

## Australian and New Zealand College of Anaesthetists (ANZCA)

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# Guidelines on Pre-Anaesthesia Consultation and Patient Preparation

## 1. INTRODUCTION

Adequate pre-anaesthesia consultation has been identified as an important factor in patient safety. The terms “pre-anaesthesia consultation” and “anaesthesia” in this document refer not only to situations pertinent to the administration of general anaesthesia but also includes those related to regional anaesthesia/analgesia and sedation. Consultation with a patient prior to anaesthesia by an anaesthetist or a medical practitioner whose scope of practice includes anaesthesia is essential (see *PS57 Statement on the Duties of an Anaesthetist*, *PS59 Statement on Roles in Anaesthesia and Perioperative Care*, and *Good Medical Practice: A Code of Conduct for Doctors in Australia*<sup>1</sup>).

“Consultation” differs from “assessment” in that an assessment (medical or nursing) contributes to the establishment of the health status of a patient at a particular point in time whereas consultation (medical) involves an assessment as part of a broader process that also includes:

- 1.1 ensuring that the patient’s state of health has been optimised
- 1.2 preparing a plan of perioperative management
- 1.3 allowing discussion with the patient and/or guardian
- 1.4 obtaining informed consent for the anaesthesia and related procedures.

Anaesthetists and medical practitioners undertaking to provide anaesthesia should be familiar with the principles outlined in the Medical Board of Australia’s *Good Medical Practice: A Code of Conduct for Doctors in Australia*<sup>1</sup> and the New Zealand Medical Council’s *Good Medical Practice*<sup>2</sup>. There must also be an awareness of patient autonomy and patients’ rights to privacy as set out by the Privacy Act 1993 (NZ)<sup>3</sup>, the Privacy Act 1998 (Cth)<sup>4</sup> and the Privacy Amendment (Private Sector) Act 2000 (Cth)<sup>5</sup>. *Supporting Anaesthetists’ Professionalism and Performance: A Guide for Clinicians*, and *PS26 Guidelines on Consent for Anaesthesia or Sedation*).

These requirements are also reflected in the *New Zealand Code of Health and Disability Consumers’ Rights*<sup>6</sup> issued by the New Zealand Health and Disability Commissioner, and the *Australian Charter of Healthcare Rights*<sup>7</sup> (endorsed July 2008).

## 2. PURPOSE

The purpose of this document is to assist practitioners to ensure that patients are adequately assessed, prepared, and have given consent for the recommended treatment. It recognises the integral role of the pre-anaesthesia consultation to improved outcomes, as well as coronial recommendations highlighting poor outcomes associated with inadequate pre-anaesthesia assessment.



In addition, it is essential that patients are appropriately selected for the facility in which their procedure is to be performed, taking into consideration their co-morbidities and the services and support available in the facility. The facility must be appropriately staffed and equipped both for the provision of anaesthesia and surgery as well as throughout the period of post-operative hospitalisation (see also *PS15 Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery* and *PS29 Statement on Anaesthesia Care of Children in Healthcare Facilities Without Dedicated Paediatric Facilities*).

### 3. SCOPE

This document is intended to apply to all anaesthetists planning to administer either major regional analgesia (see *PS03 Guidelines for the Management of Major Regional Anaesthesia*) or anaesthesia (as defined above). However, these guidelines should be followed by any practitioner responsible for administering drugs that have the potential for alteration of a patient's conscious state, at all levels of sedation through to general anaesthesia, as well as techniques requiring the use of large volumes of local anaesthetic. (See *PS02 Statement on Credentialing and Defining the Scope of Clinical Practice in Anaesthesia* and *PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures*).

The executive summary and recommendations of *Safety of Anaesthesia: A review of Anaesthesia-related Mortality in Australia and New Zealand 2009-2011*<sup>8</sup> should also be noted because of its emphasis on the importance of adequate preoperative assessment.

### 4. GENERAL PRINCIPLES

- 4.1 The process involved in delivering a safe and effective pre-anaesthesia consultation will vary with the type of practice and environment in which the medical practitioner responsible for the anaesthesia works.
- 4.2 The difficulties of undertaking an adequate pre-anaesthesia consultation for patients admitted on the day of their surgery or medical procedure must be recognised. Ideally such patients should be reviewed prior to admission. Otherwise admission times, list planning and session times must accommodate the extra time required for pre-anaesthesia consultations. (See *PS15 Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery* and *PS29 Statement on Anaesthesia Care of Children in Healthcare Facilities Without Dedicated Paediatric Facilities*).
- 4.3 As part of a pre-admission process, written or computer-generated questionnaires, screening assessments, or documented telephone assessments by medical or nursing staff may be used to supplement the consultation as long as the requirement of 4.4 is followed.
- 4.4 Even if a preliminary pre-anaesthesia assessment has been performed by some other person, the anaesthetist or medical practitioner responsible for administering the anaesthesia must be satisfied that all elements of that assessment have been adequately addressed, and if necessary repeat any elements about which there may be doubt.
- 4.5 The consultation must take place at a time prior to anaesthesia and the planned procedure that allows for adequate consideration of all factors related to assessment and optimisation for surgery, anaesthesia and pain management.

This is particularly important where:

- 4.5.1 there is significant patient co-morbidity
  - 4.5.2 major surgery is planned
  - 4.5.3 there are specific anaesthesia and pain management concerns
- 4.6 In some circumstances, early consultation will not be possible (e.g. emergency surgery, labour ward, and in emergency and critical care departments) but the consultation must not be omitted except when the overall welfare of the patient is at risk.
- 4.7 Pre-anaesthesia consultation facilities must include appropriate equipment, hand washing/disinfecting facilities (see *PS28 Guidelines on Infection Control in Anaesthesia*) and space to allow for a consultation and clinical examination in privacy, as well as support people if required by the patient. An equipped consulting room or single bed hospital room is ideal. For elective procedures, it is not appropriate for this consultation to occur in the operating theatre. Under certain circumstances, such as emergency surgery the consultation may occur in the holding/waiting bay or anaesthesia room. In situations, where the practitioner is confident that there has been thorough preoperative assessment, and verbal specialist consultation (as per 4.3, 4.4 and 4.5 above) the assessment and consultation process may be completed in the anaesthesia room. It is essential that issues regarding facilities, patient confidentiality, privacy, the presence of support people if required, autonomy, religious and cultural sensitivities, and patient questions are adequately addressed. (See also *PS26 Guidelines on Consent for Anaesthesia or Sedation* and the Australian Society of Anaesthetists *ASA-PS03 Minimum Facilities for Pre-anaesthesia Consultations*<sup>9</sup>)
- 4.8 A patient under the care of an anaesthetist must not be left unattended for the purpose of a pre-anaesthesia assessment and consultation. Should it be necessary to undertake a pre-anaesthesia assessment and consultation whilst managing a patient under anaesthesia, there must be strict compliance with *PS53 Statement on the Handover Responsibilities of the Anaesthetist*, as outlined under item 2. Protocol for transfer of responsibility during anaesthesia.

## 5. GUIDELINES

The pre-anaesthesia consultation should include:

- 5.1 Identification and introduction of the medical practitioner performing the consultation.
- 5.2 Confirmation with the patient of the patient's identity, the proposed procedure(s) including site(s) and side, and the proceduralist involved.
- 5.3 A medical assessment of the patient including relevant medical history, which may be assisted by a questionnaire and/or review of relevant patient records, clinical examination, review of medications and review of the results of relevant investigations. Further investigations and/or therapeutic interventions may be considered necessary to optimize the patient's physical status and mental wellbeing. Thus the medical assessment may lead to delay, postponement, reappraisal or even cancellation of the planned procedure.

- 5.4 Review of previous anaesthesia records if indicated. On occasions it may be necessary to obtain these from another medical facility.
- 5.5 Consultation with professional colleagues if required.
- 5.6 Consideration of the facilities, equipment, and staffing with respect to the proposed procedure and patient co-morbidities to ensure that appropriate levels of care are available throughout the patient admission: preoperative, intraoperative and postoperative. Prior to any procedure the anaesthetist must be satisfied that necessary postoperative monitoring and staffing, both in terms of numbers and skill set, are available.
- 5.7 Provision to the patient (and/or guardian) in a timely manner, of information of significance to the patient including details regarding the conduct of the anaesthesia/sedation, pain management (see *PS45 Statement on Patient's Rights to Pain Management*) and relevant potential complications and risks. This material may be in the form of verbal discussion, written pamphlets, electronic information or internet links and to be effective must be given to the patient ahead of the proposed procedure to allow time for consideration. In addition, the patient must be provided with an opportunity for questions on, and discussions about, issues of concern to them. An interpreter should be provided if necessary.
- 5.8 Obtaining informed consent for anaesthesia/sedation and related procedures. This should include consent regarding the type of anaesthesia, invasive procedures, blood and product transfusion if appropriate, procedures and plans for pain management, and where, pertinent, informed financial consent (see *PS26 Guidelines on Consent for Anaesthesia and Sedation*). Where consent has been obtained in a preanaesthesia assessment clinic the procedural anaesthetist must still discuss the proposed treatment with the patient to ensure that all appropriate preparation and explanation has occurred
- 5.9 The provision of information regarding medication management and ordering/modification/cessation of any additional medications considered necessary.
- 5.10 Instructions for fasting according to Appendix 1 below unless otherwise specifically prescribed by the anaesthetist.
- 5.11 Provision of further information such as escort requirements on discharge. Patients undergoing day-stay procedures with anaesthesia or sedation must be discharged into the care of a responsible person in accordance with guidelines as set out in *PS15 Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery*.
- 5.12 As part of the anaesthetist's role in health advocacy, as well as in optimal preparation or surgery, the pre-anaesthesia consultation is a valuable opportunity to encourage and educate patients regarding modifiable health factors such as encouraging smokers to quit (see *PS12 Guidelines on Smoking as Related to the Perioperative Period*).
- 5.13 The pre-anaesthesia consultation should identify and take note of any advanced care directives. In their absence the consultation may represent an appropriate opportunity to recommend consideration of such directives, where relevant.

- 5.14 Contemporaneous written notes documenting the consultation and informed consent should become part of the medical record of the patient. (See PS06 Recommendations on the Recording of an Episode of Anaesthesia Care and also PS26 Guidelines on Consent for Anaesthesia or Sedation.)

## APPENDIX 1

## FASTING GUIDELINES

The aim of fasting prior to a surgical or medical procedure is to decrease the risk of peri-operative regurgitation, which may result in aspiration syndrome. This may be associated with chemical pneumonitis, bacterial pneumonia or airway obstruction depending upon whether foreign material (food) and/or gastro-intestinal fluids (gastric acid, bile or other bowel contents) have been aspirated into the lungs. Such patients may require treatment in critical care units. The fasting guidelines refer not only to situations pertinent to the administration of general anaesthesia but also includes those related to regional anaesthesia/analgesia and sedation.

Prolonged fasting from fluids for more than 6 hours fails to achieve an optimally empty stomach and may have deleterious metabolic effects as well as an impact on patient well-being. Consideration may be given to the provision of clear carbohydrate rich fluids, specifically developed for perioperative use, up to two hours prior to commencement of anaesthesia. The duration of fasting should be sufficient to minimise the risk of aspiration but adults and children should be encouraged to drink clear fluids up to 2 hours before elective surgery. A volume of up to 200ml per hour up until two hours before a procedure is currently recommended for adults. A safe upper limit for volume has not yet been clearly identified, and will vary from patient to patient, however many studies have shown that in adults it is safe to administer up to 400 mL of clear fluids 2 hours prior to surgery. Proposed timing of anaesthesia/sedation should be taken into account and patients instructed accordingly. The practice of "fasting from midnight" for a morning procedure is appropriate for solids but not appropriate for clear fluids in most circumstances.

The guidelines are as follows:

- i. For adults having an elective procedure, limited solid food may be taken up to six hours prior to anaesthesia and clear fluids may be taken up to two hours prior to anaesthesia. Clear fluids are regarded as water, pulp free fruit juice, clear cordial, black tea and coffee. It excludes particulate or milk based drinks.
- ii. For children over six months of age having an elective procedure, breast milk or formula and limited solid food may be given up to six hours and clear fluids up to two hours prior to anaesthesia.
- iii. For infants under six months of age having an elective procedure, formula may be given up to four hours, breast milk up to three hours and clear fluids up to two hours prior to anaesthesia.
- iv. Prescribed medications may be taken with a sip of water less than two hours prior to anaesthesia unless otherwise directed (for example oral hypoglycaemics and anticoagulants).
- v. An H2-antagonist, proton pump inhibitor or other agent that decreases gastric secretion and acidity should be considered for patients with an increased risk of gastric regurgitation.

These fasting guidelines may not apply to patient groups at increased risk of perioperative regurgitation or vomiting. This includes patients having emergency procedures and those with known/suspected delayed gastric emptying or oesophageal motility disorders, and obstetric patients in labour. Patients who have had bariatric surgery (in particular those with adjustable gastric bands) may also fall into this category. In this regard practitioners may choose to vary from these guidelines to reduce risk for individual patients. The practitioner responsible will need to exercise discretion regarding adequacy of fasting times versus the risk of aspiration. In any of these situations it may be necessary to delay the planned procedure and/or use airway protective manoeuvres, both physical and pharmacological.

Chewing gum must be discarded. This is primarily due to its risk as a foreign body rather than increased gastric content.

#### RELATED ANZCA DOCUMENTS

- PS02 Statement on Credentialing and Defining the Scope of Clinical Practice in Anaesthesia
  - PS03 Guidelines for the Management of Major Regional Analgesia
  - PS06 Recommendations on the Recording of an Episode of Anaesthesia Care
  - PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures
  - PS12 Guidelines on Smoking as Related to the Perioperative Period
  - PS15 Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery
  - PS26 Guidelines on Consent for Anaesthesia or Sedation
  - PS28 Guidelines on Infection Control in Anaesthesia
  - PS29 Statement on Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities
  - PS41 Guidelines on Acute Pain Management
  - PS45 Statement on Patient's Rights to Pain Management
  - PS57 Guidelines on the Duties of an Anaesthetist
  - PS59 Statement on Roles in Anaesthesia and Perioperative Care
- ANZCA Supporting Anaesthetists' Professionalism and Performance: A guide for clinicians

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## FURTHER READING

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