Standards of service provision of Emergency Gynaecology and Early pregnancy service

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Guidelines Definition

Clinical guidelines are systemically developed statements that assist clinicians and patients in making decisions about appropriate treatments for specific conditions.

They allow deviation from a prescribed pathway according to the individual circumstances and where reasons can be clearly demonstrated and documented.

Minor Amendments

If a minor change is required to the document, which does not require a full review please identify the change below and update the version number.

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Introduction

Gynaecological emergencies can arise at any time of the day. The introduction of early pregnancy units (EPU) has led to an organised assessment of women with complications of early pregnancy, the most common cause of emergency assessment. Thus, most of these women are seen within working hours. However, some women have severe symptoms, which cannot wait until an EPU opens, and others have non-pregnancy related conditions. The emergency gynaecology and early pregnancy service should be consultant led, with decision-making made in a timely manner, and at a sufficiently senior level. The service should be women centred, safe, effective, evidence based and multidisciplinary

The delivery of a high-quality emergency gynaecology service requires:

- Leadership – a lead senior clinical leader
- Organisation – a good infrastructure including sufficient theatre capacity and manpower
- Practice and training – adequate numbers and supervision of junior staff
- Managerial and patient focus on emergency gynaecology services

Leadership:

- Each unit must have a named lead consultant who is responsible for the emergency gynaecological service.
- This responsibility includes clinical organisation, standards of practice, governance and directing the most effective use of resources in the emergency gynaecology service.
- This responsibility should be reflected by dedicated time in the named consultant's job plan based on the size of the unit and its volume of activity.
- The named consultant should work within a team, including a senior nurse or matron, Clinical director, Head of midwifery and nursing and the directorate manager. They must hold quarterly multidisciplinary risk management meetings
- Clinical reviews of difficult cases and root cause analyses of significant clinical incidents must take place regularly. The frequency of these meetings will depend upon the size and activity of the service but should be held at least monthly. These meetings should report through the departmental and Trust governance structures.

Women centred care

- There needs to be a focus on patient-centred care and despite the urgency of care, an attempt should be made for any plans to be made through shared decision making. This can be achieved through proper communication, involving women in decision making and ensuring the continuity of care
- Patients' views must be taken into account when developing emergency gynaecological services. Trusts have a variety of mechanisms for gathering patients' views about services and these should be used to assess emergency gynaecological services.
- Patient information leaflets should be available covering the common emergency gynaecological conditions.
- Good quality national leaflets are available, such as those produced by the RCOG.3 These should be supplemented by local information, such as where to find help (contact telephone numbers and so on), especially for those patients being managed in the outpatient setting

Continuity of care:

- Each woman should have a named consultant gynaecologist responsible for their overall care during their admission.
- For women who are already admitted into hospital under the care of another specialty, it should be clear to both the woman and the admitting specialty, when a transfer of care takes place and when this is just specialist input into her care. This should be documented in the hospital notes.

Communication

- Information should be displayed in waiting areas showing the patient pathway through the unit. Ideally information should be available as to waiting times and women updated about any likely delays to their care.
- Women attending an acute assessment or triage unit should be provided with verbal and written information about the purpose of the unit and what to expect during the initial episode.
- The need for interpreting services should be identified at the point of referral, and assessment should not be delayed by waiting for a face-to-face interpreter.
- However, in the case of emergency care, the use of family members may be acceptable if it allows more rapid assessment and treatment and the family member is in agreement.
- If a woman declines an interpreter, this should be documented in the notes. A telephone interpreter should be used to emphasise why an interpreter is needed and the implications for her subsequent care.

Confidentiality

- As in all areas of gynaecology, a woman's confidentiality should be respected with particular emphasis on not divulging information to family members without the woman's consent
- Care must be taken around confidentiality as in an unscheduled presentation the woman may be accompanied by people who are not close family or friends. The woman should be asked who she wishes to remain with her for the consultation and examination, and this should be documented in the notes.
- Examination should be with verbal consent, chaperoned and within a private area even outside of a dedicated gynaecology area. This may involve moving the woman into a side room or treatment room for the examination or, if not possible, at least ensuring that only clinical staff and other patients are in the immediate vicinity, and staff may need to ask visitors to leave the area temporarily.

Access to Early pregnancy services

- All women should be able to access their local Early Pregnancy Unit (EPU) within 24 hours of concern being raised.
- This may be telephone access or physical attendance. The optimal provision of an EPU service is one across seven days of the week. The provision of a weekend service may require the sharing of service provision between different EPU units on a rotational basis.
- There must be agreed pathways so that it is clear to GPs, emergency medicine staff and hospital switchboards how to refer women with early pregnancy problems.
- There must be adequate privacy provided within the assessment area.
- Where women are assessed with pain and bleeding in early pregnancy, this should be done in a setting which has immediate access to medical staff. This may be within the emergency department or the gynaecology ward or the gynaecology assessment unit that is appropriately staffed and resourced with reliable immediate access to a member from the gynaecology medical team.
- There should be adequate provision of toilet facilities.
- Within this assessment unit, the following should be available:
    - Point of care urine pregnancy tests and urinalysis.
    - Speculums and functional lighting.
    - Swabs for urogenital microbiology samples.
    - Vaginal packs.

- If unscheduled gynaecological patients are seen in an accident and emergency department without access to gynaecological services or admissions, then there must be policies in place to enable safe transfer to the gynaecological unit, rapid access ambulance service and direct communication to the admitting unit.

Point of care assessment

- Women should be triaged by a healthcare professional within 15 minutes of arrival in the unit in order to prioritise their care.
- The initial assessment must include a full set of physiological observations plotted on an early warning chart (e.g. NEWs).
- The frequency of subsequent observations will be determined by the initial score but, as a minimum for an unwell woman, this should be every four hours until a full assessment has taken place and a plan of care has been made. Any abnormal observations should be escalated to the appropriate healthcare professional according to local guidelines.
- Women should be told not to eat or drink (including chewing gum) until a full initial review has taken place. This is to ensure that where surgery is required, patient safety is increased by optimising the fasting time prior to anaesthesia.
- If women are bleeding heavily, or have evidence of respiratory or circulatory collapse, they must be admitted directly to the emergency department for resuscitation, assessment and triage. There should be a system in place to urgently contact the on-call gynaecology team for these women, e.g. emergency call system and a clear escalation plan, should they not be immediately available.
- Modified Early Warning Score charts and scores should be used to assess women presenting with early pregnancy complications. These charts enable an accurate assessment of the patients' current state and to trigger action in patients who are deteriorating before they reach a critical point.

Assessment by Gynaecology team

- Assessments are performed by the healthcare professional in either an examination room or an environment with screens designed to protect patients' privacy while being examined.

- There should be two employees present during the consultation and examination, at least one member of which must be female. Women must be given the option of inviting partners or other accompanying persons to join them during the examination, but these should not be used as chaperones. Chaperones should **always** be present regardless of the sex of the examiner.

- No person should enter the room during the examination apart from a senior employee who may be invited to check the ultrasound findings or discuss management options. The patient should be informed of this in advance.

- A concise history should be taken and the details must be entered in the medical records. The aim and the process of the examination, as well as likely findings, should be discussed with the patient. An explicit verbal consent should be obtained and documented in the medical records as given before any intimate examination is undertaken

- The on-call gynaecology consultant must be updated on all unscheduled referrals at a minimum of every 14 hours
- It must be clear to primary care, emergency department staff and hospital switchboards which member of the gynaecology team is available to accept referrals.
- All women should have a venous thromboembolism (VTE) risk assessment completed within 24 hours of admission and repeated every 48 hours. The assessment should include an assessment of the bleeding risks and take into account the potential need for urgent surgery.
- Trainees should have direct access to a consultant for advice, to review unwell women and for surgical interventions. The consultant should be informed of any decision to take a woman to theatre for emergency surgery.

- Women scoring four or more on their NEWS must be seen promptly by a member of the gynaecology team, with the competencies of ST3 or above and discussed with the consultant.
- If her condition deteriorates, the initial score is seven or more, or she fails to respond to treatment, then referral to the critical care outreach team and the consultant gynaecologist must attend the patient within one hour.
- Medical students may see women in the acute setting and assist in theatre but consent for examination should be sought
- The on-call gynaecology consultant must be made aware of referrals from other specialities and involved in the management plan.
- Women referred for specialist gynaecological opinion from other specialities should be seen and assessed by a second on-call gynaecologist as a minimum. Where the woman can be managed on an existing care pathway (e.g. early pregnancy) this should be followed. Following initial assessment, it should be agreed if care is to be transferred to the care of the gynaecology team or if the woman should continue under the care of her current healthcare professional. The woman should be informed of this decision and the plan documented in the medical records.

- A working diagnosis should be presented to the woman within 24 hours of admission. This should include whether or not she is likely to need a surgical procedure or other intervention. Where a diagnosis has not been reached then a plan of further investigation and/or referral should be made and shared with the woman within the same timeframe. This should be supplemented with written information wherever possible as for the elective patient pathway.

Handover

- There must be both a verbal and written handover of care whenever a woman is transferred between clinical areas.
- Handover should use a recognised tool such as the SBAR format. Ideally handover should be multi- professional and involve all the team.
- All women on an unscheduled pathway should be discussed at the handover.
- An electronic or paper record should be kept of all women having an episode of unscheduled care and discussed at each handover between shifts. This must include women under the care of the gynaecology team on outlying wards, women in high dependency and critical care beds, women under the care of other specialties requiring gynaecology input and women being managed as outpatients.
- All women should be included in the handover of care at each change of medical staff. This should include:
    - Women in the acute gynaecology unit.
    - Women awaiting admission to the unit.
    - Women under the care of the gynaecology team in other wards and clinical areas.
    - Women in other clinical areas who need or have already had a gynaecological opinion or review.
    - Women being managed as out- patients**.**
- The current location of the woman should be noted if they are not within the gynaecology unit and a daily review undertaken on all women under the care of gynaecology. Attempts should be made to re-locate gynaecology patients to a gynaecology ward as soon as possible in order that they can receive specialist nursing care as well as medical input.

Staffing level

Each department should appoint a lead consultant to take responsibility and leadership of the emergency gynaecology services, overseeing the early pregnancy unit, emergency gynaecology clinics/ ambulatory emergency gynaecology as well as provision of theatre time with adequate equipment and staffing.

- There must be sufficient staff allocated to see unscheduled care patients throughout a 24-hour period.
- Staffing will vary depending on the size and activity of the unit.
- As a minimum there should be a first on-call doctor or an advanced non-medical practitioner with a similar level of skill immediately available.
- A higher specialty doctor in gynaecology (ST3 or above) or equivalent and/or a consultant should be available, if required, within 30 minutes.
- The first on-call review may be by a doctor working in another surgical specialty through shared care and the hospital at night system. However, systems must be in place for the woman to be immediately discussed with a more senior gynaecologist (ST3 or above) or reviewed by them within an appropriate time frame which may be guided by the NEWs score and other clinical information.
- Similarly, there must be sufficient nursing and healthcare assistants to triage women as they are admitted, care for them and to chaperone and assist the medical staff.
- Doctors and advanced non-medical practitioners providing first on-call care should have direct access to a consultant at all times. In the majority of units, they will also have direct access to a doctor with the competencies of ST3 or above.
- Similarly, where nursing or support staff undertake advanced roles such as ultrasound examinations, they should have direct access to a senior gynaecologist (ST4 or above) should problems arise.
- During normal working hours, a core and a higher specialty doctor should be available for gynaecology supported by a consultant. Trainees working at the level of a core specialty doctor may be a trainee in another specialty training programme, e.g. general practice or in a foundation training programme. In smaller units this role may be shared between both obstetrics and gynaecology
- Out of hours, there should be a doctor, equivalent of a core specialty doctor, immediately available to review any unwell woman. In the smallest units this may involve sharing the role with other specialities, e.g. in 'the hospital at night'. Where this occurs there must be a clear escalation policy to call the higher specialty doctor or consultant to ensure that the patient is seen and assessed in a timely manner.
- ***All emergency admissions must be seen by a consultant gynaecologist within 14 hours***

Clinical Governance

Guidelines must be in place for the most common emergencies and updated on a regular basis

Clinical audit should be carried out according to a rolling programme set out by the speciality. Auditable standards include:

- Number of referrals received according to local protocols.
- Documented handover of care between specialties.
- Handover of care at each shift change.
- The information provided on need for and referral to a named service.
- The availability of additional information prior to the initial contact if required by provision of a contact number or other method of obtaining advice.
- Time waiting for first contact.
- The clinical environment including privacy for waiting.
- The information provided on initial contact
- Number of women triaged within 15 minutes of arrival.
- Number of women with recording of full NEWs score.
- Number of women seen within appropriate time frames by a consultant.
- Medical handover at each change of shift.
- Number of women reviewed by an experienced gynaecologist on a daily basis.
- Number of procedures carried out outside normal working hours.
- Number of women having a pre-operative assessment prior to unscheduled surgery.
- Number of women with a documented discussion of risks and benefits of treatment.
- The quality of consent for unscheduled treatment.
- Use of the safer surgery theatre checklist for unscheduled surgery.
- The number of women where the GP receives a discharge summary within 24 hours of discharge.
- The number of women discharged on the day planned and any reasons for a delay explored.
- The availability of discharge medications

In addition, a clinical incident report should be generated by:

- Unavailability of a suitably trained gynaecologist to undertake an operative procedure.
- Lack of available critical care bed when required.

A review of service provision should address patient satisfaction with:

- Waiting time to be seen and assessed.

- Waiting time for discharge from the Unit.
- Waiting environment.
- Confidence in the healthcare team providing initial care.
- The amount and quality of information provided.
- Contact details for additional advice and information after leaving the clinic.

In addition a clinical incident report should be generated for:

- Unavailability of a senior gynaecologist to review a woman with a raised NEWs score within an appropriate timeframe.

Organisation of services

- If the woman is admitted by a first on-call doctor or equivalent, the woman must be discussed with and ideally reviewed by a doctor with the competencies of an ST3 or above, prior to discharge. The higher specialty doctor or equivalent responsible for women on the unit should be aware of all women admitted and updated as to their condition at least at every handover of medical care. This is to avoid unnecessary admissions, avoid any delays in discharge and to ensure unwell women are reviewed by suitably experienced medical staff.
- Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.
- Laboratory and imaging diagnostic capabilities should be readily available as determined by the clinical condition.
- Availability of transabdominal and transvaginal ultrasound examination by appropriately trained and experienced healthcare personnel should be available within 24 hours of admission.
- Unscheduled admissions to gynaecology services should be reviewed by a suitably trained member of staff before discharge home

Education and training

- Where training in gynaecology is provided, there should be adequate opportunity for all levels of trainees to assess unscheduled admissions, discuss care with a senior gynaecologist, to complete workplace-based assessments and to undertake operative procedures under direct supervision at least during normal working hours.
- Trainees should have direct access to a named duty consultant at all times.

- For operating theatre, this access ranges from a consultant being physically present in the theatre or on the Unit to telephone access. If the duty consultant is not present in theatre, they must be readily available and on site. The degree of supervision is dependent on the individual trainee's competencies. Trainees must have been assessed as competent to manage the cases with no direct supervision or assistance (level 3) for the specific operations, to be left without a consultant present in theatre. Careful consideration should be given to the co-morbidities of the woman as this will affect the trainee's ability to perform the procedure safely.
- Trainees have to acquire certain skills early in their career, e.g. surgical completion of miscarriage. Senior trainees can appropriately directly supervise these procedures, with the knowledge of the duty consultant.

Plan of care

- All unscheduled admissions should have a plan of care documented as to the next stage of treatment.
- The aim of any initial management for unscheduled admissions should be stabilisation followed by any further investigations required to reach a working diagnosis.
- Subsequent management of gynaecological conditions may involve no treatment, a period of observation, medical treatment or surgical treatment. Surgical procedures may involve minor procedures under local anaesthesia (e.g. manual vacuum aspiration for miscarriage) as well as formal procedures under general anaesthetic.
- Wherever possible, non-operative options of management should be offered in order to reduce risks of surgery, hospital acquired infections, wait for theatre lists, longer recovery time. Where a patient has been fasting and a decision is made not to operate, the patient should be offered something to eat and drink.
- Women admitted and undergoing unscheduled surgery, should undergo an equivalent process to those admitted electively before anaesthesia is induced.
- Anaesthetic preoperative assessment should take place as early as possible for those women where surgery is a likely outcome.
- This will usually be by the duty anaesthetic team. Women should be optimally resuscitated before emergency surgery with early involvement of critical care services.
- Where surgery is planned it must be safe, timely, and necessary that the woman is fully informed of the procedure, risks and consequences. There should be shared decision-making where clinical condition and time constraints allow.

- When further active management is likely to be futile, senior clinicians should discuss limits to care, including end-of-life pathways both with the woman and/or relatives, and preferably with all relevant specialties. Clear documentation is essential, and limits to care including 'DNR' should be regularly reviewed.
- Decision to operate may have to be made on an urgent basis but whenever there is time, the woman must be given sufficient information to agree to proceed to surgery.
- The degree of urgency for treatment should not lessen the amount of information given to the woman about her care.
- The same standards for consent apply as for women undergoing scheduled treatment and the woman has the right to give or withhold consent to examination, investigation or treatment. If the woman is unable to give consent due to being incapacitated (e.g. unconscious), and requires emergency surgery to save her life, then a senior clinician should conduct the operation in her best interest. The reasons why treatment was necessary must be fully explained when the woman has recovered.
- It is good practice to keep her family informed but they cannot legally give consent for her.
- Girls under the age of 16 can give consent if they fulfil the Fraser competency requirements but should be encouraged to explain the surgery to their parents.
- Treatments for all gynaecological emergencies should be provided at the site of admission. Where care cannot be provided in the local unit, arrangements must be in place for the safe transfer of the woman to a unit providing that treatment.
- Where not provided, the woman should be re- directed at the point of initial referral or following initial assessment.
- Most unscheduled gynaecological surgical procedures can be performed during daytime hours.
- The gynaecologist who is going to perform the emergency surgery must see the woman before she is anaesthetised and familiarise themselves with the case and the consent if it has already been signed.
- The WHO surgical safety checklist must be completed in theatre for unscheduled procedures.
- The pre- and post-operative care arrangements must be appropriate to enable recognition of and adequate response to the acutely ill woman.

Environment

- Women admitted under the care of a gynaecologist should be in a female-only ward. There should be a private area available for intimate examinations as a minimum and ideally also for consultation. There should be ready access to toilets and bathroom

facilities dedicated to female patients. The woman should be orientated to the unit and told where to find the appropriate facilities.

- There must be appropriate equipment available to perform vaginal examinations and to obtain urogenital microbiology samples. There should be access to equipment for minor procedures such as MVAs and drainage of Bartholin's cysts and these services should be offered as day cases.
- Systems must be in place for the sensitive disposal of any pregnancy tissue obtained whether at examination, during surgery or presented by the woman herself. The woman must sign written consent for any histological examination of pregnancy tissue. She must be clearly informed verbally and in writing what the options are for disposal of the tissues and who to contact to make arrangements.
- There should be appropriate equipment available within each organisation to care for women with morbid obesity. This includes appropriate beds, trolleys, operating tables and equipment for women with morbid obesity.
- Clearly signed and appropriate blood storage facilities need to be in close proximity to the emergency operating theatre. There should be policies in place for the safe and rational use of blood and blood products and appropriate equipment immediately available for rapid transfusion.

Following unscheduled admission

- A clear discharge plan should be made and shared with all the relevant healthcare professionals and the woman herself.
- Whether or not the woman was admitted, there should be a clear discharge plan that makes clear the next stage of care, where and when it will be provided and who is responsible for ongoing care.
- The woman must be given a discharge summary to take home and a copy sent to her GP within 24 hours.
- The follow-up and discharge of women admitted through the unscheduled pathway is identical to that described within the scheduled pathway

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