

Tools for 'safety netting' in common paediatric illnesses: a systematic review in emergency care

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ABSTRACT

Context Follow-up strategies after emergency department (ED) discharge, alias safety netting, is often based on the gut feeling of the attending physician.

Objective To systematically identify evaluated safety-netting strategies after ED discharge and to describe determinants of paediatric ED revisits.

Data sources MEDLINE, Embase, CINAHL, Cochrane central, OvidSP, Web of Science, Google Scholar, PubMed.

Study selection Studies of any design reporting on safety netting/follow-up after ED discharge and/or determinants of ED revisits for the total paediatric population or specifically for children with fever, dyspnoea and/or gastroenteritis. Outcomes included complicated course of disease after initial ED visit (eg, revisits, hospitalisation).

Data extraction Two reviewers independently assessed studies for eligibility and study quality. As meta-analysis was not possible due to heterogeneity of studies, we performed a narrative synthesis of study results. A best-evidence synthesis was used to identify the level of evidence.

Results We summarised 58 studies, 36% (21/58) were assessed as having low risk of bias. Limited evidence was observed for different strategies of safety netting, with educational interventions being mostly studied. Young children, a relevant medical history, infectious/respiratory symptoms or seizures and progression/persistence of symptoms were strongly associated with ED revisits. Gender, emergency crowding, physicians' characteristics and diagnostic tests and/or therapeutic interventions at the index visit were not associated with revisits.

Conclusions Within the heterogeneous available evidence, we identified a set of strong determinants of revisits that identify high-risk groups in need for safety netting in paediatric emergency care being related to age and clinical symptoms. Gaps remain on intervention studies concerning specific application of a uniform safety-netting strategy and its included time frame.

INTRODUCTION

When patients are discharged from the emergency department (ED) without definite diagnosis, monitoring children's course of disease to rule out serious infections is mandatory.¹ This theme is covered by the term 'safety netting', introduced to general practice in 2004 by Roger Neighbour who considered it a core component of general practice consultation.² Safety netting can be described as a set of procedures or guidelines, which should be followed when a patient is discharged from the ED. This strategy is

What is already known on this topic

- The importance of safety netting after emergency department (ED) discharge to monitor disease course is well recognised and applied.
- Evidence-based approaches on this topic are underexposed in literature, since strategies are often based on the gut feeling of the ED physician.

What this study adds

- It remains difficult to determine high-risk patient groups for whom safety netting is essential.
- Studies concerning follow-up were mostly conflicting or with limited evidence.
- Young children, medical history, infectious/respiratory symptoms, seizures and progression/persistence of symptoms were the strongest associated determinants of revisits.

required in situations with increased risk for serious complications, either in the diagnosis itself (eg, dehydration in patients with gastroenteritis) or if individual patient characteristics are associated with a high risk of complications (eg, significant comorbidity or immunosuppressive therapy).¹ Patients who revisit the ED may be regarded as the high-risk population of possible failure of this safety-netting strategy.

The importance of safety netting is increasingly recognised in emergency care and literature.³ Healthcare physicians lack standardised safety-netting methods since strategies are often based on the gut feeling of the ED physician,⁴ and key gaps are described in need of studies on methods and effects of safety netting.^{3 5} Therefore, we planned to systematically review the literature on this important topic.

Our first aim was to systematically summarise evaluated safety-netting strategies after ED discharge. Second, we identified children at risk for revisits to improve the identification of children prone to deteriorate after emergency discharge, by studying determinants of ED revisits. Both aims were studied in the total ED population or specifically for children with common illnesses as fever, dyspnoea and gastroenteritis.



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METHODS

Inclusion criteria

We considered all types of studies eligible if they reported about safety netting and/or their strategy after ED discharge and extended our search for determinants of ED revisits as a proxy of failing safety-netting strategies. We included studies on the total ED population or specific for children with fever, dyspnoea and gastroenteritis. Studies reporting data on adult and children together as well as studies in low-income countries, due to differences in healthcare organisation, were excluded. Two reviewers independently assessed inclusion (EdV-K and MW); discrepancies were resolved by a third reviewer (RO).

Outcome measures

Outcomes included complicated course of disease after initial ED visit, mainly dominated by revisits and hospitalisation.

Search strategy

We searched the following electronic databases: MEDLINE OvidSP, Embase (Excerpta Medica dataBASE), CINAHL (Cumulative Index to Nursing and Allied Health Literature), Cochrane central register of controlled trials, Web of Science, Google Scholar and PubMed as publisher (searches updated in January 2014) (see online supplementary information 1). We checked the reference list of these papers for additional articles that were not included in the initial computerised search.

Data extraction

We retrieved the full text copies of all articles identified as potentially relevant by reviewing the abstracts of search results. Two reviewers' extracted data on the following: study design, disease/working diagnosis, study population, number of revisits, follow-up period and type of revisit. The determinants were grouped into: child characteristics, social/demographics, disease characteristics, physician and process characteristics. Finally, data on follow-up after ED discharge, including the follow-up strategy, were extracted.

Risk-of-bias assessment and best-evidence synthesis

Two authors (EdV-K/DHFG) independently assessed the potential risk of bias of the studies included using the *MINORS*, a methodological index for non-randomised studies,⁶ together with the presence of revisits as primary outcome measure and the number of events (see online supplementary information 2). Consensus was reached by the two reviewers (EdV-K/DHFG); otherwise, the independent opinion of a third reviewer was decisive (RO).

We performed two separate 'best-evidence' syntheses based on the study of van Tulder *et al*.⁷ one according to safety-netting strategies and one according to determinants of revisits as meta-analysis of results was not possible owing to heterogeneity in participants, interventions, outcome measures and methodological quality⁷ (see online supplementary information 2).

RESULTS

Identification and selection of the literature

The literature search identified 2604 references (figure 1). Overall, 36 of 83 full text articles screened for eligibility were excluded on the basis of incorrect study aims, data on adult patients, reviews or low-income populations. Data extraction was performed for 58 articles, including 11 articles added from reference lists. Forty two articles described determinants of

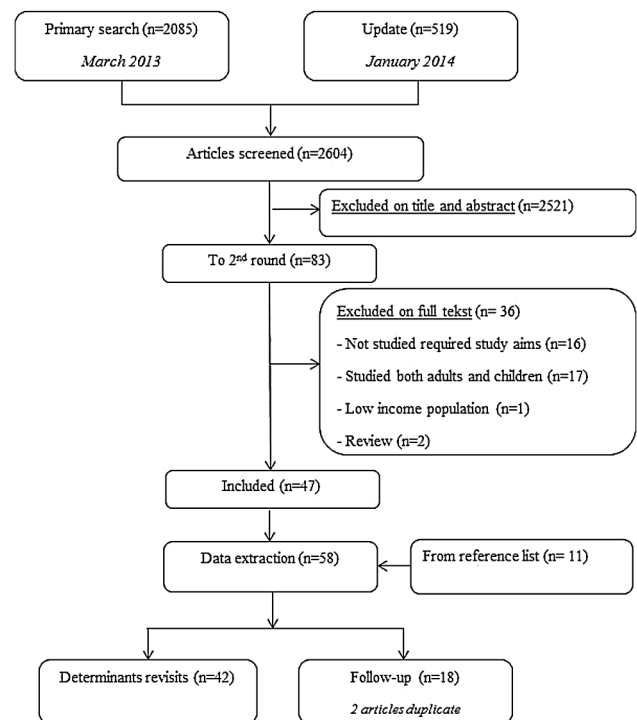


Figure 1 Flowchart of the study selection and exclusion stages during the systematic review process.

revisits, and 18 articles (2 articles duplicate) reported on follow-up after ED discharge (figure 1).

Description of included studies

Study characteristics are presented in tables 1 and 2. Included studies were mostly cohort studies (72%, n=42). Fifty two per cent (n=30) of the studies originated from the USA and 19% (n=11) from the UK. Year of publication varied between 1995 and 2013, with 33% (n=19) published in the last 2 years. Most studies (n=34) included all children presented to the ED or the most common paediatric illnesses; 14 studied febrile children and 10 studies reported specific diseases only (eg, gastroenteritis, influenza, respiratory tract infections). Study populations varied between 13 and 568 845 children (median: n=1371) and number of events (revisits or hospitalisation after revisit) varied between 9 and 36 734 (median: n=189). Follow-up period after ED discharge varied between 1 and 656 days (median: 3 days). Most studies (n=29, 50%) described scheduled and unscheduled revisits together; 19 (33%) only measured unscheduled revisits (tables 1 and 2).

Risk-of-bias assessment

Online supplementary information 2 shows the potential risk of bias with 36% (n=21) of the studies having low risk of bias. For all studies, the reviewers achieved uniform bias assessment. Ten studies (17%) were scored as high risk of bias because only abstracts were available (nine Congress abstracts and one Spanish abstract). Initial disagreement on 55 out of 880 assessed items (6%) for opportunity of bias was solved by consensus reached by the two reviewers (EdV-K/DHFG) or by the decision of a third reviewer (RO).

Safety netting after discharge

Figure 2 presents an overview of the different safety-netting strategies evaluated in the included studies (n=18) and the

Table 1 Characteristics of included studies regarding the first study aim: safety-netting strategies after emergency department (ED) discharge

Author Year Country	Study design	Article/ abstract	Disease/ working diagnosis	Primary outcome: revisits	N total, male %	N outcome, male %	Age inclusion Median (IQR)/ mean age (SD)	Follow-up* (days)	Type of revisit	Risk of bias (high/low)
Baker 2009 USA	CP	Article	Fever	Yes	280 NR	105 NR	3–36 months NR	319–656†	suR	Low
Bloch 2013 USA	RCT	Article	All‡	No	436 54%	216 58%	1 month to 18 years NR	2–5	NA	Low
Browne 2001 Australia	BA	Article	GE, asthma, croup	Yes	5534 NR	240 NR	NR	NR	suR	High
Considine 2007 Australia	BA	Article	Fever	No	40 NR	15 NR	<16 years 3.1 years ±2.5 before 1.8 years ±1.3 after	2	NA	High
Chande 1996 USA	RCT	Article	All	Yes	130 59%	37 NR	All 39 months§ ±36 63 months¶ ±58	30, 90 and 180	suR	High
Fagbuyi 2011 USA	CP	Article	Influenza-like	No	38 646 53%	1091 NR	6 months to 21 years 82.3 months ±84.6	7	uR	High
Horne 1995 USA	CP	Article	All	No	250 NR	171 NR	All NR	3	NA	Low
Ismail 2013 USA	RCT	Abstract	Fever	No	63 16%	NR	NR	14	NR	High
Lawrence 2009 USA	CR	Article	All	Yes	40 418 NR	979 NR	NR 2 years (0.5–7.0)	3	suR	High
Maguire** 2011 UK	CP	Article	Fever	No	220 56%	29/56 NR	<5 years 27% ≤1 years	NS	suR	High
Moineau** 2004 Canada	CR	Abstract	GE	Yes	1862 NR	108 NR	NR 2.6 years ±2.8	7	uR	High
O'Neill-Murphy 2001 USA	BA	Article	Fever	No	87 NR	NR	3 months to 5 years NR	14, 56	suR	High
O'Neill 2001 USA	CR	Article	All	No	NR	NR	NR	NR	NA	High
Patel 2009 USA	nRCT	Article	GE	No	291 NS	NA	3 months to 18 years 60% <1 years	1, 2	NA	High
Porter 2000 USA	CP	Article	Fever	No	92 NR	NA	≤36 months 27.4 years ±9.2	NA	NA	High
Roland 2011 UK	CP	Abstract	Fever	No	457 NR	NR	NR	NR	uR	High
Scarfone 1996 USA	CP	Article	All	No	179 55%	91 NR	NR 31 months††	1	NA	Low
Yang 2012 Taiwan	BA	Article	All	Yes	1285 54%	9 56%	NR 34 months§ (0–207)	3	suR	High

*Time until revisit.

†See online supplementary information 2.

‡Common illnesses, without children with traumatic presenting symptoms.

§In the intervention group.

¶In the control group.

**Studies included for both study aims (Maguire *et al* 2011 and Moineau *et al* 2004).

††Mean (CI).

All, all ED diagnoses; BA, before after trial; CP, cohort study, prospective; CR, cohort study, retrospective; GE, gastroenteritis; NA, not applicable; NR, not recorded; nRCT, non-randomised controlled trial; NS, not specified; RCT, randomised controlled trial; suR, scheduled and unscheduled revisit; uR, unscheduled revisit.

corresponding level of evidence as identified by the colours of the plus/minus signs, according to the best-evidence synthesis (details in online supplementary information 3a and 3c).

Moderate/limited evidence

There was moderate evidence for the positive influence of a standardised follow-up programme (including, eg, a venue for handling calls after ED visits)⁸ on patient care and patient satisfaction.^{8–9} Limited evidence was found that clinical pathways at the ED resulted in a reduced admission rate, shortened length of stay and fewer revisits after discharge.¹⁰ We found limited

evidence for risk factors associated with non-compliance of scheduled revisits; for example, parents' perception that their child is not severely ill, parents' age (<21 years) and ED physicians uncertainty about patients' return.¹¹

Conflicting evidence

We found conflicting evidence for the association between safety-netting advice and the reduction of revisits. According to four studies,^{9–12–14} revisits could be reduced by providing consistent verbal and written discharge information regarding the natural history of disease¹³ and temperature measurement/

Table 2 Characteristics of included studies regarding the second study aim: determinants of revisits

Author Year Country	Study design	Article/ abstract	Disease/ working diagnosis	Primary outcome: revisits	N total, male % of total population	N outcome (revisits), male %	Age inclusion Median (IQR)/ mean age (SD)	Follow-up* (days)	Type of revisit	Risk of bias† (high/low)
Alessandrini 2004 USA	CR	Article	All	Yes	54 784 NR	1893 NR	All 4.6 years ±4.9‡	2	suR	Low
Ali 2012 USA	CP	Article	All	Yes	8742 NR	124 52%	All 3.0 years (1.1–12)‡	3	suR	High
Angoulvant 2012 France	CP	Article	All§	Yes	501 NR	206 51%	<6 years 18 months (7–39)	7	suR	High
Augustine 2013 USA	CS	Abstract	All	Yes	13 NR	13 NR	All 4.2 years¶	2	uR	High
Berry 2013 USA	CR	Article	All	Yes	568 845 NR	36 734** NR	≤18 years 3 years (0–10)	30	uR	Low
Black 2010 UK	CR	Abstract	All	Yes	2345 NR	91 NR	<17 years 76% <5 years	3	uR	High
Callery 2010 UK	CR	Article	All	Yes	43 372 NR	2433 NR	<15 years NR	7	suR	Low
Chang 2008 Taiwan	CR	Article	All	No	3216 58%	188 NR	<18 years 5 years ±0.1	3	suR	Low
DePiero 2002 USA	CR	Article	All	Yes	51 195 NR	261** NR	All NR	3	suR	Low
Dunlop 2005 Australia	CR	Article	Fever	No	260 52%	35 NR	6 months to 6 years 25.7 months††	1	suR	High
Easter 2012 USA	CR	Article	All	Yes	97 374 NR	1091** 52%	0–21 years 52% <5 years‡	4	suR	Low
Florin 2013 USA	CR	Article	Pneumonia	Yes	100 615 54%	6439 NR	2 months to 18 years 3 years (1–6)	3	suR	Low
Freedman 2013 Canada	CR	Article	GE	Yes	3346 55%	526 57%	<18 years 3.4 years ±3.5	7	uR	Low
Gallagher 2013 USA	CR	Article	All	Yes	119 792 53%	1499** NR	All 7.6 years¶	3	uR	Low
Gaucher 2012 Canada	CR	Article	All	No	49 146 51%	2534 NR	<19 years 62% <5 years	2	uR	Low
Goldman 2006 Canada	CR	Article	All	Yes	37 725 NR	1990 NR	<19 years 18% <1 year	3	uR	Low
Goldman 2011 Canada	CR	Article	All	Yes	2062 55%	353** 59%	<19 years 57 months (0–215)	3	suR	High
Gregor 2009 USA	CP	Article	RTI/GE	No	455 59%	49 NR	6 weeks to 8 years 1.9 years ±1.9	60	suR	High
Hacking 2012 UK	CR	Abstract	All	Yes	2453 NR	130 NR	NR 4 years††	NR	uR	High
Jacobstein 2005 USA	CC	Article	Fever	Yes	15 384 54%	165 54%	All 38 months ±43	3	uR	Low
Jain 2010 USA	CR	Article	All	No	452 868 54%	17 335 NR	<19 years 22% <1 years	3	suR	Low
Klein-Kremer 2011 Canada	CR	Article	Fever	Yes	397 NR	92 67%	3–36 months 17 months ±8‡	3	suR	High
Lal <i>et al</i> 1999 UK	CP	Article	All	Yes	7328 NR	65 NR	NR	3	uR	High
LeDuc 2006 USA	CP	Article	All	Yes	932 NR	237 49%	All 4 years¶	2, 90	suR	High
Liberman 2012 USA	CR	Article	RTI	No	467 59%	189 NR	<19 years NR	7, 30	suR	Low
Logue 2013 Canada	CR	Article	All	Yes	1173 NR	261 61%	All 4.4 years¶	3	suR	High
Maguire†† 2011 UK	CP	Article	Fever	No	220 56%	127 NR	<5 years 27% ≤1 years	NS	suR	High
Mansbach 2008 USA	CP	Article	Bronchiolitis	No	1456 58%	837 58%	<2 years 6.9 (4.2–11.3)§§	14	NS	Low
Michelson 2012 USA	CR	Article	All	No	198 778 NR	7281 NR	All 10% <1 years	2	suR	High
Mintegui 2000 Spain	CR	Abstract	All	Yes	3667 NR	495 NR	All NR	7	uR	High
Mistry 2007 USA	CP	Article	Fever	Yes	322 57%	76 NR	28 days to 17 years 31.5 months¶	10	uR	High

Continued

Table 2 Continued

Author Year Country	Study design	Article/ abstract	Disease/ working diagnosis	Primary outcome: revisits	N total, male % of total population	N outcome (revisits), male %	Age inclusion Median (IQR)/ mean age (SD)	Follow-up* (days)	Type of revisit	Risk of bias† (high/low)
Mistry 2009 USA	CP	Article	Fever	No	97 56%	18 NR	2–18 years 58.7 months ±40.1	7–10	uR	High
Moineau‡ 2004 Canada	CR	Abstract	GE	Yes	1862 NR	108 NR	NR 2.6 years ±2.8	7	uR	High
O'Loughlin 2012 UK	CR	Article	All	Yes	10 573 NR	532 NR	<16 years 34% <2 years	7	uR	High
Roback 1997 USA	CC	Article	Bronchiolitis	Yes	181 NR	57 NR	<1 year NR	4	NS	High
Roggen 2012 Belgium	CR	Abstract	All§	Yes	46 386 NR	1864 NR	<16 years NR	3	suR	High
Samuels-Kalow 2013 Canada	CR	Abstract	Fever	Yes	202 NR	14 NR	2–24 months NR	3	suR	High
Sartain 2002 UK	RCT	Article	All	No	399	31 NS	All 25.7 months¶	90	suR	High
Seow 2007 Taiwan	CR	Article	Fever	No	345 47%	115 NR	3–36 months NR	3	uR	Low
Simmons 2012 UK	CR	Abstract	All	Yes	NR	51 NR	All 59% <2 years	7	uR	High
Small 2005 UK	CP	Article	GE	No	112 NR	56 NR	1–6 years 1.9 (1.3)**	7, 30	suR	Low
Zimmerman 1996 USA	CR	Article	All	Yes	5228 58%	242 NR	<18 years 13% <1 years	14	suR	Low

*Time until revisit.

†Minimum and maximum.

‡Of the number of children with revisits.

§Common illnesses, without children with traumatic complaints.

¶Mean (CI).

**Revisits requiring admission.

††Median (IQR).

‡‡Studies included for both study aims (Maguire *et al*¹² and Moineau *et al*¹³).

§§Of the number of children sent home.

All, all emergency department diagnoses; CC, case-control study; CP, cohort study, prospective; CR, cohort study, retrospective; CS, cross-sectional study; GE, gastroenteritis; NR, not recorded; RCT, randomised controlled trial; RTI, respiratory tract illnesses; suR, scheduled and unscheduled revisit; uR, unscheduled revisit.

treatment.¹⁴ In contrast, other studies concluded that the provision of safety-net advice did not affect the number of revisits.^{15–16} We found conflicting evidence for the association between educational interventions at the ED and parental recall of discharge instructions or revisits.^{16–24} One study reported that video home management of fever improved caregiver's knowledge of fever, but did not decrease ED use.¹⁸ There was conflicting evidence about the role of telephone follow-up as safety-netting strategy. One study reported that this was an effective way of providing, for example, health information, managing remaining symptoms and recognising complications.²⁵ In contrast, another study advocated caution in the implementation of telephone follow-up because of moderate success rate in reaching patients.²⁶

Determinants of revisits

Figure 3 presents an overview of all determinants of revisits described in the included studies (n=42), their association with revisits and the corresponding level of evidence, according to the best-evidence synthesis (details in online supplementary information 3b and 3c).

Strong evidence

Child characteristics

We found strong evidence for the association of ED revisits with younger children, ranging from ≤12 months until <6 years.^{12–27–40} Moreover, for the association between medical

history and revisits, although including heterogeneous definitions, we found strong evidence.^{12–28–35–37–41–42} Maquire *et al*¹² concluded that history of illness in febrile children was one of the reasons for parental advice-seeking behaviour. However, for children with bronchiolitis, this association was conflicting.^{35–41} With strong evidence, no association was found between gender and revisits to the ED^{27–30–43} or revisits to the primary care provider.³³ Gender was neither discriminating in the comparison of admitted children with the discharged ones after revisiting the ED nor a prognostic factor in safe discharge of children with bronchiolitis.^{35–41–44}

Social and demographic characteristics

There was conflicting evidence that ED revisits were associated with ED crowding.^{27–29–42} Two studies were positively associated with revisits,^{39–45} and three other studies were even associated with lower ED crowding during late evening or night shifts.^{32–40–46}

Disease characteristics

Strong evidence was found for the association of revisits of children with symptoms of infectious diseases^{9–29–31–33–35–37–39–43–45–47–50} or respiratory symptoms^{29–30–35–37–41–45–47–49–51} compared with all ED revisits. Strong evidence was found for the association between revisits and seizures or other nervous system diseases.^{27–37–39} Lastly, strong association was found between progression/persistence of symptoms and revisits.^{9–13–36–38–39–44–48–51–56}

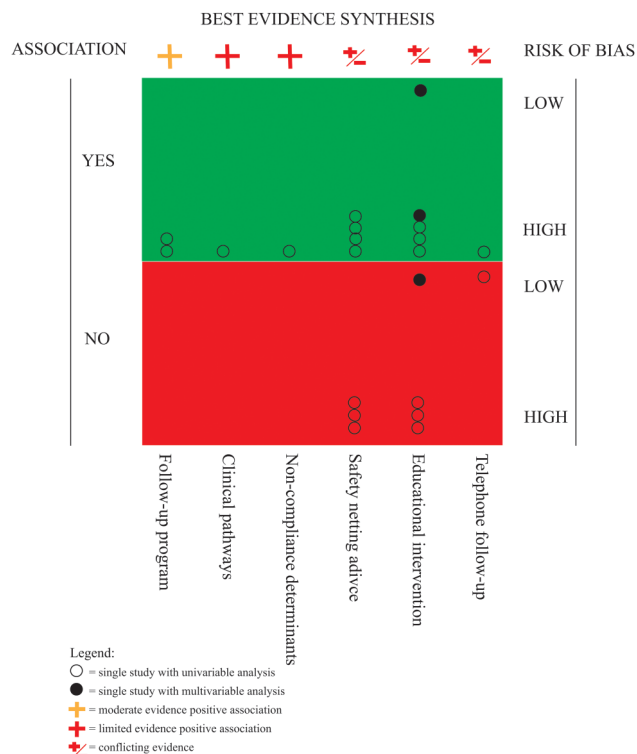


Figure 2 Level of evidence safety-netting strategies according to the best-evidence synthesis.

Physician characteristics

We found no association between physicians' characteristics, such as being paediatrician or resident^{42 57} or physicians' years of experience,^{41 58} and revisits.^{41 42 57 58}

Process characteristics

We observed strong evidence for the absence of the association between revisits and the performance of diagnostic tests or therapeutic interventions at the index visit.^{43 48 55 59 60}

Limited/moderate evidence

Child characteristics

Mistry *et al* studied a health-related quality-of-life instrument (PedsQL). There was limited evidence for the association between lower changes in PedsQL scores and ED revisits, which implied less improved quality of life for the revisiting child.⁶¹

Process characteristics

No association was found between revisits and paediatric hospital at home service compared with conventional hospital care for children suffering from breathing difficulty, diarrhoea and vomiting, or fever.⁶² We found no association between revisits and children with acute gastroenteritis admitted to hospital compared with a comparable group of children managed at home.⁶³

Conflicting evidence

Child characteristics

There was conflicting evidence for the association between ethnicity and revisits. In disease-specific studies (bronchiolitis and

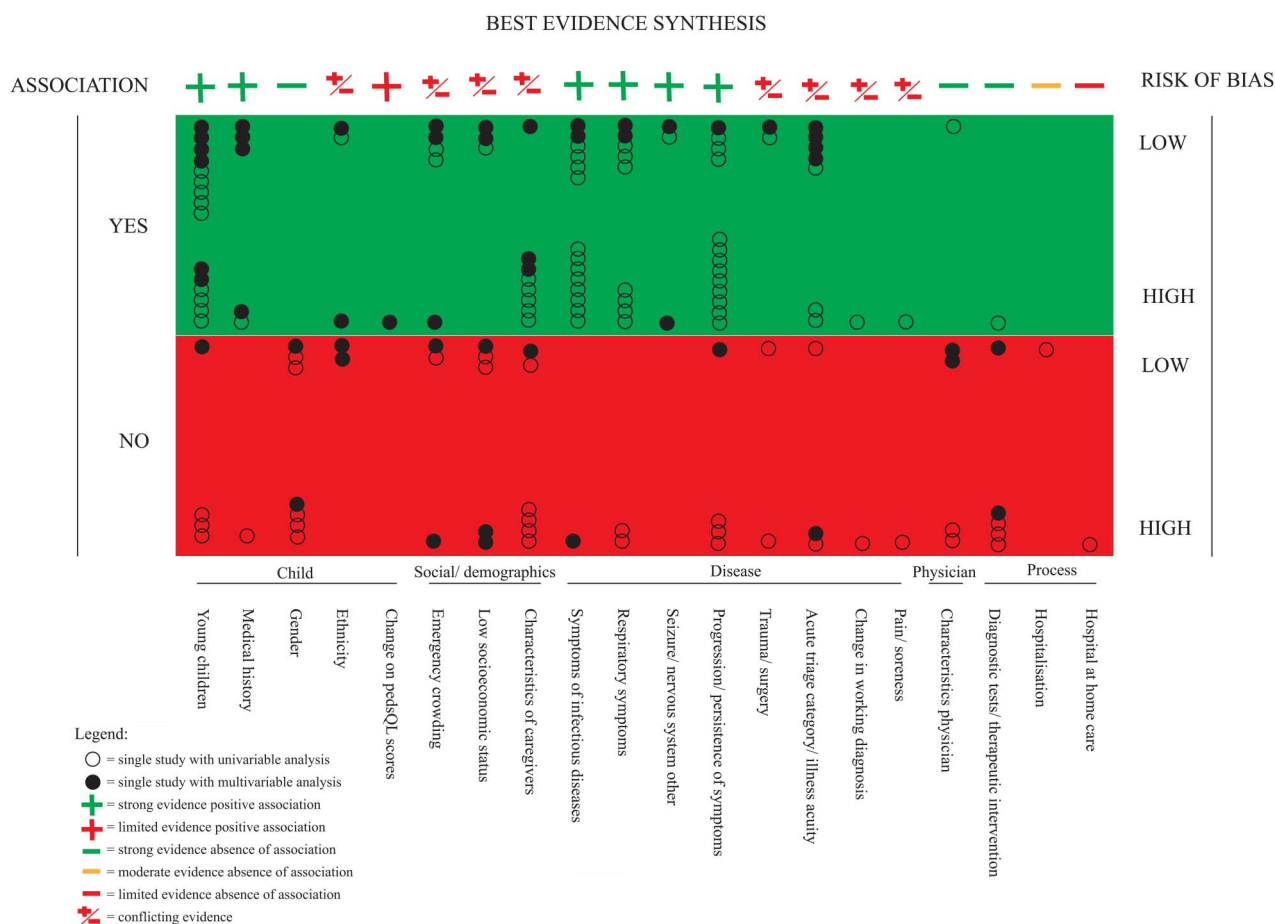


Figure 3 Level of evidence determinants of revisits according to the best-evidence synthesis.

fever), ethnicity was not associated with revisits^{42 35} in contrast to studies including the total ED population.^{27 30 37}

Social and demographic characteristics

There was conflicting evidence for the association between revisits and characteristics of caregivers. For example, caregiver's age, marital status and presence/age of other children were not associated with revisits in five studies.^{33 42–44 55} In contrast, other studies concluded that language spoken at home or single caregivers were associated with revisits.^{9 12 28 36 40 50 51 64} Next, we found conflicting evidence for the association between lower socioeconomic status and revisits.^{27 28 30 33 37 40 42 45}

Disease characteristics

Associations between trauma, surgical problems or pain^{43 48} and revisits were conflicting.^{29 30 37 48} Conflicting evidence was found for the association between revisits in change of working diagnosis^{44 47} and ED triage acuity.^{13 28 29 32 33 36 38 40 42}

DISCUSSION

Follow-up after discharge and determinants of revisits: main outcomes

Limited evidence was observed for different strategies of safety netting, with educational interventions being mostly studied. Identified determinants of children at risk for revisits included young children, relevant medical history, infectious/respiratory symptoms or seizures and progression/persistence of symptoms. No association with revisits was found for gender, emergency crowding, physicians' characteristics and diagnostic tests and/or therapeutic interventions at the index ED. For other described determinants, no statement was possible due to conflicting evidence.

Strengths and weaknesses of this review

The development of evidence-based strategies of safety netting is a challenging new topic. Available studies describing revisits of the ED population and their characteristics vary in populations, study aims and methodology. The main strength of this systematic review is combining all information on determinants of revisits using a best-evidence synthesis. Most studies about safety netting are rather descriptive, and did not study their effectiveness.^{1 5} In our review, we summarised the literature that evaluated the clinical consequences of their safety-netting intervention.

This review has some limitations. Because of the heterogeneity of the studies, we could not perform a meta-analysis. This systematic review is limited to the provision of whether there is evidence for a significant association or not. This approach limits the interpretation and clinical relevance of the reported associations, but is a consequence of the large heterogeneity of present studies on this topic. Second, there is no standardised risk-of-bias assessment method for the variation of study designs and outcomes included in this systematic review. To overcome lack of general accepted thresholds determining the study's risk of bias, and to include relevance to the research question on the risk-of-bias criteria,⁶⁵ we used the MINORS risk-of-bias criteria.⁶ We added two important items, which would be the most appropriate for our included studies. With this approach, we aimed to perform best available systematic risk-of-bias analysis. We classified determinants to 'strong evidence' on the presence of low risk-of-bias studies, although high risk-of-bias studies may also have studied the same determinants (see online supplementary information 2).

Furthermore, there are limitations embedded in the study design of the included studies itself. The majority of studies are analysed with univariable statistical approaches, with only 35% (20/58) of the studies using multivariable statistical analysis. It remains unknown to what extent the determinants are independently associated with revisits. Second, although we followed the focus of most studies by defining 'revisits' as proxy for high-risk populations of failed safety-netting strategies, hospitalisation after revisiting the ED is probably the most effective outcome to evaluate this topic. However, study of this outcome is limited due to its low prevalence. Third, some study characteristics increased heterogeneity between our different determinant categories. For example, determinants were not always specified, for example, 'history of illnesses' was not further described in the study of Maguire *et al.* Furthermore, outcome measures were not homogenous and included, for example, revisits or admission after revisit. Finally, study comparisons varied between revisits versus total ED population or subgroups of revisits (discharged vs admitted children).

Implications for clinical practice and future research

A content of safety-net advice, as included in the National Institute for Health and Care Excellence (NICE) guideline,⁶⁶ has been published in relation to general practice where consensus was reached among general practitioners and paediatric ED consultants using a modified Delphi approach.^{1 4} Safety-netting advice should include: (1) the existence of uncertainty, (2) what exactly to look out for, (3) how exactly to seek further help, (4) what to expect about time course. Our systematic review shows that a variety of safety-netting techniques are used, but the effective components or the best way to perform remains unknown, as has been identified by others.^{1 5} Second, we generated answers on what determinants are associated with revisits, and those who are not. Moreover, the conclusions of our review can improve homogeneity in study design on follow-up strategies, and can add to progress in this research area. In essence, the importance of this knowledge should be combined with parent-related factors as their ability to understand and to comply with the designed safety-netting strategy.¹¹ Lastly, one notable gap in safety-netting literature is its time frame strategy. The NICE fever guideline claims 'to arrange a follow-up appointment at a certain time and place'.⁶⁷ In future research, we need to study the (efficacy of) safety-netting strategies in which the aspect of time is taken into account.^{5 67}

CONCLUSION

Determination of a high-risk group in need for safety-netting strategies in paediatric emergency care remains difficult. We identified a set of strongly associated determinants of revisits that could be used for this identification; being young children, relevant medical history, infectious/respiratory symptoms or seizures and progression/persistence of symptoms. Gaps remain on intervention studies concerning specific application of a uniform safety-netting strategy and its included time frame.

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Contributors EdV-K substantially contributed to the conception and design of the study. She participated in the literature search and assessed studies for eligibility. She undertook data extraction, risk-of-bias assessment and performed the best-evidence synthesis. She drafted the initial manuscript, and approved the final manuscript as submitted. DHFG substantially contributed to the conception and design of the study, and reviewed and revised the manuscript. She participated in the risk-of-bias assessment, and approved the final manuscript as submitted. MW participated in the literature search, and assessed studies for eligibility. She reviewed and revised the manuscript, and approved the final manuscript as submitted. HAM substantially contributed to the conception and design of the study. She reviewed

and revised the manuscript. She participated in discussion about each step of the results, and approved the final manuscript as submitted. RO substantially contributed to the conception and design of the study. She reviewed and revised the manuscript, and approved the risk-of-bias assessment and best-evidence synthesis analyses. She participated and supervised the discussion about each step of the results, and approved the final manuscript as submitted.

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REFERENCES

- Almond S, Mant D, Thompson M. Diagnostic safety-netting. *Br J Gen Pract* 2009;59:872–4; discussion 4 Online.
- Neighbour R. The inner consultation. Oxford: Radcliffe Publishing, 2004.
- Roland D, Jones C, Neill S, *et al.* Safety netting in healthcare settings: what it means, and for whom? *Arch Dis Child Educ Pract Ed* 2014;99:48–53.
- Van den Bruel A, Thompson M, Buntinx F, *et al.* Clinicians' gut feeling about serious infections in children: observational study. *BMJ* 2012;345:e6144.
- Jones CH, Neill S, Lakhanpaul M, *et al.* The safety netting behaviour of first contact clinicians: a qualitative study. *BMC Fam Pract* 2013;14:140.
- Slim K, Nini E, Forestier D, *et al.* Methodological index for non-randomized studies (minors): development and validation of a new instrument. *ANZ J Surg* 2003;73:112–16.
- van Tulder M, Furlan A, Bombardier C, *et al.* Editorial Board of the Cochrane Collaboration Back Review G. Updated method guidelines for systematic reviews in the Cochrane Collaboration back review group. *Spine (Phila Pa 1976)* 2003;28:1290–9.
- O'Neill K, Silvestri A, McDaniel-Yakscoe N. A pediatric emergency department follow-up system: completing the cycle of care. *Pediatr Emerg Care* 2001;17:392–5.
- Augustine EM, Kreling BA, Chamberlain JM. The parent perspective on return emergency department visits. *J Invest Med* 2013;61:678.
- Browne GJ, Giles H, McCaskill ME, *et al.* The benefits of using clinical pathways for managing acute paediatric illness in an emergency department. *J Qual Clin Pract* 2001;21:50–5.
- Scarfone RJ, Joffe MD, Wiley JF, *et al.* Noncompliance with scheduled revisits to a pediatric emergency department. *Arch Pediatr Adolesc Med* 1996;150:948–53.
- Maguire S, Ranmal R, Komulainen S, *et al.* Which urgent care services do febrile children use and why? *Arch Dis Child* 2011;96:810–16.
- Moineau G, McKinnon A, Gaboury I, *et al.* Unscheduled return visits for gastroenteritis to a pediatric emergency department. *Pediatric Research* 2004;55:129A.
- Porter RS, Wenger FG. Diagnosis and treatment of pediatric fever by caretakers. *J Emerg Med* 2000;19:1–4.
- Roland D, Geliot T, Patel A. Delivering safety net advice and the emergency department clinical quality indicator of unplanned re-attendance in children. *Emerg Med J* 2011;28:A13.
- Fagbuyi DB, Brown KM, Mathison DJ, *et al.* A rapid medical screening process improves emergency department patient flow during surge associated with novel H1N1 influenza virus. *Ann Emerg Med* 2011;57:52–9.
- Patel B, Kennebeck SS, Caviness AC, *et al.* Use of a discharge facilitator improves recall of emergency department discharge instructions for acute gastroenteritis. *Pediatr Emerg Care* 2009;25:558–64.
- Baker MD, Monroe KW, King WD, *et al.* Effectiveness of fever education in a pediatric emergency department. *Pediatr Emerg Care* 2009;25:565–8.
- Considine J, Brennan D. Effect of an evidence-based education programme on ED discharge advice for febrile children. *J Clin Nurs* 2007;16:1687–94.
- Ismail S, McIntosh M, Kalynych C, *et al.* Impact of video discharge instructions from the emergency department in regard to caregiver understanding of their child's fever and closed head injury. *Ann Emerg Med* 2013;62:S17.
- Bloch SA, Bloch AJ. Using video discharge instructions as an adjunct to standard written instructions improved caregivers' understanding of their child's emergency department visit, plan, and follow-up: A randomized controlled trial. *Pediatr Emerg Care* 2013;29:699–704.
- O'Neill-Murphy K, Liebman M, Barnsteiner JH. Fever education: does it reduce parent fever anxiety? *Pediatr Emerg Care* 2001;17:47–51.
- Chande VT, Wyss N, Exum V. Educational interventions to alter pediatric emergency department utilization patterns. *Arch Pediatr Adolesc Med* 1996;150:525–8.
- Lawrence LM, Jenkins CA, Zhou C, *et al.* The effect of diagnosis-specific computerized discharge instructions on 72-hour return visits to the pediatric emergency department. *Pediatr Emerg Care* 2009;25:733–8.
- Yang C, Chen CM. Effects of post-discharge telephone calls on the rate of emergency department visits in paediatric patients. *J Paediatr Child Health* 2012;48:931–5.
- Horne A, Ros SP. Telephone follow-up of patients discharged from the emergency department: how reliable? *Pediatr Emerg Care* 1995;11:173–5.
- LeDuc K, Rosebrook H, Rannie M, *et al.* Pediatric emergency department recidivism: Demographic characteristics and diagnostic predictors. *J Emerg Nurs* 2006;32:131–8.
- Gregor MA, Wheeler JRC, Stanley RM, *et al.* Caregiver adherence to follow-up after an emergency department visit for common pediatric illnesses: Impact on future ED use. *Med Care* 2009;47:326–33.
- Alessandrini EA, Lavelle JM, Grenfell SM, *et al.* Return visits to a pediatric emergency department. *Pediatr Emerg Care* 2004;20:166–71.
- Zimmerman DR, McCarten-Gibbs KA, DeNoble DH, *et al.* Repeat pediatric visits to a general emergency department. *Ann Emerg Med* 1996;28:467–73.
- Black L. Unscheduled re-attendances to a paediatric emergency department: an audit. *Emerg Med J* 2010;27:A9–10.
- Goldman RD, Ong M, Macpherson A. Unscheduled return visits to the pediatric emergency department-one-year experience. *Pediatr Emerg Care* 2006;22:545–9.
- Liberman DB, Shelef DQ, He J, *et al.* Low rates of follow-up with primary care providers after pediatric emergency department visits for respiratory tract illnesses. *Pediatr Emerg Care* 2012;28:956–61.
- O'Loughlin K, Hacking KA, Simmons N, *et al.* Paediatric unplanned reattendance rate: A&E clinical quality indicators. *Arch Dis Child* 2013;98:211–13.
- Mansbach JM, Clark S, Christopher NC, *et al.* Prospective multicenter study of bronchiolitis: predicting safe discharges from the emergency department. *Pediatrics* 2008;121:1680–8.
- Logue EP, Ali S, Spiers J, *et al.* Characteristics of patients and families who make early return visits to the pediatric emergency department. *Open Access Emerg Med* 2013;5:9–15.
- Berry JG, Toomey SL, Zaslavsky AM, *et al.* Pediatric readmission prevalence and variability across hospitals. *JAMA* 2013;309:372–80.
- Freedman SB, Thull-Freedman JD, Rumanitir M, *et al.* Emergency department revisits in children with gastroenteritis. *J Pediatr Gastroenterol Nutr* 2013;57:612–18.
- Easter JS, Bachur R. Physicians' assessment of pediatric returns to the emergency department. *J Emerg Med* 2013;44:682–8.
- Gallagher RA, Porter S, Monuteaux MC, *et al.* Unscheduled return visits to the emergency department: the impact of language. *Pediatr Emerg Care* 2013;29:579–83.
- Roback MG, Baskin MN. Failure of oxygen saturation and clinical assessment to predict which patients with bronchiolitis discharged from the emergency department will return requiring admission. *Pediatr Emerg Care* 1997;13:9–11.
- Jacobstein CR, Alessandrini EA, Lavelle JM, *et al.* Unscheduled revisits to a pediatric emergency department: risk factors for children with fever or infection-related complaints. *Pediatr Emerg Care* 2005;21:816–21.
- Angoulvant F, Jemel S, Prot-Labarthe S, *et al.* Multiple health care visits related to a pediatric emergency visit for young children with common illnesses. *Eur J Pediatr* 2013;172:797–802.
- Goldman RD, Kapoor A, Mehta S. Children admitted to the hospital after returning to the emergency department within 72 hours. *Pediatr Emerg Care* 2011;27:808–11.
- Callery P, Kyle RG, Campbell M, *et al.* Readmission in children's emergency care: An analysis of hospital episode statistics. *Arch Dis Child* 2010;95:341–6.
- Michelson KA, Monuteaux MC, Stack AM, *et al.* Pediatric emergency department crowding is associated with a lower likelihood of hospital admission. *Acad Emerg Med* 2012;19:816–20.
- Mintegui Raso S, Benito Fernandez J, Vazquez Ronco MA, *et al.* Children's unscheduled return visits to an emergency department. *An Esp Pediatr* 2000;52:542–7.
- Klein-Kremer A, Goldman RD. Return visits to the emergency department among febrile children 3 to 36 months of age. *Pediatr Emerg Care* 2011;27:1126–9.
- Hacking K, Christian W. Clinical quality indicators in the children's emergency department-why do children re-attend? *Arch Dis Child* 2012;97:A144–A5.
- Simmons N, Syahaneer R, Marzouk O, *et al.* Audit of unplanned re-attendance to a pediatric emergency department. *Arch Dis Child* 2012;97:A153.
- Lal MK, Kibirige MS. Unscheduled return visits within 72 hours to an assessment unit. *Arch Dis Child* 1999;80:455–8.
- Ali AB, Place R, Howell J, *et al.* Early pediatric emergency department return visits: a prospective patient-centric assessment. *Clin Pediatr* 2012;51:651–8.
- Depiero AD, Ochenschlager DW, Chamberlain JM. Analysis of pediatric hospitalizations after emergency department release as a quality improvement tool. *Ann Emerg Med* 2002;39:159–63.
- Dunlop S, Taitz J. Retrospective review of the management of simple febrile convulsions at a tertiary paediatric institution. *J Paediatr Child Health* 2005;41:647–51.
- Mistry RD, Stevens MW, Gorelick MH. Short-term outcomes of pediatric emergency department febrile illnesses. *Pediatr Emerg Care* 2007;23:617–23.

- 56 Roggen I, Van Berlaer G, Lauwaert D, *et al.* Hospitalization rate and diagnosis severity increase on children's return visits to the ED. *Acad Emerg Med* 2012;19:773.
- 57 Chang YC, Lo HC, Tzeng YM, *et al.* Comparative clinical practice of residents and attending physicians who care for pediatric patients in the emergency department. *Pediatr Emerg Care* 2008;24:364–9.
- 58 Gaucher N, Bailey B, Gravel J. Impact of physicians' characteristics on the admission risk among children visiting a pediatric emergency department. *Pediatr Emerg Care* 2012;28:120–4.
- 59 Jain S, Elon LK, Johnson BA, *et al.* Physician practice variation in the pediatric emergency department and its impact on resource use and quality of care. *Pediatr Emerg Care* 2010;26:902–8.
- 60 Florin TA, French B, Zorc JJ, *et al.* Variation in emergency department diagnostic testing and disposition outcomes in pneumonia. *Pediatrics* 2013;132:237–44.
- 61 Mistry RD, Stevens MW, Gorelick MH. Health-related quality of life for pediatric emergency department febrile illnesses: an evaluation of the Pediatric Quality of Life Inventory(trademark) 4.0 generic core scales. *Health Qual Life Outcomes* 2009;7:5.
- 62 Sartain SA, Maxwell MJ, Todd PJ, *et al.* Randomised controlled trial comparing an acute paediatric hospital at home scheme with conventional hospital care. *Arch Dis Child* 2002;87:371–5.
- 63 Small F, Alderdice F, McCusker C, *et al.* A prospective cohort study comparing hospital admission for gastro-enteritis with home management. *Child Care Health Dev* 2005;31:555–62.
- 64 Samuels-Kalow ME, Stack AM, Amico K, *et al.* The association between parental language and 72-hour revisits following pediatric emergency department discharge. *Acad Emerg Med* 2013;20:S188.
- 65 Hayden JA, Cote P, Bombardier C. Evaluation of the quality of prognosis studies in systematic reviews. *Ann Intern Med* 2006;144:427–37.
- 66 Fields E, Chard J, Murphy MS, *et al.* Assessment and initial management of feverish illness in children younger than 5 years: summary of updated NICE guidance. *BMJ* 2013;346:f2866.
- 67 Thompson MJ, Ninis N, Perera R, *et al.* Clinical recognition of meningococcal disease in children and adolescents. *Lancet* 2006;367:397–403.

Supplemental information 1a: systematic review search strategy

Embase

((('hospital readmission'/de OR (readmiss* OR reattend* OR rehospital* OR revisit* OR ((re OR second OR return* OR repeat* OR recur*) NEAR/3 (admiss* OR attend* OR visit* OR hospital* OR emergenc* OR present*)) OR (safe* NEAR/3 net*)):ab,ti) OR (('hospital discharge'/de OR (discharge* OR postdischarge*):ab,ti) AND ('evaluation and follow up'/de OR 'health care quality'/exp OR evaluation/de OR 'follow up'/de OR (evaluat* OR (follow* NEXT/1 up) OR followup):ab,ti))) AND ('emergency ward'/de OR 'emergency patient'/de OR 'emergency treatment'/de OR 'first aid'/de OR 'emergency care'/de OR 'emergency health service'/de OR 'emergency medicine'/de OR (emergen* OR 'first aid'):ab,ti) AND (child/exp OR newborn/exp OR adolescent/exp OR adolescence/exp OR 'child behavior'/de OR 'child parent relation'/de OR (adolescen* OR infan* OR newborn* OR (new NEXT/1 born*) OR baby OR babies OR neonat* OR child* OR kid OR kids OR toddler* OR teen* OR boy* OR girl* OR minors OR underag* OR (under NEXT/1 ag*) OR juvenil* OR youth* OR kindergar* OR puber* OR pubescen* OR prepubescen* OR prepubert* OR paediatric* OR paediatric* OR school* OR preschool* OR highschool*):ab,ti) AND (infection/exp OR fever/de OR dyspnea/exp OR gastroenteritis/de OR vomiting/de OR diarrhea/exp OR (infecti* OR virus* OR viral OR bacterial OR fever OR febril* OR dyspne* OR dyspnoe* OR gastroenterit* OR vomit* OR diarrh*):ab,ti)

Medline OvidSP

((("Patient Readmission"/ OR (readmiss* OR reattend* OR rehospital* OR revisit* OR ((re OR second OR return* OR repeat* OR recur*) ADJ3 (admiss* OR attend* OR visit* OR hospital* OR emergenc* OR present*)) OR (safe* ADJ3 net*)):ab,ti.) OR (("Patient Discharge"/ OR (discharge* OR postdischarge*):ab,ti.) AND ("Program Evaluation"/ OR Evaluation Studies.pt. OR exp "Quality of Health Care"/ OR "Follow-Up Studies"/ OR (evaluat* OR (follow* ADJ up) OR followup).ab,ti.))) AND ("Emergency Service, Hospital"/ OR "Emergency Medical Services"/ OR "emergency treatment"/ OR "emergency medicine"/ OR "first aid"/ OR (emergen* OR "first aid"):ab,ti.) AND (exp child/ OR exp infant/ OR adolescent/ OR exp "child behavior"/ OR exp "Parent-Child Relations"/ OR (adolescen* OR infan* OR newborn* OR (new ADJ born*) OR baby OR babies OR neonat* OR child* OR kid OR kids OR toddler* OR teen* OR boy* OR girl* OR minors OR underag* OR (under ADJ ag*) OR juvenil* OR youth* OR kindergar* OR puber* OR pubescen* OR prepubescen* OR prepubert* OR paediatric* OR paediatric* OR school* OR preschool* OR highschool*):ab,ti.) AND (exp infection/ OR exp fever/ OR exp dyspnea/ OR gastroenteritis/ OR vomiting/ OR exp diarrhea/ OR (infecti* OR virus* OR viral OR bacterial OR fever OR febril* OR dyspne* OR dyspnoe* OR gastroenterit* OR vomit* OR diarrh*):ab,ti.)

Cochrane central

((readmiss* OR reattend* OR rehospital* OR revisit* OR ((re OR second OR return* OR repeat* OR recur*) NEAR/3 (admiss* OR attend* OR visit* OR hospital* OR emergenc* OR present*)) OR (safe* NEAR/3 net*)):ab,ti) OR (((discharge* OR postdischarge*):ab,ti) AND ((evaluat* OR (follow* NEXT/1 up) OR followup):ab,ti))) AND ((emergen* OR 'first aid'):ab,ti) AND ((adolescen* OR infan* OR newborn* OR (new NEXT/1 born*) OR baby OR babies OR neonat* OR child* OR kid OR kids OR toddler* OR teen* OR boy* OR girl* OR minors OR underag* OR (under NEXT/1 ag*) OR juvenil* OR youth* OR kindergar* OR puber* OR pubescen* OR prepubescen* OR prepubert* OR paediatric* OR paediatric* OR school* OR preschool* OR highschool*):ab,ti) AND ((infecti* OR virus* OR viral OR bacterial OR fever OR febril* OR dyspne* OR dyspnoe* OR gastroenterit* OR vomit* OR diarrh*):ab,ti)

Web-of-Science

TS((((readmiss* OR reattend* OR rehospital* OR revisit* OR ((re OR second OR return* OR repeat* OR recur*) NEAR/3 (admiss* OR attend* OR visit* OR hospital* OR emergenc* OR present*)) OR (safe* NEAR/3 net*))) OR (((discharge* OR postdischarge*)) AND ((evaluat* OR (follow* NEXT/1 up) OR followup)))) AND ((emergen* OR "first aid")) AND ((adolescen* OR infan* OR newborn* OR (new NEXT/1 born*) OR baby OR babies OR neonat* OR child* OR kid OR kids OR toddler* OR teen* OR boy* OR girl* OR minors OR underag* OR under age* OR juvenil* OR youth* OR kindergar* OR puber* OR pubescen* OR prepubescen* OR prepubert* OR paediatric* OR paediatric* OR school* OR preschool* OR highschool*)) AND ((infecti* OR virus* OR viral OR bacterial OR fever OR febril* OR dyspne* OR dyspnoe* OR gastroenterit* OR vomit* OR diarrh*)))

PubMed as publisher

((readmiss*[tiab] OR reattend*[tiab] OR rehospital*[tiab] OR revisit*[tiab] OR ((re[tiab] OR second[tiab] OR return*[tiab] OR repeat*[tiab] OR recur*[tiab]) AND (admiss*[tiab] OR attend*[tiab] OR visit*[tiab] OR hospital*[tiab] OR emergenc*[tiab] OR present*[tiab])) OR safety net*[tiab])) OR (((discharge*[tiab] OR postdischarge*[tiab])) AND ((evaluat*[tiab] OR follow up[tiab] OR followup[tiab])))) AND ((emergen*[tiab] OR first aid[tiab])) AND ((adolescen*[tiab] OR infan*[tiab] OR newborn*[tiab] OR new born*[tiab] OR baby[tiab] OR babies[tiab] OR neonat*[tiab] OR child*[tiab] OR kid[tiab] OR kids[tiab] OR toddler*[tiab] OR teen*[tiab] OR boy*[tiab] OR girl*[tiab] OR minors[tiab] OR underag*[tiab] OR under ag*[tiab] OR juvenil*[tiab] OR youth*[tiab] OR kindergar*[tiab] OR puber*[tiab] OR pubescen*[tiab] OR prepubescen*[tiab] OR prepubert*[tiab] OR paediatric*[tiab] OR paediatric*[tiab] OR school*[tiab] OR preschool*[tiab] OR highschool*[tiab])) AND ((infection*[tiab] OR infectious*[tiab] OR virus*[tiab] OR viral OR bacterial OR fever OR febril*[tiab] OR dyspne*[tiab] OR dyspnoe*[tiab] OR gastroenterit*[tiab] OR vomit*[tiab] OR diarrh*[tiab])) AND publisher[sb])

CINAHL

((MH "Readmission"+ OR (readmiss* OR reattend* OR rehospital* OR revisit* OR ((re OR second OR return* OR repeat* OR recur*) N3 (admiss* OR attend* OR visit* OR hospital* OR emergenc* OR present*)) OR (safe* N3 net*))) OR ((MH "Patient Discharge"+ OR (discharge* OR postdischarge*)) AND (MH "Program Evaluation"+ OR MH "Quality of Health Care"+ OR MH "Prospective Studies"+ OR (evaluat* OR (follow* N up) OR followup)))) AND (MH "Emergency Service "+ OR MH "Emergency Treatment (Non-Cinahl)" + OR MH "emergency medicine"+ OR (emergen* OR "first aid")) AND (MH child+ OR MH infant+ OR adolescent+ OR MH "child behavior"+ OR MH "Parent-Child Relations"+ OR (adolescen* OR infan* OR newborn* OR (new N born*) OR baby OR babies OR neonat* OR child* OR kid OR kids OR toddler* OR teen* OR boy* OR girl* OR minors OR underag* OR (under N ag*) OR juvenil* OR youth* OR kindergar* OR puber* OR pubescen* OR prepubescen* OR prepubert* OR paediatric* OR paediatric* OR school* OR preschool* OR highschool*)) AND (MH infection+ OR MH fever+ OR MH dyspnea+ OR MH gastroenteritis OR MH vomiting+ OR MH diarrhea+ OR (infecti* OR virus* OR viral OR bacterial OR fever OR febril* OR dyspne* OR dyspnoe* OR gastroenterit* OR vomit* OR diarrh*))

Google Scholar

(readmission|reattendance|rehospitalization|"safety (netting|net)") (emergency|"first aid")
 (child|newborn|adolescent|adolescence|baby|babies|neonates|children)
 (infection|fever|dyspnea|gastroenteritis|vomiting|diarrhea|virus|virussus|viral|bacterial)

Supplemental information 1b: number of articles per database

Database	Number of articles	Number of articles after deleting duplicates
Embase	1842	1835
Medline OvidSP	1268	425
Web-of-Science	538	131
CINAHL	199	25
Cochrane central	54	3
PubMed as publisher	28	23
Google Scholar	200	162
	4129	2604

Supplemental information 2

Risk of bias assessment

Two authors (EK/DG) independently assessed the potential assessed risk of bias of the studies included using the *MINORS*, a methodological index for non-randomised studies.¹ The items were scored 0 if not reported; 1 when reported but inadequate; and 2 when reported and adequate. The global ideal score was 16 for non-comparative studies and 24 for comparative studies (supplemental information 2). As a higher event rate allows to give a more precise estimate of the influence of studied determinants we chose to select the number of events to include in our risk of bias assessment (score 2: A for >500 events, B for 100-500 events and C if less events occurred) , and together with the presence of revisits as primary outcome measure (score 1: A for revisits as primary outcome and B if not) the total risk of bias was assessed (supplemental information 3). We considered low risk of bias when studies fulfilling all *MINORS* criteria; or studies scored a minimum of two A's in score 1 and 2; or studies scored a minimum of B in score 1, 2 and *MINORS*. We considered high risk of bias in all other studies (supplemental information 3). If only abstracts were available they were automatically judged to be at high risk of bias. Consensus was reached by the two reviewers (EK/DG) when there was difference in opinion on an item. If no consensus was reached, the independent opinion of a third reviewer was decisive (RO).

Data analysis - best-evidence synthesis

A narrative 'best-evidence' synthesis based on the study of Tulder et al.(11) was carried out, as meta-analysis of results was not possible owing to heterogeneity in participants, interventions, outcome measures and methodological quality.(11) We performed separate syntheses for the two separated study aims. Strong evidence was defined as two or more studies with low risk of bias and generally consistent findings in all studies ($\geq 75\%$ of the studies reported consistent findings). Moderate evidence was defined as one study with low risk of bias and/or two or more studies with high risk of bias and generally consistent results. Limited evidence was defined as generally consistent findings were found in one study with high risk of bias. Conflicting evidence was defined as less than 75% of the studies reported consistent findings.

Table 1: individual MINORS score

	Clearly stated aim	Inclusion of consecutive patients	Prospective data collection	Endpoints appropriate to study aim	Unbiased assessment of study endpoint	Follow-up period appropriate to study aim	<5% lost to follow-up	Prospective calculation of study size	Adequate control group	Contemporary groups	Baseline equivalence of groups	Adequate statistical analyses	Total
Alessandrini 2004 ²	2	2	1	2	2	2	2	0	NA	NA	NA	NA	13/16
Ali 2012 ³	2	1	2	2	2	2	1	0	NA	NA	NA	NA	12/16
Angoulvant 2013 ⁴	2	1	2	2	1	2	1	0	NA	NA	NA	NA	11/16
Augustine 2013 ⁵	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Baker 2009 ⁶	2	1	2	2	2	1	2	2	2	2	2	2	22/24
Berry 2013 ⁷	2	1	1	2	2	1	2	0	NA	NA	NA	NA	11/16
Black 2010 ⁸	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Bloch 2013 ⁹	2	2	2	2	2	2	1	0	2	2	2	2	21/24
Browne 2001 ¹⁰	2	2	2	2	2	1	2	0	2	1	2	2	20/24
Callery 2010 ¹¹	2	2	1	2	2	2	2	0	NA	NA	NA	NA	13/16
Chang 2008 ¹²	2	1	1	2	2	2	0	0	2	2	2	2	18/24
Considine 2007 ¹³	2	1	2	2	2	2	2	0	2	2	2	2	21/24
DePiero 2002 ¹⁴	2	2	1	2	2	2	2	0	NA	NA	NA	NA	13/16
Dunlop 2005 ¹⁵	2	2	1	2	2	0	2	0	NA	NA	NA	NA	11/16
Easter 2012 ¹⁶	2	2	1	2	2	2	1	0	NA	NA	NA	NA	12/16
Fagbuyi 2011 ¹⁷	2	2	2	2	2	2	2	0	2	1	2	2	21/24
Florin 2013 ¹⁸	2	2	1	2	2	2	2	0	NA	NA	NA	NA	13/16
Freedman 2013 ¹⁹	2	2	1	2	2	2	1	1	NA	NA	NA	NA	13/16
Gallagher 2013 ²⁰	2	2	1	2	2	2	2	0	NA	NA	NA	NA	13/16

[illegible]

Roggen 2012 ⁴⁹	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Samuels-Kalow 2013 ⁵⁰	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Sartain 2002 ⁵¹	2	1	2	2	2	1	2	2	2	2	2	2	22/24
Scarfone 1996 ⁵²	2	1	2	2	2	2	2	0	NA	NA	NA	NA	13/16
Seow 2007 ⁵³	2	2	1	2	2	2	2	0	NA	NA	NA	NA	13/16
Simmons 2012 ⁵⁴	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Small 2005 ⁵⁵	2	2	2	2	2	2	2	2	2	2	2	2	24/24
Yang 2012 ⁵⁶	2	2	2	2	2	2	1	0	2	1	2	2	20/24
Zimmerman 1996 ⁵⁷	2	2	1	2	2	2	2	0	NA	NA	NA	NA	13/16

Table 2.1: Risk of bias assessment

Score 1: Revisit primary outcome		Score 2: Number of events (revisits)		Score 3: MINORS score	
Yes	A	>500	A	16 or 24	A
No	B	100-500	B	>12 - <16 or >20 - <24	B
		<100	C	≤12 or ≤20	C

Risk of bias (low/ high)

Low risk of bias:

1. Studies fulfilling all MINORS criteria (A)
2. Full article with a minimum of 2 A's in score 1 and 2
3. Minimum of B in score 1, 2 and MINORS

High risk of bias:

1. all other studies

Table 2.2: Risk of bias assessment

Author Year Country	Revisits primary outcome	Score 1	N outcome (revisits)	Score 2	MINORS quality score*	Score 3	Risk of bias (low/ high)
<i>Alessandrini</i> 2004 USA	Yes	A	1,893	A	13/16	B	Low risk of bias
<i>Ali</i> 2012 USA	Yes	A	124	B	12/16	C	High risk of bias
<i>Angoulvant</i> 2012 France	Yes	A	206	B	11/16	C	High risk of bias
<i>Augustine</i> 2013 USA	Yes	A	13	B	NA	NA	High risk of bias
<i>Baker</i> 2009 USA	Yes	A	105	B	22/24	B	Low risk of bias
<i>Berry</i> 2013 USA	Yes	A	36,734	A	11/16	C	Low risk of bias
<i>Black</i> 2010 UK	Yes	A	91	C	NA	NA	High risk of bias
<i>Bloch</i> 2013 USA	No	B	216	B	21/24	B	Low risk of bias
<i>Browne</i> 2001 Australia	Yes	A	240	B	20/24	C	High risk of bias
<i>Callery</i> 2010 UK	Yes	A	2,433	A	13/16	B	Low risk of bias
<i>Chang</i> 2008 Taiwan	No	B	188	B	18/24	B	Low risk of bias

<i>Considine</i> 2007 Australia	No	B	15	C	21/24	B	High risk of bias
<i>DePiero</i> 2002 USA	Yes	A	261	B	13/16	B	Low risk of bias
<i>Dunlop</i> 2005 Australia	No	B	35	C	11/16	C	High risk of bias
<i>Easter</i> 2012 USA	Yes	A	1,091	A	12/16	C	Low risk of bias
<i>Fagbuyi</i> 2011 USA	No	B	620	A	21/24	C	High risk of bias
<i>Florin</i> 2013 USA	Yes	A	6,439	A	13/16	B	Low risk of bias
<i>Freedman</i> 2013 Canada	Yes	A	543	A	13/16	B	Low risk of bias
<i>Gallagher</i> 2013 USA	Yes	A	1,499	A	13/16	B	Low risk of bias
<i>Gaucher</i> 2012 Canada	No	B	2,534	A	14/16	B	Low risk of bias
<i>Goldman</i> 2006 Canada	Yes	A	1,990	A	21/24	B	Low risk of bias
<i>Goldman</i> 2011 Canada	Yes	A	353	B	20/24	C	High risk of bias
<i>Hacking</i> 2012 UK	Yes	A	130	B	NA	NA	High risk of bias
<i>Gregor</i> 2009 USA	No	B	49	C	15/16	B	High risk of bias
<i>Horne</i> 1995 USA	No	B	171	B	14/16	B	Low risk of bias
<i>Ismail</i> 2013 USA	No	B	63	C	NA	NA	High risk of bias
<i>Jacobstein</i> 2005 USA	Yes	A	165	B	22/24	B	Low risk of bias
<i>Jain</i> 2010 USA	No	B	17,335	A	21/24	B	Low risk of bias
<i>Klein-Kremer</i> 2011 Canada	Yes	A	92	C	20/24	C	High risk of bias
<i>Lal et al.</i> 1999 UK	Yes	A	65	C	13/16	B	High risk of bias
<i>Lawrence</i> 2009 USA	Yes	A	979	A	20/24	C	High risk of bias
<i>LeDuc</i> 2006 USA	Yes	A	237	B	11/16	C	High risk of bias
<i>Liberman</i> 2012 USA	No	B	189	B	13/16	B	Low risk of bias
<i>Logue</i> 2013 Canada	Yes	A	261	B	11/16	C	High risk of bias

<i>Maguire</i> 2011 UK	No	B	29	C	10/16	C	High risk of bias
<i>Mansbach</i> 2008 USA	No	B	837	A	22/24	B	Low risk of bias
<i>Michelson</i> 2012 USA	No	B	7,281	A	12/16	C	High risk of bias
<i>Mintegui</i> 2000 Spain	Yes	A	495	B	NA	NA	High risk of bias
<i>Mistry</i> 2007 USA	Yes	A	76	C	14/16	B	High risk of bias
<i>Mistry</i> 2009 USA	No	B	18	C	15/16	B	High risk of bias
<i>Moineau</i> 2004 Canada	Yes	A	108	B	NA	NA	High risk of bias
<i>Roback</i> 1997 USA	Yes	A	57	C	22/24	B	High risk of bias
<i>O'Loughlin</i> 2012 UK	Yes	A	532	A	10/16	C	High risk of bias
<i>O'Neill</i> 2001 USA	No	B	NS	C	6/16	C	High risk of bias
<i>Patel</i> 2009 USA	No	B	NA	C	21/24	B	High risk of bias
<i>Porter</i> 2000 USA	No	B	NA	C	10/16	C	High risk of bias
<i>Roggen</i> 2012 Belgium	Yes	A	1,864	A	NA	NA	High risk of bias
<i>Roland</i> 2011 UK	No	B	NR	NA	NA	NA	High risk of bias
<i>Samuels-Kalow</i> 2013 USA	Yes	A	14	C	NA	NA	High risk of bias
<i>Sartain</i> 2002 UK	No	B	31	C	22/24	B	High risk of bias
<i>Scarfone</i> 1996 USA	No	B	91	C	13/16	B	High risk of bias
<i>Seow</i> 2007 Taiwan	No	B	115	B	13/16	B	Low risk of bias
<i>Simmons</i> 2012 UK	Yes	A	51	C	NA	NA	High risk of bias
<i>Small</i> 2005 UK	No	B	56	C	24/24	A	Low risk of bias
<i>Yang</i> 2012 Taiwan	Yes	A	9	C	20/24	C	High risk of bias
<i>Zimmerman</i> 1996 USA	Yes	A	242	B	13/16	B	Low risk of bias

Legend supplemental information 3:

* Minors: 1. clearly stated aim; 2. inclusion of consecutive patients; 3. prospective data collection; 4. endpoints appropriate to study aim; 5. unbiased assessment of study endpoint; 7. <5% lost to follow-up; 8. prospective calculation of study size; *Additional criteria in the case of comparative study*: 9. adequate control group; 10. contemporary groups; 11. baseline equivalence; 12. adequate statistical analyses

References:

1. Slim K, Nini E, Forestier D, Kwiatkowski F, Panis Y, Chipponi J. Methodological index for non-randomized studies (minors): development and validation of a new instrument. *ANZ J Surg.* 2003;73(9):712-716.
2. Alessandrini EA, Lavelle JM, Grenfell SM, Jacobstein CR, Shaw KN. Return Visits to a Pediatric Emergency Department. *Pediatr Emerg Care.* 2004;20(3):166-171.
3. Ali AB, Place R, Howell J, Malubay SM. Early pediatric emergency department return visits: A prospective patient-centric assessment. *Clin Pediatr.* 2012;51(7):651-658.
4. Angoulvant F, Jumel S, Prot-Labarthe S, Bellettre X, Kahil M, Smail A, et al. Multiple health care visits related to a pediatric emergency visit for young children with common illnesses. *Eur J Pediatr.* 2013;172(6):797-802.
5. Augustine EM, Kreling BA, Chamberlain JM. The parent perspective on return emergency department visits. *J Invest Med.* 2013;61(3):678.
6. Baker MD, Monroe KW, King WD, Sorrentino A, Glaeser PW. Effectiveness of fever education in a pediatric emergency department. *Pediatr Emerg Care.* 2009;25(9):565-568.
7. Berry JG, Toomey SL, Zaslavsky AM, Jha AK, Nakamura MM, Klein DJ, et al. Pediatric readmission prevalence and variability across hospitals. *JAMA.* 2013;309(4):372-380.
8. Black L. Unscheduled re-attendances to a paediatric emergency department: An audit. *Emerg Med J.* 2010;27:A9-A10.
9. Bloch SA, Bloch AJ. Using video discharge instructions as an adjunct to standard written instructions improved caregivers' understanding of their child's emergency department visit, plan, and follow-up: A randomized controlled trial. *Pediatr Emerg Care.* 2013;29(6):699-704.
10. Browne GJ, Giles H, McCaskill ME, Fasher BJ, Lam LT. The benefits of using clinical pathways for managing acute paediatric illness in an emergency department. *J Qual Clin Pract.* 2001;21(3):50-55.
11. Callery P, Kyle RG, Campbell M, Banks M, Kirk S, Powell P. Readmission in children's emergency care: An analysis of hospital episode statistics. *Arch Dis Child.* 2010;95(5):341-346.
12. Chang YC, Lo HC, Tzeng YM, Yen DHT, Jeng MJ, Huang CI, et al. Comparative clinical practice of residents and attending physicians who care for pediatric patients in the emergency department. *Pediatr Emerg Care.* 2008;24(6):364-369.
13. Considine J, Brennan D. Effect of an evidence-based education programme on ED discharge advice for febrile children. *J Clin Nurs.* 2007;16(9):1687-1694.
14. Depiero AD, Ochsenschlager DW, Chamberlain JM. Analysis of pediatric hospitalizations after emergency department release as a quality improvement tool. *Ann Emerg Med.* 2002;39(2):159-163.
15. Dunlop S, Taitz J. Retrospective review of the management of simple febrile convulsions at a tertiary paediatric institution. *J Paediatr Child Health.* 2005;41(12):647-651.
16. Easter JS, Bachur R. Physicians' Assessment of Pediatric Returns to the Emergency Department. *J Emerg Med.* 2012.
17. Fagbuyi DB, Brown KM, Mathison DJ, Kingsnorth J, Morrison S, Saidinejad M, et al. A rapid medical screening process improves emergency department patient flow during surge associated with novel H1N1 influenza virus. *Ann Emerg Med.* 2011;57(1):52-59.
18. Florin TA, French B, Zorc JJ, Alpern ER, Shah SS. Variation in emergency department diagnostic testing and disposition outcomes in pneumonia. *Pediatrics.* 2013;132(2):237-244.
19. Freedman SB, Thull-Freedman JD, Rumanitir M, Atenafu EG, Stephens D. Emergency department revisits in children with gastroenteritis. *J Pediatr Gastroenterol Nutr.* 2013;57(5):612-618.
20. Gallagher RA, Porter S, Monuteaux MC, Stack AM. Unscheduled return visits to the emergency department: the impact of language. *PEDIATR EMERG CARE.* 2013;29(5):579-583.
21. Gaucher N, Bailey B, Gravel J. Impact of physicians' characteristics on the admission risk among children visiting a pediatric emergency department. *Pediatr Emerg Care.* 2012;28(2):120-124.
22. Goldman RD, Ong M, Macpherson A. Unscheduled return visits to the pediatric emergency department-one-year experience. *Pediatr Emerg Care.* 2006;22(8):545-549.
23. Goldman RD, Kapoor A, Mehta S. Children admitted to the hospital after returning to the emergency department within 72 hours. *PEDIATR EMERG CARE.* 2011;27(9):808-811.
24. Gregor MA, Wheeler JRC, Stanley RM, Mahajan PV, Maio RF, Piette JD. Caregiver adherence to follow-up after an emergency department visit for common pediatric illnesses: Impact on future ED use. *Med Care.* 2009;47(3):326-333.
25. Horne A, Ros SP. Telephone follow-up of patients discharged from the emergency department: How reliable? *PEDIATR EMERG CARE.* 1995;11(3):173-175.
26. Hacking K, Christian W. Clinical quality indicators in the children's emergency department-why do children re-attend? *Arch Dis Child.* 2012;97:A144-A145.
27. Ismail S, McIntosh M, Kalynych C, Joseph M, Wylie T, Butterfield R, et al. Impact of video discharge instructions from the emergency department in regard to caregiver understanding of their child's fever and closed head injury. *Ann Emerg Med.* 2013;62(4):S17.
28. Jacobstein CR, Alessandrini EA, Lavelle JM, Shaw KN. Unscheduled revisits to a pediatric emergency department: risk factors for children with fever or infection-related complaints. *Pediatr Emerg Care.* 2005;21(12):816-821.
29. Jain S, Elon LK, Johnson BA, Frank G, DeGuzman M. Physician Practice Variation in the Pediatric Emergency Department and Its Impact on Resource Use and Quality of Care. *Pediatric emergency care.* 2010;26(12):902-908.
30. Klein-Kremer A, Goldman RD. Return visits to the emergency department among febrile children 3 to 36 months of age. *Pediatr Emerg Care.* 2011;27(12):1126-1129.
31. Lal MK, Kibirige MS. Unscheduled return visits within 72 hours to an assessment unit. *Arch Dis Child.* 1999;80(5):455-458.
32. Lawrence LM, Jenkins CA, Zhou C, Givens TG. The effect of diagnosis-specific computerized discharge instructions on 72-hour return visits to the pediatric emergency department. *Pediatr Emerg Care.* 2009;25(11):733-738.
33. LeDuc K, Rosebrook H, Rannie M, Gao D. Pediatric emergency department recidivism: Demographic characteristics and diagnostic predictors. *J Emerg Nurs.* 2006;32(2):131-138.
34. Liberman DB, Shalef DQ, He J, McCarter R, Teach SJ. Low rates of follow-up with primary care providers after pediatric emergency department visits for respiratory tract illnesses. *Pediatr Emerg Care.* 2012;28(10):956-961.

35. Logue EP, Ali S, Spiers J, Newton AS, Lander JA. Characteristics of patients and families who make early return visits to the pediatric emergency department. *Open Access Emerg Med.* 2013;5:9-15.
36. Maguire S, Ranmal R, Komulainen S, Pearce S, Maconochie I, Lakhanpaul M, et al. Which urgent care services do febrile children use and why? *Arch Dis Child.* 2011;96(9):810-816.
37. Mansbach JM, Clark S, Christopher NC, LoVecchio F, Kunz S, Acholonu U, et al. Prospective multicenter study of bronchiolitis: Predicting safe discharges from the emergency department. *PEDIATRICS.* 2008;121(4):680-688.
38. Michelson KA, Monuteaux MC, Stack AM, Bachur RG. Pediatric emergency department crowding is associated with a lower likelihood of hospital admission. *Acad Emerg Med.* 2012;19(7):816-820.
39. Mintegui Raso S, Benito Fernandez J, Vazquez Ronco MA, Ortiz Andres A, Capape Zache S, Fernandez Landaluce A. Children's unscheduled return visits to an emergency department. *An Esp Pediatr.* 2000;52(6):542-547.
40. Mistry RD, Stevens MW, Gorelick MH. Short-term outcomes of pediatric emergency department febrile illnesses. *Pediatr Emerg Care.* 2007;23(9):617-623.
41. Mistry RD, Stevens MW, Gorelick MH. Health-related quality of life for pediatric emergency department febrile illnesses: An Evaluation of the Pediatric Quality of Life Inventory(trademark) 4.0 generic core scales. *Health Qual Life Outcomes.* 2009;7.
42. Moineau G, McKinnon A, Gaboury I, Grant V, Pitters C. Unscheduled return visits for gastroenteritis to a pediatric emergency department. *Pediatric Research.* 2004;55(4):129A-129A.
43. Roback MG, Baskin MN. Failure of oxygen saturation and clinical assessment to predict which patients with bronchiolitis discharged from the emergency department will return requiring admission. *Pediatr Emerg Care.* 1997;13(1):9-11.
44. O'Loughlin K, Hacking KA, Simmons N, Christian W, Syahane R, Shamekh A, et al. Paediatric unplanned reattendance rate: A&E clinical quality indicators. *Arch Dis Child.* 2013;98(3):211-213.
45. O'Neill K, Silvestri A, McDaniel-Yaksoe N. A pediatric emergency department follow-up system: completing the cycle of care. *Pediatr Emerg Care.* 2001;17(5):392-395.
46. Patel B, Kennebeck SS, Caviness AC, Macias CG. Use of a discharge facilitator improves recall of emergency department discharge instructions for acute gastroenteritis. *PEDIATR EMERG CARE.* 2009;25(9):558-564.
47. Porter RS, Wenger FG. Diagnosis and treatment of pediatric fever by caretakers. *J Emerg Med.* 2000;19(1):1-4.
48. Roland D, Geliot T, Patel A. Delivering safety net advice and the emergency department clinical quality indicator of unplanned re-attendance in children. *Emerg Med J.* 2011;28:A13.
49. Roggen I, Van Berlaer G, Lauwaert D, Hubloue I. Hospitalization rate and diagnosis severity increase on children's return visits to the ED. *Acad Emerg Med.* 2012;19(6):773.
50. Samuels-Kalow ME, Stack AM, Amico K, Porter SC. The association between parental language and 72-hour revisits following pediatric emergency department discharge. *Acad Emerg Med.* 2013;20(5):S188.
51. Sartain SA, Maxwell MJ, Todd PJ, Jones KH, Bagust A, Haycox A, et al. Randomised controlled trial comparing an acute paediatric hospital at home scheme with conventional hospital care. *Arch Dis Child.* 2002;87(5):371-375.
52. Scarfone RJ, Joffe MD, Wiley JF, Loiselle JM, Cook RT. Noncompliance with scheduled revisits to a pediatric emergency department. *Archives of pediatrics & adolescent medicine.* 1996;150(9):948-953.
53. Seow VK, Lin ACM, Lin IY, Chen CC, Chen KC, Wang TL, et al. Comparing different patterns for managing febrile children in the ED between emergency and pediatric physicians: impact on patient outcome. *Am J Emerg Med.* 2007;25(9):1004-1008.
54. Simmons N, Syahane R, Marzouk O, Grice J. Audit of unplanned re-attendance to a paediatric emergency department. *Arch Dis Child.* 2012;97:A153.
55. Small F, Alderdice F, McCusker C, Stevenson M, Stewart M. A prospective cohort study comparing hospital admission for gastroenteritis with home management. *Child Care Health Dev.* 2005;31(5):555-562.
56. Yang C, Chen CM. Effects of post-discharge telephone calls on the rate of emergency department visits in paediatric patients. *J Paediatr Child Health.* 2012;48(10):931-935.
57. Zimmerman DR, McCarten-Gibbs KA, DeNoble DH, Borger C, Fleming J, Hsieh M, et al. Repeat pediatric visits to a general emergency department. *Ann Emerg Med.* 1996;28(5):467-473.

Supplemental information 3a: Detailed study information about safety netting after ED discharge

	Univariable		Multivariable		Best evidence synthesis	
	Low risk of bias	High risk of bias	Low risk of bias	High risk of bias	Association	Level of evidence
<i>Approach of safety netting management</i>						
Follow-up program		yes (2) Augustine 2013 (all) O'Neill 2001 (all)			Yes	Moderate
Clinical pathways at initial ED visit		yes (1) Browne 2001 (spec)			Yes	Limited
Non-compliance to scheduled revisit		yes (1) Scarfone 1996 (all)			Yes	Limited
Explicit and consistent safety netting advice [^]		yes (4) Augustine 2013 (all) Maguire 2011 (fever) Moineau 2004 (spec) Porter 1999 (all) no (3) Fagbuyi. 2011 (spec) Liberman 2012 (spec) Roland 2011 (fever)			unclear	Conflicting
Educational intervention [*]		yes (3) Considine 2007 (fever) Ismail 2013 (fever) O'Neill 2001 (fever) no (3) Chande 1996 (all) Fagbuyi. 2011 (spec) Lawrence 2009 (all)	yes (1) Bloch 2013 (all) no (1) Baker 2009 (fever)	yes (1) Patel 2009 (spec)	unclear	Conflicting
Telephone follow-up	no (1) Horne 1995 (all)	yes (1) Yang 2011 (all)			unclear	Conflicting

Legend supplemental information 4a: see supplemental information 4c

Supplemental information 3b: Detailed study information about determinants of revisits

	Univariable		Multivariable		Best evidence synthesis	
	Low risk of bias	High risk of bias	Low risk of bias	High risk of bias	Association	Level of evidence
DETERMINANTS OF REVISITS						
<i>CHILD CHARACTERISTICS</i>						
Younger children	yes (5) Alessandrini 2004 (all) Easter 2012 (all) Goldman 2006 (all) Lieberman 2012 (spec) Zimmerman 1996 (all)	yes (4) Black 2010 (all) Logue 2013 (all) Maguire 2011 (fever) O'Loughlin 2012 (all) no (3) Angoulvant 2013 (all) Goldman 2011 (all) Roback 1997 (spec)	yes (4) Berry 2013 (all) Gallagher 2013 (all) Freedman (spec) Mansbach 2008 (spec) no (1) Jacobstein 2002 (fever)	yes (2) Gregor 2009 (spec) LeDuc2006 (all)	Yes	Strong
Medical history ¹		yes (1) Maguire 2011 (fever) no (1) Roback 1997 (spec)	yes (3) Berry 2013 (all) Mansbach 2008 (spec) Jacobstein 2002 (fever)	yes (1) Gregor 2009 (spec)	Yes	Strong
Gender	no (2) Lieberman 2012 (spec) Zimmerman 1996 (all)	no (3) Angoulvant 2013 (all) Goldman 2011 (all) Roback 1997 (spec)	no (1) Mansbach 2008 (spec)	no (1) LeDuc2006 (all)	No	Strong
Ethnicity ⁼	yes (1) Zimmerman 1996 (all)		yes (1) Berry 2013 (all) no (2) Jacobstein 2002 (fever) Mansbach 2008 (spec)	yes (1) LeDuc2006 (all)	unclear	Conflicting
Change on pedsQL scores				yes (1) Mistry 2009 (fever)	Yes	Limited
<i>SOCIAL/ DEMOGRAPHIC CHARACTERISTICS</i>						
Emergency crowding ⁺	no (1) Alessandrini 2004 (all) yes (2) Callery 2010 (all) Easter 2012 (all)		yes (1) Goldman 2006 (all) Gallagher 2013 (all) no (2) Jacobstein 2002 (fever)	yes (1) Michelson 2012 (all) no (1) LeDuc2006 (all)	unclear	Conflicting
Low SES ^{##}	no (2) Callery 2010 (all) Lieberman 2012 (spec) yes (1) Zimmerman 1996 (all)		no (1) Gallagher 2013 (all) yes (2) Berry 2013 (all) Jacobstein 2002 (fever)	no (2) Gregor 2009 (spec) LeDuc 2006 (all)	unclear	Conflicting
Characteristics care givers [#]	no (1) Lieberman 2012 (spec)	yes (5) Augustine 2013 (all) Logue 2013 (all) Lal 1999 (all) Maguire 2011 (fever) Simmons 2012 (all) no (4) Angoulvant 2013 (all) Goldman 2011 (all) Mistry 2007 (fever) Roback 1997 (spec)	yes (1) Gallagher 2013 (all) no (1) Jacobstein 2002 (fever)	yes (2) Gregor 2009 (spec) Samuels-Kalow 2013 (fever)	unclear	Conflicting
<i>DISEASE CHARACTERISTICS</i>						
Symptoms of infectious diseases [*]	yes (4) Alessandrini 2004 (all) Callery 2010 (all) Easter 2012 (all) Lieberman 2012 (spec)	yes (8) Angoulvant 2013 (all) Augustine 2013 (all) Black 2010 (all) Hacking 2012 (all) Klein-Kremer 2011	yes (2) Berry 2013 (all) Mansbach 2008 (spec)	no (1) LeDuc2006 (all)	Yes	Strong

Respiratory symptoms**	yes (3) Alessandrini 2004 (all) Callery 2010 (all) Zimmerman 1996 (all)	(fever) Logue 2013 (all) Mintegui 2000 (all) Simmons 2012 (all) yes (4) Hacking (2012) Klein-Kremer 2011 Lal 1999 (all) Mintegui 2000 (all) no (2) Angoulvant 2013 (all) Roback 1997 (spec)	yes (2) Berry 2013 (all) Mansbach 2008 (spec)		Yes	Strong
Seizure and other nervous system	yes (1) Easter 2012 (all)		yes (1) Berry 2013 (all)	yes (1) LeDuc2006 (all)	Yes	Strong
Progression/persistence of symptoms^	yes (3) Ali 2012 (all) DePiero 2002 (all) Easter 2012 (all)	yes (9) Augustine 2013 (all) Dunlop 2005 (fever) Klein-Kremer.2011 (fever) Lal 1999 (all) Logue 2013 (all) Maguire 2011 (fever) Mistry 2007 (fever) Moineau 2004 (spec) Roggen 2012 (all) no (3) Hacking 2012 (all) Roback 1997 (spec) Goldman 2011 (all)	yes (1) Freedman (spec) no (1) Mansbach 2008 (spec)		Yes	Strong
Trauma/ surgery	yes (1) Alessandrini 2004 (all) no (1) Zimmerman 1996 (all)	no (1) Klein-Kremer 2011 (fever)	yes (1) Berry 2013 (all)		unclear	Conflicting
Acute triage category/ Illness acuity\$	yes (1) Alessandrini 2004 (all) no (1) Lieberman 2012 (spec)	yes (2) Goldman 2011 (all) Logue 2013 (all) no (1) Moineau 2004 (spec)	yes (4) Freedman 2013 (spec) Gallagher 2013 (all) Goldman 2006 (all) Jacobstein 2002 (fever)	no (1) Gregor 2009 (spec)	unclear	Conflicting
Change in working diagnosis		yes (1) Mintegui 2000 (all) no (1) Goldman 2011 (all)			unclear	Conflicting
Pain/ soreness		yes (1) Klein-Kremer 2011 (fever) no (1) Angoulvant 2013 (all)			unclear	Conflicting

PHYSICIAN CHARACTERISTICS

Characteristics physician~~	yes (1) Seow 2007 (fever)	no (2) Chang 2008 (all) Roback 1997 (spec)	no (2) Gaucher 2012 (all) Jacobstein 2002 (fever)		No	Strong
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PROCESS CHARACTERISTICS

Diagnostic tests/ therapeutic intervention^^		no (3) Angoulvant 2013 (all) Klein-Kremer 2011 (fever) Mistry 2007 (fever) yes (1) Angoulvant 2013 (all)	no (1) Jain 2010 (all)	no (1) Florin 2013 (spec)	No	Strong
Hospitalisation	no (1) Small 2005 (spec)				No	Moderate
Hospital at home care		no (1) Sartain 2002 (all)			No	Limited

Legend supplemental information 4b: see supplemental information 4c

Supplemental information 3c: explaining determinant-differences of all included studies

All: all disease studied;

Fever: febrile patients studied;

Spec: disease specific studies, e.g. respiratory tract infections, gastroenteritis, bronchiolitis, influenza-like illness

[^] *Explicit and consistent safety netting advice, including:*

- Generic discharge instructions (Augustine 2013)
- Pre-printed discharge prescription and instructions (Fagbuyi 2011)
- Discharge information sheets (Moineau 2004)

^{*} *Educational intervention, including:*

- Classroom-style parent discharge education (Fagbuyi 2011)
- Evidence-based education of emergency nurses on parental advice regarding fever management (Considine 2007)
- Video discharge instructions (Bloch 2013; Ismail 2013)
- Computer-generated diagnosis-specific discharge instructions (Lawrence 2009)
- Verbal reinforcement of written discharge instructions by a bilingual discharge facilitator (Patel 2009)

⁼ *Ethnicity, including:*

- Hispanic vs white (LeDuc 2006; Zimmerman 1996)
- Black vs other (Jacobstein 2002)
- Non-white vs white (Mansbach 2008)
- Black and Latino vs white (Berry 2013)

^l *Medical history, including:*

- History of intubation and/or eczema (Mansbach 2008)
- No ED visit during past week (Mansbach 2008)
- History of wheezing and family history of asthma (Roback 1997)
- Chronic condition indicator (CCI) group and CCI count (Berry 2013)
- Prior ED use (Gregor 2009)
- Chronic disease (Jacobstein 2002)
- Anemia or neutropenia (Berry 2013)
- Sickle cell anemia crisis (Berry 2013)

[#] *Characteristics care givers, including:*

- Caregivers age; education status; employment status (Jacobstein 2002)
- Living near hospital/ primary care physician (Jacobstein 2002; Liberman et al. 2012)
- Family demographics: age primary caregiver; marital status; presence and age of other children; presence of other caregivers (Mistry 2007)
- Language spoken at home (Gallagher 2013; Goldman 2011; Samuels 2013)
- Parental perception of illness (Maguire 2011; Lal 1999)
- Single caregivers (Gregor et al. 2009)
- Consultation with sibling (Angoulvant 2013)
- Dissatisfaction with initial visit (Augustine 2013)
- Anxious/ stressed carer (Logue 2013; Simmons 2012)
- Demographical data (Roback 1997)

Low social economic status (SES), including:

- Living in low SES area (Callery et al. 2010)
- Insurance type (Jacobstein 2002; Liberman 2012)
- Public insurance (Zimmerman 1996)
- Insurance type (Berry 2013; Gregor 2009; LeDuc 2006)
- Carers' highest level of education (Gallagher 2013)

+ Emergency crowding, including:

- Timing of revisit (Alessandrini 2004)
- Same day discharges (Callery 2010)
- Weekend/ weekday (Jacobstein 2002)
- Arriving 3pm-11pm via private transportation (Easter.2012)
- Arrival in evening/ weekend hours (Goldman 2006; leDuc 2006)
- Arrival during overnight shift (Gallagher 2013)

**Symptoms of infectious diseases, including:*

- Feverish illnesses (Angoulvant 2013; Augustine 2013; Callery 2010; Easter 2012; Mintegui 2000)
- Initial diagnosis of URTI (Black 2010; Easter 2012; Hacking 2012)
- Gastroenteritis//diarrhoea/ dehydration/ vomiting (Berry 2013; Black 2010; Callery 2010; Easter 2012; Hacking 2012; Klein-Kremer 2011; LeDuc 2006; Simmons 2012)
- No adequate oral intake (Mansbach 2008)
- Temperature in triage (Klein-Kremer2011)

*** Respiratory symptoms, including:*

- Respiratory related illnesses (Alessandrini 2004)
- Breathing difficulty (Callery 2010)
- Cough (Klein-Kremer 2011)
- Respiratory symptoms (Angoulvant 2013; Mintegui 2000)
- Respiratory diagnoses (Berry 2013; Hacking 2012; Zimmerman 1996)
- Specific respiratory symptoms, including:
 - Age-specific respiratory rates (Mansbach 2008; Roback 1997)
 - Severe retractions (Mansbach 2008; Roback 1997)
 - Initial oxygen saturation <94% (Mansbach 2008; Roback 1997)
 - More albuterol/epinephrine in first hour (Mansbach 2008; Roback 1997)
 - No adequate oral intake (Mansbach 2008)

= Trauma/ surgery

- Limping (Klein-Kremer 2011)
- Trauma (Alessandrini 2004)
- Minor trauma (Zimmerman 1996)
- Ventricular shunt procedures (Berry 2013)

\$ Illness acuity, including:

- Mild disease severity at ED index visit (Gregor 2009)
- Higher acuity in 2nd visit (Goldman 2011)

^ Progression/ persistence of symptoms, including:

- Prolonged fever (Klein-Kremer 2011)
- Impairment in child activities (Mistry 2007)

- Parental perception of illness (Lal 1999; Maguire 2011)
- Time elapsing from 1st visit – revisit (Goldman 2011)

~~ Characteristics physician, including:

- Treatment by physician versus intern (Jacobstein 2005)
- Physicians' year of experience/ training level (Gaucher 2012; Roback 1997)
- Attending physician versus resident (Chang 2008)
- Pediatrician vs Emergency physician (Seow 2007)

^^ Diagnostic tests/ therapeutic intervention, including:

- Obtaining blood cultures/ tests (Angoulvant 2013; Klein-Kremer 2011)
- Radiological assessment (Angoulvant 2013)