Healthcare
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Discharge Readiness: Sound Protocols Help Reduce Outpatient Risk

Ambulatory settings are expressly designed to expedite care, and their financial success depends upon maintaining a steady pace of work and high patient volume. During the ongoing COVID-19 pandemic, with its sharp cutbacks in elective procedures, providers at outpatient facilities may feel pressure to relax their patient discharge-related protocols, in order to maximize efficiency. However, it should be remembered that premature and/or unaccompanied discharge following outpatient procedures can imperil patients and expose providers and healthcare organizations to potential litigation and reputational harm, as demonstrated by the following hypothetical scenario:

> *A 52-year-old man is scheduled to undergo an arthroscopic procedure at an ambulatory surgery center, in order to repair a torn left lateral meniscus. During the preoperative consultation, he is told that, as he cannot drive for at least six hours following the operation, he must be accompanied by a competent adult who can take him home afterward. The patient agrees to this condition. However, his escort cancels at the last minute, and the patient presents alone to the facility on the day of surgery.*
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> *After a brief discussion, the surgeon and anesthesiologist decide to proceed with the operation under local anesthesia with light sedation. Intraoperatively, the patient becomes agitated. In consultation with the surgeon, the anesthesiologist administers intravenous sedation, including low doses of midazolam, fentanyl and propofol. Following the procedure, the post-anesthesia care unit (PACU) staff makes an unsuccessful and undocumented attempt to contact the accompanying party noted on the admission form. When the patient satisfies the PACU discharge requirements – including the ability to eat, urinate and walk – he is released. No attempt is made to prevent him from driving himself home. While driving, the patient dozes off, due to the aftereffects of the sedation drugs and the stress of the operation. His car strikes a cement-and-metal highway barrier at high speed, producing severe injuries that leave him quadriplegic.*
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> *A lawsuit is filed, and the court determines that the surgical center's medical and nursing staff, as well as the organization itself, were negligent in their duty to exercise due post-procedure precautions. The case results in a damage award in the seven figures.*

This scenario illustrates just how vulnerable patients are post-operatively, and why ambulatory healthcare facilities need to examine their patient discharge practices on a regular basis. Discharge-related policies should support two major risk management objectives: first, ensuring that patients who may be under the residual influence of sedatives do not drive, and second, preventing potential medical complications stemming from insufficient recovery time or medically unadvised discharge. This edition of *inBrief*® features a gap analysis tool designed to help ambulatory settings assess key policy areas – such as discharge criteria, staff and patient education, "responsible adult" qualifications, discharge against medical advice safeguards, contingency planning and follow-up – and develop protocols that minimize liability exposure by protecting patients from the hazards associated with unaccompanied or premature discharge.

Gap Analysis Tool: Outpatient Discharge Process

Safety Factors	Present (Yes/No)	Comments
Basic policy and procedure:		
1. **A formal discharge protocol for surgical/medical/diagnostic procedures is established,** which complies with regulatory and professional clinical standards for patients recovering from general or regional anesthesia and/or moderate or deep sedation.		
2. **Post-procedure transportation requirements are outlined in written policy,** especially the requirement that all patients discharged under the influence of mind-altering substances must be accompanied by a designated responsible adult.		
3. **In the event that a designated escort does not arrive with the patient, the individual is contacted by staff** to verify that he/she will be available to drive the patient home following discharge. This contact is documented in the patient healthcare information record.		
4. **If safe post-discharge transportation and care arrangements cannot be verified, the scheduled procedure is postponed** or, if feasible, only local anesthesia/analgesic is utilized.		
5. **If necessary, use of a licensed medical transport service is arranged prior to the day of surgery/treatment** and documented in the patient healthcare information record.		
6. **Use of ordinary taxicabs and livery or ride-hailing services is prohibited,** as these drivers are not trained to convey vulnerable patients and the carriage contract does not assume liability for medical transport.		
Discharge criteria and related documentation:		
1. **Surgical, medical and diagnostic discharge criteria are established** and implemented using a widely recognized method, such as the Post-anesthetic Discharge Scoring System (PADSS).		
2. **Widely accepted clinical indicators are incorporated into formal discharge criteria,** including, but not limited to, the following:		
• Stable vital signs.		
• Alert and coordinated movement of extremities.		
• Absence of nausea and significant pain.		
• No indication of surgical bleeding.		
• Ability to drink, void and walk without dizziness.		
3. **All four dimensions of discharge readiness are documented in the patient healthcare information record,** i.e., physical status, ability to perform personal care, awareness of post-operative restrictions and potential complications, and presence of a support system.		

Safety Factors	Present (Yes/No)	Comments
Staff and patient education:		
1. **During orientation and annually thereafter, surgeons, anesthesiologists, and other providers and clinical staff are informed of the factors that most affect patients' driving ability and recovery time,** including sedative agents used and pain relief medications taken, as well as subjective variables such as sleep disruption, lingering pain, stress and anxiety.		
2. **Staff are reminded regularly that being judged clinically ready for discharge does *not* necessarily mean ready to drive,** as psychomotor impairment and cognitive deficits may be present but not readily apparent.		
3. **Clinical staff members are instructed periodically to warn patients of the lingering effects of anesthetics and analgesics during the pre-operative assessment,** as well as the danger of driving under the influence of these drugs.		
4. **Prior to the procedure, patients are educated about the three stages of recovery,** consisting of …		
• **Early recovery,** i.e., the period of awakening when vital reflexes return.		
• **Intermediate recovery,** i.e., the period of continuing monitoring when vital signs stabilize and patients regain control of their bodies.		
• **Late recovery,** i.e., the post-discharge period during which the aftereffects of sedation gradually dissipate.		
5. **During the preoperative informed consent discussion, patients are told of the potential consequences of failing to present with a designated escort,** including cancellation of the procedure.		
6. **Patients are asked to sign and date a form indicating their understanding and acceptance of discharge protocols,** including the need for a suitable escort following discharge.		
7. **Written post-procedure instructions are reviewed with patients and their accompanying responsible adult upon discharge,** in order to ensure that they are alert to possible complications and are aware of the appropriate response. Signed acknowledgment is made of receipt.		
Accompanying adult qualifications and safeguards:		
1. **Qualified "responsible adults" are defined in writing** as individuals 18 years of age or older who are licensed to drive and are also ...		
• **Aware of the patient's condition** and physical needs.		
• **Competent to make decisions** if the patient cannot.		
• **Willing and able to assist and support the patient if complications ensue** upon return home, such as nausea, vomiting, dizziness, pain or bleeding.		
• **Capable of requesting medical assistance** in the event of an emergency.		
2. **The name, telephone number and email address of the responsible adult is requested during preoperative registration** and documented in the patient healthcare information record.		
3. **The designated responsible adult is asked to be present upon patient admission** and to be available following the procedure.		

Safety Factors	Present (Yes/No)	Comments
Contingency planning:		
1. **An action plan is created concerning discharge of unescorted patients,** and is implemented consistently when this situation arises.		
2. **A list is compiled of nearby short-term recovery options** – such as "hotel beds" with on-site nursing staff and recovery beds in acute care or aging services settings – for patients who require continued close observation and/or lack proper home care arrangements. Terms are negotiated in advance.		
3. **Local social service agencies are contacted to coordinate transportation and/or home care services** for patients who cannot depend upon family or friends.		
4. **If no responsible adult is available post-discharge,** a licensed medical transport service is hired to take the patient home safely.		
AMA management:		
1. **Discharge "against medical advice" (AMA) is defined in written policy** as when a patient places him/herself at risk by leaving the facility prematurely.		
2. **An informed refusal procedure is developed to manage AMA discharge requests,** which includes documenting the patient's stated reasons for leaving prematurely, as well as attempting to persuade the individual to reconsider the decision.		
3. **Prior to an AMA discharge, the following risk management actions are taken,** in order to prevent medical complications and consequent allegations of abandonment:		
• **Determination of patient's mental capacity** and decision-making ability.		
• **Explanation of the risks** of premature discharge.		
• **Development of an alternative care plan** that satisfies the patient's medical and emotional needs, such as home nursing visits or assistance from a responsible adult.		
• **Documentation of discharge-related safety measures taken,** e.g., discussions conducted with patient, transport and care arrangements made, and prescriptions and medical contact information provided, including location of the nearest emergency room.		
4. **Patients who insist on leaving prematurely are requested to read and sign a form acknowledging the risks of AMA discharge** and the benefits of continued monitoring during recovery (i.e., a standard AMA waiver).		
5. **Staff members are prohibited from forcibly interfering with patients who insist on leaving AMA,** or concealing their car keys or clothing, in order to avoid allegations of improper restraint.		
6. **A policy is established concerning whether to notify police when an impaired patient or driver leaves the facility.** The protocol is reviewed by risk management and/or legal counsel to ensure that it accords with HIPAA privacy and confidentiality provisions.		

Safety Factors	Present (Yes/No)	Comments
Post-discharge patient follow-up:		
1. **Patients who leave prematurely are contacted soon after discharge** to confirm their safe arrival and the availability of in-home assistance.		
2. **Written protocols are drafted regarding steps to take if a patient who leaves prematurely cannot be reached post-discharge,** such as making documented calls to the patient's designated contact and/or law enforcement agencies, as circumstances warrant.		
3. **Follow-up telephone calls are placed to all patients within 24 hours of discharge** after an invasive surgical/medical/diagnostic procedure, in order to check for the following signs of potential complications, among others:		
• Significant bleeding		
• Sore throat and/or hoarseness		
• Elevated temperature		
• Localized pain		
• Generalized discomfort or weakness		
• Nausea or vomiting		
• Headache		
• Drowsiness, lethargy, lightheadedness, dizziness or fainting		
4. **During follow-up telephone calls, the patient is asked about any additional complaints he/she may have,** and also whether prescriptions have been filled, prescribed or over-the-counter drugs taken, and any visits made to the emergency department or primary care provider.		

Quick Links

(A brief, noninclusive resource listing.)

Guidelines, resources and position statements:

- Agency for Healthcare Research and Quality, Patient Safety Network: "Ambulatory Care Safety." Updated September 2019.
- American Association of Nurse Anesthetists: "Discharge After Sedation or Anesthesia on the Day of the Procedure: Patient Transportation with or Without a Responsible Adult." Adopted July 2018.
- American Society of Anesthesiologists: "Guidelines for Ambulatory Anesthesia and Surgery." Approved October 2003, reaffirmed October 2018.

Professional associations:

- Ambulatory Surgery Center Association (ASCA)
- American Association of Nurse Anesthetists (AANA)
- American College of Surgeons (ACS)
- American Society of Anesthesiologists (ASA)
- American Society of PeriAnesthesia Nurses (ASPAN)
- Association of periOperative Registered Nurses (AORN)
- Society for Ambulatory Anesthesia (SAMBA)
- Society of Interventional Radiology (SIR)

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