10.7861/fhj.9-2-s104

Improving documentation regarding ceilings of care upon intensive care unit discharge: a quality improvement project

Authors: Sita Shah[A] and Robert Chapman[A]

Introduction

The discharge of a patient from the intensive care unit (ICU) to the ward requires clear communication in order to maintain patient safety and ensure continuity of care.[1] The discharge summary is an essential piece of documentation that summarises the patient's journey through the ICU. It contains information regarding the patient's treatment and ongoing care needs, as well as information on the patient's resuscitation status and ceilings of care. This information can also be relayed through a verbal handover. Together, they ensure patient safety is maintained.[2] We aimed to assess and improve the quality of ICU discharge documentation at a district general hospital.

Materials and methods

A quality improvement project (QIP) was designed using a plan, do, study, act (PDSA) cycle technique. The ICU discharge summaries produced over a 2-month period were retrospectively analysed. Data was collected on the patient age, gender, and evidence of documentation of resuscitation status and ICU readmission status. The results were analysed and presented to the ICU team through an educational session on the importance of documentation (first intervention). The cycle was then repeated and discharge summaries were analysed again after a 2-month period post-intervention.

Results and discussion

In the first PDSA cycle, 53 patients were included (mean age 63, 55% male). In total, 47 of these patients were discharged to hospital wards, two were discharged home and four patients sadly passed away. Of the patients alive at discharge, only 67% of them had ICU readmission status documented, while only 55% of discharge summaries contained documentation of resuscitation status. The second PDSA cycle included 30 patients (mean age 53, 64% male), 28 of whom were discharged to the wards. Following our intervention, there was a vast improvement in documentation of resuscitation status to 80% and readmission status to 73%.

The documentation of a patient's ceiling of care is essential to maintain patient wishes, dignity and to ensure prior decisions are respected. Many discussions regarding ceilings of care may occur while a patient is in ICU, and thus clear documentation and handover of such is critical.[3] 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 readmission 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 resulted in a positive change in the documentation of these decisions when patients are discharged from ICU. ■

References

1 Coon E, Kramer N, Fabris R, Burkholder D, Klaas J, Graff-Radford J *et al.* Structured handoff checklists improve clinical measures in patients discharged from the neurointensive care unit. *Neurol Clin Pract* 2015;5:42–9.
2 van Sluisveld N, Hesselink G, van der Hoeven J, Westert G, Wollersheim H, Zegers M. Improving clinical handover between intensive care unit and general ward professionals at intensive care unit discharge. *Intensive Care Med* 2015;41:589–604.
3 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:e0244919.

Author: [A]Princess Alexandra Hospital, Harlow, UK