Standard ASC.03.03

Each patient's postanesthesia status is monitored, and the patient is discharged from the recovery area by a qualified individual or by using established criteria.

Intent of ASC.03.03

The ongoing, systematic collection and analysis of data on the patient's status in recovery support decisions about moving the patient to other settings and less intensive services. Monitoring during the anesthesia period is the basis for monitoring during the postanesthesia recovery period. Monitoring consists of several elements, such as the list of physiological criteria to be monitored, frequency of monitoring and documentation, and general guidance and/or parameters for recovery goals. Monitoring during the postanesthesia recovery period must be performed according to professional practice guidelines and as defined in hospital policy. Recording of monitoring data provides the documentation to support discontinuing recovery monitoring or the discharge decisions. When the patient is transferred directly from the operating theatre to a receiving unit, monitoring and documentation are the same as would be required in the recovery room.

The time of arrival at and discharge from the recovery area (or the time recovery begins and the time of discontinuation of recovery monitoring) and monitoring findings for the postanesthesia recovery period are documented in the patient's medical record.

Measurable Elements of ASC.03.03

1. Ⓓ Patients are monitored during the postanesthesia recovery period according to professional practice guidelines and as defined in hospital policy.
2. Monitoring findings are documented in the patient's medical record.
3. Patients are discharged from the postanesthesia unit or recovery monitoring is discontinued in accordance with one of the following alternatives:
   - The patient is discharged, or recovery monitoring is discontinued, by a fully qualified anesthesiologist or other individual authorized by the individual(s) responsible for managing the anesthesia services.
   - The patient is discharged, or recovery monitoring is discontinued, by a nurse or similarly qualified individual in accordance with postanesthesia criteria developed by hospital leaders, and the patient's medical record contains evidence that criteria are met.
   - The patient is discharged to a unit that is capable of providing postanesthesia or postsedation care for selected patients, such as a cardiovascular intensive care unit or neurosurgical intensive care unit, among others.
4. The following anesthesia recovery times are recorded in the patient's medical record:
   - Time recovery starts
   - Time recovery phase is complete

Surgical Care

Standard ASC.04.00

Each patient's surgical care is planned based on the results of the preoperative assessment and documented in the patient's medical record.

Intent of ASC.04.00

The *preoperative assessment* is a clinical risk assessment to determine if it is safe for the patient to undergo surgery; therefore, it is an important deciding factor to move forward with planning the surgical procedure.

In addition, the assessment is used to select the appropriate surgical procedure and determine patient needs related to the surgery.

The preoperative assessment evaluates the patient's condition and needs prior to surgery. The assessment includes the following:

- Physical exam and test results
- Medical needs
- Psychological needs
- Social needs (for example, safe housing and support with activities of daily living)
- Economic needs (for example, ability to pay for postoperative medication or medical equipment)
- Discharge needs (for example, transfer to rehabilitation center or home nursing needs)

Results of the preoperative assessment are documented in the patient's medical record prior to surgery. The assessment provides information necessary to do the following:

- Select the appropriate surgical procedure and the optimal time to perform the surgery.
- Perform the procedure safely.
- Interpret the findings of patient monitoring during surgery.

Surgical procedure selection depends on such factors as the following:

- Patient history
- Physical status
- Diagnostic data
- Risks and benefits of the procedure for the patient

Procedure selection considers the information from the initial assessments and reassessments, diagnostic tests, and other available sources. The assessment process is carried out in a shortened time frame when an emergency patient needs surgery.

The planned surgical care is documented in the patient's medical record and includes a preoperative diagnosis. The name of the surgical procedure alone does not constitute a diagnosis.

Measurable Elements of ASC.04.00

1. A preoperative assessment is performed and documented by a qualified provider before surgery.
2. The preoperative assessment includes the following:
    - Physical exam and test results
    - Medical needs
    - Psychological needs
    - Social needs
    - Economic needs
    - Discharge needs
3. Surgical care for each patient is planned based on the preoperative assessment information.
4. A preoperative diagnosis and the planned surgical procedure are documented in the patient's medical record prior to the procedure.

Standard ASC.4.01

The risks, benefits, and alternatives are discussed with the patient and their family or those who make decisions for the patient.

Intent of ASC.04.01

Adequate information and education must be provided to the patient, their family, and/or decision-makers on the risks, benefits, and alternatives related to surgical care to participate in care decisions and to provide the informed consent required in Standard PCC.03.00. Patient education and engagement can be promoted