

EVIDENCE-BASED PRACTICE: VIDEO-DISCHARGE CrossMark

INSTRUCTIONS IN THE PEDIATRIC EMERGENCY DEPARTMENT

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Abstract

Problem: While a high quality discharge from a Pediatric Emergency Department helps caregivers feel informed and prepared to care for their sick child at home, poor adherence to discharge instructions leads to unnecessary return visits, negative health outcomes, and decreased patient satisfaction. Nurses at the Inova Loudoun Pediatric ED utilized the Johns Hopkins Model of Evidence Based Practice to answer the following question: Among caregivers who have children discharged from the ED, does the addition of video discharge instructions (VDI) to standard written/verbal discharge instructions (SDI) result in improved knowledge about the child's diagnosis, treatment, illness duration, and when to seek further medical care?

Methods: A multidisciplinary team reviewed available evidence and created VDI for three common pediatric diagnoses: gastroenteritis, bronchiolitis, and fever. Knowledge assessments

were collected before and after delivery of discharge instructions to caregivers for both the SDI and VDI groups.

Results: Analysis found that the VDI group achieved significantly higher scores on the post test survey ($P < .001$) than the SDI group, particularly regarding treatment and when to seek further medical care. After integrating the best evidence with clinical expertise and an effective VDI intervention, the team incorporated VDI into the discharge process.

Implications for Practice: VDI offer nurses an efficient, standardized method of providing enhanced discharge instructions in the ED. Future projects will examine whether VDI are effective for additional diagnoses and among caregivers for whom English is not the primary language.

Key words: Evidence-based practice; Video discharge; Pediatric; Emergency department

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Introduction

A high quality discharge from the Pediatric Emergency Department (ED) educates caregivers on the child's treatment and prognosis. While effective instructions help caregivers feel informed and prepared to care for their child at home, limited comprehension of discharge instructions leads to poor treatment compliance, inadequate follow-up, ED re-admission, added patient and facility expenses, and decreased patient satisfaction.^{1,2} Brief video discharge instructions (VDI) added to standard written/verbal discharge instructions (SDI) have been shown to improve caregiver knowledge, information retention, and family satisfaction.³⁻⁷ In an effort to provide families with the best possible discharge education, nurses from the Inova Loudoun Pediatric Emergency Department engaged in an Evidence-Based Practice Project (EBP) to determine if VDI would improve caregiver knowledge at discharge and increase patient satisfaction.

The discharge process on our unit consisted of verbal instructions from the nurse or provider, and preformatted

written information about the child's diagnosis. This method is standard in EDs across the United States, however it presents many challenges. Verbal discharge instructions are often incomplete and parents frequently do not have the opportunity to ask questions,⁸ potentially leaving parents unprepared to care for their child at home. Written instructions often overestimate the caregiver's reading level, health literacy and language proficiency, resulting in limited comprehension of instructions.⁹ Time limitations, the chaotic ED environment and varying levels of nurse experience may prohibit adequate, consistent education for ED aftercare.¹

VDI have proven to be effective for educating families with low literacy levels.^{1,10,11} Ismail and colleagues (2013) reported that VDI, in conjunction with written and verbal instructions, improved low-literacy caregivers' understanding of their child's diagnosis, disease process and prognosis. Further, study effects were found to be similar between parents with limited education and those with higher levels of education.¹²

The Pediatric ED recognized an opportunity to implement this EBP quality improvement project when tablet devices were donated to the unit to entertain and distract pediatric patients during their stay. While we were brainstorming ideas on how we could use this technology to also improve patient care, our hospital system created and funded an inaugural Evidence-Based Practice Fellows Program which acted as the catalyst for the project.

Methods

The Johns Hopkins Nursing model for Evidence Based Practice (JHNEBP) was chosen to guide the process of creating and testing the VDI intervention.¹³ First, a multi-disciplinary team was formed which consisted of unit nurses and the nurse manager, physicians, child life specialists, a statistician, the patient experience nurse for the hospital system, two graduate nursing students and a parent advocate. A project timeline was created, and the practice question was developed and refined.¹³ Following the next step in the JHNEBP model, the project team conducted a literature search, reviewed the evidence, and organized the research into a hierarchy using JHNEBP tools.¹³ The evidence was integrated with the clinical expertise of the team, patient preferences and current standard of practice to plan an evidence-based VDI intervention in our clinical environment.

The interprofessional EBP team collaborated to develop VDI scripts for the three most commonly seen diagnoses in our ED, gastroenteritis, fever and bronchiolitis. These scripts

mirrored the content of the written discharge instructions given to caregivers, with the addition of images to enhance the content. Each VDI featured a member of the EBP team reading a 3-5 minute script with images and text to reinforce the verbal messages. The videos described symptoms associated with the diagnosis, treatment of the symptoms, expected illness duration and when to seek further medical care.

During triage, EBP team members identified caregivers who fit inclusion criteria: caregivers over 18 years of age for children up to 21 years of age, and English as a primary language. The project was described to caregivers, and verbal assent was obtained. During the first half of the data collection period (2 months) caregivers received standard discharge instructions (SDI), which consisted of a written print-out and verbal instructions from their provider and discharge nurse. Caregivers during the second half of the data collection period (8 weeks) were shown the VDI that corresponded to their child's diagnosis in addition to the SDI.

MEASURES

Questionnaires were created to assess caregiver knowledge before and after receiving discharge instructions. After triage, both the SDI group and VDI group filled out a 5-question survey that determined caregiver knowledge about the child's diagnosis, treatment, illness duration and when to seek further medical care. At the conclusion of their ED stay, caregivers in both groups received a questionnaire that included the same 5 questions as the pre-instructions knowledge assessment with one additional survey question regarding their satisfaction with the discharge process using a Likert-like scale.

ANALYSIS

Caregiver knowledge is described using mean, median, and quartile percentage of correct answers pre- and post-instructions, by study group, diagnosis, and question type. Interquartile range (25th-75th percentile) was evaluated to understand variations in caregiver knowledge by group. Improvements in post-instructions knowledge was evaluated for all caregiver participants using nonparametric paired Wilcoxon signed rank tests. Caregiver knowledge was compared between the VDI and SDI group using nonparametric Wilcoxon rank sum tests. Analyses were conducted for the entire study cohort and then stratified by diagnosis groups (gastroenteritis, fever, and bronchiolitis) and question type (diagnosis, treatment, duration, and seek care).

Two measures of comparison were evaluated to assess the effectiveness of the VDI. The first method compared the improvement in knowledge between pre- and

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