Discharge Planning - June 2012

Welcome to the June 2012 bulletin on Discharge Planning being produced by the HEFT Library Services. This bulletin is produced to support VITAL for Nurses core skills programme developed in the Trust. This issue will highlight evidence published in the previous four months. Full text articles can be accessed with your HEFT Athens ID.

Admission prevention

Reducing unplanned care: a new paradigm.

Rowe, Simon

British Journal of Healthcare Management. February; 18(2) p.104-108

There is a financial need to cut the number of unplanned accident and emergency admissions. In this study, analysis from NHS Wakefield District was used to reveal two major findings which could help to cut admission numbers.

Available in *fulltext* at EBSCOhost

Using ambulatory A&E care to cut admissions.

Hattrick, G. ; Bentham, C.

Nursing Times. April; 108 14(15) p.14-15

Describes a pilot project to implement ambulatory emergency care pathways which reduced admissions and improved patients' experiences. Available in full text here.

Preventing avoidable rehospitalizations by understanding the characteristics of "frequent fliers".

Mulder BJ; Tzeng HM; Vecchioni ND

Journal of Nursing Care Quality. January 27(1) p.77-82

This project used chart review to evaluate 22 patients labelled as "frequent fliers," each with 4 to 8 readmissions over a 6-month period at a Michigan community hospital. The goal was to identify whether the 4 key elements identified by the Institute for Healthcare Improvement for reducing rehospitalization had been put into place for these patients. It found that a clear discharge plan was only documented for 15 (68%) of the 22 patients.

Emergency hospital admissions for ambulatory care-sensitive conditions.

Tian, Yang; Dixon, Anna and Gao, Haiyan King's Fund, April 2012

This data briefing considers patterns of admissions for Ambulatory care-sensitive conditions (ACSCs) in terms of age, sex, condition, socioeconomic group and local authority area and suggests how they could be reduced as they currently account for more than one in six emergency hospital admissions in England.

Available in full text here.

Bed management

Nothing to report.

Capacity planning

Nothing to report.

Discharge coordination

Preoperative prediction of non-home discharge: a strategy to reduce resource use after cardiac surgery.

Pattakos G; Johnston DR; Houghtaling PL; Nowicki ER; Blackstone EH

Journal of the American College of Surgeons. February 214(2) p. 140-7

The study hypothesized that preoperatively identifying patients likely to require non-home discharge would allow earlier discharge planning, shorten length of stay, and thereby reduce resource use. This study sought to develop a validated tool for preoperative planning of non-home discharge.

Available in *fulltext* at MD Consult ; Note: You will need to register (free of charge) with MD Consult the first time you use it.

Discharge process

Hospital discharge criteria following colorectal surgery: a systematic review.

Fiore, JF Jr et al.

Colorectal Disease. March 14(3) p. 270-81

The aim of this study was to identify and synthesize the hospital discharge criteria that have been used in the colorectal surgery literature.

A cost-effectiveness evaluation of hospital discharge counseling by pharmacists.

Chinthammit C.; Armstrong E.P.; Warholak T.L.

Journal of Pharmacy Practice. April 25(2) p.201-208

This study estimated the cost-effectiveness of pharmacist discharge counselling on medication-related morbidity in both the high-risk elderly and general US population.

Re-engineering the post-discharge appointment process for general medicine patients.

Chang, R; Spahlinger, D; Kim, CS

The Patient: Patient-Centered Outcomes Research. 2012 5(1) p.27-32

The aim was to determine whether actively engaging patients in scheduling post-discharge appointments before leaving the hospital affects the rate of patients seeing an ambulatory care physician.

The effects of a 'discharge time-out' on the quality of hospital discharge summaries.

Mohta, N et al

BMJ Qual Saf. May 5. Epub ahead of print

High-quality discharge summaries are a key component of a safe transition in care. The purpose of this study was to determine the effects of standardised feedback and a 'discharge time-out' (DTO) on the quality of discharge summaries.

Available in fulltext here.

Criteria to determine readiness for hospital discharge following colorectal surgery.

Fiore Jr. J.F. et al Diseases of the Colon and Rectum. April 55(4) p.416-423

The aim of this study is to achieve an international consensus on hospital discharge criteria for patients undergoing colorectal surgery. Available in *fulltext* at *Ovid.*

Carers UK: BAME hospital discharge brief.

Carers UK. April 2012

The purpose of this briefing is to improve the knowledge and practice of supporting black and minority ethnic carers at the point of hospital discharge. It draws on expertise, knowledge and involvement of carers and professionals across London.

Available in fulltext here.

Completing discharge summaries reduces delays.

Shebli,K et al

British Journal of Healthcare Management. March 18(3) p.141-143

Describes how completing discharge summaries in operating theatres can help to reduce length of patient stay and improve patient satisfaction, as well as maintaining patient care standards.

Available in *fulltext* at EBSCOhost

Education and Practice

Nothing to report.

Estimating dates for discharge

The relationship between inpatient discharge timing and emergency department boarding.

Powell, E.S et al.

Journal of Emergency Medicine. February 42(2) p.186-196

This study uses computer modelling to analyse the impact of inpatient discharge timing on ED boarding. Three policies were tested: a sensitivity analysis on shifting the timing of current discharge practices earlier; discharging 75% of inpatients by 12:00 noon; and discharging all inpatients between 8:00 a.m. and 4:00 p.m.

Multidisciplinary team discharges

Multidisciplinary initiate cuts length of stay.

Hospital Case Management. January 20(1) p.13-4

Available in *fulltext* at EBSCOhost Available in *fulltext* at ProQuest

---

Early Stroke Discharge Team: a participatory evaluation.

Moule, Pam, Young, Pat, Glogowska, Margaret, Weare, Jayne

International Journal of Therapy and Rehabilitation. June 18(6) p.319-328

Qualitative research investigating how multidisciplinary Early Stroke Discharge (ESD) team members and external stakeholders experienced the development and introduction of an ESD service. ESD team members' experiences of setting up the team; multidisciplinary team working and the team's ability to achieve its aims including positive feedback from patients are discussed.

Available in *fulltext* at EBSCOhost

Nurse-led discharge

Evaluation of nurse-led discharge following laparoscopic surgery.

Graham, Lisa et al

Journal of Evaluation in Clinical Practice. February 18(1) p.19-24

The article highlights a research undertaken in a hospital in Leicester to evaluate the value of patient discharge by a laparoscopic nurse specialist after day surgery. Criteria for discharge are listed and time taken before discharge when carried out by the nurse or by a doctor is considered.

From hospital to home: a brief nurse practitioner intervention for vulnerable older adults.

Enguidanos, Susan; Gibbs, Nancy; Jamison, Paula

Journal of Gerontological Nursing. March 38(3) p.40-50

This is a randomized controlled trial that was conducted to evaluate the impact of a brief nurse practitioner (NP) intervention on care transitions among older hospitalized adults discharged to home (N = 199).

Available in *fulltext* at ProQuest

Improving nursing satisfaction and quality through the creation of admission and discharge nurse team.

Spiva L, Johnson D

Journal of Nursing Care Quality. January 27(1) p.89-93

The admission and discharge (AD) process involves a significant amount of nursing time. The organization explored the use of an AD nurse team on the basis on recommendations from the organization's aging nurse workforce and in an effort to provide bedside nurses more time in direct patient care. A pre-post design was used to evaluate the intervention.

Effectiveness of heart failure management programmes with nurse-led discharge planning in reducing re-admissions.

Lambrinou, Ekaterini et al

International Journal of Nursing Studies. May 49(5) p.610-624

This article highlights a meta-analysis that was undertaken to estimate the effect of Heart failure –management programmes (HF-MP) with a nurse-driven pre-discharge phase on the outcomes of HF and all-cause re-admission.

Patient centred discharges

Frequent-user patients: reducing costs while making appropriate discharges.

Fader H.C.; Phillips C.N.

Healthcare financial management. March 66(3) p.98-100, 102, 104

Premature discharge of homeless patients who lack access to the health resource can result in their being readmitted to the hospital in a short time, leading to higher costs for the hospital. Hospitals can address this problem by developing clear, effective homeless discharge policies and by developing ongoing relationships with appropriate medical respite care providers.

Available in *fulltext* at *EBSCOhost*

Available in *fulltext* at *ProQuest*

Readmissions

Planned readmissions: a potential solution.

Berkowitz SA, Anderson GF

Archives of Internal Medicine. February; 172(3) p.269-270

Available in *fulltext* at Highwire Press

The relationship between in-hospital mortality, readmission into the intensive care nursing unit and nurse staffing levels.

Diya, Luwis, Van den Heede, Koen, Sermeus, Walter, Lesaffre, Emmanuel

Journal of Advanced Nursing. May; 68(5) p. 1073-1081

The aim of this article was to assess the relationship between (1) in-hospital mortality and/or (2) unplanned readmission to intensive care units or operating theatre and nurse staffing variables.

Available in *fulltext* at Ovid

Reducing Hospital Readmissions.

Birk, Susan

Healthcare Executive. March; 27(2) p. 16-22

The article offers information on the reduction of hospital readmissions. It cites the early team-based intervention during hospitalization combined with follow-up communication as the centre piece of the strategy to reduce readmissions at SSM St. Mary's Health Center.

Available in *fulltext* at EBSCOhost Available in *fulltext* at ProQuest

Acute kidney injury (AKI) and risk of readmissions in patients with heart failure.

Thakar C.V., Parikh P.J., Liu Y.

American Journal of Cardiology. May; 109(10) p.1482-1486

In this study, 6,535 patients discharged with primary diagnoses of heart failure (HF) derived from a state wide inpatient database were examined. The association between Acute Kidney Injury, with and without chronic kidney disease, and risk for 30-day readmission with HF was assessed.

Available in *fulltext* at MD Consult; Note: You will need to register (free of charge) with MD Consult the first time you use it.

Association of National Hospital Quality Measure adherence with long-term mortality and readmissions.

Shahian DM et al

BMJ Quality and Safety. April 21(4) p.325-36. Epub 2012 Mar 2.

In existing studies, the association between adherence with recommended hospital care processes and subsequent outcomes has been inconsistent. This has substantial implications because process measure scores are used for accountability, quality improvement and reimbursement. This study addresses methodological concerns with previous studies to better clarify the process-outcomes association for three common conditions.

Available in full text here.

Thirty-day readmissions--truth and consequences.

Joynt KE, Jha AK

New England Journal of Medicine. April 366(15) p.1366-9

Available in *print* at *Good Hope Hospital Library.*

Variations in hospital standardised mortality ratios (HSMR) as a result of frequent readmissions.

van den Bosch WF, Spreeuwenberg P, Wagner C.

BMC Health Services Research. April 12(1):91 Epub ahead of print

The study investigated the impact that variations in the frequency of readmissions had upon a hospital's standardised mortality ratio (HSMR). An adapted HSMR model was used in the study. Calculations were based on the admissions of 70 hospitals in the Netherlands during the years 2005 to 2009.

Available in full text here.

Postdischarge follow-up phone call.

Michelle, Mourad; Stephanie, Rennke

Agency for Healthcare Research and Quality M&M Rounds. Published online March 2012

This 'spotlight case' and accompanying commentary about a patient with chronic obstructive pulmonary disease (COPD) in the USA shows how a hospital readmission was prevented.

Available in full text here.

International variation in and factors associated with hospital readmission after myocardial infarction.

Kociol RD et al

JAMA. January 307(1) p.66-74

To determine international variation in and predictors of 30-day readmission rates after STEMI and country-level care patterns.

Available in *fulltext* at EBSCOhost EJS; Note: Go to link "Available on Publisher's Site:"

Hospital Readmission Rates Higher for Chronic Conditions.

Agency for Healthcare Research and Quality

AHRQ News and Numbers. March 7 2012.

The readmission rate following a hospital stay for a chronic condition such as congestive heart failure or diabetes can be substantially higher than for an acute condition like pneumonia or a heart attack, according to the latest News and Numbers from the Agency for Healthcare Research and Quality (AHRQ).

Available in full text here.

Re-engineered discharge cuts readmissions.

Hospital Case Management. May 20(5) p.70-75

By re-engineering its discharge process, a medical centre in USA reduced the number of readmissions within 30 days from 29% to 15%. This article highlights the steps they took to achieve this.

Available in *fulltext* at EBSCOhost Available in *fulltext* at ProQuest

---

Simple discharges and Complex discharges

Gender as risk factor for 30 days post-discharge hospital utilisation.

Woz, S et al

BMJ Open. 18 April; 2(2) e000428 Print 2012

This study evaluated the association between gender and hospital utilisation within 30 days of discharge.

Available in *fulltext* here.

Designing and implementing a COPD discharge care bundle.

Hopkinson NS et al

Thorax. January; 67(1) p. 90-2

The study developed a care bundle, comprising a short list of evidence-based practices to be implemented prior to discharge for all patients admitted with this condition, based on a review of national guidelines and other relevant literature, expert opinion and patient consultation.

Available in *fulltext* at Highwire Press

Further Information

Multiple sources – websites, journals and healthcare databases – have been searched for evidence published in the last four weeks are identified and highlighted here. For a detailed list of sources that have been scanned, please contact Preeti via Preeti.Puligari@heartofengland.nhs.uk or call ext 47836 (Good Hope Hospital).

To request articles where there is no full text link, please complete an online article request form available on HEFT Library website www.heftlibrary.nhs.uk under 'Electronic Forms' menu. Please note that there is now a charge of £1 for such requests.

For more information on how to register for Athens, access the Athens Registration leaflet via HEFT Library website www.heftlibrary.nhs.uk under the 'Publications' menu.

Please login with your Athens ID on www.evidence.nhs.uk 'before' clicking on any of the journal full text links in this bulletin for seamless access.

Original Editor - Your name will be added here if you created the original content for this page. Top Contributors - Lucinda hampton and Rachael Lowe. Discharge planning is an important element in preventing adverse events post discharge. Nearly 20 percent of patients experience an adverse event within 30 days of discharge. Research has shown that 75% of these could have been prevented or ameliorated. Common post-discharge complications include adverse drug events, hospital-acquired infections, and Start studying Discharge planning, Discharge planning. Learn vocabulary, terms and more with flashcards, games and other study tools.Â data collected by PTA but required from PTA. role of PTA in discharge planning. comm w PT: independence of pt and safety in functional activities, HEP, and equipment, psychosocial limiting factors (family), need for support of others and nature of support vs available support, environment after discharge (home), equipment needs (ADs), known financial considerations (insurance, personal), recommendations for community resources or referrals. in-patient discharge committee. pt, family/caregiver, dr, nurse, PT, OT, SW. out patient discharge committee.