Aneurin Bevan University Health Board

Consenting Guidance for Junior Medical Staff

Maternity Services

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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1 Executive Summary

This document is a clinical guideline designed to support safe and effective practice.

1.1 Scope of guideline

This guideline applies to junior medical staff and can be cross matched to Standards for Healthcare Services Standard 9: Patient Information & Consent.

1.2 Essential Implementation Criteria

Consent is audited annually as part of the Aneurin Bevan University Health Board and Maternity Services' rolling audit programme.

2 Aims

To provide support for clinicians when taking consent.

3 Responsibilities

The Gynaecology and Maternity Management teams.

4 Training

Consent forms part of the directorate training programme.

5 Monitoring and Effectiveness

Consent is audited annually as part of the Aneurin Bevan University Health Board and Maternity Services' rolling audit programme.

This policy has undergone an equality impact assessment screening process using the toolkit designed by the NHS Centre Equality & Human Rights. Details of the screening process for this policy are available from the policy owner.

6 Introduction

The following provides guidance on consent for various obstetric and gynaecological procedures in common practice. This is produced with an intention to guide junior doctors with no/very minimal experience in Obstetrics and Gynaecology.

The various aspects of the operation to be discussed during consenting are described in simple language avoiding medical jargon. This includes a brief description of preoperative preparation, how the operation is performed, what are the risks involved, duration of the operation and also provides information on postoperative period. Most of the queries the patients have with respect to recovery, driving, exercises, sexual intercourse are discussed.

Also included are few tips for interpretation of ECG which is a forgotten skill especially for the career SHOs. The reference ranges for various biochemical tests taken from Royal Gwent Hospital Laboratory are included at the end.

The appendix contains a summary of the risks associated with each procedure along with the incidence, taken from RCOG green top guidelines. These percentages and risks are for your reference only and it is wise not to quote them routinely to patients unless they ask, too much information can actually upset and confuse the patients.

Eido consenting is a mandatory online training course covering the legal issues surrounding consent. The registration and login details are provided in the appendix.

We hope that it would be of some help to junior doctors who are the ones working in the preclerking clinic most of the times in our hospital.

Obstetric Procedures

7. ELECTIVE CAESAREAN SECTION:

- The operation takes about 45min- 1hour

- You will have an injection in the back to numb the area from below the waist or very rarely you might have to be put to sleep

- You birthing partner will be called into the theatre just before starting the operation (as long as the operation is under regional anaesthetic)

- You will have a cut along the bikini line about 10 -15cm long and a similar cut on the womb to deliver the baby. To close the skin you may have stitches which dissolve and do not need to be removed, or a stitch or staples which have to be removed after 5-6 days

- Complications can occur: (look at the appendix for RCOG figures)
    - bleeding during or after operation (if heavy will require blood transfusion),
    - Persistent abdominal discomfort for few months after
    - infection
    - clots in the legs or lungs
    - rarely, injury to either bowel, bladder or ureter as they are close by
    - Cuts to the baby's head or bottom (much more common than bladder injury!!)

- You will have a catheter in your bladder until you are mobile. You will also have an IV cannula (tube) for fluids. You will be allowed to eat and drink within a few hours after the operation. You will be given painkillers to relieve any postoperative pain. You will have stockings and blood thinning injections until you are out of the hospital

- You can start breastfeeding as soon as you are comfortable after the operation

- If everything goes well, you should be able to go home within 24-48 hours and the community midwife will visit your home for the initial few days. She will also remove the stitch on day 5/6. You might have bleeding down below until 14 days

- Once you are home, you can gradually resume your day to day activities. Strenuous exercises and lifting weights such as vacuum cleaners, bags of shopping, babies in carriers are to be avoided for at least 8-10 weeks

- Sexual intercourse can be resumed after starting contraception if you are not planning a pregnancy

- You can start to drive after 4-6 weeks as long as you can safely do an emergency stop. You need to check with your insurance company before starting.

8. EXTERNAL CEPHALIC VERSION (ECV):

- External cephalic version is the term used to turn your baby to a head-first position if the baby is lying bottom first in the womb (breech). Usually done after 36 weeks

- You should not eat or drink after 6:00 am on the morning of the procedure

- The procedure is done on delivery suite. We will do a scan to check if the baby is still breech. The baby will be monitored for about 30 min both before and after turning.

- You will be given an injection (sometimes a tablet or inhaler) to relax your tummy muscles. Firm pressure is applied on your tummy which helps the baby turn a somersault in the womb to lie head first. It is not usually painful, but can be uncomfortable. If you are experiencing pain please let the doctor know and he or she will be happy to stop if you are experiencing too much discomfort.

- The procedure is successful in 50% of women. It is possible to have a second attempt on another day. If the baby does not turn after a second attempt, we will discuss your options for birth

- As vaginal breech birth is more complicated than normal birth, we advise you to have a caesarean section. This is done at around 39 weeks and we will book the date before you leave the labour ward. **Discuss LSCS as above**

- ECV is generally safe and does not cause any harm to the baby or yourself. However, sometimes it can lead to bleeding, breaking of waters (rupture of membranes), or cord prolapse which might

necessitate an emergency caesarean section. The possibility of this happening is only 0.5% (1 in 200) and preparation for such an emergency will already be in place to ensure that you and your baby are safe

- After you go home, you should contact us if you have bleeding, abdominal pain, contractions or reduced movements.

9. REPAIR OF THIRD DEGREE PERINEAL TEAR:

- You have had a tear extending into the back passage which needs repairing. The repair which takes about 30min- 1hour and is done in theatre

- You will have an injection in the back to numb the area from below the waist

- Your legs will be popped up on the stirrups and the doctor will examine the vagina and back passage and will suture the tear. All the stitches are absorbable

- Complications can occur:
    - bleeding (if heavy will require blood transfusion)
    - wound infection leading to improper healing
    - failure to control faeces and flatus (incontinence)
    - scarring leading to painful intercourse
    - Difficulty or discomfort in passing stools immediately after

- You will have a catheter in your bladder until you are mobile. You will also have an IV cannula (tube) for fluids. You will be allowed to eat and drink within few hours after the operation. Once you can move around, both the catheter and IV cannula will be removed. You will be given painkillers to relieve any pain

- You will be given a course of antibiotics and stool softeners (laxatives) to avoid constipation

- You should keep the area clean. Have a bath or a shower once a day and change your sanitary pads regularly. Drink at least 2 litres of water every day and eat a healthy balanced diet with fruit, vegetables, cereals, wholemeal bread and pasta

- You will be referred to do pelvic floor exercises for at least 6 to 12 weeks after surgery. Lifting heavy weights and constipation should be avoided for at least 6 weeks

- Contact your midwife or general practitioner if your stitches become more painful, smell offensive or are not healing properly. These may be signs of an infection

- You will have a follow up appointment with your consultant's team in the hospital after 6 weeks when we will check the wound and whether you have problems in controlling faeces and flatus. You will also receive an appointment to be seen in the specialist pelvic floor clinic or your consultant after 3 months. If there are still problems at this stage, you will be referred to bowel surgeons for further investigations

- Most women deliver normally in the next pregnancies if there are no symptoms of incontinence and you will have opportunity to discuss this in detail during your antenatal visits.

10. MANUAL REMOVAL OF PLACENTA:

- This is a procedure which takes place in theatre.

- You will have an injection in the back to numb the area from below the waist or very rarely you might have to be put to sleep

- Your legs will be popped up on the stirrups and the doctor will introduce a hand into the womb and remove the afterbirth

- Complications can occur:
    - bleeding during and after the operation, (if heavy will require blood transfusion)
    - womb infection
    - the placenta might stick inside so that small pieces might be left behind

- You will have a catheter in your bladder for about 8-12hours. You will also have an IV cannula (tube) for fluids and IV antibiotics for 24 hours. You will be allowed to eat and drink within few hours after the operation. Once you move around, both the catheter and IV cannula will be removed. You will be given painkillers to relieve any pain and antibiotics to prevent infection

- If you are well, you should be able to go home after 24 hours. Once you go home, if you feel unwell or if you have smelly discharge/bleeding down below or severe tummy pain you should contact the GP or community midwife

- Your periods usually resume after 6 weeks depending upon the type of feeding (late if breast feeding).

11. TRIAL OF INSTRUMENTAL DELIVERY:

- You will have an injection in the back to numb the area from below the waist or very rarely you might have to be put to sleep

- You birthing partner will be called into the theatre just before delivery

- Your legs will be popped up on the stirrups and the doctor will examine you and decide the best way to deliver the baby. This could be with a suction cup or forceps applied to the baby's head depending upon the position of the head. You may have a cut given down below (episiotomy) which will be repaired after the delivery. If we can't deliver the baby this way, we may have to proceed to caesarean section.

- Discuss LSCS

- Complications can occur:
    - bleeding during or after operation (if heavy will require blood transfusion),
    - Infection
    - High vaginal tears or perineal tear, sometimes third and fourth degree involving the back passage which will be repaired
    - Marks on the baby's face if forceps and swelling on baby's head if cup is used. These usually settle down in 24 hrs
    - Small cuts on the baby's face or scalp can happen, usually heal quickly
    - Clots in the legs or lungs
    - Rarely, injury to either bowel or bladder as they are close by

- The doctor will come and explain all the events after the procedure.
- You may feel bruised and sore after the procedure and regular pain relief will help.
- Most women who have had an assisted vaginal birth deliver spontaneously next time around.

Note: Rest as LSCS

Gynaecological Procedures

12. PELVIC FLOOR REPAIR:

- This is a major operation. You will either be put to sleep or have an injection in the back to numb the area from below the waist

- This operation is performed through the vagina/ front passage to tighten up the tissues of the pelvic floor the weakness of which led to the prolapse. The bladder and rectum are returned to their normal position. A cut is made in the vaginal tissue covering the bladder, the bladder is pushed up and the tissue around it is tightened with stitches. Similarly, a cut is made in the vaginal tissue covering the rectum (back passage), the rectum is pushed back and the tissue around it tightened with stitches

- Complications can occur: (see appendix for RCOG fig)
    - Infection
    - Clots in the legs or lungs
    - Bleeding during or after operation (if heavy will require blood transfusion)
    - Pain during intercourse
    - Rarely, injury to either bowel, bladder or ureter as they are close by. If that happens we will have to open the tummy and repair the injured structures.
    - New symptoms from your bladder – urgency, stress incontinence, voiding difficulty
    - There could be recurrence of the prolapse of bladder and rectum after the operation in the years to come (30%)

- You will have a catheter in your bladder and a gauze pack in your vagina for about 24-48 hours. You will also have an IV cannula (tube in your vein) for fluids. You will be given painkillers to relieve any pain. You will experience a small amount of vaginal bleeding which is normal

- If you are well, you should be able to go home in 24-48 hours depending on how well you recover; you will need to be able to pass urine normally. There is no need for removal of stitches

- You may have some discharge and some bleeding initially and this should stop in 3-6 weeks.

- Once you are home, you can gradually resume your day to day activities. We advise you to do tummy and pelvic exercises as soon

as you are comfortable. Strenuous exercises and lifting weights such as vacuum cleaners, bags of shopping, are to be avoided for 2 months and heavy lifting, prolonged constipation should be avoided lifelong.

- Sexual intercourse can be resumed after 6 weeks. Driving to be resumed only if you are confident that you can make an emergency stop comfortably

- In order to improve your muscle tone, perform pelvic floor exercises 4 times a day

13. VAGINAL HYSTERECTOMY:

- This is a major operation.

- You will either be put to sleep or have an injection in the back to numb the area from below the waist

- The womb and the neck of the womb are removed through the vagina/ front passage. The tubes and the ovaries are not removed

- Complications can occur: (see appendix for RCOG fig)
    - infection
    - clots in the legs or lungs
    - bleeding during or after operation (if heavy will require blood transfusion)
    - Rarely, injury to either bowel, bladder or ureter as they are close by. If that happens we will have to open the tummy and repair the injured structures
    - New symptoms from your bladder – urgency, stress incontinence, voiding difficulty
    - There could be recurrence of the prolapse of the vaginal walls after the operation in the years to come (30%)

- You will have a catheter in your bladder and a gauze pack in your vagina for about 24-48 hours. You will also have an IV cannula (tube in your vein) for fluids. You will be given painkillers to relieve any pain. You will experience a small amount of vaginal bleeding which is normal

- If you are well, you should be able to go home in 24-48 hours depending on how well you recover; you will need to be able to pass urine normally. There is no need for removal of stitches

- You may have a discharge and some bleeding initially and this should stop in 3-6 weeks.

- Once you are home, you can gradually resume your day to day activities. We advise you to do tummy and pelvic exercises as soon as you are comfortable. Strenuous exercises and lifting weights such as vacuum cleaners, bags of shopping, are to be avoided for 2 months and heavy lifting, prolonged constipation should be avoided lifelong.

- Sexual intercourse can be resumed after 6 weeks

- Try to pass urine at regular intervals to empty your bladder

- In order to improve your muscle tone, perform the pelvic floor exercises 4 times a day

- Driving to be resumed usually after 6 weeks, you need to check with your insurance company before starting

14. TOTAL ABDOMINAL HYSTERECTOMY +/- BILATERAL SALPINGO-OOPHORECTOMY:

- This is a major operation.

- You may either be put to sleep or have an injection in the back to numb the area from below the waist

- You will either have a cut along the bikini line about 8-10cm long or one up and down if the womb is big. Your womb, neck of the womb and the tubes and ovaries will be removed and the cut closed. To close the skin you may have stitches which dissolve and do not need to be removed, or a stitch or staples which have to be removed after 5-6 days.

- Complications can occur: (see appendix for RCOG fig)
    - Infection
    - Clots in the legs or lungs
    - Bleeding during or after operation (if heavy will require blood transfusion)
    - Rarely, injury to either bowel, bladder or ureter as they are close by. If that happens we will have to repair it.
    - You might need to go on HRT after the operation if your ovaries are removed

- You will have a catheter in your bladder for about 24hours. You will also have an IV cannula (tube) for fluids as you won't be eating or drinking for 24 hours. Once you are well enough to eat and drink and move around, both the catheter and IV cannula will be removed. You will be given painkillers to relieve any pain

- If you are well, you should be able to go home on day 2-4

- You may have sutures that are dissolvable.

- Once you are home, you can gradually resume your day to day activities. We advise you to do tummy and pelvic exercises as soon as you are comfortable. Strenuous exercises and lifting weights such as vacuum cleaners, bags of shopping, are to be avoided for 3 months

- Sexual intercourse can be resumed after 6 weeks

- Driving to be resumed usually after 6 weeks, you need to check with your insurance company before starting

15. DIAGNOSTIC LAPAROSCOPY (Lap and dye/Sterilisation/ Salpingectomy for ectopic)

- This operation and you will be put to sleep.

- You will have a small cut of about one centimetre on the skin of the belly button. The tummy is filled with gas and a telescope is passed through this cut to see the uterus, tubes and ovaries.
  - *for lap and dye - mention that dye will be injected from below into the womb and will be checked if it flows through the tubes*
  - *for sterilisation mention that the tubes will be blocked by applying clips on them*
  - *for salpingectomy mention that the tube containing the ectopic pregnancy is removed*

- A small cut along the bikini line and one or two small cuts along the sides of the tummy may have to be done in order to pass other instruments used in the operation. These cuts will be stitched with absorbable sutures or closed with glue

- Complications can occur: (see appendix for RCOG fig)
  - shoulder tip pain
  - bruising
  - failure to gain entry and a need to make a bigger cut

- infection
- Bleeding during or after operation (if heavy will require blood transfusion).
- Rarely, (1:1000) there can be injury to womb, bowel, bladder or blood vessels. If that happens we will have to give you either a cut along the bikini line or up and down your tummy to repair the injured structures
- *For sterilisation mention the additional complications*:
    - Failure rate of 1/200
    - Permanent procedure and some women regret the procedure and chances of success with reversal are slim, reversal not funded by the NHS
    - Increased risk of ectopic if the procedure fails

- You will also have a cannula into the vein in your forearm for fluids as you won't be eating or drinking for a few hours. Once you are well enough to eat and drink, this will be removed

- You will be given painkillers to relieve any pain. If everything goes well, you should be able to go home the same day once you are well and have passed urine

- Once you are home, you can gradually resume your activities. You can have a shower the following day. You can return to work usually 1 week after the operation, unless you have a heavy work which involves lifting and carrying

- Driving to be resumed after checking with your insurance company

- You need to contact the ward or GP if you have severe pain, fever, offensive discharge, prolonged bleeding

16. HYSTEROSCOPY, DILATATION AND CURETTAGE:

- This is a minor operation

- You will be put to sleep/or have under spinal anaesthetic

- This does not require any cuts. A telescope (of the width of a pen) is passed through the neck of the womb to have a look inside and a sample from the lining of the womb is taken

- Complications can occur: (see appendix for RCOG fig)
    - Infection

  - Bleeding during or after operation (if heavy will require blood transfusion).
  - There is 1 in 1000 chance of having damage to the womb which might need an operation to sort it out and a longer stay in the hospital afterwards. The operation will involve a cut along the bikini line and antibiotics afterwards
  - The risks due to anaesthesia will be explained by the anaesthetist when you come for the operation

- You will also have a cannula into the vein in your forearm for fluids as you won't be eating or drinking for a few hours. Once you are well enough to eat and drink, this will be removed

- You will be given painkillers to relieve any pain

- If everything goes well, you should be able to go home the same day once you are well and have passed urine

- Once you are home, you can gradually resume your activities and work from next day

- You need to contact the ward or GP if you have severe pain, fever, offensive discharge or prolonged bleeding

17. ERPC (Evacuation of retained products of conception)

- This is a minor operation

- You will be put to sleep or have spinal anaesthetic

- This does not require any cuts. The products from this pregnancy will be removed by suction and scraping from the inside of the womb
- Complications can occur:
  - Infection
  - Bleeding during or after operation (if heavy will require blood transfusion).
  - There is 1 in 1000 chance of having damage to the womb, bladder or bowel which might need an operation to sort it out and a longer stay in the hospital afterwards.
  - The risks due to anaesthesia will be explained by the anaesthetist when you come for the operation

- You will also have a cannula into the vein in your forearm for fluids as you won't be eating or drinking for a few hours. Once you are well enough to eat and drink, this will be removed

- You will be given painkillers to relieve any pain

- If everything goes well, you should be able to go home the same day once you are well and have passed urine

- Once you are home, you can gradually resume your activities and work from next day and resume contraception if you are not planning to conceive in the immediate future.

- In case of increased bleeding and signs of infection such as feeling unwell or fever, report to emergency gynaecology unit ASAP.

- You need to contact the ward or GP if you have severe pain, fever, offensive discharge or prolonged bleeding

18. TIPS FOR ECG INTERPRETATION:

Systematic approach:

- Rate:
  - ✓ H/R=300 / no. of big squares between R-R interval
    5 small squares = 1 big square = 0.2 sec = 0.5 mV
  - ✓ PR interval = 0.12 – 0.2 sec (3 – 5 small squares)
  - ✓ QRS complex = < 0.12 sec (3 small squares)

  If pt. Symptomatic or no specific reason found for bradycardia ask for help

  Chest Leads:
  - ✓ Inferior leads - II, III and aVF
  - ✓ Anterior leads – V1 and V2
  - ✓ Septal leads – V3 and V4
  - ✓ Lateral leads - I, aVL, V5 and V6

- Rhythm

Blocks

- ✓ 1°AV block: PR interval > 0.2 sec
- ✓ 2°AV block (Type 1): Gradual prolongation of PR interval, till a drop beat occurs.
- ✓ 2°AV block (Type 2): Intermittent failure of atrial conduction to ventricles.

- ✓ Complete heart block: Separate atrial & ventricular rhythm
- ✓ LBBB: M pattern in V5,V6
- ✓ RBBB: M pattern in V1,V2

Tacharrhythmias

- ✓ Atrial fibrillation: Irregular rhythm with no P waves
- ✓ Atrial Flutter: Saw tooth pattern best seen in II, III, aVF, V1
  If haemodynamically unstable – needs urgent action
- ✓ SVT: Regular narrow complex (qrs), p wave may be seen.
- ✓ VT: Broad based complex with no p waves
- ✓ VF: Irregular rhythm

Ventricular hypertrophy

- ✓ Right: R > S wave in V1
- ✓ Left: R > S wave in V5, V6

ST / T changes: Asymptomatic: Non urgent referral /Review

Symptomatic: Urgent referral /Review
If in doubt/pt symptomatic – ask for help
* Urgent action required

19. Risks associated with various procedures (RCOG)

Caesarean section:

Serious risks:

- Maternal: Hysterectomy (0.7–0.8%)
  - Need for further surgery at a later date, including curettage (0.5%)
  - Admission to intensive care unit 0.9%
  - Bladder injury (0.1%)
  - Ureteric injury (0.03%)
  - Death (rare/dependent on indication) 1/12000
- Foetal injury: Lacerations (2.0%)
- Future pregnancies: Increased risk of uterine rupture during subsequent pregnancies/deliveries (up to 0.4%)
  - Antepartum stillbirth (0.4%)
  - Increased risk in subsequent pregnancies of placenta praevia and placenta accrete (0.4–0.8%)

Frequent risks:

- persistent wound and abdominal discomfort in the first few months after surgery
- increased risk of repeat caesarean section for subsequent pregnancies

Any extra procedures that may become necessary during the procedure:

- Blood transfusion
- Other procedures:
  - repair of bladder and bowel damage
  - surgery on major blood vessels
  - ovarian cystectomy/oophorectomy in response to unsuspected pathology
  - hysterectomy

<u>Total abdominal hysterectomy:</u>

Serious risks:
Two women in every 100 undergoing abdominal hysterectomy will experience at least one of these complications:

- Damage to the bladder and/or the ureter (0.7%) and/or long-term disturbance to the bladder function
- Damage to the bowel (0.04%)
- Haemorrhage requiring blood transfusion (1.5%)
- Return to theatre for additional stitches (0.6% – of these, in 39% the procedure was completed vaginally)
- Pelvic abscess/infection (0.2%)
- Venous thrombosis or pulmonary embolism (0.4%)

Frequent risks:

- Wound infection and bruising
- Frequency of micturition
- Delayed wound healing
- Keloid formation
- Early menopause: evidence is inconclusive

Any extra procedures which may become necessary during the procedure:

- Blood transfusion (overall transfusion rate 1.5%)

- Other procedures:
  - repair to bladder, bowel or major blood vessel
  - oophorectomy for unsuspected disease (this must be discussed and consent obtained prior to surgery)

Vaginal hysterectomy and pelvic floor repair:

Serious risks:

- Damage to bladder/urinary tract.
- Damage to bowel.
- Excessive bleeding requiring transfusion or return to theatre.
- Long-term disturbance to bladder function.
- Pelvic abscess.
- Venous thrombosis and embolism.
- Dyspareunia.
- Failure to achieve desired results; recurrence of prolapse.

Frequent risks:

- Urinary retention.
- Vaginal bleeding.
- Frequency of micturition and infection.
- Pain.

Any extra procedures which may become necessary during the procedure:

- Blood transfusion: 2 women in every 100 undergoing vaginal hysterectomy will require intraoperative blood transfusion.
- Other procedures:
  - repair of bladder and bowel damage
  - laparotomy and conversion to abdominal approach.

Hysteroscopy:

Serious risks:

- Uterine perforation (0.76%)
- Pelvic infection
- Failure to visualise uterine cavity

Frequent risks:

- Vaginal bleeding and discharge
- Pain: pelvic or shoulder

Any extra procedures which may become necessary during the procedure

- Laparoscopy in the event of perforation
- Blood transfusion – very rare

Laparoscopy:

Serious risks:

- Damage to bowel, bladder, major blood vessels
- Failure to gain entry to abdominal cavity
- Uterine perforation
- The overall risk of complications from diagnostic laparoscopy is approximately 2 in 1000
- 3–8 women in every 100000 undergoing laparoscopy die as a result of complications

Frequent risks:

- Failure to identify disease
- Bruising
- Shoulder-tip pain

Any extra procedures which may become necessary during the procedure:

- Laparotomy
- Repair of damage to bowel, bladder or blood vessels

FURTHER READING:

1. RCOG guidelines on Consent for various procedures

2. RCOG Obtaining Valid Consent: Clinical Governance Advice No 6

20. Consent to Treatment - On - line training - "Be INFORMED"

Who should access this training?

- **Consultants**, **Staff Grades** and **Associate Specialist Doctors** must as part of their Job Plan/Appraisal process undertake this training.

- It will be mandatory for **Nurses** who have extended roles in treating patients i.e. Nurse Endoscopist, or who take consent on behalf of a doctor to undertake this training.

- **Diagnostic and Therapies:** training needs will be assessed by individual managers. Please refer to your line manager for further advice as to what training you are required to undertake and if it is to be accessed via cascade or this module.

- **Other** any member of staff can register and access the system either to complete the course as evidence of continuous professional development or to use the system as a reference tool.

The overall aim of the resource, which consists of four modules, is to provide you with the necessary knowledge of the law concerning consent to treatment, with the objective of reducing the possibility of litigation claims being brought against you.

It specifically provides information about:

- the current law surrounding patient consent to treatment
- the consequences of not obtaining patient consent to treatment
- the issues surrounding minors and their consent to treatment
- the treatment of patients who are lacking capacity
- the ethical issues surrounding the use of new or experimental treatments
- end of life decision making

Time taken to complete the course will vary, however you should aim to spend between one and four hours on each module to

achieve a sound knowledge of the information and to succeed in passing the modules.

To access the On-line training for consent you will need:

Trust ID: GWENT
Password: 010306
Internet Link: www.beinformedplus.com

Please note ID and Password are both **case sensitive**

If this is your first visit to Be INFOrMED you will need to register. You can do this by clicking on the orange word **register** below the LOGIN box.

IMPORTANT INFORMATION on the registration page you will be asked for some personal information including your email address. Please enter your **five digit personal number** here (found on the top left hand corner of your payslip) if you do not have it today please complete it as soon possible as this will be used to register your attendance on the course for PRISM, KSF and Appraisal purposes. There is a drop down box on the registration screen reminding you to do this – due to the nature of the program you will need to select that box also – unfortunately failing to do so will hold up registration.

If you are already registered you will have a unique login ID which is **case sensitive**. It will consist of your surname, first initial and the number of the day of your birth.

If you have forgotten your unique login ID contact:
Jeanette Wells Tel: 01633 623481 or email
jeanette.wells@gwent.wales.nhs.uk

21. BIOCHEMISTRY:

Reference ranges from RGH laboratory

FBC:

Hb: 11.5 – 16.5 (gm/dl)
RBD: 3.8 – 5.8 (10^12/l)
HCT: 0.36 – 0.47
MCV: 78 – 101 (fl)
MCH: 27 – 32 (pg)
WCC: 4 – 11 (10^9/l)

Neut: 2 – 7.5 (10^9/l)
Lymph: 1 – 4 (10^9/l)
Mono: 0.2 – 1 (10^9/l)
Eos: 0.0 – 0.5 (10^9/l)
Baso: 0.0 – 0.1 (10^9/l)
Platelets: 150 – 400 (10^9/l)

CRP: 0 – 10 (mg/l)

U & Es:

Sodium: 135 – 145 (mmol/l)
Potasssium: 3.4 – 5.0 (mmol/l)
Chloride: 98 – 107 (mmol/l)
Urea: 2.5 – 7 (mmol/l)
Creatinine: 50 – 100 (umol/l)

Serum Uric acid: 0.1 – 0.36 (mmol/l)

LFTs:

Total bilirubin: 1 – 22 (umol/l)
Alanine Transaminase: 0 - 45 (iu/l)
Alkaline Phosphotase: 30 – 115 (iu/l)
Total protein: 64 – 83 (g/l)
Albumin: 35 – 50 (g/l)
Globulin: 21 – 30 (g/l)

Coagulation Screen:

Prothrombin Time: 9 – 12 sec
APTT: 22 – 31 sec

Plasma Glucose:

Fasting: 3 – 6 (mmol/l)
Random: 3 – 7.7 (mmol/l)

Tumour markers:

Ca125: 0 – 40 (u/ml)
Ca19.9: 0 – 37 (u/ml)
Ca153: 0 – 22 (u/ml)
CEA: 0 – 5 (ug/l)
AFP: 0 – 8 (ku/l)

Thyroid function tests:

Free T4: 9.2 – 24.5 (pmol/l)
TSH: 0.2 – 4.5 (mu/l)

Others:

Serum folate: 3 – 20 (ug/l)
B12: 145 – 684 (ng/l)