Children discharged against medical advice

Discharge against medical advice can jeopardise children’s health. This article explores the factors for early discharge and offers strategies to prevent harm.

In this article...

- Why parents may discharge their child against medical advice
- Nurses’ role in reducing harm if parents discharge their children
- Advice on preventing discharge against medical advice

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Abstract

Discharge against medical advice (DAMA) occurs when a patient leaves a clinical setting before the end of treatment and against medical recommendation.

The most important aspects of DAMA are to ensure ongoing medical needs are met and that it is documented meticulously.

This article describes a recent retrospective case note (audit) study of DAMA in paediatric patients attending a district general hospital, followed by a literature review. It also discusses the legal implications of DAMA and offers some strategies for clinical practice.

Discharge against medical advice (DAMA) can be defined as a situation where a patient chooses to leave hospital before the treating clinician considers discharge to be appropriate (Alfandre, 2009).

Studies have shown that patients who discharge themselves from hospital against medical advice are at higher risk of readmission; it not only jeopardises their medical care but also can lead to increasing costs for the care provider (Paul and Remorino, 2010).

The prevalence of DAMA varies considerably, depending on geographical area (Roodpeyma et al, 2010); in countries where healthcare services are not free at the point of delivery, financial constraints can often lead to patients discharging themselves as soon as they feel some improvement (Onyiriuka, 2011).

DAMA in paediatrics

The reported prevalence of DAMA among paediatric patients varies greatly between healthcare facilities, and rates from 1.2% to 31.7% have been documented (Onyiriuka, 2011).

Decisions to DAMA are generally made by parents, but older children can sometimes contribute to this decision. Children who are not under the influence of drugs or alcohol and are not considered to be at immediate risk may be involved in discharge discussions along with their parents to prevent DAMA. If DAMA becomes inevitable, there should be a responsible adult ready to take the child home.

Taking children home against medical advice increases the risk of inadequate treatment and readmission and can lead to prolonged morbidity (Paul and Remorino, 2010). When parents decide to take DAMA on behalf of their children in circumstances where the child’s health and wellbeing may be jeopardised, child protection issues should be raised (Alfandre, 2009).

A study of DAMA involving children aged 0-18 years in Chichester showed a readmission rate of 15% within 48 hours of the child going home. Our study also highlighted that children with serious conditions are occasionally taken home against medical advice, which may lead to legal implications for the paediatric team (Paul and Remorino, 2010).

Audit study

In order to gain evidence about DAMA in paediatric settings, we conducted a

Audit study

5 key points

1 Patients discharged against medical advice have a higher risk of readmission, jeopardising their medical care and increasing costs for the care provider

2 Child protection issues should be considered when parents decide to take a child home when advised against this

3 Parents should be asked to sign a DAMA form, but clinicians are still at risk of legal action if the patient deteriorates

4 Conversations on discharge against medical advice should all be documented thoroughly in medical notes

5 Parents’ mental capacity should be assessed and concerns escalated

Signed forms do not protect staff legally
We assessed children who left hospital by DAMA over a five-year period, from March 2008 to February 2013. Cases were identified using the hospital patient administration system “discharge against medical advice” code and amounted to a total of 40 children aged 0-17 years.

We used the case notes of each patient to find their age, sex, reason for attending, outcome, duration of admission and whether a DAMA form had been signed (Fig 1). All 40 children had a medical assessment, 37 were taken home within 48 hours of admission and 22 had a DAMA form signed and filed in the medical notes. One child was readmitted while another was brought back to hospital with a police protection order.

Alcohol/drug intoxication (8/40) and a respiratory illness (5/40) were the two most common conditions noted for children discharged against medical advice. Some commonly occurring themes were parental assessment that the child had improved, childcare issues and financial constraints.

The study highlighted some important points that may explain the factors that make DAMA more likely and steps that can help to reduce its prevalence.

**Influence of age**

The age distribution of the 40 cases reviewed had two peaks – under two year of age and 12-18 years. Other studies on DAMA have demonstrated similar peaks in these age groups (Okechukwu, 2011; Paul and Remorino, 2010; Roodpeyma et al, 2010; Reinke et al, 2009).

It is possible that parents of children under two year of age may have other young children at home and choose to discharge the child because they have childcare concerns, or may not consider their child to be seriously unwell so will recover quickly. Teenagers tended to be admitted for less serious medical conditions such as alcohol/drug intoxication. A study by Reinke et al (2009) suggested that teenagers are more likely to display impulsive behaviour that could contribute to their increased likelihood of DAMA.

**Timing of DAMA**

Most of the children in our study were taken home during the first 24-48 hours of admission (37/40 cases). These findings were similar to those noted in other studies (Okechukwu, 2011; Onyiriuka, 2011; Paul and Remorino, 2010).

This may be because patients who need to stay in hospital for longer periods are likely to have more serious illnesses and are less likely to be perceived to be well enough to go home. This perception may be due to a clinical improvement in the child’s condition, for example temperature settling in a febrile child. Parents may also believe their child is well if there has been no deterioration in hospital and the child has been assessed by a doctor.

DAMA is also more likely to happen during the out-of-hours period from 5pm-9am, as highlighted in a study by Paul and Remorino (2010), which showed that 30 out of 37 children (77%) were taken home by DAMA during this period. One possible reason for this is that, because there is less access to primary care at this time, admission is more likely to be recommended (Gill et al, 2013).

**Financial constraints**

Financial factors are more relevant in countries where health services are not free at point of care, as highlighted in studies from Nigeria and Iran, where financial constraints were cited as a common reason for DAMA (Okechukwu, 2011; Onyiriuka, 2011).

However, indirect socioeconomic factors can also influence parental decisions and may not be overtly evident. For example, one father in our study chose to take his child home because his friend had offered him a lift and he was unable to afford a taxi or public transport. Another father said his partner would have to take a day of unpaid leave (the following day) if he did not take his child home that night.

Although these situations may not have direct safeguarding implications, families who depend on others for transporting a sick child to hospital may delay presentation of their sick child in future. In our experience, these families are often receiving benefits and may need extra financial help to be put in place through social service involvement to ensure their child’s health is not jeopardised due to financial constraints.

**Legal issues**

In our study, only 22 out of 40 cases (55%) had a DAMA form signed before leaving hospital; these figures were similar to those in a previous study, which found that 56.5% did not have this document signed (Paul and Remorino, 2010).

Although the DAMA form does not absolve health professionals of legal responsibility, the form should be signed by someone with parental responsibility for paediatric patients. This can demonstrate that there has been a discussion about the likely adverse outcomes that the child may experience following DAMA and the parents have understood the consequences before signing the form.

Health professionals often have a false sense of security when a form for DAMA is signed by parents or carers. However, this document does not confer any legal protection for the attending clinician and it is important that every effort is made to...
A DAMA form may be signed if the patient or parents taking DAMA have the mental capacity to make the decision and that this has not been impaired by alcohol or drugs. Concerns over capacity should be documented and acted on if necessary, the consultant and clinical site manager should be informed and asked to review the patient before discharge. Before DAMA, all the necessary medicines should be prescribed, a clear follow-up plan decided, open access given to the medical team (depending on unit policy) and clear instruction given to parents that the child should be brought back for medical attention if their condition deteriorates.

The way forward

Every health professional plays an important role when a child is admitted to hospital and can play a vital role in preventing DAMA. Useful strategies for doing this are listed below; this has been drawn up from the literature and our experience in managing patients with DAMA:

- Parents/patients who wish to take DAMA should be given all relevant information and the dangers of taking DAMA should be explained and clearly documented in medical notes;
- Adequate supplies of medicines and devices should be provided before the patient leaves so ongoing medical care is not compromised;
- Teenage patients admitted with alcohol/drug intoxication should be recognised as being at high risk of absconding and should be observed carefully and regularly;
- Parents/patients’ mental capacity should be assessed. Nurses play a vital role in counselling parents and updating clinicians about any concerns picked up during their dealings with families;
- A DAMA form may be signed if the hospital policy requires it but should not be considered as a legal safety net;
- Follow-up care or an appointment should be arranged before DAMA. If DAMA poses a serious risk to the child, it should be prevented initially through regular discussion, the involvement of senior staff and, if necessary, police and social services. If a child is taken home by DAMA and this has been judged to be unsafe, the child needs to be brought back to hospital through a police protection order. Social services should be involved as early as possible as they can instigate child safety measures and find out if there are any ongoing child safety concerns.

Conclusion

Discharge against medical advice is uncommon in paediatric practice in the UK, but is known to occur and can jeopardise the health of the child. The priority should always be the child’s safety and wellbeing. Staff need to assess and document risk and ensure the child’s ongoing medical care is not compromised.

References