

Community Children’s Nursing Evidence Update

March/April 2018 (Quarterly)



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Training Calendar 2018

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April (12.00-13.00)

17th (Tue) Statistics

25th (Wed) Literature Searching

May (13.00-14.00)

3rd (Thu) Critical Appraisal

11th (Fri) Statistics

14th (Mon) Literature Searching

22nd (Tue) Critical Appraisal

30th (Wed) Statistics

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Journal Tables of Contents

Click on the hyperlinked title (+ Ctrl) for contents. If you would like any of the papers in full then please email the library: library@uhbristol.nhs.uk

[British Journal of Community Nursing](#)

January 2018, Volume 23, Issue 1 (Quarterly)

[Archives of Disease in Childhood](#)

April 2018, Volume 103, Issue 4

[Nursing Children and Young people](#)

March 07 2018, Volume 30, Issue 2

Departmental News

News, Research, Conferences, Training etc

Please contact us with any departmental news you wish to share here with your colleagues in your Evidence Update bulletin.

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Recent Database Articles: Community Paediatric Nursing HDAS Search

If you would like any of the articles in full text, or if you would like a more focused search on your own topic, please contact us: library@bristol.nhs.uk

Models of community childrens nursing

1. Integrated children's clinic care (ICCC) versus a self-directed care pathway for children with a chronic health condition: a multi-centre randomised controlled trial study protocol.

Author(s): Frakking, Thuy Thanh; Waugh, John; Teoh, Hsien-Jin; Shelton, Doug; Moloney, Susan; Ward, Donna; David, Michael; Barber, Matthew; Carter, Hannah; Mickan, Sharon; Weir, Kelly

Source: BMC pediatrics; Feb 2018; vol. 18 (no. 1); p. 72

Publication Date: Feb 2018

Publication Type(s): Research Support, Non-u.s. Gov't Journal Article

PubMedID: 29458335

Available at [BMC pediatrics](#) - from BioMed Central

Available at [BMC pediatrics](#) - from Europe PubMed Central - Open Access

Available at [BMC pediatrics](#) - from EBSCO (MEDLINE Complete)

Abstract:BACKGROUND Children with chronic health conditions have better health-related outcomes when their care is managed in a personalised and coordinated way. However, increased demand on Australian ambulatory care hospital services has led to longer waitlist times to access specialists and appropriate intervention services; placing vulnerable children at increased risk of poorer short-term (e.g. social difficulties) and long-term (e.g. convictions) health and social outcomes. Traditional approaches to increasing frequency and service of delivery are expensive and can have minimal impact on caregiver burden. A community based service-integration approach, rather than self-directed care is proposed as increased service linkages are more likely to occur and improve the health outcomes of children with a chronic health condition. METHODS An open, unblinded, multi-centre randomised controlled trial in two Australian public hospitals. 112 children (0-16 years) fulfilling the inclusion criteria will be randomised to one of two clinical pathways for management of their chronic health condition: (1) integrated children's care clinic (ICCC) or (2) self-directed care pathway. All children and caregivers will be interviewed at 1 week, and 3, 6 and 12 month time intervals. Primary outcome measures include the Pediatric Quality of Life (PedQOL) questionnaire, Subjective Units of Distress Scale, Child Behaviour Checklist (CBCL) and Rotter's Locus of Control Scale. Secondary outcome measures include the total number of medical appointments, school days missed and quantity of services accessed. Our main objectives are to determine if the ICCC results in better health and economics outcomes compared to the self-directed care pathway. DISCUSSION The success of a health systems approach needs to be balanced against clinical, mortality and cost-effectiveness data for long-term sustainability within a publicly funded health system. A clinical pathway that is sustainable, cost-effective, provides efficient evidence-based care and improves the quality of life outcomes for children with chronic health conditions has the potential to reduce waitlist times, improve access to health services, increase consumer satisfaction; and prevent costs associated with poorly managed chronic health conditions into adulthood. This study will be the first to provide clinical and health economics data on an integrated care pathway for the management of chronic health conditions in children. On a broader scale, results from this study will help guide care

coordination frameworks for children with chronic health conditions; particularly with the introduction and implementation of a National Disability Insurance Scheme (NDIS) across Australia. TRIAL REGISTRATION Australia and New Zealand Clinical Trials Register (ANZCTR) ACTRN12617001188325 . Registered: 14th August, 2017.

Database: Medline

[Paediatric Palliative Care in the community](#)

1. A Summary of Pediatric Palliative Care Team Structure and Services as Reported by Centers Caring for Children with Cancer.

Author(s): Weaver, Meaghann S; Rosenberg, Abby R; Tager, Julia; Wichman, Christopher S; Wiener, Lori

Source: Journal of palliative medicine; Apr 2018; vol. 21 (no. 4); p. 452-462

Publication Date: Apr 2018

Publication Type(s): Journal Article

PubMedID: 29173030

Abstract:BACKGROUND Little is known about the composition, availability, integration, communication, perceived barriers, and work load of pediatric palliative care (PPC) providers serving children and adolescents with cancer. OBJECTIVE To summarize the structure and services of programs to better understand successes and gaps in implementing palliative care as a standard of care. METHOD Cross-sectional online survey about the palliative care domains determined by the Psychosocial Care of Children with Cancer and Their Families Workgroup. SUBJECTS A total of 142 surveys were completed with representation from 18 countries and 39 states. RESULTS Three-fourths of sites reported having a PPC program available for the pediatric cancer population at their center. Over one-fourth (28%) have been in existence less than five years. Fewer than half of sites (44%) offered 24/7 access to palliative care consultations. Neither hospital-based nor local community hospice services were available for pediatric patients at 24% of responding sites. A specific inpatient PPC unit was available at 8% of sites. Criteria for automatic palliative referrals ("trigger" diagnoses) were reported by 44% respondents. The presence of such "triggers" increased the likelihood of palliative principle introduction 3.41 times ($p < 0.003$). Six percent of respondents perceived pediatric oncology patients and their families "always" were introduced to palliative care concepts and 17% reported children and families "always" received communication about palliative principles. The most prevalent barriers to palliative care were at the provider level. DISCUSSION Children and adolescents with cancer do not yet receive concurrent palliative care as a universal standard.

Database: Medline

2. Interdisciplinary Pediatric Palliative Care Team Involvement in Compassionate Extubation at Home: From Shared Decision-Making to Bereavement.

Author(s): Postier, Andrea; Catrine, Kris; Remke, Stacy

Source: Children (Basel, Switzerland); Mar 2018; vol. 5 (no. 3)

Publication Date: Mar 2018

Publication Type(s): Case Reports

PubMedID: 29518983

Available at [Children \(Basel\)](#) - from Europe PubMed Central - Open Access

Available at [Children \(Basel\)](#) - from PubMed Central

Abstract: Little is known about the role of pediatric palliative care (PPC) programs in providing support for home compassionate extubation (HCE) when families choose to spend their child's end of life at home. Two cases are presented that highlight the ways in which the involvement of PPC teams can help to make the option available, help ensure continuity of family-centered care between hospital and home, and promote the availability of psychosocial support for the child and their entire family, health care team members, and community. Though several challenges to realizing the option of HCE exist, early consultation with a PPC team in the hospital, the development of strategic community partnerships, early referral to home based care resources, and timely discussion of family preferences may help to make this option a realistic one for more families. The cases presented here demonstrate how families' wishes with respect to how and where their child dies can be offered, even in the face of challenges. By joining together when sustaining life support may not be in the child's best interest, PPC teams can pull together hospital and community resources to empower families to make decisions about when and where their child dies.

Database: Medline

3. Changing place of death in children who died after discharge from paediatric intensive care units: A national, data linkage study.

Author(s): Fraser, Lorna K; Fleming, Sarah; Parslow, Roger

Source: Palliative medicine; Feb 2018; vol. 32 (no. 2); p. 337-346

Publication Date: Feb 2018

Publication Type(s): Journal Article

PubMedID: 28494634

Available at [Palliative Medicine](#) - from PubMed Central

Abstract: **BACKGROUND** Although child mortality is decreasing, more than half of all deaths in childhood occur in children with a life-limiting condition whose death may be expected. **AIM** To assess trends in place of death and identify characteristics of children who died in the community after discharge from paediatric intensive care unit. **DESIGN** National data linkage study. **SETTING/PARTICIPANTS** All children resident in England and Wales when admitted to a paediatric intensive care unit in the United Kingdom (1 January 2004 and 31 December 2014) were identified in the Paediatric Intensive Care Audit Network dataset. Linkage to death certificate data was available up to the end of 2014. Place of death was categorised as hospital (hospital or paediatric intensive care unit) or community (hospice, home or other) for multivariable logistic modelling. **RESULT** The cohort consisted of 110,328 individuals. In all, 7709 deaths occurred after first discharge from paediatric intensive care unit. Among children dying, the percentage in-hospital at the time of death decreased from 83.8% in 2004 to 68.1% in 2014; 852 (0.8%) of children were discharged to palliative care. Children discharged to palliative care were eight times more likely to die in the community than children who died and had not been discharged to palliative care (odds ratio = 8.06 (95% confidence interval = 6.50-10.01)). **CONCLUSION** The proportion of children dying in hospital is decreasing, but a large proportion of children dying after discharge from paediatric intensive care unit continue to die in hospital. The involvement of palliative care at the point of discharge has the potential to offer choice around place of care and death for these children and families.

Database: Medline

4. Paediatric palliative care improves patient outcomes and reduces healthcare costs: evaluation of a home-based program.

Author(s): Chong, P H; De Castro Molina, J A; Teo, K; Tan, W S

Source: BMC palliative care; Jan 2018; vol. 17 (no. 1); p. 11

Publication Date: Jan 2018

Publication Type(s): Journal Article

PubMedID: 29298714

Available at [BMC palliative care](#) - from BioMed Central

Available at [BMC palliative care](#) - from Europe PubMed Central - Open Access

Abstract:BACKGROUND Around the world, different models of paediatric palliative care have responded to the unique needs of children with life shortening conditions. However, research confirming their utility and impact is still lacking. This study compared patient-related outcomes and healthcare expenditures between those who received home-based paediatric palliative care and standard care. The quality of life and caregiver burden for patients receiving home-based paediatric palliative care were also tracked over the first year of enrolment to evaluate the service's longitudinal impact. METHOD A structured impact and cost evaluation of Singapore-based HCA Hospice Care's Star PALS (Paediatric Advance Life Support) programme was conducted over a three-year period, employing both retrospective and prospective designs with two patient groups. RESULTS Compared to the control group (n = 67), patients receiving home-based paediatric palliative care (n = 71) spent more time at home than in hospital in the last year of life by 52 days (OR = 52.30, 95% CI: 25.44-79.17) with at least two fewer hospital admissions (OR = 2.46, 95% CI: 0.43-4.48); and were five times more likely to have an advance care plan formulated (OR = 5.51, 95% CI: 1.55-19.67). Medical costs incurred by this group were also considerably lower (by up to 87%). Moreover, both patients' quality of life (in terms of pain and emotion), and caregiver burden showed improvement within the first year of enrolment into the programme. DISCUSSION Our findings suggest that home-based paediatric palliative care brings improved resource utilization and cost-savings for both patients and healthcare providers. More importantly, the lives of patients and their caregivers have improved, with terminally ill children and their caregivers being able to spend more quality time at home at the final stretch of the disease. CONCLUSION The benefits of a community paediatric palliative care programme have been validated. Study findings can become key drivers when engaging service commissioners or even policy makers in appropriate settings.

Database: Medline

5. Partnership working between hospice and children's community nursing teams.

Author(s): Bennett, Helen; McCarthy, Lesley; McKinnon, Sam

Source: Nursing children and young people; Nov 2016; vol. 28 (no. 9); p. 26-30

Publication Date: Nov 2016

Publication Type(s): Journal Article

PubMedID: 27821000

Available at [Nursing children and young people](#) - from EBSCO (CINAHL Plus with Full Text)

Abstract: This article describes the implementation and evaluation of a new partnership between a children's hospice service and an NHS children's community nursing team to support children's palliative care in the community. Aims and outcomes of the service were established in its initial design and it was monitored for quality and improvement over its first year. Mixed methods of audit and evaluation strategies were used to assess the quality of the service. Findings demonstrate that it has offered significant support to children, and families valued the role of the new Alexander's

nurse. Professionals described improved communication and working relationships through the collaborative partnership. The evaluation also identified areas of learning for future development of the service.

Database: Medline

[Hospital at home services for children](#)

1. Interdisciplinary Pediatric Palliative Care Team Involvement in Compassionate Extubation at Home: From Shared Decision-Making to Bereavement.

Author(s): Postier, Andrea; Catrine, Kris; Remke, Stacy

Source: Children (Basel, Switzerland); Mar 2018; vol. 5 (no. 3)

Publication Date: Mar 2018

Publication Type(s): Case Reports

PubMedID: 29518983

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Database: Medline

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Abstract: BACKGROUND Although child mortality is decreasing, more than half of all deaths in childhood occur in children with a life-limiting condition whose death may be expected. AIM To assess trends in place of death and identify characteristics of children who died in the community after discharge from paediatric intensive care unit. DESIGN National data linkage study. SETTING/PARTICIPANTS All children resident in England and Wales when admitted to a

paediatric intensive care unit in the United Kingdom (1 January 2004 and 31 December 2014) were identified in the Paediatric Intensive Care Audit Network dataset. Linkage to death certificate data was available up to the end of 2014. Place of death was categorised as hospital (hospital or paediatric intensive care unit) or community (hospice, home or other) for multivariable logistic modelling. **RESULTS** The cohort consisted of 110,328 individuals. In all, 7709 deaths occurred after first discharge from paediatric intensive care unit. Among children dying, the percentage in-hospital at the time of death decreased from 83.8% in 2004 to 68.1% in 2014; 852 (0.8%) of children were discharged to palliative care. Children discharged to palliative care were eight times more likely to die in the community than children who died and had not been discharged to palliative care (odds ratio = 8.06 (95% confidence interval = 6.50-10.01)). **CONCLUSIONS** The proportion of children dying in hospital is decreasing, but a large proportion of children dying after discharge from paediatric intensive care unit continue to die in hospital. The involvement of palliative care at the point of discharge has the potential to offer choice around place of care and death for these children and families.

Database: Medline

3. Barriers and facilitators to the implementation of a paediatric palliative care team.

Author(s): Verberne, Lisa M.; Kars, Marijke C.; Schepers, Sasja A.; Schouten-van Meeteren, Antoinette Y. N.; Grootenhuis, Martha A.; van Delden, Johannes J. M.

Source: BMC Palliative Care; Feb 2018; vol. 17 ; p. 1-1

Publication Date: Feb 2018

Publication Type(s): Academic Journal

Available at [BMC Palliative Care](#) - from BioMed Central

Available at [BMC Palliative Care](#) - from Europe PubMed Central - Open Access

Abstract: Background: Over the last decade, paediatric palliative care teams (PPCTs) have been introduced to support children with life-limiting diseases and their families and to ensure continuity, coordination and quality of paediatric palliative care (PPC). However, implementing a PPCT into an organisation is a challenge. The objective of this study was to identify barriers and facilitators reported by healthcare professionals (HCPs) in primary, secondary or tertiary care for implementing a newly initiated multidisciplinary PPCT to bridge the gap between hospital and home. Methods: The Measurement Instrument for Determinants of Innovations (MIDI) was used to assess responses of 71 HCPs providing PPC to one or more of the 129 children included in a pilot study of a PPCT based at a university children's hospital. The MIDI (29 items) assessed barriers and facilitators to implementing the PPCT by using a 5-point scale (completely disagree to completely agree) and additional open-ended questions. Items to which $\geq 20\%$ of participants responded with 'totally disagree/disagree' and $\geq 80\%$ responded with 'agree/totally agree' were considered as barriers and facilitators, respectively. A general inductive approach was used for open-ended questions. Results: Reported barriers to implementing a PPCT were related to the HCP's own organisation (e.g., no working arrangements related to use of the intervention [PPCT] registered, other organisational changes such as merger going on). Reported facilitators were mainly related to the intervention (correctness, simplicity, observability and relevancy) and the user scale (positive outcome expectations, patient satisfaction) and only once to the organisation scale (information accessibility). Additionally, HCPs expressed the need for clarity about tasks of the PPCT and reported having made a transition from feeling threatened by the PPCT to satisfaction about the PPCT. Conclusion: Positive experiences with the PPCT are a major facilitator for implementing a PPCT. Tailored organisational strategies such as working arrangements by management, concrete information about the PPCT itself and the type of support provided by the PPCT should be clearly communicated to involved HCPs to increase awareness about benefits of the PPCT and ensure a successful implementation.

New PPCTs need protection and resources in their initial year to develop into experienced and qualified PPCTs.

Database: CINAHL

4. Paediatric palliative care improves patient outcomes and reduces healthcare costs: evaluation of a home-based program.

Author(s): Chong, P H; De Castro Molina, J A; Teo, K; Tan, W S

Source: BMC palliative care; Jan 2018; vol. 17 (no. 1); p. 11

Publication Date: Jan 2018

Publication Type(s): Journal Article

PubMedID: 29298714

Available at [BMC palliative care](#) - from BioMed Central

Available at [BMC palliative care](#) - from Europe PubMed Central - Open Access

Abstract:BACKGROUND Around the world, different models of paediatric palliative care have responded to the unique needs of children with life shortening conditions. However, research confirming their utility and impact is still lacking. This study compared patient-related outcomes and healthcare expenditures between those who received home-based paediatric palliative care and standard care. The quality of life and caregiver burden for patients receiving home-based paediatric palliative care were also tracked over the first year of enrolment to evaluate the service's longitudinal impact. METHOD A structured impact and cost evaluation of Singapore-based HCA Hospice Care's Star PALS (Paediatric Advance Life Support) programme was conducted over a three-year period, employing both retrospective and prospective designs with two patient groups. RESULTS Compared to the control group (n = 67), patients receiving home-based paediatric palliative care (n = 71) spent more time at home than in hospital in the last year of life by 52 days (OR = 52.30, 95% CI: 25.44-79.17) with at least two fewer hospital admissions (OR = 2.46, 95% CI: 0.43-4.48); and were five times more likely to have an advance care plan formulated (OR = 5.51, 95% CI: 1.55-19.67). Medical costs incurred by this group were also considerably lower (by up to 87%). Moreover, both patients' quality of life (in terms of pain and emotion), and caregiver burden showed improvement within the first year of enrolment into the programme. DISCUSSION Our findings suggest that home-based paediatric palliative care brings improved resource utilization and cost-savings for both patients and healthcare providers. More importantly, the lives of patients and their caregivers have improved, with terminally ill children and their caregivers being able to spend more quality time at home at the final stretch of the disease. CONCLUSION The benefits of a community paediatric palliative care programme have been validated. Study findings can become key drivers when engaging service commissioners or even policy makers in appropriate settings.

Database: Medline

5. How dislocation and professional anxiety influence readiness for change during the implementation of hospital-based home care for children newly diagnosed with diabetes - an ethnographic analysis of the logic of workplace change.

Author(s): Nilsson, Gabriella; Hansson, Kristofer; Tiberg, Irén; Hallström, Inger

Source: BMC Health Services Research; Jan 2018; vol. 18 ; p. 1-10

Publication Date: Jan 2018

Publication Type(s): Academic Journal

PubMedID: 29382386

Available at [BMC Health Services Research](#) - from BioMed Central

Available at [BMC Health Services Research](#) - from Europe PubMed Central - Open Access

Available at [BMC Health Services Research](#) - from EBSCO (MEDLINE Complete)

Available at [BMC Health Services Research](#) - from PubMed Central

Abstract:Background: In 2013-14, the evidence based care model Hospital-based Home Care for children newly diagnosed with diabetes was implemented at a large paediatric diabetes care facility in the south of Sweden. The first step of the implementation was to promote readiness for change among the professionals within the diabetes team through regular meetings. The aim was to analyse the implicit facilitators and barriers evident on a cultural micro level in discussions during the course of these meetings. What conceptions, ideals and identities might complicate, or facilitate, implementation?Methods: A case study was conducted during the implementation process. This article draw on ethnographic observations carried out at team meetings (n = 6) during the introductory element of implementation. From a discourse theoretical perspective, the verbal negotiations during these meetings were analysed.Results: Three aspects were significant in order to understand the dislocation during this element of implementation: an epistemological disagreement that challenged the function of information within care practice; a paradoxical understanding of the time-knowledge intersection; and expressions of professional anxiety. More concretely, the professionals exhibited an unwillingness to give up the opportunity to provide structured, age-independent information; a resistance against allowing early discharge; and a professional identity formed both by altruistic concern and occupational guardianship. The findings suggest the necessity of increased awareness of the conceptions and ideals that constitute the basis of a certain professional practice; a deeper understanding of the cultural meaning that influences care practice within a specific logic in order to predict in what way these ideals might be challenged by the implemented evidence.Conclusions: Our main contribution is the argument that the implemented evidence in itself needs to be examined and problematized from a cultural analytical perspective before initiation in order to be able to actively counter negative connotations and resistance.

Database: CINAHL

6. The role of hospice in the transition from hospital to home for technology-dependent children-A qualitative study.

Author(s): Price, Jayne; McCloskey, Sharon; Brazil, Kevin

Source: Journal of Clinical Nursing; Jan 2018; vol. 27 (no. 1/2); p. 396-406

Publication Date: Jan 2018

Publication Type(s): Academic Journal

Abstract:Aims and objectives To report parent and professional perspectives of step-down care in assisting the transition from hospital to home, within one children's hospice in a constituent country of the United Kingdom. Background In recent years, increasing numbers of children-dependent on long term assisted ventilation have been noted. Meeting the complex physical, emotional and social needs of the child and family is challenging. Many of these children spend extended periods in hospital even when medically stable. Design This was a qualitative study using an inductive, semantic analytic approach within a realist epistemology. Methods Data collection was carried out in 2013. Interviews took place with parents (n = 5) and focus groups with professionals (n = 26) who had experience of step-down care. Results Multiple benefits of step-down in the hospice were clear. Both sets of accounts suggested that for children and families life was 'on hold' in hospital. Hospice was considered a home-like environment where the child and family could 'live again'. Parents reflected that, in hospice they were 'living, not existing' while professionals highlighted hospice as nurturing and empowering the whole family, promoting the child's development while safely

meeting their clinical needs. Conclusions and relevance to clinical practice The study highlights a number of crucial benefits to the child and family both in the immediate and longer terms. The collective perspectives therefore endorse hospice as a potential viable choice for these children and their families during the always difficult, usually protracted transition from hospital to home.

Database: CINAHL

7. Hospital to Home: A Quality Improvement Initiative to Implement High-fidelity Simulation Training for Caregivers of Children Requiring Long-term Mechanical Ventilation.

Author(s): Thrasher, Jodi; Baker, Joyce; Ventre, Kathleen M.; Martin, Sara E.; Dawson, Jessica; Cox, Roberta; Moore, Heather M.; Brethouwer, Sarah; Sables-Baus, Sharon; Baker, Christopher D.

Source: Journal of Pediatric Nursing; Jan 2018; vol. 38 ; p. 114-121

Publication Date: Jan 2018

Publication Type(s): Academic Journal

Abstract:Background Preparing families of children requiring long-term mechanical ventilation (LTMV) to manage medical emergencies at home is challenging. Opportunities for family caregivers to rehearse crisis management in a controlled setting before discharge are limited. Objective We aimed to create a multimodal discharge preparedness curriculum, incorporating high-fidelity simulation training, to prepare family caregivers of children with complex medical conditions requiring long-term mechanical ventilation. We sought to determine which curricular elements were most helpful and whether this curriculum impacted the rate of readmissions within 7 days of hospital discharge. Methods The curriculum included instructional videos, printed handouts, cardiopulmonary resuscitation training, and two mandatory high fidelity simulation scenarios depicting tracheostomy- and ventilator-related emergencies. Teams of one to three family caregivers per patient managed each scenario. A video-based debriefing focused on identifying and closing performance gaps. Participants rated their perceptions regarding each curricular element and its relative impact on their preparedness for discharge. Results 87 family caregivers completed the curriculum. Simulation-enhanced curriculum was well-received by participants. Participants reported that post-simulation debriefing was the most beneficial component. We observed a trend toward reduced readmissions within 7 days of discharge since implementation of our revised curriculum. Conclusion Simulation training can be incorporated into discharge training for families of children requiring LTMV. Rehearsal of emergency management in a simulated clinical setting increases caregiver confidence to assume care for their ventilator-dependent child.

Database: CINAHL

8. Effect of a children's at-home nursing team on reducing emergency admissions

Author(s): Farnham , Laura; Harwood , Hannah; Robertson , Meredith

Source: Nursing Children and Young People (2014+); Dec 2017; vol. 29 (no. 10); p. 31

Publication Date: Dec 2017

Publication Type(s): Journal Article

Available at [Nursing Children and Young People](#) - from EBSCO (CINAHL Plus with Full Text)

Abstract:This article explores the effect of a children's at-home nursing team, Hospital at Home (H@H), which aimed to reduce demand on acute hospital beds, support families to improve patient experience, and empower parents to care safely for their unwell children and help prevent emergency department (ED) reattendance. Data on demographics and clinical presentation of H@H and ED attendances were collected and compared. A survey measuring parents' confidence in

managing their unwell children was also conducted. Of 72 patients treated by the H@H service between May and July 2016, 32 (44%) would have been admitted to hospital from the ED if the H@H service had not existed. This is equivalent to a saving of 64 bed days. Patients treated by the H@H service had similar demographics to those discharged from the ED to usual care. The H@H service took on patients with higher Bedside Paediatric Early Warning System scores before discharge. Parents reported that they would be more confident caring for their children after discharge from the H@H service. The H@H service decreased the number of unnecessary ED admissions. The service promotes a positive patient experience and increases parents' confidence when caring for unwell children at home.

Database: BNI

9. The Hospital at Home program: no place like home.

Author(s): Lippert, M; Semmens, S; Tacey, L; Rent, T; Defoe, K; Bucsis, M; Shykula, T; Crysdale, J; Lewis, V; Strother, D; Lafay-Cousin, L

Source: Current oncology (Toronto, Ont.); Feb 2017; vol. 24 (no. 1); p. 23-27

Publication Date: Feb 2017

Publication Type(s): Journal Article

PubMedID: 28270721

Available at [Current Oncology](#) - from Europe PubMed Central - Open Access

Available at [Current Oncology](#) - from PubMed Central

Abstract:BACKGROUNDThe treatment of children with cancer is associated with significant burden for the entire family. Frequent clinic visits and extended hospital stays can negatively affect quality of life for children and their families.METHODSHere, we describe the development of a Hospital at Home program (H@H) that delivers therapy to pediatric hematology, oncology, and blood and marrow transplant (bmt) patients in their homes. The services provided include short infusions of chemotherapy, supportive-care interventions, antibiotics, post-chemotherapy hydration, and teaching.RESULTSFrom 2013 to 2015, the H@H program served 136 patients, making 1701 home visits, for patients mainly between the ages of 1 and 4 years. Referrals came from oncology in 82% of cases, from hematology in 11%, and from bmt in 7%. Since inception of the program, no adverse events have been reported. Family surveys suggested less disruption in daily routines and appreciation of specialized care by hematology and oncology nurses. Staff surveys highlighted a perceived benefit of H@H in contributing to early discharge of patients by supporting out-of-hospital monitoring and teaching.CONCLUSIONSThe development of a H@H program dedicated to the pediatric hematology, oncology, or bmt patient appears feasible. Our pilot program offers a potential contribution to improvement in patient quality of life and in cost-benefit for parents and the health care system.

Database: Medline



Library Clinic

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May 2nd: **Canteen (Level 9, BRI) 12.00-14.00**

June 6th: **Terrace (Level 4, Education Centre) 12.00-14.00**

June 19th: **Welcome Centre, BRI 10.00-16.00**

July 3rd: **Welcome Centre, BRI 10.00-16.00**

July 4th: **Canteen (Level 9, BRI) 12.00-14.00**

August 8th: **Foyer, Education Centre 12.00-14.00**

August 29th: **Foyer, St Michael's Hospital 12.00-14.00**

September 5th: **Canteen (Level 9, BRI) 12.00-14.00**

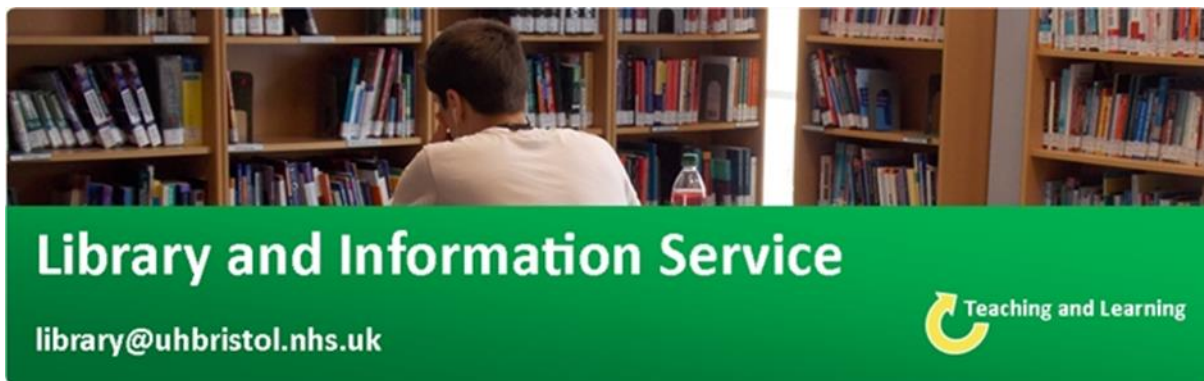
September 11th: **Welcome Centre, BRI 10.00-16.00**

October 3rd: **Terrace (Level 4, Education Centre) 12.00-14.00**

November 7th: **Canteen (Level 9, BRI) 12.00-14.00**

December 5th: **Foyer, Education Centre 12.00-14.00**

December 11th: **Welcome Centre, BRI 10.00-16.00**



Library Opening Times

Staffed hours: 8am-5pm, Monday to Friday

Swipe-card access: 7am-11pm, seven days a week

Level Five, Education and Research Centre

University Hospitals Bristol

Contact your Outreach Librarian:

Helen Pullen

library@uhbristol.nhs.uk

Ext. 20105