



Safe Discharge of Pediatric Patients from the Emergency Department

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The future condition of pediatric patients discharged from the emergency department can never be guaranteed even when the diagnosis has been clearly defined. As a result we are dependent on our clinical judgment of the patients' stability as well as the understanding and capability of the parents in safely discharging patients. Up to 75% of patients/parents do not understand the instructions given at the time of emergency department discharge and not surprisingly almost all malpractice complaints arising from the emergency department have incomplete discharge instructions as a component.¹

Joint Commission guidelines discharge instructions include written in appropriate language, in no more than a 5th - 7th grade reading level, and specifically address description of signs and symptoms associated and expected during the progression of the illness. ^{2,3} Joint Commission also comments that generic discharge instructions for the emergency department as a whole do not adequately address the unique needs of pediatric emergency medicine and should be individually tailored to the pediatric patient. Below are some guidelines for safe discharge from the pediatric emergency department.

1. Objectively assess physiologic stability by directly evaluating vital signs and clearly document your cognitive process. Normal values are readily available in texts. Do not exclusively depend on observations by nurses and other ancillary personnel and contemplate the implications of each vital sign. This should be the culmination of a series of observations throughout the emergency department stay. You should always document vital sign course, stabilization, and conclusions at the time of discharge. Teach parents how to measure heart rate and respiratory rate as well as acceptable values.

2. Personally discuss with the patient/family regarding the diagnosis or lack thereof and the implications, treatments, and expectations as well as when to conclude expectations are not being met.

For example:

"The vomiting should cease but if returns and is persistent..."

"Normally strep pharyngitis resolves quickly but if vomiting recurs or she will not eat for a significant period of time..."

"She may run fever for 2-3 days with influenza. However if she refuses to eat, vomits repetitively, or has decreased activity or increased work of breathing please..."

"The CAT scan of the abdomen was normal but if ... occurs please return"

1. You must become astute at measuring parent wherewithal. This includes overcoming language barriers, assessing concern and competence, assessing living condition including transportation and phone access as well as subsistence including housing and food. In some cases patients who would be normally discharged may be admitted or observed due to a lack of these items. Your altruism and patient focused concern should guide your decision not insurance status or financial capability.

2. Adequate follow-up opportunities must be offered to the greatest degree possible. The emergency physician bears some responsibility in ensuring follow-up. For patients/family who have no primary care provider, the follow-up may have to be with you or a direct phone call to the primary care provider/specialist may be needed to ensure follow-up.^{4,5} Unfortunately, hospitals may provide a mandatory call list for follow-up purposes but a call lists does not guarantee access and is rarely enforced. As such the emergency department remains the safety net for many patients. Conversely, the importance of follow-up must be emphasized to some families and patients. You should always clearly document discussions dealing with follow-up options including return to the emergency department for further care.

3. Consider using a discharge specialist. Having a dedicated person to discharge patients frees up other healthcare providers and allows for consistent uninterrupted instruction delivery.

References

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