

The Caregiver Perspective on Unscheduled 72-Hour Return Visits to Pediatric Acute Care Sites: A Focus on Discharge Processes

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ABSTRACT

OBJECTIVE: To characterize pediatric caregivers' reasons for 72-hour emergency department (ED) and urgent care (UC) returns.

METHODS: A sample of caregivers returning within 72 hours of initial visit to a pediatric ED or affiliated UC site was surveyed from November 2014 to June 2015; patients evaluated at outside ED/UC, scheduled for return, or non-English/Spanish speaking were excluded. Caregiver surveys underwent item generation, validation, and pilot testing. Survey items included caregiver reasons for unscheduled returns, with a specific assessment of delivery of key components of discharge instructions (diagnosis, duration of illness, home care, return precautions). Complete delivery of instructions was defined by caregiver reported receipt of instructions on all 4 components.

RESULTS: Of the 500 caregiver surveys analyzed 495 children received a 72-hour return ED/UC visit. Mean age of caregivers was 33 years, 62% completed college. Children were 2 years of age or younger (47%), male (52%), Caucasian (55%), and publicly insured (64%). Reported reasons for ED/UC return

included belief that their child's illness had not resolved (51%) or worsened (41%). Many caregivers (41%) were not instructed on all key components of discharge. Almost half of caregivers (47%) were not educated on anticipated duration of illness. Complete delivery of discharge instructions was associated with ED/UC satisfaction (odds ratio, 5.7; 95% confidence interval, 3.8–8.5).

CONCLUSIONS: Among caregivers of children returning for an unscheduled ED/UC visit, most do not receive complete discharge instructions at initial visit. Improving delivery of key components of discharge instructions has the potential to increase ED/UC satisfaction and reduce unscheduled 72-hour returns.

KEYWORDS: caregiver; discharge; return visits; unscheduled returns

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WHAT'S NEW

Reasons for unscheduled returns from the caregiver perspective have not been well studied. Caregivers frequently do not receive comprehensive instructions at discharge at initial visits. Poor discharge practices are associated with low patient satisfaction, and might contribute to unnecessary return visits.

IT IS ESTIMATED that between 2.8% and 5% of children evaluated in a pediatric emergency department (ED) return to the ED for care within 72 hours of discharge.^{1–4} Nationally, this corresponds to more than 1,000,000 additional pediatric ED visits each year. Therefore, return visits (RVs) place a substantial burden on EDs, and the health care system as a whole.⁵ However, only 19% to 30% of all children making 72-hour RVs require

hospital admission, suggesting that a significant portion of RVs are potentially preventable, and possibly unnecessary.^{1,4} Thus, RVs represent an important quality indicator and benchmark for ED care.⁶

Previous studies that evaluated the underlying determinants of RVs to pediatric EDs have been limited to retrospective analyses, often focused on demographic and clinical factors related to the initial ED visit. These studies have determined that respiratory and infectious diseases, acuity on initial ED visit, younger age, and language barriers are associated with RVs.^{1,2,7–11} Few studies have examined parental factors resulting in ED RVs, or assessed parental perceptions related to RVs after initial ED visitation. Discharge instructions and anticipatory guidance are often used to provide caregivers with an understanding of their child's illness. Subsequently, caregivers are expected to provide recommended treatment and follow-up. As shown in a recent evaluation

of caregivers making return ED visits, caregivers lack understanding of their child's illness after ED discharge.^{7,8} However, caregivers' cannot be expected to understand their child's illness and home care if instructions are not effectively provided at ED discharge.

As the ultimate decision-makers for their child, it is vital to understand caregivers' motives for returning to the ED. The objective of this study was to examine parent perceptions and indications for unscheduled 72-hour pediatric RVs to a pediatric ED or urgent care (UC) site. Specifically, we aimed to evaluate caregiver perception of their child's illness severity, perception of delivery of discharge instructions at ED/UC discharge, and ability to access appropriate follow-up.

METHODS

STUDY DESIGN

This was a prospectively administered caregiver survey of patients who returned within 72 hours of their initial visit to a pediatric ED or an affiliated UC site within a single children's hospital health system between November 2014 to June 2015. The study was approved as quality improvement research by the institution's Organizational Research Risk and Quality Improvement Review Panel, under agreement with the Colorado Multiple Institutional Review Board.

STUDY SETTING AND POPULATION

The study was conducted at 7 sites within a single children's hospital health system. These sites included: the ED of an academic tertiary care pediatric hospital, a tertiary-care satellite pediatric ED, and 5 satellite pediatric UC sites. UC sites in our health system are used as pediatric acute care settings in areas where our academic tertiary care hospital cannot reach. Therefore, ED and UC sites are viewed and used similarly, and patients are not preferentially diverted to UC sites over EDs. Annual census for the institution's ED and UC system is approximately 147,500 patient visits with an unscheduled 72-hour RV rate of 3.4%; approximately 20% of children returning for care within 72 hours are subsequently hospitalized.

STUDY PROTOCOL

Eligible patients included those who returned to an ED/UC site within 72 hours of initial evaluation and discharge from any site within the ED/UC system, as identified by a triage nurse. Triage nurses at all sites screened patients for inclusion 24 hours a day, 7 days a week, by directly asking all ED/UC patients if they had been seen within the past 72 hours at any ED/UC site. Children who arrived for a scheduled visit, were initially evaluated at an outside institution, or whose caregivers spoke a language other than English or Spanish were excluded.

At the academic tertiary care ED, triage nurses flagged potentially eligible subjects in the electronic ED tracking system for research assistants (RAs) to approach for study participation. Before recruiting patients for the study, all

nurses underwent training in screening procedures, and RAs were trained regarding enrollment procedures and completion of data collection forms. Study surveys were administered to caregivers by RAs via computerized tablets. Tablet-based surveys directly recorded study data into a database for further analysis; therefore the treatment team was blinded to results. At the satellite ED and UC sites, where RAs were not present, triage nurses were responsible for subject identification as well as enrollment. Paper study surveys were administered at these sites and at the academic tertiary care ED site when RAs were not available. Paper surveys were given to caregivers at triage and collected by ED/UC nurses after completion at any point during the ED/UC course. All surveys were then placed in locked drop boxes. Study investigators collected paper surveys from the satellite sites on a weekly basis for data entry.

All study participants were given a statement describing their participation in this quality improvement research study, and verbal consent was obtained from caregivers before survey completion.

STUDY SURVEY AND MEASUREMENTS

The study survey was designed to evaluate caregiver factors that contributed to unscheduled 72-hour RVs, including a specific assessment of current discharge processes. Our institutional discharge process uses standard computerized diagnosis-specific instructions by Pediatric Advisor 2015.1 (published by Relay Health, ©1986–2015 Barton D. Schmitt, MD), which are available in English and Spanish. At the academic tertiary care ED, discharge instructions are administered by nurses as well as providers (ie, physicians, physician assistants, nurse practitioners, and trainees); whereas at all satellite ED/UC sites discharge procedures are predominantly performed by nurses.

Survey items included caregiver reasons for return, perception of discharge processes, and ability to obtain primary care physician (PCP) follow-up (see Appendix for survey). Survey questions were formatted as nominal multiple-choice questions with an "other" option for free text entry to allow better understanding of caregivers' perspectives. Multiple answers were allowed for reasons to return and type of provider recommending return. Delivery of discharge instructions was assessed by caregiver report of receipt of education on 4 key components of discharge from the initial visit: 1) criteria for return, 2) illness duration, 3) home care, and 4) knowledge of ED/UC diagnosis. "Complete delivery of discharge instructions" was defined as caregiver recollection of instruction on all 4 components. Free text was used for assessing caregiver knowledge of diagnosis at initial visit. Accurate knowledge of discharge diagnosis at initial visit was assessed by comparing caregiver-reported diagnosis with provider-documented diagnosis from the initial ED/UC visit discharge instructions in the medical record. Discharge diagnoses were classified on the basis of categories reported in previous studies that evaluated return

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