hemodynamic parameters. Complications associated with moderate sedation and analgesia may be avoided if signs and symptoms of adverse drug effects such as cardiovascular decompensation or cerebral hypoxia are detected and treated in a timely manner. Patient monitoring includes strategies for the following:

- Monitoring patient level of consciousness assessed by the response of patients during procedures performed with moderate sedation/analgesia
- Monitoring patient ventilation and oxygenation, including ventilatory function, by observation of qualitative clinical signs, capnography, and pulse oximetry
- Hemodynamic monitoring, including blood pressure, heart rate, and electrocardiography
- Contemporaneous recording of monitored parameters
- Availability/presence of an individual responsible for patient monitoring

In addition to monitoring the physiological criteria, other important strategies to include are the frequency of monitoring and documentation, and general guidance and/or parameters for recovery goals. Objective established criteria help identify patients who are recovered and/or ready for discharge and are used by qualified individuals who are not qualified anesthesiologists but authorized by the individual(s) responsible for managing the anesthesia services.

Measurable Elements of ASC.02.02

1. A presedation assessment is performed that includes at least the following criteria when evaluating risk and appropriateness of procedural sedation for the patient:
   - Identify airway problems that may influence the type of sedation used.
   - Evaluate at-risk patients for appropriateness of procedural sedation.
   - Select and plan the type and level of sedation needed based on the patient assessment, identified risks, and type of procedure being performed.
   - Safely administer sedation based on the plan.
   - Interpret findings from patient monitoring during procedural sedation and recovery.
2. A qualified individual monitors the patient during the period of sedation and documents the monitoring in the medical record.
3. Established criteria are used and documented for the recovery and discharge from procedural sedation when a patient is discharged by an authorized individual other than a fully qualified anesthesiologist.
4. The presedation assessment is performed by an individual(s) qualified to do so and documented in the patient's medical record.
5. Ⓓ The following criteria are based on professional practice guidelines and defined in hospital policy:
   - Scope and content of the presedation assessment
   - Criteria for the recovery and discharge from procedural sedation, including criteria for monitoring

Standard ASC.02.03

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

Intent of ASC.02.03

Adequate information and education must be provided to the patient, their family, and/or decision-makers on the risks, benefits, and alternatives related to procedural sedation so an informed decision can be reached when obtaining consent for the procedure. The procedural sedation planning process includes this information and education. This discussion occurs as part of the process to obtain consent for procedural sedation as required in Standard PCC.03.00. A qualified individual provides this education.

Measurable Elements of ASC.02.03

1. The patient, family, and/or decision-makers are educated on the risks, benefits, and alternatives of procedural sedation. (*See also* PCC.03.00, ME 2)
2. The patient, family, and/or decision-makers are educated about postprocedural sedation recovery and pain management. (*See also* PCC.04.00, ME 1)
3. A qualified individual provides and documents the education.

Anesthesia Care

Standard ASC.03.00

A qualified individual conducts a preanesthesia assessment and preinduction assessment.

Intent of ASC.03.00

Because anesthesia carries such a high level of risk, administration is carefully planned. Therefore, an anesthesiologist or another qualified individual conducts the preanesthesia assessment. The patient's preanesthesia assessment is the basis for the anesthesia plan of care, which includes identifying what findings from the clinical assessment and from monitoring during anesthesia and recovery may be significant, and for the use of postoperative analgesia. The preanesthesia assessment may be carried out some time prior to admission or prior to the surgical procedure or shortly before the surgical procedure, as in emergency and obstetrical patients.

The preinduction assessment is separate from the preanesthesia assessment, as it focuses on the physiological stability and readiness of the patient for anesthesia and occurs immediately prior to the induction of anesthesia. When anesthesia must be provided emergently, the preanesthesia assessment and preinduction assessment may be performed immediately following one another, or simultaneously, but are documented independently.

Measurable Elements of ASC.03.00

1. A preanesthesia assessment is performed that includes at least the following elements when evaluating risk and appropriateness of anesthesia for the patient:
   - Identify airway problems that may influence the type of anesthesia used.
   - Evaluate at-risk patients for appropriateness of anesthesia.
   - Select the anesthesia and plan anesthesia care.
   - Safely administer an anesthetic based on patient assessment, identified risks, and type of procedure.
   - Interpret findings from patient monitoring during anesthesia and recovery.
   - Provide information for the use of analgesia following surgery.
2. A separate preinduction assessment is performed to reevaluate patients immediately before the induction of anesthesia.
3. The preanesthesia assessment and the preinduction assessment are performed by an individual(s) qualified to do so and documented in the patient's medical record.
4. Ⓓ The scope and content of the preanesthesia assessment and the preinduction assessment are based on professional guidelines and defined in hospital policy.

Standard ASC.03.01

Each patient's anesthesia plan of care is discussed with the patient and/or those who make decisions for the patient and documented in the patient's medical record.