Introduction: Research demonstrates registered nurses who provide direct patient care are well poised to design systems and processes to accomplish the goals of safe quality care. However, many processes of patient care are richly steeped in tradition and are not evidence-based.

Identification of the Problem: One long-standing tradition in our organization centers on discharging tonsillectomy patients using a “pre-specified period of time” (360 minutes). The presumption is using a “pre-specified time” provides ample opportunity for patients to recovery. This current practice has resulted in inefficiency, increased hospital cost, and a decrease in patient satisfaction.

Purpose of the Study: We designed this study to determine “discharge-readiness” of tonsillectomy patients using clinical indicators. We hypothesized that discharge-readiness could be determined using clinical indicators.

Methodology: A descriptive comparative approach was used to test the hypothesis. Using a convenience sample, patients (≥ 3 years) were recruited on the day of surgery. Although patients were discharged using the pre-specified time (comparison), discharge-readiness was determined. Data (45 data points) were collected on each patient’s progression (preoperative baseline, perianesthesia phase I and II, and a phone call 24-48 hours after discharge). Perianesthesia nurses recorded all data on the “Patient Information Form”. ASPAN’s Guidelines and Aldrete Score served as resources for clinical indicators. The study was approved by the Institutional Review Board and informed written consent for participation was obtained from all participants.

Results: Descriptive statistics were used to analyze data from 93 patients. The sample included 47(50.5%) males and 46 (49.5%) females with ages ranging from three to 34 with a mean of 9.95 and SD of 7.005. The majority of participants were white (88/94.6%). The surgery length ranged from 14-125 minutes (mean 41.7; SD 20.702) and the recovery time includes: Phase 1: 44-246 minutes (mean 88.95; SD 38.410); and Phase II: 92-480 minutes (mean 256.28; SD 63.974). Discharge-readiness ranged from 84-481 minutes with a mean of 253.36; SD 79.001. Discharge-readiness “time” was less than the pre-specified time (360 minutes) for 77 (82.8%) patients. Of the 77 patients, no complications occurred after the documented discharge-readiness time. Discharge-readiness for 11(11.3%) patients’ was greater than the pre-specified time. Patients’ complications include pain, nausea, and vomiting. Five of the 11 patients needed to contact their surgeon after returning home for vomiting (4); pain (1); and slight bleeding (1). Of the five patients, none returned to the hospital (ED). Key data elements were missing on seven patients (5.4%) so we could not determine discharge-readiness.
Discussion: Perianesthesia nurses were able to determine discharge-readiness for their patients. Of the 77(82.8%) patients whose discharge-readiness was less than the pre-specified time, no complications occurred. The discharge-readiness time for 11(11.3%) patients was greater than the pre-specified time. Patients’ complications include pain, nausea, and vomiting. The findings support perianesthesia nurses’ capability in determining discharge-readiness for tonsillectomy patients.

Conclusion: Based on the findings, an evidence-based nursing practice and policy change has been developed and implemented.

Implications: Findings inform the development of hospital policies for discharging tonsillectomy patients using discharge-readiness.