International Journal of Integrated Care

Snelling, P et al 2017 Short-stay unit Asthma Video Education (SAVE) "Understanding your child's wheeze". *International Journal of Integrated Care*, 18(S1): A156, pp. 1-8, DOI: dx.doi.org/10.5334/ijic.s1156

POSTER ABSTRACT

Short-stay unit Asthma Video Education (SAVE) "Understanding your child's wheeze"

1st Asia Pacific Conference on Integrated Care, Brisbane, 06-08 Nov 2017

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Introduction: Reactive airways disease or exacerbation of asthma are frequently admitted to the Emergency Short-Stay Unit (ESSU) and require education prior to discharge.[1]A busy emergency environment can lead to inconsistent quality of education, incomplete or missed caregiver education[2], and can increase length of stay if education is required for simultaneous patients.Adverse outcomes from inadequate education include increased morbidity, such as incorrect home management by caregivers, unplanned representations or readmissions, and potential mortality, given that caregiver understanding is paramount.[3] The benefits of video education includes empowering caregivers to access information, multimodal reinforcement of key messages [4], consistent delivery of information, broaching sensitive issues (e.g. passive smoking), and has the potential to save resources, such as staff time.

Aims: To pilot the implementation of asthma video education at the bedside in the ESSU

To quantify the benefits through feedback: especially its non-inferiority to face-to-face education and caregiver satisfaction

Intervention: A series of asthma education videos were sourced, with permission, from Asthma Australia and combined into a single video to be viewed at the bedside.[5] The video via the Patient Entertainment System directly complements the face-to-face education that is provided to every caregiver/child that is admitted to the ESSU.[6] The pilot project ran over 1 month in 2016, where the video was voluntarily viewed by the caregivers in conjunction with the standard education checklist on the clinical pathway. After viewing the video, the caregiver was given standard face-to-face asthma education and invited to participate in the survey, which was comprised of questions with a 5 point Likert scale.

Results: Video education was successfully implemented in the paediatric ESSU and was well received by both caregivers and nursing staff. The feedback received deemed that use of the video was non-inferior to conventional bedside face-to-face delivery of asthma education.

63 caregivers provided surveys over the 1 month period:

100% found the video useful

78% agreed that it significantly improved their understanding of childhood asthma

100% felt confident in recognising deterioration in their child's asthma and administering their child's asthma medication.

There was no preference to either video or face-to-face education, both were considered equally valid and complemented written handouts.

Discussion: This pilot project has demonstrated the opportunity to develop similar videos for other conditions. Video education complements face-to-face education, which still affords families the opportunity to ask questions and clarify their understanding. Video education is a means to ensure education is still delivered in a busy emergency environment, where patients can be missed. The video has been adopted for routine use within the ESSU and could become part of the clinical pathway, including discharge checklist. The video is now available throughout Queensland, with a child friendly version and other videos being developed.

Conclusion: Video education is a valuable tool for delivery of bedside education, which empowers families to understand and manage their health needs [7-8]. Technology is an under-utilised resource for delivery of education, particularly in this digital technology age.

Keywords: patient; video; education; wheeze; asthma