

## NURSING PRACTICE STANDARD

### B-00-13-10184 – MSSU/OPAT (8D) Discharge Criteria

#### MSSU/OPAT (8D): Discharge from Facility Criteria

##### Site Applicability

Medical Short Stay Unit (MSSU) / Outpatient Ambulatory Therapy (OPAT) at SPH only

**Skill Level** Basic RN

##### Related Guidelines and Resources:

1. [B-00-12-10135](#) – BCG Bladder Instillation Procedure for the Medical Short Stay Unit
2. [B-00-13-10016](#) – Liver Biopsy (Medical Short Stay Unit): Care of Patient
3. [B-00-13-10046](#) – Procedural Sedation and Analgesia in Clinics and Procedure Rooms
4. [B-00-13-10148](#) – Chemotherapy: Administration of Parenteral Chemotherapy

##### Clinical Indication:

Patient assessment prior to discharge from ambulatory care MSSU and OPAT at SPH when a prescriber has ordered “Discharge when criteria met”

##### Need To Know:

An order from a prescriber overrides the use of this protocol

The discharge assessment and documentation will be done within 30 minutes before the patient leaves the MSSU and/or OPAT on 8D.

#### PRACTICE GUIDELINE

##### Assessment and Discharge Criteria:

Patient’s receiving procedural sedation will be assessed as per the [Procedural Sedation and Analgesia protocol](#).

Assessment	Criteria
<b>CNS</b>	<ul style="list-style-type: none"><li>• Orientated to person place, time or orientation equivalent to patients admission status</li><li>• Strength and ROM in all limbs equivalent to patients admission status</li></ul>
<b>Respiratory</b>	<ul style="list-style-type: none"><li>• Respiratory rate 10 to 20 breaths/ minute</li><li>• SpO<sub>2</sub> 92% or more on room air <b>OR</b> within +/- 20% of admission level and/or patients usual values.</li><li>• Intact protective airway reflexes present (gag, swallow, cough and ability to clear secretions).</li></ul>

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Assessment	Criteria
<b>Cardiovascular:</b>	<ul style="list-style-type: none"> <li>BP, HR (heart rate) within +/- 20% of admission level and/or patients usual values.</li> <li>Skin warm and dry with evidence of adequate tissue perfusion, temperature below 37.5°C</li> </ul>
<b>Gastrointestinal:</b>	<ul style="list-style-type: none"> <li>No or mild nausea</li> </ul>
<b>Genitourinary:</b>	<ul style="list-style-type: none"> <li>No bladder distension or evidence of urinary retention</li> </ul>
<b>Vascular Access</b>	<p>Peripheral IV – Discontinued <b>OR</b> as below:</p> <p>Venous Access Devices (includes PIV and CVC/PICC)</p> <ul style="list-style-type: none"> <li>Secured in place</li> <li>Dressing dry and intact</li> <li>Patient has received instruction on line/site care.</li> </ul>
<b>Dressings</b>	<ul style="list-style-type: none"> <li>Dry and intact, no signs of bleeding</li> <li>Patient has received instruction on dressing/site care</li> </ul>
<b>Medications:</b>	<ol style="list-style-type: none"> <li><b>Oral medications</b> <ul style="list-style-type: none"> <li>May be discharged immediately following administration of medication.</li> </ul> </li> <li><b>IV Medications</b> including IV Direct (push); first dose of antibiotics; antiemetics and analgesia <ul style="list-style-type: none"> <li>MSSU minimum stay 15 minutes following dose</li> <li>OPAT – Ensure patient education completed prior to patient leaving (see below)</li> </ul> </li> <li><b>Subcutaneous narcotic</b> <ul style="list-style-type: none"> <li>Minimum stay 30 minutes following administration of medication</li> </ul> </li> </ol>
<b>Pain</b>	No pain or mild pain (0 to 3 on pain scale) <b>OR</b> a pain management plan is in place.
<b>Blood and blood products</b>	<ul style="list-style-type: none"> <li>Transfusion complete, no signs or symptoms of transfusion reaction</li> <li>Patient has received instruction on what to do if any symptoms of a delayed reaction</li> </ul>
<b>Miscellaneous</b>	<ul style="list-style-type: none"> <li>Patient education material (e.g. chemotherapy fever card, Neutropenia information, post procedure care information), prescriptions, lab requisitions etc have been given to patient/family</li> <li>Verbal discharge teaching completed as applicable (patient and where possible family), including what to do in case of ongoing pain, delayed allergic reaction, bleeding or other adverse reaction</li> </ul>

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#### **Patient/Family Education:**

Provide Patient and/or family member written and verbal instructions (see above) as needed. Ensure that they understand what they have been told and have had an opportunity to ask questions/clarify information.

Prior to the patient leaving the unit, ensure they are aware of signs and symptoms of adverse reaction to medication and what to do if they suspect a reaction (call physician, go to Emergency Department).

#### **Documentation:**

1. MSSU/OPAT Flow sheet – assessments and interventions, patient status at discharge

#### **References:**

1. Kingdon, B, Newman, K. (2006) Determining Patient Discharge Criteria in an Outpatient Surgery Setting. AORN, April Vol. 83:4 989-904

#### **Persons/Groups Consulted:**

Clinical Nurse Specialist, Chemotherapy  
Nurse Educator Medicine SPH  
Immunologist SPH

#### **Developed By:**

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#### **Approved By: Professional Practice Standards Committee**

#### **Date of Creation/Review/Revision:**

August 2017