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. **Introduction**

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

2. **The Guidance**

2.1. 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.

2.2. These guidelines have been written using the most recent literature, and our present guidelines

2.3. **The Anaesthetic Clinic**

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

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

2.6. For advice on which anaesthetist will be covering a particular list speak to the anaesthetic rota co-ordinator on ext. 8197. The list can be accessed from the intranet.

2.7. **CRITERIA FOR ANAESTHETIC CONSULTANT REVIEW/OPINION**

2.8. 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. 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.

2.9. 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?

2.10. 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

2.11. General Systems examination

2.12. The aim is to pick up any abnormalities and to identify and institute any investigations.

2.13. Results of investigations to be reviewed by nurse…. Any abnormalities, act on them.

2.14. Refer to the NICE guidelines for pre-op testing (see end of document).

2.15. Previous anaesthetic problems / difficult airway / anaphylaxis

2.16. 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.
<table>
<thead>
<tr>
<th>Congenital:</th>
<th>Acquired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pierre Robin Syndrome</td>
<td>Tonsillar hypertrophy</td>
</tr>
<tr>
<td>Treacher Collins Syndrome</td>
<td>Glottic Web</td>
</tr>
<tr>
<td>Goldenhar Syndrome</td>
<td>Haemangioma</td>
</tr>
<tr>
<td>Apert Syndrome</td>
<td>Subglottic Stenosis</td>
</tr>
<tr>
<td>Crouzon Syndrome</td>
<td>Temporomandibular joint disease</td>
</tr>
<tr>
<td>Hurlers Syndrome</td>
<td>Cervical Spinal Fusion</td>
</tr>
<tr>
<td>Hunters Syndrome</td>
<td></td>
</tr>
<tr>
<td>Beckwith Wiederman Syndrome</td>
<td></td>
</tr>
<tr>
<td>Downs Syndrome</td>
<td></td>
</tr>
</tbody>
</table>

2.17. **Cardiovascular Disease**

2.18. *Heart Murmur*- Is it known or unknown?

2.19. 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.

2.20. *Previous cardiac history*; check recommendations from cardiologist, including recent clinic letters. Most children in Cornwall with cardiac disease are known to the Bristol paediatric cardiology service and will have clinic letters including the most recent echo. Children who have had out of County consultations- request notes from Hospital involved.

2.21. 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)?

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

2.23. Obstructive lesions such as coarctation of the aorta or pulmonary valve stenosis may cause ventricular pressure overload. ASD or VSD results in overperfusion to the lungs… think congestive cardiac failure (SOB on exertion, chest infections, wheeze breathlessness.)

2.24. Check BP with other vital signs… if elevated must have 3 readings.

2.25. 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.

2.26. Children with other syndromes may have a cardiac association, i.e. Di-George syndrome, tracheo-oesophageal fistula, oesophageal atresia, downs syndrome and VACTERL association.
2.27. Notify Anaesthetist if:
- 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

2.28. Respiratory disease

2.29. 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). Children should be instructed to bring their regular inhalers/medication.

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

2.30. 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 Dr Prendiville +/- 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 Dr Prendiville 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 likely/confirmed

2.31. Ex Premature baby

Paediatric Pre – Operative Assessment

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- Did the baby have RDS/ were they O2 dependant? Baby will be at risk of apnoeas/ bradycardias post op.
- Corrected age of baby is important, as is weight of baby. Check anaesthetic rota for paediatric anaesthetist.
- 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?
- There is a risk of hypoglycaemia in premature babies that are starved for prolonged periods.
- Consider Gastro oesophageal reflux disease and check that children take anti reflux medicines pre op.

2.32. 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.

2.33. Child with URTI
2.34. 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.

2.35. 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.)

2.36. Endocrine disease
2.37. (See separate guideline for perioperative management of diabetes in children). Follow diabetic policy, and liaise with paediatric diabetic nurse for fasting information.

2.38. Thyroid disease: As long as child is asymptomatic and followed up regularly with

2.39. 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.

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

2.41. Renal disease / abnormal biochemistry
- Anaesthetist should be informed:
- All patients requiring dialysis for renal failure.
- Patients with deranged renal function (severe renal impairment creatinine >177)
- Patients with significant electrolyte abnormalities. (Na < 125, K > 6, Ca > 3 mmol/l)
- Check bloods pre op

### 2.42. Haematological problems

#### 2.43. Sickle cell disease

- To be considered for all children who are:
  - African
  - Afro Caribbean
  - Cypriot
  - Eastern Mediterranean
  - Middle Eastern
  - Asian

- Sickle cell 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.

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

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

### 2.48. Blood Transfusion

#### 2.49. Repeated transfusions increase the likelihood of red-cell antibodies.

- Is the planned surgery high risk for peri-op bleeding?
- (e.g. 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 optimised

### 2.50. Rheumatoid / Neuro-muscular / CNS disease

- Think: Are they difficult to intubate?
- Hypermobility/ lax joints could lead to injury. Ehlers Danlos Syndrome is associated with cardiac abnormalities and increased bleeding risk.

#### 2.51. Refer to Anaesthetist if:
- 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.
- Unstable epilepsy with frequent seizures despite treatment.

2.52. **Special Educational Needs**

2.53. 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.

2.54. **Major surgery**

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

2.56. 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.

2.57. **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

2.58. **Morbid Obesity / Multiple co-morbidities.**

- Right-sided heart failure/pulmonary hypertension should be considered, especially if oxygen saturations are below 96% at rest.
- Consider Lung Function tests: FEV1 and FVC.

2.59. **Refer to Anaesthetist if:**

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

2.60. **Pre op testing (Nice guidelines 2003)**

- 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 ASA1)
  - Consider FBC, Renal Function, Urine Analysis
- Grade 4 surgery major + (children ASA 1)
Consider FBC, renal function, urinalysis

2.61. 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.

2.63. 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 and needs 4-point identification.

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

2.66. Guidelines for pre-operative echocardiogram
Echocardiography should be considered if:
  ▪ New murmur
  ▪ Especially if:
    o Poor functional capacity
    o Syncope or dizzy spells
    o There are no notes on a child with a cardiac anomaly

2.68. Guidelines for pre-operative X-rays
Consider the child having orthopaedic surgery. Has the child had a recent X-ray?

2.70. Always consult with the relevant orthopaedic Consultant to ascertain if an X-ray is required.

2.71. Children with chronic lung disease, CF or muscular dystrophy may need a chest X-ray, check with named consultant and anaesthetist.

2.72. Follow clinical imaging referrer protocol for registered nurses for those able to undertake the role of referrer.

2.73. Medicines

2.74. 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.

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

2.76. 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
required. Laparoscopy is not regarded as a major operation [See separate guidelines].

2.77. 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.

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

3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Patients cancelled on day of surgery. Ward clerk to provide addressograph.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Yvette Williams</td>
</tr>
<tr>
<td>Tool</td>
<td>Retrospective audit 1 week per month for 3 months</td>
</tr>
<tr>
<td>Frequency</td>
<td>3 Yearly</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>Ward manager Paediatric anaesthetists</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Paediatric anaesthetic staff</td>
</tr>
<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>
</tr>
<tr>
<td></td>
<td>Audit pre op assessment document</td>
</tr>
</tbody>
</table>

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
   i The Child was ill on the day of operation?
   ii There was an omission in the pre-op procedure? If so can you identify the omission?
   iii 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.

4.2. **Equality Impact Assessment**

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

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Paediatric Pre – Operative Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>1 August 2013</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>1 August 2013</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>1 August 2016</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>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>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.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Pre-operative assessment, POA, pre op guidelines, paediatric</td>
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<tr>
<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td></td>
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<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>New Guideline</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>New Guideline</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Paediatric audit and Guidelines Anaesthetic Dept paediatrics</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Julie Major</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Not required</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet</td>
</tr>
<tr>
<td>Document Library Folder/Sub Folder</td>
<td>Clinical / Paediatrics</td>
</tr>
<tr>
<td>Links to key external standards</td>
<td>Nice Guidelines pre op testing 2003</td>
</tr>
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</table>

Training Need Identified? No

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 13</td>
<td>V1.0</td>
<td>Initial Issue</td>
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</table>

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This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

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### Appendices

**Appendix 2. Initial Equality Impact Assessment Screening Form**

<table>
<thead>
<tr>
<th><strong>Name of service, strategy, policy or project (hereafter referred to as policy) to be assessed:</strong> Paediatric Pre – Operative Assessment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Directorate and service area:</strong> Child Health</td>
<td><strong>Is this a new or existing Procedure?</strong> New</td>
</tr>
<tr>
<td><strong>Name of individual completing assessment:</strong> Yvette Williams</td>
<td><strong>Telephone:</strong> 01872 253909</td>
</tr>
<tr>
<td><strong>1. Policy Aim</strong>*</td>
<td><strong>To deliver high quality pre op assessment to all children undergoing surgery</strong></td>
</tr>
<tr>
<td><strong>2. Policy Objectives</strong>*</td>
<td><strong>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</strong></td>
</tr>
<tr>
<td><strong>3. Policy – intended Outcomes</strong>*</td>
<td><strong>To provide safe, effective, high quality care to the child and family.</strong></td>
</tr>
<tr>
<td><strong>5. How will you measure the outcome?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>5. Who is intended to benefit from the Policy?</strong></td>
<td>Child and family Nurses undertaking the assessment</td>
</tr>
<tr>
<td><strong>6a. Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?</strong></td>
<td>Paediatric anaesthetists Paediatrics</td>
</tr>
<tr>
<td><strong>b. If yes, have these groups been consulted?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>c. Please list any groups who have been consulted about this procedure.</strong></td>
<td></td>
</tr>
</tbody>
</table>

*Please see Glossary*

### 7. The Impact

Please complete the following table using ticks. You should refer to the EA guidance notes for areas of possible impact and also the Glossary if needed.

- Where you think that the *policy* could have a **positive** impact on any of the equality group(s) like promoting equality and equal opportunities or improving relations within equality groups, tick the ‘Positive impact’ box.
- Where you think that the *policy* could have a **negative** impact on any of the equality group(s) i.e. it could disadvantage them, tick the ‘Negative impact’ box.
- Where you think that the *policy* has **no impact** on any of the equality group(s) listed below i.e. it has no effect currently on equality groups, tick the ‘No impact’ box.
<table>
<thead>
<tr>
<th>Equality Group</th>
<th>Positive Impact</th>
<th>Negative Impact</th>
<th>No Impact</th>
<th>Reasons for decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
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<td>Disability</td>
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<td>Religion or belief</td>
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<tr>
<td>Gender</td>
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<td>Transgender</td>
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<td>Pregnancy/Maternity</td>
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<td>Race</td>
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<tr>
<td>Sexual Orientation</td>
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<tr>
<td>Marriage / Civil Partnership</td>
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<td></td>
<td>✓</td>
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</tr>
</tbody>
</table>

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

- A negative impact and
- No consultation (this excludes any policies which have been identified as not requiring consultation).

8. If there is no evidence that the policy promotes equality, equal opportunities or improved relations - could it be adapted so that it does? How?  

Full statement of commitment to policy of equal opportunities is included in the policy

Please sign and date this form.

Keep one copy and send a copy to Matron, Equality, Diversity and Human Rights,  
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Chyvean House, Penventinnie Lane, Truro, Cornwall, TR1 3LJ

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

Signed  

Date  

Paediatric Pre –Operative Assessment  
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