

When the planned care includes surgical or invasive procedures, anesthesia consent is obtained. This consent process provides the information of the anesthesia plan, risks, benefits, and alternatives and documents the identity of the individual providing the information and witness.

**AN.6 Pre-anesthesia assessment and anesthesia planning are conducted for each patient prior to any inpatient or outpatient surgery/procedure, by an individual qualified to administer anesthesia.**

AN.6.1 The pre-anesthesia assessment should be completed and dated in less than thirty days prior to the scheduled surgery/procedure date. A review and update of the patient's current condition is documented in the medical record before conducting the procedure.

AN.6.2 The pre-anesthesia assessment includes:

AN.6.2.1 Patient interview and physical examination, including airway assessment and limited intra-vascular access.

AN.6.2.2 Medical history including anesthesia, drug and allergy history.

AN.6.2.3 Other additional pre-anesthesia evaluation if applicable and as required in accordance with the standard practice prior to administering anesthesia (e.g., stress tests or additional specialist consultations).

AN.6.2.4 Notation of anesthesia risk according to established standards of practice (ASA classification).

AN.6.2.5 Anesthetic plan and discussion of the risks and benefits.

AN.6.2.6 Documentation of an informed consent.

AN.6.2.7 Appropriate pre-medication and prophylactic antibiotic orders (if indicated).

AN.6.3 The anesthesiologist reassesses the patient immediately prior to induction of anesthesia focusing on the physiologic stability and readiness of the patient for anesthesia. Findings are documented in the patient's medical record.

**Standard Intent:**

Patients planned to have anesthesia should have a pre-anesthesia assessment performed by an anesthetist. The assessment should be less than 30 days old prior to the procedure and should be based on the elements of the substandard AN.6.2.1 through AN.6.2.7. In addition to the documented pre-anesthesia assessment, the anesthetist performing the procedure should perform and document an immediate pre-induction assessment to ensure the physiological stability of the patient at the time.

**AN.7 There is an anesthesia record for documentation of planned anesthesia care.**

AN.7.1 The planned anesthesia care is documented in anesthesia record for each patient during anesthesia. The following information must be documented:

AN.7.1.1 Age, sex, weight, height, and pre-operative vital signs.

AN.7.1.2 The anesthetic agent.