



Guidance on the provision of Paediatric Anaesthesia Services

When considering the provision of anaesthesia, the Royal College of Anaesthetists recommends that the following areas should be addressed. The goal is to ensure a comprehensive, quality service dedicated to the care of patients and to the education and professional development of staff. The provision of adequate funding to provide the services described should be considered.

Summary

- Anaesthesia services for children require specially trained clinical staff together with equipment, facilities and an environment appropriate to the needs of children.^{1,2}
- The service should be led at all times by consultants who regularly anaesthetise children.^{3,4}
- At all times, there must be adequate skilled, dedicated assistance;⁵ assistance for paediatric anaesthesia should be provided by staff specifically trained for the task.
- In a life-threatening emergency where transfer is not feasible, the most senior appropriately experienced anaesthetist available should undertake anaesthesia.⁶
- Paediatric resuscitation equipment must be available wherever and whenever children are treated, and anaesthetists must maintain their skills in paediatric resuscitation to the level of advanced paediatric life support or equivalent. Equivalent requirements are a matter for local agreement.^{1,7}
- There should be a properly staffed¹ and funded acute pain service that covers the needs of children.
- Neonatal and paediatric high dependency and intensive care services should be available as appropriate for the type of surgery performed.^{8,9}
- Parents (or carers) should, wherever possible, be involved in all aspects of care and decisions regarding the management of their children.¹⁰⁻¹²

Introduction: The importance of paediatric anaesthesia services

- Children comprise 25% of the population. Many will require anaesthesia to allow treatment for a variety of surgical conditions including ENT, orthopaedic, dental, plastic, cardiothoracic, ophthalmic and paediatric general surgery.
- Children who undergo anaesthesia and surgery have special requirements. They are not small adults: they differ physiologically, emotionally and socially. Doses of drugs and fluids need to be precisely calculated and anaesthetic equipment for smaller children differs from that used in older children and adults.
- Wherever and whenever children undergo anaesthesia and surgery, their particular needs must be recognised and they should be managed in separate facilities and looked after by staff with appropriate experience and training.
- Most surgical procedures performed on children will be elective, relatively straightforward and performed in district general hospitals, usually on fit infants and children.
- Children with significant acute or chronic medical problems, those undergoing more complex procedures, neonates and small infants are usually

referred to specialist units or tertiary paediatric centres.^{13–16}

- Nevertheless, district general hospitals should have arrangements for managing and treating simple surgical emergencies; in addition, they should be able to resuscitate and stabilise seriously ill children of all ages, prior to their transfer.¹⁷
- At all times anaesthesia in children should be undertaken or supervised by consultants who have undergone appropriate training in paediatric anaesthesia (see section 4: Training and education).
- All consultant anaesthetists with a CCT or equivalent will have obtained paediatric anaesthetic training as STs, following which they should, as a minimum, have been competent to provide peri-operative anaesthetic care for common surgical conditions, both elective and emergency, for children aged 3 years and older. Unless there is no requirement to anaesthetise children it is expected that this competence will need to be sustained through regular exposure, CPD and/or refresher courses. However, there will be consultants who have acquired more advanced competencies thus allowing provision of a more extensive anaesthetic service; these competencies will still require to be sustained through the same mechanisms. There should be locally agreed guidelines on cases which can be managed on site and those which require transfer to a specialist unit.

Levels of provision of service

1 Staffing requirements

- 1.1 Children should be anaesthetised by consultants who have regular and relevant paediatric practice sufficient to maintain core competencies. Children may also be anaesthetised by staff or Associate specialist (SAS) anaesthetists or specialty doctors (SDs), provided they fulfil the same criteria and there is a nominated supervising consultant anaesthetist. When trainees anaesthetise children, they should be supervised by a consultant with appropriate experience.
- 1.2 The level of supervision of a trainee will vary according to their ability and experience, the complexity and location of the procedure, the presence of any relevant co-morbidity and the age of the patient. For example, while ST1s with limited experience require direct supervision, experienced STs who have undergone a period of paediatric anaesthetic higher training might be supervised by a consultant outside the hospital. If clinical supervision of a trainee is being provided by an SAS/SD, the trainee must always have unimpeded access to a consultant.¹⁸
- 1.3 When a child undergoes anaesthesia, the anaesthetist must be assisted by staff (operating department practitioners/assistants/anaesthetic nurses) who have specific paediatric training and skills.
- 1.4 In the period immediately following anaesthesia, the child should be managed in the recovery ward or post-anaesthesia care unit on a one-to-one basis, by designated staff who undergo regular paediatric resuscitation training. A registered children's nurse should be directly involved with the organisation and training of staff in this area, and a member of staff trained and competent in advanced paediatric life support should always be on shift.
- 1.5 Children should be nursed on a ward where there are at least two registered children's nurses on duty for every shift that the child is present.

2 Equipment, support services and facilities

Equipment

- 2.1 A full range of monitoring devices, paediatric anaesthetic equipment and disposable items for general and regional anaesthesia should be available in theatres and all other areas where children are anaesthetised.¹⁹ This should incorporate a full range of equipment including the following which should be appropriate for use in children of all sizes and ages:
 - airway management equipment
 - blood pressure cuffs
 - intravenous cannulae
 - temperature probes
 - pulse oximetry
 - ultrasound devices.^{20,21}
- 2.2 Resuscitation drugs and equipment, including an appropriate defibrillator, should be routinely available at all sites where children are to be anaesthetised.
- 2.3 Anaesthetic machines should incorporate ventilators, which have controls and bellows permitting their use over the entire age range together with the facility to provide pressure controlled ventilation.
- 2.4 There should be appropriate thermostatic control of the operating room; temperature monitoring and patient warming devices should be available in both the operating room and recovery area.

- 2.5 Intravenous fluids should be administered in a way that allows rapid and accurate delivery.

Support services

- 2.6 Paediatric high dependency and intensive care services should be available as appropriate for the type of surgery performed.^{8,9}
- 2.7 Children undergoing anaesthesia and surgery as day cases or in-patients will benefit from the input of play-specialists who can help in the preparation of the child for surgery.¹
- 2.8 On-site haematology, chemical pathology, radiology and blood transfusion services should meet the requirements of infants and children with particular reference to the removal and analysis of small blood samples. The use of routine pre-operative blood testing should be kept to a minimum, unless there are specific clinical indications.
- 2.9 There should be pharmacy staff with specialised paediatric knowledge available to provide advice and ensure safe and effective management of drugs in children.¹ Where appropriate, intravenous injections and infusions for children should be prepared in the pharmacy under controlled conditions. Copies of the 'British National Formulary for Children' or equivalent should be widely available and used in all ward and theatre areas.²²
- 2.10 There should be a properly staffed and funded acute pain service (APS) which covers the needs of children and undergoes regular audit (see Chapter 6: Guidance on the provision of anaesthesia services for acute pain management).^{1,23} Analgesia guidelines appropriate for children should be readily available and pain scoring, using validated tools appropriate to developmental age, should be performed routinely on any child who has undergone a surgical procedure.²³ A member of the acute pain service should attend paediatric wards daily, and all children who have had major surgery should be assessed regularly.
- 2.11 Particular care is required when infants and children undergo investigations or surgical procedures under sedation alone. Recommended guidelines for the conduct of paediatric sedation have been published by The Scottish Intercollegiate Guidelines Network.²⁴

Facilities

- 2.12 Children should be separated from and not managed directly alongside adults, whether in the operating theatre department, the post-anaesthesia care unit (recovery), a critical care unit, in-patient

wards or the day care unit.²⁵ Theatre design, the appearance of the anaesthetic and recovery areas and working practices should all reflect the emotional and physical needs of children.¹ If there are genuine problems, such as the need to use older buildings or the need for children to be cared for close to a facility that is essential for any aspect of their care, efforts should be made to comply with the overall requirement for separation from adult patients.

- 2.13 Recovery areas for children should be separate or screened from those used by adults and provided with paediatric airway and resuscitation equipment.
- 2.14 In the accident and emergency department there should be a separate area for children, together with all the necessary resuscitation equipment and protocols required to manage the seriously ill child.¹
- 2.15 Services and facilities should take account of the specific needs of adolescents and young people, which are different from those of children and adults.
- 2.16 Resident accommodation should be available for parents of children who require overnight admission to hospital.

3 Areas of special requirement

Intensive care: care of the critically ill child

- 3.1 Children may require admission to critical care facilities as a planned part of their care, for example after surgery, because of trauma or an acute illness or because of extreme prematurity or illness at birth. Paediatric intensive care is provided in designated units, staffed by doctors and nurses with specialised training.^{9,26} Most paediatric intensive care units are based at children's hospitals or tertiary paediatric centres and serve a defined geographical area; they must comply with national standards.⁷⁻⁹ Children who require intensive care following an operation should therefore undergo their surgery in one of these hospitals/units with a designated paediatric intensive care unit (PICU).
- 3.2 However, arrangements for the immediate care of critically ill children should be in place in any hospital which manages children.^{7,17} It must be recognised that this need can arise suddenly and unpredictably in the accident and emergency department, the operating theatre or the in-patient wards. In-house arrangements are therefore required for providing emergency treatment, initiating intensive care and stabilising critically ill children, prior to their transfer to a PICU.⁶

- 3.3** In all accident and emergency departments receiving children, neonatal and paediatric resuscitation equipment should be readily available together with all the necessary equipment, drugs and infusions necessary to resuscitate, stabilise and prepare an infant or child for PICU transfer. Resuscitation equipment should also be available in all other sites where children undergo treatment.¹
- 3.4** There should be hospital protocols for management of critically ill children. These include the management of head injuries, the indications for CT scanning, management of acute upper airway obstruction, suspected meningococcal septicaemia, seizures, severe asthma, poisoning and major burns. Clinical management of these children, in tertiary or non-tertiary settings, will require close co-operation and multidisciplinary teamwork between nurses, paediatricians, surgeons, anaesthetists, intensivists, and other relevant clinicians. Both during and following the initial stages of resuscitation of a critically ill or 'collapsed' child, it is important that further stabilisation and management are not left within the sole remit of the anaesthetist. 'In a retrieval network the tertiary centre(s) have a responsibility to the DGH units ... both to offer clinical advice and help in locating a suitable PIC bed.'¹⁷
- 3.5** A critically ill child may require short-term admission to a general critical care facility while awaiting the arrival of the PICU retrieval team. There may also be occasions when a child requires a very short period of intensive care; these may not require transfer to a PICU, provided there is a suitable facility within the hospital and the episode will last only a few hours.⁷
- 3.6** Transfer of critically ill children to specialist care services is normally undertaken by a paediatric emergency transfer team operating from the appropriate PICU.⁷ When this is not feasible (e.g. because the transfer is urgent and the transfer team is not immediately available), the general hospital making the referral may have to undertake the transfer of a critically ill child who is 'intubated and ventilated'. This may occur, particularly, in the case of the child who presents at a district hospital with a serious head injury and an expanding intracranial haematoma requiring urgent surgical decompression by a neurosurgeon. Under these circumstances:
- there should be a designated consultant with responsibility for transfers
 - portable monitors, transfer equipment, drugs and relevant guidelines must be available
- The on-call consultant has a duty to deploy staff appropriately. Patients being transferred should normally be accompanied by a doctor with relevant training and experience in paediatric life support including advanced airway management skills, who should be accompanied by a suitably trained assistant. It is the responsibility of the hospital management to ensure adequate and appropriate staffing levels.¹⁷
- 3.7** Portable transfer monitors and equipment with appropriate staff will also be required when transferring a critically ill child between different departments of a hospital (e.g. accident and emergency department to CT scan or ICU).
- #### Day care surgery and anaesthesia
- 3.8** Day care surgery is particularly appropriate for children, provided the operation is not complex or prolonged and the child is healthy with no significant co-existing medical illness.
- 3.9** The management and care of day cases should comply with standards contained in the report 'Just for the Day', irrespective of whether children are managed in a specialist paediatric unit or an adult unit adapted for children.²⁵
- 3.10** Selection for day care surgery should be made according to surgical, anaesthetic, medical and social criteria.
- 3.11** The lower age limit for day case surgery depends on the facilities and experience of staff and the medical condition of the infant. Preterm or ex-preterm neonates should not be considered for day case surgery unless they are medically fit and healthy and have reached 60 weeks post-conceptual age. Infants with a history of chronic lung disease or 'apnoeas' should be managed in a centre equipped with facilities for post-operative ventilation.^{10,11}
- 3.12** Babies who require surgery in the neonatal period should be managed in facilities offering post-operative intensive care. Generally, care is delivered jointly by consultant neonatologists/intensivists and surgeons, with input from consultant paediatric anaesthetists.
- 3.13** Parents and children should be provided with good quality information which includes fasting guidelines and what to do if the child becomes unwell before or after the operation.
- 3.14** There should be clear discharge criteria following day care surgery; patients should be given drugs for pain relief with clear instructions to parents for their use.

4 Training and education

- 4.1** Children who undergo anaesthesia must be managed by staff who have received appropriate training and whose competency in anaesthesia and resuscitation is adequate for the management of the children they serve.
- 4.2** Consultants with a substantial commitment to paediatric anaesthesia, including full-time paediatric anaesthetists, are usually appointed to posts in specialist children's hospitals or tertiary paediatric units. They will normally have satisfied the higher and advanced level competency-based training requirements of the RCoA.²⁷
- 4.3** Some consultants are appointed to posts with a designated sub-specialty interest in paediatric anaesthesia at district general hospitals. In many instances, they are nominated as the lead consultant for paediatric anaesthesia. Typically, they might undertake at least one paediatric list or equivalent per week and are responsible for co-ordinating and overseeing anaesthetic services for children, with particular reference to equipment, protocols, guidelines, pain management, resuscitation services, sedation, teaching etc. These individuals should normally acquire the competencies listed for higher training in paediatric anaesthesia during ST years 5, 6 or 7.²⁷ They should also have advanced training in life support for children and have maintained the skills so learnt.
- 4.4** All anaesthetists who work with children should maintain appropriate clinical skills, have training in child protection and be aware of the arrangements for child protection in their own hospitals.²⁸
- 4.5** In paediatrics, as in all areas of anaesthetic practice, anaesthetists must recognise and work within the limits of their professional competence. Some anaesthetists working in district general hospitals do not have a regular paediatric commitment; they may, in the absence of a separate paediatric rota, have to provide out-of-hours cover for emergency surgery in children. Anaesthetic involvement may also be required in the management of critically ill children who, on presentation, require intubation, resuscitation and initiation of intensive care before the arrival of a retrieval team and eventual transfer to a PICU. Whilst virtually all career grade anaesthetists, as trainees, will have received some formal training in paediatric anaesthesia, several years may have elapsed since this was obtained. It is important that such consultants obtain training in paediatric resuscitation and are able to maintain these skills. In addition, there

should be arrangements for undertaking regular supernumerary attachments to paediatric lists (see below), or secondments to specialist centres/ paediatric simulator work, in order to update and maintain paediatric knowledge and skills.

- 4.6** There must be arrangements which are fully funded to enable all consultant and career grade staff who provide anaesthesia or anaesthetic cover for children to participate in CPD which relates to paediatric anaesthesia and resuscitation. In particular, consultants who have no fixed paediatric lists but have to provide out-of-hours cover should undertake regular annual CPD which involves supervised work with a paediatric anaesthetic colleague.
- 4.7** Arrangements should also be made between specialist paediatric units and district general hospitals to facilitate continuing professional development (CPD) and refresher training in paediatric anaesthesia. The establishment of regional groups/networks of paediatric anaesthetists may facilitate joint CPD.
- 4.8** Where appropriate, joint appointments may be considered, allowing designated consultants from district general hospitals a regular commitment within a dedicated tertiary paediatric centre in order to maintain and develop their skills.

5 Research and audit

- 5.1** Audit plays a vital role in the quality assurance process and in measuring performance. Simple indicators, such as unplanned in-patient admission following day case surgery or unplanned admission to the intensive care unit following surgery, can easily be measured and the reasons documented. The information can be analysed and compared with accepted norms. A number of suggested topics, specifically relating to paediatric anaesthesia or adaptable from those suggested for adult anaesthesia, are set out in the Royal College of Anaesthetists document 'Raising the Standard: a compendium of audit recipes'.²⁹
- 5.2** There should be departmental audit and morbidity meetings relating to paediatric anaesthesia. Where appropriate, this should be multidisciplinary and incorporate input from parents, guardians and patients.
- 5.3** Audit activity should include the regular analysis of critical and untoward incidents. Serious events and near misses will need to be investigated thoroughly and reported to the National Patient Safety Agency in England and Wales, or equivalent elsewhere, in line with national requirements.

5.4 There should be an audit of all children transferred between hospitals. This should be monitored by the referring and receiving hospitals' paediatric or other appropriate committee.

6 Organisation and administration

6.1 There should be a hospital committee consisting of a paediatrician, anaesthetist, surgeon, pharmacist and registered children's nurse. Local protocols should define surgery possible in that particular hospital with regard to such matters as the age and condition of patients, extent of elective and emergency surgical provision, staffing, local environmental constraints and thresholds for transfer to a larger or tertiary unit. This committee should be responsible for the overall management, improvement, integration and audit of anaesthetic and surgical services for children.

6.2 When children are admitted for surgery, their overall care should be supervised by a specialist paediatric surgeon or paediatrician. Where this is not the case, a named paediatric medical consultant should oversee care in conjunction with the child's surgeon.

6.3 Children who undergo surgery should normally be concentrated on designated paediatric operating lists, ideally in a separate children's theatre area.²

6.4 In hospitals where children undergo anaesthesia, there should be readily available evidence-based guidelines and protocols relating to resuscitation, peri-operative care and the management of conditions such as anaphylaxis and malignant hyperpyrexia.

6.5 All patients should be assessed before their operations by an anaesthetist; both the parents and the child should be given the opportunity to ask questions.

6.6 There should be systems to ensure the safe use and prescription of drugs in children. There should be awareness of the implications of using 'off-label' and 'unlicensed' drugs for children. Copies of the 'British National Formulary for Children' or equivalent should be available.²²

6.7 Parents (and others *in loco parentis*) should be involved in the care process. This includes physical and psychological preparation of the patient for surgery. A child centred approach to anaesthesia and surgery should be employed, with, as far as possible:

- segregation between adults and children in the operating department, post-anaesthesia care unit, day care unit, in-patient wards and the accident and emergency department

- provision for parents to accompany children, both to the anaesthetic room and into recovery areas.¹ There may be exceptions to this; for example, anticipated difficulty in tracheal intubation or rapid sequence induction.

6.8 Arrangements should be in place with a specialist paediatric unit for the transfer of sick infants or children.

6.9 It is recommended that regional networks be developed, with the establishment of close links between departments of anaesthesia and critical care in district general hospitals and the corresponding departments in tertiary paediatric centres.⁷⁻¹⁰ This should facilitate provision of advice (when required), the production of evidence-based protocols and guidelines, and the arrangement of clinical attachments.

7 Patient information/consent

7.1 Before the admission of a child for elective surgery, parents should receive full written information together with a contact telephone number should they have further questions. Written information should be based on or make reference to that provided in 'Anaesthesia Explained' and the information leaflets relating to paediatric anaesthesia that are available from the Royal College of Anaesthetists.³⁰

7.2 Anaesthetists should be aware of legislation including the Children Act, rights of the child, child protection issues and the process of obtaining consent.^{31,32}

7.3 Although separate written consent for anaesthesia is not mandatory, there should be discussions with the child and/or parent about methods of induction and provision of post-operative pain relief including the use of suppositories. Where special techniques such as epidural blockade, invasive monitoring and blood transfusions are anticipated there should normally be written evidence that these have been discussed with the child (when appropriate) and with parents.

7.4 In infants and younger children, consent for medical and surgical treatment is obtained from the parent or the legal guardian; minors age 16 and over can consent to medical treatment. Nevertheless, there are some children under the age of 16 who have sufficient maturity and understanding to decide whether to undergo surgery (see section 7 of Chapter 2: Guidance on the provision anaesthesia services for pre-operative care).

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