

CTM WIDE ACUTE GYNAECOLOGY SOP

Document Type:	Clinical Guidelines
Ref:	(For Non-Clinical References – Contact: CTM_Corporate_Governance@wales.nhs.uk For Clinical References – Contact: CTM_ClinicalPolicies@wales.nhs.uk
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Approved By:	Health Board
Approval / Effective Date:	September 2026
Review Date:	September 2029
Version:	1

Target Audience:

People who need to know about this document in detail	All health care professionals working with Gynaecology Patients
People who need to have a broad understanding of this document	Womens health directorate team. Board Members, Management Board. Senior Leaders. Board Committees.)
People who need to know that this document exists	All staff involved in the development of Health Board Policies.

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date: 21/9/2026
Welsh Language Standard	Outcome:
	Yes - If Standard 82 applies you must ensure a Welsh version of this policy is maintained.
Date of approval by Equality Team:	21/9/2026
Aligns to the following Wellbeing of Future Generation Act Objective	Provide high quality, evidence based, and accessible care



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

Or visit the Policy Author Page on SharePoint:

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BACKGROUND

Guideline 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.

Scope

For all staff, medical and nursing, to provide uniformity in the Acute Gynaecological Care within Cwm Taf Morgannwg University Health Board.

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

- By audit and review of complaints relating to the Acute Gynaecology SOP
- 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.
- A comprehensive audit and evaluation of all referral pathways for Gynaecological services will be undertaken from day 1 of implementation.
- A local comprehensive audit of the GAU will be undertaken following the implementation of the unit.

Performance monitoring will be undertaken by national audits such as the RCOG national audits etc.

- Health Care Standards Framework
- Healthcare Inspectorate Wales HIW

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. Equality Impact Assessment Statement

This policy has been screened for relevance to Equality. No potential negative impact has been identified.

Royal Glamorgan Hospital

Introduction

The aim of this section is to:

- Give an overview of how gynaecological services will be provided at the Royal Glamorgan Hospital (RGH).
- Give an overview of the proposed service model for the Gynaecological Assessment Unit (GAU) with Early Pregnancy Unit (EPU) within the Gynaecology Hub at the RGH. It will detail how the unit will function and the expectations for users and support services of this facility.
- Give information on how care of gynaecological inpatients will be provided by advanced nurse practitioners (ANPs) out of hours.
- Highlight the key issues surrounding the emergency assessment and treatment of gynaecological emergencies in a GAU and the assessment and treatment of early pregnancy emergencies in the EPU.

Description of Service

Gynaecological services that are provided in RGH include:

- inpatient elective surgery
- outpatient gynaecology
- Gynaecology Hub (including GAU, EPU, Gynaecology Rapid access clinics, Postmenopausal bleeding on HRT clinics, Fertility, menopause, outpatient hysteroscopy and colposcopy services, EPU bereavement services, Urogynaecology clinics, Fast track clinics (in development), MVA services (in development) and Vulva services (in development)).

The GAU provides ambulatory care for gynaecology patients and women in early pregnancy.

Women will access this service via GP referral and or via the Emergency Department (ED) attendance and will be fast tracked to the GAU for immediate triage assessment, treatment and advice where required and clinically indicated.

Women who attend the GAU will be managed on an ambulatory basis; they may be discharged or followed up via this service. Any admission of patients from this unit will be transferred to the inpatient service at Prince Charles Hospital.

Proper and full handover should be arranged between RGH team and PCH gynaecology team at time of patient transfer to ensure continuity of care.

At all circumstances and as clinically safe, patient should be transferred to dedicated EPU/GDAU area and not ED.

The EPU will provide care for women in pregnancy up to 16/40 gestation. Women who are past this gestation will attend the Maternity Day Assessment Unit or Antenatal ward at PCH.

The Consultant/ Senior clinician ST5 and above or equivalent managing the GAU will also provide inpatient ward rounds for elective Gynaecology patients on the RGH site. Ward rounds will take place prior to commencing work in the GAU.

Out of Hours (OOH), the inpatients will be cared for by a Doctor or advanced Nurse practitioner. Proper handover should be carried out between the clinician covering GDAU and the out of hour resident doctor or ANP to ensure continuity of care.

No patients should be kept in RGH as inpatient over the weekend. With exceptional circumstances, any Gynae inpatients at RGH will require consultant led ward round over the weekend.

Gynaecology Assessment Unit/Early Pregnancy Unit

The GAU will be developed to allow for seamless ambulatory care for various Gynaecological emergencies. It will also have provision in the form of the EPU to ensure the care of women in early pregnancy.

Its aim is to provide a safe and sustainable quality service for women presenting with gynaecological and early pregnancy needs in RGH.

The unit will also support inpatient women who are under the care of other specialities but have a possible gynaecological condition or require review.

Referral Criteria to GAU/EPU/Gynaecology Hub

- Early pregnancy – PV loss / pelvic pain / hyperemesis (with day case rehydration and anti-emetics) / follow up HCGs / Follow up scans / previous recurrent miscarriage / previous molar pregnancy / previous tubal surgery.
- Initiation of home management of early miscarriage / possible MVA for early confirmed early miscarriage.
- Acute Pelvic pain – with facility for USS / swabs / medical assessment
- Emergency exacerbation of chronic conditions – prolapse (need for pessaries)
- Abnormal PV bleeding with subsequent anaemia
- Gynaecological review of the woman
- Gynaecological review following urgent request by other medical / surgical specialty.
- Post op reviews of wounds/ pain / bleeding.
- Gynae Rapid Access Service (GRAS) for PMB USC
- Postmenopausal bleeding on HRT clinics
- Menopause clinics
- Fertility clinics
- Fast Track clinics
- Urogynaecology clinics
- Hysteroscopy services
- Colposcopy services

- Vulva clinics

The unit will also have the required equipment to enable as much care and treatment to be provided without unnecessary transport to other areas of the hospital.

Referral process

Referral sources for the GAU/EPU will be:

- GP referrals – GPs will be able to refer directly to the Senior Clinician running the GAU by telephone.
- ED Referrals
- Gynae CNS referrals
- Midwifery referral for early pregnancy
- Ward referrals from other specialities or via Gynae
- Self-referral to EPU via telephone from 6 weeks pregnant with bleeding and/or pain
- Any bleeding in early pregnancy, if clinically appropriate. If under 6 weeks, please review with Senior Clinician
- Previous miscarriage
- Previous ectopic pregnancy

Staffing

Medical Staffing Model

Medical cover for the GAU between the hours of 9:00am and 17:00pm will be:

1 x Senior clinician ST5 and above or equivalent

1 x SHO

The Senior clinician is:

- Responsible for all inpatients and review of GAU/EPU day attenders. To undertake a ward round in the morning.
- To liaise with ED, GP, and GAU/EPU nurses to ensure timely and appropriate assessment of women attending this service.

Ultrasound Provision will be provided each day to cover both GAU and EPU scanning demand.

Operating hours

Monday to Friday 8:30am – 16:30pm closing

- Several 'hot clinic' appointments will be provided each day which will allow for Senior Clinician to bring women in urgently the next day, where appropriate, rather than require an admission.
- Service will be Senior Clinician delivered, supported by the nursing and radiology team.
- ANPs/SHOs will provide care for inpatient elective Gynaecology patients.

Roles and Responsibilities of RGH team covering GDAU and Inpatients

SHO

- Start time – 0830hrs.
- Carry bleep 6420 until 1700hrs.
- Ensure RGH fileshare handover is up to date in the morning.
- Perform ward round with senior of all patients.
- Ensure all medications are prescribed.
- Ensure VTE prophylaxis is prescribed if appropriate based upon VTE risk assessment document.
- Ensure all DALs are complete on
- Ensure any bloods are requested and results are acted upon.
- If covering the evening, use bleep 6018 and ensure ward round of all inpatients and above bloods chased, medications prescribed and DALs complete.
- To ensure by 20:30hrs, fileshare handover is up to date and handover to Nurse Practitioner covering night on bleep.
- If covering a Friday, ensure discharge planning is in place for women likely to be present over the weekend and ensure PCH team are made aware and consultant on call for Gynaecology is informed.

MIDDLE GRADE OR CONSULTANT

- Start time – 0830hrs.
- Carry bleep 6018 at all times until
- Ensure RGH fileshare handover is up to date in the morning.
- Perform ward round of all patients.
- Ensure all medications are prescribed.
- Ensure VTE prophylaxis is prescribed if appropriate based upon VTE risk assessment document.
- Ensure all DALs are complete on
- Ensure any bloods are requested and results are acted upon.
- If covering the evening, use bleep 6018 and ensure ward round of all inpatients and above bloods chased, medications prescribed and DALs complete.
- To ensure by 20:30hrs, fileshare handover is up to date and handover to Nurse Practitioner covering night on bleep.
- If covering a Friday, ensure discharge planning is in place for women likely to be present over the weekend and ensure PCH team are made aware and consultant on call for Gynaecology is informed.

Pathways for women presenting at ED.

Please see:

- Appendix 1 for the Management of women with bleeding and abdo pain <16 weeks
- Appendix 2 for the Management of nausea and vomiting in pregnancy.

During Working hours

- For onsite review by Gynaecology team or discharge back to Community pathway.
- If patient requires admission, to be transferred to PCH.

Out of Hours

Out of hours 5pm -9am weekdays, weekends and bank holidays advice can be sought from the on call gynaecology Registrar in PCH, if admission is deemed to be required the patient will be transferred to PCH.

If patients are deemed stable and no admission is required, they can be referred for GDAU/EPU via email:

RGH – CTT.GAUEPU@wales.nhs.uk

PCH – CTT.GAUEPU.PCH@wales.nhs.uk

or in cases of pregnancy, patients can be advised to self-refer to EPU by ringing:

- RGH: 01443 443230
- PCH: 01685 728894
- POW: 01656 754030

We provide non-resident Gynaecology on call Consultant for RGH and PCH.

Please see Appendix 3 for conditions that require Gynae referral.

Prince Charles Hospital

The purpose of this section is to provide an overview of the service model for women presenting to Prince Charles Hospital (PCH) with early pregnancy complications and gynaecology concerns (both emergency and semi-elective). The SOP sets out the clinical best practice standards in the delivery of care for women who are pregnant or have emergency gynaecology concerns and who attend PCH Emergency Department (ED), Early Pregnancy Unit (EPU), and Emergency Gynaecology Assessment Unit (EGAU) requiring medical attention. It also sets out the governance arrangements for the safe transfer of women from the ED to Gynaecology services.

Service Provision

Early pregnancy complications

- Pregnancy from up to 16 weeks – Per Vaginal loss/ pelvic pain / hyperemesis (with day case rehydration and anti-emetics will be in progress) / follow up pregnancy tests (HCGs) / Follow up scans / previous recurrent miscarriage / previous molar pregnancy / previous tubal surgery.
- Complications below 6 weeks needs review by Senior Clinician
- Initiation of home management of early miscarriage / possible Manual Vacuum Aspiration for confirmed early miscarriage (in progress).

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- Women who are past 16 weeks gestation will attend the maternity unit.

Gynaecology concerns

- Acute Pelvic pain – with facility for Ultrasound Scan/swabs /medical assessment.
- Emergency exacerbation of chronic conditions
- Prolapse (need for pessaries).
- Abnormal PV bleeding with subsequent anaemia.
- Gynaecological review
- Gynaecological review following urgent request by other medical / surgical specialty.
- Post op reviews of wounds/ pain / bleeding.

Emergency Gynaecology Assessment Unit (EGAU Ward 5)

The EGAU is an area within ward 5 that houses an assessment cubicle with scanning facilities, a ringfenced bay of 4 trolleys alongside a waiting room with 4 chairs.

This area is utilised to provide emergency early pregnancy and Gynaecology patients 24/7; and any patient that requires a medical follow up out of hours, weekends, and bank holidays (i.e. follow up BHCG LEVEL).

All women presenting with gynaecology concerns, attending ED, will be assessed to meet the criteria as defined above, in accordance with the agreed pathways.

All GP expected and accepted by the Gynaecology team and are clinically appropriate will go straight to Ward 5.

All GP referrals with a letter will go straight to Ward 5.

Ensure that Gynaecology Team, ED team, and Ward 5 work closely to establish clear lines of communication and to ensure safe and effective care for women with a gynaecological emergency.

The gynaecology team managing the EGAU will also provide inpatient ward rounds for elective gynaecology patients with ward rounds taking place prior to commencing work on the EGAU.

Patients requiring follow up BHCG LEVELS as these patients require timely follow up of their blood test which sometimes can be out of hours, weekends, or bank holiday. These patients if require further follow up during the working hours should be referred to the EPU using the email address:

RGH – CTT.GAUEPU@wales.nhs.uk

PCH – CTT.GAUEPU.PCH@wales.nhs.uk

Semi-elective Early Pregnancy and Gynae Assessment Unit (EPU)

The EPU, run by EPU nurses will provide a service for scheduled activities with the treatment room to be utilised for:

- Rapid hydration room for hyperemesis (in process).
- Prostag/ Zoladex.
- Pessary complications.
- Elective semi urgent Gynaecology complications.
- Ward catheter for Bartholin.
- Patients requiring urgent assessment (not emergency but cannot wait for clinic).

- MVA services (in development)
- Administration of Methotrexate

All pregnant women less than 16 weeks gestation, presenting with early pregnancy complications, received by the ED will be assessed to meet the criteria in accordance with agreed pathways. If clinically appropriate to be transferred to ward 5 for Gynaecology Assessment.

Once the patient has been assessed and a decision made re discharge versus admission. If clinically appropriate, patient can be referred for next available appointment in EPU or advise patient to self-refer by ringing the department during 8:30-16:30 on:

- **RGH: 01443 443230**
- **PCH: 01685 728894**
- **POW: 01656 754030**

Ensure that Gynaecology Team and ED work closely to establish clear lines of communication and to ensure safe and effective care for pregnant women.

The gynaecology team managing the EPU will also provide inpatient ward rounds for elective gynaecology patients with ward rounds taking place prior to commencing work on the EPU.

Operating Hours

- The EPU will operate Monday to Friday 8.30am-4.30pm (closed for admission/attendances at 3.45pm):
- Women requiring an overnight stay will be admitted to Ward 5
- If there are no beds available on Ward 5, the patient will need to access a trolley in EGAU on Ward 5 (4 trolleys to be ring fenced only for EGAU use).
- Out of hours 4.30pm-8.30am weekdays and 24/7 weekends and bank holidays, women presenting at ED will be able to access the EGAU on Ward 5.

Referral Process

The referral source for the EGAU/EPU will be:

- GP referrals – GPs will be able to refer directly by telephone to the Senior clinician ST4 and above or equivalent.
- Emergency Department
- Gynae CNS referrals.
- Midwifery referral for early pregnancy.
- Ward referrals from other specialities or via Gynae.
- Self-referral to EPU via telephone

In all circumstances where patient is clinically safe, they should be accepted and reviewed in a dedicated GDAU/EPU and not through emergency department.

Medical Staffing Model

On call consultant 24 hours; Resident 08:30 till 17:00 and non-resident Gynaecology on call consultant 17:00-20:30

- Responsible for all inpatients and reviews of EPU/EGAU day attenders.
- undertake a morning ward round and again at the end of the day.

- To review patients in ED when required.
- To liaise with ED, GP, and EPU/EGAU nurses to ensure timely and appropriate assessment of women attending this service.
- Perform/ assist emergency surgeries as required and clinically appropriate.
- Clinical assessment and management for all acute gynaecological services. The gynaecology history sheet should ideally be used in order to standardise assessment.
- The consultant will aim to review new admissions in line with RCOG standards (i.e. <14 hrs).

Admission process and clinical responsibilities

This will be referral by a clinician following triage assessment in the ED and meets the agreed criteria.

There will be referral to gynaecology registrar who will confirm suitability for the patient to be seen in the EPU/ EGAU. If transfer to the EGAU/EPU is not appropriate, the patient will be reviewed in ED within 45 minutes.

Accountability for the ongoing monitoring of the woman whilst awaiting attendance by the gynaecologist will sit with ED. Any deterioration or clinical concern must be escalated to the on call gynaecology team.

Escalation

If the patient deteriorates whilst awaiting gynaecology review, the ED team will escalate to the on call gynaecology team.

Princess of Wales Hospital

The acute/emergency gynaecology service aims to provide a clinical department to review women with acute gynaecological conditions, including pregnancy under 16-weeks' gestation, as an alternative to women being seen within the Emergency Department (ED). The on call gynaecology team will assess patients, there is one pathway for both the Early Pregnancy Unit (EPU) and Gynaecology Assessment Unit (GAU). Progress is being made in the development of EGAU based on surgical ward which will mirror the service provided by ward 5 PCH.

Women must be clinically stable (based on NEWS/MEWS/GCS, volume of blood loss, and other clinical variables) to be able to be moved out of ED, for onward referral within the ward areas of the hospital. Clinically unstable patients will be admitted via the ED, and the on call team should ideally attend within 15 minutes of the patient's referral from ED (or from any other clinician elsewhere in the hospital). This may vary during out-of-hours service due to the reduced staffing capacity at these times, where the obstetric service is managing both acute obstetrics and gynaecology referrals.

The service will provide support to patients:

- Following elective surgery.
- Following acute referral and/or admission.
- For early pregnancy complications.
- Who are under the care of other specialities, but have a possible gynaecological condition or require review?

Staffing

Emergency Gynaecology Service

- 1 x Consultant (covering obstetrics and gynaecology) – Call 56392
- 1 x Resident doctor (ST3-ST7)– Call 56179 1 x GMP/ Resident doctor (F2/GP/ST1 or equivalent) – Call 56428/56420

Early Pregnancy Service

The unit telephone number is on ext. 54030.

- 1 x Specialist EPU nurse daily
- 1 x HCA
- 1 x ward clerk

On Call Consultant 56392	Gynaecology Resident doctor (ST3-ST7 or equivalent)) 56179	Gynaecology Resident doctor (F2/GP/ST1 or equivalent) 56420	Obstetric Resident doctor (ST3-ST7 or equivalent)) 56279	Gynaecology Midwifery Practitioner GMP (SHO) 56428
Available 24 hours on-site from 0900-2000, Monday to Friday, and 0900-1130 Saturday to Sunday	Daytime on-site from 0900- 1700, Monday to Friday	Daytime on-site from 0800-1630 Monday to Sunday	Out of hours 5.00pm-9.00am Mon-Fri, and 24 hours daily at the weekend and on bank holidays	Overnight 8.30pm to 8.00am

The above reflect the handover times.

Responsibilities of the acute gynaecology doctors:

- clinical assessment and management for all acute gynaecological services. The gynaecology history sheet should ideally be used in order to standardise assessment 0900 and 1700 ward/board round.
- The consultant will aim to review new admissions in line with RCOG standards (i.e. <14 hrs).

Referral Process

Women will be able to access the service via:

- GP referral
- ED
- Cross referral from other hospital specialties
- Staff of the OBGYN department (nurse, midwives, doctors, managerial staff)
- Self-referral to the early pregnancy unit from 6 weeks with pain and bleeding. Patients under 6 weeks must be reviewed by senior clinician.
- Following recent attendance or admission where the patient has concerns that are unable to be addressed by their GP.

All new referrals should be referred to the emergency gynaecology Resident doctor (ST3-ST7 or equivalent)) during working hours (0900-1700hr, Monday to Friday). Outside of these times, referral

should be to the combined obstetrics and gynaecology Resident doctor (ST3-ST7 or equivalent)) on call. If the registrar is otherwise engaged, referral should be made to the Resident doctor (F2/GP/ST1 or equivalent) on call.

Referral Criteria

Whilst an exhaustive list of conditions suitable for management under the acute gynaecological service could be listed, it would seem more logical to accept any woman that is deemed to have an acute gynaecological problem should be referred for further assessment.

Patient Triage

While a referral may be taken by the GMP/Resident doctor (F2/GP/ST1 or equivalent), they should discuss all such referrals with at least a Resident doctor (ST3-ST7 or equivalent) prior to giving definitive advice, and before the woman is discharged from the service.

If suitable for delayed assessment, an appointment will be made for the patient to attend the emergency gynaecology service or early pregnancy unit on a set date/time. Ideally this should be the following day where services are available. Referrals can be made via email

CTM_POW_EPAU@wales.nhs.uk or advise patient to self-refer by calling:

- **POW: 01656 754030**
- **RGH: 01443 443230**

If a patient is not thought to be suitable for delayed assessment or review, and depending on clinical features/urgency, the patient will be seen in the:

- ED
- gynaecology clinical assessment room on EPU on a referral basis via CTM_POW_EPAU@wales.nhs.uk or ext. 754030 due to limited appointments.

Following clinical assessment, it will be decided if the woman is suitable for discharge or requires admission. If Admission is required, discussion should occur with the bed manager who will allocate an appropriate ward and bed.

Bed Manager 8am to 8pm – 56264 (daytime)

Bed Manager 8pm to 8am – 56215 (out-of-hours)

Obstetric Patients

Up to 16 weeks gestation is to be managed by the acute gynaecology service.

16+ weeks gestation is managed by obstetrics team via labour ward, the maternity day assessment unit, or out of hours by referral to the antenatal ward (ward 12) or the obstetrics and gynaecology registrar.

Escalation of Concerns

Where any person working within the service, or is referring to the service, believes that patient care may be compromised in any way, they have a duty to seek a second opinion from either the consultant on call, or their line manager. Serious issues should be escalated at consultant-to-consultant level or management-to-management level.

However, we would always suggest that gentle and reasoned communication with an explanation of why any concerns has arisen with the person involved is usually able to avoid escalation.

Where a member of the acute gynaecology service is unable to be contacted, the next most senior person should be contacted. Appendices

Appendix 1: Management of Women presenting to RGH ED

RGH Emergency Department Pathway Management of women presenting to RGH ED with PV Bleeding +/- abdominal pain and are <16 weeks' gestation



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BETWEEN 09:00-16:00 MONDAY TO FRIDAY

<13/40 GESTATION

1. If the patient is <13/40 gestation, stable and has no high risk features (see below), the patient can be discharged from ED with the advice that EPU will contact the patient to triage them over the phone.
2. ED then to contact EPU on 73230 and provide patient details including patient's phone number.

HIGH RISK FEATURES:

- News >2 or clinically shocked
 - Severe bleeding (e.g. changing pads > once per hour, flooding, or clots)
 - Severe or worsening pain
 - Shoulder tip pain or pain localising to either iliac fossa
 - Presyncope or collapse
3. Patients being sent home from ED need to be given the EPU direct line (01443 443230) and appropriate safety net advice including that if any deterioration they should attend PCH or POW.
 4. Safety net advice should also include making patient aware of high risk features and ensure this has been documented in notes.

13-16/40 GESTATION

1. If patient is 13-16/40 gestation or has any high risk features, contact EPU to discuss with on-call O&G doctor on 6018. Other contact numbers in GAU include 6420 and 73230.
2. Patients being sent home from ED need to be given the EPU direct line (01443 443230) and appropriate safety net advice including that if any deterioration they should attend PCH or POW.
3. Safety net advice should also include making patient aware of high risk features and ensure this has been documented in notes.



NB: PLEASE DO NOT INFORM PATIENTS THEY WILL HAVE A US SCAN IN EPU AS THIS IS NOT ALWAYS NECESSARY AND CREATES EXPECTATIONS

OUT OF HOURS

High risk features:

- News >2 or clinically shocked
- Severe bleeding (e.g. changing pads > once per hour, flooding or clots)
- Severe or worsening pain
- Shoulder tip pain or pain localising to either iliac fossa
- Presyncope or collapse

Is the patient is <13/40 gestation with NO high risk features present?

(all patients >13/40 gestation should be discussed with on-call O&G at PCH even if stable and no high-risk features)

Yes

No

Stable, well patients suitable for discharge from ED can have next working day follow up with O&G. (Obstetric advice available via Prince Charles Hospital (PCH) bleep 601 if needed)

Complete and email RGH ED referral form to GAU designated e-mail address with patient demographics including telephone number and reason for referral.
ctt.gaupeu@wales.nhs.uk
(CC Heidi.Marshall@wales.nhs.uk)

Ensure appropriate safety net advice has been given. This must include informing them that if there is any deterioration they should attend PCH or PoW as well as making them aware of high risk features. Ensure this has been documented in the notes.
NB please do not inform patients they will have a US scan in EPU as this is not always necessary and creates expectations

Inform patient they will be contacted by phone the following working day with an appointment time and give patient the EPU direct line (01443 443230) in case they do not hear from EPU

Contact O&G middle grade via Prince Charles Hospital (PCH) on bleep 601. (NB O&G Consultant on-call can be contacted to attend RGH if patient is too unwell to transfer to PCH)

Once need for transfer agreed inform nurse in charge (NIC) who will inform bed manager

Document conversation with O&G doctor in ED notes
Perform risk assessment as to whether patient can transfer by own transport or WAST (see RGH inter-hospital transfer risk assessment & documentation form)

Own Transport

ED notes to be photocopied and give a copy to the patient.
Patient to be given instructions on where to attend in PCH

WAST Transport

Arrange WAST transfer. ED notes to be photocopied and give a copy to the patient/WAST.



Appendix 2: Management of Nausea and Vomiting of Pregnancy

RGH Emergency Department Pathway
Management of Nausea and Vomiting of Pregnancy (NVP)/ Hyperemesis Gravidarum (HG)

Vc. Management of Nausea and Vomiting of Pregnancy (NVP)/ Hyperemesis Gravidarum (HG) in the Emergency Department

Initial assessment

Confirm diagnosis:

NVP:

- Onset of nausea and/or vomiting in early pregnancy with no other cause is identified

HG:

- Nausea and vomiting (one of which is severe)
- Onset <16 weeks' gestation
- Inability to eat and drink normally
- Symptoms limit daily activity

Consider other causes in those with:

- Abdominal pain
- Urinary symptoms
- Infective symptoms
- Possible drug cause
- Chronic H. pylori infection

Examination:

Observations:

- Temperature
- Heart rate
- Blood pressure
- Respiratory rate

Physical examination:

- Signs of dehydration
- Signs of malnutrition
- Abdominal examination
- Neurological signs

Investigations:

- Urine dipstick +/- MSU
- Urea and electrolytes
- Full blood count
- Blood glucose to assess for diabetes
- Amylase to assess for pancreatitis
- VBG to assess cause to exclude metabolic disturbance

Assess mental health status: ☐ if concerns refer to mental health services

Severity assessment using PUQE-24 scoring system and management

Document: PUQE score

In the last 24 hours:

	Not at all [1]	≤1hr [2]	2-3hrs [3]	4-6hrs [4]	>6hrs [5]
How long have you felt nauseated or sick to your stomach for?					
How many times have you vomited?	0x [1]	1-2x [2]	3-4x [3]	5-6x [4]	≥7x [5]
How many times have you had retching or dry heaves?	0x [1]	1-2x [2]	3-4x [3]	5-6x [4]	≥7x [5]

Management

Both:

- PUQE score 3-12 and
- No red flags

Discharge to community

- Start or up titrate antiemetic therapy and reassess ongoing safety
- Encourage oral hydration
- Offer dietary advice eat little and often to prevent an empty stomach
- Provide contact number for early pregnancy unit
- Referral to perinatal mental health services where required

Either:

- PUQE score ≥ 13 with no complications
- Inability to tolerate oral intake
- Community measures failed

Send to ambulatory unit if available or treat in emergency department

- Prescribe antiemetics IM or IV
- Prescribe IV fluids:
 - 0.9% saline + 20mmol Kcl over 2 hours
- Thiamine supplementation either:
 - Thiamine 300mg TDS PO
 - Phabrinex® 1+1 (vial of each) IV

Reassess

Any red flags:

- Any PUQE score + complications
- Inability to tolerate oral intake
- Unresponsive to outpatient management
- Clinical dehydration
- Weight loss >5% body weight
- Confirmed or suspected co-morbidity e.g. UTI or diabetes mellitus
- Co-morbidity and unable to take medications e.g. epilepsy, HIV, hepatobiliary or psychiatric disorders

Refer for inpatient management

For all patients consider:

- Histamine type-2 receptor blockers or proton pump inhibitors if women develop GORD (ask in pregnancy)
- Thiamine supplementation in those with severely reduced dietary intake to prevent Wernicke's encephalopathy
- Laxatives if required for constipation
- VTE risk assessment (see RCGO risk assessment tool)

Antiemetic therapy

1st line

Doxylamine and pyridoxine 20/20mg PO at night, increase to additional 10/10 mg in morning and 10/10 mg at lunchtime if required

Cyclizine 50 mg PO, IM or IV 8 hourly

Prochlorperazine 5-10 mg 4-8 hourly PO (or 3 mg buccal); 12.5 mg 8 hourly IM/IV; 25 mg PR daily

Promethazine 12.5-25 mg 4-8 hourly PO, IM or IV

Chlorpromazine 10-25 mg 4-6 hourly PO, IM or IV

2nd line

Metoclopramide 5-10 mg 8 hourly PO, IV/IM/SC

Damperidone 10 mg 8 hourly PO; 30 mg 12 hourly PR

Ondansetron 4 mg 8 hourly or 8 mg 12 hourly PO; 8 mg over 15 minutes 12 hourly IV; 16mg daily PR

Thiamine 300mg TDS PO

3rd line

Prednisolone 40-50 mg daily PO, with the dose gradually tapered until lowest maintenance dose that controls the symptoms is reached

Up titration of antiemetics:

- Initially select a 1st line antiemetic
- Use combinations of drugs in women who do not respond to a single antiemetic
- When up titrating add drugs as opposed to replacing them as different classes of drugs may have synergistic effects and some women will require a combination of 3+ antiemetics to control symptoms

Management of Nausea and Vomiting of Pregnancy (NVP)/ Hyperemesis Gravidarum (HG)

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Publish Date: 01/11/2024

Version: 2.0

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Appendix 3: Conditions requiring referral to Gynaecology from ED

Conditions requiring referral	Conditions where referrals are not required.
• Pelvic pain with Suspected PID not responding to oral antibiotics. • Suspected Ovarian Cyst accident • Bartholin's/Labial Abscess (not chronic cyst) • Menorrhagia/PV bleeding where patient is unstable. • Genital Tract trauma • Confirmed irretrievable foreign body in Vagina. • Post operative problems (within 28days) such as: ○ Wound infection ○ Wound dehiscence ○ Bleeding • Prolapse with Urinary retention/extreme pain. • Pessary problems with urinary retention/severe pain • Inability to pass urine due to gynaecological problems. • Prolapse • Severe Genital Herpes Simplex virus	Chronic abdo pain/pelvic pain • Post Menopausal bleeding • Heavy Menstrual bleeding where patient is stable. • Missing coil threads unless uterine perforation • Non-infected Bartholin's cyst • Endometriosis • Routine Pessaries • Urinary Tract infections • Pregnant with pain/bleeding in clinically stable and well patients. If known to gynaecology, request FU within 6 weeks. If not known to Gynaecology, refer patient back to Community Health Pathway.



WAST Pathway

CWM TAF MORGANNWG OBSTETRICS AND GYNAECOLOGY REFERRAL CRITERIA

This document is to provide guidance for Ambulance Paramedics to identify eligible patients for referral to Obstetrics and Gynaecology services within the Cwm Taf Morgannwg Health Board area.

ANY FEMALE MEETING THE INCLUSION CRITERIA FOR **OBSTETRIC AND GYNAECOLOGY** CONCERNS SHOULD BE TAKEN DIRECTLY TO EITHER THE **PRINCE CHARLES OR PRINCESS OF WALES HOSPITALS** AND NOT TAKEN TO THE ROYAL GLAMORGAN HOSPITAL AS THERE IS NO ON SITE MEDICAL OBSTETRIC AND GYNAECOLOGY COVER

INCLUSION CRITERIA

Positive pregnancy test **OR** high suspicion of pregnancy **WITH** PV bleeding and/or abdominal pain

Suspected ectopic pregnancy – symptoms include.

- *Acute abdominal/pelvic pain/shoulder tip pain*
- *Gastrointestinal or unusual bowel symptoms, including diarrhoea, vomiting.*
- *Dizziness or unexplained fainting*

At scene crew to determine:

- Last menstrual period (LMP)
- A recent positive pregnancy test (ask patient)
- Gestation less than 16/40
- Baseline observations

This section should be read in conjunction with the relevant JRCALC guidance.

Symptoms of haemodynamic compromise

- Systolic blood pressure <100mmHg
- Heart rate > 100bpm, CRT > 2 seconds
- Severe abdominal pain
- Active bleeding with estimated blood loss > 500mls
- Any other clinical concern

Bleeding:

- Size of clot >3cm (golf ball)
- Fully soaked pad >1
- Soaked through clothing

Pain:

- LIF/RIF pain scoring >7/10
- Shoulder tip pain
- Dizziness
- Self-administered analgesia has been ineffective



IF YES TO ANY

TRANSFER TO NEAREST ED: PCH OR POWH

- Decision for urgent transfer to nearest ED with on-call gynaecology service
- Secure IV access
- Pre Alert ED who will notify Obs/Gynae SpR

PCH Contact:

- **O&G SpR Bleep 991**
- **OOH SpR Bleep 601**
- **O&G SHO Bleep 584 (985 1-9pm)**
- **OOH SHO Bleep 620**

POW Contact:

- **O&G SpR 56179**
- **OOH SpR 56279 after 5pm**
- **O&G SHO 56420**
- **OOH SHO 56428**

IF NO TO ALL

If patient is stable and does not require immediate care:

- Advise patient to contact GP or provide information for patients to **self-refer** to nearest EPAU/ GDAU (Monday-Friday 9am-4pm):
 - **RGH: 01443 443230**
 - **PCH: 01685 728894**
 - **POW: 01656 754030**
- Provide worsening advice for increased PV bleed or abdominal pain.
- Provide Recall advice.
- Leave an after the Paramedic has left leaflet with patient

Clinical Appropriateness

This locally agreed referral criteria provide a guide to enhance on scene clinical decision making. The guidance should be followed in conjunction with JRCALC guidance along with a dynamic patient assessment to determine if the patient presents with any life threatening issues. A timely Pre Alert should be provided to the receiving unit who will notify the on-call Gynae SpR prior to patient's arrival.

Clinical Advice

If you require clinical advice or guidance to support, you on scene clinical decision making please either contact the APP desk/ Clinical desk or Senior Clinical on call

