assessment of the child, patient factors (i.e. children with special needs), drug factors or procedure-related and operator factors. A previous episode of failed sedation may necessitate consideration for future procedures to be performed under GA instead of sedation.

2.7 Prolonged sedation

The intention to reduce costs and avoid long theatre waiting times resulted in an escalation in demand for procedures to be performed outside of hospital operating theatres in primary care. Sometimes, these procedures are quite lengthy and often require the provision of deep sedation and analgesia in children. SPs are increasingly faced with the decision as to how long a child can be safely kept sedated outside of the hospital operating theatre, especially when using intravenous techniques. SPs themselves are concerned that they are sometimes faced with procedures in children which may last up to four hours in primary care.

Prolonged sedation for lengthy procedures, especially in children, carries increased risk. Mechanisms must be instituted to ensure the safety of the child. Currently, there is no guidance for SPs on the definition of prolonged sedation in children. It is recommended that in children, any sedation for procedures performed outside of a hospital and lasting more than 1.5 hours is considered prolonged sedation. Even though this approach may not be practical, these procedures should probably best be staged into two or more separate procedures. Alternatively, the recommendation for procedures expected to last more than 1.5 hours, is to perform the procedure under GA in-hospital.

3. Environment and clinical setting

SPs must understand the limitations of working in the relative isolation of the out-of-hospital setting. The premises and supporting facilities where sedation is performed, must meet the requirements of safe sedation practice. Preprocedure assessment and selection of paediatric patients will determine if the facility fulfils the requirements for each individual child. The minimal requirements for facilities, equipment and drugs for procedures to be performed outside of a hospital operating room, must include those detailed in *Appendix 1: Basic equipment and drugs for procedural sedation and analgesia in children*.

Treatment areas must be large enough to enable adequate access for the sedation team. Furthermore, sedation should only be performed in an environment where staff, facilities, equipment and drugs meet requirements to manage emergencies in children. There must also be enough room for managing medical emergencies. Resuscitation equipment suitable for children must be available, maintained and regularly checked, especially before the start of the procedure. The equipment must be in working order and the drugs within their expiry date. Records of the maintenance of equipment must be retained and be made available for formal inspections. During all surgeries, there must be filled oxygen cylinders with appropriate

attachments, as well as access to a defibrillator in case the child needs resuscitation. The clinical setting must permit access for emergency services and the transfer of the child, if necessary. Irrespective of the setting, the sedation team should have access to an intensive care setting.

The recovery facility may either be a dedicated recovery area or a treatment area that is used as such. Children must be continually monitored in the recovery area until they have completely recovered from the effects of the sedation. The recovery area must be equipped to facilitate the management of any sedation-related adverse events.

All providers of procedural sedation services for paediatric patients are responsible to ensure that the sedation facility in which care is delivered, is appropriate for the needs and safety of the SPs, paediatric patients and staff, and that it is in line with guidelines and standards of care. *Appendix 2: Practice appraisal protocol for paediatric sedation* serves as a benchmark for SPs to determine whether the location they work in fulfils the requirements as set out in the guidelines.

The SP, together with the owner of the premises, must also ensure that the premises are inspected and accredited by an independent, recognised sedation authority. The focus of the review should be on the procedures, sedation techniques and processes used. Records of the audit process and outcomes must be retained and made available for inspection. Regular audits should be considered a core requirement for sedation providers involved in patient care. It is recommended that SOSPOSA, or equivalent body, be contacted for accreditation and evaluation of the sedation facility.

Last but not least, is it imperative that all team members are sensitive to the need for maintaining a child-friendly environment. It may be necessary to make adjustments for the specific needs of paediatric patients.

4. Valid informed consent to sedation and analgesia for medical or dental procedures

Valid informed consent (Appendix 3) is a complex process. The General Dental Council (GDC), UK, provides valuable principles and standards for the dental team regarding consent for dental procedures.[6] It should be documented that appropriate consent was obtained from the patient, or a responsible person (parent/caregiver), according to local and international requirements.

Before the process can be completed, information about the sedation and procedure must be provided in a clear and understandable way. This should happen at an appropriate time in order for the patient/parent/caregiver to be able to digest the information and formulate questions. The discussion should, therefore, if possible, not occur immediately before the procedure or even on the day of the procedure. Informed consent must never be obtained