TOPIC	REQUIREMENTS	MET	NOT MET	N/A	COMMENTS
SEDATION CONSENT	Consent version used is current.				
	Consent written in laymen's terms (easy to understand/non-clinical)				
	Provider signed consent.				
	Provider dated & timed only his/her own signature.				
	Witness signed consent (appropriate witness process if telephone consent).				
	Witness dated & timed only his/her own signature.				
	Consent provided in the patient/ authorized decision makers' preferred language.				
	Patient or appropriate authorized decision maker signed the consent.				
	Patient or appropriate decision maker dated his/her own signature.				
	Type of anesthesia/sedation specified on consent.				
	The consent addresses the risks, benefits and alternatives to the sedation/anesthesia and the risks and benefits of the alternatives.				
PROCEDURAL CONSENT	Consent version used is current.				
	Consent written in laymen's terms (easy to understand/non-clinical)				
	Provider signed consent.				
	Provider dated & timed only his/her own signature.				
	Witness signed consent (appropriate witness if telephone consent).				
	Witness dated & timed only his/her own signature.				
	Consent provided in the patient/ authorized decision makers' preferred language.				
	Patient or appropriate authorized decision maker signed the consent.				
	Patient or authorized decision maker dated his/her own signature.				
	Consent clearly documents the following: • Indications for the operation/treatment/procedure • Benefits/likelihood of success (if applicable) for the operation/treatment/ procedure • Major risk/complication for the operation/treatment/procedure				

TOPIC	REQUIREMENTS	MET	NOT MET	N/A	COMMENTS
	Consent clearly documents the reasonable alternatives for the operation/treatment/procedure.				
	Consent clearly documents the risks & benefits of the alternatives.				
	Site/Side indicated.				
PAIN ASSESSMENT	Initial pain rating (score) (using an age-appropriate standardized pain rating scale).				
	For pain score > 0: documented an initial pain assessment (characteristics) was conducted.				
	Self-reported pain goal obtained (for patients who can self-report and are greater than 7 years of age)?				
	Initial pain rating (score)-(using an age-appropriate standardized pain rating scale) documented with first assessment post-procedure.				
	Pain assessment (characteristics) documented with first assessment.				
	Pain rating (score) documented prior to each dose of pain medication.				
	Routine pain assessment (characteristics and score) documented q 2 hours and PRN, for pain score greater than 0 Mark as N/A if patient is discharged prior to next due score.				
	A pain rating (score) documented within 60 minutes of discharge or transfer to floor.				
	Pain assessment (characteristics) documented within 60 minutes of discharge or transfer to the floor for pain score > 0.				
PRE-PROCEDURE ASSESSMENT	Pre-sedation assessment is documented prior to procedure with 6 required elements present: • Heart • Lungs • Airway Assessment (e.g., Mallampati, etc.) • ASA classification • Plan for anesthesia care • Review of medical history (anesthesia, drug and allergy history)				

TOPIC	REQUIREMENTS	MET	NOT MET	N/A	COMMENTS
H&P AND H&P UPDATE NOTE	H&P completed no more than 30 days before or 24 hours after patient admission and before procedure; and H&P Update Note (or progress note for inpatients) within 24 hours after registration/admission (but before procedure).				
	Comprehensive H&P contains the following minimum elements (hospital by-laws): • Chief complaint or reason for admission/surgery • Clinically pertinent physical & diagnostic findings • Plan for care • Current medications • Allergies (with clinically significant adverse reactions & intolerances)				
EQUIPMENT	Equipment and supplies are assembled prior to the procedure to: • Monitor the patient's physiological status • Administer intravenous fluids and medications • Administer blood and blood components, if needed • Provide resuscitation, if needed				
PATIENT EDUCATION	The patient is provided with preprocedural education based on the plan for care. This would include post-procedure instructions for activity, diet, and other instructions. Patient received instructions pertinent to post-sedation activities and limitations.				
PATIENT MONITORING	Oxygenation, ventilation, and circulation are monitored continuously during the procedure.				
BRIEF POST-PROCEDURE NOTE	Brief post-procedure note is present immediately after procedure with 7 required elements are present: • Provider and assistant names • Procedure performed • Pre-procedure diagnosis • Description of findings • Post-procedure diagnosis				

TOPIC	REQUIREMENTS	MET	NOT MET	N/A	COMMENTS
	• Estimated blood loss • Specimens removed				
POST SEDATION EVALUATION	Post-sedation evaluation is documented no more than 48 hours post-procedure with 7 required elements are present: • Respiratory function • Cardiovascular function • Mental status • Pain • Temperature • Nausea and vomiting • Postoperative hydration				
	All post-sedation vital signs were documented in the post-sedation evaluation.				
	Post-sedation evaluation vital signs were pulled after the end of the procedure.				
	All vital signs in the post- sedation evaluation were within normal limits or baseline range.				
DETAILED POST-PROCEDURE NOTE	Detailed post-procedure note is present and finalized within 7 days post-procedure with 8 required elements present: • All 7 elements specified for immediate post-op note PLUS • Detailed description of procedure				
DISCHARGE/ TRANSFER	The medical record contains documentation that the patient was discharged from the post-sedation care area by the physician or other licensed practitioner responsible for the patient's care or according to discharge criteria.				
	The post-procedural documentation contains the name of the physician or other licensed practitioner responsible for discharge.				