Welcome to the second 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 weeks. Full text articles can be accessed via your HEFT Athens ID.

**Admission Prevention**

June 17th, 2011

**6 ways to prevent hospital readmissions**

June 17th, 2011

Citation: Case Management Advisor, 01 April 2011, vol./is. 22/4(40-40), 10535500

Full Text: Available in *fulltext* at [EBSCO Host](http://www.ebscohost.com)

**On-site nurses reduce readmissions, overall LOS.**

June 17th, 2011

Citation: Case Management Advisor, 01 April 2011, vol./is. 22/4(40-41), 10535500

Full Text: Available in *fulltext* at [EBSCO Host](http://www.ebscohost.com)

**Unravel the reasons for admissions**

June 17th, 2011

Exercise to identify the causes of readmission to hospital in order to implement effective interventions in West Suffolk Hospitals. Use of a database to record details of patients readmitted, together with clinicians’ comments and data from Dr Foster is described. Citation: Health Service J, April 2011, vol./is. 121/6253(24-5), 0952-2271 (2011 21 Apr) Author(s): Wilson, N

**Bed Management and Capacity Planning**

June 17th, 2011

Nothing to report

**Discharge coordination**

June 17th, 2011

**Collaboration of hospital case managers and home care liaisons when transitioning patients.**

June 17th, 2011

This article focuses on the collaborative relationship between the hospital case manager and on-site liaison whose primary role centers around care coordination and patient teaching. This article discusses how collegiality, collaboration, and role clarification between hospital case managers and on-site home care liaisons can improve coordination of care and services for patients and their families in the transition from hospital to home care. Citation: Professional Case Management, 01 May 2011, vol./is. 16/3(128-138), 19328087 Author(s): Kelly, Margaret M., Penney, Erika D.
The challenge of managing change: what can we do differently to ensure personalisation?

Critique of traditional change management approaches in relation to the introduction of the personalisation agenda to health and social care. The example of hospital discharge is used to illustrate the need for an alternative model to encourage cultural transformation and to create communities of practice to improve collaborative working between agencies. Citation: J Integrated Care, April 2011, vol./is. 19/2(22-9), 1476-9018 (2011 Apr) Author(s): Cornes, M Full Text: Available in fulltext at EBSCO Host

Discharge process

2011 Benchmarks in Healthcare Case Management: Responsibilities, Results

The article offers information from 201 healthcare organizations on the responsibilities of case managers and case management-driven results in healthcare utilization, compliance, and costs. Moreover, the benchmarks present case management activity in health coaching and discharge planning. Citation: Biomedical Market Newsletter, 17 May 2011, vol./is. /(439-440), 10644180

Medicines management

Advice on safety procedures which need to be followed when discharging patients with their prescribed medicines. The use of a self administration of medicines programme, and patient specific directions (PGDs) are discussed. Citation: Nursing Standard, April 2011, vol./is. 25/33(28), 0029-6570 (2011 20 Apr) Author(s): Griffiths, M Full Text: Available in fulltext at EBSCO Host Available in fulltext at ProQuest (Legacy Platform)

Feasibility of same-day discharge after laparoscopic surgery in gynecologic oncology

The purpose of this study is to evaluate whether same-day discharge after laparoscopic gynecologic oncology surgery is feasible and determines factors associated with admission. Conclusion: Same-day discharge for laparoscopic gynecologic oncology surgery is feasible, with low morbidity and few readmissions within three weeks of surgery. Successful same-day discharge can increase by refining patient selection and operating room scheduling. Citation: Gynecologic Oncology, May 2011, vol./is. 121/2(339-343), 0090-8258;1095-6859 (01 May 2011) Author(s): Gien L.T., Kupets R., Covens A.

Education and Practice

Nothing to report

Estimating dates for discharge

Nothing to report

Multidisciplinary team discharges

Nothing to report
A literature review of interprofessional working and intermediate care in the UK.

June 17th, 2011

Systematic research review of intermediate care provision, focusing on interprofessional care in this setting and interventions used to develop interprofessional working. The methodologies and topics of studies published in 2000-2006 were investigated, including intermediate care policies and definitions in the UK's 4 countries and the promotion and perceived importance of interprofessional working, particularly in elderly care. Citation: J Clinical Nursing, March 2011, vol./is. 20/5-6(775-83), 0962-1067 (2011 Mar) Author(s): Rout, A, Ashby, S, Maslin-Prothero, S

A service model for delivering care closer to home.

June 17th, 2011

A service model in Worcestershire delivering individualised care to adult patients with complex care needs during acute health crises. The multi-agency collaborative service model, which was introduced to prevent unnecessary hospital admissions and facilitate early discharge from hospital, and the role of the Complex Care Team are described. The results of an evaluation of the service are discussed. Citation: Primary Health Care Research & Development, April 2011, vol./is. 12/2(95-111), 1463-4236 (2011 Apr) Author(s): Dodd, J, Taylor, C, Bunyan, P

Organizing home ventilation

June 17th, 2011

The number of children and young people receiving long term ventilation continues to rise, with increasing survival from intensive care, improvements in equipment and changing attitudes towards providing respiratory support. There are a number of barriers to discharge for this group of children, including professional attitudes, problems with commissioning and funding, and establishment of care packages, in addition to complex social issues and difficulties with housing. Good discharge planning starts at the outset of establishing a child on long term ventilation, and aims to overcome these barriers, facilitating discharge in a safe and timely manner. A full assessment of a child and family's needs, having a discharge coordinator and working in partnership with the family and the agencies involved, are all key to the success of this process. Citation: Paediatrics and Child Health, May 2011, vol./is. 21/5(224-229), 1751-7222 (May 2011) Author(s): Smith H., Hilliard T.

Nurse-led discharge

June 17th, 2011

Nothing to report

Patient centred discharges

June 17th, 2011

Information needs of Chinese surgical patients on discharge: a comparison of patients' and nurses' perceptions.

June 17th, 2011

Qualitative research in Hong Kong exploring Chinese patients’ discharge information needs after abdominal surgery. Nurse and patient perceptions of patient discharge information needs were compared, including those relating to physical health, wound care, pain and prevention of complications. Patients’ unmet information needs in respect of their psychological, social and cultural concerns are highlighted. Citation: J Advanced Nursing, May 2011, vol./is. 67/5(1041-52), 0309-2402 (2011 May) Author(s): Yiu, H, Chien, W, Lui, M Full Text: Available in fulltext at Ovid

Ensure patients' needs are met after discharge

June 17th, 2011

Understand patients' benefits, and create a discharge plan based on co-pays they can afford. Consider medication assistance or asking for cheaper alternatives if their prescriptions aren't covered. Look for alternatives to home health if
Simple discharges and Complex discharges
June 17th, 2011

Hospital discharge risk score system for the assessment of clinical outcomes in patients with acute myocardial infarction (Korea Acute Myocardial Infarction Registry KAMIR score)
June 17th, 2011

The aim of this study was to develop a novel and simple assessment tool for better hospital discharge risk stratification. In conclusion, the KAMIR score for patients with acute myocardial infarction is a simpler and better risk scoring system than the GRACE hospital discharge risk model in prediction of 1-year mortality.

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.Puligari@heartofengland.nhs.uk

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