risks and adverse effects of the treatment,
- alternative courses of treatment, and
- likely consequences of not having the treatment (CNO, 2013; CPSO, 2012).

In emergency situation when consent cannot be obtained from the patient or SDM, in which case the healthcare provider will proceed with treatment as outline in HRH's *General Requirements* of *Informed Consent Policy and the Heath Care Consent Act* (HRH, 1990).

Physician Action

1. Assess the patient in a timely manner
2. Give further order(s) for care of the patient

Documentation

Triage Nurse

The ED RN who initiates medical directives at triage must take the following steps to ensure accurate documentation:

- Specify the medical directive to be initiated and document in the "Triage assessment screen" in Meditech.
- Enter the appropriate orders under the medical directive category during order entry.
- Alternatively, order entry can be delegated to clerical staff.

Acute/ Subacute/ Ozone/ Fast Track:

The ED RN who initiates the medical directive must take the following steps to ensure accurate documentation:

- Specify the medical directive being initiated and document in the "Medical Directives Initiated" screen in Meditech.
- Enter the appropriate orders under the medical directive category during order entry.

Clerical Action

1. The ED Clerk will enter Medical Directive Order(s) initiated by ED RN after registration.

Electronic Documentation

Document consent, assessment findings, medical imaging tests completed and patient's response to those procedures.

Nursing/HCP Action

Responsibility

It is the responsibility of the ED RN to assess the patient for the following:

- Time, approximate force, and mechanism of injury.
- Ability to use extremity and any sensory changes following the injury.
- Any lacerations, abrasions, edema, ecchymosis, and /or deformity.
- Range of motion (ROM), weight bearing ability, and function before and after the injury.

- Neurovascular status of the inured extremity, checking for the 6 P's: pulses, pain, pallor, paresthesia, paralysis and polar (temperature).
- Tetanus status in the presence of broken skin integrity.
- Complaints of any additional injury.

Nursing Action

The ED RN will:

1. Initiate the medical directive after a focused musculoskeletal/integumentary assessment is completed based on their clinical presentation.
2. Carefully remove any jewelry or constricting clothing distal or near the injury.
3. Apply an ice pack and elevate the extremity (apply ice 15-20 minutes on, 15-20 minutes off). Ensure that the ice pack is wrapped in a pillow case or towel to prevent cold exposure.
4. Immobilize the affected limb with a splint or sling if able. Reassess and document the neurovascular status of the injured limb after the application of the splint.
5. Assess the need for analgesia prior to x-ray and determine route of analgesia administration as per ED medication medical directive.
6. Obtain informed consent by completing the following:
   - explain the reason(s) for the x-ray
   - explain the general risks and benefits of performing the x-ray
   - answer any questions the patient might have
7. Order entry for specific extremity x-ray in Meditech.

Medical Radiation Technologist Action

The Medical Radiation Technologist will:

1. Review all orders for extremity x-rays for ED patients and verify following information (*Medical Imaging Exams – Requests for and Requirements of Policy* (HRH, 2022) :
   - patient identifiers
   - name of attending ER physician
   - clinical indication for examination
   - order initiated under medical directive
   - name of emergency RN initiating medical directive
2. Assess appropriateness of ordered examination, given clinical indications specified in the orders as well as inclusion and exclusion criteria as outlined above.
3. Assess female patients for possibility of pregnancy.
4. Consult the attending ED physician prior to examination in instances where the technologist has concerns regarding the appropriateness of the ordered examination, or is unable to verify that the RN initiating the medical directive is authorized to do so.
5. Complete medical imaging examination, given that all inclusion/exclusion criteria have been met and that examination is appropriate to specified clinical indications.

All patients will be cared for using Infection Prevention and Control Routine Practices and Additional Precautions as outlined in **Provincial Infectious Diseases Advisory Committee (PIDAC):** Routine Practices and Additional Precautions, Ministry of Health and Long-term Care, as per HRH policy. All staff will perform Hand Hygiene as per HRH guideline.

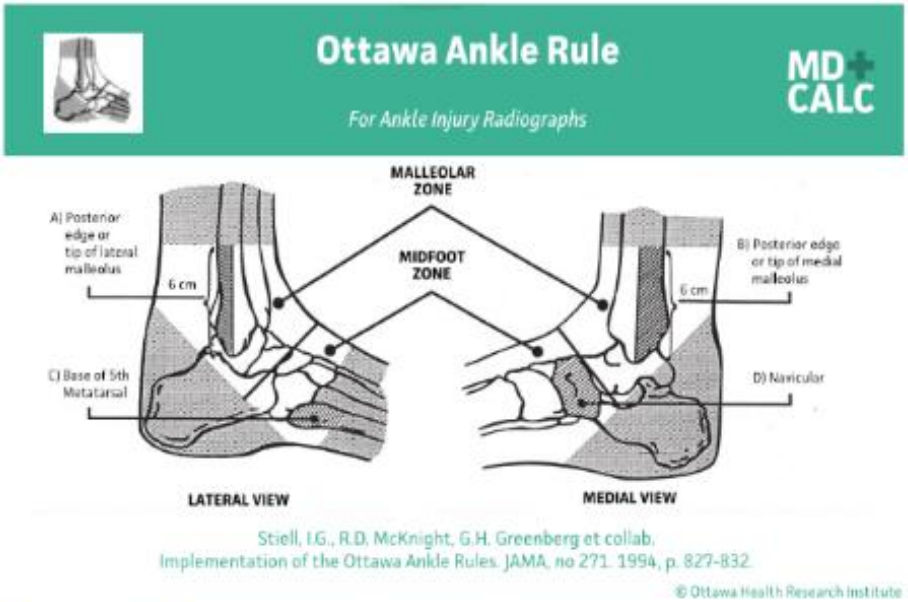
Medical Imaging Medical Directives

Medical Imaging	Patient Conditions
Ankle X-Ray	An *ankle* radiographic series is required only if there is any pain in malleolar zone and any of these findings as per the **Ottawa Ankle/Foot Rules**: • bone tenderness at A (see diagram below), or • bone tenderness at B, or • inability to bear weight both immediately and in the ED (4 steps, or unable to transfer weight twice onto each lower limb regardless of limping).
Foot X-Ray	A *foot* radiographic series is required only if there is any pain in midfoot zone and *any* of these findings as per the **Ottawa Ankle/Foot Rules**: • bone tenderness at C (see diagram below), or bone tenderness at D, or • inability to bear weight both immediately and in the ED (4 steps, or unable to transfer weight twice onto each lower limb regardless of limping).
Knee X-Ray	A *knee* radiographic series is required only if one or more of these findings: • isolated tenderness of the patella (that is, no bone tenderness of the knee other than the patella) • tenderness at the head of the fibula • inability to flex to 90 degrees • inability to bear weight both immediately and in the ED (4 steps, or unable to transfer weight twice onto each lower limb regardless of limping)
Tibia/Fibula X-Ray	A *tibia/fibula* radiographic series is required if: • deformity and/or swelling in the area • localized bony tenderness
Hip/Pelvis X-Ray	A *hip/pelvis* radiographic series is required if: • external rotation, abduction, and shortening of the affected limb

	• For pelvis: Pain during gentle palpation on the iliac crests toward the midline and gentle downward pressure over the symphysis pubis • age is over 55 years
Hand X-Ray	A *hand* radiographic series is required if: • deformity and or swelling in the area, impaired range of motion and localized bony tenderness
Finger X-Ray	A *finger(s)* radiographic series is required if: • isolated finger injury distal to the metacarpophalangeal (MCP) joint
Scaphoid X-Ray	A *scaphoid* radiographic series is required if one or more of these findings: • pain at the anatomic "snuff box" • pain on axial compression of thumb • tenderness to scaphoid tubercle • snuffbox edema
Wrist X-Ray	A *wrist* radiographic series is required if: • deformity and swelling in the area, impaired range of motion and localized bony tenderness
Forearm X-Ray	A *forearm* radiographic series is required if: • deformity and swelling in the area, localized bony tenderness
Elbow X-Ray	An *elbow* radiographic series is required if: • deformity and or joint effusion or swelling in the area, impaired range of motion and localized bony tenderness
Shoulder X-Ray	A *shoulder* radiographic series is required if: • inability to abduct the affected shoulder and step-off of the acromion
Chest X-Ray PA and LAT (See Therapeutic Procedure Medical Directive for additional orders)	Signs and symptoms of or including on or more of the following: • Acute Coronary Syndrome • Suspected sepsis
Portable Chest X-Ray (See Therapeutic Procedure Medical	*For patients with unstable vital signs that cannot be safety transferred to Medical Imaging Department

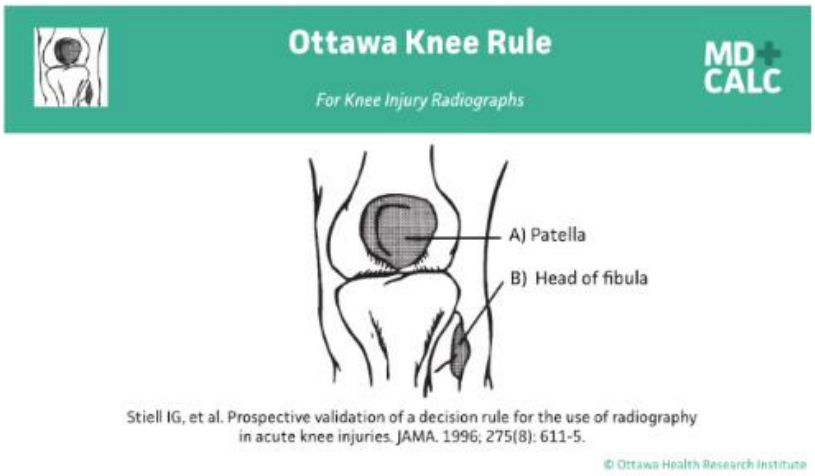
Directive for additional orders)	Signs and symptoms of or including on or more of the following: • Acute Coronary Syndrome • Suspected sepsis

Ottawa Ankle Rules



https://www.mdcalc.com/ottawa-ankle-rule

Ottawa Knee Rule



https://www.mdcalc.com/ottawa-knee-rule

Infection Prevention and Control Considerations

All patients will be cared for using Infection Prevention and Control Routine Practices and Additional Precautions as outlined in **Provincial Infectious Diseases Advisory Committee (PIDAC):** Routine Practices and Additional Precautions, Ministry of Health and Long-term Care, as per HRH policy. All staff will perform Hand Hygiene as per HRH guideline.

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Humber River Health

Salbutamol and Ipratropium for Respiratory Distress	

Patient Conditions	Assessment of the patient for any of the following specific clinical conditions:
	• shortness of breath
	• increased work of breathing
	  ○ accessory muscles use
	  ○ retractions
	  ○ paradoxical abdominal breathing
	• diaphoresis
	• cyanosis
	• increased respiratory rate >20
	• wheezing
	• decreased air entry
	• patients in respiratory distress –i.e.- O2 Saturation < 90% and signs of respiratory distress, triage as CTAS 1 and paged physician STAT

Inclusion Criteria	The patient **must** have a history of one or more of the following: • asthma • COPD (Emphysema, Chronic Bronchitis) • or previous Salbutamol (Ventolin) use
Exclusion Criteria	• Weight < 33 kg • Patient with a fever > 38.0 °C • Allergy or sensitivity to salbutamol or adrenergic amines (salmeteral, terbutaline, albuterol, fomerterol)
Nursing Action PPPPG Print Date: 3/19/2025	NOTE: It is the responsibility of the Emergency Triage Nurse to assess the patient utilizing the *OHA Triage Guidelines and ED Standard of Care*. If the assessment reveals signs and symptoms of acute respiratory distress as identified above, the patient will be categorized as a CTAS level 1 or 2, and the patient brought immediately into the department for further evaluation. The ED RN will: 1. Initiate the medical directive after a patient assessment is completed and allergy information is obtained in accordance with the ED Standards of Care. 2. Administer oxygen @ 4L/min via nasal prongs or provide supplemental oxygen to maintain O_2 sat >90%. Call physician STAT 3. Administer the following inhalation therapy via **metered dose inhaler**: • **Salbutamol (100 micrograms/puff) 6 puffs inhaled STAT** **AND** • **Ipratropium (20 micrograms/puff) 6 puffs inhaled STAT**

	AND
	• **Repeat inhalation therapy q 20 minutes PRN x2.**
	
	4. Reassess the patient's response and vital signs within 15 minutes following administration or as indicated.
	
	• Reassessment of vital signs, pulse oximetry, air entry, and any adventitious sounds is completed and documented following each administration of the IT.
	• Give oxygen by mask or nasal prongs between IT to maintain oxygen saturation > 90%.
	• Inform the ED physician immediately of deterioration of patient's status:
	  o respiratory Rate <10 or > 25 bpm
	  o saturation < 94% despite O2 therapy to a maximum FiO2 of 50%
	  o systolic BP <90mmHg or >180 mm HG or a decrease of >40 mmHg
	  o heart Rate <45 or >115 bpm
	  o changes in LOC or a decrease in GCS of 2 points

INHALATION THERAPY: PEDIATRIC (LAKERIDGE HEALTH)

Asthma Management- Paediatrics

Order:	Indications:	Contraindications:	Notes:
1. Paediatric Respiratory Assessment Measure (PRAM) Score (**Appendix B**) **2.** Salbutamol (Ventolin) 100 mcg/puff by metered dose inhaler (MDI) and spacer q 20 min x 3 based on the following dosing: **Less than 20 kg**: 4 puffs (400 mcg) q20 minutes x 3 doses **Greater than or equal to 20 kg**: 8 puffs (800 mcg) q 20 minutes x 3 doses **3.** Ipratropium (Atrovent) 20 mcg/puff by MDI and spacer q 20 min x 3 based on the following dosing: **Less than 20 kg**: 4 puffs (80 mcg) q20 minutes x 3 doses **Greater than or equal to 20 kg:** 8 puffs (160 mcg) q 20 minutes x 3 doses	Paediatric patient (Age 1 - 17 years) with wheeze and/or cough AND asthma diagnosis and/or past history of wheeze AND presents with symptoms of asthma as assessed by the PRAM	Patient presents with history of acute or chronic condition other than asthma, including cardiac conditions. Patient is unable to cooperate with the procedure	**NOTIFY** Physician / RRT **STAT** if PRAM score is 4 or greater. A PRAM score >12 indicates impending respiratory failure.
4. Administer oxygen via nasal prongs or mask	if SpO2 less than or equal to 92%		
5. Dexamethasone 0.6 mg/kg PO once (maximum 20 mg)	Paediatric patient (Age 1 - 17 years) with moderate or severe asthma (PRAM 5-12) OR Symptoms of croup such as stridor, barking cough, mild to moderate respiratory distress.	Patient cannot tolerate PO	**Notify Physician STAT** if PRAM score >12 (indicates impending respiratory failure)

PAIN AND FEVER MANAGEMENT: ADULT (HUMBER RIVER HEALTH)

Humber River Health

Acetaminophen for Fever	
Patient Conditions	Assessment of the patient for the following conditions: • Temperature > 38 C when measured by any route
Inclusion Criteria	The patient must: • present with a fever as indicated above, and • be alert and have an intact gag reflex (if the oral route is to be used).
Exclusion Criteria	• Allergy or hypersensitivity to acetaminophen • Dose of acetaminophen within the past 4 hours • Alcoholic or intoxicated patients • Signs & symptoms of liver disease, liver dysfunction, hepatitis, or liver transplant patients • Abdominal pain
Nursing Action	The ED RN will: 1. Initiate the medical directive after a patient assessment is completed, and vital signs and allergies are obtained in accordance with the ED standards of care. 2. Assess whether or not a dose of acetaminophen has been given in the previous 4 hours. NOTE: Do not give PO medications in cases where patient is obviously going to require surgery and consult physician for fever management. 3. Administer: • **Acetaminophen 1000 mg PO/PR as a one-time dose** 4. Reassess patient and document patient response within 30-60 minutes of administration

Acetaminophen or Ibuprofen for Mild to Moderate Pain	
Patient Conditions	Assessment of the patient triaged as CTAS 2 – 5 with mild to moderate pain (equal to or less than 7/10 on pain scale) as follows: • headache pain, • dental pain, • ear, nose and/or throat pain, • musculoskeletal pain, and/or • skin pain
Inclusion Criteria	The patient must: • present with pain as indicated above, and • be alert and have an intact gag reflex NOTE: Do not give medications by mouth in cases where patient is obviously going to require surgery or patient is in severe pain, consult physician for pain management within 30 minutes of arrival.
Exclusion Criteria	Acetaminophen: • allergy or sensitivity to acetaminophen • ingestion of acetaminophen in last 4 hours • hepatitis or liver disease Ibuprofen: • abdominal pain • history of liver or renal disease • allergy or sensitivity to ASA, ibuprofen or non-steroidal anti-inflammatory drugs (NSAIDs) • history of inflammatory bowel disease, peptic ulcer, GI bleed • ingestion of ibuprofen within the last 6 hours • pregnant or nursing
Nursing Action	The ED RN will: 1. Initiate the medical directive after a patient assessment is completed and allergies information is obtained in accordance with the ED standards of care. 2. Assess for allergies to acetaminophen/ibuprofen and whether or not the patient has had a preceding dose of one of these medications.

PPPPG Print Date: 3/19/2025

PAIN AND FEVER MANAGEMENT: PEDIATRIC (LAKERIDGE HEALTH)

Analgesia for Pain- Paediatrics

Order:	Indications:	Contraindications:	Notes:
Acetaminophen 15 mg/kg PO/PR once (maximum dose 650 mg) **OR** Ibuprofen 5 - 10 mg/kg PO once (maximum dose 400 mg)	Patients who are greater than 3 months old with clinical suspicion of pain or self/parent report of pain	Decreased level of consciousness (GCS <15 AND deviation from baseline by two points) **Acetaminophen:** Recent acetaminophen administration in the last 4 hours **OR** more than 5 acetaminophen doses in past 24 hour period History of cirrhosis or chronic liver disease **Ibuprofen:** Recent Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) administration in the past 6 hours **OR** more than 3 doses in the past 24 hours Allergic manifestations precipitated by ASA or other non-steroidal anti-inflammatory agents History of kidney injury or impaired renal function, any clinical bleeding or platelet disorders	Measure weight (kg) of child **NOTIFY Physician STAT** for child less than 3 months of age presenting with pain or temperature greater than or equal to 38˚C

Fever Management- Paediatrics

Order:	Indications:	Contraindications:	Notes:
Acetaminophen 15 mg/kg PO/PR once (maximum dose 650mg) **OR** Ibuprofen 5 - 10 mg/kg PO once (maximum dose 400 mg)	Patients who are greater than or equal to 3 months old with a temperature of greater than or equal to 38°C	Decreased level of consciousness (GCS <15 AND deviation from baseline by two points) **Acetaminophen:** Recent acetaminophen administration in the last 4 hours **OR** more than 5 acetaminophen doses in past 24-hour period History of cirrhosis or chronic liver disease **Ibuprofen:** Recent Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) administration in the past 6 hours **OR** more than 3 doses in the past 24 hours Allergic manifestations precipitated by ASA or other non-steroidal anti-inflammatory agents History of kidney injury or impaired renal function, any clinical bleeding or platelet disorders.	**NOTIFY Physician STAT** for child less than 3 months of age presenting with temperature greater than or equal to 38˚C Reassess temperature 30 minutes after administration of medication **Checking Temperature:** **Rectal**: <2 years of age **Oral**: >2 years of age **Axillary**: If oral and rectal are contraindicated. **Tympanic:** Screening Only **Temporal**: Screening Only
		Rectal temperature is contraindicated for pediatric cancer patients (i.e. Febrile Neutropenia).	

ORAL REHYDRATION THERAPY (MACKENZIE HEALTH)

			response to intervention
Oral Rehydration Solution **Oral rehydration solution (ORS) 45-50 mmol/L sodium (Pedialyte™, Enfalyte™)** **Some (mild) to Moderate Dehydration:** o **Replace fluid deficit by giving 50-100 mL of ORS/kg of body weight** **Aim to administer "1-2-3 ounces" method as follows:** **6 months – 5 years old: 30 sips per 10 mins** **>5-10 years old: 60 sips per 10 mins** **>10 years old: 90 sips per 10 min** **Offer alternative fluid options based on taste preference if child refuses ORS**	Infant/Child must have vomited and/or diarrhea and have signs of some (mild) to moderate dehydration as described in the table (see Appendix F: Clinical Signs of Dehydration: Clinical Dehydration Scale) Pre-Administration: o Obtain vital signs including blood pressure, capillary refill, and level of alertness o Obtain weight in kilograms o assess level of dehydration o assess and document history of oral intake and the number of stools/vomiting o history of allergies	Do not implement this medical directive and notify physician immediately if: o severe dehydration is noted o child appears extremely ill, lethargic, has altered perfusion o child has bilious or bloody vomiting o protracted vomiting despite small, frequent feeding o severe dehydration with shock-like state o impaired consciousness o paralytic ileus o monosaccharide malabsorption	Administration: o Consider offering Ondansetron prior to offering ORS o Give fluids by the appropriate method (medication cup or syringe) starting with small volumes o Bottle feeding can be used, but fluid should be offered in small amounts o Breastfeeding may be continued in addition to ORS. The duration of breastfeeding should be kept brief o Parents may administer ORS, explain the process clearly to the parents and ask them to keep record of amounts taken Post-Administration: o Observed the infant's/child's response at least every 30 minutes, including frequency of vomiting and stooling o Reassess vital signs including blood pressure, capillary refill, and level of alertness

			○ Monitor intake/output, weigh diapers to determine urine/fluid volume output NOTE: if unable to increase oral intake 1-2 hours post administration notify physician Notify physician if signs of severe dehydration are present and/or with any signs of deterioration

ACUTELY PRESENTING OLDER ADULT (LAKERIDGE HEALTH)

Acutely Presenting Older Adult

Order:	Indications:	Contraindications:	Notes:
1. CBC, Na, K, Cl, CO_2, Urea, Creatinine, Glucose, Calcium, Magnesium, Phosphorus,	Patient is 65 years or older presenting with any of the following complaints: • General weakness • Feeling unwell • Difficulty ambulating • Recent Falls • Confusion (GCS <15 AND deviation from baseline by two points).	Meets indications for another existing medical directive (ie. Sepsis, Abdominal Pain, etc.)	
2. INR	Patient is on anticoagulants or unknown if on anticoagulants		
3. GEM Referral (GEM Nurse/Nurse Practitioner)	If the patient meets the following criteria: • Cognitive decline affecting hygiene, managing medication, • banking, driving and/or meal preparation • Complex medication regimen/polypharmacy • Recent falls or mobility changes • Recent physical or functional decline • Responsive behaviours (agitation, wandering, paranoia, • hallucinations, inappropriate behaviours) • Caregiver(s) having difficulty coping		

Test and Procedure Based Medical Directives

LABORATORY TESTING BLOOD TESTING AND URINE TESTING (UNIVERSITY HELATH NETWORK)

Medical Directive

RN/RPN Emergency Department: Medical Directive for Initiation of Medication, Diagnostic Tests and Interventions

Authorized To:

This medical directive is authorized to RN/RPN's working in the emergency department (ED) who have completed a departmental orientation program and who have the following:

- competency in venipuncture for blood specimen collection and vascular access
- completed a medical directive educational session and formal quiz
- knowledge regarding the implementation of a medical directive as per policy #3.10.022

This medical directive includes orders for procedures that are within the legislated scope of practice of nurses.

Description of Procedure:
The Registered Nurse (RN)/Registered Practice Nurse (RPN), on authority of this medical directive, can implement the medical directive for initiating medications and initiating diagnostic tests/interventions as listed in the enclosed tables for ED non-admit patients under the care of an attending UHN Emergency physician.

Indications:
The RN/RPN may initiate the approved medications, and diagnostic tests/interventions, in accordance with the identified indications listed in the attached tables.

Contraindications:

- This medical directive is not to be enacted on patients less than 16 years of age
- Patient does not provide consent

Note: hemodialysis lines and apheresis lines must not be accessed for laboratory tests.

The RN/RPN will not initiate the directive for any medication if there is a history of a skin reaction, swelling, trouble swallowing or breathing, severe abdominal cramps, and/or lightheadedness in response to any medication, as reported by the patient, family or noted by an attending health care professional. Any new hypersensitivity or allergic reaction must be reported as per UHN allergy and reverse reactions policy (3.30.011) to the attending physician or nurse practitioner.

Controlled Acts: (Choose all that apply):

☐ The _____ will order, but not perform the order.
☒ The RN/RPN will order and perform the order.
☒ All controlled acts are within the profession's legislated scope of practice.
☐ There are no controlled acts in this medical directive.
☐ There are controlled acts in this medical directive which are delegated.

Documentation:
The RN/RPN will document the assessment and initiation of this Medical Directive in the Health Information System (HIS).

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Medical Directive	RN/RPN Emergency Department: Medical Directive for Initiation of Medication, Diagnostic Tests and Interventions	Page Approval Date Review/Revision Date(s) Version Date (no full review)	Page 1 of 18 10/02/2023 11/16; 05/10/2017; 10/02/2023 28/06/2019;12/08/2019; 20/09/2019; 14/04/2020; 05/06/2021;25/05/2022;11/04/2023
Number	MDir 1011		

Diagnostic Tests / Interventions

Diagnostic Test/Intervention	EPIC Order Terminology and Order Code	Indications	Absolute Contraindications	Special Considerations (Including contraindications)
Routine blood work (RBW)				
CBC	CBC [LAB294]	RBW for patients presenting to the Emergency Department with any of the following medical conditions and/or signs and symptoms: • Cardio-pulmonary disease: chest pain, shortness of breath, weak and dizzy • Alteration in neurologic status i.e. decreased level of consciousness, confusion, suspected stroke • Chronic medical conditions who are being treated for an acute condition • Moderate to severe abdominal pain • Trauma • Major bleeds • Temperature (**oral** *not* tympanic) greater than or equal to 38 °C and recently received active cancer treatment for cancer (within last 4 weeks) • Looks *unwell* and immunocompromised (i.e. HIV, transplant, chronic steroid use, splenectomy, diabetic, rheumatoid arthritis, lupus) • Looks *unwell* and greater than 65 years of age • Suspected dehydration		
Random Glucose	Glucose, Random [LAB82]			
Creatinine	Creatinine [LAB66]			
Bicarbonate	Bicarbonate [LAB55]			
Electrolytes (Sodium, Potassium, Chloride)	Electrolytes (Na, K, Cl), Serum [LAB16]			
		• Abnormal vital signs per Emergency Medicine: Vital signs monitoring policy 53.20.004 • Drug or alcohol ingestion/overdose • Patients in whom surgery is anticipated		
Drug Levels				
Alcohol level	Ethanol [LAB 46]	• Suspected drug ingestion/overdose • Patient who has symptoms of alcohol intoxication • Consider for patient with altered level of consciousness	• Not for forensic investigation	• For clinical assessment ONLY. • If the police request an alcohol level for forensic investigation they must inform the patient and OBTAIN the patient's signed consent. If the police request access to patient information (i.e. lab values) a warrant must be provided. Refer to • Release of Information/ Specimens/Items to Police policy 1.40.011
Serum Salicylate, Acetaminophen	Acetaminophen [LAB43]	• Suspected drug ingestion/overdose • Patient with altered level of consciousness		• Ensure routine blood work and LFTs have been collected.
Lithium level	Lithium Serum [LAB 552]	• Suspected drug ingestion/overdose • Patient with altered level of consciousness believed to be on lithium		
Phenytoin Level	RAPID LAB – Phenytoin (Dilantin) [LAB 31]	• Seizure (patient on phenytoin) • Suspected toxicity		• Suspect toxicity if patient presents with nystagmus, on lateral gaze, ataxia, dysarthria and lethargy

Carbamazepine Level	Carbamazepine {LAB 21]	• Seizure, vomiting, ataxia (patient on Carbamazepine) • Suspected toxicity		• Suspect toxicity if patient presents with drowsiness, ataxia, nausea and vomiting, tremors, blurred vision, nystagmus and hallucinations
Digoxin level	Digoxin [LAB 23]	• Patient on digoxin who presents with arrhythmia • Suspected toxicity		• Suspect toxicity if patient presents with arrhythmia (i.e. PVCs, heart block), confusion (especially in the elderly); yellow vision, blurred vision, "halos" around objects, and photophobia
Microbiology				
Blood Cultures – from PIV or CVAD	Blood Culture (Includes Yeast) [LAB 462]	• Temperature greater than or equal to 38° C (oral) and one of the additional SIRS / qSOFA criteria • Temperature greater than 38° C and has received active cancer treatment within the last 4 weeks • Temperature greater than 38° C and has an indwelling vascular access device • Patients greater than 65 years of age who present with one of the following: ○ Complaint of "not feeling well" ○ Altered level of consciousness ○ 2 to 3 day history of a temperature greater than 38° C with or without a focus of infection ○ Rigors ○ Intense headache, neck rigidity, and vomiting		• Two sets of cultures are required. Draw first set, wait 10 minutes, collect second set from a different site • If patient has indwelling vascular access device obtain blood cultures from each lumen or port in addition to peripheral sets as per UHN policy Vascular Access – Blood Specimen Collection 3.60.007 • Lactate should be drawn whenever blood cultures are done
				• ***Systemic Inflammatory Response Syndrome (SIRS) criteria:*** ○ temperature greater than 38°C or less than 36° C ○ heart rate greater than 90 beat/min ○ respiratory rate greater than 20 ○ with a potential source of infection. • ***Quick Sequential Organ Failure Assessment (qSOFA) criteria:*** ○ Altered mental status (GCS less than 15), ○ Elevated respiratory rate (greater than or equal to 22 breaths per minute) ○ SBP less than or equal to 100
C & S Swab, • Skin Swab • Wound Swab	Miscellaneous Swab Culture [LAB1230102]	• Immunocompromised patient with: • Red or inflamed areas • Inflammation or drainage from central venous access device (CVAD) insertion site • Any draining wound		
Miscellaneous (serum)				
Lipase	Lipase, Total [LAB 99]	• Right upper quadrant abdominal pain • Epigastric pain		• Ensure routine blood work and LFTs have also been collected

BHCG Quantitative Pregnancy Screen	HCG, Quantitative Pregancy [LAB 143]	• Suspected ectopic pregnancy • Known pregnancy with lower abdominal pain or vaginal bleeding		• Complete and confirm positive urine BHCG first
Group and Screen – RBC Crossmatch	Blood Group and Antibody Screen [LAB 276]	• Major trauma • Hypotension • Chest, abdominal, or back pain suggestive of vascular emergency i.e. dissecting aneurysm • Actual or potential loss of large volume of blood i.e. GI bleed, pelvic fractures • Pallor, known or suspected anemia • Ascites whose anticipated clinical course includes paracentesis and possible albumin administration • Hematological malignancies and suspected thrombocytopenia and anemia • Pregnant patients with abdominal pain and/or vaginal bleeding • Female patients with symptoms suggestive of ectopic pregnancy • Patients in whom surgery is anticipated		• Routine blood work should also be collected • A group and screen should be collected prior to transfusing a patient, unless there is an in-date sample within the Transfusion Report of the Blood Flowsheet in Health Information System (HIS).
Lactate	Lactate, Plasma [LAB 1231100002]	• Patients with known or suspected significant infection and a temperature greater than 38°C • Patients with suspected ischemic bowel or severe dehydration		• Patients having blood cultures drawn should also have a serum lactate • Specimen must be collected in gray-top tube and immediately transferred to lab • See blood cultures and SIRS/qSOFA criteria

Liver Functions Tests (LFT)				
Aspartate Transaminase (AST)	Aspartate Aminotransferase (AST) [LAB131]	• Blunt/penetrating abdominal trauma • Right upper quadrant abdominal pain • Epigastric pain • Jaundice • History of liver disease • GI bleed • Ascites • History of alcohol (ETOH) -dependency • Suspected acetaminophen overdose • Suspected febrile neutropenia		• Ensure routine blood work has also been collected
Alanine Transaminase (ALT)	Alanine Aminotransferase (ALT) [LAB132]			
Total Bilirubin (T-Bili)	Bilirubin Total, Fluid [LAB182]			
Alkaline Phosphatase (ALP)	Alkaline Phosphatase (ALP) [LAB112]			
Lactate Dydrogenase (LD)	Lactate Dehydrogenase [LAB 96]			
Osmolality (serum)	Osmolality, Serum [LAB 107]	• Suspected ingestion of isopropanol, methanol or ethylene glycol		

PT/INR & aPTT	PT/INR [LAB320]
	
	APTT [LAB325]
		• Symptoms suggestive of acute coronary syndrome (ACS)
		  • Chest pain, substernal discomfort indigestion
		  • Neck, jaw, shoulder, arm or back pain
		  • Nausea, vomiting, shortness of breath, weakness, diaphoresis, syncope and palpitations
		
		• Symptoms suggestive of pulmonary embolus or deep vein thrombosis		

		• Dyspnea, tachypnea, hemoptysis
		• Pleuritic chest pain
		• Tachycardia
		  ☐ Anxiety, restlessness
		• History of liver disease
		• On warfarin
		• Neurological symptoms suspicious of acute stroke or head injury
		  • Facial weakness, unilateral weakness, confusion, trouble speaking
		  • Headache, nausea and vomiting
		  • Sudden visual disturbance, vertigo, ataxia
		  • Numbness or tingling
		• Alcohol –dependency
		• Trauma
		• Anticipated surgery		

RALI-Dx IL-6 Severity Triage Test (when available)	RALI-Dx IL-6 Severity Triage Test [LAB1231100276]	• Patients aged greater than 18 years presenting with clinical suspicion of viral respiratory illness (such as acute respiratory distress, fever, cough, etc.)		• Specimen must be collected in a lavender top tube (single label, cannot be combined with other tests or existing specimens) • Treat sample as a stat test and send to lab immediately • Refer to RALI-Dx™ IL-6 Severity Triage Test Education
Troponin I	Troponin I (HS) STAT [LAB 747]	• Chest pain suggestive of acute coronary syndrome (ACS)		
Venous Blood Gas	Blood Gas, Venous [LAB 79]	• Signs and symptoms of acute respiratory distress or metabolic disorders • Metabolic disorder such as Diabetic Ketoacidosis (DKA) – presentation of tachycardia, tachypnea, polydipsia, polyphagia, polyuria) • Signs and symptoms of hemodynamic instability (pale, diaphoretic, tachycardia, tachypnea, hypotension, altered LOC, etc.) • Oxygen saturation less than 90% on room air or with oxygen supplementation		Sample must be drawn in heparinized syringe and sent to the lab on ice as soon as possible.
Urine testing				
Urinalysis—routine Point-of-care testing		• Abdominal pain • Urinary symptoms • Acute onset of confusion in patients aged 65 years and older • Suspected DKA • Temperature over 38°C		Only nurses who have completed the competency validation program may perform routine POCT urinalysis
Urine—Pregnancy screen Point-of-care testing		• Abdominal pain (lower) in female patients of childbearing age • Abnormal vaginal bleeding in females of childbearing age • To be completed when pregnancy status is unknown, prior to x-ray/CT and MRI where IV contrast is given.		Only nurses who have completed the competency validation program may perform beta hCG urinalysis testing

CAPILLARY BLOOD GLUCOSE TESTING (LAKERIDGE HEALTH)

Capillary Blood Glucose

Order:	Indications:	Contraindications:	Notes:
1. STAT capillary blood glucose	Assessment of a patient from all ages (>35 weeks old) presenting with **hypoglycemia** OR **hyperglycemia** AND one or more of the following symptoms: • Hyperventilation, Abdominal pain, Polyuria, Polydipsia, Weight loss, Diaphoresis, Shaking/Tremors, Confusion/Agitation, Behavioural Changes, Lethargy, Fatigue, Recent/Active Seizure, Suspicion of Alcohol Ingestion	Patients <35 weeks of age.	**Notify Physician STAT** if patient has hyperglycemia or hypoglycemia with hemodynamic instability and/or altered level of consciousness. Please follow the Hypogylcemia protocol (Regional) if Blood Glucose is < 4mmol/L for Adult patients >18 years of age. **Notify Physician STAT** if a ***pediatric*** patient <18 years of age has hypoglycemia with hemodynamic instability and/or altered level of consciousness. Sick Kids' Normal Glucose Levels – Fasting Values (Appendix C)
2. CBC, Na, K, Cl, CO_2, Urea, Creatinine, Glucose, Venous Blood Gas, Serum Osmolality, Serum Ketones, AST, ALT, Ca, Mg, Phosphorus **3.** Urinalysis	For Adult patients >18 years of age with **Hyperglycemia** AND one or more symptoms mentioned above.		

ELECTROCARDIOGRAM (UNIVERSITY HEALTH NETWORK)

UHN Toronto General Toronto Western Princess Margaret Toronto Rehab
Medical Directive

Intervention				
12 Lead Electrocardiogram (ECG) STAT	ECG 12 lead- STAT [ECG1]	Signs and symptoms of, or including one or more of the following: • Signs and symptoms of ACS (e.g. chest pain, upper abdominal pain, shortness of breath, nausea, diaphoresis) • Palpitations, light-headedness or syncope • Respiratory distress (shortness of breath, tachypnoea) • Cerebrovascular accident • Major trauma to chest • Electrical injury		Should be completed within 10 minutes of the patient arrival / onset of symptoms if indicated and shown to the Emergency Department Physician for interpretation.
15 Lead Electrocardiogram (ECG) STAT	ECG 15 lead- STAT [ECG30410]	If a 12 Lead ECG is performed and one or more of the following items are noted: • If ST segment elevation in lead II, III, or AVF (indicative of an inferior ST elevated segment myocardial infarction (STEMI))		To be completed immediately post 12 lead ECG if clinically indicated. Should be shown together with the 12 Lead ECG to the Emergency Department
		• If ST segment depression (reciprocal changes) in V1-V3 (indicative of a posterior STEMI)		physician for interpretation within 10 min of completion.

VASCULAR ACCESS (UNIVERSITY HEALTH NETWORK)

Vascular access			
Vascular Access Insert Peripheral IV and Saline lock	• Acute chest pain • Acute shortness of breath • Acute abdominal/flank pain • Active GI bleeding • Active vaginal bleeding • Dehydration • Overdose of medications, alcohol, and/or other substances • Trauma • Patient meets SIRS criteria/ qSOFA criteria (see criteria under blood cultures) Intravenous access may also be initiated under the following circumstances: • in anticipation of medication administration • in anticipation of blood product administration • suspected febrile neutropenic patient • antipated emergency surgey		• Do not access hemodialysis or apheresis lines • Two large bore (18 gauge) peripheral intravenous catheters should be placed for all hemodynamically unstable patients • The nurse will communicate with the Physician if the patient is unstable, systolic BP less than 100 mmHg, or if patient requires fluid resuscitation

OXYGEN ADMINISTRATION (MOUNT SINAI HOSPITAL)

Mount Sinai Hospital
Sinai Health System
Joseph & Wolf Lebovic Health Complex

Title	Description of Procedure	Indications	Contraindications
Oxygen **Authorized To:** RN	Registered Nurses may initiate and or titrate oxygen with the intent of treating or preventing symptoms of hypoxemia. The initiation of oxygen must be documented on the patient record - dated, timed and signed.	• Supplemental oxygen may be administered to patients with: • Oxygen saturation level less than 90% or an oxygen saturation level below the desirable range for a clinical situation. • Cardio-pulmonary compromise i.e. chest pain, acute shortness of breath, shock, major bleed, in resuscitation. • Short term oxygen therapy during or after procedural sedation.	• No specific contraindications to oxygen therapy exist when the indications are judged to be present.

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