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Governance of Patient Readiness Before Procedures in Ambulatory Care A Scoping Review Integrating Nursing, Radiologic Technology, Pharmacy Support, Dentistry, Healthcare Security, and Health Administration

حوكمة جاهزية المريض قبل الإجراءات في الرعاية الخارجية: مراجعة نطاقية لتكامل أدوار التمريض وتقنية الأشعة والدعم الصيدلي وطب الأسنان والأمن الصحي والإدارة الصحية

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Abstract

Patient readiness before an outpatient procedure depends on clinical assessment, accurate information, patient understanding, and access to the appropriate service. These requirements are distributed across professions, creating opportunities for missed checks, inconsistent instructions, and unresolved responsibility. This review examines how nursing, radiologic technology, pharmacy support, dentistry, healthcare security, and health administration can contribute to readiness without extending their authorized scopes of practice. A targeted scoping review examined twenty verified publications within a 2010–2026 eligibility window, using indexed abstracts and accessible full texts. Sources addressed preoperative assessment, fasting, attendance, procedural checklists, imaging safety, medication histories, dental verification, and violence prevention. Structured charting distinguished primary empirical findings, evidence reviews, and professional consensus. The review used purposeful selection rather than exhaustive database screening and did not include duplicate assessment or quantitative pooling. The synthesis organized readiness into clinical suitability, information integrity, patient comprehension, operational preparation, and safe access. Evidence supported several component practices, but their populations, outcomes, and study designs differed. Null checklist findings and incomplete clinical outcome evidence limited assumptions about effectiveness. A conceptual framework connects early screening with profession-specific verification, an authorized decision to proceed or defer, and feedback about unresolved requirements. Security and administrative contributions concern access, coordination, and escalation rather than clinical clearance. No participants, patient records, or institutional performance data were analysed. The framework offers a structured basis for protocol development and future evaluation, but does not establish a reduction in complications or cancellations. Prospective studies should assess feasibility, equity, workload, privacy, and patient outcomes before wider adoption.

Keywords: patient readiness; ambulatory care; preprocedural assessment; interprofessional governance; radiologic technology; pharmacy technicians; dental safety; healthcare security.

الملخص
تعتمد جاهزية المريض قبل الإجراءات في العيادات الخارجية على التقييم السريري وصحة المعلومات وفهم التعليمات والقدرة على الوصول إلى الخدمة. وتتوزع هذه المتطلبات بين تخصصات متعددة، مما قد يؤدي إلى إغفال الفحوص اللازمة أو تضارب التعليمات أو غموض المسؤولية عن المتابعة. يهدف البحث إلى تحليل تكامل التمريض وتقنية الأشعة والدعم الصيدلي وطب الأسنان والأمن الصحي والإدارة الصحية في تنظيم الجاهزية، مع الحفاظ على حدود الممارسة المهنية. اعتمد البحث مراجعة نطاقية موجهة لعشرين منشورا موثقا ضمن الفترة من 2010 إلى 2026، بالاستناد إلى الملخصات والنصوص الكاملة المتاحة. وشملت الموضوعات التقييم السابق للإجراء والصيام والحضور وقوائم التحقق وسلامة التصوير والتاريخ الدوائي والتحقق في طب الأسنان والوقاية من العنف. وفصل استخراج البيانات بين الدراسات والمراجعات والتوافقات المهنية. استخدمت المراجعة اختيارا قصديا للمصادر، دون ادعاء البحث الشامل أو التقييم المستقل المزدوج أو التجميع الإحصائي. نظم التحليل الجاهزية في خمسة مجالات تشمل الملاءمة السريرية وسلامة المعلومات وفهم المريض والاستعداد التشغيلي والوصول الآمن. دعمت الأدلة ممارسات جزئية، لكن اختلاف البيئات والنتائج والتصميمات حد من تعميم الفعالية. وأسهمت النتائج غير الدالة لبعض قوائم التحقق ونقص قياس النتائج السريرية في ضبط الاستنتاجات. ويقترح البحث إطارا يربط الكشف المبكر والتحقق التخصصي والقرار المعتمد بالمضي أو التأجيل وإبلاغ الأطراف بالمتطلبات غير المكتملة. وتتعلق مساهمة الأمن والإدارة بتيسير الوصول والتنسيق والتصعيد، ولا تشمل اعتماد الجاهزية السريرية. لم يجمع البحث بيانات مرضى أو مؤسسات ولم يجند مشاركين. ويقدم الإطار أساسا لتطوير السياسات والتقييم المستقبلي، دون إثبات انخفاض المضاعفات أو الإلغاءات. ويوصي البحث بتقييم الجدوى والعدالة والخصوصية وعبء العمل ونتائج المرضى قبل التوسع في التطبيق، مع مراعاة الموارد واحتياجات المرضى والمراجعة للمسؤوليات المهنية.
الكلمات المفتاحية: جاهزية المريض؛ الرعاية الخارجية؛ التقييم قبل الإجراء؛ الحوكمة بين المهن الصحية؛ تقنية الأشعة؛ فنيو الصيدلة؛ سلامة الأسنان؛ الأمن الصحي.

1. INTRODUCTION

A patient may arrive for a planned outpatient procedure with an appointment but without all the conditions needed for safe care. A referral can omit relevant clinical information, medication instructions can remain unclear, and the expected procedure can differ from the patient's understanding. Staff may recognize these problems only after travel, registration, and preparation have occurred. This review uses patient readiness to describe the coordinated state in which clinical requirements, reliable information, informed participation, operational resources, and safe access have been addressed before an authorized professional decides whether to proceed.

Readiness should not be reduced to the completion of a checklist. The systematic review of preoperative patient readiness by Torres et al. (2021) considers the patient's capacity to understand information and engage with a decision. That patient-centred perspective complements physiological and procedural assessment. Virtual preoperative assessment offers an alternative way to complete parts of preparation, but evidence about cancellation and satisfaction does not demonstrate equivalence for every patient or every physical examination requirement (Zhang et al., 2021). A randomized trial of digital versus face-to-face assessment further illustrates the need to define the population and endpoint before claiming comparable performance (van Hoorn et al., 2023).

The timing and organization of preparation can also affect service delivery. Hovlid et al. (2012) examined redesign of an elective surgical pathway and reported fewer cancellations after implementation. The study supports attention to the whole pathway, although its hospital surgical context differs from routine imaging or dental care. Greenup and Best (2025) reviewed telehealth and in-person attendance, providing more recent evidence about access and non-attendance. Attendance, cancellation, and clinical readiness remain different outcomes. A patient who attends may still be unprepared, and a cancelled procedure may represent an appropriate safety decision rather than a service failure.

Procedural safety research provides both supportive and cautionary findings. de Vries et al. (2010) evaluated a comprehensive safety system spanning the surgical pathway and observed improvements after implementation. In contrast, Urbach et al. (2014) found no significant improvement in major measured outcomes following checklist introduction across Ontario hospitals. These studies examined different interventions and implementation conditions, so they should not be treated as simple replications with opposing answers. Their combined relevance is to question whether an organization has changed how staff work, or has merely introduced another document.

The present review therefore examines readiness as a relationship between requirements, verification, and decision authority. It asks how the six participating professional domains can contribute without making support staff responsible for clinical clearance. The aim is a transparent theoretical synthesis and an explicitly unvalidated governance framework. Evidence about component interventions is used to identify plausible design requirements, while the effectiveness of the complete framework remains a question for future research.

Imaging services illustrate why a generic preparation process is insufficient. Koetser et al. (2013) developed RADPASS to address the work processes surrounding interventional radiology. The systematic review by Alexander et al. (2021) subsequently examined checklists for image-guided interventions and identified limitations in outcome evidence. These publications support procedure-specific verification while making clear that a

completed checklist is not automatically a demonstrated reduction in harm. Routine diagnostic imaging also differs from an invasive image-guided intervention in staffing, consent, equipment, and recovery requirements.

The joint imaging safety paper by the European Society of Radiology [ESR] and the European Federation of Radiographer Societies [EFRS] (2019) connects correct identification, suitable clinical information, communication, and radiation protection. Radiologic technologists make important contributions to technical preparation and verification, but their responsibilities do not erase the role of the referring clinician or radiological medical practitioner. Contrast-related preparation provides another example of the need for interpretation. Davenport et al. (2020) distinguishes kidney injury associated with contrast exposure from injury caused by contrast, cautioning against indiscriminate denial of useful imaging. The present manuscript uses this evidence to emphasize an authorized risk–benefit decision rather than a universal exclusion rule.

Medication information crosses nursing, dental, and imaging work. A pharmacy technician may obtain and verify a medication history within a supervised service, while an authorized clinician or pharmacist evaluates its implications. In a randomized study, Pevnick et al. (2018) found that pharmacy staff improved admission medication history accuracy. Cater et al. (2015) examined technician-supported reconciliation in an emergency department pathway, while Baker et al. (2021) investigated additional verification of medication histories. These studies supply evidence for structured information collection, not permission for technicians to prescribe or independently instruct patients to stop treatment.

The transfer to ambulatory procedures is consequently conceptual and task specific. Reliable medication information can alert an appropriate clinician to a potential issue before an appointment, but the reviewed studies largely concern admission processes. The relevant readiness requirement is to know whether medication information has been obtained, who reviewed it when required, and how an unresolved question will be escalated. Recording a medication name does not establish that the associated procedural risk has been assessed.

Readiness governance also needs to make scope and applicability explicit. Not every imaging examination needs fasting, contrast, laboratory testing, or medication adjustment. Not every dental procedure needs an escort or recovery monitoring. A common governance framework can specify how applicable requirements are selected and checked, while local clinical protocols determine their content. This distinction prevents a broad interdisciplinary model from becoming an indiscriminate list of burdensome prerequisites that could delay necessary care.

Dental readiness connects the referral, the patient's account, the clinical record, radiographs when indicated, and the intended tooth or procedure. Saksena et al. (2014) describe the development and refinement of an outpatient safety checklist, while Jacob et al. (2021) examine a computerized checklist in general dental practice. The systematic review by Bailey et al. (2015) identifies a small, heterogeneous evidence base for dental safety interventions. These sources justify explicit dental verification but do not show that hospital surgical findings can be transferred unchanged to every dental setting.

Preparation instructions require equally careful interpretation. Green et al. (2020) developed fasting recommendations specifically for procedural sedation, while Rüggeberg et al. (2026) provide a recent multidisciplinary consensus for adult peri-operative fasting. Their scopes differ and both require attention to the intended technique and patient characteristics. This review does not prescribe fasting intervals or replace current clinical guidance. It instead asks how an approved instruction reaches the patient, how understanding is assessed, and which professional resolves conflicting advice before a procedure.

Healthcare security contributes to access and response to immediate operational threats. Its role should remain distinct from assessment of clinical suitability. Arnetz et al. (2017) evaluated a data-informed violence prevention intervention across hospital units, supporting attention to local information and organized response. That evidence does not directly evaluate security involvement in outpatient readiness. Here the proposed security contribution concerns safe entry, proportionate response, and communication of current operational concerns while clinical staff assess the patient's needs.

The twenty publications cited in this introduction span patient-centred readiness, assessment modalities, pathway organization, procedural verification, imaging, medication information, dentistry, fasting, and violence prevention. Their overlap in concern for reliable systems does not make their outcomes interchangeable. A reduction in documentation discrepancies cannot be interpreted as a proven reduction in procedural complications. A consensus recommendation supplies professional guidance rather than a new trial of the proposed framework. These differences shape both the review methods and the interpretation of results.

The primary review question asks how published evidence can inform governance of patient readiness across nursing, radiologic technology, pharmacy support, dentistry, healthcare security, and health administration. Subsidiary questions examine applicable readiness requirements, allocation of verification and decision responsibilities, and the distinction between process completion and patient benefit. The scope remains theoretical throughout. No local failure rate, organizational performance comparison, or empirical validation is claimed. The following literature review examines twenty publications before the methodology describes targeted retrieval and

charting, the results present the conceptual synthesis, and the conclusion and recommendations define a proportionate evaluation agenda.

2 Literature review

Patient readiness as a patient-centred construct

Torres et al. (2021) systematically reviewed preoperative patient readiness, examining literature about programmes intended to foster preparation and studies exploring the construct itself. The review places understanding and decision-making alongside the technical conditions for surgery. The work concerns surgical readiness and cannot establish the effectiveness of a specific cross-professional outpatient protocol. Differences in definitions and interventions also constrain comparison between included studies. Its contribution here is conceptual: readiness should include the person's ability to engage with information rather than only staff completion of tasks. Nursing and dental teams can identify questions that require clinical explanation, while administrative services can arrange accessible communication. Those proposed contributions require assessment in the intended setting. Patient participation remains supported by the organization, rather than becoming a substitute for professional verification or a reason to blame patients for incomplete preparation.

Virtual preoperative assessment

Zhang et al. (2021) systematically reviewed and meta-analysed virtual preoperative assessment in surgical patients. The review considered cancellation rates, patient experience, and other comparative outcomes across different virtual approaches. Cancellation rates were similar to those reported for in-person assessment in the included evidence. However, the intervention labelled virtual assessment varied across technologies, populations, and services. The review therefore informs the choice of an assessment route rather than a universal preference for remote care. In the proposed framework, early remote contact may identify missing information before travel to the facility. Patients who need physical assessment, interpretation support, or assistance using technology should retain an appropriate alternative. The evidence does not establish that a digital questionnaire alone is adequate for every outpatient procedure. Local eligibility and escalation criteria should determine which preparation tasks can safely occur remotely.

Comparative interpretation

These reviews show that patient-centred preparation and the mode of assessment answer different questions. Understanding and decision-making require more than successful completion of a remote contact. A readiness framework should therefore record whether the chosen route was appropriate and whether an unresolved need for clinical examination or explanation remains.

Digital versus face-to-face evaluation

Van Hoorn et al. (2023) conducted a randomized noninferiority trial comparing digital and face-to-face preoperative assessment. The principal comparison concerned quality of recovery among patients undergoing predominantly low- to moderate-risk surgery. Digital assessment met the study's noninferiority criterion for that endpoint. A substantial difference between randomization and the population eventually analysed requires attention when interpreting the result. The findings also remain attached to the patients, technology, and care pathways studied. Its relevance to this review is to support selective redesign with clearly specified endpoints. An institution could evaluate whether remote preparation identifies unresolved requirements early while preserving access to clinical review. Administrative convenience should not determine clinical suitability. Radiologic, dental, and nursing services would need their own applicable requirements, and patients unable to use the digital pathway should be offered a practical alternative.

Redesign of the elective pathway

Hovlid et al. (2012) evaluated redesign of an elective surgical pathway in a Norwegian general hospital. The intervention addressed organizational processes across the pathway rather than a single preoperative question. The authors reported a sustained reduction in cancellations and an increase in operations performed after redesign. Because the intervention was multifaceted and not randomized, the effect of any one component cannot be isolated. Its contribution is to show why preparation, scheduling, and resource coordination should be considered together. A patient may meet clinical requirements while equipment, staffing, or appointment information remains unresolved. The framework therefore distinguishes clinical suitability from operational preparation. Health administration can coordinate resources and make unresolved tasks visible, while authorized practitioners decide

whether the procedure is appropriate. Cancellation measures should also distinguish avoidable organizational failures from clinically justified decisions to defer care.

Comparative interpretation

The assessment trial and pathway redesign study address different levels of work. One tests an alternative assessment route against a specified endpoint; the other reorganizes service processes. Together they support coordinating preparation early while preserving separate measures of clinical suitability, resource availability, and justified cancellation.

A comprehensive safety system

De Vries et al. (2010) studied implementation of a comprehensive surgical safety system covering several stages of care. A controlled before-and-after design compared outcomes before and after implementation, with additional control hospitals. Complications decreased in the implementation hospitals. Nevertheless, it was not a randomized test and its components were implemented together. The findings do not demonstrate that an isolated checklist item caused the observed change. For this manuscript, the source supports connecting upstream preparation with the final decision to proceed. A requirement identified during booking should remain traceable until it is resolved or consciously deferred by an authorized clinician. Verification should connect earlier preparation with the final decision about the procedure. Application to ambulatory imaging and dentistry requires adaptation to their different risks and staffing. The proposed framework adopts the pathway perspective without importing the study's numerical effects or claiming equivalent benefit.

Null findings after checklist introduction

Urbach et al. (2014) evaluated the introduction of surgical safety checklists across Ontario hospitals using a large before-and-after comparison. The study examined mortality and surgical complications using routinely collected data. Checklist introduction was not associated with significant improvement in the major measured outcomes. This is an important counterexample to treating policy adoption as proof of effectiveness. The findings concern implementation across a health system and do not establish that all well-implemented checklists are ineffective. Routine administrative data may also differ from active surveillance in the events they detect. For the present framework, the study strengthens the need to examine actual use, local context, and fidelity. A signed readiness form could coexist with unresolved medication questions or inconsistent patient instructions. Evaluation should therefore ask whether the intended verification occurred and whether concerns changed the plan. The framework remains a testable proposal rather than a claim that additional documentation necessarily improves care.

Comparative interpretation

The surgical studies caution against treating checklist introduction as a uniform intervention. Pathway coverage, implementation fidelity, and outcome surveillance differ. The proposed framework uses verification as an accountable process and leaves its effectiveness open to evaluation, rather than assuming that a newly required signature proves safer care.

RADPASS in interventional radiology

Koetser et al. (2013) developed the RADiological Patient Safety System checklist and evaluated its influence on interventional radiology processes. The study focused on procedural deviations and problems around radiological interventions. After introduction, deviations from the intended process decreased. These endpoints describe process reliability rather than a definitive reduction in clinical complications. Its relevance lies in specifying preparation around the actual procedure and workflow. Interventional imaging can require coordination of identity, planned intervention, relevant clinical information, equipment, and postprocedure arrangements. Routine imaging may require a different set of checks. The proposed framework consequently contains a common governance structure with procedure-specific clinical content. Radiologic technologists contribute verification within their competence, while the appropriate medical practitioner retains clinical decision authority. The study informs the design of preparation tasks but does not validate the six-domain framework.

Evidence on image-guided checklists

Alexander et al. (2021) systematically reviewed checklists used for image-guided interventions across interventional radiology and related settings. The review sought to identify checklist content and evidence about patient safety. Included reports described varied tools, implementation approaches, and endpoints. The evidence was more informative about checklist use and procedural processes than about definitive reductions in harm. This distinction matters because checklist adoption can be easier to document than changes in rare clinical events. The

review also includes evidence related to individually discussed radiology studies, so its findings should not be counted as independent replications. For the conceptual synthesis, the main implication is that a local tool needs a defined purpose and an evaluation plan. Required checks should match procedure risk and available personnel. The framework therefore separates applicability, verification, and authorization to proceed. It avoids prescribing a single universal checklist for all diagnostic and therapeutic procedures.

Comparative interpretation

Radiology-specific evidence supports adapting readiness to the intended intervention. A checklist designed for invasive procedures cannot automatically define preparation for all imaging. The common governance requirement is to establish which checks apply, who verifies them, and who resolves an exception before the appropriate practitioner authorizes care.

Professional guidance on imaging safety

ESR and EFRS (2019) present a joint professional paper on patient safety in medical imaging. The publication addresses identification, communication, radiation protection, and other aspects of safe imaging practice. It is a professional synthesis rather than a trial of a new preparation intervention. Consequently, it provides a rationale for requirements but no direct effect estimate for the proposed framework. Its relevance is the connection between patient information, the intended examination, and professional responsibilities. A correct referral and an appropriately identified patient must remain linked at the point of imaging. Radiologic technologists, referring practitioners, and radiological medical practitioners have distinct contributions within that process. The proposed framework makes unresolved mismatches visible before proceeding. Patient explanations also need to reflect the planned examination and communication needs. This source supports the imaging component of readiness while leaving administrative and security integration as a separate conceptual extension requiring local assessment.

Contrast decisions and kidney risk

Davenport et al. (2020) developed joint consensus statements on intravenous iodinated contrast media in patients with kidney disease. The publication distinguishes contrast-associated acute kidney injury from injury attributable to contrast itself. It also emphasizes the consequences of withholding clinically useful imaging when risk has been overstated. This is consensus guidance informed by evidence, not a randomized trial of readiness governance. Its scope is intravenous iodinated contrast and should not be generalized to every contrast agent or imaging technique. The source informs how the framework handles unresolved clinical questions. A technician or administrative worker may identify a missing assessment or flag a discrepancy, but the decision requires an authorized professional considering benefit and risk. The framework therefore avoids automatic exclusion based on a generic label of renal risk. It proposes traceable review and communication of the resulting plan, while current local protocols determine applicable testing and preparation.

Comparative interpretation

These professional statements concern complementary aspects of imaging readiness. Identification and communication must remain reliable, while clinical risk requires proportionate interpretation. A governance system should make concerns visible without turning uncertainty into automatic refusal of beneficial investigation or unauthorized decisions by support personnel.

Medication histories obtained by pharmacy staff

Pevnick et al. (2018) randomized patients to usual admission medication history processes or histories obtained by pharmacists or pharmacist-supervised pharmacy technicians. Pharmacy staff obtained histories before admission medication orders were placed. The trial found fewer medication history errors in both pharmacy-staff groups than in usual care. This supports structured collection and verification of information within a supervised service. It does not establish that technicians can independently make clinical decisions about medication changes. The emergency department admission setting also differs from preprocedural outpatient assessment. In this review, transfer is therefore limited to the information function. A reliable history can support subsequent professional assessment when medication information is relevant to the procedure. The framework requires a visible distinction between history collection, discrepancy resolution, and a clinical decision. No reduction in outpatient procedural complications is inferred from the admission history endpoint.

Technician-supported reconciliation before admission

Cater et al. (2015) evaluated medication reconciliation using pharmacy technicians in an emergency department pathway through a prospective cohort design. The timing of medication history taking differed between intervention and control processes. The study found no significant reduction in unjustified medication discrepancies

or their severity after earlier technician involvement. A reduction in discrepancies or prescribing errors is not identical to demonstrated prevention of patient injury. The source contributes to the proposed principle that information should be available before the decision it is intended to support. Applied conceptually to ambulatory readiness, relevant medication questions should reach a qualified reviewer before the patient is prepared for an intervention. Nursing and dental teams may depend on that information, while pharmacy support helps establish its accuracy. The review does not specify medication withholding instructions or substitute technician judgement for pharmacist or prescriber assessment.

Comparative interpretation

The medication studies support early availability of reliable information, with careful limits on transfer from admission to outpatient procedures. Pharmacy support can strengthen collection and verification, but clinical interpretation remains a distinct task. The framework connects both tasks while preserving supervision and professional responsibility.

Additional verification of medication histories

Baker et al. (2021) assessed a pharmacy technician medication history programme with a prospective randomized intervention examining additional source verification. The study considered discrepancies in preadmission medication information and their implications for medication use. Additional verification identified information that could otherwise remain unresolved. Its endpoint concerns medication history accuracy and related discrepancies, rather than a direct measure of outpatient procedural harm. For the framework, the important distinction is between a documented list and a sufficiently verified list. A field marked complete should indicate what verification occurred when it is clinically required. Patients and caregivers can provide essential information, but a contradictory source may still require professional reconciliation. The proposed model connects collection to a named reviewer and a documented resolution, with escalation when the information remains uncertain before an authorized procedural decision.

Outpatient dental checklist development

Saksena et al. (2014) describe the development, introduction, and refinement of a checklist intended to prevent wrong tooth extraction in outpatient oral surgery. The report examines policy, team practice, and cultural change rather than presenting a randomized comparison. Its relevance is the need to connect the referral, clinical record, patient discussion, and intended extraction site. Introducing a form alone did not remove the need for reliable team behaviour. The publication is therefore used as an implementation account, not a universal estimate of checklist effectiveness. In the framework, dental verification remains led by a suitably qualified dental practitioner. Supporting staff can help ensure that the necessary records are available and that unresolved inconsistencies are raised. A nondental team member should not be assumed competent to confirm tooth identity independently. The source supports procedure-specific readiness and explicit professional responsibility, while the complete interdisciplinary model remains untested.

Comparative interpretation

These sources connect verification to the information needed for a decision, although their clinical contexts differ. The practical question is whether a discrepancy has been resolved by someone competent to do so. Documented completion without resolution would leave the underlying readiness concern unchanged.

Computerized verification in dental practice

Jacob et al. (2021) examined use of a computerized checklist intended to prevent wrong tooth extraction in general dental practice. The work involved a defined group of clinicians and focused on documentation and compliance with best practice. Its practical setting makes it relevant to outpatient dental preparation. However, improvements in completion or recording should not be interpreted as proof of a reduction in rare wrong-site events. The limited scale also restricts generalization to other organizations and systems. The study informs the framework's distinction between making a verification step visible and establishing that it was performed meaningfully. Digital design should support reconciliation of the patient, clinical records, and intended procedure. It should also permit staff to stop and seek clarification when information conflicts. Clinical site verification remains a dental responsibility, with administrative and nursing contributions shaped by competence and the specific service. The study does not validate automatic authorization through checkbox completion.

The dental intervention evidence base

Bailey et al. (2015) systematically reviewed interventions intended to maintain or improve patient safety in dentistry. Nine studies met the inclusion criteria and covered checklists, reporting systems, electronic notes, and trigger tools. Evidence quality varied and independent verification of findings was limited. The review identified promising checklist results but did not establish that every safety tool improves clinical outcomes. Its age means it cannot represent all current dental research, so it is considered alongside later dental verification evidence in this corpus. The review contributes a boundary on inference: identifying a plausible tool is different from establishing effectiveness across settings. The proposed framework uses that distinction when recommending local adaptation and evaluation. Dental readiness should reflect the intended procedure and patient needs, while additional requirements should have a clear purpose. The current synthesis does not pool the underlying dental results or count overlap as independent evidence.

Comparative interpretation

The dental evidence illustrates the difference between procedure-specific verification and general checklist compliance. A computerized step may improve visibility, but the team still needs the competence and authority to interpret discrepancies. The framework therefore preserves dental ownership of site assessment and avoids substituting documentation for judgement.

Operational safety and local violence information

Arnetz et al. (2017) randomized forty-one hospital units to a data-informed violence prevention intervention or control condition. Intervention units received local event information to support the development of action plans. The authors found lower violent-event rates at six months and lower injury risk at twenty-four months compared with controls. These outcomes and times are distinct and should not be merged into one effect. The intervention did not directly test preprocedural screening or security clearance in outpatient services. Its contribution to this manuscript is therefore indirect. Safe access and an organized response to immediate risk may support delivery of care, but security personnel do not determine clinical suitability. The framework proposes communication of current operational concerns, proportionate escalation, and continued access to clinical assessment. Local data can guide organizational learning without creating unsupported permanent labels. Evaluation should examine delayed care and unnecessary restrictions alongside worker and patient safety.

Fasting specific to procedural sedation

Green et al. (2020) developed an international multidisciplinary consensus on fasting before procedural sedation in adults and children. The recommendations were based on an extensive review and risk-based interpretation of aspiration evidence. The publication distinguishes procedural sedation from general anaesthesia, making scope central to its use. It supplies professional guidance rather than a controlled trial of a preparation pathway. For the present framework, the important implication concerns applicability and instruction consistency. A service should identify whether fasting requirements apply, select the relevant approved protocol, and ensure that the patient receives one coherent plan. Staff should have a route for resolving conflicting instructions rather than automatically cancelling or extending fasting. This review does not reproduce clinical fasting intervals. It proposes accountable communication and authorized decision-making around the requirements established by current guidance.

Comparative interpretation

The security and sedation sources sit at different boundaries of care. They are combined here to explain why applicability and authority must be explicit. Operational safety actions and clinical preparation requirements should be coordinated, while neither domain should silently assume responsibility for decisions belonging to the other.

Attendance in virtual and in-person care

Greenup and Best (2025) systematically reviewed and meta-analysed no-show or non-attendance rates in telehealth and in-person models. The evidence comprised retrospective cohort studies across varied services. Overall findings favoured telehealth attendance, but heterogeneity and the observational designs limit causal conclusions. Most importantly, attendance does not establish that patients are clinically prepared for a procedure. The source informs the operational and equity dimensions of readiness rather than clinical clearance. Remote contact may reduce some travel barriers while introducing others related to connectivity, privacy, disability, or language. Health administration should consequently retain accessible alternatives and avoid interpreting non-attendance as a simple patient deficit. The proposed framework separates contact success from understanding and clinical suitability. Future evaluation should examine who benefits from the chosen preparation route and who needs additional support, alongside measures of unresolved requirements and justified deferral.

Current multidisciplinary fasting consensus

Rüggeberg et al. (2026) developed an international multidisciplinary consensus on peri-operative fasting in adults using evidence review and a Delphi process. The stakeholder panel included patients and professionals from several disciplines. The statement addresses unnecessary prolonged fasting while retaining the need for safe practice and defined applicability. Its adult peri-operative scope also differs from the procedural-sedation focus of the earlier consensus. This recent publication demonstrates why preparation protocols require version control and clear ownership. A patient should not receive conflicting advice from booking staff, nursing personnel, and the procedural service. The framework therefore links approved instructions to a responsible clinical service and an escalation route for uncertainty. It does not infer that all local protocols should be replaced identically or that any staff member can alter fasting instructions. Implementation must remain consistent with current clinical governance.

Comparative interpretation

The most recent sources add two temporal concerns: appointment formats may change access, and clinical guidance may change instructions. A readiness system must therefore monitor unequal barriers and maintain current approved protocols. These are proposed governance requirements, with effectiveness and feasibility still to be assessed in defined services.

3 Methodology

This manuscript uses a targeted scoping review with conceptual framework development. The population comprises patients and staff involved in planned ambulatory procedures; the concept is readiness before an authorized decision to proceed; and the context includes outpatient dental, imaging, and related clinical services. Hospital surgical and admission studies are retained as adjacent evidence when they address transferable mechanisms. Patient-journey reasoning draws on Carayon et al. (2020), while scoping review conduct and reporting are informed by Peters et al. (2020) and Tricco et al. (2018). The review does not claim complete compliance with an exhaustive JBI or PRISMA-ScR process.

Public searches and indexed record retrieval were conducted on 16 November 2026. Discovery terms combined patient readiness, preoperative assessment, procedural checklist, radiology, dental extraction, medication history, pharmacy technician, fasting, attendance, and violence prevention. Exact-title or PubMed-identifier queries in Europe PMC then verified selected records. Examples include TITLE:"Checklists for image-guided interventions", EXT_ID:28986515 AND SRC:MED, and EXT_ID:41657234 AND SRC:MED. The complete verified corpus is reported in Table 2. These examples describe targeted verification, not a reproducible comprehensive database search.

Twenty core publications were purposefully selected to cover the clinical and support functions relevant to this group. The publication eligibility interval was 1 January 2010 through 16 November 2026, and the retained corpus includes a 2026 fasting consensus. Selection was not independently duplicated, no protocol was registered, and subscription databases were not exhaustively screened. No screening totals, duplicate-removal counts, or PRISMA flow are invented. The unit of analysis is a readiness requirement crossing a professional or organizational boundary, rather than a newly sampled patient or institution.

Table 1 Eligibility and interpretation rules

Dimension	Operational inclusion	Boundary for interpretation
Period	2010 to 16 November 2026	Publication year is distinct from data collection
Context	Ambulatory procedures and relevant adjacent settings	Surgery and admission evidence transferred cautiously
Concept	Preparation, verification, access, instructions, authorization	General teamwork alone is insufficient
Evidence	Primary studies, evidence reviews, consensus guidance	Design families remain separate
Verification	Indexed record, abstract, DOI; full text where accessible	Unverified citations excluded

Dimension	Operational inclusion	Boundary for interpretation
Inference	Mechanisms, implementation issues, framework proposals	No pooled effect or institutional performance claim

Each record was checked for title, authors, publication year, journal, DOI, and readable abstract. Simultaneous publications of the same professional statement were treated as one source; the Insights into Imaging version of the ESR–EFRS paper was retained. Indexed abstracts were read for all twenty publications, and available full texts supplied additional methodological and interpretive detail. Table 2 identifies the access level used for each source. Full-text availability is not a score of study quality.

Charting extracted the evidence design, setting, readiness mechanism, professional contribution, outcome type, direction of reported findings, limitations, and relevance to the proposed framework. One primary domain was assigned to each publication for the descriptive chart. Primary empirical reports were distinguished from systematic reviews and professional guidance; the dental implementation account was grouped with empirical service reports. The newer fasting statement used a Delphi process but remains guidance for this descriptive classification.

A single analytical synthesis and consistency check were performed. Independent duplicate screening, inter-rater reliability testing, a formal new risk-of-bias assessment, and a new GRADE certainty rating were not undertaken. Methodological limitations were considered narratively. Overlap between reviews and primary publications was acknowledged, preventing sums of patient samples or votes based on favourable findings. Both null and supportive findings were retained.

Table 2 Verified core evidence and access

Publication	Evidence family	Primary domain	Access
Torres et al. (2021)	Review	Readiness and access	Abstract
Zhang et al. (2021)	Review	Readiness and access	Full text
van Hoorn et al. (2023)	Primary	Readiness and access	Abstract
Hovlid et al. (2012)	Primary	Readiness and access	Full text
de Vries et al. (2010)	Primary	Procedural checklists	Abstract
Urbach et al. (2014)	Primary	Procedural checklists	Abstract
Koetser et al. (2013)	Primary	Imaging safety	Full text
Alexander et al. (2021)	Review	Imaging safety	Abstract
ESR and EFRS (2019)	Guidance	Imaging safety	Full text
Davenport et al. (2020)	Guidance	Imaging safety	Abstract
Pevnick et al. (2018)	Primary	Medication information	Abstract
Cater et al. (2015)	Primary	Medication information	Abstract
Baker et al. (2021)	Primary	Medication information	Abstract
Saksena et al. (2014)	Primary	Dental safety	Abstract
Jacob et al. (2021)	Primary	Dental safety	Full text
Bailey et al. (2015)	Review	Dental safety	Full text
Arnetz et al. (2017)	Primary	Operational safety	Abstract
Green et al. (2020)	Guidance	Readiness and access	Full text
Greenup and Best (2025)	Review	Readiness and access	Full text
Rüggeberg et al. (2026)	Guidance	Readiness and access	Abstract

The synthesis first preserved each source's direct findings and then considered their implications for readiness. The deductive prompts were applicability, reliable information, patient understanding, verification ownership, clinical authority, resources, and unresolved requirements. They organized interpretation rather than constituting a

validated qualitative instrument. Five proposed readiness domains emerged from that conceptual integration: clinical suitability, information integrity, patient comprehension, operational preparation, and safe access. These domains are framework outputs, not categories validated through participant coding.

Table 3 specifies the proposed readiness record. Its fields connect an applicable requirement to evidence, a responsible verifier, and an authorized decision. A requirement can be complete, unresolved, or not applicable; a blank field should not be assumed complete. No numerical readiness score or universal threshold was calculated. Different procedures and professional scopes make an undifferentiated score potentially misleading. The figures describe corpus composition and the proposed model, without invented local rates or predictions.

Ethical considerations

The ethical analysis concerns responsible representation of published evidence and the future use of the model. No participants were recruited, no patient records were accessed, and no identifiable institutional dataset was analysed. No ethics committee approval, exemption, or consent waiver is claimed. An empirical implementation would require the ethics and governance determination appropriate to its design and jurisdiction. The contributor roster was used for professional context and the requested title page, not as a research dataset. Missing affiliations and email addresses were not invented.

Privacy and equity are design requirements. Security staff should receive only information needed for a legitimate operational response, without unsupported diagnostic labels. Technicians and administrative personnel should not independently provide clinical clearance or medication instructions beyond their authorization. Patients need accessible explanations and alternatives to digital-only preparation. Deferral reasons should be recorded without blaming patients for failures of communication or resources. Future evaluation should monitor unwanted disclosure, delayed care, excessive fasting, unnecessary restrictions, and staff burden. The WHO action plan supplies a policy basis for patient-centred coordinated safety work, not validation of this framework (World Health Organization, 2021).

Table 3 Proposed readiness record for future evaluation

Field	Proposed content	Interpretive requirement
Procedure and applicability	Intended procedure and applicable preparation checks	Do not impose irrelevant requirements
Identity and information	Correct patient, referral, records, relevant medication data	Resolve contradictions before dependent decisions
Patient comprehension	Approved instructions, language needs, questions	Contact does not establish understanding
Verification ownership	Named competent verifier and evidence reviewed	Collection differs from clinical interpretation
Operational readiness	Resources, scheduling, access, necessary support	Attendance differs from readiness
Decision and exceptions	Authorized proceed, clarify, defer, or urgent pathway	No automatic clearance through form completion
Feedback and review	Outstanding tasks, patient communication, learning	Closure remains traceable to the responsible service

4 Results

The targeted corpus contains twenty publications across six primary domains. Seven concern general readiness, fasting, or access; four concern imaging; three concern medication information; three concern dental safety; two concern general procedural checklists; and one concerns violence prevention. Figure 1 shows this mutually exclusive descriptive mapping. The distribution reflects purposeful selection rather than the worldwide volume of evidence or the relative frequency of harm. The evidence families comprise eleven primary empirical or service reports, five reviews, and four professional guidance publications.

The sources support component requirements with different levels of directness. Dental and imaging publications directly inform verification around those procedures, while admission medication studies inform the availability and accuracy of information. Surgical pathway studies provide adjacent organizational evidence. The security contribution is the most indirect, because the retained violence trial did not evaluate outpatient readiness. No

publication tested the complete six-domain governance framework or established its effectiveness as a single intervention.

The cross-source comparison identified five useful distinctions. Attendance is different from readiness; a medication list is different from a clinically reviewed plan; checklist completion is different from meaningful verification; a risk flag is different from a reason to deny care; and patient contact is different from understanding. These distinctions are analytical outputs of the synthesis. They connect the differing endpoints in Greenup and Best (2025), Pevnick et al. (2018), Urbach et al. (2014), and Davenport et al. (2020), while preserving the original studies' contexts.

Mixed findings shaped the proposed framework. The supportive safety-system study and the null Ontario checklist study discourage a uniform claim about checklist effectiveness. Similarly, the favourable pharmacy-staff trial and the null technician cohort show that superficially similar services can produce different outcomes. Interpretation requires attention to workflow, supervision, population, and endpoint. The framework therefore specifies conditions to be evaluated rather than assuming that interprofessional participation alone produces benefit.

	Referral and booking	Early assessment	Targeted preparation	Decision and feedback
Nursing	Identify support needs	Assess and escalate	Explain approved instructions	Report unresolved clinical concerns
Radiologic technology	Check imaging request	Flag technical requirements	Verify imaging preparation	Confirm checks to authorized clinician
Pharmacy support	Identify medication information needs	Collect history under supervision	Verify sources and route discrepancies	Clinical review by pharmacist or prescriber
Dentistry	Clarify planned dental procedure	Assess dental requirements	Verify procedure and site	Make authorized dental decisions
Healthcare security	Support accessible entry arrangements	Identify immediate operational concerns	Coordinate proportionate response if needed	Share operational status only
Health administration	Coordinate booking and contact details	Track outstanding requirements	Arrange resources and appointments	Communicate plan and follow-up tasks

Figure 1 Primary domains of the twenty selected publications. Counts describe this review corpus only; they are not incident rates, quality scores, or independent intervention effects.

The conceptual model in Figure 2 organizes preparation around five readiness domains. Clinical suitability concerns assessment appropriate to the procedure. Information integrity concerns correct identity and sufficiently reliable records. Patient comprehension concerns understanding of approved instructions and remaining questions. Operational preparation concerns staffing, equipment, scheduling, and required support. Safe access concerns reaching and entering the service with proportionate management of operational risk. The framework proposes that unresolved requirements remain visible until an authorized decision is made.

The pathway begins during referral or booking, when the intended procedure determines which requirements apply. Early screening identifies missing information and patients needing additional explanation or assessment. Profession-specific verification then addresses applicable clinical and technical requirements. An authorized practitioner decides whether to proceed, seek clarification, modify the plan, or defer. An urgent clinical pathway remains available when ordinary preparation arrangements are inappropriate. Information about unresolved tasks and the resulting plan returns to the patient and relevant services.

These relationships extend the pathway perspective of Hovlid et al. (2012) and de Vries et al. (2010), while preserving the need for procedure-specific checks illustrated by Koetser et al. (2013) and Saksena et al. (2014). They do not imply that those publications tested the new model. The framework's contribution is to connect applicability, verification, and decision authority. Its proposed decision point should prevent both uncritical progression with missing requirements and avoidable delay caused by checks that do not apply.

A composite pass score is deliberately absent. A high administrative completion rate could coexist with an unresolved clinical concern, and a single irrelevant missing item should not automatically prevent care. Each requirement instead has an applicability state, an accountable verifier, and a route for exception handling. Timing thresholds, clinical criteria, and emergency responses must come from current approved local protocols. The model supplies a structure for managing those requirements, rather than clinical instructions for fasting, contrast administration, or medication changes.

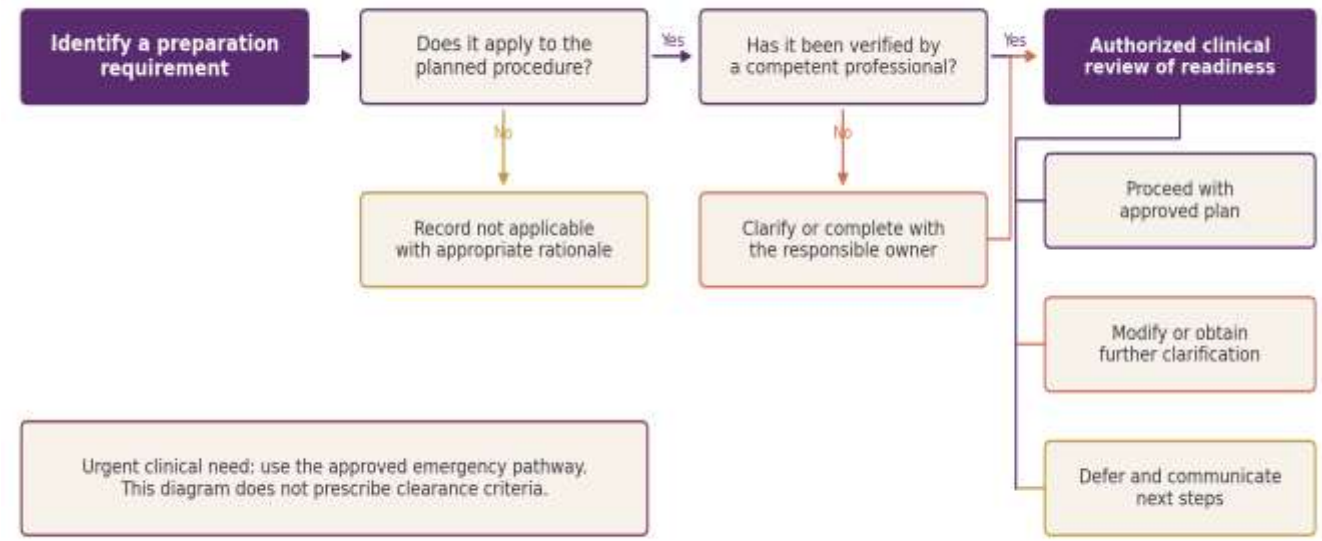


Figure 2 Proposed governance of readiness before ambulatory procedures. Domains and connections are conceptual outputs, not a validated clearance algorithm or a clinical decision rule.

Figure 3 maps proposed professional contributions to readiness activities. Nursing contributes assessment, patient explanation, and escalation within scope. Radiologic technology contributes imaging preparation and technical verification. Pharmacy support contributes structured collection and verification of medication information under appropriate supervision. Dentistry leads dental assessment and procedure or site verification. Healthcare security supports safe access and proportionate response. Health administration coordinates resources, appointments, information routes, and organizational oversight. Authorized medical practitioners and pharmacists remain involved whenever the task requires their expertise.

The map assigns responsibility for a task rather than ranking professional importance. A clinical decision may depend on several completed checks, but its final authority cannot be transferred to a support worker by marking a form complete. Medication studies support information functions with differing results, while the guidance statements define professional concerns rather than proving this allocation. The proposed roles must therefore be reconciled with local authorization, staffing, and service arrangements before any implementation.

The main limitations are purposeful selection, English-language indexed retrieval, uneven full-text access, and the absence of independent duplicate review. Older evidence may not reflect contemporary technology, while the 2026 fasting statement is guidance rather than a new outcome trial. Surgical, admission, and hospital violence findings do not establish outpatient effectiveness. Review overlap prevents treating twenty publications as twenty independent tests. These restrictions limit claims about completeness, certainty, and national applicability.

Future evaluation should prespecify the proportion of applicable requirements verified before arrival, the proportion of unresolved concerns receiving an authorized decision, patient understanding of instructions, avoidable repeat visits, and reasons for deferral. Denominators must distinguish eligible procedures, attended appointments, and patients actually assessed. Clinical complications, privacy incidents, prolonged fasting, delays, and staff workload need separate assessment. These are proposed measures without numerical targets. The result is an evidence-informed framework and evaluation agenda, not measured institutional improvement.

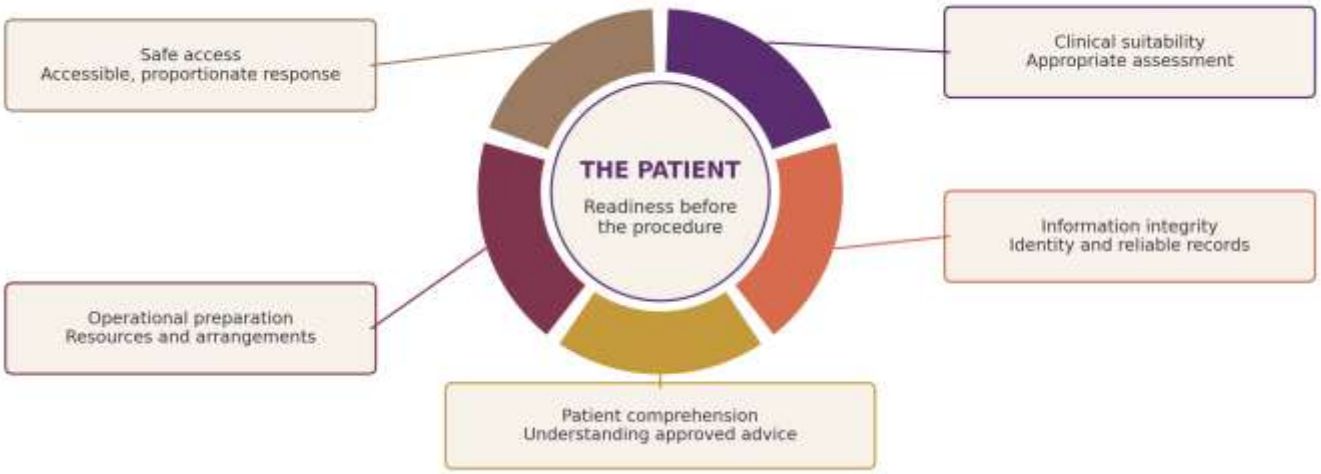


Figure 3 Illustrative proposed responsibility map. L = lead within authorized scope; C = contribute or coordinate; blank = no routine assignment. Clinical decision authority remains with the appropriately authorized practitioner.

5 Conclusion and recommendations

5.1 Conclusion

Patient readiness before ambulatory procedures is an organizational responsibility with distinct clinical, informational, educational, operational, and access requirements. The reviewed evidence indicates that these requirements can be addressed through several component practices, including early assessment, reliable medication histories, procedure-specific verification, coherent instructions, and coordinated scheduling. Their integration requires ownership and an authorized response when a requirement remains unresolved.

The evidence does not establish that a single checklist or a larger team automatically produces safer care. Surgical checklist findings were mixed, medication information interventions differed in their outcomes, and consensus statements supplied guidance rather than trials of the proposed model. Attendance, documentation, patient understanding, and clinical outcomes must therefore remain separate constructs. A service should know which requirement applies and whether it has been meaningfully verified before interpreting a record as evidence of readiness.

This manuscript contributes a conceptual framework integrating nursing, radiologic technology, pharmacy support, dentistry, healthcare security, and health administration. It preserves the role of authorized practitioners in clinical decisions and limits support responsibilities to legitimate functions. The framework has not been tested and provides no estimate of reduced complications, cancellations, or costs.

Its value lies in making preparation requirements and unresolved responsibilities visible across services. Future research should first examine feasibility, acceptability, implementation fidelity, and equity in defined pathways. Comparative evaluation can then assess clinical and organizational consequences with appropriate governance. Until that evidence exists, the framework should guide structured discussion and careful local adaptation rather than be presented as an established clearance instrument for every outpatient setting.

5.2 Recommendations

Services considering this framework should begin with an outpatient pathway and identify the requirements that genuinely apply to its procedures. Frontline professionals and patients should map current preparation, clarify responsibility for verification, and agree who can resolve an exception. The resulting protocol should distinguish clinical suitability from operational completion and retain an urgent pathway when routine arrangements would delay necessary care.

Nursing, dental, and imaging teams should use approved procedure-specific instructions, with an accessible route for patients to clarify conflicting advice. Pharmacy support should strengthen medication information within supervision arrangements, while pharmacists and authorized prescribers retain relevant clinical decisions. Security personnel should support proportionate access and response, and administrators should coordinate resources without making clinical clearance decisions.

Education should use cases involving incomplete referrals, uncertain medication information, inconsistent fasting advice, and barriers to attendance. Digital systems should display unresolved requirements and ownership without converting checkbox completion into automatic authorization. Patients should receive explanations suited to language, literacy, disability, and communication preferences, with alternatives to digital-only preparation.

Evaluation should prespecify process and patient outcomes before implementation. Measures should distinguish applicable checks, verified information, patient understanding, authorized decisions, and reasons for deferral. Clinical harm, unnecessary fasting, repeated visits, confidentiality incidents, delayed access, and staff workload require separate monitoring. Feasibility studies should precede broad rollout, followed by comparative designs where justified and practical. Ethics and organizational governance determinations should match the evaluation design, and effectiveness claims should remain conditional until relevant evidence demonstrates benefit without disproportionate burdens for patients, staff, or healthcare services.

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