AN.17.2 The pre-sedation assessment is documented in the patient's medical record.

Standard Intent:

The pre-moderate and deep sedation assessment must be carried by a qualified physician and documented in the patient medical record. The assessment includes:

- History and physical examination.
- History of medication allergy and adverse experience with sedation and analgesia as well as with anesthesia.
- History of systemic illness or major organ impairment.
- Verification of the patient (NPO) status.
- American Society of Anesthesiologists (ASA) physical status class.
- Vital signs.
- Age and weight.

AN.18 Patients are continuously monitored during and after moderate and deep sedation/analgesia.

AN.18.1 Patients are monitored during and after moderate and deep sedation/analgesia, including the following parameters:

AN.18.1.1 Vital signs.

AN.18.1.2 Oxygen saturation.

AN.18.1.3 Skin color.

AN.18.1.4 Level of consciousness/response to stimuli.

AN.18.1.5 ECG findings.

AN.18.2 Patient monitoring is continued during the recovery period until the patient is stable and adequate function is restored.

AN.18.3 Findings of monitoring are documented in the patient's medical record.

AN.18.4 The patient is always attended by a physician and nurse during and immediately after procedures involving moderate and deep sedation/analgesia.

Standard Intent:

Monitoring of patients receiving moderate and deep sedation is a continuous process that extends to the complete recovery from sedation. Monitoring findings must be documented in the patient medical record. It includes but not limited to the following:

- Vital signs.
- Oxygen saturation.
- Skin color.
- The level of consciousness/response to stimuli.