ANESTHESIA & the LAW
A Risk Management Newsletter
JULY 2025 – ISSUE 58
PPM

Safe Passage Home: The Critical Role of a Responsible Adult in Post-Anesthesia Discharge

Introduction

In the evolving landscape of ambulatory and same-day surgical care, anesthesia and perioperative professionals play a pivotal role in safeguarding patients through every phase of the perioperative experience—from preoperative assessment to post-anesthesia discharge. One critical but sometimes underestimated element of this continuum is ensuring that patients who have received sedation or anesthesia are discharged into the care of a responsible adult or individual. This practice is a patient and public safety imperative grounded in the guidance of leading professional and regulatory organizations, including the American Society of Anesthesiologists (ASA), American Association of Nurse Anesthesiology (AANA), Association of periOperative Registered Nurses (AORN), American Society of PeriAnesthesia Nurses (ASPAN), The Joint Commission, Centers for Medicare & Medicaid Services (CMS), and the Accreditation Association for Ambulatory Health Care (AAAHC). The following case study underscores the crucial importance for patients to have a responsible adult escort to transfer them home and the devastating consequences that can occur absent that support.

Case Study

A 34-year-old female presented for elective bilateral breast augmentation at a med spa. A non-PPM insured anesthesiologist designated the patient an ASA II. The anesthesiologist administered 50 mg fentanyl, 2 mg midazolam and continuous infusion of propofol. Lidocaine local anesthesia was injected into the tissues by the plastic surgeon. The surgery lasted from 1415 to 1640. The anesthesiologist noted the propofol was stopped approximately 20 minutes prior to his note at 1640 and the patient was awake and stable.

There was no formal PACU at this facility so the patient was taken to a waiting area to recover. The anesthesiologist stayed with the patient; however, there was no documentation of postoperative vital signs, no documentation of care after the patient left the OR, and no copy of discharge instructions present in the chart.

Approximately 3 hours after the surgery ended, she was ready to be discharged. However, the patient drove herself to the med spa. She wanted to drive herself home but this was not allowed. One of the patient's friends was contacted by the facility but she never arrived to take the patient home. A taxi was called and one of the facility's staff members accompanied the patient to the taxi. The patient stumbled while being escorted to the taxi. The patient told the facility staff that her mother would be with her and take care of her when she arrived home.

"SHE WAS FOUND DECEASED THAT AFTERNOON BY FRIENDS AND FAMILY STILL WEARING HER COAT AND SITTING ON HER COUCH"

The following day, the patient did not arrive for a scheduled follow-up visit with the plastic surgeon. She was found deceased that afternoon by friends and family still wearing her coat and sitting on her couch. EMS noted that rigor mortis had started when they arrived.

It was subsequently discovered that the plastic surgeon provided the patient with a prescription

for a 50 mg fentanyl transdermal patch. The patient filled the prescription at a Walmart Pharmacy. The prescription indicated that the fentanyl transdermal patch "should be brought to surgery." The fentanyl transdermal patches carry a black box warning which provides that it is not for acute pain, opiate naïve individuals, or for postoperative use.

The patient's mother, with whom the patient lived, sued the plastic surgeon, the surgeon who owned the med spa, the non-PPM insured anesthesiologist, and the PPM insured anesthesia practice group with which the non-PPM insured anesthesiologist had an employment contract.

Additionally, the plastic surgeon and the surgeon who owned the med spa brought a third-party action against the Walmart pharmacy that filled the fentanyl transdermal patch prescription. Specifically, the allegations were that the pharmacist filled and dispensed the fentanyl transdermal patch to the decedent in a box marked "not for acute postoperative use," with a label stating "bring to surgery" and with a warning sheet that stated "should only be used for long term chronic pain requiring continuous around the clock narcotic pain relief…do not use this medicine for pain occurring after surgery or pain that does not require medicine on a regular schedule." The third-party plaintiffs alleged that the pharmacist had a duty to confer with the decedent and to call the plastic surgeon to discuss filling the prescription. Walmart denied all of the allegations and took the position that all they did was fill a prescription for fentanyl.

The plaintiff alleged that the defendants: (1) failed to take notice of the FDA safety advisory or manufacturer's warnings regarding the use of a fentanyl transdermal patch; (2) improperly prescribed a fentanyl transdermal patch for the decedent; (3) improperly prescribed and administered fentanyl in combination with other medications; (4) ignored the contraindications to having the decedent use a fentanyl transdermal patch; (5) improperly dosed the decedent; (6) failed to properly monitor, evaluate, or test decedent after the procedure ; (7) failed to recognize signs and symptoms consistent with fentanyl intoxication or overdose; and (8) discharged the unaccompanied decedent to a taxi despite the fact that she appeared lethargic and could barely walk without assistance.

"DURING DISCOVERY, THE PLASTIC SURGEON TESTIFIED THAT PRIOR TO THE PROCEDURE IN THIS CASE, SHE HAD UTILIZED FENTANYL PATCHES APPROXIMATELY 5 OR 6 TIMES WHILE PERFORMING PROCEDURES AT THE MED SPA"

During discovery, the plastic surgeon testified that prior to the procedure in this case, she had utilized fentanyl patches approximately 5 or 6 times while performing procedures at the med spa. She testified further that the fentanyl patch was used in this case because the spa was waiting for certification from the DEA and she needed a way to sedate her patients until the certification was received. Yet, she also acknowledged that she was aware that IV fentanyl was also being utilized by the anesthesiologist for the decedent's procedure but prescribed the patch anyway because she liked how it controlled pain postoperatively. She claimed that one of the anesthesiologists (she didn't remember which anesthesiologist) said that was an acceptable practice – notwithstanding the black box warning in the Physicians' Desk Reference (PDR).

The surgeon who owned the med spa acknowledged that a fentanyl patch was utilized during the decedent's procedure. Further, he admitted that the DEA had provided a license to the med spa for the use of IV fentanyl prior to the procedure in question. However, he testified that he was not aware at the time that there was a black box warning in the PDR that stated fentanyl patches should not be utilized for postoperative pain. He admitted that he had a PDR in his office and testified that it was "medical error not to follow the black box warnings in the PDR."

The attending non-PPM insured anesthesiologist testified that he performed anesthesia services at the med spa. He testified further that he performed anesthesia services for the spa on his own and he was not acting as a partner or employee of the PPM-insured anesthesia practice group. He testified that the decedent did not tell him that she had a patch on or was taking any medications on the day of the procedure. He also testified that the physical examination was done in a side room and that the patient had her shirt on during the exam. He listened through the shirt to the patient's lungs, both front and back. He next saw the patient in the OR where she was laying on her back with a gown on and was already marked for the procedure. Therefore, he would not have been able to see a patch on the patient's back area.

The med spa's receptionist testified that she remembered the decedent was given a prescription for a fentanyl patch. She indicated that it was a typical prescription given to a patient prior to a breast augmentation procedure. She also testified that it was common knowledge at the med spa that fentanyl patches were prescribed to patients and they were instructed to apply the patch one hour before the procedure. She recalled that she helped the decedent get to the taxi. She indicated the decedent appeared sore and stumbled on the stairs after her foot slipped. She testified that although the decedent seemed groggy, she appeared alert and oriented.

"FOLLOWING DISCOVERY, THE PLAINTIFF MADE A SETTLEMENT DEMAND IN THE AMOUNT OF $1,970,000 AS TO ALL OF THE DEFENDANTS"

Following discovery, the plaintiff made a settlement demand in the amount of $1,970,000 as to all of the defendants. Defense counsel for the PPM insured anesthesia practice group filed a motion for summary judgment based on the attending non-PPM insured's testimony that he was working on his own in providing anesthesia services at the med spa and was not working on behalf of the PPM insured anesthesia practice group. The attending anesthesiologist also filed a motion for summary judgment based on his testimony and a lack of evidence he was aware of the fact that the patient had been prescribed and was utilizing a fentanyl transdermal patch on the day of the procedure.

Prior to the court's rulings on the pending motions for summary judgment, the co-defendant plastic surgeon and the owner of the med spa settled the case for a confidential amount believed to be in the seven figures.

Why It Matters: The Post-Anesthesia Risk Window

Anesthesia and sedation medications, even those designed for rapid metabolism, can have subtle yet significant residual effects that impair a patient's cognitive and physical faculties long after they appear awake and alert. These effects can include:

- **Residual Impairment**: Anesthetic agents, even short-acting ones, can cause residual drowsiness, dizziness, impaired balance, and decreased reaction time. This impairment can lead to falls, motor vehicle accidents (if the patient attempts to drive), and other injuries. A responsible adult can provide physical support and prevent such incidents.

- **Cognitive Dysfunction and Amnesia**: Anesthetics can temporarily affect memory and the ability to process new information. Patients may forget discharge instructions, medication dosages, or warning signs of complications. A responsible adult can absorb, recall, and reinforce these vital instructions, ensuring adherence to the post-operative plan.

- **Delayed Onset of Complications**: While rare, some complications of anesthesia or surgery may not manifest immediately. These can include delayed allergic reactions, airway compromise, bleeding, or persistent nausea and vomiting. A responsible adult can monitor for these signs and symptoms and initiate timely medical intervention if necessary.

- **Medication Management**: Patients may be prescribed new medications post-procedure, often with specific instructions regarding dosage and timing. The responsible adult can help ensure accurate medication administration, reducing the risk of errors.

- **Emotional Support and Reassurance**: The post-anesthesia period can be disorienting and anxiety-provoking. A responsible adult can provide comfort, reassurance, and practical assistance, contributing to a smoother and more positive recovery experience.

- **Legal and Ethical Considerations**: From a legal standpoint, discharging an impaired patient without appropriate supervision can expose healthcare providers and facilities to significant liability. Anesthesia professionals' and other healthcare providers' primary ethical obligation to promote the well-being of patients encompasses an obligation to collaborate in a discharge plan that is safe for the patient.

Professional Guidelines: A Unified Stance on Safety

The commitment to patient safety regarding post-anesthesia discharge is unequivocally articulated across the guidelines and position statements of the ASA, AANA, AORN and ASPAN. While each organization focuses on its specific area of expertise, a common thread weaves through their recommendations: the necessity of a responsible individual or adult to accompany the patient home.

- **American Society of Anesthesiologists (ASA)**: The ASA's Practice Guidelines for Postanesthetic Care consistently emphasize the importance of discharging patients to a responsible adult.[1] The ASA Statement on Ambulatory Anesthesia and Surgery expressly states that patients who receive other than unsupplemented local anesthesia must be discharged with a responsible adult.[2] Their recommendations highlight that patients should be evaluated for readiness for discharge, including being able to ambulate safely and having minimal or no residual effects of anesthetic agents. Importantly, they stipulate that patients should not be discharged to public transportation unaccompanied and generally require a responsible adult to escort them home and remain with them for a period post-discharge. Their guidelines underscore that the discharge decision should be based on established criteria, ensuring the patient is stable and has a clear understanding of post-discharge instructions, with a responsible adult present to assist.
- **American Association of Nurse Anesthesiology (AANA)**: Certified Registered Nurse Anesthetists (CRNAs) adhere to the AANA's standards and guidelines. The AANA's practice considerations for post-anesthesia care mirror the emphasis on patient safety, advocating for comprehensive discharge planning that includes instructing the patient and the responsible adult on postoperative care, potential complications, and when to seek further medical attention. The AANA reinforces that patients should not be discharged without a responsible adult, recognizing the CRNA's professional accountability for patient outcomes.[3]
- **Association of periOperative Registered Nurses (AORN)**: AORN, representing the perioperative nursing community, reinforces this imperative through its Guidelines for Perioperative Practice.[4] While their focus is broad, the principles of safe patient transfer and discharge are deeply embedded. AORN's guidelines implicitly support the need for a responsible individual by emphasizing

comprehensive discharge education, which includes instructions on what to expect postoperatively and when to seek medical attention. AORN's emphasis on a coordinated and continuous plan of care extends to the post-discharge period, acknowledging that the patient's immediate safety is enhanced by the presence of a responsible adult.

- **American Society of PeriAnesthesia Nurses (ASPAN)**: ASPAN's practice recommendations and standards for post-anesthesia nursing care provide detailed guidance for assessing patient readiness for discharge from the Post Anesthesia Care Unit (PACU) and Phase II recovery. ASPAN's guidelines strongly advocate for discharging patients to a responsible adult, emphasizing the nurse's role in educating both the patient and the responsible individual escort about discharge instructions, medication regimens, activity restrictions, and signs/symptoms requiring urgent medical attention.[5]

Regulatory and Accreditation Requirements

- Centers for Medicare and Medicaid Services (CMS) Condition for Coverage requires ambulatory surgery centers (ASCs) to ensure all patients are discharged in the company of a responsible adult, unless the patient is exempted by an attending physician.[6] Failure to comply can result in loss of reimbursement eligibility.

- The Joint Commission[7] and the Accreditation Association for Ambulatory Health Care (AAAHC) both require discharge to a responsible adult.[8] Failure to comply can result in survey citations.

Defining "Responsible Individual"

While the exact definition may vary slightly across institutional policies, a "responsible individual" generally refers to an adult who is:

- **Capable**: Mentally and physically able to assist the patient, understand instructions, and respond to potential complications. Age is not the only factor in determining a responsible individual. The most important description of the responsible individual is one who can provide post-procedure care and report any post-procedure or post-anesthesia complications.[9]

- **Reliable**: Committed to accompanying the patient home, assisting with their immediate needs, and monitoring their recovery for a specified period (typically 12-24 hours).

- **Available**: Can provide direct care and support and is not similarly impaired or incapacitated.

- **Knowledgeable**: Has received and understood discharge instructions regarding medications, activity limitations, potential complications, and emergency contact information.

It is critical for healthcare providers to assess the suitability of the designated responsible individual to ensure they can fulfill this vital role. This assessment often involves verbal confirmation and providing clear, concise written instructions.

Rideshare and taxi drivers are not considered to be a “responsible adult” for purposes of post-discharge support and care. Rideshare and taxi services are only responsible for transporting riders to their destination. Moreover, rideshare and taxi drivers likely have little or no training or experience in transporting people who may need assistance due to medical conditions during transportation or upon arrival at their destination. If using a rideshare, taxi, or other transportation services, it should be accompanied by a responsible adult who can ensure safe transport and provide post-discharge care.[10]

CMS, through its Medicaid program, may cover transportation to and from medical appointments and healthcare facilities for some eligible Medicaid beneficiaries for Non-Emergency Medical Transportation (NEMT). NEMT coverage and procedures can vary state by state, so it's essential to check with the specific state's Medicaid agency for details.[11]

Risk Management Strategies and Considerations

Implementing effective admission and discharge policies and procedures requires a collaborative effort from the entire interprofessional team and the healthcare facility. This includes:

- **Thorough Pre-Procedure Assessment**: Identifying patients who may have difficulty securing a responsible individual and addressing these concerns proactively.
- **Verification of Responsible Individual's Presence and Competency**: Ensuring the designated individual is present, understands their responsibilities, and appears capable of providing the necessary support.
- **Clear and Consistent Communication**: Educating patients and their designated responsible individuals about the importance of their role, providing both verbal and written discharge instructions in an understandable format using teach-back methods.
- **Assess Readiness**: Rigorously evaluate the patient's readiness for discharge based on established criteria.
- **Documentation**: Thorough documentation of discharge instructions provided, the identity of the responsible individual, and confirmation of their understanding.
- **Handle Exceptions Cautiously**: If an exemption is granted, require documentation from the responsible provider, and consider extended observation or alternative discharge plans.
- **Contingency Planning**: Developing protocols for situations where a responsible individual is not available, which may include offering to reschedule the case, canceling the case, extended observation, social work intervention, or delayed discharge. If a patient wants to leave against medical advice (AMA), do not hold them against their will which could result in civil and criminal charges for false imprisonment. Consult the facility risk manager or administrator regarding leaving AMA. AMA departures should be thoroughly documented in the medical record.

Conclusion

Discharging patients to a responsible adult following sedation or anesthesia is a fundamental patient safety measure, universally endorsed by the professional guidelines of the ASA, AANA, AORN and ASPAN. This practice recognizes the inherent vulnerabilities of patients recovering from pharmacological interventions and establishes a crucial layer of support during a critical transitional period. By adhering to this principle, healthcare providers not only fulfill their professional obligations but also contribute significantly to optimal patient outcomes, minimizing risks and ensuring a safe and successful journey home. The responsible escort is not just a ride home; they are an essential partner in the continuum of safe patient care.

References:

1. American Society of Anesthesiologists. *Practice Guidelines for Postanesthetic Care: An Updated Report*. Anesthesiology. 2013;118(2):291–307. doi:10.1097/ALN.0b013e31827773e9.
2. American Society of Anesthesiologists. *Statement on Ambulatory Anesthesia and Surgery*. Last amended October 18, 2023. Accessed June 2025. https://www.asahq.org/standards-and-practice-parameters/statement-on-ambulatory-anesthesia-and-surgery.
3. American Association of Nurse Anesthesiology. *Standards for Nurse Anesthesia Practice*. Updated 2023. Accessed June 2025. https://www.aana.com.
4. Association of periOperative Registered Nurses (AORN). *Guidelines for Perioperative Practice*. AORN; 2023.
5. American Society of PeriAnesthesia Nurses (ASPAN). *Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements.* 2023–2025. ASPAN; 2023.
6. Centers for Medicare & Medicaid Services (CMS). *State Operations Manual: Appendix L – Guidance for Ambulatory Surgical Centers*. Rev. 2023. https://www.cms.gov.
7. The Joint Commission. *Comprehensive Accreditation Manual for Ambulatory Care (CAMAC)*. 2024. https://www.jointcommission.org.
8. Accreditation Association for Ambulatory Health Care (AAAHC). *Accreditation Handbook for Ambulatory Health Care*. 2024. https://www.aaahc.org.
9. American Society of PeriAnesthesia Nurses, Fleisher F, Schick L, Windle P. *Clinical practice: Frequently asked question*.; 2024. https://www.aspan.org/Portals/88/Clinical%20Practice/FAQs/FAQ%20Responsible%20Adult.pdf?ver=VySePTw3xKGCZdM9plVh_Q%3d%3d.
10. Krisza J. Legal update: The Ride Home: Uber complicated or easy Lyft? Outpatient Surgery Magazine. https://www.aorn.org/outpatient-surgery/article/2019-February-legal-update-the-ride-home-uber-complicated-or-easy-lyft. Published January 17, 2023.
11. Non-Emergency Medical Transportation | CMS. https://www.cms.gov/medicare/medicaid-coordination/states/non-emergency-medical-transportation.

PREFERRED PHYSICIANS MEDICAL RISK RETENTION GROUP
11880 College Boulevard, Suite 300
Overland Park, KS 66210-2141

T 913.262.2585 • 800.562.5589
F 913.262.3633

NEWSLETTER EDITOR
Brian J. Thomas, JD
Vice President-Claims & Risk Management

ANESTHESIA & the LAW
A Risk Management Newsletter
JULY 2025 – ISSUE 58

In This Issue

There is a clear trend of increasing outpatient procedures in the United States, driven by advancements in technology, cost-effectiveness, and patient preference, according to healthcare industry reports. This shift is evident in the growing number of surgeries performed in ambulatory surgery centers, hospital outpatient departments, and office-based practices. While there are many factors and benefits driving the number of outpatient procedures, discharging patients after they have received sedation or anesthesia raises several patient and public safety concerns. One of those concerns, and a common question from PPM's insureds, is the need for a responsible individual to accompany the patient home and provide home assistance and support. In this issue, we provide an overview of several professional and regulatory organizations' position statements and guidelines supporting the requirement for a responsible individual to accompany patients home post-discharge. We also highlight a case study that underscores the critical importance for patients to have a responsible adult escort to transfer them home and the devastating consequences that can occur absent that support. Finally, we provide some risk management strategies and considerations to assist PPM's insureds in working with their practice facilities and other healthcare providers to develop and implement admission and discharge policies to assist the perioperative team and patients in decision making.

Thanks for reading,

Brian J. Thomas, Editor