

Guidance in the event of a late cancellation in paediatric elective surgery

Paediatric Guideline number:

Date agreed: Draft V1 14/06/21

Guideline Reviewer: Emma Lillie
Version: 1
Approval Committee: Children's Safety and Quality Committee
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Cross reference:

Key Principles:

A protocol is a set of measurable, objective standards to determine a course of action.

Professional judgement may be used in the application of a protocol.

Scope:

This protocol applies to:

- All paediatric elective surgery patients

Responsibilities:

Paediatric nursing and medical staff:

- To access, read, understand and follow this guidance
- To use their professional judgement in application of this protocol

Management Team:

- To ensure the protocol is reviewed as required in line with Trust and National recommendations
- To ensure the protocol is accessible to all relevant staff

This guidance is based on National Guidance for the recovery of elective surgery in children.¹

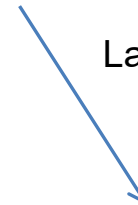
This is an adjunct to current UHS theatre guidance, which states all elective patients should have a negative RT-PCR 24-72hrs prior to surgery.

This guidance applies in the event of a **late cancellation**, on an **elective** paediatric theatre list, during periods of **low regional COVID-19 prevalence** (<0.5%).

In this event a lateral flow test can be done in the few hours (6hours or less) prior to surgery to enable the theatre slot to be filled. This is to maximise theatre efficiency due to the unprecedented surgical waiting list arising from the COVID pandemic whilst maintaining staff and patient safety (Table 1).

Green Theatre Pathway²

- Elective Paediatric Patients
- Low regional prevalence (<0.5%)



Late cancellation

- RT-PCR 24-72hrs pre-surgery

Lateral Flow Test
6hrs or less pre surgery
+
RT-PCR *

* In the event a paediatric patient will not tolerate a 2nd COVID test, the RT-PCR swab test can be sent to theatre and performed while the patient is under anaesthesia provided the lateral flow result is negative. It is the responsibility of the team booking the patient to follow up RT-PCR result.

Sources:

1. <https://www.rcpch.ac.uk/resources/national-guidance-recovery-elective-surgery-children>
2. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/990923/20210602_Infection_Prevention_and_Control_Guidance_for_maintaining_services_with_H_and_C_settings_1_.pdf

Table 1 (from the document National Guidance for the recovery of elective surgery in children. RCPCH)

Number of patients, per 100,000, that would pose a risk during the procedure. This value captures those who would return a false positive test, and the number of asymptomatic infections that would develop between test and the start of procedure. Those who develop **symptoms** have been excluded to mirror IPC practice. Estimated sensitivity values for LFD of 0.6 for unsupervised testing and 0.8 if test undertaken by a professional in a care setting.

Prevalence (%)	Test	Sensitivity	Time between test and procedure (hours)	Unidentified infections at time of procedure (per 100,000 patients)
0.1	LFD	0.6	0.5	12
			1	12
			2	13
			3	13
			6	14
		0.8	0.5	5
			1	5
			2	5
			3	6
			6	7
	PCR	0.9	12	8
			24	12
			36	15
			48	17
			72	22
0.5	LFD	0.6	0.5	57
			1	58
			2	61
			3	63
			6	69
		0.8	0.5	29
			1	30
			2	32
			3	35
			6	41
	PCR	0.9	12	39
			24	59
			36	73
			48	88
			72	112

This table demonstrates that fewer children with an unidentified infection will undergo a procedure when a test with lower sensitivity (e.g. lateral flow device) is taken within 6 hours of the procedure compared to a test with higher sensitivity (e.g. PCR) taken 36 hours before a procedure.