Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Standards of service provision for scheduled Gynaecology surgery

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Target Audience:

People who need to know about this document in detail	(*For example:* Authors and owners of policies, procedures and written control documents)
People who need to have a broad understanding of this document	(*For example:* Board Members, Management Board. Senior Leaders. Board Committees.)
People who need to know that this document exists	(*For example:* All staff involved in the development of Health Board Policies.)

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date:**
	Outcome:
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Aligns to the following Wellbeing of Future Generation Act Objective	Choose an item.

Disclaimer:

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

COMPONENTS:

A policy must contain the following components and must also be written to include the values and behaviours of the organisation wherever relevant:

It is accepted that for Clinical Policies and or other Written Control Documents (Procedures, Guidance etc.) the policy components below may not all be relevant.

For guidance on Clinical Policy Development please contact:

CTM_ClinicalPolicies@wales.nhs.uk

For guidance on Non Clinical Policy Development please contact:

CTM_Corporate_Governance@wales.nhs.uk

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BACKGROUND

Purpose and scope

The aim of this guideline is to provide clinicians with up-to-date, evidence-based information regarding Standards of provision of service for scheduled Gynaecology surgery, with particular reference to optimising the woman's experience.

Roles and Responsibilities

In seeking further advice on any uncertainties contained in this document, or if you feel that there is new or more updated advice it is your responsibility to contact the guideline author or Approval Group manager so that any amendments can be made.

The guideline Approval Group is responsible for disseminating this guideline to all appropriate staff.

The guideline author or a named alternative is responsible for updating the guideline with any amendments that they become aware of or are highlighted to them.

All health professionals are responsible to ensure that the guideline is utilised effectively, and to ensure that they are competent and compassionate in the implementation of it.

Training Requirements

There is no mandatory training associated with this guideline.

Monitoring of Compliance

- The Governance Department will collate any complaints and distribute to the relevant individuals for comments, and share any learning points.
- The Service Lead will oversee any governance issues, make relevant recommendations to the directorate, and advise the Clinical Director or the directorate of any matters that require implementation.
- The Health Board reserves the right, without notice, to amend any monitoring requirements in order to meet any statutory obligations or the needs of the organisation

Complaints

All complaints should try to be resolved with the patient during any contact to avoid escalation. There concerns should be listened to and documented. If it is not possible to address any concerns at the time, or if the complaint is of a serious nature, the patient's complaint should be discussed with the consultant in charge for the day, or the patient should be given details of how to raise a formal complaint via the local governance department.

Introduction

- Delivery of a high quality and safe service for women at all times is imperative. All members of the multidisciplinary team must have the appropriate competencies to deliver high quality care.
- Appropriate consultant presence should maximise training opportunities, with a balance between direct and indirect supervision.
- Clear pathways for referral into the service and between services.

Patient centred care

- Women should be given information which should include options of other treatments, including the proposed operation, and the information they have received documented in the notes
- Women should be informed of the increasing number of decision aids available at NHS Choices to help them with their choices. They should also be informed of relevant patient societies that might help to support them with their condition.
- Where appropriate, women should be cautioned against websites or sources of information that contain significant bias.
- In some cases, women may have to alter their lifestyle (e.g. smoking cessation) or medication. This may include the changing of medication that affects coagulation or the stopping of hormone replacement therapy (HRT) preoperatively.
- Regimens will need to be discussed with the woman and GP and this may affect the timing of her surgery
- Information provided in gynaecology is likely to be of a sensitive nature. The woman should be informed that it is usual practice to record all relevant information (in paper or electronic notes) but she is invited to specify any details she wishes to not be shared in correspondence with the GP or with anyone else that may accompany her to the consultation. These must be clearly identified and marked in the notes.
- If the appointment generates a letter, women should be asked if they would like to receive a summary of the consultation. This could be either a copy of the letter sent to the GP or a separately constructed letter to the woman if the original is too technical or could cause harm or distress.
- The woman should have an option to opt out of receiving these letters if she desires
- All women (and relatives where relevant) should be fully informed about the planned procedure and be encouraged to be active participants in decisions about their care (collaborative decision making).

Intimate examination and Chaperone

Good medical practice sets out the principles, values, and standards of care and professional behaviour expected of all medical professionals

Healthcare professionals must approach intimate examinations with sensitivity, professionalism, and respect for patient dignity. When conducting such examinations, clinicians should:

1. Explain the Need for the Examination

- Clearly communicate the reason for the examination and what it will involve.
- Address and consider any communication barriers
- Provide the patient with an opportunity to ask questions or voice any concerns.
- Explain what the examination will involve in a way the patient can understand, so that they have a clear idea of what to expect, including any pain or discomfort
- Explain to the patient that they can ask at any time for the examination to stop

2. Obtain Explicit Consent

- Ensure the patient understands and agrees to proceed.
- Document the consent process appropriately, particularly if the patient declines a chaperone.

3. Offer a Chaperone

- Patients should be informed of their right to have a chaperone present, regardless of gender.
- The chaperone should be a trained healthcare professional who is familiar with the procedure and understands their role in providing reassurance and safeguarding both patient and clinician and able to stay for the whole examination and be able to see what you are doing, as much as practical without obstructing the examination or interfering with the patient's dignity. Chaperone should not be patients' relatives or friends
- A chaperone should usually be a health professional and their role is to be:
    - sensitive and respect the patient's dignity and confidentiality
    - alert to the patient showing signs of distress or discomfort
    - aware of the most appropriate route to raise concerns and do so if they are concerned about the medical professional's behaviour or actions
- A chaperone should also be given the chance to ask questions if anything about their role is not clear to them prior to the examination.
- If patient asks for relative or friend to be there during examination, we should comply with reasonable request
- You should not assume that the patient doesn't want a chaperone. If no suitable chaperone is available, or if either of you is uncomfortable with the choice of chaperone, you may offer to delay the examination to a later date when a suitable chaperone will be available, as long as the delay would not adversely affect the patient's health.
- <u>Patient declining chaperone</u>
    - Explain clearly why you want a chaperone present. If the patient wishes to proceed without a chaperone but you remain uncomfortable with this, you may wish to consider referring the patient to a colleague who would be willing to examine them without a chaperone, as long as the delay would not adversely affect the patient's health.
- Detail and outcome of any discussion about chaperones should be documented in the patient's medical record.

4. Respect Privacy and Dignity

- Conduct the examination in a private setting, ensuring appropriate draping to maintain dignity.
- Allow the patient time to undress and dress in private.

5. Maintain Professionalism

- Use clear, non-technical language to describe actions during the examination.
- Avoid unnecessary comments or actions that could be misinterpreted.
- Be alert to the patient showing signs of discomfort or distress
- Check whether the patient has questions, wants to stop the examination or agrees for the examination to continue and stop the examination if the patient asks you to

6. Document the Examination

- Record details of the examination, including the offer and presence of a chaperone.
- If the patient declines a chaperone, note this in their medical records.

7. Examination under anaesthesia

- Ensure that the patient has given consent to all aspects of the proposed examination, or that it is in the best interests of the patient if they are not able to give consent.
- You must not carry out, or supervise, an intimate examination on an anaesthetised patient for educational purposes, without checking that the patient has given consent in writing or as a signed entry in their records.
- Patient's privacy and dignity should be maintained even while under anaesthesia.

Shared waiting list

- The woman may have been allocated from a shared waiting list.
- The consultant must have the opportunity to review the notes prior to agreeing to do the procedure and, if not confident of the assessment, to either reject the allocation or arrange to see the woman in an outpatient clinic. This should happen before booking woman for surgery
- Consultant who operates becomes the responsible consultant for the woman's on-going care
- The named consultant for ongoing care must be clear to the woman and other members of the team.
- The consultant responsible for a theatre list should work with the booking coordinators to ensure that the composition of the list is appropriate in terms of timing, expertise and equipment availability

Women booked for surgery

- All women should be reviewed before being booked for surgery. During this visit, the proposed surgical plan, alternative options including no action should be discussed in details including the risks and benefits of each option
- All women should be provided with the appropriate up to date patients' information leaflets. Standard patients' information leaflets should be used across the health board. EIDO leaflets area available on the intranet page.
- Where EIDO leaflets do not cover the proposed management plan, each speciality should decide in their MDT meetings, the appropriate source for patients' information leaflets and that source should be standardised across the health board.
- The woman should be given a minimum of four weeks' notice for routine treatment or surgery unless she agrees to accept a date at short notice.
- A date for treatment or surgery may be decided during the clinic consultation. If the date is to be decided after the consultation, waiting times should be explained. Women should be given details of how to make contact to check arrangements, whether this is a phone number, a designated person or an email address.
- Women should be told that they have a right to delay or cancel appointments and/or the procedure should they wish.

When care is transferred between two hospital sites within the trust

- Virtual discussion with the woman informing her about the need to transfer, expected care and the follow up care.
- Written referral letter from responsible consultant to named consultant colleague in the other site outlining the details of the case, the management plan and the indications for transfer
- Where care is transferred between two lead health professionals the woman should be informed who her new lead professional will be and the reasons for the transfer of care.
- Women should be reviewed by consultant in the other site (Virtual or face to face) before the time of expected surgery to ensure good understanding of the nature of the operation, the benefits, risks and complications.
- Following the procedure and before discharge, woman should be counselled about the follow up care appointment and the expectation that the follow up will be in the site where operation was performed.

- If the woman will not be able to attend the follow up care, arrangement must be done to fulfil her requirements in regards to the follow up care
- In the event of the consultant in the other site is not in agreement with the proposed procedure after patient's review, multidisciplinary discussion should take place with the referring consultant and final decision in MDT approach should be delivered to the woman with the proper counselling and discussions about the change of plan of care
- Patient centred care as evidenced by involvement of women in all aspects of care
- Evidence of multidisciplinary care and team working such as multispecialty clinics and discussion forums, consultants working together in teams and also supporting each other in decision making for difficult or controversial cases, offering a second opinion where appropriate.

Preoperative assessment

- All women who are to have surgery should have a preoperative assessment.
- All women should attend a preoperative clinic. These services are usually nurse led. There should be
- The assessment should give time to optimise the woman's health for surgery and identify and correct modifiable risk factors
- Women with significant co-morbidities should be referred to an anaesthetist before booking for surgery for further assessment.
- The pre-operative assessment should identify women with specific problems such as diabetes, dementia (with risk of post-operative delirium) and poor nutritional status (with increased risk of morbidity) and hence allow appropriate planning including discharge arrangements.
- Healthy women having minor day-case surgery can undergo assessments over the telephone.
- As a result of the assessment, the appropriate level of post-operative care should be determined and booked in a day surgery facility, inpatient ward, high dependency unit or critical care unit, enabling both optimum care and efficient planning.

Consent

- Gaining consent for treatment is a legal requirement and dependent on good clinical practice based on agreed principles:
    - Partnership (working in partnership with patients)
    - Sharing information to support their decisions, and discussing treatment options
    - Discussing side effects, complications and other risks
    - Making decisions and respecting their decisions
    - Expressing consent
    - Recording decisions
    - Reviewing decisions
- Consent should usually be taken by the healthcare professional who recommends that the woman should undergo the intervention or by the person carrying out the procedure
- Consent may also be delegated to a healthcare professional who is suitably trained and qualified, is sufficiently familiar with the procedure and possesses the appropriate communication skills.
- The recent Montgomery ruling must be taken into account when consenting a woman
- The woman should have had sufficient time to consider the information prior to signing the form as the consent process will have started in clinic
- Where the care episode involves management of miscarriage or abortion, the woman's wishes regarding the sensitive disposal of tissue should be established and documented.
- Children under the age of 16 may sign their own consent form if deemed competent.
- <u>Documentation of consent process:</u>

- Thorough risks/benefits adding failed procedure to risks
- All aspects of the consent process and information completed well
- Full range of alternative treatment discussed
- Documentation to support inclusion of patient in decision making. Provision of supportive leaflet.
- Documentation to support engagement with patient in decision making process provision of supportive literature for patient alongside verbal discussions held
- Documenting available alternatives and providing information on procedure.

On Day of surgery

- Woman should be admitted to the appropriate ward, offered the appropriate welcome and offered support during the preoperative period
- The person carrying out the procedure should discuss the consent form again with the woman, answering any questions, prior to signing the form themselves.
- The consent form should be checked for the woman's signature and if she has not already done so, she should sign it on admission.
- If the woman signed the form prior to admission and changes are made to the form then she must resign it and date it. Once signed, the woman should be offered a copy of the consent form.
- If the woman agrees that a medical student may perform a vaginal examination on her under anaesthesia, then this should be written on the consent form before the woman signs it.
- Thromboprophylaxis risk assessment should be completed and documented
- Pregnancy test should be performed with informed consent for women in reproductive age according to hospital policy
- Need of antibiotics should be discussed with appropriate check and consideration of any allergy

In theatre

- Safer surgery checklist (e.g. WHO checklist) must be conducted for all women. This commences with all members of the theatre team introducing themselves at the start of the theatre list (briefing). If a new member of staff joins the list later, they must also be introduced.
- It is important that all staff know who each other are, understand their roles and all members of staff should be able to speak out during a theatre session.
- Sign in, time out and sign out must be conducted for each woman and the theatre team should spend time at the end of the list debriefing, including trainees in the process.
- Confirmation must be gained that the woman wishes to undergo the operation, she signs the consent form (if not already done) and the surgeon signs the confirmation of consent

Post-operative care

- The appropriate level of post-operative care should be determined and arranged for the woman, be this in a day surgery facility, inpatient ward, high dependency unit or critical care unit.
- Choices about care should be fully explained to the women, and their understanding, as well as their decisions, should be documented
- Women undergoing gynaecology operations or admissions may have complex needs. In order to meet these needs, women should be nursed in a specific gynaecology ward or area. Women should not be cared for in mixed sex units.
- Care should be taken when allocating women to beds in bays or open wards to do this with sensitivity. For example, do not place a woman for an abortion next to a woman with a miscarriage or infertility.
- There should be provision of side rooms for women who are undergoing mid or late pregnancy loss, or either medical termination or late miscarriage.

- The facilities for safe post-operative and general ward management must be available, including an ability to escalate care to High Dependency care (HDU) if necessary and have access to critical care outreach teams.
- If surgery has been performed away from the main gynaecological unit, then transfer arrangements must be clear.
- If surgery has been performed in unit where there is no medical cover over the weekend, transfer arrangement should be performed if the woman has to stay over the weekend with complex post-operative complications
- Women should be monitored as per local guidelines, including basic observations and fluid balance as her condition dictates.
- The gynaecology team looking after the wards must hand over information between shifts
- Handover sheets should be updated every shift and should include the current clinical condition of the inpatient cases and clear plan of management.
- On each nursing shift there should be at least one nurse who is specifically trained in gynaecology
- There should be a minimum of one trained member of staff for every eight in patients
- All women remaining in hospital should be seen at least once a day by the gynaecology ward medical team and regularly by a consultant gynaecologist. This should include a doctor with the appropriate competencies to understand the surgery that the woman has undergone.
- It is good practice for the woman's consultant to see her after the surgery and for there to be a consultant ward round on a daily basis to review all women.
- There must be a first on-call doctor available 24 hours a day and if not gynecologically trained, there must be a clear pathway of how that doctor seeks advice from a gynaecologist
- The doctors looking after the gynaecological ward must have adequate competencies to manage gynaecological emergencies and postoperative women and know who to ask for help from, with ready access to a consultant opinion
- Whilst an inpatient, observations should be made on a national early warning score (NEWS) chart.
- Frequency of observations should be specified on admission but will be a minimum of twice a day for any inpatient. Fluid balance charts should be maintained accurately where required, and the medical staff informed if the woman's condition deteriorates.
- Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI) and pathology.
- There must be regular communication between the medical and nursing staff on the ward, both to co-ordinate care on the ward and discharge planning.
- If ward cover is allocated to more junior members of the team, there must be a doctor allocated to do the rounds with them who has the appropriate competencies, for patient safety and education.
- A consultant should be part of the daily ward round to provide a senior clinical opinion and teaching. Hospital inpatients should be reviewed by an on-site consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the woman's care pathway.
- Following the treatment or surgery, one of the healthcare professionals involved in the procedure should see the woman and explain the findings and describe the procedures undertaken. She should be given written information about her condition, when possible. Interpreters should be arranged. The woman should be given information about expected length of stay and what will happen on each day. Care of drips, drains and catheters should be explained

Discharge planning

- All women must be informed about the investigations and treatment they have undergone, whether this was conservative, medical or surgical. All women should be informed about how they will receive the results of any pending investigations and the expected time frame.

- Following discharge from hospital, there should be an agreed shared clear plan regarding the next stage of care, where and when it will be provided and who is responsible for ongoing care.
- It should be clear who is responsible for arranging the next stage of care.
- Women must be fully informed before discharge from the unit. This involves details of:
    - What procedure, if any, has been carried out.
    - What treatment is planned.
    - Any discharge medication and how long it should be continued, including contraceptives, HRT and
    - thromboprophylaxis. It must be made clear whether the medication is to be continued by her GP and for how long
    - Where and when any follow up will occur.
    - Post treatment care instructions including if pregnancy needs to be avoided for certain time period and any
    - change in contraception
    - Warning symptoms and signs and when and how to seek urgent medical consultation if needed
- The GP must receive an electronic discharge summary within 24 hours of discharge or a paper copy be issued within 24 hours.
- Women should receive information about their recovery and a copy of their discharge summary before leaving the unit.
- Electronic discharge summaries should be commenced early during the woman's admission so that they can be completed in a timely manner and ready for the day of discharge. The summary should include the nature of treatment received, operative findings (if any), discharge medications and any follow up instructions
- There should be arrangements in place for speedy organisation of medications to take home and this should include some medications available on the ward for out-of-hours discharge. The woman should have her discharge medication fully explained and a check made of her understanding.

Organisation of service

- The consultant gynaecologist must ensure that he she has appropriate assistance before booking the woman for an operation
- When a consultant is not present in the theatre, the unit will have to cancel the theatre list if it cannot guarantee in advance, that a named trainee with appropriate competencies, matched to the women on the list, has appropriate supervision. These decisions should be taken at the time it is known a consultant will not be present to ensure that women are given appropriate notification of cancellation
- Gynaecologists who perform elective surgery should be able to demonstrate their competency at the procedures they perform. This will be by continuous personal audit of the number of different procedures and log of outcomes (when possible, as many women are now not seen for hospital review), any complications, readmissions, return to theatre and complaints. This information is required for consultant appraisal.
- Surgical complications must be reported
- Awareness of complication rates from therapeutic interventions for the unit as a whole which are shared with the service users, the medical teams and the managers.
- All cases of morbidity/mortality and unexpected outcome needs to be discussed in the senior MDT meetings with feedback to the ILG through the ILG governance structure
- Gynaecology lead is responsible for collecting all the information regarding the cases subjected to morbidity/mortality and unexpected complications and the learning outcome and share all the information with the senior team for further assessment and action

- Well-developed clinical governance structure in place in order to continually review and develop the services that they provide .This will incorporate clinical guidelines, clinical incident reporting, training and patient feedback.

Auditable standards

- Efficient use of available theatre time. Quality improvement projects should look towards achieving occupancy of at least 80%.
- Number of women who had a pregnancy test performed prior to procedure/ adherence to local guideline
- Number of women who had a thromboprophylaxis risk assessment performed prior to procedure/ adherence to local guideline
- The standard of written consent.
- Administration of antibiotic prophylaxis.
- Completion of all elements of safer surgery checklist
- Any return to theatre following complications of an operative procedure.
- All readmissions within 30 days of treatment.
- Number of women reviewed on a daily basis by the gynaecology team and/or the consultant.
- Recording of early warning scores at appropriate time intervals.

References

- Providing quality of care for women. Standards for Gynaecology care. RCOG November 2016
- GMC good medical practice guidance