We identified 120 episodes of procedural sedation for 24 indications, utilising eight agents in 26 different locations (table 1).

Mean patient age was 6.6 years (range 12 weeks to 19 years). Twenty two per cent of sedations were performed after hours. Neither medical nor nursing staff were present during 7% of sedations nor during 23% of recovery periods. Formal monitoring of any vital signs was performed in 72%. Only 11% of patients were fasted for 6 hours solids/2 hours liquids or longer. Non-pharmacological or psychological techniques were used in 39% of patients and 28% were physically restrained. Staff rated the quality of the sedations episodes as very satisfactory or satisfactory in 86%. Where restraint was required the quality of the sedation episode was rated as very satisfactory or satisfactory in 76% and unsatisfactory or very unsatisfactory in 24%. The procedures were completed successfully in 95%.

This hospital wide study indicates that procedural sedations occur frequently (estimated 2000 episodes/year) and with variable quality of care. Areas for improvement have become apparent. Unmonitored or parent or technician only sedations should be abolished. Sedations should be shifted from low frequency and remote locations to higher frequency settings. Requirements for pre-sedation assessment, personnel, monitoring, and recovery should be defined and embedded into an educational process.² Deeper sedation requires participation of trained senior medical or anaesthesia staff as it is associated with higher risk of sedation related adverse events.³ Non-pharmacological interventions should be increased⁴ and staff understanding of an "ideal sedation" in terms of restraint use should be reviewed. We suspect that our core findings might be similar in other institutions that also lack a comprehensive sedation programme.

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Cost minimisation of RSV prevention with palivizumab

An outpatient respiratory syncytial virus (RSV) prophylaxis programme has been provided in Glasgow since 1999. Initially only high risk neonates were included but subsequently patients with congenital heart disease, congenital lung abnormalities, and other complex histories have been offered prophylaxis. Early attempts to minimise drug wastage via a buddy system were unsuccessful, with only a 1.4% cost saving in 2003–04. During the 2004–05 RSV season we aimed to strictly coordinate the delivery of effective prophylaxis while minimising drug costs through patient cohorting and vial sharing.

Local referral criteria were agreed. Referring clinicians were contacted to encourage timely referral to a designated coordinator (SW). Standardised information letters were then sent to parents and general practitioners.

Breakthrough infections immediately prior to or following the second dose of palivizumab had occurred during the early years of our prophylaxis programme. We therefore administered the second dose after three weeks with subsequent doses prescribed at four weekly intervals.

Outpatient clinics were held in the Ambulatory Ward of the Royal Hospital for Sick Children, Glasgow. The start date was chosen to predate the appearance of RSV infection and to avoid the need to attend for subsequent doses on Christmas or New Year holidays. Three cohorts of between 20 and 30 infants attended on consecutive afternoons. Referrals to the coordinator continued throughout the RSV season as eligible babies were discharged home. These infants were grouped together and, where possible, joined an initial cohort for subsequent doses.

We calculated projected vial usage if every infant had been individually dosed and compared this with our actual usage identified from our pharmacy database.

Eighty six referrals were received prior to the start of the season. These were divided into three cohorts. By the end of the season 93 infants were receiving prophylaxis in Glasgow in eight cohorts. In total 356 doses were given to 114 patients. Four patients (4.4%) were hospitalised with RSV infection. None required intensive care. Total drug costs for the year were £220 847, representing a saving of 16% (table 1).

Our experience shows that it is possible to minimise the cost of palivizumab administration by large group cohorting. This allowed us to maximise the use of 100 mg vials in preference to the more expensive 50 mg vials (table 1). This does however require tight coordination and appropriate outpatient resources. A national consensus on patient selection would facilitate coordinated local administration and perhaps positively influence the cost-benefit analysis of palivizumab prophylaxis.

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Patient's consent for publication of case report: need for developing a universal consent form

A patient's consent for publication of case report is a contentious issue and difficulties in this context have been reported.^{1,2} One of the lesser recognised problems is the lack of a universal patient consent form. Thus, different journals may have their own patient consent forms; for example, the consent form of *The Lancet* is not acceptable to *Archives of Disease in Childhood*. This means that the patient has to sign another consent form should the manuscript be rejected by one journal. This requires a repeat visit by the patient to his doctor. Since many of the patients, especially those receiving treatment at tertiary care centres, live a long way away, the repeat visit may be delayed, or worse, may not materialise at all. An alternative is to obtain the signature on the consent form by mail. This, in our experience, is not a rewarding exercise, especially if the patient does not understand the significance of this exercise.

Another alternative is to ask the patient to sign the consent forms of multiple journals. However, this has the potential of causing unnecessary alarm for the patient and may

Table 1 Palivizumab wastage and monetary savings

	Usage if individually dosed	Actual usage	Savings with vial sharing
50 mg vials	154	52	102
100 mg vials	322	317	5
Total mg	39900 mg	34300 mg	5600 mg
Drug discarded	7255 mg	1730 mg	5495 mg
Total cost	£262 374	£220 847	£41 527