



Complete Summary

GUIDELINE TITLE

(1) Guidelines for monitoring and management of pediatric patients during and after sedation for diagnostic and therapeutic procedures. (2) Guidelines for monitoring and management of pediatric patients during and after sedation for diagnostic and therapeutic procedures: addendum.

BIBLIOGRAPHIC SOURCE(S)

American Academy of Pediatrics (AAP). Guidelines for monitoring and management of pediatric patients during and after sedation for diagnostic and therapeutic procedures. Pediatrics 1992 Jun;89(6 Pt 1):1110-5. [44 references] [PubMed](#)

Guidelines for monitoring and management of pediatric patients during and after sedation for diagnostic and therapeutic procedures: addendum. Pediatrics 2002 Oct;110(4):836-8. [9 references] [PubMed](#)

COMPLETE SUMMARY CONTENT

- SCOPE
- METHODOLOGY - including Rating Scheme and Cost Analysis
- RECOMMENDATIONS
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- BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
- QUALIFYING STATEMENTS
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- IDENTIFYING INFORMATION AND AVAILABILITY

SCOPE

DISEASE/CONDITION(S)

Conditions requiring elective and emergency use of sedative agents in nontraditional settings.

GUIDELINE CATEGORY

Evaluation
Management

CLINICAL SPECIALTY

Anesthesiology
Pediatrics

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

1992 Guideline

To revise the American Academy of Pediatrics guidelines for the use of depressant agents in children, first presented in 1985 under the title "Guidelines for the Elective Use of Conscious Sedation, Deep Sedation, and General Anesthesia in Pediatric Patients"

2002 Addendum

To clarify some of the terms used in the 1992 guideline document and to more thoroughly delineate the responsibilities of the practitioner when sedating children

TARGET POPULATION

Pediatric patients undergoing elective and emergency procedures requiring the use of sedative and general anesthetic agents in any surgical setting

INTERVENTIONS AND PRACTICES CONSIDERED

Monitoring and documentation performed during and after a procedure for children receiving sedatives and general anesthetic agents.

MAJOR OUTCOMES CONSIDERED

Morbidity and mortality associated with the use of sedative and general anesthetic agents in the nontraditional surgical setting.

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note from the National Guideline Clearinghouse and the American Academy of Pediatrics: In 1992, the American Academy of Pediatrics (AAP) Committee on Drugs published a revision of the policy statement, "Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures." Subsequently, the statement had been reaffirmed in 1995 and 1998. Sedation-related accidents continue to occur. In

October 2002, the American Academy of Pediatrics published an addendum to the 1992 statement.

2002 Addendum

The 2002 addendum is meant to clarify some of the terms used in the 1992 document and to more thoroughly delineate the responsibilities of the practitioner when sedating children. Regardless of the intended level of sedation or route of administration of sedative, sedation of a patient represents a continuum and may result in loss of the patient's protective reflexes; a pediatric patient may move easily from a level of light sedation to obtundation. The AAP Committee on Drugs continues to emphasize that sedation of children is different from sedation of adults. Sedatives are generally administered to gain the cooperation of the child. The ability of the child to cooperate depends on chronologic and developmental age. Often, children younger than 6 years and those with developmental delays require deep levels of sedation to gain their cooperation. Children in this age group are particularly vulnerable to the adverse effects of sedatives on respiratory drive, patency of the airway, and protective reflexes. Because deep sedation may occur after administration of sedatives in any child, the practitioner must have the skills and equipment necessary to safely manage patients who are sedated.

The 2002 addendum reaffirms the following principles for the sedation of children:

1. The patient must undergo a documented presedation medical evaluation, including a focused airway examination.
2. There should be an appropriate interval of fasting before sedation.
3. Children should not receive sedative or anxiolytic medications without supervision by skilled medical personnel (ie, medication should not be administered at home or by a technician without medical supervision*).
4. Sedative and anxiolytic medications should only be administered by or in the presence of individuals skilled in airway management and cardiopulmonary resuscitation.
5. Age- and size-appropriate equipment and appropriate medications to sustain life should be checked before sedation and be immediately available.
6. All patients sedated for a procedure must be continuously monitored with pulse oximetry.
7. An individual must be specifically assigned to monitor the patient's cardiorespiratory status during and after the procedure; for deeply sedated patients, that individual should have no other responsibilities and should record vital signs at least every 5 minutes.
8. Specific discharge criteria must be used.

* The term "medical supervision" refers to supervision by a practitioner who, by virtue of training, education, certification, or applicable licensure, law, or regulation, is qualified to supervise the delivery of medical care. The individual may be a physician, nurse, dentist, or other appropriately trained health professional.

The term "conscious sedation" is confusing and, as used in the 1992 statement, has been misinterpreted as a state in which the patient retains only reflex withdrawal to pain. In the 1992 statement, conscious sedation was defined as a state of sedation that "permits appropriate response by the patient to physical

stimulation or verbal command, eg, 'open your eyes.'" The minimal responses of reflex withdrawal (a spinal reflex) or moaning in response to a needle insertion are not consistent with this definition of conscious sedation. The intention of the AAP Committee on Drugs was to define "conscious sedation" as a very minimal state of sedation in which the patient would make an appropriate response to a painful stimulus, such as crying, saying "ouch," or pushing away the offending stimulus. In older children, an appropriate response implies that the patient retains the capability to interact with the patient care team. Purely reflexive activity, such as the gag reflex, simple withdrawal from pain, or making inarticulate noises, does not constitute an appropriate response for the purpose of this definition. A sedated child who displays only reflex activity of this sort is in a state of deep sedation, not a state of conscious sedation. The AAP Committee on Drugs recommends that it is more appropriate to recognize the most current terminology of the American Society of Anesthesiologists and replacement of the term "conscious sedation" with "moderate sedation." The Joint Commission on Accreditation of Healthcare Organizations has adopted revisions to its anesthesia care standards consistent with the American Society of Anesthesiologists standards, and the AAP Committee on Drugs recommends that the Academy adopt the same language. "Mild sedation" is equivalent to anxiolysis; "moderate sedation" is equivalent to the previously used term "conscious sedation" or "sedation/analgesia."

In the 1992 statement, the AAP Committee on Drugs defined deep sedation as "a medically controlled state of depressed consciousness or unconsciousness from which the patient is not easily aroused. Deep sedation may be accompanied by a partial or complete loss of protective reflexes, including the inability to maintain a patent airway independently and to respond purposefully to physical stimulation or verbal command." The AAP Committee on Drugs stated, "Deep sedation and general anesthesia are virtually inseparable for purposes of monitoring." The guidelines stipulated that these levels of sedation require support personnel whose only responsibility is to monitor the patient (ie, this person should not be assisting with the procedure). In addition, a time-based record of vital signs to allow tracking of trends every 5 minutes was recommended.

Another area of confusion relates to the location in which the guidelines should be applied. Regardless of the medications selected or the route of administration (oral, rectal, nasal, intramuscular, intravenous, inhalation), the potential for serious adverse effects exists. Therefore, the skills of the practitioner and the availability of age- and size-appropriate equipment, medications, and monitoring are most important in rescuing the child should an adverse sedation event occur. The AAP Committee on Drugs has concluded that the guidelines apply in all locations and to all practitioners who care for children. At the time the original statement was published, most children sedated for a procedure received sedatives in a hospital. At present, many children receive sedatives in nonhospital facilities, where the guidelines are not always followed. This is unfortunate, because it is in the nonhospital environment that skilled rescue teams may be least accessible in an emergency. Recent information confirms that adverse sedation events that occur in a practitioner's office are more likely to be fatal than events that occur in a hospital or hospital-like setting. Deaths have also occurred when the sedative or anxiolytic medication (even when administered at recommended doses) was administered at home before a procedure.

Proper recovery procedures (including strict discharge criteria) in particular are important, because some patients may become more deeply sedated after the stimulus of the procedure is discontinued, whereas others will have prolonged sedation effects because of the pharmacokinetic or pharmacodynamic profile of the medications chosen for sedation or anxiolysis (eg, chloral hydrate, pentobarbital, chlorpromazine). The systematic approach to sedation was intended to provide a uniform guideline for appropriately observing and caring for children requiring sedation for a procedure regardless of where the procedure was performed (office, free-standing medical facility, or hospital).

The AAP Committee on Drugs wishes to emphasize the following recommendations:

1. The "Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures" apply regardless of the settings in which sedatives are administered or the specific training or profession of the practitioners involved.
2. Sedative or anxiolytic medications should not be administered at home as part of a preprocedural sedation plan.
3. Sedative or anxiolytic medications should not be administered by anyone who is not medically skilled or supervised by skilled medical personnel.
4. When children are deeply sedated, at least one individual must be present who is trained in, and capable of, providing pediatric basic life support, and who is skilled in airway management and cardiopulmonary resuscitation; training in pediatric advanced life support is strongly encouraged.
5. It is crucial that age- and size-appropriate resuscitation equipment and medications be immediately available.
6. Children who receive sedative medication with a long half-life may require extended observation.
7. On occasion, on the basis of careful, documented review of the medical history, physical examination, and proposed procedure, a practitioner may determine that a hospital is the only appropriate venue for administering sedatives.
8. Third-party payers should respect medical decisions that conform to these guidelines and provide the level of care most appropriate for the patient.

1992 Guidelines:

General Guidelines

Candidates

Patients who are American Society of Anesthesiologists (ASA) class I and II are frequently considered appropriate candidates for conscious or deep sedation (see Appendix 2 in original guideline document). Patients in ASA class III or IV present special problems that require additional and individual consideration.

Responsible Person

The pediatric patient shall be accompanied to and from the treatment facility by a parent, legal guardian, or other responsible person.

Facilities SEE ADDENDUM ABOVE

The practitioner who uses sedation must have immediately available the facilities, personnel, and equipment to manage emergency situations. Possible complications include, but are not limited to, vomiting, seizures, anaphylaxis or anaphylactoid reactions, and cardiorespiratory impairment, which may lead to a cardiopulmonary arrest.

Back-up Emergency Services SEE ADDENDUM ABOVE

A protocol for access to back-up emergency services shall be clearly identified, with an outline of the procedures necessary for immediate use. For nonhospital facilities, an emergency assist system should be established, and ready access to ambulance service must be assured.

On-Site Equipment SEE ADDENDUM ABOVE

Equipment must be suitable for children of all ages and sizes being treated. A positive-pressure oxygen delivery system, capable of administering greater than 90% oxygen for at least 60 minutes, and a functional suction apparatus with appropriate suction catheters must be immediately available. Note that if a self-inflating type bag is used, 15 L/min flow is required. Equipment for noninvasive measurement of blood pressure (sphygmomanometer and blood pressure cuffs) and oxygen saturation monitoring (pulse oximetry) must be available. Airway management and breathing equipment must be checked for appropriate function before each sedation.

An emergency cart or kit must be immediately accessible. This cart or kit must contain equipment to provide the necessary age-appropriate drugs and equipment to resuscitate a nonbreathing and unconscious patient. The contents of the kit must allow for the provision of continuous life support while the patient is being transported to a medical facility or to another area within a medical facility. All equipment and drugs must be checked and maintained on a scheduled basis. (See Appendix 3 in the original guideline document for suggested drugs and Appendix 4 in the original guideline document for emergency life support equipment.)

Inhalation sedation equipment must (1) have the capacity of delivering 100% and never less than 25% oxygen concentration at a flow rate appropriate to the size of the patient, and (2) be used in conjunction with a calibrated and functional oxygen analyzer.

Consideration should be given to the National Institute of Occupational Safety and Health Standards for the scavenging of waste gases.

Documentation SEE ADDENDUM ABOVE

Documentation shall include, but not be limited to, the guidelines that follow.

Before Sedation

1. Informed consent.
The patient record shall document that appropriate informed consent was obtained according to local, state, and institutional requirements.
2. Instructions and information provided to the responsible person.
The practitioner shall provide verbal and/or written instructions to the responsible person. Information shall include objectives of the sedation and anticipated changes in behavior during and after sedation. A 24-hour telephone number for the practitioner or his/her associates should be provided to all patients and their families. Instructions shall include limitations of activities and appropriate dietary precautions.

Dietary Precautions

The use of sedation must be preceded by an evaluation of food and fluid intake (see Appendix 5 in the original guideline document).

Documentation at the Time of Sedation

1. Health evaluation.
Before conscious or deep sedation, a health evaluation shall be performed by an appropriately licensed practitioner and reviewed at the time of treatment. This health evaluation should include:
 - Age and weight
 - Health history, including (1) allergies and previous allergic or adverse drug reactions; (2) drug use including dosage, time, route, and site of administration for prescription, over-the-counter, or illicit drugs; (3) relevant diseases, physical abnormalities, and pregnancy status; (4) a summary of previous relevant hospitalizations; (5) history of sedation or general anesthesia, and any complications; and (6) relevant family history
 - Review of systems
 - Vital signs, including heart rate, blood pressure, respiratory rate, and temperature
 - Physical examination, including an evaluation of the airway
 - Physical status evaluation (ASA classification, see Appendix 2 in the original guideline document)
 - Name, address, and telephone number of the child's or family's physician

For hospitalized patients, the current hospital record may suffice for adequate documentation of presedation health; however, a brief note shall be written documenting that the chart was reviewed, positive findings were noted, and a management plan was formulated. If the clinical or emergency condition of the patient precludes acquiring complete information before sedation, this health evaluation should be obtained as soon as feasible.

2. Prescriptions.
When prescriptions are used, a copy of the prescription or a note describing the content of the prescription should be in the patient's chart along with a description of the instructions that were given to the responsible person.

Documentation During Treatment

The patient's chart shall contain documentation at the time of treatment that the patient's level of consciousness and responsiveness, heart rate, blood pressure, respiratory rate, and oxygen saturation were monitored until the patient satisfied predetermined discharge criteria (see Appendix 1 in the original guideline document). The patient's chart shall also contain a time-based record that includes the name, route, site, time, dosage, and patient effect of administered drugs. During administration, the inspired concentrations of oxygen and inhalation sedation agents and the duration of their administration shall be documented. Adverse events shall be documented. Special attention must be paid to calculation of dosage, ie, mg/kg or mg/lb.

Documentation After Treatment

The time and condition of the child at discharge from the treatment area or facility shall be documented; this should include documentation that the child's level of consciousness has returned to a state that is safe for discharge by recognized criteria (see Appendix 1 in the original guideline document).

Specific Guidelines for Level of Sedation

Conscious Sedation SEE ADDENDUM ABOVE

Conscious sedation is a medically controlled state of depressed consciousness that (1) allows protective reflexes to be maintained; (2) retains the patient's ability to maintain a patent airway independently and continuously; and (3) permits appropriate response by the patient to physical stimulation and/or verbal command, eg, "open your eyes." A minimally depressed level of consciousness should be used for the very young or handicapped child incapable of the usually expected verbal responses.

The caveat that loss of consciousness should be unlikely is a particularly important aspect of the definition of conscious sedation, and the drugs and techniques used should carry a margin of safety wide enough to render unintended loss of consciousness highly unlikely. Since the patient who receives conscious sedation may progress into a state of deep sedation and obtundation, the practitioner should be prepared to increase the level of vigilance corresponding to that necessary for deep sedation. Sedatives should only be administered at the health care facility where appropriate monitoring can be instituted.

Personnel

The practitioner.

The practitioner responsible for the treatment of the patient and/or the administration of drugs for sedation must be competent to use such techniques, to provide the level of monitoring provided in these guidelines, and to manage complications of these techniques. The practitioner must be trained in, and capable of providing, at the minimum, pediatric basic life support; training in pediatric advanced life support is strongly encouraged.

Support personnel.

The use of conscious sedation shall include provision of a person, in addition to

the practitioner, whose responsibility is to monitor appropriate physiologic parameters and to assist in any supportive or resuscitation measures, as required. It is strongly encouraged that this individual be trained in pediatric basic life support. The support person shall have specific assignments in the event of an emergency and, thus, current knowledge of the emergency cart inventory. The practitioner and all ancillary personnel should participate in periodic reviews of the facility's emergency protocol to ensure proper function of the equipment and staff interaction.

Monitoring and Documentation

Baseline.

Before administration of sedative medications, a baseline determination of vital signs shall be documented.

During the procedure.

The practitioner shall document the name, route, site, time of administration, and dosage of all drugs administered. There shall be continuous quantitative monitoring of oxygen saturation (e.g., pulse oximetry) and heart rate, and intermittent recording of respiratory rate and blood pressure; these should be monitored and recorded in a time-based record. Restraining devices should be checked to prevent airway obstruction or chest restriction. The child's head position should be checked frequently to ensure airway patency. If a restraint device is used, a hand or foot should be kept exposed. A functioning suction apparatus must be present.

After the procedure.

The child who has received conscious sedation must be observed in a suitably equipped facility; ie, the facility must have functioning suction apparatus, as well as the capacity to deliver more than 90% oxygen and positive-pressure ventilation, eg, bag and mask. The patient's vital signs should be recorded at specific intervals. If the patient is not fully alert, oxygen saturation (pulse oximetry) and heart rate monitoring shall be used continuously until appropriate discharge criteria are met (see Appendix 1 in the original guideline document).

The Use of Nitrous Oxide for Conscious Sedation

The use of nitrous oxide for conscious sedation is defined as the administration of nitrous oxide--50% or less, with the balance as oxygen, without any other sedative, narcotic, or other depressant drug before or concurrent with the nitrous oxide--to an otherwise healthy ASA class I or II patient. The patient is able to maintain verbal communication throughout. A second individual whose responsibility is to monitor the patient may also assist with the procedure. While pulse oximetry is not required under this specific method of sedation, it is strongly encouraged.

Deep Sedation SEE ADDENDUM ABOVE

Deep sedation is a medically controlled state of depressed consciousness or unconsciousness from which the patient is not easily aroused. Deep sedation may be accompanied by a partial or complete loss of protective reflexes, including the inability to maintain a patent airway independently and to respond purposefully to

physical stimulation or to verbal command. The state and risks of deep sedation may be indistinguishable from those of general anesthesia.

Personnel

The state of deep sedation, regardless of how it is achieved, requires that there must be one person available whose only responsibility is to constantly observe the patient's vital signs, airway patency, and adequacy of ventilation, and to either administer drugs or direct their administration. At least one individual must be present who is trained in, and capable of, providing pediatric basic life support, and who is skilled in airway management and cardiopulmonary resuscitation; training in pediatric advanced life support is strongly encouraged.

Equipment

In addition to the equipment previously cited for conscious sedation, an electrocardiograph monitor and a defibrillator for use in pediatric patients should be readily available.

Vascular Access

Patients receiving deep sedation should have an intravenous line in place or have immediately available a person skilled in establishing vascular access in pediatric patients.

Monitoring

The patient shall be observed continuously by a competent individual, and monitoring shall include all parameters described for conscious sedation. Vital signs, including oxygen saturation and heart rate, must be documented at least every 5 minutes in a time-based record. The use of a precordial stethoscope or capnograph to aid in monitoring adequacy of ventilation is encouraged. The practitioner shall document the name, route, site, time of administration, and dosage of all drugs administered. The inspired concentrations of inhalation sedation agents and oxygen and the duration of administration shall be documented.

Postsedation Care

The facility and procedures followed for postsedation care shall conform to those described under "Conscious Sedation."

Special Considerations

Local anesthetic agents.

All local anesthetic agents are cardiac depressants and may cause central nervous system excitation or depression. Particular attention should be paid to dosage in small children. To ensure that the patient will not receive an excessive dose, the maximum allowable safe dosage (eg, mg/kg or mg/lb) should be calculated prior to administration. There may be enhanced sedative effects when local anesthetic drugs are used with other sedatives or narcotics.

Inhalation sedation.

The use of nitrous oxide poses special risks. Except under the direction of an anesthesiologist or anesthesiologist, nitrous oxide should not be used in patients of ASA physical status 3 and 4, in patients with an altered level of consciousness, or in patients for whom sequential assessment of level of consciousness is critical. Using inhalation sedation with nitrous oxide in conjunction with sedatives, narcotics, or other depressant medications may rapidly produce a state of deep sedation or general anesthesia and requires the level of monitoring described under "Deep Sedation."

Special Considerations for Monitoring during Magnetic Resonance Imaging

The special technologic problems associated with monitoring patients in a magnetic resonance imaging scanner--specifically, the powerful magnetic field and the generation of radiofrequency--necessitate the use of special equipment to provide continuous patient monitoring throughout the scanning procedure. Pulse oximeters capable of continuous function even during scanning are now available and should be used in any sedated or restrained pediatric patient. Thermal injuries can result if appropriate precautions are not taken; avoid coiling the oximeter wire and place the probe as far from the magnetic coil as possible to diminish the possibility of injury. Electrocardiogram monitoring during magnetic resonance imaging has been associated with thermal injury, and it should be used with caution in this setting.

Definition of Terms

- Pediatric patients: all patients through 21 years of age, as defined by the American Academy of Pediatrics.
- Must or shall: indicates an imperative need or duty that is essential, indispensable, or mandatory.
- May or could: indicates freedom or liberty to follow a suggested or reasonable alternative.
- ASA Physical Status Classification: guidelines for classifying the physical status according to the American Society of Anesthesiologists.
- Conscious sedation: a medically controlled state of depressed consciousness that (1) allows protective reflexes to be maintained; (2) retains the patient's ability to maintain a patent airway independently and continuously; and (3) permits appropriate response by the patient to physical stimulation or verbal command, e.g. "open your eyes." SEE ADDENDUM ABOVE
- Deep sedation: a medically controlled state of depressed consciousness or unconsciousness from which the patient is not easily aroused. It may be accompanied by a partial or complete loss of protective reflexes, and includes the inability to maintain a patent airway independently and respond purposefully to physical stimulation or verbal command.
- SEE ADDENDUM ABOVE
- General anesthesia: a medically controlled state of unconsciousness accompanied by a loss of protective reflexes, including the inability to maintain a patent airway independently and respond purposefully to physical stimulation or verbal command. SEE ADDENDUM ABOVE

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

1992 Guideline

The type of supporting evidence is not specifically stated for each recommendation.

2002 Addendum

Definition changes are supported by the evidence-based guidelines and standards of the American Society of Anesthesiologists.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate monitoring and management of pediatric patients during and after sedation for diagnostic and therapeutic procedures.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The monitoring and care outlined in these guidelines may be exceeded at any time, based on the judgment of the responsible physician.

Although these guidelines are intended to encourage high-quality patient care, observing these guidelines cannot guarantee a specific patient outcome. They are subject to revision from time to time, as warranted by the evolution of technology and practice.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

American Academy of Pediatrics (AAP). Guidelines for monitoring and management of pediatric patients during and after sedation for diagnostic and therapeutic procedures. Pediatrics 1992 Jun;89(6 Pt 1):1110-5. [44 references] [PubMed](#)

Guidelines for monitoring and management of pediatric patients during and after sedation for diagnostic and therapeutic procedures: addendum. Pediatrics 2002 Oct;110(4):836-8. [9 references] [PubMed](#)

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1992 Jun (reaffirmed 1998; addendum published 2002 Oct)

GUIDELINE DEVELOPER(S)

American Academy of Pediatrics - Medical Specialty Society

SOURCE(S) OF FUNDING

American Academy of Pediatrics

GUIDELINE COMMITTEE

Committee on Drugs

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

1992 Guideline
Committee on Drugs, 1991 to 1992: Ralph E. Kauffman, MD, Chairman; William

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2002 Addendum

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

The June 1992 publication, along with the October 2002 addendum, represent the current release of the guideline.

AAP Policies are reviewed every 3 years by the authoring body. The AAP review process involves an evaluation of new literature that has emerged since the original publication date. Following this review, a recommendation is made that the policy be retired, revised, or reaffirmed without change. Until the Board of Directors approves a revision or reaffirmation, or retires a statement, the current policy remains in effect.

GUIDELINE AVAILABILITY

Electronic copies of the original guideline: Available in Portable Document Format (PDF) from the [American Academy of Pediatrics \(AAP\) Policy Web site](#).

Electronic copies of the 2002 Addendum: Available from the [AAP Web site](#).

Print copies: Available from AAP, PO Box 747, Elk Grove Village, IL 60009-0747.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on April 19, 1999. It was sent to the guideline developer for review on April 20, 1999. This summary was updated by ECRI on October 22, 2002 to incorporate information published in an addendum to the original guideline. The summary was verified by the developer on November 12, 2001.

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The logo for FIRSTGOV, featuring the word "FIRSTGOV" in a stylized font with a red star above the "I".

