Escorts essential for ensuring postop patient safety

Before any elective surgery, patients are expected to arrange for an escort who will take responsibility for them at discharge—someone who will drive them home and possibly care for them as they recover from the effects of anesthesia.

Despite a strict policy that patients must have a “responsible adult escort,” on occasion a postanesthesia care unit nurse has faced the dilemma of a patient whose escort has failed to appear and who, in embarrassment or bravado, insists, “I’ll be fine.”

In the ambulatory surgery setting, a lone, impaired patient could present more of a problem than elsewhere. A physician may refuse to schedule a case without assurance from the patient that an escort is available; hospitals have the option, as a last resort, of admitting the patient. An ambulatory surgery center (ASC), in contrast, depends on the physician to bring up the escort issue, but is responsible for enforcing the policy much later, when the patient is waiting to leave and no bed is available.

Research indicates it is extremely rare for an unescorted patient to leave an ASC, which would violate accreditation and Medicare rules, or to injure himself or another person.

Nevertheless, the generally healthy patient population and careful patient selection associated with ASCs should not imply less need for vigilance.

In no shape to drive

“This issue plagues doctors’ offices and facilities alike,” notes Robert Langer, MD, a Flushing, New York-based anesthesiologist who specializes in outpatient procedures. “Studies show that even after sedation, reaction time can be slowed for up to 8 hours. Obviously, allowing someone to drive themselves home would be ill advised.”

Even an apparently recovered patient is still at risk. “In the young and healthy patient population, having light sedation for outpatient procedures, the anesthesia wears off fairly completely in an hour or two. Patients can get themselves around pretty well without problems. The issue is that you never know if the patient has some underlying problem that may lead to a complication, and without an escort to recognize and act on the patient’s behalf, there is a risk that something bad could happen to the patient. Then, we run into the issue of liability,” Dr Langer explains.

The Pennsylvania Patient Safety Authority (PPSA) in 2007 found ASCs in that state had varying rules for patient discharge. Following a review of 20 knee arthroscopy cases, the PPSA issued an advisory warning ASCs that “compared to healthy individuals, patients showed impaired driving skills and lower alertness levels preoperatively and at 2 hours postoperatively.” It was not safe for patients to drive until 24 hours had passed after receiving general anesthesia.

A 2004 study of 103 endoscopy patients, published in Gastroenterology Nursing, found the following symptoms remaining after surgery:

- 94% could not remember the physician’s instructions
- 67% could not remember the nurse’s instructions
- 31% said they could not have managed without a caregiver
- 29% did not feel normal the morning after the procedure
• 24% experienced pain after leaving the ASC
• 12% became dizzy or fell after the procedure
• 9% were still disoriented after arriving home
• 7% reported nausea or vomiting.

The study, which was designed to identify conditions that were present the day after surgery, reinforced the evidence that patients also need help getting home. “The telephone survey showed a significant number of patients experienced a postprocedure issue,” the authors conclude.

With more complex procedures being performed at ASCs, the chance of a patient being less healthy to begin with has increased. Recognizing the need to balance the convenience of ambulatory surgery with the need for follow-up care, accrediting and professional organizations require escorts following any type of sedation other than local anesthetic. The Joint Commission, Accreditation Association for Ambulatory Health Care, American Society of PeriAnesthesia Nurses, and American Society of Anesthesiologists have guidelines or standards calling for escorts for discharged patients.

Why no escort?
A 2005 study by Frances Chung, FRCPC, medical director of the ambulatory surgical unit at Toronto Western Hospital, found that 2 out of 1,000 ambulatory surgery patients, or 0.2%, did not have an escort present at discharge. Patients without escorts were more likely to be female. Their age ranged from 18 to 72, and the most common procedure was termination of pregnancy, where escorts were absent in 1.2% of cases. However, the study found no difference in the clinical outcomes or readmission rate to the hospital related to absence of an escort.

Specific demographics are hard to come by, but anecdotal evidence indicates escorts may be hard to find for individuals living alone with no close family or friends or those whose family members are working. In one case, 3 months were needed to coordinate the schedules of patient, escort, and surgeon.

Most patients, and nearly all health care facilities, are aware of the risks and avoid endangering themselves or the public. Reports of arrests for driving under the influence of drugs administered in surgery are either nonexistent or inaccurately combined with alcohol-related incidents.

Denver attorney John Buckley, a former emergency medical technician, has heard of situations in which a defendant was found to be impaired following surgery, but he has never encountered one personally. “I think it’s pretty rare,” he says.

According to Buckley, ASCs should be proactive in making sure an escort is available. “They should not begin the procedure unless they have a driver present,” he says. That is the policy at many ASCs, yet patients are still sometimes left stranded.

At Mountain Laurel Surgery Center in Honesdale, Pennsylvania, the rule is that each patient must arrive with an escort, and the escort must stay on the premises while the procedure is done. The center specializes in upper endoscopies and colonoscopies. “We want to have the escort there to hear the postdischarge information,” explains Patricia Williams, RN, director of nursing. “The doctor sees the patient to discuss the results, but the patient may not remember.”

If the escort is not there, the staff finds someone else. “We don’t let a patient leave alone,” Williams says. “We walk them to the car and make sure they get in ok.”

Lakeview Surgery Center in West Des Moines, Iowa, ensures that a driver is present at the time of admission; if not, the procedure is cancelled. Any driver who needs to leave during a procedure must provide a cell phone number. “We are sticklers on this subject,” administrator Rikki Knight says. Patients who may think they do not
need escorts include those having local anesthesia and those who visit frequently, for example, for pain management. “They still need escorts,” Knight says. Lakeview has also seen a growing number of elderly patients who have no one to care for them. These patients need home care as well as drivers, she says.

**What about taxis?**

Peacock Limousine Service in Centennial, Colorado, specializes in ferrying clients to proms, weddings, and other celebrations. However, manager Victor Joseph receives 2 or 3 calls per month from Denver-area hospitals and surgery centers requesting patient transport. “We do offer that,” Joseph says, “but we don’t advertise it, and we don’t have medical training.”

In New York, there are several “ambulette” services that provide nonemergency patient transport in urban areas. Drivers have some training and assist patients in and out of buildings.

Jefferson Regional Medical Center in Pittsburgh has for the past 5 years contracted with a local ambulance company to take patients home following outpatient surgery. When patients are unable to arrange for an escort, Jefferson pays the company to send a medically trained driver to take them home.

However, there is no US service to compare with that of the United Kingdom, whose National Health Service (NHS) employs “ambulance care assistants” to drive patients to and from surgery and other medical care. The assistants have basic medical training and, according to the NHS web site, “they often see the same people on a regular basis and get to know them.”

A taxi driver cannot help in case of a medical problem and will leave the patient at the curb without further assistance, and thus does not meet the definition of the “responsible adult” required for accreditation. Some ASCs have used taxis as a last resort, but patients must be fully recovered before leaving the facility.

**Loss of balance**

There are other means of transportation, such as buses, bicycles, and walking, but these are problematic, Dr Langer says. Anesthesia affects equilibrium as well as reaction time. “I would consider biking equivalent to driving—a danger to both patient and others—and if no other option were available, I would not provide anesthesia to that patient that day,” he says.

Dr Langer says he would allow a colonoscopy patient to walk home, but only if the person was young and healthy and lived close to the physician’s office or ASC. Even then, the patient would be asked to stay longer to allow more of the sedation to wear off. “So far, we have not had any problems with that policy,” he says. “However, there is still a liability risk, as a slower reaction time may leave the patient at risk to be hit by a car they didn’t see.”

Public transportation poses similar risks; patients need to climb stairs to board buses or trains and may experience complications in a crowd of strangers. “Being trapped on a train if something were to go wrong would be truly frightening,” Dr Langer says. “If the problem resulted in unconsciousness, who would speak for the patient to say what was wrong?”

For that reason, he treats public transportation the same as driving, and he will not provide anesthesia for unescorted patients relying on it.

**Reducing the risk**

While patient safety is the primary reason to insist on escorts, ASCs have tried to address their own liability risks as well. Many ask or require patients to sign a release
form saying they were advised of the need for an escort and refused. Whether such forms release ASCs from further liability is uncertain, especially if the patient signs one while sedated.

It helps to have a written policy explaining the reasons a patient cannot leave unescorted; many of them do not realize the degree of impairment that follows anesthesia, and they may very well feel competent after waking.

Meanwhile, the most practical approach is to do everything possible to ensure that an escort will be present. This includes obtaining telephone numbers of as many contacts as possible before the procedure. At many facilities, escorts must sign a form containing contact information and certifying that they intend to drive the patient home. Even more reliable is the increasingly common policy of requiring the escort to arrive with the patient and remain in the building during the procedure. ❖

—Paula DeJohn

References
