AN.5.2 The consent process is documented and witnessed.

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.

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.
- 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).

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.