

A retrospective review of direct discharge home from a Paediatric Intensive Care Unit: A Nurse-led quality improvement project

Annmarie Wherton-Whitehurst (Advanced Clinical Practitioner), Sara Lightfoot (Sister)
Rosie Ellis (Staff Nurse), Shannon Berry (Staff Nurse)

Children Intensive Care Unit – Staffordshire Children's Hospital, University Hospitals of North Midlands

P33

Introduction and Aims

Anecdotally, discharge home from PICU often occurs following delayed transition to step-down care provision, due to lack of bed availability, both locally and regionally. In these cases, ward level care is provided on PICU and patients discharged home when medically fit. The first stage of the quality improvement project aimed to identify local data relating to direct discharge home.

Method

Data was extracted from the electronic documentation system (PDMS), for patients directly discharged home, between January 2019 and December 2021. Quantitative data collection focused on diagnosis on admission, co-morbidities, length of stay and post discharge follow-up. Qualitative data collection focused on documentation surrounding the discharge process.

Results

Between 2019 and 2021, 103 patients were discharged home directly from PICU (figure 1), equating to a 3 year average discharge rate of 14%. Of the patients discharged home, 61% had complex care needs. Local patients accounted for 31% of admissions, with both regional and out of region patients making up the remainder of cases. The predominant presenting condition was respiratory illness (figure 2). 46% of patients required intubation. The average length of stay was less than 7 days. Direct discharge home was achieved in 2 days following extubation in 72% of cases. The requirement for follow-up was documented in the records of 84 patients. Pre-arranged GP and/or clinic appointments were identified as an appropriate means of achieving this in 20% of cases. Open access was arranged at the base hospital for 2.9% of patients.

Discussion and Conclusion

The number of direct discharges home from our unit was higher than the average of 6.8% seen across units in England¹. Direct discharge home was perceived to improve patient flow, when step down to ward level care was delayed due to lack of beds, locally, regionally and out of region. There was minimal variation in the discharge data between years, despite changes to PICU service provision in our unit during COVID. Documentation relating to the nature of communication with primary and secondary care, discharge follow-up and safety netting was lacking. We therefore recommend that a formal discharge protocol be developed within our unit, to support this process, focusing on the identification of discharge criteria, patient safety-netting requirements and effective communication related to post-discharge follow-up.

References

1. GIRFT. Paediatric Critical Care Royal Stoke University Hospital RJE: University Hospitals of North Midlands NHS Trust (Level 3 unit data submitted to PICANet) Unit Level Report. Place of publication: Getting it Right First Time; 2020.

Figure 1

Local direct discharge home vs national average

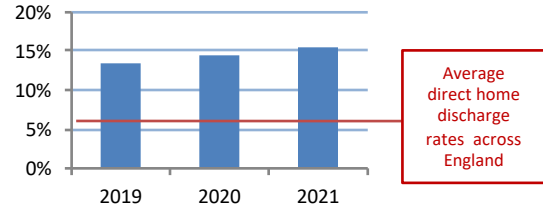


Figure 2

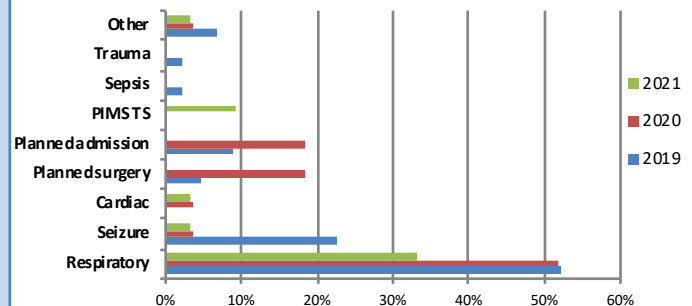


Figure 3

Documented post discharge follow-up recommendation

