

Anaesthetists: Please help with this project!

Paediatric caNcellation ratEs And PerioPerative clinical Evaluation


Please complete a case report form (CRF) for **every** child 0-16 years old who has a planned procedure under GA in the 14-day study period

Lead Consultant: _____

Lead Trainee: _____

Contact: _____

pineapple@apagbi.org.uk

Your Initials _____		PINEAPPLE Paediatric cancellation rates and perioperative clinical evaluation			
DOB (mm/yy) __ / __ / __		Date of Surgery (dd/mm/yy) __ / __ / __		Speciality _____	
ASA 1 / 2 / 3 / 4		Planned post op destination		Co-Morbidities	
		<input type="checkbox"/> Daycase <input type="checkbox"/> Inpatient Overnight <input type="checkbox"/> HDU <input type="checkbox"/> PICU <input type="checkbox"/> NICU		<input type="checkbox"/> Asthma <input type="checkbox"/> Pulmonary HTN <input type="checkbox"/> Neuromuscular <input type="checkbox"/> Autistic Spectrum <input type="checkbox"/> Anxiety <input type="checkbox"/> Ex Prem <input type="checkbox"/> Other _____	
				<input type="checkbox"/> Cardiac <input type="checkbox"/> Syndromic <input type="checkbox"/> Dev Delay <input type="checkbox"/> ADHD <input type="checkbox"/> Obesity <input type="checkbox"/> Diabetes	
Prior to the day of surgery – did this child have any form of pre-operative assessment?					
Yes			No		
Date of Preassessment __ / __ / ____ Unknown			Would pre-assessment have been helpful?		
What was the format of this preassessment? (tick all that apply) <input type="checkbox"/> Health Questionnaire <input type="checkbox"/> Telephone Consultation <input type="checkbox"/> Virtual consultation <input type="checkbox"/> Face to Face Consultation <input type="checkbox"/> Unknown			Yes No (if needed please write a sentence on the overside and indicate this has been done by ticking the box below)		
What was the role of an anaesthetist in the process? (tick all that apply) <input type="checkbox"/> No Anaesthetist involvement required <input type="checkbox"/> Anaesthetist Notes Review <input type="checkbox"/> MDT discussion involving anaesthetics <input type="checkbox"/> Telephone Call with family <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown			<input type="checkbox"/>		
Was management altered as a result of pre-assessment? (tick all that apply) <input type="checkbox"/> No change to management <input type="checkbox"/> Clinical (bed allocation, referral) <input type="checkbox"/> Further investigations requested <input type="checkbox"/> Administrative (notes request etc) <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown					
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure					
If Yes, how was this addressed (tick all that apply) <input type="checkbox"/> Play specialist <input type="checkbox"/> Psychologist <input type="checkbox"/> Little Journey or similar app <input type="checkbox"/> Hospital Visit <input type="checkbox"/> Other _____					
In your opinion, did pre-assessment make a difference to this individual patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure					
Was anxiety an issue perioperatively? (tick all that apply) <input type="checkbox"/> No <input type="checkbox"/> Delay in list <input type="checkbox"/> Change in list order <input type="checkbox"/> Return to ward for pre-med <input type="checkbox"/> Cancellation <input type="checkbox"/> Other _____					
Outcome <input type="checkbox"/> Proceed as planned <input type="checkbox"/> Organisational Delay <input type="checkbox"/> Unplanned overnight stay <input type="checkbox"/> Cancellation (please state reason) _____					