Discharge documentation for febrile children in the emergency department: how can it be improved?

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Background

- Full documentation of patients' discharge plan from the paediatric emergency department (PED) provides a record of patient care and communication, but is often neglected in the interests of time[1].
- Initial audit at our local hospital showed deficiencies in several areas of documentation of discharge planning for febrile children.
- We planned appropriate interventions based on these findings; our goal was to assess the effectiveness of these interventions on documentation of discharge planning.
- The outcome was to improve both discharge documentation and discharge planning for febrile children in the PED.

Methodology

- Population: representative sample of febrile children, 0 - 16 years old, discharged home from PED at Mater Dei Hospital, Malta.
- Initial data collection performed during 6 week period (December 2015 to January 2016) by manual search of PED records.
- Documentation of discharge planning assessed for diagnosis, treatment prescribed, doses prescribed, advice given, legibility and follow-up plan. Deficiencies were identified.
- Implemented changes:
  - presentation of findings to medical staff;
  - follow-up clinic for febrile children discharged home from PED;
  - handout for parents with information about caring for the febrile child, including when to seek medical advice.
- Second audit repeated one year later to assess for changes in the number of casualty sheets showing adequate documentation.
- Chi-squared test used to test for significance.

Results and Discussion

- 380 children in each audit cycle.
- 77.9% diagnosed with viral infections.
- Significant improvement in some areas of documentation, as shown in Table 1.
- Reason for deterioration in legibility needs further evaluation.
- Formal teaching does not necessarily result in improvement in documentation[1].
- Written instructions are useful for carers[2] and were the most effective intervention for improving documentation.

Parameter	Quality of Documentation: Initial Audit (number of patient records)			Quality of Documentation: Re-Audit (number of patient records)			Chi	P value	Trend
	Complete	Partial	None	Complete	Partial	None			
Diagnosis	324	N/A	62	301	N/A	79	2.85	0.09	
Treatment prescribed	285	N/A	101	302	N/A	78	3.40	0.07	
Doses prescribed	114	40	131	149	97	56	58.01	**<0.0001**	Improving
Advice given	44	243	99	185	107	88	140.27	**<0.0001**	Improving
Follow-up	122	N/A	264	153	N/A	227	6.24	**0.01**	Improving
Legibility	324	56	6	266	97	17	21.9	**<0.0001**	Worsening

Table 1: Pre and post-intervention audit results

Conclusion

- Study looked at the effectiveness of three alternative interventions on documentation of discharge planning of febrile children from PED.
- There was significant improvement in some areas.
- Ongoing measures are necessary to maintain and improve the level of documentation of discharge planning for febrile children from the PED.

References

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