Appendix 1: Evidence Search Service
Results of your search request

Discharge and transitions of care

Name: Emma Cox
Organisation: AHSN

ID of request: 9089
Date of request: 22nd September, 2016
Date of completion: 4th October, 2016

If you would like to request any articles or any further help, please contact: Alison McLaren (Owen) at alisonmclaren1@nhs.net


Date range used (5 years, 10 years): 2011-
Limits used (gender, article/study type, etc.): English language
Search terms and notes (full search strategy for database searches below):
Discharge -- planning -- transition* -- transfer -- care -- community -- GP -- acute -- care pathway -- delay* -- length of stay -- admission* -- readmission* -- social care -- public health -- local government -- housing -- voluntary sector -- whole systems -- system approach -- system interaction

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For more information about the resources please go to:
http://www.surreyandsussexlibraryservices.nhs.uk
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Search History
National and International Guidance

*International Journal of Stroke*

**Canadian Stroke Best Practice Recommendations: Managing transitions of care following Stroke, Guidelines Update 2016** (2016)
Cameron JI et al...
[Available online at this link](#)

Every year, approximately 62,000 people with stroke and transient ischemic attack are treated in Canadian hospitals. For patients, families and caregivers, this can be a difficult time of adjustment. The 2016 update of the Canadian Managing Transitions of Care following Stroke guideline is a comprehensive summary of current evidence-based and consensus-based recommendations appropriate for use by clinicians who provide care to patients following stroke across a broad range of settings. The focus of these recommendations is on support, education and skills training for patients, families and caregivers; effective discharge planning; interprofessional communication; adaptation in resuming activities of daily living; and transition to long-term care for patients who are unable to return to or remain at home. Unlike other modules contained in the Canadian Stroke Best Practice Recommendations (such as acute inpatient care), many of these recommendations are based on consensus opinion, or evidence level C, highlighting the absence of conventional evidence (i.e. randomized controlled trials) in this area of stroke care. The quality of care transitions between stages and settings may have a direct impact on patient and family outcomes such as coping, readmissions and functional recovery. While many qualitative and non-controlled studies were reviewed, this gap in evidence combined with the fact that mortality from stroke is decreasing and more people are living with the effects of stroke, underscores the need to channel a portion of available research funds to recovery and adaptation following the acute phase of stroke.

**NICE Guidance**

**Transition between inpatient hospital settings and community or care home settings for adults with social care needs** (2015)
[Available online at this link](#)

The guideline includes recommendations on: person-centred care and communication and information sharing before admission to hospital including developing a care plan and explaining what type of care the person might receive admission to hospital including the establishment of a hospital-based multi-disciplinary team during hospital stay including recording medicines and assessments and regularly reviewing and updating the person’s progress towards discharge from hospital including the role of the discharge coordinator supporting infrastructure training and development for people involved in the hospital discharge process.

**Systematic Reviews**

**Age and Ageing**

**Discharging older patients from the emergency department effectively: a systematic review and meta-analysis.** (2015)
Lowthian JA
[Available online at this link](#)
BACKGROUND: a decline in health state and re-attendance are common in people aged ≥65 years following emergency department (ED) discharge. Diverse care models have been implemented to support safe community transition. This review examined ED community transition strategies (ED-CTS) and evaluated their effectiveness. METHODS: a systematic review and meta-analysis using multiple databases up to December 2013 was conducted. We assessed eligibility, methodological quality; risk of bias and extracted published data and then conducted random effects meta-analyses. Outcomes were unplanned ED representation or hospitalisation, functional decline, nursing-care home admission and mortality. RESULTS: five experimental and four observational studies were identified for qualitative synthesis. ED-CTS included geriatric assessment with referral for post-discharge community-based assistance, with differences apparent in components and delivery methods. Four studies were included in meta-analysis. Compared with usual care, the evidence indicates no appreciable benefit for ED-CTS for unplanned ED re-attendance up to 30 days (odds ratio (OR) 1.32, 95% confidence interval (CI) 0.99-1.76; n = 1,389), unplanned hospital admission up to 30 days (OR 0.90, 95% CI 0.70-1.16; n = 1,389) or mortality up to 18 months (OR 1.04, 95% CI 0.83-1.29; n = 1,794). Variability between studies precluded analysis of the impact of ED-CTS on functional decline and nursing-care home admission. CONCLUSIONS: there is limited high-quality data to guide confident recommendations about optimal ED community transition strategies, highlighting a need to encourage better integration of researchers and clinicians in the design and evaluation process, and increased reporting, including appropriate robust evaluation of efficacy and effectiveness of these innovative models of care.

Cochrane Database of Systematic Reviews

Discharge planning from hospital (2016)
Goncalves-Bradley DC
Available online at this link

Discharge planning is a routine feature of health systems in many countries. The aim of discharge planning is to reduce hospital length of stay and unplanned readmission to hospital, and to improve the co-ordination of services following discharge from hospital. This is the third update of the original review. Objectives: To assess the effectiveness of planning the discharge of individual patients moving from hospital. Search methods: We updated the review using the Cochrane Central Register of Controlled Trials (CENTRAL) (2015, Issue 9), MEDLINE, EMBASE, CINAHL, the Social Science Citation Index (last searched in October 2015), and the US National Institutes of Health trial register (ClinicalTrials.gov). Selection criteria Randomised controlled trials (RCTs) that compared an individualised discharge plan with routine discharge care that was not tailored to individual participants. Participants were hospital inpatients. Data collection and analysis: Two authors independently undertook data analysis and quality assessment using a pre-designed data extraction sheet. We grouped studies according to patient groups (elderly medical patients, patients recovering from surgery, and those with a mix of conditions) and by outcome. We performed our statistical analysis according to the intention-to-treat principle, calculating risk ratios (RRs) for dichotomous outcomes and mean differences (MDs) for continuous data using fixed-effect meta-analysis. When combining outcome data was not possible because of differences in the reporting of outcomes, we summarised the reported data in the text. Main results: We included 30 trials (11,964 participants), including six identified in this update. Twenty-one trials recruited older patients with a medical condition, five recruited participants with a mix of medical and surgical conditions, one recruited participants from a psychiatric hospital, one from both a psychiatric hospital and from a general hospital, and two trials recruited participants admitted to hospital following a fall. Hospital length of stay and readmissions to hospital were reduced for participants admitted to hospital with a medical diagnosis and who were allocated to discharge planning (length of stay MD – 0.73, 95% CI – 1.33 to –
0.12, 12 trials, moderate certainty evidence; readmission rates RR 0.87, 95% CI 0.79 to 0.97, 15 trials, moderate certainty evidence). It is uncertain whether discharge planning reduces readmission rates for patients admitted to hospital following a fall (RR 1.36, 95% CI 0.46 to 4.01, 2 trials, very low certainty evidence). For elderly patients with a medical condition, there was little or no difference between groups for mortality (RR 0.99, 95% CI 0.79 to 1.24, moderate certainty). There was also little evidence regarding mortality for participants recovering from surgery or who had a mix of medical and surgical conditions. Discharge planning may lead to increased satisfaction for patients and healthcare professionals (low certainty evidence, six trials). It is uncertain whether there is any difference in the cost of care when discharge planning is implemented with patients who have a medical condition (very low certainty evidence, five trials). Authors' conclusions: A discharge plan tailored to the individual patient probably brings about a small reduction in hospital length of stay and reduces the risk of readmission to hospital at three months follow-up for older people with a medical condition. Discharge planning may lead to increased satisfaction with healthcare for patients and professionals. There is little evidence that discharge planning reduces costs to the health service.

**Journal of Managed Care and Specialty Pharmacy**

**Identifying the Optimal Role for Pharmacists in Care Transitions: A Systematic Review** (2015)

Ensing HT et al...

Available online at this link

BACKGROUND: A transition from one health care setting to another increases the risk of medication errors. Several strategies have been applied to improve care transitions and reduce adverse clinical outcomes. Pharmacist intervention during and after hospitalization has been frequently studied and show a variable effect on these outcomes. OBJECTIVE: To identify the components of pharmacist intervention that improve clinical outcomes during care transitions. METHODS: MEDLINE, EMBASE, International Pharmaceutical Abstracts, and Web of Science databases were searched for randomized controlled trials (RCTs) that studied pharmacist intervention with regard to hospitalization. Two reviewers independently screened all references published from inception to November 2014, extracted data, and assessed risk of bias. RESULTS: A total of 30 studies met the inclusion criteria. A model was created to categorize and cluster components of pharmacist intervention. The average number of components deployed, stages of hospitalization covered, and intervention targets were equally distributed between effective and ineffective studies. A best evidence synthesis of 15 studies revealed strong evidence for a clinical medication review in multifaceted programs (5 effective vs. 0 ineffective studies). Conflicting evidence was found for an isolated post discharge intervention, admission medication reconciliation, combining post discharge interventions with in-hospital interventions, and covering of multiple stages. Closely collaborating with other health care providers enhanced the effectiveness. CONCLUSIONS: Although there is a need for well-designed and well-reported RCTs, the study heterogeneity enabled a best evidence synthesis to elucidate effective components of pharmacist intervention. In isolated post discharge intervention programs, evidence tends towards collaborating with nurses and tailoring to individual patient needs. In multifaceted intervention programs, performing medication reconciliation alone is insufficient in reducing post discharge clinical outcomes and should be combined with active patient counseling and a clinical medication review. Furthermore, close collaboration between pharmacists and physicians is beneficial. Finally, it is important to secure continuity of care by integrating pharmacists in these multifaceted programs across health care settings. Ultimately, pharmacists need to know patient clinical background and previous hospital experience.
Work

Interventions to improve patient safety in transitional care--a review of the evidence (2012)
Laugaland K. et al...
Available online at this link

When a patient’s transition from the hospital to home is less than optimal, the repercussions can be far-reaching - hospital readmission, adverse medical events, and even mortality. Elderly, especially frail older patients with complex health care problems appear to be a group particularly at risk for adverse events in general, and during transitions across health providers in particular. We undertook a systematic review to identify interventions designed to improve patient safety during transitional care of the elderly, with a particular focus on discharge interventions. We searched the literature for qualitative and quantitative studies on the subject published over the past ten years. The review revealed a set of potential intervention types aimed at the improvement of communication that contribute to safe transitional care. Intervention types included profession-oriented interventions (e.g. education and training), organisational/culture interventions (e.g. transfer nurse, discharge protocol, discharge planning, medication reconciliation, standardized discharge letter, electronic tools), or patient and next of kin oriented interventions (e.g. patient awareness and empowerment, discharge support). Results strongly indicate that elderly discharged from hospital to the community will benefit from targeted interventions aimed to improve transfer across healthcare settings. Future interventions should take into account multi-component and multi-disciplinary interventions incorporating several single interventions combined.

Institutional Publications

NHS England

Discharge to assess (2016)
Available online at this link

These local examples of discharge to assess showcase how improvements can be made as part of ongoing changes in ways of working and in response to issues with performance: South Warwickshire, Sheffield, Medway.

NHS Providers

Right place, right time better transfers of care: a call to action ‘Doing the obvious thing is the radical thing’ (2015)
Available online at this link

The Right place, right time commission was launched by NHS Providers to capture good practice with regard to transfers of care in all settings – across acute, community, mental health and ambulance services. The Right place, right time commission conducted a literature review of existing evidence and materials exploring the issues surrounding transfers of care: NHS Providers’ Right place, right time commission into transfers of care: literature review, 10 November 2015. This can be found in the “health horizons” section of the NHS Providers website. The Commission received over 50 written submissions, conducted site visits and interviewed experts in health and social care, from national statutory bodies, to improvement experts and frontline managers and clinicians. The Commission was led by Professor Paul Burstow, former care minister and chair of Tavistock and Portman NHS Foundation Trust.
Queen’s Nursing Institute

Discharge planning: Best practice in transitions of care (2016)
Available online at this link

This report provides a summary of the work undertaken by The Queen’s Nursing Institute (QNI) on behalf of the Department of Health (DH) to identify the barriers and challenges preventing effective discharge from hospital to home. The report seeks to provide key recommendations that contribute to an improved discharge experience for patients, carers and their families, and identifies examples of effective discharge planning. The report includes the background to the report, findings from the literature review, explanation of the methods used to collect the data, a summary of the main findings, examples of best practice and the conclusion and recommendations following the analysis of the data.

The King’s Fund

Making our health and care systems fit for an ageing population (2014)
Oliver D. et al...
Available online at this link

Improving services for older people requires us to consider each component of care, since many older people use multiple services, and the quality, capacity and responsiveness of any one component will affect others. The key components we have set out in this paper are:

- Healthy, active ageing and supporting independence
- Living well with simple or stable long-term conditions
- Living well with complex co-morbidities, dementia and frailty
- Rapid support close to home in times of crisis
- Good acute hospital care when needed
- Good discharge planning and post-discharge support
- Good rehabilitation and re-ablement after acute illness or injury
- High-quality nursing and residential care for those who need it
- Choice, control and support towards the end of life
- Integration to provide person-centred co-ordinated care

Within each component, we present evidence and guidance for how to provide high-quality care, with examples of local innovations. Key issues include the use of comprehensive geriatric assessment at the right time, and the effective provision of co-ordinated primary, community and social care services close to home.

Original Research

1. A systematic review of the effectiveness of discharge care bundles for patients with COPD
Ospina MB et al... Thorax 2016; doi:10.1136/thoraxjnl-2016-208820
Background: A COPD discharge bundle is a set of evidence-based practices aimed at improving patient outcomes after discharge from acute care settings following an exacerbation. We conducted a systematic review on the effectiveness of COPD discharge bundles and summarised their individual care elements. Methods: Biomedical electronic databases and clinical trial registries were searched from database inception through April
2016 to identify experimental studies evaluating care bundles offered to patients with COPD at discharge. Random-effects meta-analyses of clinical trials data were conducted for hospital readmissions, mortality, and quality of life (QoL). Results: The review included 14 studies (5 clinical trials, 7 uncontrolled trials, and 2 interrupted time series). A total of 26 distinct elements of care were included in the bundles of individual studies. Evidence from four clinical trials with moderate-to-high risk of bias showed that COPD discharge bundles reduced hospital readmissions (pooled risk ratio (RR): 0.80; 95% CI 0.65 to 0.99). There was insufficient evidence that care bundles influence long-term mortality (RR: 0.74; 95% CI 0.43 to 1.28; four trials) or QoL (mean difference in St. George's Respiratory Questionnaire: 1.84; 95% CI −2.13 to 5.8). Conclusions: Discharge bundles for patients with COPD led to fewer readmissions but did not significantly improve mortality or QoL. Future studies should employ higher quality research methods, fully report care bundle elements, implementation strategies and intervention fidelity to better evaluate the effectiveness of packaging evidence-based interventions together to improve outcomes of patients with COPD discharged from acute care settings.

Available online at this link

2. Comprehensive Geriatric Assessment and Transitional Care in Acutely Hospitalized Patients: The Transitional Care Bridge Randomized Clinical Trial.
Abstract IMPORTANCE: Older adults acutely hospitalized are at risk of disability. Trials on comprehensive geriatric assessment (CGA) and transitional care present inconsistent results. OBJECTIVE: To test whether an intervention of systematic CGA, followed by the transitional care bridge program, improved activities of daily living (ADLs) compared with systematic CGA alone. DESIGN, SETTING, AND PARTICIPANTS: This study was a double-blind, multicentre, randomized clinical trial conducted at 3 hospitals with affiliated home care organizations in the Netherlands between September 1, 2010, and March 1, 2014. In total, 1070 consecutive patients were eligible, 674 (63.0%) of whom enrolled. They were 65 years or older, acutely hospitalized to a medical ward for at least 48 hours with an Identification of Seniors at Risk-Hospitalized Patients score of 2 or higher, and randomized using permuted blocks stratified by study site and Mini-Mental State Examination score (<24 vs ≥24). The dates of the analysis were June 1, 2014, to November 15, 2014. INTERVENTIONS: The transitional care bridge program intervention was started during hospitalization by a visit from a community care registered nurse (CCRN) and continued after discharge with home visits at 2 days and at 2, 6, 12, and 24 weeks. The CCRNs applied the CGA care and treatment plan. MAIN OUTCOMES AND MEASURES: The main outcome was the Katz Index of ADL at 6 months compared with 2 weeks before admission. Secondary outcomes were mortality, cognitive functioning, time to hospital readmission, and the time to discharge from a nursing home. RESULTS: The study cohort comprised 674 participants. Their mean age was 80 years, 42.1% (n = 284) were male, and 39.2% (n = 264) were cognitively impaired at admission. Intent-to-treat analysis found no differences in the mean Katz Index of ADL at 6 months between the intervention arm (mean, 2.0; 95% CI, 1.8-2.2) and the CGA-only arm (mean, 1.9; 95% CI, 1.7-2.2). For secondary outcomes, there were 85 deaths (25.2%) in the intervention arm and 104 deaths (30.9%) in the CGA-only arm, resulting in a lower risk on the time to death within 6 months after hospital admission (hazard ratio, 0.75; 95% CI, 0.56-0.99; P = .045; number needed to treat to prevent 1 death, 16). No other secondary outcome was significant. CONCLUSIONS AND RELEVANCE: A systematic CGA, followed by the transitional care bridge program, showed no effect on ADL functioning in acutely hospitalized older patients.
Available online at this link
3. **Identifying distinct healthcare pathways during episodes of chronic obstructive pulmonary disease exacerbations**
   Kuwornu J.P. Medicine (United States) 2016; 95(9):-.  
   Healthcare pathways are important to measure because they are expected to affect outcomes. However, they are challenging to define because patients exhibit heterogeneity in their use of healthcare services. The objective of this study was to identify and describe healthcare pathways during episodes of chronic obstructive pulmonary disease (COPD) exacerbations. Linked administrative databases from Saskatchewan, Canada were used to identify a cohort of newly diagnosed COPD patients and their episodes of healthcare use for disease exacerbations. Latent class analysis (LCA) was used to classify the cohort into homogeneous pathways using indicators of respiratory-related hospitalizations, emergency department (ED) visits, general and specialist physician visits, and outpatient prescription drug dispensations. Multinomial logistic regression models tested patients' demographic and disease characteristics associated with pathway group membership. The most frequent healthcare contact sequences in each pathway were described. Tests of mean costs across groups were conducted using a model-based approach with \( x^2 \) statistics. LCA identified 3 distinct pathways for patients with hospital-(n=963) and ED-initiated (n=364) episodes. For the former, pathway group 1 members followed complex pathways in which multiple healthcare services were repeatedly used and incurred substantially higher costs than patients in the other pathway groups. For patients with an ED-initiated episode, pathway group 1 members also had higher costs than other groups. Pathway groups differed with respect to patient demographic and disease characteristics. A minority of patients were discharged from ED or hospital, but did not have any follow-up care during the remainder of their episode. Patients who followed complex pathways could benefit from care management interventions to streamline their journeys through the healthcare system. The minority of patients whose pathways were not consistent with recommended follow-up care should be further investigated to fully align COPD treatment in the province with recommended care practices.  
   Available from Ovid in this link

4. **Impact of a transition nurse program on the prevention of thirty-day hospital readmissions of elderly patients discharged from short-stay units: study protocol of the PROUST stepped-wedge cluster randomised trial**
   Occelli P. BMC Geriatrics 2016; 16(57):eprint.  
   In France, for patients aged 75 or older, it has been estimated that the hospital readmission rate within 30 days is 14 %, a quarter being avoidable. Some evidence suggests that interventions “bridging” the transition from hospital to home and involving a designated professional (usually nurses) are the most effective in reducing the risk of readmission, but the level of evidence of current studies is low. Our study aims to assess the impact of a care transition program from hospital to home for elderly admitted to short-stay units. Methods: This is a multicentre, stepped-wedge cluster randomised trial. The program will be implemented at three times of the transition: 1) during the patient’s stay in hospital: development of a discharge plan, creation of a transitional care file, and notification of the primary care physician about inpatient care and hospital discharge by the transition nurse; 2) on the day of discharge: meeting between the transition nurse and the patient to review the follow-up recommendations; and 3) for 4 weeks after discharge: follow-up by the transition nurse. The primary outcome is the 30-day unscheduled hospital readmission or emergency visit rate after the index hospital discharge. The patients enrolled will be aged 75 or older, hospitalized in an acute care geriatric unit and at risk of hospital readmission or an emergency visit after returning home. In all, 630 patients will be included over a 14-month period. Data analysis will be blinded to allocation, but due to the nature of the intervention,
physicians and patients will not be blinded. Discussion: Our study makes it possible to evaluate the specific effect of a bridging intervention involving a designated professional intervening before, during, and after hospital discharge. The strengths of the study design are methodological and practical. It permits the estimation of the intervention effect using between- and within-cluster comparisons; the study of the fluctuations in unscheduled hospital readmission or emergency visit rates; the participation of all clusters in the intervention condition; the implementation of the intervention in each cluster successively.
Available online at this link

5. **Personalised discharge care planning for post myocardial infarction patients through the use of the Personalised Patient Education Protocol - implementing theory into practice**
AIMS AND OBJECTIVES: This study aims to evaluate the service impact of the integration of an evidence-based instrument - the Personalised Patient Education Protocol - into an existing post myocardial infarction care pathway. BACKGROUND: Recent research indicates that while better patient health outcomes can be achieved when care planning is personalised, delivery staff feel less satisfied and less confident in its provision. To achieve a shift to personalised care, innovations are needed to enable an effective transition for staff.
DESIGN: A service evaluation using a patient survey and nurse interviews. METHOD: A longitudinal patient survey measured changes in patient illness beliefs, cardiac diet and exercise self-efficacy, anxiety, depression and quality of life study of a patient cohort of 74. Paired t-tests analysed the effects before and after the implementation of the Personalised Patient Education Protocol. Cardiac rehabilitation nurses who implemented the Personalised Patient Education Protocol were interviewed and a patient survey identified perceptions of the usefulness of the service innovation. RESULTS: Analysis of change from baseline to three months results showed statistically significant changes in Illness Belief component 'Understanding' and the Dartmouth Quality of Life 'General Health'. The integration of the Personalised Patient Education Protocol into the existing discharge process identified service improvements for cardiac nurse training and care pathway delivery, while patients identified the level and frequency of their use of the protocol following discharge. CONCLUSION: The introduction of the Personalised Patient Education Protocol succeeded in increasing patient engagement, facilitated a more patient-centred service by enabling practitioners to systematically provide personalised patient education, and gave patients a post discharge structure to better follow-up their illness concerns with health professionals in the community. RELEVANCE TO CLINICAL PRACTICE: Integration of the Personalised Patient Education Protocol into an existing post myocardial infarction care pathway enabled nurses to systematically respond to individual patients’ illness beliefs and expectations.
Available online at this link

6. **Utilisation of health and social care services by the over 65s Population: a system dynamics study**
Meskarian R. et al... 2016; eprint.
This paper focuses on a system dynamics simulation approach modelling the flow of frail elderly patients in health and social care systems in the South of England, UK. A system dynamics model of this pathway is designed that enables testing and informs redesign of the pathway to enhance integrated working between health and social care agencies leading to reduced number of acute hospital admissions and fewer delayed transfer of care. Given the complexity of the model, a number of different scenarios are considered.
Available online at this link
7. **Who know best? Older people’s contribution to understanding and preventing avoidable hospital admissions**  
Glasby J. et al... 2016; epub.  
Although focused primarily on inappropriate admission, the report discusses problems with the discharge process, lack of social care / family / community support resulting in readmissions  
[Available online at this link](#).

8. **Improving critical care discharge summaries: a collaborative quality improvement project using PDSA**  
Around 110,000 people spend time in critical care units in England and Wales each year. The transition of care from the intensive care unit to the general ward exposes patients to potential harms from changes in healthcare providers and environment. Nurses working on general wards report anxiety and uncertainty when receiving patients from critical care. An innovative form of enhanced capability critical care outreach called ‘iMobile’ is being provided at King’s College Hospital (KCH). Part of the remit of iMobile is to review patients who have been transferred from critical care to general wards. The iMobile team wished to improve the quality of critical care discharge summaries. A collaborative evidence-based quality improvement project was therefore undertaken by the iMobile team at KCH in conjunction with researchers from King’s Improvement Science (KIS). Plan, Do, Study, Act (PDSA) methodology was used. Three PDSA cycles were undertaken. Methods adopted comprised: a scoping literature review to identify relevant guidelines and research evidence to inform all aspects of the quality improvement project; a process mapping exercise; informal focus groups / interviews with staff; patient story-telling work with people who had experienced critical care and subsequent discharge to a general ward; and regular audits of the quality of both medical and nursing critical care discharge summaries. The following behaviour change interventions were adopted, taking into account evidence of effectiveness from published systematic reviews and considering the local context: regular audit and feedback of the quality of discharge summaries, feedback of patient experience, and championing and education delivered by local opinion leaders. The audit results were mixed across the trajectory of the project, demonstrating the difficulty of sustaining positive change. This was particularly important as critical care bed occupancy and throughput fluctuates which then impacts on work-load, with new cohorts of staff regularly passing through critical care. In addition to presenting the results of this quality improvement project, we also reflect on the lessons learned and make suggestions for future projects  
[Available online at this link](#).

9. **Using the Technology Acceptance Model to explore community dwelling older adults’ perceptions of a 3D interior design application to facilitate pre-discharge home adaptations**  
Money AG et al... BMC Medical Informatics and Decision Making 2015; 15(73):eprint.  
In the UK occupational therapy pre-discharge home visits are routinely carried out as a means of facilitating safe transfer from the hospital to home. Whilst they are an integral part of practice, there is little evidence to demonstrate they have a positive outcome on the discharge process. Current issues for patients are around the speed of home visits and the lack of shared decision making in the process, resulting in less than 50 % of the specialist equipment installed actually being used by patients on follow-up. To improve practice there is an urgent need to examine other ways of conducting home visits to facilitate safe discharge. We believe that Computerised 3D Interior Design Applications (CIDAs) could be a means to support more efficient, effective and collaborative practice. A previous study
explored practitioners perceptions of using CIDs; however it is important to ascertain older adult’s views about the usability of technology and to compare findings. This study explores the perceptions of community dwelling older adults with regards to adopting and using CIDs as an assistive tool for the home adaptations process. Methods: Ten community dwelling older adults participated in individual interactive task-focused usability sessions with a customised CIDA, utilising the think-aloud protocol and individual semi-structured interviews. Template analysis was used to carry out both deductive and inductive analysis of the think-aloud and interview data. Initially, a deductive stance was adopted, using the three pre-determined high-level themes of the technology acceptance model (TAM): Perceived Usefulness (PU), Perceived Ease of Use (PEOU), Actual Use (AU). Inductive template analysis was then carried out on the data within these themes, from which a number of sub-themes emerged. Results: Regarding PU, participants believed CIDs served as a useful visual tool and saw clear potential to facilitate shared understanding and partnership in care delivery. For PEOU, participants were able to create 3D home environments however a number of usability issues must still be addressed. The AU theme revealed the most likely usage scenario would be collaborative involving both patient and practitioner, as many participants did not feel confident or see sufficient value in using the application autonomously. Conclusions: This research found that older adults perceived that CIDs were likely to serve as a valuable tool which facilitates and enhances levels of patient/practitioner collaboration and empowerment. Older adults also suggested a redesign of the interface so that less sophisticated dexterity and motor functions are required. However, older adults were not confident, or did not see sufficient value in using the application autonomously. Future research is needed to further customise the CIDA software, in line with the outcomes of this study, and to explore the potential of collaborative application patient/practitioner-based deployment. Available online at this link

10. An ethnographic study of knowledge sharing across the boundaries between care processes, services and organisations: the contributions to ‘safe’ hospital discharge

Waring J. Health Services and Delivery Research 2014; 2(29):--.

Background: Hospital discharge is a vulnerable stage in the patient pathway. Research highlights communication failures and the problems of co-ordination as resulting in delayed, poorly timed and unsafe discharges. The complexity of hospital discharge exemplifies the threats to patient safety found ‘between’ care processes and organisations. In developing this perspective, safe discharge is seen as relying upon enhanced knowledge sharing and collaboration between stakeholders, which can mitigate system complexity and promote safety. Aim: To identify interventions and practices that support knowledge sharing and collaboration in the processes of discharge planning and care transition. Setting: The study was undertaken between 2011 and 2013 in two English health-care systems, each comprising an acute health-care provider, community and primary care providers, local authority social services and social care agencies. The study sites were selected to reflect known variations in local population demographics as well as in the size and composition of the care systems. The study compared the experiences of stroke and hip fracture patients as exemplars of acute care with complex discharge pathways. Design: The study involved in-depth ethnographic research in the two sites. This combined (a) over 180 hours of observations of discharge processes and knowledge-sharing activities in various care settings; (b) focused ‘patient tracking’ to trace and understand discharge activities across the entire patient journey; and (c) qualitative interviews with 169 individuals working in health, social and voluntary care sectors. Findings: The study reinforces the view of hospital discharge as a complex system involving dynamic and multidirectional patterns of knowledge sharing between multiple groups. The study shows that discharge planning and
Care transitions develop through a series of linked ‘situations’ or opportunities for knowledge sharing. It also shows variations in these situations, in terms of the range of actors, forms of knowledge shared, and media and resources used, and the wider culture and organisation of discharge. The study also describes the threats to patient safety associated with hospital discharge, as perceived by participants and stakeholders. These related to falls, medicines, infection, clinical procedures, equipment, timing and scheduling of discharge, and communication. Each of these identified risks are analysed and explained with reference to the observed patterns of knowledge sharing to elaborate how variations in knowledge sharing can hinder or promote safe discharge. Conclusions: The study supports the view of hospital discharge as a complex system involving tightly coupled and interdependent patterns of interaction between multiple health and social care agencies. Knowledge sharing can help to mitigate system complexity through supporting collaboration and co-ordination. The study suggests four areas of change that might enhance knowledge sharing; reduce system complexity and promote safety. First, knowledge brokers in the form of discharge co-ordinators can facilitate knowledge sharing and co-ordination; second, colocation and functional proximity of stakeholders can support knowledge sharing and mutual appreciation and alignment of divergent practices; third, local cultures should prioritise and value collaboration; and finally, organisational resources, procedures and leadership should be aligned to foster knowledge sharing and collaborative working. These learning points provide insight for future interventions to enhance discharge planning and care transition. Future research might consider the implementation of interviews to mediate system complexity through fostering enhanced knowledge sharing across occupational and organisational boundaries. Research might also consider in more detail the underlying complexity of both health and social care systems and how opportunities for knowledge sharing might be engendered to promote patient safety in other areas.

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11. Effectiveness of discharge interventions on readmissions for patients with chronic obstructive pulmonary disease: A systematic review protocol
Review question/objective This review aims to identify discharge interventions that can reduce readmission or prolong the time before the next readmission of patients with chronic obstructive pulmonary disease (COPD) The specific review question is: What is the impact of a structured planned discharge intervention for patients with chronic obstructive pulmonary disease after admission to hospital due to exacerbation in COPD. Background Chronic obstructive pulmonary disease is a preventable and treatable disease that is characterized by airflow limitation. Chronic obstructive pulmonary disease is usually progressive and associated with an enhanced chronic inflammatory response in the airways and the lungs to noxious particles or gases. Exacerbations and comorbidities are known to contribute to the overall severity in individual patients. Chronic obstructive pulmonary disease remains as a major public health problem worldwide. By 2020, it is projected that COPD will rank fifth globally in burden of diseases, according to a study published by the World Bank/World Health Organization. Depending on the stage of COPD, the illness will have a significant impact on the life of patients. Patients have to cope with physical symptoms such as breathlessness, reduced activity level and malnutrition. Patients often report isolation, loss of independence, reduced quality of life and depression. Additionally, COPD often coexists with other diseases that may have a significant impact on the prognosis. During the last 15 to 20 years, the development towards better treatment, rehabilitation, care and medication has taken massive steps forward, and the attitude towards this group of patients has changed: "a nihilistic attitude towards the patient with COPD is no longer justified". Instead, patients with COPD
nowadays meet with well-informed, multidisciplinary and intersectional teams work together with the patient with the goal of helping and educating him/her to self-management, stable physical condition and to increase quality of life, as recommended by global initiative for chronic obstructive lung disease (GOLD).<sup>1</sup> Many of these initiatives are based on the chronic care model (CMM) as defined by Wagner.<sup>4</sup> The six components of this model are: organization of health care, self-management support, decision support, delivery system design, clinical information system, community resources and policies. The essential purpose of the model is to increase the quality of health care without increasing cost. The main issue is the patient-centered approach and then the model recommends systematic care planning, intersectional collaboration, patient empowerment, evidence-based care, and ongoing evaluation of humanistic, clinical and economic outcomes.<sup>4</sup> In spite of these extensive efforts worldwide, patients are often readmitted after hospitalization due to acute exacerbations of COPD (AECOPD). The number of AECOPD incidents has been estimated to be 0.6-3.5 per patient per year.<sup>5</sup> A number of these patients have to be admitted/readmitted to hospital for instance because of the need for invasive or mechanical ventilation. The admission/readmission is necessary, despite the fact that admission caused by acute exacerbation has a negative impact on mortality, and a negative influence on the patients' quality of life and health care costs.<sup>5</sup> The question of whether it is possible to prevent a number of the exacerbations and thereby some of the admissions remains. The focus of this study is on the effect of discharge initiatives as a preventing intervention. Transition from hospital to home is not always easy, especially for elderly and chronically ill patients, and as the average length of hospital stay has decreased during the last decades,<sup>6</sup> many initiatives are taken to meet this challenge. A preliminary literature search showed that there are a number of intervention studies, for example, on case management and action plans,<sup>7,8</sup> that seem to have an impact on reducing readmission for patients with COPD. There was a systematic review concerning discharge interventions for mixed patient groups, which showed that combining discharge planning and discharge support tends to lead to the greatest effect on readmissions.<sup>6</sup> A meta-analysis from Cochrane concluded that "The evidence suggests that a discharge plan tailored to the individual patient probably brings about reductions in length of hospital stay and readmission rates for older people admitted to hospital with a medical condition".<sup>9(p.14)</sup> Aside from the discomfort for the patient, the cost for hospitalization is greater than taking care of the patient at home. It is therefore vital to develop and implement an effective health care initiative that reduces both the negative impact from readmission for the patient with COPD at the individual level, as well as the overall cost for health care system. An initial search on the databases of CINAHL, JBI CONNECT+, DARE, PubMed, Cochrane Library, TRIP and PROSPERO showed that no systematic review on this topic exists or in progress currently. Definitions Acute exacerbation of COPD (AECOPD) defined as an acute and sustained worsening of the patient's condition beyond normal day-to-day variations and requiring medical intervention. It is also a common complication of COPD. Discharge interventions are defined as "in-hospital interventions or interventions after discharge performed (partly) by hospital-based professionals, explicitly targeted to smooth the transition from hospital to home or to prevent or diminish problems after hospital discharge".<sup>6(p.2)</sup> The interventions can be divided into two groups: discharge preparation (pre-discharge) and discharge support/after care (post-discharge).<sup>6</sup> Readmission is defined as hospitalization to the same or a different hospital due to AECOPD within the following year after discharge.
12. **Implementing evidence-based stroke Early Supported Discharge services: a qualitative study of challenges, facilitators and impact**
OBJECTIVES: To explore the perspectives of healthcare professionals and commissioners working with a stroke Early Supported Discharge service in relation to: (1) the factors that facilitate or impede the implementation of the service, and (2) the impact of the service.
DESIGN: Cross-sectional qualitative study using semi-structured interviews. Data were analysed by two researchers using a thematic analysis approach. SETTING: Two Early Supported Discharge services in Nottinghamshire. PARTICIPANTS: Purposive sampling identified 35 key informants including practitioners, managers and commissioners. RESULTS: The identified facilitators to the implementation of evidence-based services were: (1) the adaptability of the intervention to the healthcare context, (2) the role of rehabilitation assistants and (3) cross-service working arrangements. Perceived challenges included: (1) lack of clarity regarding the referral decision making process, (2) delays in securing social care input and (3) lack of appropriate follow-on services in the region. Most respondents perceived the impact of the services to be: (1) reducing in-hospital stay, (2) aiding the seamless transfer of care from hospital to the community and (3) providing intensive stroke specific therapy. Commissioners called for greater evidence of service impact and clarity regarding where it fits into the stroke pathway. CONCLUSIONS: Early Supported Discharge services were perceived as successful in providing home-based, stroke specific rehabilitation. Teams would benefit from capitalising on identified facilitators and developing strategies to address the challenges. The remit and impact of the services should be clear and demonstrable, with teams strengthening links with other health and social care providers. 
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13. **Intern reflections on transitions of care educational experience: Insights gained from participation in post hospital discharge home visit and skilled nursing facility visit**
Miller R.K. Journal of General Internal Medicine 2014; 29:-.
BACKGROUND: Transitions of care, particularly for the elderly and medically complex patient, are a high risk period of time. Through enacted legislation and proposed insurance payment changes, care transitions are under increased scrutiny. Given the importance of recognizing and improving the current care transition system and ACGME competencies and milestones focusing on transitional care, medicine residences are increasing formal education on this topic. Our goal was to provide interactive post-hospitalization transitions of care learning experiences for interns and to determine key intern perspectives and insights gained from the curriculum. METHODS: The 2012-13 UPenn internal medicine intern class participated in both post-hospitalization home visits with a visiting nurse (HVs) and skilled nursing facility (SNF) transitions experience with geriatric faculty member. Interns were asked to write a reflection essay on each experience with the following questions: How has this visit changed your perception of discharge?, How will this experience change the way you care for patients?, Did anything in particular surprise you on the visit? The responses were entered into NVivo 10 for analysis. We used a modified grounded theory approach to the analysis. Codes were generated by the team based on the research question and the content of the data. Coders applied these codes to each line of text. A subset of narratives were double-coded for inter-rater reliability. Coding discrepancies were resolved by consensus. RESULTS: Of the 46 interns, 36 and 34 completed the reflection essays on their HV and SNF experiences, respectively. Two overarching themes arose: the need to create more comprehensive yet articulate discharge instructions and a better appreciation of the patient’s post-hospital care personnel (namely nurses and pharmacists). Additional themes included awareness of need to improve the post-hospital medication reconciliation and importance of assessing a patient’s living situation and social support system before
discharge. Interestingly, very few residents placed blame on the patients for any perceived breakdowns in care; most identified barriers to care were a lack of social support, difficult living circumstances, or messy and inadequate discharge instructions including misperceptions or gaps surrounding follow-up care and medication management.

CONCLUSIONS: The intern transitions of care curriculum, out of the hospital, and into the homes and skilled nursing facilities of discharged patients, sought to teach key elements of safer discharge in an interactive format. The reflection essays revealed that the interns gained insights into the importance of effective communication (accurate and informative medication reconciliation, comprehensive discharge summaries/instructions), the roles of interprofessionals in facilitating safe discharges, and the need for in-hospital teams to elicit potential health care challenges. Future goals will be using these to inform and improve specific parts of the discharge process and to determine whether there is a long-term impact in intern actions in discharge planning and patient outcomes.

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14. The impact of a new emergency admission avoidance system for older people on length of stay and same-day discharges.
BACKGROUND: unplanned hospital admissions of older patients continue to attract the attention of UK policymakers, advisors and media. Reducing the number and length of stay (LOS) of these admissions has the potential to save NHS substantial costs while reducing iatrogenic risks. Some NHS trusts have introduced geriatric admission-avoidance systems, but evidence of their effectiveness is lacking. In September 2010, The Royal Free Hospital and Haverstock Healthcare Ltd, a GP provider organisation, introduced an admission-avoidance system for patients aged 70 or over: the Triage and Rapid Elderly Assessment Team (TREAT). OBJECTIVE: to measure the effect of TREAT on LOS and the rate of same-day discharges (an inverse measure of admission rate). SETTING: TREAT was based in the Accident and Emergency (A&E) department of the Royal Free Hospital, London. DESIGN: a pre- and post-retrospective cohort study comparing the 5,416 emergency geriatric admissions in the 12 months preceding the introduction of TREAT with the 5,370 emergency geriatric admissions in the 12 months following. Emergency geriatric admissions were divided into TREAT-matching and residual (non-matching) cohorts from hospital provider spell records, using the Healthcare Resource Group (HRG), treatment function and patient classification of the TREAT admissions. LOS and same-day discharge rates were measured over the pre- and post-TREAT periods: for the TREAT-matching cohort; for the residual cohort of emergency geriatric admissions; and for all emergency geriatric admissions. INTERVENTION: TREAT is a system of care combining early Accident and Emergency (A&E)-based senior doctor review, Comprehensive Geriatric Assessment (CGA), therapist assessment and supported discharge; post-discharge supported recovery; and a rapid access geriatric ‘hot-clinic’. TREAT was supported by a post-acute care enablement (PACE) team, providing short-term nursing support immediately following discharge. RESULTS: TREAT accepted 593 geriatric admissions over a 12-month period, of which 32.04% were discharged on the day of admission. The mean LOS was 4.41 days, and the median LOS was 1 day. After the introduction of TREAT, mean LOS reduced by 18.16% (1.78 days, P < 0.001) for TREAT-matching admissions; by 11.65% (1.13 days, P < 0.001) for all emergency geriatric admissions; and by 1.08% (0.11 days, P = 0.065) for the residual population. Over the same period, the percentage of admissions resulting in same-day discharges increased from 12.26 to 16.23% (OR: 1.386, 95% CI: 1.203-1.597, P < 0.001) for TREAT-matching admissions, but
CONCLUSIONS: TREAT appears to have reduced avoidable emergency geriatric admissions, and to have shortened LOS for all emergency geriatric admissions. It aims to address the King's Fund's call for an 'overall system of care rather than lots of discrete processes' through 'better design and co-ordination of services following the needs of older people'. The ease of set-up lends itself to replication and testing in clinical and cost-effectiveness studies. Further studies are needed to measure the impact of TREAT on re-admission rates, patient outcomes and satisfaction.

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15. Timely care for frail older people referred to hospital improves efficiency and reduces mortality without the need for extra resources.
Background: hospitals are under pressure to reduce waiting times and costs. One strategy that may be effective focuses on optimising the flow of emergency patients. Objective: we undertook a patient flow analysis of older emergency patients to identify and address delays in ensuring timely care, without additional resources. Design: prospective systems redesign study over 2 years. Setting: the Geriatric Medicine Directorate in an acute hospital (Sheffield Teaching Hospitals NHS Foundation Trust) with 1920 beds. Subjects: older patients admitted as emergencies. Methods: diagnostic patient flow analysis followed by a series of Plan Do Study Act cycles to test and implement changes by a multidisciplinary team using time series run charts. Results: 60% of patients aged 75+ years arrived in the Emergency Department during office hours, but two-thirds of the admissions to GM wards were outside office hours highlighting a major delay. Three changes were undertaken to address this, Discharge to Assess, Seven Day Working and the establishment of a Frailty Unit. Average bed occupancy fell by 20.4 beds (95% confidence interval (CI) −39.6 to −1.2, P = 0.037) for similar demand. The risk of hospital mortality also fell by 2.25% (before 11.4% (95% CI 10.4–12.4%), after 9.15% (95% CI 7.6–10.7%) which equates to a number needed to treat of 45 and a 19.7% reduction in relative risk of mortality. The risk of re-admission remained unchanged. Conclusion: redesigning the system of care for older emergency patients led to reductions in bed occupancy and mortality without affecting re-admission rates or requiring additional resources.
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16. A follow-up intervention in severely demented patients after discharge from a special Alzheimer acute care unit: impact on early emergency room re-hospitalization rate.
BACKGROUND: Emergency room (ER) re-hospitalizations are prevalent in severe Alzheimer's disease affected older patients. DESIGN: Quasi-experimental before and after study. SETTING: Discharge of severely demented patients from a Special Alzheimer Acute Care Unit. PARTICIPANTS: A total of 390 patients hospitalized in the unit from 2007 through 2009, with at least one of the following characteristics: severe disruptive behavioral and psychological symptoms of dementia (BPSD) (agitation, aggressiveness, and psychotic symptoms), change of living arrangement related to BPSD, exhaustion of the principal caregiver, and discharge of a subject with anosognosia living alone in the community. INTERVENTION: The intervention consisted of an individualized care plan, targeting the problems observed during the hospital stay, implemented by the means of regular telephone contacts (in the first week after discharge, before the end of the first month, and then at 3 and 6 months) between a geriatric team and the patient’s caregiver. Information was gathered on
functional decline, BPSD, change of living arrangement and treatment. The calls were followed by a telephone intervention providing advice, support, and information to the caregiver. When required, these calls were followed by a consultation with a physician or psychologist, or by a consultation in the patient's home. MEASUREMENTS: The primary outcome measure was the ER re-hospitalization rate, defined as occurring within 31 days of discharge. RESULTS: The early ER re-hospitalization rate was 8.39% in 2007 versus 8.02% in 2008 (p = 0.818) and 7.47% in 2009 (p = 0.563). Vocal disruptive behavior are more prevalent in re-hospitalized patients (9.64% versus 3.97%, p = 0.05) than in non-re-hospitalized patients. CONCLUSION: We found a non-significant decrease of early ER re-hospitalization rate at 1 month after discharge. Interventions addressing severe dementia affected patients with BPSD are needed, as this is a major issue in the organization of health care systems.

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17. A primary care physician’s ideal transitions of care—where’s the evidence?
Reducing hospital readmissions is a national healthcare priority. Most of the interventions to reduce hospital readmission have been concentrated in the inpatient setting. However, there is increasing attention placed on the role of primary care physicians (PCPs) in improving the transition from hospital to home. In this article, a primary care physician’s perspective of how inpatient and outpatient providers can partner to create the ideal care transition is described. Seven steps that occur during the hospitalization are highlighted: communicate with the PCP on admission, involve the PCP early regarding discharge planning, notify the PCP on hospital discharge, complete the discharge summary at time of discharge, schedule follow-up appointments by discharge, ensure prescriptions are available at the patient’s pharmacy, and educate the patient about self-management. Another 7 are described as the role of the PCP and clinic staff: call the patient within 72 hours of discharge, ensure follow-up appointments with the PCP, coordinate care, repeat above until medically stable, create access for patients with new symptoms, track readmission rates, and track and review frequently admitted patients. Insights are offered on how the changing financial landscape can help support elements of this idealized transition-of-care program
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18. A qualitative study exploring patients’ and carers’ experiences of Early Supported Discharge services after stroke
OBJECTIVE: To investigate patients’ and carers’ experiences of Early Supported Discharge services and inform future Early Supported Discharge service development and provision. DESIGN AND SUBJECTS: Semi-structured interviews were completed with 27 stroke patients and 15 carers in the Nottinghamshire region who met evidence-based Early Supported Discharge service eligibility criteria. Participants were either receiving Early Supported Discharge or conventional services. SETTING: Community stroke services in Nottinghamshire, UK. RESULTS: A thematic analysis process was applied to identify similarities and differences across datasets. Themes specific to participants receiving Early Supported Discharge services were: the home-based form of rehabilitation; speed of response; intensity and duration of therapy; respite time for the carer; rehabilitation exercises and provision of technical equipment; disjointed transition between Early Supported Discharge and ongoing rehabilitation services. Participants receiving Early Supported Discharge or conventional community services experienced difficulties related to: limited support in dealing with carer strain; lack of education and training of carers; inadequate provision and delivery of stroke-related information; disjointed transition between Early Supported Discharge and ongoing
rehabilitation services. CONCLUSIONS: Accelerated hospital discharge and home-based rehabilitation was perceived positively by service users. The study findings highlight the need for Early Supported Discharge teams to address information and support needs of patients and carers and to monitor their impact on carers in addition to patients, using robust outcome measures. Available online at this link

19. Development of a checklist of safe discharge practices for hospital patients
BACKGROUND: Discharge from hospital can be a vulnerable period for patients. Multifaceted "discharge bundles" facilitate care transitions and possibly decrease adverse outcomes. We describe a structured approach to discharge planning, starting from admission and proceeding through discharge, using a standardized checklist of tasks to be performed for each hospitalization day. OBJECTIVE: To create an evidence-based checklist of safe discharge practices for hospital patients. METHODS: In the province of Ontario, the Ministry of Health and Long-Term Care convened a panel of expert members from multiple disciplines and across several healthcare sectors. The panel conducted a systematic search of the literature and used a structured approach to review evidence-based practices that ensure efficient, effective, safe, and patient-centered care transitions. A discharge-checklist tool was created to facilitate safe discharge from hospital. RESULTS: The final checklist describes the processes necessary for a safe and optimal discharge and recommended timeline of when to complete each step, starting from the first day of admission. The checklist domains include (1) indication for hospitalization, (2) primary care, (3) medication safety, (4) follow-up plans, (5) home-care referral, (6) communication with outpatient providers, and (7) patient education. CONCLUSIONS: The Checklist of Safe Discharge Practices for Hospital Patients summarizes the sequence of events that need to be completed throughout a typical hospitalization. Standardizing discharge planning and initiating processes early on in a patient’s hospital stay may ensure a safe transition home. Available online at this link

20. Review of current conceptual models and frameworks to guide transitions of care in older adults
Older adults are at high risk for gaps in care as they move between health care providers and settings during the course of illness, such as following hospital discharge. These gaps in care may result in unnecessary re-hospitalization and even death. Nurses can assist older adults to achieve successful transitions of care by taking a systematic approach and individualizing care to meet patient and family health literacy, cognitive, and sensory needs. This article reviews trends in transitions of care, models, partnerships, and health literacy. Models described include the Transitional Care Model, Care Transitions Program, Project BOOST (Better Outcomes for Older adults through Safe Transitions), Project RED (Re-engineered Discharge), Chronic Care Model, and INTERACT<sup>II</sup> (Interventions to Reduce Acute Care Transfers). Approaches to transitions of care are discussed, and resources for geriatric nurses are provided.

21. The Effectiveness of a Geriatric Hip Fracture Clinical Pathway in Reducing Hospital and Rehabilitation Length of Stay and Improving Short-Term Mortality Rates
Background: A geriatric hip fracture clinical pathway, led by an orthopedic surgeon, was developed in 2007. This clinical pathway team is multidisciplinary and consists of surgeons, physicians, anesthetists, nurses, physiotherapists, occupational therapists, medical social
workers, dieticians as well as voluntary support groups. Methods: From early 2007 onward, all patients older than 65 years with acute isolated hip fractures were included. During the whole inpatient treatment, all relevant data were captured prospectively. The data in 2006, before the implementation of the clinical pathway, were collected retrospectively through computer record system. A study of the length of stay in acute and rehabilitation hospital and also the short-term mortality rate was carried out to compare the difference before and after the implementation of the pathway. Results: From 2007 onward, more than 1300 hip fractures were treated. After the implementation of the pathway, the preoperative length of stay was markedly shortened by 4 days, from an average of 6.1 days in 2006 to 1.5 days in 2011 (P < .05). The postoperative length of stay and the overall acute hospital length of stay also improved significantly. The length of stay in rehabilitation hospital was also significantly shorter in the 4-year period. Although the number of hip fractures increased annually with increased age and number of comorbidities each year, the inpatient mortality rate showed a gradual decrease from 2.7% in 2006 to 1.25% in 2010. The 30 days mortality rate also showed a decrease from 3.65% in 2006 to 2.75% in 2010. Conclusion: Geriatric hip fracture clinical pathway is an excellent approach to the geriatric hip fracture service. The most significant improvement is the dramatic shortening of the length of hospital stay. Our success in the past 5 years has proven its value and sustainability.

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22. Evaluation of an admission and discharge programme at a UK specialist palliative day hospice.


This paper reports on a system of managing admissions and discharges from a specialist palliative day hospice (SPDH) in the south of England. SPDH is a well-established component of palliative care provision in the UK, but studies have rarely addressed issues around admission and discharge. Case study methodology was used to evaluate the programme. Interviews were conducted with five patients who had attended the day hospice, taken a break or been discharged and returned; their carer(s); the key worker from the day hospice; and any other health professional who was involved in the patient's care during the admission. Communication issues were found within the team regarding referral and discharge processes, documentation of care, decision making, and information giving. Family members did not feel involved in decision making in relation to the programme. The most significant finding was the emotional and psychological impact on the patients of taking the break. Discharge from SPDH is known to be a difficult and sensitive issue, especially when patients are living with life-limiting illnesses that can change quickly. The patients in this study all had some form of dependency on the service and four of the five would have chosen to continue attending if they could. They experienced deterioration in psychological and physical wellbeing during the period in which they did not attend.

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<td>system*.ti,ab</td>
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