

British Association of Day Surgery

Handbook Series

Guidelines about the discharge process and the assessment of fitness for discharge.

Membership of the Working Party

Heather Cahill, Lecturer & ENB A21 Course Leader, University of York
Ian Jackson, Consultant Anaesthetist, York Health Services Trust
Doug McWhinnie, Consultant Surgeon, Milton Keynes



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Introduction

The successful provision of day surgery depends upon the attention to detail and quality throughout the patients stay. This is especially true when considering the assessment of fitness for discharge and the accompanying discharge procedures. This handbook contains advice from the British Association of Day Surgery on what we consider to be best practice and on how to formulate your own local guidelines. The reader will note the multidisciplinary nature of the Working Party responsible for this handbook, it will be impossible to institute our recommendations without a similar group working together in each hospital. Most units will already have guidelines in place and we hope this handbook will help as part of their regular review.

The Council of BADS welcomes feedback from our members or others with experience in day surgery about any of the handbook series.

Recent Reports

Several of the reports that deal with this issue in day surgery are now several years old but contain useful information that can be used as a starting point.

- Association of Anaesthetists booklet Day Case Surgery: The Anaesthetist's Role in Promoting High Quality Care.
- Royal College of Surgeons handbook Guidelines for Day Case Surgery. London.
- National Health Service Management Executive, Value for Money Unit. Day Surgery: Making it happen.

Discharge Criteria

Every patient should be seen following their operation by the anaesthetist and surgeon involved in their care. Assessment of when the patient is 'street fit' or ready for discharge can and should be performed by nursing staff. Each unit needs to identify clear discharge criteria as part of a written policy for staff to follow. These need to consider social factors as well as a medical assessment of sufficient recovery for discharge. All guidelines should address the following areas

- vital signs stable for at least one hour
- correct orientation as to time, place and person
- adequate pain control and has supply of oral analgesia
- understands how to use oral analgesia supplied and has been given written information about these
- ability to dress and walk where appropriate
- minimal nausea, vomiting or dizziness
- has at least taken oral fluids
- minimal bleeding or wound drainage
- has passed urine (if appropriate)
- has a responsible adult to take them home
- has agreed to have a carer at home for next 24 hours
- written and verbal instructions given about postoperative care
- knows when to come back for follow up (if appropriate)
- emergency contact number supplied

Criteria for discharge of patient from Day Unit

Scoring systems exist to aid in the assessment of recovery and are extensively used in Canada and the USA. Suitable systems include the Post Anaesthesia Recovery Score modified for Day Surgery which was published by Aldrete in 1995. In this system patients can score a maximum of 20 and those with a score of 18 or greater are said to be fit for discharge.

| | Score |
|--|--------------|
| <i>Activity</i> | |
| Able to move 4 extremities voluntarily or on command | 2 |
| Able to move 2 extremities voluntarily or on command | 1 |
| Unable to move extremities voluntarily or on command | 0 |
| <i>Respiration</i> | |
| Able to breathe deeply and cough freely | 2 |
| Dyspnoea or limited breathing | 1 |
| Apneic | 0 |
| <i>Circulation</i> | |
| BP \pm 20% of preanaesthetic level | 2 |
| BP \pm 20 to 49% of preanaesthetic level | 1 |
| BP \pm 50% of preanaesthetic level | 0 |
| <i>Consciousness</i> | |
| Fully awake | 2 |
| rousable on calling | 1 |
| Not responding | 0 |
| <i>Oxygen saturation</i> | |
| Able to maintain saturation >92% on room air | 2 |
| Needs oxygen to maintain saturation >90% | 1 |
| Saturation <90% even with oxygen | 0 |
| <i>Dressing</i> | |
| Dry and clean | 2 |
| Wet but stationary or marked | 1 |
| Growing area of wetness | 0 |
| <i>Pain</i> | |
| Pain free | 2 |
| Mild pain handled by oral medication | 1 |
| Severe pain requiring parenteral medication | 0 |
| <i>Ambulation</i> | |
| Able to stand up and walk straight | 2 |
| Vertigo when erect | 1 |
| Dizziness when supine | 0 |
| <i>Fasting-feeding</i> | |
| Able to drink fluids | 2 |
| Nauseated | 1 |
| Nausea and vomiting | 0 |
| <i>Urine output</i> | |
| Has voided | 2 |
| Unable to void but comfortable | 1 |
| Unable to void and uncomfortable | 0 |

Another more recent system is the Postanesthesia Discharge Scoring System (PADSS) developed by Marshall and Chung. The total possible score is 10 and patients scoring 9 or above are fit for discharge.

| | Score |
|-----------------------------|--|
| Vital signs: | <i>vital signs must be stable and consistent with age and preoperative baseline.</i> |
| | BP and pulse within 20% of preoperative baseline 2 |
| | BP and pulse within 20-40% of preoperative baseline 1 |
| | BP and pulses >40% from preoperative baseline 0 |
| Activity level: | <i>Patient must be able to ambulate at preoperative level.</i> |
| | Steady gait, no dizziness(or meets preoperative level) 2 |
| | Requires assistance 1 |
| | Unable to ambulate 0 |
| Nausea and Vomiting: | <i>The patient should have minimal nausea and vomiting prior to discharge.</i> |
| | Minimal: successfully treated with oral medication 2 |
| | Moderate: successfully treated with intramuscular medication 1 |
| | Severe: continues after repeated treatment 0 |
| Pain: | <i>The patient should have minimal or no pain prior to discharge. The level of pain that the patient has should be acceptable to the patient. Pain should be controllable by oral analgesics. The location, type and intensity of pain should be consistent with the anticipated postoperative discomfort.</i> |
| | Acceptability: Yes 2 |
| | No 0 |
| Surgical Bleeding: | <i>Postoperative bleeding should be consistent with expected blood loss for the procedure.</i> |
| | Minimal: does not require dressing change 2 |
| | Moderate: up to two dressing changes required 1 |
| | Severe: more than three dressing changes required 0 |

Whether scoring systems have advantages over the simple tick list of the criteria outlined previously is for each individual unit to decide. However if a scoring system is to be used it is important that the scoring system is reproduced in full in the patients care plan and that those criteria not addressed by this system are included at some stage in the assessment. Scoring systems are useful to judge reproducible endpoints for use in research projects, however no current system covers all the social, psychological and physical assessments necessary to ensure that the patient

is indeed ready for discharge. Perhaps a system that encourages nursing staff to look at both the patient and their carer and not just a score sheet, will ultimately provide the best results.

Discharge Process & information needs

Regardless of how patient discharge is organised within individual units, the actual discharge process should create a climate in which patients and their carers understand their roles and responsibilities in ongoing care and therefore feel confident to go home. In general, avoiding discharging patients too early will usually ensure that any essential discharge criteria are met. Preparation of specific discharge information should be collected in readiness for each patient so discharge is as smooth and unrushed as possible. The communication skills of nurses in co-ordinating this process are therefore of utmost importance.

With the possible exception of a diagnosis, none of the information provided during the discharge process should be new. The practice of patients being given diagnostic information when still under the effects of anaesthetic should be avoided whenever possible. Uncertainty and anxiety about a diagnosis as a result of post anaesthetic drowsiness will also interfere with the processing of other necessary discharge information. When this is unavoidable, nursing staff must ensure that information given is reinforced prior to discharge.

Whenever possible, the patients identified carer should be involved in all pre-discharge assessment and information giving. Nursing staff must ensure that they assess both patient and carers understanding of their ongoing care responsibilities through structured questioning. As a general guide, procedure specific information should encompass

- medication - specific instructions regarding prescribed analgesia, antiemetics or antibiotics
- wound care & when patient is able bathe or shower
- arrangements for dressing renewal and suture removal (if appropriate)
- resuming normal activities
- what 'normal' symptoms may be expected and their duration
- what would be abnormal symptoms and what to do if they occur
- contact telephone numbers for information or in an emergency
- arrangements for follow -up (telephone and out-patients)

Local development of guidelines

Guidelines for patient discharge within individual units requires the consensus opinion of Anaesthetists, Day Unit Nurses and Surgeons. The Guideline document should address generic criteria for discharge as suggested here but should also consider discharge criteria for particular groups of patients. Sometimes these will address issues such as the minimum time span of stay of the patient prior to considering discharge (this is particularly pertinent when considering more invasive procedures, for example laparoscopic cholecystectomy, tonsillectomy and thyroid surgery).

Alternatively the specific discharge criteria may directly contradict the generic criteria, for example the patient may be unable to walk unaided from the Unit following orthopaedic surgery to the foot. Common sense in such situations is clearly required and thus the individual surgical procedure or type of surgery undertaken may prompt additional specific criteria. Once again this demonstrates problems with any system that is too rigid be it scoring or criteria based.

It is important that the criteria are used once they have been agreed. Members of staff (Surgeons, Anaesthetists or Nurses) who ignore the guidelines put the reputation of the Unit and the Day Surgery as a whole at risk. It is important that this

is not allowed to happen and is dealt with promptly to ensure our patients continue to receive the quality service we all strive to provide.

References

1. Aldrete JA. The post-anesthesia recovery score revisited. *Journal of Clinical Anesthesia*. 1995;7:89-91.
2. Marshall S, Chung F. Assessment of 'home readiness': discharge criteria and postdischarge complications. *Current Opinions in Anesthesiology* 1997;10:445-50.
3. Marshall SI, Chung F. Discharge criteria and complications after ambulatory surgery. *Anesthesia & Analgesia*. 1999;88:508-17