

PROTOCOL FOR: Discharge of Ambulatory Patients (Phase 2)

- POLICY:**
1. Patients will be discharged home from the Perioperative area only under the direct authorization of an attending physician with appropriate clinical privileges.
 2. Patients who have received anesthesia services require a discharge signature within 30 minutes prior to discharge home.
 3. GI Endoscopy, Local By Surgeon, Interventional Radiology, Electrophysiology, and Cardiopulmonary patients may be discharged upon achievement of appropriate criteria and must have a discharge signature from the appropriate attending physician on the chart.
 4. Ambulatory patients will be discharged with a designated individual who will be responsible for any patient who has received moderate or deep sedation; monitored anesthesia care; regional blockade anesthesia, including, but not limited to spinal, epidural or peripheral nerve blockage; or general anesthesia and who will receive necessary postoperative care instructions.

DESIRED PATIENT

OUTCOME: Patient will be discharged with full return of reflexes, respiratory adequacy, cognitive function, pain control, and steady gait, commensurate with preadmission status.

**CLINICAL
ASSESSMENT
AND CARE:**

1. General discharge criteria include:
 - stable vital signs for a minimum of 30 minutes after last sedation administered.
 - airway unobstructed; effective cough and/or noiseless respirations
 - BP at or within 20% of baseline; if patient voids, urine output > 30 ml/hr;
 - dressing dry and intact; no unexpected bleeding;
 - skin warm, dry, smooth, and intact, with no sign of damage;
 - have minimal nausea, vomiting, or dizziness;
 - pain level ≤ 4 , or as identified by the patient as acceptable;
 - be oriented to time, place, and person, or at baseline function;
 - IV discontinued & insertion site dressed; no bleeding from site and infiltration scale rating 0 - 1;
 - be accompanied by a responsible adult (parent/guardian for pediatric patients), unless formal exception has been arranged (e.g., local anesthesia only);
 - patient/responsible adult verbalizes comprehension of discharge instructions.
2. Discharge criteria following spinal or epidural anesthesia include
 - meet above criteria;
 - have return of strength and proprioception in lower extremities, and a steady gait or return to baseline mobility;
 - have return of normal sensation; and
 - be able to void, unless otherwise indicated by attending physician.

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3. Discharge criteria after gynecologic and / or urologic procedures include:
 - meet general discharge criteria;
 - be able to void spontaneously unless otherwise indicated by attending surgeon;
 - absence of gross hematuria.
4. Discharge criteria after endoscopic procedures include:
 - meet general discharge criteria;
 - lower GI: have soft, pain free abdomen and no evidence of covert bleeding;
 - upper GI and transesophageal echocardiogram (TEE): be able to swallow, no epigastric pain;
 - bronchoscopy: O₂ saturation level as identified by pulmonary service;
5. Discharge criteria after Interventional Radiology, Electrophysiology, and Interventional Cardiology procedures include:
 - meet general discharge criteria;
 - pulses in affected extremities at baseline or improved, as appropriate;
 - absence of bleeding or hematoma formation at puncture site(s)

PATIENT TEACHING: Patient and family will be given both verbal and written discharge instructions, with the exception of patients who are returning to a facility with skilled nursing care, in which case the institution / care givers will receive the instructions.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 1/98

REVISION DATE: 6/03, 2/06, 6/06, 2/08, 6/08

REVIEWED DATES: 8/09