SOUTHAMPTON Children's Hospital

Safely Home?



QIC learn

NHS University Hospital Southampton NHS Foundation Trust

Improving the discharge processes from a children's emergency department

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Background Learning from two significant incidents suggested improvements could be made in the discharge process from the children's emergency department (CED). Safe Discharge criteria were subsequently created (see table below, right) to standardise discharge practices. A baseline 10-week audit of discharge processes1 showed poor results across all 7 criteria

Aim To improve adherence to all elements of the discharge bundle to 95% by September 2023

Method IHI model for improvement methodology was used. Percentage adherence to each criteria was plotted on run charts. Regular feedback to the whole CED team who were engaged in ideas for change and testing PDSA cycles (*see table below for details*).

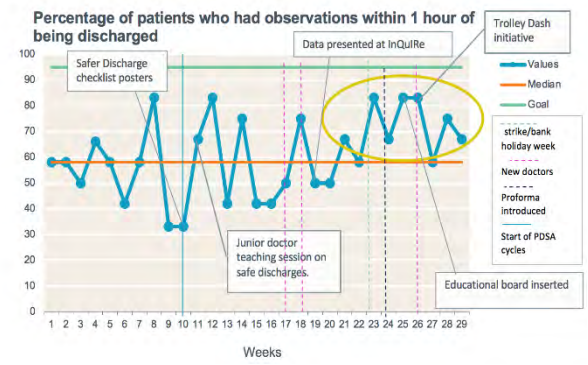
PDSA Test #	PLAN	Do	STUDY	ACT
1	Educate CED team on the importance of the safe discharge checklist	Posters, educational sessions, 'Trolley Dashes'	Significant improvement in most domains	Adapted and adopted
2	Facilitate the documentation of discussions and leaflets given	Create a tick-box in notes to act as prompt and documentation aide	40% uptake in the use of the tick-box in the notes	Adopt and continue
3	To improve observations being performed within 1 hour prior to discharge	Create Discharge Champions that will push to ensure observations are performed	Recent significant improvement seen in this domain	Adopt and adapt
4	Increase the repertoire of conditions that CED has discharge advice for	Created safety-net leaflets for chest pain & BRUE and signposted CED team to existing leaflets	Yet to be performed (leaflets are currently awaiting governance approval)	Yet to be performed

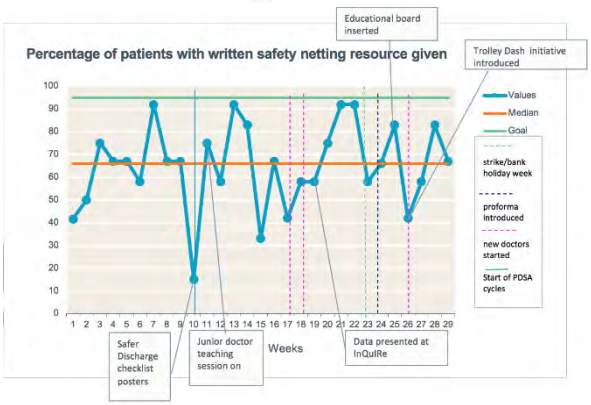
Safe Discharge Criteria:

	Standard	Target
1	Observations recorded within 1 hour of discharge and stable/improving	95%
2	Repeat pain score documented (if appropriate)	95%
3	Safety-net advice given	95%
4	Written safety netting resource/plan given	95%
5	Name of resource given	95%
6	Family happy with discharge plan	95%
7	Expected progression of illness discussed	95%

What are the rules that apply to run charts to show significant change?

Results Significant improvement has been achieved in 6 of the 7 safer discharge criteria. No signals of effective change seen to date in one: Written safety netting resource given (see below)





More than 6 consecutive points above the median line suggesting non-random variation and significant change

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What did the other run charts show?

5 or fewer consecutive points above or below the median can be attributed to chance and therefore no significant improvement seen in criteria: Written safety netting resource given

Standard	Baseline median	Max achieved	Target
Observations recorded within 1 hour of discharge and stable/improving	58%	83%	95%
Repeat pain score documented (if appropriate)	12%	**100%**	95%
Safety-net advice given	25%	**100%**	95%
Written safety netting resource/plan given	66%	92%	95%
Name of resource given	21%	83%	95%
Family happy with discharge plan	16%	75%	95%
Expected progression of illness discussed	8%	75%	95%

Implications: Embedding change in a department's culture is challenged by frequent staff changeover, time and resource constraints. Solutions can be found in change champions, regular communication of the common goal and timely responses when challenges are fed back in order to maintain staff engagement

References:
1) Holmes B, Ahmed F, Arsanious M, James, D, Pryde K. 2023. Safe to leave? An audit of discharges from a children's emergency department [Manuscript submitted for presentation] RCPCH annual Conference, Glasgow
2) NHS improvement. Online Library of Quality, Service Improvement and Redesign tools. December 2021. [online], available at: https://www.england.nhs.uk/wp-content/uploads/2021/12/qsir-run-charts.pdf