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Perspectives From Home Care for Guiding Patients and Families to a Successful Transition Home After Same-Day Surgery

Jessica Lahr

Brenda Elliott
Messiah University, belliott@messiah.edu

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MANY PATIENTS TODAY go through surgical procedures in a 1 day/same-day/ambulatory surgery setting. The shift from inpatient care to caring for patients in their own homes after discharge places countless demands on patients and their families during recovery. Patients and families often mistake same-day surgery for same-day recovery and underestimate needs they may have upon discharge. In a sample of patients undergoing joint procedures, approximately 38% were discharged directly to home care postprocedure and more than 50% went to some type of facility before being discharged to home care.[1] With trends moving toward more outpatient surgical procedures,[2] and with the increasing number of elderly patients,[3] referrals from ambulatory surgery to home care will likely grow as well. This article describes the literature related to challenges and key practice issues nurses face when transitioning patients to skilled home care after ambulatory surgery, as well as evidence-based interventions to reduce these issues.

Background

A challenge for ambulatory surgical centers today is timely patient discharge without forfeiting patient safety, quality of care, or patient satisfaction.[4] There are high demands for day surgery centers on productivity and cost effectiveness to stay in business. According to Gollogly and Wilson,[2] advances in technology, long-acting local anesthesia and minimally invasive procedures, decreased costs, and increased efficiency are contributing to more surgeries being performed in ambulatory surgical centers. However, this can often place more stress on the patient, family, and caregivers than what may be anticipated. In 2010, 48.3 million procedures were performed in ambulatory surgical centers, with 39% being performed on patients aged 45 to 64, 19% in ages 65 to 74, and 14% on patients aged 75 years and older.[5] Thus, one-third of cases were patients older than 65 years. According to the National Council on Aging,[6] 80% of adults older than 65 years have at least one chronic health problem and 68% have two or more, adding to the complexity of this patient population. With more elderly patients, who often have several comorbid conditions, take multiple medications, and may experience cognitive changes even in the absence of anesthesia during same-day surgery, interventions need to be examined to ensure safety upon returning home.[3]

Patient education is critical for postoperative care and should include what can be realistically expected at every stage of the surgical process, including after discharge.[4] With a large number of nurses not having clinical experience in skilled home care, it may be helpful to understand some basic regulations that govern this practice area so that safety in transition can be improved.[7] First, under the Conditions of Participation (COP) from the Centers for Medicare and Medicaid Services, patients must be under the care of a physician, confined to the home or homebound, and require intermittent skilled services to qualify for skilled home care.[8] Leaving the home would require a considerable and taxing effort for the patient. For this reason, it is important for nurses to assess day surgery patients preoperatively to determine their ability to manage at home and begin teaching them about managing any postoperative wound care, drains, or other daily

care needs, as daily visits are not permitted under the COP for home care. Second, the COP requires that a home care agency see a patient within 48 hours from referral to that agency unless a specific start of care date is ordered by the physician.[8] Patients are unknowingly provided misinformation from those unfamiliar with home care regulations and are often told they will be seen the same day or next day after discharge, which may not always be the case. Being aware of this requirement is crucial to ensure the patient or caregivers can provide necessary oversight until a home care nurse does visit.[7]

Review of the Literature

Several factors can complicate the transition from ambulatory surgery to home. At the top of the list would be a lack of standard readiness for discharge criteria to home.9, 10 Although discharging a patient from a same-day surgical center to home implies that the patient is clinically stable and competent to care for oneself at home to some degree, there is currently no formal evidence-based clinical criteria to help nurses determine a patient's readiness for discharge home.[9] There are several common variables among the different discharge assessments used, including pain, vital signs, nausea and vomiting, and conscious state.[10] However, no systematic review of literature related to safe discharge for patients from the recovery room to the home environment has been published to date. With growing pressure to be productive and efficient, nurses may experience moral dilemma in providing good care as they are often left to use their own judgment to determine discharge readiness for a patient after ambulatory surgery.[4] Many institutions either adopt their own criteria or use some version of currently published readiness for discharge tools. A comparison of these tools can be found in Table 1.

Table 1. Comparison of Discharge Checklists

Anesthesia Recovery Assessment Tools				
Assessment Criteria	**Aldrete PARS**	**React**	**MASS**	**RDAT**
Activity	x	x (energy)	x	X
Respirations	x	x	x	X
Pulse				X
Blood pressure	x	x	x	X
Temperatures		x		X
Oxygen saturation	x (color)		x	X
Consciousness/mental status	x (consciousness)	x (alertness)	x (consciousness)	X
Pain				X

Anesthesia Recovery Assessment Tools				
Assessment Criteria	**Aldrete PARS**	**React**	**MASS**	**RDAT**
Nausea				X
Surgical bleeding				X
Scoring				
Number of items	5	5	5	10
Range	0-10	0-10	0-10	Yes/no
Scoring	0-1-2	0-1-2	0-1-2	Yes/no
Threshold for discharge	9 or 10 certain institutions may be okay with an 8	8 unless pre-existing condition	9 or 10 certain institutions may be okay with an 8	All must be yes

PARS, postanesthesia recovery score; MASS, modified Aldrete scoring system; RDAT, readiness for discharge assessment tool.

Communication is another important factor that can contribute to a positive or a negative transition to home. Communication errors come from both what health care providers write or verbally explain to patients as well as what patients and caregivers hear and understand. Among the many exchanges are opportunities for miscommunication or not asking the right questions. Evidence supports poor patient outcomes being directly associated with a lack of patient education. Furthermore, inadequate preoperative education for same-day surgery patients may lend to complications such as unexpected pain, fatigue, and the inability to care for oneself.11, 12, 13 Failing to evaluate a patient's ability to self-manage is also problematic.[14] In a 2003 National Assessment of Adult Literacy survey, and only National survey to date, only 12% of US adults had a competent level of health literacy, which also impacts how well a patient and/or a family member understands their discharge instructions.[15] With the number of elderly patients having outpatient surgery increasing, so are complications and hospital readmissions.[16] In a recent study by De Oliveria et al,[16] patients aged 65 and older had a 54% increased chance of being readmitted after ambulatory surgery than those younger than 65 years, with the most prevalent reasons being wound problems, infections, bleeding, and pain. Patients were not readmitted because they were sicker but rather because they were older and had trouble understanding their discharge instructions and medications because of cognitive impairment and poor health literacy.

Outcomes

The American Society of PeriAnesthesia Nurses Pain and Comfort Clinical Guidelines (2003)[17] expected outcomes during Phase II/III recovery are presented in Table 2. In addition to these outcomes, further measures can be tracked to determine if discharge coordination and education have been effective, such as patient satisfaction, rate of emergency rooms visits, rate of unexpected hospital admissions from ambulatory surgery, cost of surgical care, and surgical site infections or other complications. These data can be located from a number of sources, such as individual hospitals, Centers for Medicare and Medicaid Services, and home care Outcome and Assessment Information Sheet (OASIS) data. Although there is readiness for discharge criteria checklists, additional home management considerations should be discussed with the patient and family/caregivers. Table 3 is a short checklist of tasks and/or activities for discussion that home care nurses evaluate. It is therefore recommended that any concerns for completing these activities should be addressed or resolved before the patient leaves the ambulatory center so appropriate services can be provided to the patient and a safer transition can be completed.

Table 2. Expected Outcomes During Phase II/III Recovery

•Patient will state acceptable comfort with movement or activity on discharge to home

•Patient verbalizes understanding of discharge instructions, including what medications are to be taken, frequency of the medications, potential side effects, and drug interactions, and any specific precautions with medications

•Name, telephone number of physician or other health care member to notify of pain, problems, or concerns

•Patient states understanding and shows effective use of nonpharmacologic methods

•Patient states achievement of pain and level of satisfaction with pain relief and comfort management in the perianesthesia setting

Adapted from 2003 American Society of PeriAnesthesia Nurses pain and comfort clinical guidelines.[17]

Table 3. Checklist for Home Management

Patient/Caregiver Able	**Services Needed**	**Self-Care Activity**
□	□	Bathing
□	□	Dressing
□	□	Meal preparation

Patient/Caregiver Able	Services Needed	Self-Care Activity
□	□	Managing medications (all routes)
□	□	Taking medications (all routes)
□	□	Getting in/out of home
□	□	Emergency plan
□	□	Assistive devices/ability to transfer
□	□	Available caregivers (paid or unpaid)
□	□	Laundry and light house keeping

Improving the Transition From Ambulatory Surgical Center to Home

Poorly executed care transitions negatively affect patients' health, well-being, and family resources, as well as unnecessarily increase health care system costs.[14] All patients being discharged from the ambulatory surgery center should know the responsible physician's name and number to contact for emergencies, the center's number and hours of operation, and the name, address, and phone number of the emergency care facility to go to if unable to reach the surgeon.[14] Clear communication and evidence-based interventions to improve transitions of care for older adults after ambulatory surgery are needed.18, 19, 20 According to Jones et al,[19] discharge planning programs, patient education, and primary care follow-up are all standards of care; however, better coordination in planning and education that starts early, is multimodal, and continues beyond discharge may reduce readmissions. In addition, research supports that individualized, patient-focused, and procedure-specific education is needed, not just standardized instructions.11, 12, 19, 20 Other beneficial transition interventions that focus on postdischarge support may include follow-up phone calls and home care visits10, 14 and various forms of health coaching.[21]

To address health literacy, discharge materials should be geared to a sixth-grade reading level or lower.13, 18 Font, layout, and complexity should also be considered with less technical language preferred. The use of pictographs using simple line drawings in combination with basic text is an effective means of improving discharge education, especially in the older adult population.22, 23 Nurses should evaluate educational level, as well as for any mental, emotional, or sensory deficits before the initiation of education. Using the teach-back method or asking the patient or family to rephrase instructions can help gauge understanding of instructions, allowing health care providers to identify what knowledge deficits may still need to be addressed.[14] Repeating key information, making eye contact, speaking slowly and clearly, and sitting close to the patient may help with the retention of information.11, 18 Culture and language barriers are another consideration.[20]

Conclusion

As technology continues to develop and patients are having same-day surgical procedures later in life, more research is needed to examine the specific transition between ambulatory and home health care settings. For now, nurses and other health care providers need to continually identify patients who may need referrals to other levels of care after their surgery, ideally before surgery, and provide evidence-based discharge planning based on interventions that are effective. Creating realistic expectations, evaluating a patient's ability to care for themselves, and starting postoperative education before a surgical procedure are key in helping patients and families to be prepared after discharge from same-day surgery. Understanding regulatory rules of skilled home care can assist nurses working in same-day surgery to ensure patients and families have adequate follow-up care postdischarge, and a smooth transition to home, thus reducing potential complications or readmissions.

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Jessica Lahr, MSN, RN, ACM, Geisinger Health System, Danville, PA

Brenda Elliott, PhD, RN, CNE, Wilson College, Chambersburg, PA