Our ability to provide analgesia and sedation for children has evolved over the past several years. We have progressed from papoose boards to oral sucrose solutions to soothe babies during procedures. Many procedures that were traditionally performed in the operating room are being performed in remote settings: inpatient wards, satellite units, and emergency rooms. The delivery of pediatric sedation is no longer restricted to a limited group of specialists, but instead is delivered by specialists and physicians as well as non-physicians, in the field of anesthesia, hospital medicine, pediatrics, intensive care medicine, dental medicine, emergency medicine, and radiology. Some sedatives and analgesics have been introduced to market within the past decade whereas others, still in use, have existed for over a century.

Analgesia and sedation practices are not uniform; guidelines, policies, and protocols differ among professional organizations, provider groups, countries, institutions and among providers within the same institution. The inability to reach a consensus on safe practice and appropriate guidelines threatens our ability to provide safe, consistent care and fuels debate and malcontent amongst and between some specialties.

The magnitude of human and financial cost of jeopardizing patient safety in sedation is large and adverse outcomes should be rare. The numerical value of rare should not be a percentage; for example, a 99.9% probability of having a given outcome or 0.1% (1 in 1000) probability of a serious adverse outcome as a result of sedation is not acceptable. An acceptable aim for pediatric sedation should be “six sigma” which will reduce adverse outcome to 3-4 errors per a million incidents [7].

Ensuring that the practice of pediatric analgesia and sedation follows the same rigorous safety monitoring at all times by all providers, and in any setting across the world is a common responsibility shared by healthcare providers caring for children.
References


