Paediatric Pre-Operative Assessment Clinical Guideline

V2.0

February 2019
Summary.

This Guideline applies to all nurses undertaking pre-operative assessment in children and young people. The Guideline is to ensure that all children receive the same high quality standard of care, which will in turn lead to a safe outcome for surgery.
1. **Aim/Purpose of this Guideline**

1.1. This Guideline applies to all nurses undertaking pre-operative assessment in children and young people. The Guideline is to ensure that all children receive the same high quality standard of care, which will in turn lead to a safe outcome for surgery.

1.2. **Data Protection Act 2018 (Also Known as General Data Protection Regulations – GDPR) Legislation**

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We can’t rely on Opt out, it must be Opt in.

The DPA18 covers how the Trust obtains, hold, record, use and store all personal and special category (e.g. Health) information in a secure and confidential manner. This Act covers all data and information whether held electronically or on paper and extends to databases, videos and other automated media about living individuals including but not limited to Human Resources and payroll records, medical records, other manual files, microfilm/fiche, pathology results, images and other sensitive data.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the ‘information use framework policy’, or contact the Information Governance Team rch-tr.infogov@nhs.net

1.3. Good pre-assessment prior to elective surgery has many benefits:

- Dissemination of information
- Improved patient safety
- Increase the quality of patient’s hospital experience
- Decreased cancellation rates on the day of surgery
- The facilitation of Day Of Surgery admissions
- Decreased bed days
- Facilitation of the MRSA screening process, if applicable (see MRSA policy)

2. **The Guidance**

The aim is for all elective patients to be pre-assessed face to face, or occasionally, if appropriate, by telephone. This is a nurse lead service. Currently, difficult cases will be reviewed and/or seen by the consultant anaesthetist responsible for the operating list.

These guidelines have been written using the most recent literature, and our present guidelines
2.1. The Anaesthetic Clinic

2.1.1. There is 1 paediatric pre-assessment clinic area at RCHT. Clinics run Monday to Thursday from 0830 to 16:00 at RCHT.

2.1.2. When referring patients, please make clear the nature of the referral and the question/s you need answered.

2.1.3. For advice on which anaesthetist will be covering a particular list speak to the anaesthetic Rota coordinator on ext. 8197.

2.2. Review/ Opinion

2.2.1. These guidelines illustrate the range of patients in whom referral for an anaesthetic opinion would be appropriate. They are not exhaustive and some patients who do not meet these specific criteria may still merit a specialist assessment.

2.2.2. Most identified problems can be managed by e-mailing the anaesthetist for the list. Occasionally the anaesthetist will need to assess the child formally and an appointment will need to be made. Currently, this will need to be organised with the individual anaesthetist for the list the child is on.

2.2.3. Pre-op assessment
   - Check that demographic information- up to date?
   - Check what the patient is listed for?
   - History of presenting complaint, does the patient have the same symptoms?
   - Do they still want the operation?
   - Has anything changed?
   - Does the patient need support due to additional needs (such as physical, mental health, learning disability, sensory etc)? Refer to Liaison team or for specialised equipment.

2.2.4. General Systems: History Taking
   - Let the parent/ patient talk, ask the right questions
   - Identify co existing medical illnesses
   - Identify patients with a high risk of complications
   - Think anaesthetic risks
   - Think surgical risks

2.2.5. General Systems Examination
   - The aim is to pick up any abnormalities and to identify and institute any
investigations.
• Results of investigations to be reviewed by nurse. Any abnormalities, act on them. Discuss with Anaesthetist and or Paediatrician, if the child has one.
• Refer to the NICE guidelines for pre-op testing (see end of document).

2.3. Previous anaesthetic problems. Difficult airway/ anaphylaxis

Notify Anaesthetist if:

• History of major anaesthetic related complication, such as a cardiac arrest, unplanned ICU admission, prolonged admission following surgery.
• Documented difficult intubations e.g. grade 4 laryngoscopy, failed or fibre-optic intubation.
• Anticipated difficult intubation, for example, minimal mouth opening, pharyngeal, laryngeal or tracheal tumours, poor neck extension, unstable cervical spine or particular conditions associated with difficult intubation (Box 1).
• Family history of malignant hyperthermia / atypical cholinesterase (scoline/ suxamethonium apnoea) / porphyria.
• History of genuine anaphylaxis.
• Conditions associated with abnormal airway and/or difficult intubation
• If the child has been referred to a tertiary Centre because of anaesthetic risks

(Box 1)

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<tr>
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<td>Glottic Web</td>
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<tr>
<td>Goldenhar Syndrome</td>
<td>Haemangioma</td>
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<tr>
<td>Apert Syndrome</td>
<td>Subglottic Stenosis</td>
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<tr>
<td>Crouzon Syndrome</td>
<td>Temporomandibular joint disease</td>
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<td>Cervical Spinal Fusion</td>
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<tr>
<td>Beckwith Wiederman Syndrome</td>
<td></td>
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<tr>
<td>Downs Syndrome</td>
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</table>
2.4. Cardiovascular Disease

2.4.1. Heart Murmur

Is it known or unknown? If a new murmur is picked up at pre op assessment the child must have an ECG done in clinic (This can be arranged on internal maxims referral with drop down box paediatric cardiology non-invasive diagnostic service) and then a review of the ECG by a Paediatrician.

2.4.1.1. If picked up on the day of surgery for minor surgery in an otherwise well child over 1 year old, we would usually proceed and ask the GP to follow it up- agree with this and GP to refer to Paediatric Cardiology if indicated.

2.4.1.2. If picked up at nurse led pre assessment:

- Under-1s and children with other signs would be referred pre-op by using internal referral on maxims ->New referral registration->marked as Urgent to Paediatric Outpatient service -- Speciality Paediatric Service required- Cardiology. Please do an ECG at time of referral and forward ECG to Paediatric Cardiac secretary extension 5081 and leave a message to the secretary. (Current average waiting time 12-14 weeks for routine cardiac assessments). If surgery planned before this time, make that clear on the referral and contact Paediatric Cardiology Consultants (Sam Padmanabhan or Ola Elmasry to expedite review. If emergency please phone Paediatric Consultant on service via switchboard who will guide further plans

- If a murmur be detected/ noted in an otherwise well child over 1, please do an ECG and forward ECG with history and saturations to Paediatric Cardiac secretary extension 5081 who will discuss with one of the Consultants. Provided it is OK, we would continue surgery. These children again need to be reviewed by the GP after surgery for presence of murmur and referred to Paediatric cardiology service if indicated

Paediatric ECGs can be difficult to interpret and may require a paediatric cardiologist to review. It is important to distinguish between innocent and pathological murmurs.

2.4.2. Previous cardiac history

2.4.2.1. Check recommendations from cardiologist or paediatricians with special interest in cardiology, including recent clinic letters. Most children in Cornwall with cardiac disease are known to the Bristol Paediatric Cardiology Service or paediatricians with special Paediatric Pre-Operative Assessment Clinical Guideline V2.0
interest in cardiology and will have clinic letters including the most recent Echo. If the letter says the heart defect was hemodynamically insignificant then it would be advised to carry on with surgery. Children who have had out of County consultations- request notes from Hospital involved/ and or GP.

2.4.2.2. Check with paediatric cardiologist if it's appropriate for the child can have surgery at RCHT? (This discussion should be had by the anaesthetist and cardiologist). This can be facilitated through the secretary for visiting paediatric cardiologist on extension 5081 at Treliske. Emailing visiting cardiologist might help to resolve the query but please log query to her secretary on extension 5081 at Treliske.

2.4.2.3. Is child stable and well compensated? There is an increased risk of mortality in children less than 6 months who are compromised.

2.4.2.4. Obstructive lesions such as co-arctation of the aorta or pulmonary valve stenosis may cause ventricular pressure overload. ASD or VSD results in over perfusion to the lungs, think congestive cardiac failure (SOB on exertion, chest infections, wheeze breathlessness.)

2.4.2.5. Check BP with other vital signs, if elevated must have 3 readings

2.4.2.6. Children with severe or prolonged obstructive sleep apnoeas may be at risk of pulmonary hypertension (also consider with children with bronchopulmonary dysplasia, muscular dystrophy, adenotonsillar hypertrophy). Symptoms include breathlessness, syncope, and cough. The Child should have an ECG if sleep study shows oxygen saturations <80%. The results should be sent to Paediatric Respiratory Consultant.

2.4.2.7. Children with other syndromes may have a cardiac association, i.e. Di-George syndrome, tracheoesophageal fistula, oesophageal atresia, downs syndrome and VACTERL association

2.4.2.8. Notify Anaesthetist if:

- The child has had previous complex cardiac surgery
- Episodes of cyanosis or a ‘balanced circulation’
- Non-corrected cardiac structural defects
- Low weight/failure to thrive
- Anti-failure therapy (diuretic or ACE Inhibitor)
- Syncope/fainting episodes
- Any anti-failure/anti-arrhythmic therapy should be continued on the day of surgery, regardless of starvation rules
- There is a need to discuss with Paediatric cardiologist
2.5. Respiratory Disease

2.5.1. Asthma
- Is there an exacerbation within last month? Look for markers of poor control
- Check peak flow, this should be within 75% of predicted
- Auscultate, are there any abnormal breath sounds? Is the asthma well managed, or is the child having frequent steroid therapy or hospital admissions with asthma. Take history to ascertain type, frequency, and severity of asthma. It is unwise to anaesthetise within 4 weeks of major exacerbation (at risk of brochospasm and pneumothorax).

<table>
<thead>
<tr>
<th>Potential markers of poor control/ brittle asthma</th>
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<tbody>
<tr>
<td>Recent/recurrent hospital admission</td>
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<tr>
<td>Recent oral steroid therapy</td>
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<tr>
<td>Previous ICU admission</td>
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<tr>
<td>Home nebuliser</td>
</tr>
</tbody>
</table>

- Children should be instructed to bring their regular inhalers/ medication and should continue their normal medication on the day of surgery

2.5.2. Obstructive Sleep apnoea:
- More likely in obese children or adenotonsillar hypertrophy.
- Ask parent/child:
  - Witnessed episodes of apnoea at night?
  - Heavy snoring?
  - Daytime somnolence (falling asleep in the day)
- Does this child need a sleep study? (Follow sleep apnoea protocol – consider discussing with Paediatric Respiratory Consultant +/- ENT Consultant). Are there any other symptoms associated with the complications of long term sleep apnoea?
- If severe OSA is identified (particularly SpO2<80% on overnight oximetry), pulmonary hypertension should be ruled out. An ECG may be required. Referral to Paediatric Respiratory Consultant advised.
- Will need overnight stay and SpO2 monitoring overnight. If severe sleep apnoea (o/night oximetry SpO2<80%) or at risk group (e.g. Wt<10kg or with an associated syndrome) will need to HDU bed.
- Contact Anaesthetist if OSA is likely to be confirmed.

2.5.3. Child with CF
- Assessment is to ascertain severity of the disease (i.e. cough, productivity of sputum, frequency of respiratory infections, and frequency of physio)
• Is the child anaemic (poor dietary intake).
• Some centres commence pre-operative antibiotics and chest physio pre and post-op. check with respiratory consultant and inform child’s consultant of admission.

2.5.4. Child with URTI

• There is an increase in peri-operative complications for a child with respiratory symptoms up to 6 weeks pre op (laryngospasm, hypoxia). Surgery is usually postponed 4-6 weeks after URTI. There is a 10-fold increase in airway-related complications when anaesthesia is carried out in the presence of a recent URTI.

• Caveat: however, often children have serial URTIs throughout winter with little respite, so often a decision is made to continue surgery, provided the child feels well, and are apyrexial with a non-productive cough. This decision is at the anaesthetist’s discretion. (There is some evidence that pre-operative management with macrolide antibiotics and steroids may improve respiratory health and reduce morbidity if child is at risk.)

2.5.5. Recent Pneumonia

If the child is still symptomatic, OR the child has required antibiotics for pneumonia in the last 2 months inform anaesthetist and the child will need a recent X-Ray.

2.6. ENT

Children having tonsillectomy: Children who have an active tonsillitis should be postponed for 4 weeks.

2.7. Ex Premature Baby

2.7.1. Did the baby have RDS/ were they O2 dependent? Baby will be at risk of apnoeas/ bradycardias post op.

2.7.2. Corrected age of baby is important, as is weight of baby. Check anaesthetic Rota for paediatric anaesthetist.

2.7.3. Babies with Bronchopulmonary dysplasia/ chronic lung disease (as a result of RDS) may be at risk of pulmonary compromise/ non-compliant lungs and are at an increased risk of chest infection. Babies that have been previously intubated may have subglottic stenosis. Was the baby intubated after birth? If so, for how long?
2.7.4. There is a risk of hypoglycaemia in premature babies that are starved for prolonged periods.

2.7.5. Consider Gastro oesophageal reflux disease and check that children take anti reflux medicines pre op.

2.7.6. Inform the anaesthetist if the prem-baby is less than 52/40 post conceptual age OR has any ongoing oxygen requirements.

2.8. Endocrine Disease


2.8.2. Thyroid disease: As long as child is asymptomatic and followed up regularly with blood tests and correct medication. This can be checked on MAXIMS

2.8.3. Inform the anaesthetist if the child has Addisons disease (adrenocortical insufficiency) will need careful planning to ensure adequate steroid replacement. Patients carry the risk of Addisonian crisis if steroid therapy is interrupted or inadequate. Also liaise and inform the child's paediatrician for advice pre op.

2.8.4. Contact Anaesthetist if there is an endocrine condition other than controlled diabetes/thyroid disease.

2.8.5. Ask paediatric consultant if any bloods needed preoperatively. Request on Maxims/ print labels/ attach bottles

2.9. Renal Disease/ Abnormal Biochemistry

Anaesthetist should be informed:

- Dr Williams knows the children with renal disease and he can be contacted for advice. Ask if any bloods need to be taken pre operatively/ intraoperatively and print out forms/ bottles on MAXIMS
- All patients requiring dialysis for renal failure.
- Patients with deranged renal function (severe renal impairment <GFR)
- Patients with significant electrolyte abnormalities. (Na < 125, K > 6, Ca > 3 mmol/l)
- Check bloods pre op
2.10. Haematological Problems

2.10.1. Sickle cell disease to be considered for all children who are:

- African
- Afro Caribbean
- Cypriot
- Eastern Mediterranean
- Middle Eastern
- Asian

2.10.2. Sickle cell trait/ thalassaemia trait is not associated with increased risk with anaesthesia.

Testing is required if we don't know family status. Liaise with Sarah Johns/ Dr Creagh (haematology). They will take history. A sickledex test is a simple quick screening tool for SCD, but does not distinguish between SCD and sickle cell trait. IF SCD is suspected, plasma electrophoresis may be required, which takes longer. SCD is usually associated with a degree of anaemia and failure to thrive.

2.10.3. Hereditary spherocytosis will need pre op Hb check for anaemia.

2.10.4. Thalassaemia- suspect if history of anaemia from endemic areas – FBC and cardiac investigations may be required.

2.11. Blood Transfusion

2.11.1. Repeated transfusions increase the likelihood of red-cell antibodies.

- Is the planned surgery high risk for peri-op bleeding?
- (e.g. All children need Group and Save for major hip surgery)
- Children having tonsillectomy who are Jehovah witness may need FBC and counselling. Parents to sign living will. Check with ENT consultant responsible for care to ensure they are involved with pre-operative planning. Follow haematology protocol for pre-operative optimisation.
- For children undergoing tonsillectomy check anaemic/iron deficiency anaemia. If not sure take FBC, ferritin levels. Check child’s diet as a guide to likely iron deficiency anaemia.
• Children who are anaemic... refer to anaesthetist. They may need to be postponed whilst this is investigated or optimized

2.12. Rheumatoid / Neuro-muscular / CNS disease

2.12.1. Think: Is the child difficult to intubate?

2.12.2. Hypermobility/ lax joints could lead to injury. Ehlers Danlos Syndrome is associated with cardiac abnormalities and increased bleeding risk, so inform the anaesthetist.

2.12.3. Refer to Anaesthetist if:

- There is severe arthritis involving cervical spine or jaw which significantly limits mouth opening or neck extension. i.e. Kyphoscoliosis
- Patients with muscular dystrophy/ Neuromuscular disease must always be referred to the anaesthetist/ and the child’s paediatrician needs to be notified.
- Unstable epilepsy with frequent seizures despite treatment.
- Epidermolysis Bullosa- can cause the skin to be very fragile and blister. This group of children needs careful planning and the outreach team will need to be informed. Ask Parents who the contact is for the outreach team (based in London). Inform the anaesthetist.

2.13. Special Educational Needs

Many of these patients will be known to the Learning Disabilities team and the hospital. Often a complex care package may need to be in place, for example premedication of the patient at home specific times of day for procedures, increased numbers of carers. Involvement of the Learning Disabilities team and Anaesthetist is essential to ensure a smooth peri-operative course. Some of these children will have a hospital passport.

2.14. Major Surgery

2.14.1. All patients undergoing complex major surgical procedures are appropriate for discussion with an anaesthetist, particularly those who may require post-operative high dependency care.

Major surgery includes, for example, major hip surgery for a child with co-morbidities or < 15kg, abdominal surgery and gut...
resection. It also includes prolonged surgical procedures, and those in which there are large fluid shifts, significant blood loss or unstable haemodynamic situations. Laparoscopy is not regarded as a major operation [See separate guidelines].

2.14.2. DVT is uncommon in young children however it is most frequently seen following prolonged indwelling lines (e.g. Hickman catheters). Risks in older children are similar to adults.

2.14.3. Surgical severity score

- Grade 1: Minor procedures, e.g. diagnostic endoscopy, biopsy. Dental extractions grommets
- Grade 2: inguinal hernia repair, adenotonsillectomy, knee arthroscopy
- Grade 3: ligament reconstructions, abdominal surgery
- Grade 4: Major procedures, elective major procedures are unusual in children at RCH

2.15. Morbid Obesity / Multiple co-morbidities.

2.15.1. Right-sided heart failure/pulmonary hypertension should be considered, especially if oxygen saturations are below 96% at rest.

2.15.2. Consider Lung Function tests: FEV1 and FVC.

2.15.3. Refer to Anaesthetist if:

- Morbidly obese patients with a BMI > 45
- Morbidly obese patients BMI > 35 with other co-morbidities (diabetes, cerebral palsy, poor mobility)

2.16. Medicines

2.16.1. Broadly speaking, most regularly prescribed medications should be continued to the day of surgery. Pre-operative starvation should not preclude the administration of medication, which may be taken either as a liquid or as tablets with a small amount of water.

2.16.2. Exceptions include diabetic medication and anticoagulants, where specific plans will need to be put in place.

2.16.3. Oral contraceptives containing oestrogen increase the risk of post-operative thrombo-embolism and should be discontinued 4-6 weeks before major elective surgery and orthopaedic limb surgery.
Alternative methods of contraception are advised.

2.16.4. Herbal Medicines: Omit two weeks before surgery e.g. Echinacea, Ephedra, Garlic, Ginkgo, Ginseng, Kava, St John's Wort, Valerian.

2.17. Pre Op Testing (Nice Guidelines 2003- No Other Updates)

- Grade 1 surgery (minor, Children ASA 1)
  - No pre op routine testing is necessary
- Grade 2 surgery (children ASA 1)
  - No routine pre op testing is required
- Grade 3 surgery major (children ASA 1)
  - Consider FBC, Renal Function, Urine Analysis
- Grade 4 surgery major + (children ASA 1)
  - Consider FBC, renal function, urinalysis

2.17.1. FBC
Children with known or suspected anaemia and all patients undergoing major surgery or with suspected or known low Hb (<12) should have a FBC and ferritin.

2.17.2. Group & Screen / X-match
Blood should be taken for group and screen at pre-assessment clinic for all those undergoing major surgery and other listed operations. A further sample will need to be taken on the day of admission if it is predicted that blood may need to be ordered for surgery. This is a decision for the anaesthetist on the day and the surgical team. Labelling of blood samples must be meticulous. Nurses to use the Llama system.

Blood bank will make suitable arrangements should a sample taken at pre-assessment show antibodies.

2.17.3. Guidelines for pre-operative echocardiogram.
Echocardiography should be considered if:

- New murmur
- Especially if:
  - Poor functional capacity
  - Syncope or dizzy spells

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Page 14 of 21
There are no notes on a child with a cardiac anomaly

2.17.4. Guidelines for pre-operative X-rays

- Consider the child having orthopaedic surgery. Has the child had a recent X-ray?
- Always consult with the relevant orthopaedic Consultant to ascertain if an X-ray is required.
- Children with chronic lung disease, CF or muscular dystrophy may need a chest X-ray, check with named consultant and anaesthetist.
- Follow clinical imaging referrer protocol for registered nurses for those able to undertake the role of referrer.

3. Monitoring compliance and effectiveness

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<th>Element to be monitored</th>
<th>Patients cancelled on day of surgery. Ward clerk to provide addressograph.</th>
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<td>Lead</td>
<td>Yvette Williams</td>
</tr>
<tr>
<td>Tool</td>
<td>Retrospective audit 1 week per month for 3 months</td>
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<tr>
<td>Frequency</td>
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<tr>
<td>Reporting arrangements</td>
<td>Ward Manager Paediatric anaesthetists</td>
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<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Paediatric anaesthetic staff</td>
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<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and actioned within 2 months. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.</td>
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</table>

Audit pre op assessment document:
1. Did the child have his/her operation on the day as planned?
2. Was the operation cancelled for any reason?
3. If the operation was cancelled was it because
   3a. The Child was ill on the day of operation?
   3b. There was an omission in the pre-op procedure? If so can you identify the omission?
3c. Other reason, please state
4. **Equality and Diversity**

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the ‘Equality, Inclusion & Human Rights Policy’ or the Equality and Diversity website.

4.2. **Equality Impact Assessment**
The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

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<th>Document Title</th>
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<td>1 August 2013</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>February 2019</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>February 2022</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Dr Roger Langford, Anaesthetics Yvette Williams, Paediatrics</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 253909</td>
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**Brief summary of contents**

This Guideline applies to all nurses undertaking pre-operative assessment in children and young people. The Guideline is to ensure that all children receive the same high quality standard of care, which will in turn lead to a safe outcome for surgery.

**Suggested Keywords:** Pre-operative assessment, POA, pre op guidelines, paediatric

**Target Audience**

<table>
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<th>RCHT</th>
<th>CFT</th>
<th>KCCG</th>
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**Executive Director responsible for Policy:** Medical Director

**Date revised:** December 2017

**This document replaces (exact title of previous version):** CLINICAL GUIDELINE FOR PAEDIATRIC PRE –OPERATIVE ASSESSMENT

**Approval route (names of committees)/consultation:** Paediatric Audit and Guidelines Anaesthetic Dept Paediatrics

**Divisional Manager confirming approval processes**

Tunde Adewopo

**Name and Post Title of additional signatories**

Not Required

**Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings**

{Original Copy Signed}

Caroline Amukusana

**Signature of Executive Director giving approval**

{Original Copy Signed}
Publication Location (refer to Policy on Policies – Approvals and Ratification): Internet & Intranet ✓ Intranet Only

Document Library Folder/Sub Folder Clinical/ Paediatrics

Links to key external standards NICE Guidelines Pre-Op Testing 2003

Related Documents: NICE Guidelines 2003

Training Need Identified? No

Version Control Table

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<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<td>Initial Issue</td>
<td></td>
<td>R. Langford (anaesthetist)</td>
</tr>
<tr>
<td>Dec 2017</td>
<td>V2.0</td>
<td>Addition of what to do with a child that has an incidental heart murmur. Changes from bullet points to sub numbering throughout document and minor name change to meet requirements of Policy Review Group.</td>
<td>R. Langford (anaesthetist)</td>
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</tbody>
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All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry. This document is only valid on the day of printing.

Controlled Document
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager.
Appendix 2. Initial Equality Impact Assessment Form

*This assessment will need to be completed in stages to allow for adequate consultation with the relevant groups.*

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
<th>Paediatric Pre-Operative Assessment Clinical Guideline V2.0</th>
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<td>Directorate and service area:</td>
<td>Is this a new or existing Policy?</td>
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<tr>
<td>Child Health</td>
<td>Existing</td>
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<td>Name of individual completing assessment:</td>
<td>Telephone:</td>
</tr>
<tr>
<td>Yvette Williams</td>
<td>01872 253909</td>
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</tbody>
</table>

1. **Policy Aim***
   - Who is the strategy / policy / proposal / service function aimed at?
   - To deliver high quality pre op assessment to all children undergoing surgery

2. **Policy Objectives***
   - To standardise, the process of pre op assessment so that all children receive the care pertinent to their individual needs. To reduce cancellations on the day of surgery

3. **Policy – intended Outcomes***
   - To provide safe, effective, high quality care to the child and family.

4. *How will you measure the outcome?*

5. Who is intended to benefit from the **policy**?
   - Child and family
   - Nurses undertaking the assessment

6a Who did you consult with

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Patients</th>
<th>Local groups</th>
<th>External organisations</th>
<th>Other</th>
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<td></td>
</tr>
</tbody>
</table>

b). Please identify the groups who have been consulted about this procedure.

   - Paediatric anaesthetists
   - Paediatrics
7. The Impact
Please complete the following table. If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td>x</td>
<td></td>
<td>No areas indicated</td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td></td>
<td>x</td>
<td></td>
<td>No areas indicated</td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td></td>
<td>x</td>
<td></td>
<td>No areas indicated</td>
</tr>
<tr>
<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
<td>x</td>
<td></td>
<td></td>
<td>Those with any identified additional needs will be referred for additional support as appropriate - i.e to the Liaison team or for specialised equipment. Written information will be provided in a format to meet the patient and their family’s needs e.g. easy read, audio etc</td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td></td>
<td>x</td>
<td></td>
<td>No areas indicated</td>
</tr>
<tr>
<td>Marriage and Civil partnership</td>
<td></td>
<td>x</td>
<td></td>
<td>No areas indicated</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td></td>
<td>x</td>
<td></td>
<td>No areas indicated</td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>x</td>
<td></td>
<td></td>
<td>No areas indicated</td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or

What was the outcome of the consultation? The guideline was approved at the Child Health Directorate meeting 19/7/18
8. Please indicate if a full equality analysis is recommended. | Yes | No | x

9. If you are not recommending a Full Impact assessment please explain why. See above

No areas indicated

<table>
<thead>
<tr>
<th>Signature of policy developer / lead manager / director</th>
<th>Date of completion and submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chris Warren</td>
<td>15/11/18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Names and signatures of members carrying out the Screening Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Chris Warren</td>
</tr>
<tr>
<td>2. Human Rights, Equality &amp; Inclusion Lead</td>
</tr>
</tbody>
</table>

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa,Truro, Cornwall, TR1 3HD

This EIA will not be uploaded to the Trust website without the signature of the Human Rights, Equality & Inclusion Lead.

A summary of the results will be published on the Trust’s web site.

Signed __ ___Chris Warren___

Date ___15/11/18___