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D-00-07-30268
CLINICAL PRACTICE DOCUMENT

Care and Discharge of the Ambulatory Surgical Patient in Phase II and Extended Observation Phase

SITE APPLICABILITY:

- VGH: PACU/PCC
- UBCH: PACU/SDC
- LGH/SGH:PACU/SDC
- RH: PACU/SDC

PRACTICE LEVEL:

RN, LPN

POLICY STATEMENT:

- **All patients admitted to Phase II/Extended Observation Phase will be assessed for:**
  - level of consciousness/sedation,
  - circulation,
  - respirations,
  - SpO2,
  - activity,
  - pain,
  - PONV (Post Op Nausea & Vomiting),
  - bleeding,
  - and temperature as per the TABLE: Assessment Parameters and Frequency below.
  - Other parameters (e.g., sensory & motor level, bladder, surgical parameters) will be assessed and monitored as applicable to the individual patient, as per the TABLE: Assessment Parameters and Frequency below.
- **VGH PACU/PCC:** LPNs who have completed PCC unit specific training may admit and discharge stable, predictable, less complex patients from Phase II/Extended Observation Phase in an RN/LPN collaborative nursing assignment model.
- Patients discharged from Phase II/Extended Observation Phase must meet all stipulated criteria for discharge.
- In addition to the Discharge Criteria, a scoring system will be used. The patient must achieve 16/16 (a score of 2 in each parameter of the Score Key) prior to discharge. See Appendix A: Discharge of Phase II/Extended Observation Phase, Ambulatory Surgical Patients SCORE KEY.
- Patients who do not achieve discharge criteria require either a discharge order from an anesthesiologist and/or surgeon or a hospital admission.
- Patients who have received general anesthesia, regional anesthesia, or conscious sedation must have a responsible adult escort them home. It is recommended (required at RH) that each patient has a responsible adult stay with him/her overnight, to provide care that is required.

NEED TO KNOW:

This Policy describes the care, criteria for discharge, and discharge procedure of the Phase II/Extended Observation ambulatory surgical patient. This care may take place in any area in which patients are cared for after surgical procedures. It describes the assessment parameters, assessment frequency, and basic interventions.

Post Anesthesia Phase II occurs immediately following Post Anesthesia Phase I and includes day surgery/discharge settings. Phase II involves progressive care in preparation for a patient's transfer to home, an extended care facility, or Extended Observation.

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The Extended Observation Phase occurs immediately following Post Anesthesia Phase II, and includes patients who require ongoing nursing care/observation or intervention. This may include patients awaiting transfer to an inpatient bed, awaiting transport home, or are ready for discharge but have no caregiver/responsible escort.

PROTOCOL: Nursing staff are responsible for monitoring and documenting parameters at specified intervals and for increasing the frequency and scope of assessments as required by changes in the patient's condition. These parameters must be consistent with surgery, anesthesia, and the patient's pre-operative status.

Assessment Parameters & Frequency
To be done at the following frequency while the patient is under our care:

VS/PARAMETER	FREQUENCY
• **Level of Consciousness/Sedation** • **Circulation (BP & Pulse)** • **Respiration** • **Oxygen Saturation** • **Activity** • **PONV** • **Pain** • **Bleeding**	For patients who have met Phase I discharge criteria: Using Scoring System: • On admission (UBCH: unless done within previous 10 minutes in PACU, and transfer to Phase II is done by the PACU RN), then • Minimum Q30 min x 1, then, • if does NOT meet discharge criteria, then • Minimum Q1/2 to 1H depending on RN assessment • Monitoring must be appropriate to the patient condition. Should the patient's condition revert to Phase I status, consult with PACU charge nurse regarding transfer back to PACU. Once Phase II discharge criteria are met, and patient is awaiting transport, or requiring further observation/intervention consistent with the Extended Observation Phase): • Q1H x 2 hours, then • Q4H until discharge
Temperature	• Q1H x 2 hours, then • Q4H until discharge • Must be done at least once prior to discharge
Sensory & Motor Level Assess motor & sensory level of regional anesthesia. Neuraxial (Spinal) sensory levels will be determined by testing with ice, starting from the lower or blocked area. The dermatome documented is the first area where the patient feels a cold sensation.	Neuroaxial (spinal) Anesthesia: Sensory dermatome and motor Level • 30 to 60 minutes following spinal anesthesia or local nerve block until discharge criteria met Peripheral Blocks: Distribution of sensory/motor impairment and complications appropriate to type of block (See Appendix B of CPD C-155) • Q15-30 minutes until discharge criteria met, then • Q1H or as per medical orders
Bladder for distention/overflow, via bladder scan, palpation, or observation of clinical indicator.	• Q1H for patients following spinal anesthesia • PRN for all other patients

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SURGICAL PARAMETERS	
General: • dressings • drains • surgical site • IV site(s)	Patients who have met Phase I discharge criteria: • On admission (UBCH: unless just done in PACU), then • Q30 minutes x 1, then • Q1H until meeting discharge criteria • If have met Phase II discharge criteria and are awaiting their ride: ○ Q1H x 2 hours then Q4H until discharge

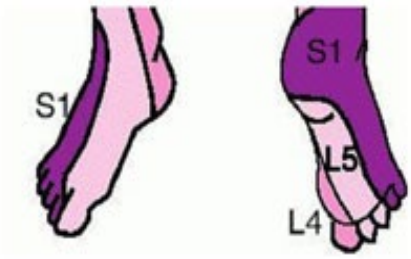
Neurovascular (CSMW):
• Ortho
• Vascular/Radiology:
  ○ CSMW to all relevant limbs
  ○ Pulses
• Graft/Fistula:
  ○ Bruit/thrill
  ○ Pulse
	If WNL (Within Normal Limits) for the patient or expected due to regional or neuraxial block:
	• On admission (UBCH: unless just done in PACU), then
	• Q30 minutes x 1 and stable, then
	• Q1H x 2 hours, then Q4H until discharge
	IF NOT WNL (i.e., due to possible surgery-related cause), notify surgeon and continue to assess:
	• Minimum Q30 minutes until normal or surgeon accepts assessment, then
	• Q1H X 2 hours and stable, then
	• Q4H until discharge

Postoperative Care and Discharge

- Complete assessment and scoring as outlined in chart above and Appendix A.
- Assess operative site and relevant surgical parameters (neurovascular, voiding).
- **Diet:** Start fluids and food if the patient desires, or as ordered.
- **Medications:** After administering medication(s), the RN will:
  - Ensure appropriate outcomes and peak effect of medications have been achieved without adverse effects
  - Monitor the patient for a minimum of 30 minutes after IV injection with the IV left in situ
  - Monitor the patient for a minimum of 45 minutes after intramuscular injection, and a minimum of 30 minutes after a subcutaneous injection **Note:** Check with the surgeon and/or anesthesiologist when patient should resume regular meds, particularly anticoagulants, insulin, antihypertensives, if not already stated in physician's orders.
- **Postoperative Instructions:** Give discharge teaching pamphlets and prescription(s). Review and reinforce instructions regarding post-anesthesia care, discharge teaching pamphlet(s) and surgical follow-up care.
- **I.V.'s:** Ensure adequate (advise 1 to 2 liters) IV fluids before removing the IV unless this is contraindicated. Remove the IV when the patient is ready to ambulate, and is alert and stable (dangling or ambulating first is recommended). Leave IV in situ until ready for discharge for patients who have had a spinal, and for Urology patients who should void prior to discharge.
- **Physician orders:** Complete and sign off orders and copy relevant instructions onto patient's discharge teaching pamphlet(s).
- **Voiding:** In the following instances, the patient must void spontaneously prior to discharge (unless otherwise ordered):
  - Following removal of an indwelling urinary catheter
  - If the patient received a spinal anesthetic and is greater than 70 years of age
  - If the patient has a previous history of voiding difficulties
  - For LGH/SGH- If patient has a spinal anesthetic and is <70 years old with a bladder scan of <400ml, may be discharged with instructions to go to emergency department if unable to void 6hrs after discharge.
- **Regional Anesthesia:**
  PROCEDURE before ambulating after Regional Anesthesia:

- **After Spinal Anesthesia:**

The patient must have full sensation to ice to the lateral aspect of the sole of the foot (S1).



Assess leg strength by asking the patient to dorsi and plantar flex the feet against resistance. The patient must be able to stand up without assistance and maintain balance before attempting to walk with a walker.

- **After a lower limb peripheral nerve block** (e.g. femoral nerve block/sciatic nerve block/popliteal block/saphenous nerve block/ankle block): the patient must use crutches for ambulation until usual strength and sensation returns to the affected leg/foot.
- **After open inguinal hernia repair**, assess femoral nerve innervated strength and sensation on the same side: ability to straight leg raise against resistance, and sensation to touch on the antero-lateral thigh.

- Patients who receive general or spinal/epidural anesthesia or sedation must be discharged in the company of a responsible adult.
- **Discharge:** If the patient does not meet Discharge Criteria, consult with Anesthesiologist. The patient requires either a discharge order from the Anesthesiologist or admission to an in-patient unit. In the event that surgical criteria are not met (e.g., operative bleeding), consult with Surgeon.
- **Discharge and admission of an ambulatory patient to In-Patient Unit:**
  - Inform patient's ride of change in plans
  - Ensure postoperative orders are written and that the surgeon has arranged to admit the patient
  - Phone or fax report to the in-patient unit and arrange transfer time
  - Send the chart and the patient's belongings with the patient to the in-patient unit.

SITE SPECIFIC PRACTICES:

VGH PCC:

- Rides: Once patient is admitted back post-operatively to PCC, provide unit clerk with Bay # and anticipated time of discharge and advise clerk to inform the patient's ride.
- Patients change at bedside and must remain in assigned Bay within the unit until their ride arrives.
- In the event of overcapacity, the patient, under the In-Charge Nurses' discretion, may be asked to sit in the PCC waiting room until their ride arrives. The patient will be given a "PCC Discharge Slip" that is to be handed in to the clerk upon arrival of their ride.
- Once ride arrives, confirm discharge criteria has been met and complete or reinforce discharge teaching as needed. Patients may walk out or use a wheelchair if their condition warrants.
- Complete discharge charting and enter discharge in PCIS. Leave chart in "out" box for clerks to disassemble.

VGH PACU:

Discharging Patient from PACU direct to home:

1. Verify:
   - patient achieves a discharge score of 16/16 or
   - written order confirming that patient may be discharged home
2. Assist patient to dress at bedside:
   - If patient admitted directly to PACU preoperatively, clothing is kept in PACU
   - If patient admitted through another unit/department (e.g., Emergency, Medical Day Bed, Radiology) call admitting unit and ask them to bring patient's clothing to PACU.

3. Contact the responsible adult designated to accompany the patient home 30 to 60 minutes prior to anticipated discharge and provide with information re:
    - specific time to arrive at hospital
    - where to park, e.g.
        - after hours - parking area at Emergency Department entrance – 10th Avenue & Laurel Street
        - Laurel Street between 10th Avenue & 12th Avenue
        - 12th Avenue at main JPP entrance
    - directions to PACU
4. Ensure documentation complete as follows:
    - Complete discharge charting including discharge score on PACU Record
      EXCEPTION: patient admitted directly to PACU preoperatively
        - Document the discharge score on the PCC Clinical Record
    - Complete and sign off "Hospital Day Service" (HFACE) face sheet
        - if form not available, print out from PCIS via "HFACE" command
    - Chart will remain in PACU until reviewed by the Patient Care Coordinator
5. Obtain wheelchair from Patient Escort as needed
    - patients may walk out or use a wheelchair as warranted by their condition
6. Escort patient and accompanying responsible adult to PACU door and discharge
7. When patient physically leaves PACU, discharge through PCIS
   Exception – patient admitted from Radiology
    - If unable to access patient in PCIS, notify Radiology to complete the discharge
    - If discharge occurs after hours or on weekends, leave patient chart and discharge time for Patient Care Coordinator who will make appropriate notifications

UBCH PACU:

- Escort Home: When satisfied that the patient will be ready for discharge within 30 to 60 minutes, enter "dispen" (discharge pending) time into PCIS, advising the clerk to inform the patient's escort. Escort must be a responsible adult who escorts the patient home by arranging for safe transportation from UBCH.
- Patients change at the bedside, with nurse's assistance as needed. After dressing, patients may wait on the recliners on the unit or return to the stretcher in their assigned bay.
- When the escort arrives, confirm discharge criteria has been met, and complete or reinforce discharge teaching as needed.
- Patients may walk out or be taken by the PHCA or Nurse in a wheelchair if their condition warrants, e.g., after spinal, regional, or lower extremity anesthetic block.
- Complete discharge charting and enter discharge into PCIS. Complete the "Anesthesia Codes" form. Leave completed chart in "out" basket for clerks to retrieve.
- Patients from **Detwiller** or **Purdy Pavilions** do not require discharge/transfer orders but do require postoperative orders, including Postop Medication Reconciliation orders. They must also meet the Phase II/Extended Observation phase discharge criteria.
    - The chart is sent with the patient back to the unit.
    - Telephone report to the ward when the patient is ready to return.
    - Transfer staff:
        - Purdy: PACU PHCA does the transfer
        - Detwiller (Psych): ward nurse is called to bring a wheelchair and transfer the patient.

LGH PACU / SDC

1. Verify patient meets discharge criteria with a score of 16/16 (Appendix A) and document:
    - Sedation Scales – Modified Aldrete Score (must score of 10/10 for discharge)
    - Periop Discharge Criteria (Phase II Discharge Criteria)

2. Return belongings as listed on Valuables/Belongings form and document return – Patient may get dressed at bedside independently or with nurse's assistance as needed.

3. Patients to be accompanied home by a responsible adult – Designated escort will be called 30-60 min ahead of anticipated discharge and provided with information:
    - Where to park (Driveway off E 15th St.)
    - Anticipated discharge time
    - Directions to surgical services if ride coming up to SDC (After hours enter through ED)
4. Patients may wait in their assigned bay or a chair in the unit until ride arrives
5. Patient may leave the unit with designated escort or be taken to pick up area by RN, porter or hospital volunteer. A wheelchair may be used if warranted.
6. Once patient has left SDC complete discharge documentation – Nursing Discharge Checklist, document Phase II Discharge Time and finalize Perioperative Doc (Phase II), discontinue relevant powerplans, Discharge Encounter in PM Conversation.
7. Place patient's chartlet in designated drawer at SDC nursing station.

SGH PACU PHASE II DISCHARGE PROCEDURE For Daycare Surgeries

- Call Patient's ride home approx. 30-60 minutes prior to estimated discharge time: instruct ride to pull up in front of main hospital entrance (and remain in car- visitor restrictions remain in effect at this time). If patient's discharge is delayed, call patient's ride to provide update/new estimated discharge time.
- When discharge criteria met for Phase 2: document final assessments (vital signs; sedation scale; incisions; pain, nausea, bladder scan if appropriate/required for spinal anesthetic)
- Write out post op instructions from surgeon/anesthesia on discharge pamphlet, include when next dose of pain medication is due/available. Include post-op pamphlets for Opioid Tapering, DVT's, Drain Care, Post-op exercises, as appropriate.
- Review post-op teaching with patient's ride home, either via phone when organizing pickup, or at car side when patient is discharged.
- Once patient has left hospital; Finalize peri-op doc with Phase 2 discharge time, discharge patient's encounter via PM conversation.

RH PACU PHASE II DISCUARGE PROCEDURE for Daycare Surgeries

- Verify patient meets discharge criteria and complete documentation on the Perianesthesia Record, including:
    - Modified Aldrete Score Revised –score of 16 / 16 for discharge
    - Periop Discharge Criteria section (Phase II Discharge Criteria)
- Return belongings and document return – patient may get dressed at bedside independently or with assistance from nurse as needed.
- Patient is to be accompanied home by a responsible adult who will be called 30-60 min ahead of anticipated discharge time.
    - Pick up location is usually the Surgical Day Care area (after hours enter through the ED).
    - Alternative pick up location arrangements can be made when discussed with the discharge nurse in advance (e.g. the patient can be transported to the main or south entrance of the hospital by the discharge nurse)
- Patients are required to have a responsible adult stay with them overnight
- Patients may wait in their assigned bay or a chair in the SDC area until their ride arrives.
- Provide patient with pamphlets for discharge teaching and review these materials with patient. Patient specific instructions may be written on the front of the pamphlet by the discharging nurse. If necessary, include family/responsible adult in discharge teaching. Ensure patient receives prescription if written by physician.
- Provide patient with water or juice. If the patient status remains unchanged and they are tolerating oral fluids, the I.V. may be removed and documented.

- Once patient has left SDC, review all discharge documentation to ensure it is complete:
  - Nursing Discharge Checklist, including time patient met discharge criteria, and official discharge time, and
  - Discharge patient from PCIS and document discharge time on the "Operating Room Record"
- If follow-up phone call required, ensure the box is completed on page 6 of the PeriAnesthesia Record and chart is left in appropriate bin for the discharge nurse to follow up the next day

EXPECTED CLIENT / FAMILY OUTCOMES:

The patient will be able to safely care for him/herself at home.

PATIENT / CLIENT / RESIDENT EDUCATION:

Initiate appropriate patient education as follows and reinforce with appropriate written discharge instructions:

After receiving general anesthesia, spinal or sedation:	Do not operate a motor vehicle or machinery or enter into legal contracts for 24 hours. Caution about the additive effects of alcoholic beverages and/or other drugs.
Pamphlets:	• ED.925.G286 General Anesthesia/Local Anesthesia/Procedural Sedation • ED.900.Sp46 Spinal or Epidural Anesthesia
After local anesthesia affecting vision or function of a limb:	Do not operate a motor vehicle or machinery for 24 hours. Protect the limb from injury until sensation and movement return to normal.
After nerve block:	Contact surgeon & anesthesiologist if nerve block persists longer than 2 days after surgery. If the leg may be affected (eg. after local anesthesia infiltration for inguinal hernia repair), RN to caution the patient about the **possibility of unexpected** weakness in the leg, which may last for several hours. Pamphlet: FM.820.P47 Peripheral Nerve Block
If unable to void within 6 hours of discharge and/or experiencing pain from bladder distention especially following epidural or spinal anesthesia or genito-urinary surgery:	Contact surgeon or hospital emergency department
Pamphlet related to surgery and other (e.g. Crutch Use, Catheter Care and Removal)	Write any instructions on pamphlet.

DOCUMENTATION:

- **UBCH:** Preop & PACU Record (Inpatient or Outpatient)
- **VGH:** Post Anaesthesia Care Record, PCC Clinical Record (for direct preoperative admissions)
- **VGH:** Perioperative Care Centre: Perioperative Care Centre Clinical Record
- **LGH/SGH:** Pre-op and PACU Record (Cerner)
- **RH:** PeriAnesthesia Record

RELATED DOCUMENTS:

- Discharge of the Post Anaesthetic Patient - Phase I [D-00-07-030267]
- Care of the Post Anesthetic Patient in Phase I [D-00-07-30260]
- Appendix A: Discharge of Phase II/Extended Observation Phase, Ambulatory Surgical Patients Score Key
- Anesthetic Codes Form
  - UBCH: VCH.VA.UBCH.0006
- Pamphlet:
  - FM.820.P47 Peripheral Nerve Block

- ED.900.Sp46 Spinal or Epidural Anesthesia
- ED.925.G286 General Anesthesia/Local Anesthesia/Procedural Sedation

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ALTERNATIVE SEARCH TERMS:	ambulatory patients	surgical patients	discharge criteria
discharge	phase II	phase 3	phase 2
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This CPD has been prepared as a guide to assist and support practice for staff working at Vancouver Acute. It is not a substitute for proper training, experience and the exercise of professional judgement.

Vancouver CoastalHealth

Appendix A

Discharge of Phase II / Extended Observation Phase Ambulatory Surgical Patients SCORE KEY

Note: If "Activity" equal to Preop, or expected due to OR/Anesthesia, the patient may be given full score (e.g. quadriplegia, after knee surgery)

PARAMETER	SCORE	CRITERIA
LEVEL OF CONSCIOUSNESS /SEDATION	**2**	Conscious, opens eyes, easy to arouse
	1	Frequently drowsy, easy to arouse
	0	Unresponsive or somnolent
CIRCULATION BP & P	**2**	Within 20% of pre-op
	1	20% to 40% of pre-op
	0	> 40% of pre-op
RESPIRATION	**2**	Able to deep breathe
	1	Limited breathing (eg. obstructed, shallow)
	0	Requires airway support
OXYGEN SATURATION	**2**	= or > 94% on room air
	1	= or > 94% on O2
	0	< 94%
ACTIVITY ***	**2**	Steady gait
	1	Moves some extremities, not ready to walk, able to turn to side
	0	No gross body movement
PONV	**2**	Controlled, acceptable to patient or maximal treatment given
	1	Further treatment required
	0	Uncontrolled after treatment
PAIN	**2**	Controlled, acceptable to patient or maximal treatment given
	1	Further treatment required
	0	Uncontrolled after treatment
BLEEDING	**2**	Minimal, no evidence of active or unexpected bleeding
	1	Operative site wet, bleeding/hematoma not increasing
	0	Increasing bleeding/hematoma