

# Best Practice Guidance

## Preoperative Care Services for Children and Young People

This Best Practice Guidance covers the care of children and young people (0–18 years old) presenting for surgery, procedures or imaging under general anaesthesia or anaesthetic-led sedation

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## Methodology

This best practice guidance is informed by published evidence, submitted expert evidence, and the recommendations of a multidisciplinary panel of clinicians. It has also been reviewed as part of a national consultation process. It builds on the earlier national guidance produced by the Royal College of Anaesthetists (RCoA) and the Association of Paediatric Anaesthetists of Great Britain and Ireland (APAGBI), first set out in the *Best Practice Guidance: Preassessment Services for Children Undergoing Surgery or Procedures* (2022).

## Guideline review

This is version 1.0 of this guidance document, published in June 2026. Any updates made to this guidance, based on feedback and/or significant changes in the academic literature, will be included in subsequent versions and reflected in the table below.

Version	Change	Date
1.0	First publication	10 June 2026

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Comments on the content of the document prior to the formal review date in July 2031 can be submitted to the Paediatric Perioperative Care Sub Committee at the Association of Paediatric Anaesthetists of Great Britain and Ireland (APAGBI) and Centre for Perioperative Care using the following email addresses: [ppoc@apagbi.org.uk](mailto:ppoc@apagbi.org.uk) and [CPOC@rcoa.ac.uk](mailto:CPOC@rcoa.ac.uk).

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## Purpose and aims

***Every child or young person requiring an anaesthetic for a procedure or operation should expect to receive a preoperative assessment that meets their medical, physical and emotional needs.***

This best practice guidance sets out how preoperative services for Children and Young People (CYP) should be organised in any hospital providing surgery or procedures under anaesthesia to patients from birth to 18 years. While preoperative assessment in adult pathways is long-established and valued for preparing and optimising patients, comparable recognition and roll-out for CYP services have not similarly progressed. This has created a national variation in the quality and availability of preoperative services for CYP. The aim of this document is to outline a consistent framework that supports equitable, standardised preoperative assessment for all CYP.

Every hospital – whether a district general, teaching hospital, or specialist children’s centre – should provide a preoperative service for children and young people requiring surgery, imaging, or other procedures, including MRI or CT scans, under general anaesthesia or anaesthetist-led sedation.<sup>1</sup>

Children and young people have distinct medical, developmental and psychosocial needs compared with adults, and therefore require a different approach throughout the preoperative journey. Effective assessment should consider physical and medical status alongside emotional readiness, communication needs, and the involvement of parents or carers. Although many children and young people are otherwise healthy and undergo routine day-case procedures, structured and well-delivered preoperative care provides meaningful benefits – supporting safer patient journeys, reducing anxiety, allowing for health optimisation and improving overall experience for CYP, parents, carers, staff and the organisation.<sup>1</sup> In areas where preoperative services for CYP are established, they deliver clear gains in safety and productivity. Structured preoperative pathways reduce same-day cancellations, improve on-time starts, and create more stable theatre flow. The Royal College of Anaesthetists also highlights that well-organised preoperative pathways and coordinated networks reduce variation and support efficient elective activity.<sup>2</sup>

Children and Young People deserve the same proven benefits offered by established adult preoperative services, with equitable access to high-quality, structured pathways of preoperative care. This guidance is designed to support services in achieving these outcomes by providing a clear, structured framework for establishing and developing safe, consistent and efficient CYP preoperative care services across all service providers.

## Section 1: Key Principles

1.1	All CYP should expect to have preoperative care which meets their specific needs, prior to the day of their procedure. <sup>2-6</sup>
1.2	Every hospital that offers care to CYP should provide a preoperative care service for all patients who are attending for surgery, imaging or other procedures that require general anaesthesia or anaesthetic sedation. <sup>3,4,6,7</sup>
1.3	Patients should be the central focus of preoperative care services, and their needs should be considered at all stages of service design and development. <sup>8,9</sup>
1.4	Preoperative care of CYP should aim to deliver a smooth, efficient and safe perioperative journey for CYP, carers and families. This should include assessment of fitness for the procedure, health optimisation by 'making every healthcare contact count', preparation, planning, education, informed consent and reduction of perioperative pathway changes, postponements and cancellations. <sup>3,4,10,11</sup>

## Section 2: Service Design and Delivery

### Early Risk Screening

2.1	All CYP should have preoperative early risk screening completed by the point they are added to the procedural waiting list. <sup>12</sup>
2.2	Providers should implement digital screening tools alongside non-digital alternatives that can be used by CYP (or their parents and carers acting on their behalf), anaesthetists or surgical teams to complete preoperative early risk screening. Support should be available to ensure no group is disadvantaged during this process. <sup>13</sup>
2.3	Preoperative early risk screening of CYP should: <ul style="list-style-type: none"> <li>■ Identify any medical or psychological needs</li> <li>■ Identify safeguarding concerns</li> <li>■ Identify the person or persons with parental responsibility</li> <li>■ Identify whether the patient is suitable to be managed by the local service provider or requires onward referral</li> <li>■ Determine the subsequent preoperative journey</li> </ul>
2.4	Preoperative assessment of elective cases should occur sufficiently in advance of surgery and before a surgical date is offered, to allow time for assessment and any optimisation of health and wellbeing. <sup>12</sup>
2.5	Trusts should have pathways in place to maintain contact with CYP whilst they are on waiting lists. This could be provided electronically or by locally agreed methods but should aim to ensure that procedures are still required and to identify emerging health issues which could affect the proposed perioperative journey. Local pathways should also define the length of preoperative assessment validity, generally between 3–6 months depending on the patient group. <sup>12</sup>

### Care Pathways

2.6	All CYP should have their preoperative assessment sufficiently in advance of surgery to allow optimisation of medical conditions, psychological preparation, management of unexpected findings and completion of essential clinical and administrative paperwork. The timeframe for preoperative assessment should align with local administrative processes such as the 6-4-2 process and should allow for satisfactory completion of preoperative assessment before a procedural date is given. <sup>1</sup>
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2.7	The preoperative care pathway should identify CYP who are fit to proceed to surgery with 'light touch' telephone/virtual preassessment only, and those who require additional input, assessment or support for their perioperative journey. <sup>14</sup>
2.8	The preoperative care service should have documented pathways to identify CYP who may require additional preparation or support, including: <ul style="list-style-type: none"> <li>■ Medical conditions requiring assessment by consultant anaesthetist with a paediatric interest</li> <li>■ Anxiety, neurodiversity or behavioural issues</li> <li>■ CYP who require referral to another more specialised centre or review by another speciality prior to their procedure, eg diabetic or cardiac patients or those with complications of excess weight <sup>14,15</sup></li> </ul>
2.9	All hospitals should have a clear policy describing which procedures they are able to deliver locally. This should include age and weight limits for local care and details of the degrees of comorbidities that can be managed safely on the local site. <sup>2</sup>
2.10	The preoperative care service should work with the wider multidisciplinary team to facilitate the patient journey. Where practical, this may include pathways for bloods, swabs, hearing tests or the combining of procedures to reduce the number of anaesthetics a CYP receives. <sup>16-18</sup>
2.11	Preoperative assessment should help inform the decision as to whether CYP are suitable to be cared for as a daycase, an inpatient or whether critical care support is required postoperatively. It should also address whether referral to a specialist centre for further care may be necessary. <sup>1</sup>
2.12	In district general hospitals or other non-paediatric specialist centres, a multidisciplinary committee should be responsible for the overall management, governance and quality improvement of anaesthetic and surgical services for CYP and should report directly to the hospital board. This committee should include a preoperative care team representative. <sup>2</sup>
2.13	On completion of a preoperative assessment, an agreed care plan should be in place for admission. For straightforward cases this may be a verbally agreed plan, accompanied by take home information in paper or electronic formats. For more complex cases a documented multidisciplinary preoperative care plan should be recorded in the patient notes and shared with the wider multidisciplinary team, prior to the day of the procedure. <sup>4,16</sup>
2.14	The perioperative care plan, including any reasonable adjustments, should be communicated with all stakeholders involved in the perioperative journey including: CYP, parents or carers, the admission hub/ward and post-operative ward(s), theatres and recovery, and other allied health professionals such as healthcare play specialists, dietitians, and physiotherapists. <sup>16,19</sup>
2.15	The preoperative care services should identify the person(s) with parental responsibility and cases when social services will need to consent. This should be communicated with the multidisciplinary team, so that appropriate advance arrangements can be made if needed. <sup>20,21</sup>
2.16	The preoperative care service should identify when an interpreter is required if this has not already been done by surgical teams, and direct CYP, parents and carers to appropriate sources of information in different languages or British Sign Language. There should be a pathway to organise and communicate this requirement for language services to the wider team.
2.17	The preoperative care service should have pathways for 'making every healthcare contact count' and health promotion. <sup>12,13,16</sup>

<b>Clinic Structure</b>	
2.18	All CYP should be seen by a nurse or suitably trained preoperative practitioner prior to a procedural date being given. This may be via telephone, virtual appointment or at a face-to-face clinic depending on the needs or preferences of the CYP, parent or carer. <sup>3,6,16</sup>
2.19	Face-to-face appointments should be offered as an option for all CYP who meet the criteria or when preferred by CYP, parents or carers. <sup>22</sup>
2.20	There should be an option for preoperative assessment which means that CYP do not need to physically attend the hospital. Virtual assessments may be preferable for CYP who live significant distances from the hospital, who struggle with the hospital environment, for those who have attended the hospital on multiple previous occasions or for those who may struggle to attend for other social or economic reasons. <sup>23</sup>
2.21	Where preoperative assessment is undertaken virtually, information relating to play or recreation preferences should be gathered and made available to the health play specialist on the admission ward. Health play specialists should be part of the preoperative assessment process and contribute to decisions and planning for supporting CYP with their admission and procedure. <sup>24-27</sup>
2.22	Nurse-led face-to-face, telephone or virtual appointments, should follow an agreed pathway designed and approved in line with local governance processes which meets published protocols and guidelines for CYP preoperative care. <sup>28</sup>
2.23	The opportunity to meet staff and see the theatre and recovery environments should be provided either through face-to-face tours or with bespoke digital options. <sup>28-31</sup>
2.24	Where CYP are seen well in advance of a surgical date, there should be a pathway for hospital visits or digital orientation closer to the date of the procedure. This may be provided through a health play specialist visit or specific health play specialist clinic. <sup>28</sup>
2.25	There should be a consultant anaesthetist led clinic for children identified as having specific medical or behavioural needs.
2.26	There should be clear referral criteria and pathways for identifying and referring CYP for preoperative consultant anaesthetist review. <sup>16</sup>
2.27	Consultant anaesthetist clinics should have the ability to offer notes reviews, face-to-face, telephone or virtual appointments, depending on the specific needs of CYP or requests from CYP, parents or carers. <sup>23,32</sup>
2.28	Paediatric preoperative care clinic sessions delivered by consultant anaesthetists should be formally represented as clinical activity within job plans to ensure an appropriate high-quality service is delivered. Job-planned time should include time required for triage, support of practitioners, and notes reviews. <sup>5,28</sup>
2.29	Consultant anaesthetist led clinics should be used to review and assess CYP with more complex conditions or undergoing more complex surgery. They should review underlying comorbidities to ensure there have been appropriate recent investigation and assessment and identify opportunities for optimisation. A more thorough clinical examination may be required and should be documented within the patient notes or care plan. <sup>28</sup>
2.30	There should be a clear pathway for obtaining senior anaesthetic advice (outside of normal consultant clinic times) for the duration of the preoperative practitioner clinic opening hours. <sup>28</sup>
2.31	There should be pathways in place for multidisciplinary team working to ensure patients are fully optimised prior to their procedure. This may include establishing links with regional children's centres and other outside agencies such as local or national charities and parent/carer groups.

2.32	All multidisciplinary discussions conducted by any media (letter, email, telephone, video meeting or face-to-face) must be recorded in the patient notes and shared with patients, parents and carers.
2.33	Appropriate information technology (IT) and administrative support must be provided for the preoperative care service. <sup>5</sup>
<b>Environment</b>	
2.34	CYP attending in-person preoperative care clinics should expect to be seen in an environment that is suitable for their age and stage of development. Where there are mixed age groups attending, décor should be appropriate for the full age range. <sup>2,27,33</sup>
2.35	Preoperative care clinics should be delivered in an environment suitable for all the patients that are seen. Consideration should be given to patients with additional needs and those with specific access requirements.
2.36	Where CYP are seen in a predominantly adult based area, a separate CYP waiting area should be available with access to play facilities. <sup>2</sup>
2.37	Toys and activities should be available to meet the play and recreation needs of all ages and abilities to provide diversionary activities in the waiting area and in consultation rooms. Local policies should be in place for their storage, cleaning and maintenance. <sup>27,33</sup>
2.38	Preoperative care clinics should have sufficient space for the safe storage of patient notes in line with trust data protection policies.
2.39	All preoperative care clinics should have the ability to measure height and weight and perform basic observations (blood pressure, heart rate, respiratory rate, oxygen saturations and temperature) in CYP of all ages. There should be access to appropriate facilities for CYP examination when needed, including hoists as appropriate. <sup>2,28</sup>
2.40	Preoperative care clinics should take place in areas with secured doors and appropriate toilet and changing facilities.
2.41	Preoperative care clinics should have immediate access to paediatric resuscitation equipment. <sup>2</sup>
2.42	Preoperative care clinics should have private consultation areas. CYP may wish to speak to the anaesthetist or preoperative care practitioner independently of their parents or carers and there should be space and local policies to facilitate this. <sup>2</sup>
<b>Play</b>	
2.43	A standard operating procedure should be available to clearly outline the role of the health play specialist in supporting CYP, parents and carers within preoperative care services. <sup>27</sup>
2.44	Clinical staff should be supported to seek the support of a health play specialist for medical interventions to mitigate the risk of psychological trauma or distress and to support patient flow and efficiency. <sup>27</sup>
2.45	Hospitals that regularly care for CYP should have a Health Play Specialist available to help CYP prepare for their admission, facilitate their healthcare journey and reduce the risk of increased anxiety or psychological trauma. <sup>2,27</sup>
2.46	Therapeutic distraction should be available for CYP to reduce anxiety and the risk of trauma for preoperative interventions including blood tests and observations delivered by a registered Health Play Specialist or other member of staff trained in therapeutic distraction techniques. <sup>27,34</sup>
2.47	There should be a clear referral process by which timely referrals are made to a health play specialist to provide psychological preparation and prepare a support plan for the day of admission. <sup>27</sup>

## Section 3: Staffing Roles and Responsibilities

### Staffing

3.1	A policy indicating the structure of the preoperative care service and the roles and responsibilities of nursing, medical and associated staff (Health Play Specialists, practitioners, healthcare assistants etc) should be available. <sup>1</sup>
3.2	The CYP preoperative care service should be predominantly delivered by appropriately trained perioperative nurses/practitioners with clinical and governance support from consultant anaesthetists with a paediatric interest. <sup>1,2</sup>
3.3	<p>The core CYP preoperative care team should include:</p> <ul style="list-style-type: none"> <li>■ Nurse/Practitioner co-ordinator (minimum Agenda for Change Band 6, who has oversight of and responsibility for the day-to-day running of the service)</li> <li>■ Registered children's nurse(s)</li> <li>■ Consultant anaesthetists</li> <li>■ Administrative staff</li> <li>■ Health Play Specialists.</li> </ul> <p>Other team members may include but are not limited to operating department practitioners, registered adult nurses, assistant practitioners and non-registered support staff.<sup>1,2,27,35</sup></p>
3.4	All CYP should expect to have access to a qualified registered Health Play Specialist. <sup>2,27</sup>
3.5	All CYP undergoing anaesthesia should have access to a consultant paediatrician either in person or via telephone/video call if required, for the duration of their hospital attendance. This could be through the on-call paediatrician for children who are not under regular paediatric follow up, and could be on the same site as surgery, or another site within the trust. There should be a local agreed policy outlining how paediatric medical assistance can be obtained if required. <sup>2,35</sup>
3.6	Each trust should have a designated lead consultant anaesthetist for the CYP preoperative care service. They should have allocated time within their job plan (in addition to any clinic time) for this role. They should be responsible for the development and provision of CYP preoperative care services within the trust to ensure there are pathways, policies and documentation in place that meet the guidance within this document. <sup>1,2</sup>
3.7	Anaesthetists involved in the preoperative care of CYP should have regular elective general anaesthetic lists treating CYP as part of their job plan and have maintained an appropriate level of competence in paediatric anaesthesia as demonstrated at annual appraisal. <sup>2</sup>
3.8	Each trust should have a named lead senior children's nurse responsible for CYP preoperative care services who ensures provision of high-quality nurse/practitioner led preoperative care. <sup>36</sup>
3.9	Services that provide preoperative care for CYP should have registered children's nurse(s) as part of the preoperative care team. <sup>35</sup>

<b>Staff Training</b>	
3.10	<p>In line with clear local policies, all members of the team should:</p> <ul style="list-style-type: none"> <li>■ Maintain mandatory training in CYP safeguarding including the policies and referral pathways within their own organisation and relevant external organisations. Staff should be aware of the named safeguarding doctor and nurse for CYP within their hospital<sup>37,38</sup></li> <li>■ Maintain training in paediatric life support. A basic life support course with a yearly update for all staff, including access to paediatric intermediate life support courses for registered children's nurses. This should include paediatric early warning scores (PEWS), Sepsis Six protocol and SBAR (Situation, Background, Assessment and Recommendation) communication system<sup>39,40</sup></li> <li>■ Have awareness and understanding of the use of restraint, relevant to the care of CYP.<sup>41,42</sup></li> <li>■ Be appropriately trained in communicating with CYP of all ages including those with additional needs<sup>43</sup></li> <li>■ Have attended training to specifically support CYP with learning disability or neurodivergence during their hospital journey.</li> </ul>
3.11	<p>All registered staff delivering CYP preoperative care should:<sup>1,2,37,44</sup></p> <ul style="list-style-type: none"> <li>■ Fully understand the General Medical Council and Nursing and Midwifery Council requirements for informed consent as appropriate to role<sup>37</sup></li> <li>■ Have a core understanding of anatomical and physiological changes in CYP from infancy to adolescence</li> <li>■ Be aware of the national CYP preoperative care guidance and local CYP preoperative care pathways, policies and routes of referral for escalation</li> <li>■ Complete competency-based training in the delivery of CYP preoperative care</li> <li>■ Undertake additional training in supporting CYP with procedure related anxiety<sup>45</sup></li> <li>■ Be trained in shared decision making conversations and processes</li> <li>■ Understand how to introduce health promotion and 'make every healthcare contact count'.</li> </ul>
3.12	<p>All staff should use communication styles that are age and stage appropriate, incorporating an approach modelled or guided by a health play specialist as required.<sup>43</sup></p>
3.13	<p>There should be local policies and training to support preoperative care practitioners/nursing staff identify and refer CYP who require further assessment, examination, and investigation to a consultant anaesthetist.</p>
3.14	<p>All staff performing clinical observations/measurements should be able to demonstrate competence, be aware of normal CYP physiological parameters and escalate appropriately where recordings are outside of expected ranges.<sup>46</sup></p>
3.15	<p>The lead anaesthetist for the CYP preoperative care service should have achieved level 3 CYP safeguarding training.<sup>2</sup></p>
3.16	<p>The lead anaesthetist and other anaesthetists who work regularly within the preoperative care service should undertake advanced training in CYP anxiety management.</p>
3.17	<p>Healthcare professionals involved in preoperative care should have initial and regular multidisciplinary training that promotes patient safety, teamwork, effective communication, openness, and technology-handling skills.<sup>47,48</sup></p>
3.18	<p>Trusts should support all staff to meet their educational needs to provide CYP preoperative care within their scope of their practice including attendance at relevant local and national meetings.<sup>36,47</sup></p>

## Section 4: Clinical Assessment, Guidelines and Standards

### Clinical Assessment

4.1	<p>There should be written guidance for staff delivering CYP preoperative care.<sup>3,4,5,6,16,28,49,50</sup></p> <p>This should include specific guidance, required investigations, planning processes and outline opportunities for optimisation for common presentations including:</p> <ul style="list-style-type: none"> <li>■ Congenital heart conditions including indications for onward referral<sup>51</sup></li> <li>■ Respiratory conditions including asthma, upper respiratory tract infections, cystic fibrosis and obstructive sleep apnoea<sup>52-56</sup></li> <li>■ Endocrine and metabolic conditions including diabetes<sup>57-60</sup></li> <li>■ Excess weight and complications of excess weight<sup>61</sup></li> <li>■ Neuromuscular conditions<sup>62</sup></li> <li>■ Epilepsy<sup>63</sup></li> <li>■ Haematological conditions<sup>64-66</sup></li> <li>■ Inherited conditions and syndromes<sup>67,68</sup></li> <li>■ Learning disabilities and neurodiversity<sup>69-76</sup></li> <li>■ Safeguarding.<sup>37,38,77</sup></li> </ul>
4.2	<p>Specific preoperative care pathways should be developed by the lead consultant anaesthetist for CYP preoperative care for co-morbidities seen regularly by the local service. This should include indications for external referral, consultant anaesthetic review and multidisciplinary team discussion.<sup>2,4,12,16</sup></p>
4.3	<p>There should be a structured pathway for the care and management of CYP who decline blood products or whose parents/carer decline to consent to blood products on their behalf.<sup>79</sup></p>
4.4	<p>There should be a governance process to ensure a multi-disciplinary approach to the care of CYP usually under the care of a specialist centre. This can be by direct links with the regional specialist centre or by working with regional Operational Delivery Networks. This should provide assurance on the most appropriate place for any procedures or investigations to be performed.<sup>2,12,16</sup></p>
4.5	<p>There should be local pathways defining investigations required prior to procedures. Ideally these should be completed at the same time as the clinic appointment to reduce attendances and in time for optimisation of the CYP.<sup>1,16,64</sup></p>
4.6	<p>A standardised proforma for CYP preoperative care should be in place for the service, linked to clinic guidelines and procedures. This may be paper or electronic but must record all elements of the clinical assessment and resulting actions.</p>

4.7	<p>The CYP preoperative care pro forma should record the following information:<sup>28,49,58</sup></p> <ul style="list-style-type: none"> <li>■ Birth history</li> <li>■ Prematurity and associated care requirements</li> <li>■ Long-term health conditions, eg home oxygen or ventilation</li> <li>■ Congenital conditions</li> <li>■ Conditions that are found in the family, eg malignant hyperpyrexia, sickle cell disease</li> <li>■ Acquired conditions</li> <li>■ Behavioural and educational needs</li> <li>■ Previous experiences of surgery and anaesthesia</li> <li>■ Anxiety issues and status</li> <li>■ Safeguarding history</li> <li>■ Immunisations</li> <li>■ Medications</li> <li>■ Allergies</li> <li>■ Menstrual periods (as appropriate)</li> <li>■ Health screening, eg smoking (CYP or family), alcohol and substance use, chronic pain, dental hygiene, sexual health, weight, diet and exercise.</li> </ul>
4.8	<p>There should be a locally agreed process for identifying previous infection control concerns, including a trust policy for methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) and carbapenemase-producing <i>Enterobacteriaceae</i> (CPE) identification and decolonisation therapy.<sup>81</sup></p>
4.9	<p>CYP who experience recurrent chest infections with underlying comorbidities such as cystic fibrosis may benefit from preoperative antibiotics and there should be a local pathway to organise this when appropriate.<sup>82</sup></p>
4.10	<p>A full Medication history should be taken from all CYP during their preoperative care clinic attendance. Medication History should specifically ask about the use of:</p> <ul style="list-style-type: none"> <li>■ Glucagon-like peptide-1 (GLP-1) medications, with consideration of individualised aspiration risk<sup>78</sup></li> <li>■ Steroid use</li> <li>■ Pain medications</li> <li>■ Hormones/puberty blockers</li> <li>■ Non prescribed supplements or medications obtained from overseas.</li> </ul> <p>For CYP on multiple or complex medications, eg chemotherapy, biologics, hormones or antihypertensives, there should be a preoperative care pathway to enable advice to be obtained from a specialist hospital pharmacist, if required, during the preoperative period.</p>
4.11	<p>All CYP with diabetes should receive a perioperative diabetes management plan prior to their procedure to reduce complications, which may be completed with the local endocrine team.<sup>60</sup></p>
4.12	<p>All CYP with endocrine and metabolic conditions should have an individualised endocrine or metabolic perioperative care plan developed with the involvement of their usual parent team.</p>
4.13	<p>CYP with significant haematological conditions including sickle cell disease, thalassaemia, haemoglobinopathies or blood coagulation deficiencies should be discussed with the local haematology team and a perioperative plan formulated prior to a surgical date being given.<sup>49,64</sup></p>
4.14	<p>There should be a local referral pathway for the care of CYP identified to have chronic pain conditions. This should include a multidisciplinary perioperative pain management plan.<sup>83,84</sup></p>

4.15	All CYP (and wider families as appropriate) should be assessed for the risk of anaesthetic complications such as a difficult airway, suxamethonium apnoea or malignant hyperpyrexia and referred for investigations if appropriate. <sup>85</sup>
4.16	Immunisation history should be recorded in the clinical assessment. Preoperative care clinics provide an opportunity to provide educational material where needed and redirect parents/carers to primary care for information and access to immunisations. <sup>4,16,86</sup>
4.17	Preoperative care services should have systems to: <ul style="list-style-type: none"> <li>■ Actively identify episodes of acute illness or injury which may affect the CYP's and provide information for parents/carers regarding how to report these at a later date should they arise</li> <li>■ Facilitate nurse-led postponement of children deemed not fit for surgery, eg upper respiratory tract infections, chicken pox etc</li> <li>■ Monitor and review day of surgery cancellation rates so that pathways can be modified in a timely fashion.<sup>55,56,87-89</sup></li> </ul>
4.18	Preoperative care services should have pathways in place to ensure all previous safeguarding documentation is available and reviewed as part of the preoperative care process. <sup>37,38,77</sup>
<b>Clinical Examination</b>	
4.19	When a preoperative care practitioner deems that clinical examination may be required as part of the preoperative assessment but is not trained in the clinical examination of CYP, there should be a local policy to facilitate this clinical examination. <sup>90</sup>
4.20	There may be some value in the routine auscultation of the heart of younger children (<2 years) presenting to preoperative care for the first time or where there is no record of a previous examination. This could happen in the preoperative clinic or on the day of surgery. Previously undetected murmurs should be discussed with the paediatric team and investigated appropriately. <sup>16,91</sup>
<b>Investigations</b>	
4.21	All CYP should have the following routine observations recorded at the preoperative care clinic whenever possible. These should be recorded onto early warning scoring systems for reference on the day of surgery. <sup>28,92,93</sup> <ul style="list-style-type: none"> <li>■ Weight, height, body mass index (BMI) and BMI centile which should be plotted onto appropriate charts</li> <li>■ Temperature</li> <li>■ Oxygen saturations</li> <li>■ Respiratory rate</li> <li>■ Heart rate</li> <li>■ Blood pressure – manual and non-manual measurement techniques should be available</li> <li>■ Airway assessment including loose deciduous teeth.</li> </ul>
4.22	Pathways should be in place for obtaining height and weight and calculating BMI centiles in those CYP who are likely not to attend face-to-face. This may be by taking measurements at surgical clinic attendances. <sup>2,61</sup>
4.23	There should be a pragmatic decision made and recorded by the most senior practitioner in clinic, when anxiety or behavioural issues make it challenging for CYP to comply with the taking of observations.

4.24	Parents/carers should be provided with information regarding observations taken as part of the preoperative process including height, weight and BMI/BMI centile. When appropriate additional information regarding potential actions they can take to optimise these should also be given. <sup>61</sup>
4.25	There should be a clinical pathway for escalation when concerns are apparent following observations including referral of unexplained hypertension.
4.26	Most CYP referred for a minor procedure do not require any investigations. There should be local pathways defining investigations required prior to specific procedures or for CYP with specific comorbidities. <sup>1,4,16,49,61,64,94</sup>
4.27	When organising investigations, consideration should be made as to how these can be taken in a single care episode or at the preoperative care clinic attendance to reduce distress for CYP, the inconvenience of repeated attendances and missed education. <sup>9</sup>
4.28	There should be a written local standard operating procedure for pregnancy screening on the day of the procedure, prior to anaesthesia. This should be discussed at the preoperative care clinic and included in preoperative information sheets. <sup>95</sup>
4.29	All CYP with asthma should have an asthma control test completed in preoperative care clinic to determine their <a href="#">current asthma control</a> , with a referral back to the GP, asthma nurse or respiratory consultant if required. <sup>80,96</sup>
4.30	CYP with cardiac problems requiring anaesthesia should have had a recent echocardiogram (echo) and/or electrocardiogram (ECG) as appropriate to their underlying problem. <sup>51,91</sup> There should be a clear pathway for advice from a paediatric cardiology team in children who have: <ul style="list-style-type: none"> <li>■ A known heart murmur and no echocardiogram result</li> <li>■ A comorbidity known to be associated with cardiomyopathy</li> <li>■ Known cardiac disease with cardiology follow-up overdue.</li> </ul>
4.31	All CYP with diabetes should have had a Glycated Haemoglobin/Haemoglobin A1c checked within the 12 weeks prior to their procedure. <sup>97</sup>
4.32	CYP with renal disease should have up-to-date blood tests prior to their procedure, including full blood count and urea and electrolytes. A perioperative multidisciplinary management plan should be in place for their care. <sup>98</sup>
4.33	CYP with known or suspected anaemia may be more likely to have adverse perioperative outcomes including death and blood transfusion. <sup>64</sup> <ul style="list-style-type: none"> <li>■ There should be a local policy to risk-assess and identify children likely to be anaemic</li> <li>■ All children in this group should have appropriate blood tests prior to their procedure and be referred for optimisation of iron status as per local guidelines</li> <li>■ Ferritin should routinely be tested in children who are anaemic</li> <li>■ All CYP with a risk of losing &gt;10% circulating blood volume or 500ml, booked for a surgical procedure should be screened and treated for preoperative anaemia</li> <li>■ If there is no response to iron therapy or a macrocytic picture is observed consideration should be given to testing vitamin B12 and folate levels.</li> </ul>
4.34	There should be a policy for agreed crossmatch volumes (Maximum Surgical Blood Ordering Schedule) and a pathway for organising these. <sup>64</sup>
4.35	All CYP with underlying thyroid disease should have had levels checked within the last 12 months or more recently if recent dose changes have been made to medications. <sup>99</sup>
4.36	There should be a pathway for the investigation of CYP presenting with an elevated BMI to screen for complications of excess weight. <sup>61</sup>

4.37	There should be a pathway for the identification and management of CYP presenting with a low BMI including those with anorexia and avoidant/restrictive food intake disorder (ARFID). This may include use of the Medical Emergencies in Eating Disorders (MEED) criteria when appropriate. <sup>100–102,103</sup>
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## Section 5: Anxiety, Behavioural and Additional Needs Management

5.1	Assessment of anxiety should form part of the clinical preoperative care pathway. There should be a clear policy aligned with national guidance, describing the management of moderate-severe anxiety in CYP. This should recognise the need for individualised plans and coping strategies. <sup>16,18,75,104,105</sup>
5.2	There should be specific passports or similar documentation to facilitate the care of CYP with additional needs which can be easily disseminated to the wider clinical team. This should include the optimal environment on admission, eg a side room, position on the list and access to the recovery area for parents/carers. <sup>75</sup>
5.3	The anxiety management policy should include elements to assist parents/carers in preparing their CYP and managing their own anxiety. <sup>75,106</sup>
5.4	Preoperative care services should have a selection of communication tools to help CYP and their parents/carers understand their procedural journey. This may include social stories, widgets or other communication resources in a variety of digital and paper formats. <sup>29–31</sup>
5.5	CYP who are anxious or have additional needs including neurodivergence, learning difficulties or communication needs that may impact on their ability to cope with their admission should be referred to a health play specialist for input and admission planning. <sup>24,25,27,33,75</sup>
5.6	Preoperative care should specifically address the needs of CYP with autism and learning disabilities and the impact of factors such as the hospital environment on their experience. <sup>2,69–76</sup>
5.7	Hospitals should have appropriate resources for the preparation of anxious CYP. This may include physical and digital options, tours of theatre or play aids. <sup>16,107</sup>
5.8	There should be a clear premedication pathway which describes the range of medications regularly used, the routes of administration and the plan for successfully delivering these on the day of surgery.
5.9	Where the least restrictive option to deliver a premedication involves any deprivation of liberty or restraint, this should be clearly discussed with the parents/carers at preoperative care clinic and documented. <sup>41,42,108,109</sup>
5.10	Preoperative care services should develop links with local providers and charities that work with CYP who have anxiety, autism or other specialist needs. <sup>75</sup>

Section 6: Information and Consent	
6.1	The preoperative care service should provide CYP and carers with sufficient age-appropriate information to provide informed consent for anaesthesia. <sup>37,86</sup>
6.2	Preoperative care services should provide specific information regarding anaesthetic risk. This may take the form of the <a href="#">RCoA risk infographic</a> or locally produced information. <sup>5</sup>
6.3	Information should be provided for CYP, parents and carers regarding the procedure, anaesthesia, and analgesia. It should include descriptions of anaesthesia (induction options, risks, benefits, side-effects, complications and alternatives) and analgesia. Benefits, risks, alternatives and option of no treatment (BRAN framework) should be discussed to allow informed shared decision making. Parents, carers and CYP whenever possible, should be encouraged to be active participants in decisions around their care. <sup>110</sup>
6.4	Information and resources should be available for CYP, including those with learning disabilities in a way they can understand utilising the skills of a health play specialist. Children and young people should have the opportunity to ask questions, be listened to and have their views taken seriously. <sup>111</sup>
6.5	Information provided to patients should take the form of paper documents as well as directions to web-based resources and age-appropriate applications. Information can also be provided via quick response code (QR code) or posters. <sup>5</sup>
6.6	Patient information should be available in different languages. If local leaflets cannot be translated preoperative care staff should be able to provide links to translations such as those <a href="#">produced by the RCoA</a> . Consideration should be given to the provision of preoperative resources for CYP, parents and carers with other communication needs.
6.7	Up-to-date guidance on preoperative fasting must be included in the information provided at preoperative clinics. Consideration should be given to assessment of aspiration risk particularly in children taking GLP-1 medications or with other significant risk factors for aspiration. <sup>58,112</sup>
6.8	Clinics should provide patients and carers with contact information should they have further questions or need to contact the clinic for another reason. This should be available in written and electronic formats.
6.9	Preoperative care staff should provide information about anaesthesia and the patient journey but are not expected to obtain consent for anaesthesia.
6.10	Preoperative information should include: <sup>5</sup> <ul style="list-style-type: none"> <li>■ Options for anaesthetic induction techniques</li> <li>■ Analgesia plan which may include regional blockade</li> <li>■ Additional procedures, eg invasive lines, blood transfusion, intensive care</li> <li>■ Common risks (<a href="#">RCoA risk infographic</a>), and any additional/specific/individualised risks</li> <li>■ Age-appropriate information to help reduce anxiety or any other specific fears</li> <li>■ Local preoperative fasting information or individual fasting plan if appropriate</li> <li>■ What to bring on the day, or for overnight stay, postoperative analgesia instructions, hospital discharge instructions, and contact information for questions or concerns</li> <li>■ Information for post menarcheal patients regarding need to establish pregnancy status</li> <li>■ Information for parents and carers including how they can help prepare their child, when they will be expected to leave the anaesthetic area and when they should expect to be called to recovery following the procedure.</li> </ul>
6.11	All CYP should be included in discussions regarding their care tailored to their level of comprehension.

6.12	Shared decision making (SDM) should be embedded into the preoperative care clinic processes with involvement of CYP at all stages of their care. The use of tools and consultation skills that facilitate SDM should be used to help prepare CYP, parents and carers. <sup>5</sup>
6.13	CYP attending for procedures should have informed consent completed by an individual competent to perform the procedure in question or have had the training to take delegated consent.
6.14	Whenever practical, informed consent for the procedure and theatre journey should be completed prior to the day of the procedure.
6.15	The capacity of the CYP, parent and carer should be considered at the time of consenting. <sup>37,113</sup>
6.16	CYP under the age of 16 years who are deemed competent to understand the proposed treatments should be encouraged to counter-sign their consent form.
6.17	Although there is no specific consent form for anaesthesia in the United Kingdom, discussions about risks, options and alternatives should be recorded. Discussions should be individualised to the needs of CYP and be delivered in a sufficient time for reflection. On the day of surgery, the anaesthetist must check that the parent/carer and CYP if applicable, understands and still agrees with the previous perioperative plan. <sup>5,114,115</sup>

## Section 7: Health Promotion and Education

7.1	<p>Within the preoperative care pathway, consideration should be given to providing advice, guidance and direction to additional support as appropriate.<sup>86,116</sup> The opportunities to provide wider help for CYP outside the surgical episode by referring on to appropriate agencies may include:</p> <ul style="list-style-type: none"> <li>■ Immunisation uptake and onward referral for advice by General Practitioner (GP) or health visitor.<sup>86,117</sup></li> <li>■ Excess weight and complications of excess weight<sup>61</sup></li> <li>■ Parent/carer or CYP smoking and vaping<sup>118,119</sup></li> <li>■ Oral health<sup>120</sup></li> <li>■ Safeguarding</li> <li>■ Sexual health</li> <li>■ Healthy lifestyles – mental wellbeing, sleep hygiene, healthy nutrition, physical activity, healthy relationships, avoidance of harmful substances.</li> </ul>
7.2	Dental decay is found in around a quarter of 0–5-year-olds and is strongly associated with living in areas of higher deprivation. All staff involved in perioperative assessment should be encouraged to perform a simple ‘lift the lip’ oral health check to look for obvious decay and other common oral health problems, using resources such as Mini Mouth Care Matters from the NHS Learning Hub. Where dental decay is identified or suspected, CYP and carers should be provided with brief prevention advice and signposted via locally agreed pathways developed with paediatric dental Managed Clinical Networks (MCNs) and integrated care boards to support timely access to dental care. <sup>120,121,122</sup>
7.3	Exposure to smoke in the home environment has been shown to increase perioperative adverse respiratory events. Screening for smoke exposure should be included in the preoperative care process. Information regarding the immediate and longer-term health benefits for both CYP and parent/carer of smoking cessation should be provided when appropriate. Signposting to smoking cessation services should be available. Advice regarding use of vapes should also be provided. <sup>118</sup>

7.4	<p>CYP weight management services across the country vary significantly. Preoperative care clinics should ensure that:<sup>61,123</sup></p> <ul style="list-style-type: none"> <li>■ They have an awareness of locally available services and how these can be accessed. They can provide information linking to generic online resources such as <a href="#">Ready, Steady, Recover</a>, Change4Life, Moving Medicine and the NHS Healthy Weight website</li> <li>■ They calculate BMI centile using the NHS calculator for each CYP</li> <li>■ At extremes of BMI (&gt;99.6th and &lt;0.4th centiles), there are referral pathways for further assessment.</li> <li>■ Healthy lifestyles are discussed with all CYP</li> <li>■ Information on identified complications of excess weight and the general health of CYP should be provided in tandem with signposting to available weight management services. These may be community-led, via social prescribing, GP, paediatrician, dietitian or via tertiary referral.</li> </ul>
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## Section 8: Governance and Quality Assurance

8.1	There should be regular audits of key aspects of the preoperative care service against regional and national guidance and standards. <sup>2</sup>
8.2	There should be a multidisciplinary and cross specialty programme for auditing perioperative care. <sup>2</sup>
8.3	Hospitals providing CYP perioperative care should designate a named CYP preoperative quality improvement (QI) lead who should champion CYP perioperative quality improvement, support local projects and share relevant patient safety updates and national initiatives with the wider team.
8.4	Preoperative care team members should have dedicated time and support to contribute to QI work.
8.5	Local incident reporting systems should be used to highlight safety concerns, with an emphasis on a no-blame culture that focuses on learning. Local excellence reporting systems should be used to highlight examples of good practice to support learning.
8.6	Local teams should consider developing dashboards or using available national dashboards to monitor trends. <sup>124</sup>
8.7	<p>Teams should identify and monitor key perioperative quality metrics, for example:</p> <ul style="list-style-type: none"> <li>■ Rate of same-day cancellations/postponements and the reasons for these</li> <li>■ Preassessment rates and outcomes</li> <li>■ Rate of unplanned overnight admission following day surgery</li> <li>■ Rate of readmission within 28 days of surgery</li> <li>■ Time to first patient in the anaesthetic room.</li> </ul> <p>These and other lessons from QI activity should be widely shared to enhance local, regional and national service development.<sup>2</sup></p>
8.8	Regular multidisciplinary (MDT) audit, morbidity and mortality meetings should be held, with an emphasis on shared learning across the MDT.
8.9	Collated feedback from CYP, parents and carers should be collected and used to redesign and improve the preoperative care service. <sup>125</sup>

## Section 9: Networks and System Working

9.1	Preoperative care services should collaborate with Surgery in Children (SiC) Clinical Networks (also referred to as Operational Delivery Networks or ODNs) through local audits, meetings and educational activities to facilitate equality of access to services and support for all children and young people. Providers should engage with SiC Clinical Networks to develop CYP preoperative care services. <sup>126</sup>
9.2	SiC Clinical Networks should develop a pathway for CYP to attend preoperative care clinics and have investigations as close to their home as possible when requiring surgery or a procedure under general anaesthetic. <sup>127</sup>
9.3	SiC Clinical Networks should support development of standardised referral pathways so that CYP requiring specialist surgery or procedures under general anaesthetic are directed to the appropriate specialist centre. Pathways should also support local preoperative care clinics and investigations for CYP, wherever possible, even when receiving specialist surgery at their tertiary hospital. <sup>126</sup>
9.4	SiC Clinical Networks should ensure all trusts have processes in place to facilitate the sharing of clinical information between hospitals to support preoperative care decision making. <sup>128</sup>
9.5	SiC Clinical Networks should develop resources such as 'Pre-assessment in a Box' or a local resource library to help share information and advance CYP preoperative care service development.
9.6	SiC Clinical Networks should facilitate competency-based CYP preoperative care practitioner training.
9.7	SiC Clinical Networks should regularly benchmark local preoperative care provision to ensure there is equitable access and limited variation across the network. <sup>129</sup>
9.8	Providers should engage with and contribute to local and national CYP preoperative care networks, eg Getting It Right First Time (GIRFT) national CYP pre-operative Network meetings. <sup>1</sup>

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