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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.

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**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.

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**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.

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**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.



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- AN.7.1.3 The dosage, time, and route of administration of all medications and anesthetic agents used.
  - AN.7.1.4 The techniques used to administer the anesthesia.
  - AN.7.1.5 If blood is used, the amount of blood, rationale for administration, and the time given.
  - AN.7.1.6 Investigations carried out e.g. blood glucose, blood gases.
  - AN.7.1.7 Unusual events or complications.
  - AN.7.1.8 The patient's status at the end of the procedure.
  - AN.7.1.9 Intravenous fluids given.
  - AN.7.1.10 The anesthesiologist and anesthesia assistant(s).
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**Standard Intent:**

The planned anesthesia care must be documented in the patient's medical record and includes important history and physical examination related information as well as the anesthetic agent, the techniques used to administer the anesthesia, the amount of blood and fluids used, and the name of staff performing the anesthesia. At a minimum the information mentioned in substandard AN.7.1.1 through AN.7.1.10 must be documented.

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**AN.8 The patient's physiological status is continuously monitored and documented during anesthesia.**

- AN.8.1 There is a policy and procedure for monitoring of patients during anesthesia (type and frequency).
  - AN.8.2 The patient's physiological status is continuously monitored and documented during anesthesia.
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**Standard Intent:**

Physiological monitoring provides reliable information about the patient's status during anesthesia period. Monitoring methods depend on the patient's pre-anesthesia status, anesthesia choice, and complexity of the surgical or other procedure performed during anesthesia. In all cases, however, the overall monitoring during anesthesia is a continuous process, and the results are written into the patient's record.

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**AN.9 Post-anesthesia patients are safely transported to the recovery room.**

- AN.9.1 Patients transported to the recovery room shall be accompanied by a qualified member of the anesthesia care team.
- AN.9.2 The patient shall be continually evaluated and treated during the transport with monitoring and support appropriate to the patient's condition.
- AN.9.3 Upon arrival to the recovery room, the patient is properly handed over and re-evaluated.
- AN.9.4 The patient's status and time of arrival to the recovery room are documented.