**PAEDIATRIC SURGERY AND ANAESTHESIA POLICY**

Safe Provision of

<table>
<thead>
<tr>
<th>Document Author</th>
<th>Authorised</th>
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<tr>
<td><strong>Written By:</strong> Paediatric Charge Nurse in conjunction with Consultant Anaesthetist and Consultant Surgeon ENT, on behalf of the Children's Surgical Users Group</td>
<td><strong>Authorised By:</strong> Chief Executive</td>
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<tr>
<td><strong>Date:</strong> 8 June 2015</td>
<td><strong>Date:</strong> 17 November 2015</td>
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<td><strong>Lead Director:</strong> Clinical Director</td>
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<td><strong>Effective Date:</strong> 17 November 2015</td>
<td><strong>Review Date:</strong> 16 November 2018</td>
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<td><strong>Approval at:</strong> Policy Management Group</td>
<td><strong>Date Approved:</strong> 17 November 2015</td>
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<tr>
<td>Date of Issue</td>
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NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust
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1 Executive Summary

This policy covers all Surgery and Anaesthesia for Paediatric patients carried out at St Mary’s Hospital, Isle of Wight.

This policy is required to ensure Paediatric Surgery and Anaesthesia is carried out in the most appropriate environment, at the most appropriate time and by the most competently qualified Surgical and Anaesthetic Practitioners.

The policy takes into account national guidance in relation to paediatric surgery and details the expectation of practice within the IOW NHS Trust.

Particular importance should be paid to the following:

- The minimum age for any surgery - emergency or elective - is 6 months old
- Children under 6 months of age should be referred for treatment at an appropriate tertiary referral paediatric centre (primarily Southampton)
- Elective surgery should not take place outside of routine hours 8am – 6pm and efforts must be made to undertake emergency surgery as soon as is safely possible.
- The grade of anaesthetic and surgical staff should always be appropriate to the physiological status and the age of the child.
  - Children under 5 must be anaesthetised by a Consultant anaesthetist
  - Over 5s may be anaesthetised by SAS staff with suitable training and experience.
  - Children under 2 should have 2 consultant anaesthetists present.
- Discussion with and or transfer to tertiary paediatric surgical services should always be considered with complex or young children.

2 Introduction

This policy is required to ensure Paediatric Surgery and Anaesthesia is carried out in the most appropriate environment, at the most appropriate time and by the most competently qualified Surgical and Anaesthetic Practitioners. Elective Procedures should not be carried out outside of routine operating hours.

Paediatric patients are defined as patients aged 16 or under
3 Definitions

APLS – Advanced Paediatric Life Support

EPLS – European Paediatric Life Support

NCEPOD – National Confidential Enquiry into Patient Outcome and Death

NNEB – National Nursery Examination Board

ODP – Operating Department Practitioner

RN Child – Registered Children’s Nurse

RSCN – Registered Sick Children’s Nurse

SAS – Staff grade or Associate Specialist

4 Scope

This Policy applies to all staff involved in paediatric surgery and anaesthesia performed at St Mary’s Hospital, Isle of Wight. It also applies to Paediatric, medical and nursing staff.

5 Purpose

The Isle of Wight NHS Trust is committed to ensuring, patients safety and clinical effectiveness at all times, and as such sets out within this document the process to be followed in order to carry out paediatric surgery and anaesthesia safely and effectively

6 Roles and Responsibilities

The responsibility of having this policy in place rests with the Chief Executive Officer of the Trust.

Surgeon: Is responsible for ensuring that procedures on paediatric patients are carried out by an appropriately trained, experienced surgeon in the most appropriate environment at the best time for the benefit of the patient. (This may involve referral to a tertiary surgical unit). The consent process must be robustly performed by adequately informed surgical staff. Risks and potential complications must be discussed with the child’s carers and also with the patient where the child has capacity to understand.

A named surgical consultant will have overall responsibility for the governance of paediatric surgery on IOW and regularly attend the paediatric surgical users group.
**Anaesthetist:** Is responsible for ensuring that procedures on paediatric patients are carried out by an appropriately trained, experienced anaesthetist in the most appropriate environment at the best time for the benefit of the patient. (This may involve referral to a tertiary surgical unit).

They are responsible for assessing the child’s fitness for surgery and anaesthesia. The anaesthetist undertaking the procedure should personally undertake the immediate pre op visit. Carers and children (where appropriate) should have the anaesthetic process explained and potential risks discussed.

**Operating Department Staff:** Are responsible for ensuring the provision of appropriate paediatric equipment, anaesthetic drugs in appropriate dosages and appropriately experienced staff.

**Paediatric Medical Staff:** Are responsible for ensuring the awareness of paediatric surgical patients on the ward, and to provide paediatric advice and expertise when requested by surgical or anaesthetic teams.

**Paediatric Nursing Staff:** Are responsible for advocating for patient and their family, and ensuring the patient is fully prepared for pending surgery by collating and completing the necessary paperwork, administering prescribed pre-operative medications and escorting the patient to theatre. They are responsible for retrieving the patient from recovery and providing nursing care until the patient is fully recovered from anaesthesia.

**Joint responsibilities for care:** There are joint responsibilities for clinical teams in the care of paediatric patients receiving emergency surgery. These are detailed in 6.3

### 7 Policy detail/Course of Action

#### 7.1 Elective Surgery

Children will be booked onto a Surgical list by OPARU and then scheduled for a pre-assessment paediatric clinic appointment – called ‘Saturday Club’, prior to their routine surgery. Short notice cases or emergencies may not have the chance to attend Saturday Club but will instead attend Children’s Ward prior to their surgery to orientate themselves and be screened for any co-morbidities.

The use of a children’s pre-assessment clinic, ‘Saturday Club’, for elective procedures is of high importance as it allows health screening and the identification of potential problem cases, through discussing the child’s health history with their parent’s, legal guardians or carers (as / where appropriate to do so).

The pre-operative psychological preparation offered by familiarisation with theatres and the ward through the Saturday Club programme is vital to minimise stress for paediatric surgical patients and their families. All elective patients must be offered the chance to attend this.
Discussion with parents and legal guardian may not be appropriate in all situations – i.e. if the child is, for example, aged sixteen and has capacity under Mental Capacity Act, and has indicated a wish to keep medical discussions confidential they can attend routinely by themselves without parents being present.

All elective cases identified by pre-assessment nursing staff as potentially difficult will be further screened by a Consultant Anaesthetist with extensive paediatric experience. This will allow appropriate skill mix management for patients where surgery on the IOW is deemed to be appropriate.

Some patients will need tertiary level (access to paediatric HDU/PICU) care because of their complex physiology. The surgical team responsible for these patients will the need to refer these patients on for surgery elsewhere (primarily SGH).

Only anaesthetists with evidenced training and regular exposure to paediatric anaesthesia should carry out elective paediatric anaesthesia. This is in line with best practice.

Wherever possible, elective paediatric lists can be used as a teaching opportunity to allow exposure of non specialist anaesthetists to paediatric work. The anaesthetist designated for the patient must perform the immediate pre-anaesthetic assessment.

The principle should be followed that elective surgical cases are grouped together on specifically nominated children’s list to allow best use of theatre and ward resources.

In order to minimise cancellations for elective surgery, Surgical Consultants and Consultant Anaesthetists should communicate their intended leave arrangements well in advance and adhere to the Trust annual leave policy. Leave arrangements for medical staffing will be managed by the General Manager for surgery to ensure adequately staffed departments to ensure safe continuity of service.

Planning elective surgery allows certainty in the skill mix and equipment available for a procedure. As a result it is feasible to provide elective surgery for younger children than would be the case for unplanned procedures.

The absolute minimum age for elective surgery is six months of age. Children aged six months to two years should only undergo minor procedures with low surgical and anaesthetic morbidity on the IOW.

For Specialty -specific standards, please consult Appendix B.

### 7.2 Age specific requirements for Paediatric Surgery

The absolute minimum age for paediatric surgery is 6 months of age.

Children under the age of two must be anaesthetised with two Consultant Anaesthetists present. At least one of the Consultant Anaesthetists must have significant experience in paediatric anaesthesia and a regular paediatric anaesthetic commitment. This applies to elective and emergency cases.
Children aged between two and five must be anaesthetised with a Consultant Anaesthetist present.

Children aged five or over may be anaesthetised by SAS staff confident in managing children without direct consultant presence.

Children with co-morbidities may need anaesthetic expertise senior to that decreed by their age and therefore the above are recommended guidelines for routine cases only. It will not be suitable to apply these guidelines in every case. In cases where the child presents with co-morbidities, the decision to anaesthetise the child must have been made after consultation with the Anaesthetic Consultant, a discussion with the Surgeon and a review of the child’s clinical notes. The decision must be clearly documented in ward patient records. There should also be clear documentation of discussions with the child (if appropriate), parents, legal guardians or carers in the child's medical notes. Risk of death must be formally noted (even if it is not possible to quantify this risk exactly) if this is a genuine risk. If the decision is not to anaesthetise on the Island the child should be referred to a tertiary centre for surgery.

7.3 Emergency surgery

The absolute minimum age for emergency surgery is 6 months of age.

Any surgeon or anaesthetist who is not competent to treat a child in particular circumstances must transfer the care to a tertiary referral paediatric surgical centre (Primarily G4 ward, Southampton General Hospital), regardless of age.

All children below two years should be stabilised and transferred to the paediatric surgical Centre (G4) at Southampton General Hospital, unless the condition is immediately life or limb threatening. Transfer should be made to Southampton General Hospital if paediatric intensive care facilities or sub-speciality support (e.g. paediatric oncology or cystic fibrosis) is required.

An exception may be made in rare cases where the surgery can be safely postponed to be performed on a scheduled list. An example might include a minor superficial abscess that needs draining.

Children with significant acute physiological imbalance should not undergo non-life saving surgery on the IOW.

Children should not undergo any major surgery on the IOW if transferring the patient to Southampton General Hospital is possible and safer than undertaking surgery locally.

In extreme cases clinicians might be required to work outside their standard clinical roles to attempt a life saving procedure for an acutely and seriously ill child where transfer would further endanger life. In such rare cases, it may not be possible to follow the procedures detailed in this policy. Clinicians must exercise their
professional judgement, linking with the multidisciplinary team and fully document the rationale, decision making process and procedure as soon as possible.

All exceptions to the recommendations in this document should be a multidisciplinary decision between the Consultant Paediatrician on-call, the relevant surgeon, and the theatre and Ward staff (except in some extreme and rare cases detailed above, where time may not allow).

For Specialty specific standards, please consult Appendix C.

7.4 Joint team responsibility for care of emergency surgical paediatric patients

All children admitted, as an emergency under the care of a Surgical Consultant should receive joint care with the on call paediatric team.

Children admitted with abdominal symptoms should be assessed by the paediatric team and referred to the general surgical team as appropriate via the on call surgical registrar / house officer.

Children may be admitted directly under the surgical team, and timely assessment by either the Surgical Consultant or registrar should be sought. Further management input from the paediatric team may be sought if clinically indicated.

Children admitted with head injuries are assessed and managed by the paediatric team with referral as appropriate.

7.5 Transfer of a child to and from Theatre

Children undergoing general anaesthesia must have an identification band in situ.

A checklist must be completed and signed by an RSCN / RN child immediately prior to transfer.

Every effort must be made to allow the parent/carer to accompany the child to theatre if that is the family’s wishes. The parent/carer should be invited to recovery to be with the child as soon as feasible.

The child and parent will be escorted to theatre by the same RSCN / RN child (NNEB nurse/play specialist can also be utilised to escort, if no pre-med has been administered or IV access established).

The receiving nurse/ODP in theatre will go through the same checklist with a parent and child, and will sign to accept responsibility.

The escort will remain with the child and parent, in a child-friendly environment, until the child is anaesthetised.
The waiting time in theatre before anaesthesia will be kept to a minimum, and will be the responsibility of the requesting theatre nurse/ODP.

Once the child is anaesthetised, the escort nurse will escort the parent from the anaesthetic room and show them to the waiting area / back to the ward, in order that they are available for their child when they are in the recovery room.

The child will be recovered in a designated children’s area of the recovery room by a RSCN / RN child, or designated nurse with paediatric recovery experience.

The child will be collected from theatre after regaining consciousness by an RSCN / RN child.

The child will receive constant supervision within the children’s unit until adequately recovered from the anaesthetic and surgery.

8 Consultation

This policy has been developed by the Children's Surgical User's Group, which allows all theatre users to comment on it. It has been circulated to all clinical speciality leads and comments have been incorporated where appropriate. Appendices B and C have been developed with the Surgical speciality teams.

9 Training

9.1 General Requirements

Those performing surgery and anaesthesia on children under sixteen years old must:

- Complete Level 2 child protection certification annually.
- Complete annual paediatric basic life support updates.
- Attend relevant supernumerary theatre lists each year in a supernumerary capacity
- Participate in regular team moulages or scenario practice.
- Ensure that they maintain evidence of achievement of appropriate paediatric continuing professional development. Those performing surgery and anaesthesia on children must identify and discuss appropriate training needs during appraisals and on an ongoing basis when identified.

9.2 Anaesthetic requirements:

In addition all anaesthetists caring for children must:

- Be trained in paediatric resuscitation (BLS) annually.
have completed (SAS staff) or passed (cons) an APLS/EPLS course within the last three years. This mandatory training requirement must be governed through the appraisal process.

- Not anaesthetise a child if appropriate skilled assistance is not available.

- Consultant Anaesthetists (and SAS) who anaesthetise young children (less than eight years) will have a regular paediatric theatre list and comply with the Association of Paediatric Anaesthetists of Great Britain and Ireland Training requirements (referenced below). Where a Consultant Anaesthetist or SAS does not have a regular paediatric theatre list, the Surgical Consultant and the Consultant Anaesthetist or SAS (as appropriate) must agree the urgency of the surgery and whether it should proceed notwithstanding this fact. Written information should be provided to the parents and, where appropriate, to the child about anaesthesia.

### 9.3 Mandatory Training

This Safe Provision of Paediatric Surgery and Anaesthesia policy does have a mandatory training requirement which is detailed in the Trust’s mandatory training matrix and is reviewed on a yearly basis. The mandatory training detailed above is also required.

### 10 Monitoring Compliance and Effectiveness

All paediatric patients will have surgery and anaesthesia carried out as per policy. Three monthly audits will be undertaken in all clinical areas which use the Safe Provision of Paediatric Surgery and Anaesthesia policy to ensure compliance by the deputy ward/team leader and local action plans developed in response to poor compliance.

To measure the impact of this policy the following key performance indicators will be reviewed to quantify impact.

- Reduced unplanned transfers to tertiary centres following surgery.
- Age appropriate anaesthesia carried out by the correct team members.
- Increased awareness and multidisciplinary management of paediatric surgical patients with both Surgical and Paediatric medical staff.

These KPI’s will be measured on the Children’s Ward and appropriate records maintained.

### 11 References

British Association of Paediatric Surgeons (2002), Paediatric Surgery, Standards of Care

Dept. of Health (2007). The acutely or critically sick or injured child in the district general hospital: A team response

NCEPOD (2011). Surgery in Children – Are we there yet?

Royal College of Nursing (2011). Transferring Children to and from Theatre

The Royal College of Anaesthetists - Guidelines for the Provision of Anaesthetic Services, (2010). Guidance on the provision of Paediatric Anaesthesia Services


Royal College of Surgeons of England, Children’s surgical forum (2010). Ensuring the provision of general paediatric surgery in the District General Hospital

Royal College of Surgeons of England, Children’s surgical forum (2010). Ensuring the provision of general paediatric surgery in the District General Hospital


12 Appendices

Appendix A Elective Specialty-specific standards
Appendix B Emergency Specialty-specific standards
Appendix C Financial and Resourcing Impact Assessment on Policy Implementation
Appendix D Equality Impact Assessment
Appendix F guidance on pre op pregnancy testing in young women undergoing elective surgery.
Appendix G Patient information leaflet regarding preop pregnancy testing in young women undergoing elective surgery
Appendix H parent /guardian leaflet regarding preop testing in young women undergoing elective surgery
Appendix A

Elective Specialty-specific standards

1. General Surgery
The following procedures are performed on the IOW:

Inguinal herniotomy, umbilical herniotomy, hydrocoele surgery, one stage orchidopexy, circumcision, in-growing toenails, thyroglossal cysts, skin lesions (except for suspected malignancy), external angular dermoids, pilonidal sinus, minor perianal surgery, teenage breast lumps, removal of Hickman lines. Children requiring the following procedures and with co-morbidities that present potential anaesthetic risk must be referred to the Paediatric Surgical team at SGH: Two-stage orchidopexy, all laparoscopic surgery, hypospadias surgery, insertion of Hickman lines.

2. Orthopaedics
No elective orthopaedic surgery is undertaken on the IOW. All children are referred to an appropriate tertiary referral paediatric hospital (SGH).

3. ENT
All elective spectrum of surgery can be performed on the IOW except bone-anchored hearing aid (BAHA), cochlear implantation, complex nasal and head and neck procedures for congenital malformations.

Consideration must be given to syndromic children with potential airway problems or children that may require HDU/ICU post operative care who should be referred to an appropriate tertiary referral paediatric hospitals (SGH, GOSH).

4. Oral Surgery and dentistry/Maxillofacial surgery
The following procedures are performed on the IOW:

Removal or repair of carious tooth, periodontal therapy. All children requiring maxillofacial procedures should be referred to an appropriate tertiary referral paediatric hospital.

5. Ophthalmic surgery
Elective ophthalmic surgery is undertaken on the IOW except treatment for congenital cataract. Strabismus is currently not operated on the island due to retirement of specialist but will be re-started in the future.

All children with congenital cataract requiring treatment are referred to an appropriate tertiary referral paediatric hospital. Currently strabismus surgery is referred to SGH.
Appendix B

Emergency Specialty-specific standards

1. **General Surgery**
The following procedures are performed on the IOW:-

Superficial abscess, acute appendicitis, acute scrotal pain, skin lacerations. Children requiring the following procedures and with co-morbidities that present potential anaesthetic risk must be referred to the Paediatric Surgical team at SGH: Intussusceptions, intestinal obstruction, irreducible/strangulated hernias. All children less than five years with proven surgical pathology requiring surgery must be referred to the Paediatric Surgical team at SGH. All children irrespective of age who may require HDU/PICU admission following surgery must be referred to the Paediatric Surgical team at SGH.

2. **Orthopaedics**
The following procedures are performed on the IOW:-

Reduction and fixation of fractures, management of acute musculoskeletal infection, removal of foreign bodies. All children requiring more complex orthopaedic procedures are referred to an appropriate tertiary referral paediatric hospital (SGH).

3. **ENT**
The following procedures are performed on the IOW:-

Removal of foreign body from airway or oesophagus, bleeding for tonsils or adenoids management of head and neck sepsis, management of ear sepsis.

Children with inhaled or ingested batteries must have their surgery within six hours of the event in view of the serious complications that can develop. All children irrespective of age who may require HDU/PICU admission following surgery must be referred to the Paediatric ENT team at SGH.

4. **Oral Surgery and dentistry/ Maxillofacial surgery**
The following procedures are performed on the IOW:-

Dental abscess, dental alveolar injuries. All children requiring maxillofacial procedures should be referred to an appropriate tertiary referral paediatric hospital (QA).

5. **Ophthalmic surgery**
Emergency ophthalmic surgery is undertaken on the IOW except treatment for Retinopathy of Prematurity (ROP) in neonates. All children with ROP requiring treatment are referred to an appropriate tertiary referral paediatric hospital (QAH, Portsmouth).

6. **Trauma**
Children who have undergone traumatic injuries and presented to St Mary’s should be stabilised and transferred to a trauma Centre within one hour of admission. Exceptions will occur when stabilisation is not possible without life-saving surgery at St Mary’s.
Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

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<tr>
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<td>Equipment &amp; Provision of resources</td>
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Summary of Impact:

Risk Management Issues:

Benefits / Savings to the organisation:

Equality Impact Assessment

- Has this been appropriately carried out? YES/NO
- Are there any reported equality issues? YES/NO

If “YES” please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

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<th>WTE</th>
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### Equipment and Provision of Resources

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<td>Building alterations (extensions/new)</td>
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<td>IT Hardware / software / licences</td>
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<td>Medical equipment</td>
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<td>Stationery / publicity</td>
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<td>Travel costs</td>
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<td>Utilities e.g. telephones</td>
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<td>Process change</td>
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<td>Rolling replacement of equipment</td>
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<td>Equipment maintenance</td>
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<tr>
<td>Marketing – booklets/posters/handouts, etc</td>
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### Additional Information
- Capital implications £5,000 with life expectancy of more than one year.

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<td>Signature &amp; date of financial accountant:</td>
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<tr>
<td>Funding / costs have been agreed and are in place:</td>
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<td>Signature of appropriate Executive or Associate Director:</td>
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### Equality Impact Assessment (EIA) Screening Tool

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<td>Target Audience</td>
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<tr>
<td>Person or Committee undertaken the Equality Impact Assessment</td>
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1. To be completed and attached to all procedural/policy documents created within individual services.

2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?

   If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

   If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

<table>
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<td>Women</td>
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<td>Asian or Asian British People</td>
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<td>Chinese people</td>
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<td>People of Mixed Race</td>
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<td>White people (including Irish people)</td>
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### Notes:

Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

#### 3. Level of Impact

<table>
<thead>
<tr>
<th>Legal (it is not discriminatory under anti-discriminatory law)</th>
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If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

#### 3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:

#### 3.2 Could you improve the strategy, function or policy positive impact? Explain how below:
3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or improves relations – could it be adapted so it does? How? If not why not?

<table>
<thead>
<tr>
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<td>Name of persons/group completing the full assessment.</td>
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<td>Date Initial Screening completed</td>
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Pregnancy testing in female patients aged 12-16 undergoing surgery.

All patients undergoing anaesthesia or exposure to ionising radiation in this age group should have their pregnancy status checked by urine bHCG testing.

Patients and their families will be informed of this prior to the day of surgery/investigation during pre op assessment (‘Saturday morning club’) using the patient information leaflet.

Patients and/or their parents/guardians will be asked to give consent for this test to take place on the day of surgery. Testing will be undertaken by the admitting children’s nurse.

Consent will either be taken from the child or parent depending on their perceived Gillick competence. Best practise will be for both child and parent/guardian to give verbal consent.

Gaining verbal consent and the outcome of the pregnancy test will be clearly documented in the ICP.

Differentiating between pre and post menarcal young women and questioning sexual activity in these groups is difficult. A blanket policy reduces the chance of potentially missing a positive result.

Unexpected positive results will be immediately discussed with the operating surgeon and the Paediatric consultant on call.

Very occasionally in young women who are incontinent of urine with physical or learning disability it may not be possible to obtain a urine sample prior to surgery. These patients should be discussed with the operating surgeon and anaesthetist on a case by case basis.
Flow chart to explain perioperative pregnancy testing in female patients aged 12-16

Reference:
Pre-procedure pregnancy checking for under-16s
Royal College of Paediatrics and Child Health
November 2012
Information given to patients

**Routine pregnancy testing before operations**

**Information for young women aged 12-16 years**

It is very important to know if you are pregnant before we carry out an operation. This is because an operation and anaesthetic may damage an unborn baby. It is also safer for you if the doctors looking after you know you are pregnant.

We know that only very few girls your age become pregnant but it is important that we look after everybody as safely as we can. We believe that testing all young female patients is the most effective way of avoiding harm. On the day of the operation you and your parents or guardians will be asked to give consent to providing a sample of urine for a pregnancy test.

If you and/or parents or guardians feel that this is not possible we will discuss the safest way to look after you.

We hope you understand our reasons for this testing.
Information given to parents and guardians

Routine pregnancy testing before operations.
Information for parents and guardians.

It is very important we know if any young woman having an operation may be pregnant. This is because an operation and anaesthetic may damage the unborn baby. It is also safer for the patient if doctors looking after a female patient know that she is pregnant.

Although there may only be a very small number of pregnancies in this age group, we believe that testing all relevant patients is the most effective way of avoiding this harm. On the day of the operation all young women aged 12-16 years and their parents will be asked to give consent to providing a sample of urine for a pregnancy test.

If a pregnancy test is refused we will discuss the safest way of proceeding but we hope you will recognise the reason for our decision.

Your understanding will be greatly appreciated.