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Review

Discharging patients: innovative postoperative care

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After surgery, the optimal goal is when the patient recovers without complications related to surgery or anaesthesia and can be discharged to home. However, that sometimes is an elusive goal. Several trends affect the ambulatory surgery population and discharge plans: today's generally older and sicker patients and more complex procedures along with economic pressure from insurers to perform procedures inexpensively. Many patients who are elderly, socially isolated, or systemically sick are forced into same day discharge after surgery whether they are ideal candidates or not. Most often the patient's home is the ideal setting for recuperation after surgery, but alternatives exist. These include home health nursing care with or without infusion therapy, 23 hour admission units, medical hotels, recovery care centres, surgical speciality hospitals, and traditional hospitalization. Each has its benefits and drawbacks, but provides a certain level of care and safety for patients after ambulatory surgical procedures.

Key words: Ambulatory surgery, discharge, recovery

Discharging patients on the same day after surgery and anaesthesia is an important responsibility. Healthcare providers must be cautious, thorough, and committed in their predischarge assessments when determining the appropriateness of each patient's physical, emotional, and social status. Is the patient physically able to return home? Are surgical or anaesthetic complications either present or likely to occur in the home recovery period? Does the adult who will be responsible for the patient display ability and desire to provide the level of attention that this patient will require? And what is the patient's attitude and desire about discharge? The patient who is motivated and eager to return home is likely to do well despite minor problems such as continuing nausea or discomfort. Whether the procedure is simple or complex, the process of same day discharge places stress and responsibilities on patients and their families.

Assuring that the patient is in the best possible condition for discharge is not only appropriate; it is essential. That process actually begins long before the time of discharge with the physician's careful selection and the proper preparation of patients for outpatient surgery. Obviously, the optimal situation occurs when the patient receives comprehensive and cautious care and recovers without complications related to surgery or anaesthesia. With careful application of the facility's discharge criteria, most patients are able to return home soon after surgery.

Current social and economic trends significantly affect the ambulatory surgery population, particularly in regards to discharge plans. With today's many medical advances that effectively prolong people's lives, the population is growing older and we see that trend reflected in the ambulatory surgery population. These older people are more likely to have co-morbid conditions such as heart disease, diabetes melitus, respiratory aliments, and other problems that can negatively affect the period of recuperation. Societal mobility leaves many families separated by great distances, without the close support of loved ones. In addition, third party payers are placing relentless requirements on providers to complete procedures in the most cost-effective manner, and that is often on an outpatient basis. This economic pressure is often at odds with the medical ideal, and many patients who are elderly, socially isolated, marginally competent, or systemically sick are forced into same day discharge after surgery whether they are ideal candidates or not. When dealing with insurers, it is becoming increasingly difficult for physicians to justify hospitalization for surgical patients.

Another trend finds more complex procedures being performed on an outpatient basis, ranging from simple mastectomy and partial thyroidectomy to extensive operative laparoscopic procedures such as cholecystectomy and laparoscopically assisted vaginal hysterectomy (LAVH). Even after these more complex procedures,

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patients who have not suffered complications may still be discharged to their own homes after surgery in well-controlled situations, for instance, if a family member is capable of the level of care required or if outside professional nursing care can be obtained.

As the healthcare community has become more experienced with these advanced types of procedures, a level of comfort has developed about the acceptability of performing them on an outpatient basis. Less stringent aftercare requirements are now understood to be safe and acceptable. This shift in ideology is logical and merely one more evolutionary change in the outpatient surgery continuum. Remember, it was only a few years ago that laparoscopic cholecystectomy coupled with early discharge was considered revolutionary and, in many circles, foolish! Today its safety and its benefits to patients and to society are well documented.

These and other issues must be considered when discharge after outpatient surgery is contemplated. First, the facility's written discharge criteria must meet the test of safety, appropriateness, and concordance with accrediting and licensing agencies. Second, an appropriate post-discharge setting must be assured. Often that site is the home, but sometimes it is an alternative. Ambulatory surgery programs have spawned many approaches to safe, cost-effective care after discharged. First, we should look at the criteria by which patients are discharged.

Disharge standards

Facility, licensing, and accrediting bodies establish standards within which ambulatory surgery programmes must operate. Some of these standards address the discharge of patients. Facility regulatory standards may differ from one location to another, but federal and accrediting standards are more universal. Payment of federal funds to a facility for care provided for Medicare patients is contingent on following the established guidelines of the Health Care Finance Administration (HCFA) whose generic quality screens for ambulatory surgery patients include the requirement for a documented discharge plan including patient education and provisions for follow-up care[1]. Appropriateness of care related to this element of the generic quality screens requires a physician evaluation for proper anaesthesia recovery prior to patient discharge, unless only topical or local anaesthesia has been used for the procedure.

Accrediting organizations also address discharge issues. Since 1988, the Standards of the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) have allowed predetermined, "relevant discharge criteria to be rigorously applied to determine the readiness of the patient for discharge." These criteria must have been previously approved by the physician staff[2]. This approach allows the nurse to act on behalf of the physician in determining the patient readiness for discharge when the physician is not immediately available, thus expediting the patient's discharge. While nurses certainly must assume professional responsibility and accountability for their actions, the ultimate responsibility for patient discharge remains with the physician through the prior approval of acceptable discharge criteria. Patients not meeting predetermined criteria require a specific physician's order prior to discharge by the nursing staff.

The Accreditation Association of Ambulatory Health Care (AAAHC) continues to require direct physician evaluation "after recovery from anesthesia, prior to discharge"[3] precluding primary nursing discharge. This scenario is cumbersome, and its current application has been questioned as outdated throughout the country by nurses who apply predetermined criteria[4].

Discharge criteria

Many well-established parameters are universally accepted as appropriate for determining discharge readiness. Examples include stability of vital signs, lack of respiratory distress, return of protective reflexes, relative comfort, no excessive surgical bleeding, availability of safe transportation and an adult companion, and return of sufficent cognitive and motor abilities. Also before discharge the patient and responsible adult must receive clear instructions for self care at home along with information on when, how and for what reasons to contact the physician for emergency care or questions.

Less universal are standards relating to the ability to void or to tolerate oral fluids before discharge and the acceptable level of nausea or vomiting continuing postoperatively[5]. The necessity of stringently meeting each of these parameters before discharge is a matter of clinical judgment and practices that varies from one facility or physician to another. Their application is also dependent on other factors such as the patient's prior state of health and hydration, age and the type of procedure performed.

The requirement for adult companionship after discharge is another area of concern that has been interpreted and applied in varied ways. Common sense as well as criteria determined by outside agencies and healthcare facilities identifies adult companionship for support and monitoring as a prerequisite to discharge. Questions certainly arise here. Who judges the acceptability of the responsible adult? What control, if any, does the physician or nurse have over the patient's plans for companionship after the actual discharge? Should a patient be allowed to leave the facility when it is known that there will be no continued supervision in the home once the transporter has dropped the patient off? Where do liability and responsibility lie when an unacceptable home situation is known (or not known) prior to surgery? Is the patient denied surgery because he is an elderly man living alone with no relatives or neighbours who he can ask to watch over him? These are difficult questions made even more difficult by a healthcare system that often will not or cannot pay for extended postoperative care for such individuals.

To address these dilemmas, each facility should create a multidisciplinary body to develop policies and criteria that will provide direction for the staff when dealing with such problems. Still, every situation is unique, so the

Table 1. Post-discharge care alternatives

Home (or alternative site) under care of responsible adult
Home (or alternative site) with nursing care
Home (or alternative site) with nursing care and infusion therapy
Twenty-three hour admission units
Medical hotels
Recovery care centers
Surgical specialty hospitals
Hospitalization

availability and willingness of adminstrative personnel, physicians, and the medical director of the unit to help solve individual situations is essential. When patients are identified who would benefit from further care after the usual time of discharge, it is clearly in the best interest of the patient and the facility for the healthcare providers to initiate such plans.

Post-discharge care alternatives

Innovative practices fuelled by patient needs have led to the development of both traditional and new approaches to surgical aftercare as listed in Table 1. The type of ambulatory surgical facility (hospital or freestanding), the patient's health insurance, state licensing mandates and legislation, the attitudes and progressiveness of the community's healthcare professionals, and the availability of community resources all play a part in the development and success of innovative post-discharge programs.

It can be challenging to convince an insurer to approve a nontraditional approach to post-discharge care, although a plan that is both safe and cost-effective may be attractive, particularly if that plan will eliminate a costly bill for hospitalization. Amazingly, some insurers continue to disapprove such innovations even when they will have to finance a more costly hospitalization by doing so. One reason given by payers is concern about the potential cost-shifting impact of removing elective surgical patients from hospitals. Another is concern over licensure status for overnight patients. As the speciality of ambulatory surgery evolves, more and more state legislatures are being challenged to open the service of post-surgical overnight care historically dominated by hospitals to allow development of innovative alternatives to hospitalization. The following discussion of various post-discharge programs assumes the availability of resources and the insurer's approval or the patient's ability to finance the care.

Care in the home setting

Discharge to home under the care of a responsible adult is clearly the simplest and most common form of outpatient discharge, but sometimes more intensive needs occur that can be met through visits from a home health nurse. This action may be taken because of the patient's lack of home support, extensive pre-existing physical ailments, or surgical complexity or complications. Plans for home health nurses should be made prior to the day of surgery to increase the likelihood of having a nurse available and assigned. The physician's or nurse's preoperative patient assessment may well uncover reasons for establishing this service. Collaboration between the home health agency, the surgical facility's nursing staff, the surgeon, and the anaesthesia team is essential for continuity and provision of appropriate aftercare. In particular, the home health nurse assigned to the patient should have prior experience with and a comfort level in caring for surgical patients and should be provided with a comprehensive report.

Some innovative surgery centres have developed packages that include providing postoperative home health care under the blanket of one payment for the insurer. Prior to becoming TOPS Surgical Speciality Hospital, then Texas Outpatient SurgiCare negotiated with home health and ambulance agencies for nursing care and transfer needs and supplied needed medications or surgical supplies for home use from the surgery centre. This approach allowed TOPS to develop a one cost quotation that was attractive to the insurer and provided patients with appropriate care following complex procedures[6].

Registered nurses in home health care provide general nursing assessment, care, and patient education; wound or drainage tubing care; dressing changes; monitoring of physical parameters such as blood pressure, temperature, or blood glucose levels; and medication adminstration. For patients who require only companionship and help with meals and hygiene a nurse's aid or house companion may be an acceptable and more cost-effective idea.

Infusion therapy in the home may be necessary after more complex surgeries. In fact, recent innovations in home infusion therapies have been a positive factor in encouraging more advanced procedures to be performed and still allow early patient discharge. Infusion therapy may be a service of the home health nursing agency or of a separate company, depending on licensing and state mandates. Therapies typically applicable after outpatient surgery include maintenance of intravenous fluids for hydration, administration of intravenous antibiotics, and maintenance of intravenous or subcutaneous patient controlled analgesia (PCA). Technological advances have produced miniaturized pumps and tamper-proof cassettes for PCA devices and basically foolproof infusion devices for antibiotics that allow patients to remain ambulatory. The registered nurse responsible for the infusion therapy monitors the equipment, the fluids and medications, the patient response to medications, and the venipuncture site.

First dosing of antibiotics is usually not an issue since the surgical patient receiving antibiotics will most likely be continuing those already given during and/or after surgery. Still, many home infusion agencies are prepared to give first doses of drugs when the physician orders the drug and approves the use of an emergency anaphylaxis kit that the infusion company supplies for the home.

As patients and society become more informed and sophisticated, many patients and families are expected to assume duties previously held by professionals. Exam-

ples include the use of continuous passive motion devices, dressing changes, foley catheter care and removal, and intramuscular injections. Whether this is a forward or a backward step is yet to be judged, but many patients and families do very well providing self care and, in fact, have the added benefit of reducing the patient's exposure to hospital acquired infection and other nosocomial occurrences such as medication errors.

In many facilities, practice and experience have resulted in a progression, or, better named, a positive 'regression', of home nursing care levels deemed necessary. Such practice changes are exemplified by the care patterns for patients having anterior cruciate ligament repair in several freestanding centres. At the Lakewood Surgical Centre in Lakewood, CO, physicans have been performing these knee procedures in the freestanding market for a number of years. According to the PACU nursing supervisor, Kee Merz, when the program began, patients received 24 hour home nursing care and were discharged with PCA pumps for analgesia support.

With experience, physicians and staff have become more comfortable with the safety and comfort level of patients. In particular, the advent of the Cryocuff and ketorolac for pain management spurred a change in the home nursing support required. Today, a primary nurse is assigned to make a preoperative patient visit. This is often in the patient's home, allowing inspection of the home situation as a positive addition to the preoperative assessment. The patient returns home about 3 hours after surgery primarily with the support of family, although the same primary nurse visits the patient postoperatively at about 4 pm and 10 pm on the evening of surgery to assess the patient and to administer intramuscular ketorolac and intravenous cefazolin. A third home visit on the next morning includes a dressing change, patient discharge teaching, and a discharge nursing assessment. The patient, family, and nurse also may exchange telephone calls during this early period.

This change in postoperative management has come about as a result of improved technology and pharmaceuticals; increased comfort with patient safety levels; experience, both surgical and procedural; and changing public and medical attitudes.

A similar pattern of care has been developed in Anchorage at the Alaska Surgery Centre where Darlene Cameron, RN, reiterates the importance of ketorolac and Cryocuff techniques as the 'key' for pain management, allowing patients to go home soon after surgery. At this centre, patients do not receive a home nurse visit, although a continuous passive motion (CPM) device is put on the patient by a representative of the company once the patient arrives home and telephones the CPM company. Both of these centres report no serious complications, no hospitalizations or resurgeries, and high patient and physician satisfaction with the mode of care.

Twenty-three hour admission units

Some facilities have the availability of keeping patients for a total of 23 hours from the time of their admission preoperatively. This type of care provides essentially the same given to any hospitalized patient: nursing observation and care, medications, meals, access to emergency response personnel, and the security of professional care in the early hours of recuperation. Families are encouraged to be with the patient, and often 'rooming in' of one family member is an option.

In the ASC set in a hospital this type of care may be provided in a special unit designed specifically for 23 hour stay patients. Other options include keeping these patients in the ambulatory surgery unit or, less ideally, assigning them to regular rooms on medical or surgical floors. The restriction of discharging within 23 hours for the patient to be classified as an ambulatory surgery patient (and, thus, receive the best insurance reimbursement or coverage) sometimes leads to very early morning discharges on the day after surgery.

Ambulatory surgery units within hospitals are most often able to provide this level of care, although freestanding surgery centres (FASC) in many states have gained the licensure necessary for extension of care beyond the usual several hours. Heritage Surgery Center in Nashville, TN, is an example of one freestanding surgery centre that has added overnight beds. Like many other centres building 23 hour care units, this centre has furnished the rooms in a decorative, homelike fashion. Cherry furniture, patterned wallpaper and draperies, and floral arrangements to help to make the rooms feel comfortable and warm. Centre administrator, Cynthia Duvall[7], explains that these rooms are often used for children who have had tonsillectomies, so a chaise chair in each provides a comfortable respite for parents who are encouraged to stay with their children.

In such states as Florida, FSCs are restricted legislatively from this service and continue to lobby for access to such licensure. Some FSCs in similarly restricted situations have developed contracts with long-term facilities such as nursing homes or rehabilitation hospitals for use of one or more rooms for the overnight care of ambulatory surgery patients. Depending on the contact specifications, these rooms may be redecorated and furnished and kept solely for the use of surgery patients, or they may be used dually by the resident and contracting facilities. While this plan is not ideal, it provides centres that would otherwise be unable to keep patients overnight with a resource allowing them to perform more advanced types of cases.

Medical hotels

An option for patients who may have travelled a long distance from home for surgery or who have no one to assist them at home might be a medical hotel. As the name implies, this is a hybrid service with characteristics of both a hotel and a medical facility. Generally speaking, although limited nursing service is sometimes available to patients in this setting, the usual admission criteria require that patients are able to take care of most or all of their own needs and require only the availability of care in the event of a problem or emergency.

This setting differs from a 23 hour admission unit in that it does not provide full service such as ongoing nursing care. Meals and medications may be provided or may be the responsibility of the patient. It is, however, an excellent, cost-effective halfway service for elderly or alone individuals who need the security of a setting where help is readily available. Financial responsibility for this service generally belongs to the patient.

Medical hotels have a variety of faces, depending on the community resources and the investment of the facility. One could consider the use of an actual hotel or motel room combined with the services of a home health nurse to be a medical hotel model. Some larger hospitals may refurnish and designate a wing or several patient rooms for hotel services; others may renovate or lease a nearby structure. Families are encouraged to stay with patients in this setting.

Recovery care centres

As the freestanding surgery market has expanded over the past 20 years, older and sicker patients and more complex surgeries have become the norm. This change has produced the need to develop facilities to provide these patients with extended postoperative care. Recovery care centres are one answer

These centres began to appear where licensure was available, although many states still discriminate against such services even though they have been found to reduce overall healthcare costs. At least 14 states currently have postoperative recovery care centres in operation with 13 others considering the option[8]. Sometimes opposition comes from hospitals that wish to restrict competition, but in some communities, hospitals and freestanding surgery centres are merging forces to develop joint recovery care services[9].

State and local laws governing licensure of such centres regulate many parameters of the recovery care business. For instance, regulating agencies may have specifications for minimum square footage, for the type of emergency equipment available, and for management of dietary and pharmaceutical services. They may establish how long patients may stay and what services must be provided. An example is the 1986 California legislation that created a pilot demonstration program for recovery care in that state. Patient stays of up to 72 hours were allowed and centres could include up to 20 patient beds. A more recent amendment has extended that demonstration project until 1994.

The first facility to open under this legislation was the Fresno Recovery Care Centre in 1988. Attached to the Fresno Surgery Centre, this facility of 20 patient beds boasted an all RN staff and a homelike environment–both of which Tony Carr, CEO at the Fresno facility, credits with contributing to patient's psychological comfort, promoting quality care, and ultimately to reduced length of stays. All the RNs at this recovery care centre are certified in advanced cardiac life support and work 12 hour shifts providing care at a usual 1:3 nurse to patient ratio[10].

Unlike this combined surgery and recovery facility, another private venture stands out as a prototype of a recovery care centre. In Arizona, the Hideaway House was developed and opened in 1979 by a business woman, Carolyn Caine, who saw a market need in her community for aftercare of plastic surgery patients. In 1985 she built a new facility renamed the Surgical Recovery Centre of Phoenix. This facility is separated geographically and by ownership from the community's surgery centres and now provides care for a wide variety of surgical patients. Even in 1986 the centre was caring for patients after traditional choleystectomies, laparotomies, appendectomies, and vaginal hysterectomies[11].

Surgical speciality hospitals

The most recent innovation in the industry is the surgical speciality hospital. This type of facility combines a surgical suite and recovery beds into one unit. Exactly as the name implies, this type of facility is licensed as a hospital, but its service are limited to surgery and its aftercare. Appropriate ancillary related services must be available as well, for instance, laboratory and radiology services. Unlike a recovery care centre, a facility licensed as a hospital is not restricted in patient length of stay and often has less difficulty obtaining payment for services from governmental and private insurers.

TOPS Surgical Speciality Hospital in Houston is a prime example of this new and exciting setting as is the Fresno facility, awaiting licensure as an acute care hospital. The latter has been renamed the Fresno Surgery Centre: The Hospital for Surgery. According to Fresno CEO Carr, little change in their policies or services was necessary to become a hospital except for the addition of an in-house laboratory and the conversion of an existing radiology room previously used for needle localizations to better meet the licensure requirement for broader radiological capabilities.

The special attention to patient comfort and provisions of a wellness-centred approach that have set ambulatory surgery programs apart for years continues to be of prime importance to the Fresno group. As Carr explains, "Good design and a friendly homelike decor help in our quest to reduce patient anxiety, which we all know can, in turn, reduce pain and blood pressure and contribute to reduced length of stays"[12].

One would expect that the lines of differentiation between ambulatory and in-house surgical procedures may become blurred in this setting. The open-ended capability to keep patients after surgery will lend the setting to increasingly more complex procedures, short, of course, of those requiring intensive postoperative nursing care. In fact, one ambulatory surgery centre, turned acute care speciality hospital, that is operated by Medical Care International, recently performed a total hip replacement. The future of these speciality hospitals will be interesting to watch.

Hospitalization

We should not omit the option of hospitalization in a discussion of aftercare. When alternate care settings are not available or are not adequate for patients suffering complications of anaesthesia or surgery, hospitalization is an appropriate step. Within the ambulatory surgery industry there is definitely a 'badge of honour' associated with avoiding hospitalization for patients. In fact, one of the statistics most eagerly shared by freestanding and hospital based ambulatory surgical programs alike is how low a hospitalization rate they can boast.

While avoiding patient complications and resulting hospitalization is an excellent goal, the care afforded by a hospital stay is often the perfect or only appropriate answer for a patient who has suffered bleeding, wound dehiscence, severe pain or vomiting, or a nonrelated medical emergency such as chest pain or an asthmatic attack.

Case study

Consider the young women who, having suffered a missed abortion in her second trimester, underwent a completion suction curettage at Belleair Surgi-Centre, a freestanding centre in Clearwater, FL, She had no problems with the general anaesthetic and recovered in a normal manner. Approximately 2 hours after surgery she had ambulated, voided, and had taken a snack and beverage without nausea. She awaited imminent discharge in the Phase II area of the centre.

Just prior to discharge her intravenous fluids were discontinued and she was escorted to the bathroom for a second time. She became faint and diaphoretic and was taken to a stretcher assessment. The nurse noticed a definite increase in abdominal firmness and a hard, palpable uterine fundus that had not been present on previous abdominal assessment. Her haemoglobin was checked at the bedside and had dropped nearly 4 grams compared to the preoperative value. The intravenous hydration she had received was obviously considered to be a factor contributing to some of that change.

The surgeon returned to the centre, and after assessing the patient, returned her to surgery where a diagnostic abdominal laparoscopy showed no free blood in the abdomen. She had none or scant vaginal bleeding and was diagnosed with intramural uterine hemorrhage. Her physiological parameters were generally stable and she was alert after her second procedure.

Hospitalization was definitely indicated for further observation, and monitoring and she was transported there via ambulance. She was later found to have laboratory changes indicative of disseminated intravascular clotting. Luckily, her systemic symptoms never progressed to an acute stage, and she recovered uneventually to go home several days postoperatively. She clearly exemplified the type of patient for whom hospitalizaion is essential.

In such instances, hospitalization is a valid and very positive step. It should be portrayed in that manner to the patient and family who may be frightened or angry about the complications that have occurred. The attitude and demeanour of the staff and physician caring for the patient definitely affects the overall attitude of the patient and family in regards to unexpected hospitalization[13]. One positive aspect of overnight admission that can be conveyed is the fact that around-the-clock nursing care will eliminate the worry of the family member who may fear not being awake if the patient needs help. Some family members may not be physically able to provide the level of care required. Often the family members will be relieved that they no longer hold full responsibility for the patient, particularly if bleeding or vomiting are involved or if it is a child who is experiencing complications.

The future

The necessary extent of care following ambulatory surgery is most often limited to a few hours spent in the ambulatory surgery unit itself. When complex procedures, medically compromised patients, or unexpected complications are involved, the availability of further care in an appropriate and safe location must be secured. Any physician or facility providing surgery and anaesthesia services must have established plans in place for that essential care.

Today's difficult economic picture makes forecasting the viability of these current programs or the development of future care sites difficult. Healthcare reforms may open the door to many innovative ideas as long as those programs can show their cost-effectiveness and safey. On the other hand, opportunities for growth in the freestanding and other nonhospital facilities may be restrained if the healthcare reform movement favours only programmes that can provide comprehensive services under one package.

Regardless of the types of settings or legislative restrains we will see in the future, we do know that the economy will be the number one driving force in healthcare in the upcoming years. The process of early discharge after surgery will continue and will probably grow to encompass even more complex procedures. It will be our challenge to show that the types of care settings we design and promote are safe and cost-effective. We also must assure that the human touch remains the focus of our care.

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