Improving Documentation regarding Ceilings of Care Upon Intensive Care Unit Discharge – A Quality Improvement Project

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INTRODUCTION

The discharge of a patient from an Intensive Care Unit (ICU) requires clear communication in order to maintain patient safety and ensure continuity of care (1).

The discharge summary forms the foundation of this and provides information about the ongoing care needs of a patient, including resuscitation and ICU re-admission status (1). We aimed to assess the quality of the ICU discharge documentation at a district general hospital (DGH).

MATERIALS & METHODS

A quality improvement project was carried out using a plan-do-study-act (PDSA) cycle. Data was retrospectively collected on patient age, sex, and documentation of resuscitation and re-admission status from ICU discharge summaries. The results were presented to ICU doctors. Discharge summaries were analysed two months later.

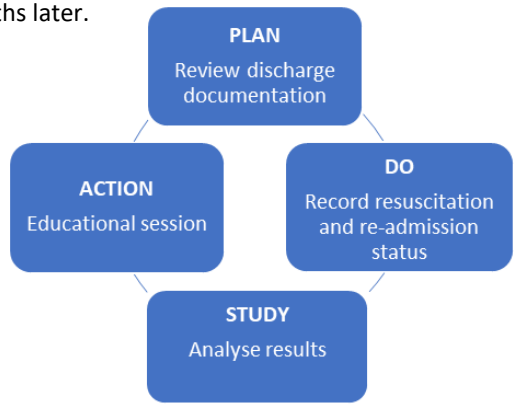


Figure 1: Flow diagram depicting PDSA cycle 1.

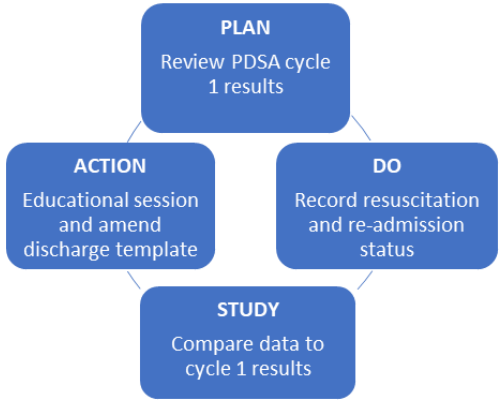


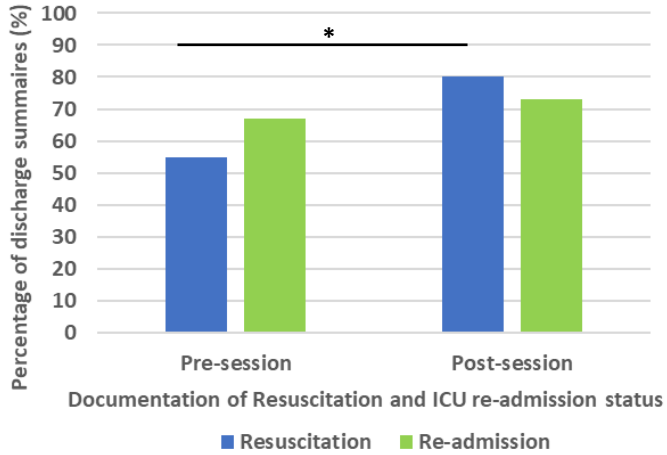
Figure 2: Flow diagram depicting PDSA cycle 2.

RESULTS & DISCUSSION

In the first PDSA cycle, 53 patients were included (mean age 63, 55% male). 47 patients were discharged to the ward, 2 discharged directly home and 4 sadly passed away. Of those alive at discharge, 67% of them had ICU re-admission status documented, whilst only 55% of discharge summaries contained documentation of resuscitation status.

The second PDSA cycle included 30 patients (mean age 53, 64% male), 28 of which were discharged to the wards. Following our intervention, there was a vast improvement in documentation of resuscitation status to 80% (p= 0.025) and re-admission status to 73%, as shown in graph 1.

The documentation of a patient's ceiling of care is essential to maintain patient wishes, dignity and to ensure prior decisions are respected.



Graph 1: Bar chart showing proportion of discharge summaries with documented resuscitation and re-admission status. *P<0.05).

Many discussions regarding ceilings of care may occur whilst a patient is in ICU, and thus the clear documentation and handover of such is critical (2).

We found that our educational intervention resulted in a vast improvement in this documentation, and subsequently had a positive impact on patient care.

CONCLUSION

Documentation of a patient's resuscitation status and ICU re-admission status is important when discharging a patient from the ICU as discussions regarding these ceilings of care often occur during an ICU admission. We performed a QIP that demonstrated a positive change in the documentation of these decisions when patients are discharged from ICU.

References
1 - Coon EA, Kramer NM, Fabris RR, Burkholder DB, Klaas JP, Graff-Radford J et al. Structured handoff checklists improve clinical measures in patients discharged from the neurointensive care unit. Neurology: Clinical Practice. 2015; 5(1):42-49
2- Jacquier M, Meunier-Beillard N, Ecarnot F, Large A, Aptel F, Labruyère M, et al. Non-readmission decisions in the intensive care unit: A qualitative study of physicians' experience in a multicentre French study. PloS one. 2021;16(1):e0244919.