Brighton and Sussex University Hospitals NHS Trust

Urogynaecology Specialist Nurse-led Clinics

Gynaecology Protocol: GP020

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Key Principles

A protocol is a set of measurable, objective standards to determine a course of action.
Professional judgement may be used in the application of a protocol.

Scope

This guideline applies to:

- The setup and actual carrying out of Urogynaecology Specialist Nurse-led Clinics
- Consent, confidentiality, documentation and communication in relation to telephone follow up clinics
- Audit, research, team working, support, training and care quality

Responsibilities

Urogynaecology Specialist Nurse and Urogynaecologisys:

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

Managers:

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

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1 Objective standards / Introduction

1.1 Nurse-led clinics have been introduced to improve the efficiency and quality of patient care. They enable high quality patient care through training, set up and team working and expand capacity through the input of experienced specialised nursing input. The role of the Urogynaecology Specialist Nurse is an essential requirement for Urogynaecology Unit Certification by the British Society of Urogynaecology, in recognition of the central importance of this role in good organisation and delivery of patient care. There are several successful examples of such roles in leading units in the United Kingdom. Brighton and Sussex University Hospitals NHS Trust adopts this practice to improve its Urogynaecology Services to gain Urogynaecology Unit Certification.

1.2 The underlying principle of Urogynaecology Specialist Nurse-led Clinics is safe and effective patient care, through training, support and audit, which will also increase capacity and enhance efficiency to meet current realities in the National Health Service. Team working is paramount so that patient care is not duplicated and proper standards are fulfilled. This will ensure that training and support are provided and care quality is improved. The role is evolving nationally and its introduction locally is in the development stage, which will progress with time.

1.3 With the change of practice, there is always the need for audit to ensure good standards and fulfilled objectives. There is also an opportunity for research to assess the impact of the change as well as the factors that can help improving it further.

1.4 The following clinics are to be provided as Urogynaecology Specialist Nurse-led Clinics:

- Urinary Incontinence Triage Clinic
- Free flowmetry and Residual Volume Clinic
- Telephone Continence Follow Up Clinic
- Pessary Replacement Clinic
- Post-operative Follow Up Clinic
- Trial Without Catheter (TWOC) Clinic
- Posterior Tibial Nerve Stimulation (PTNS) Clinic
- Intra-vesical Instillation Clinic

1.5 It is important to ensure that the patient is happy with this arrangement. If patients were to insist on being seen in person, rather

than having a Telephone Follow Up Consultation, or being seen by medical staff member, this should be organised.

2 Urinary Incontinence Triage Clinic:

2.1 Ideally, the Urinary Incontinence Triage Clinic runs in conjunction with primary care colleagues, along the pathway outlined in Nice Guidelines on Urinary Incontinence in Women.

2.2 Patients with one or more of the following features should be seen in the Urogynaecology Clinic, rather than the Urogynaecology Specialist Nurse-led Urinary Incontinence Clinic:

- Voiding dysfunction, suspected retention of urine
- Previous urinary continence procedure
- Neurological problems
- Pelvic Organ Prolapse
- Painful bladder syndrome
- Urinary Tract Infection

2.3 Patients with stress incontinence of urine and/or overactive bladder are ideally seen in the Urogynaecology Specialist Nurse-led Urinary Incontinence Triage Clinic, where history can be obtained, examination carried out and documented in the Urogynaecology Assessment Sheet and Frequency Volume Charts and Quality of Life Questionnaire Completed.

2.4 Patients should be counselled about their conditions and provided with relevant Patient Information Leaflets. These leaflets are available online at www.bsuh.nhs.uk/bsugs It is hoped that this website address will be included in future clinic letters and Primary Care Colleagues would be made aware of this website, so that they can direct patients to these leaflets prior to attendance at the clinic. This will depend on establishing a section for General Practitioners on the Trust external website.

2.5 Patients can be offered conservative measures including Fluid advice, smoking cessation, Specialist Female Pelvic Floor Physiotherapist-supervised Pelvic Floor Muscle Training (PFMT) and bladder drill.

2.6 Patients can be offered to attend the Female Pelvic Floor Support Group meetings, which will hopefully be established in the not too distant future.

2.7 The patient's General Practitioner can be asked to prescribe local oestrogen (pessary or cream), anti-muscarinics and/or beta-3 receptor agonist treatment, as appropriate.

2.8 The patient's General Practitioner can be asked to review the patient if she does not get adequate improvement and/or suffers from side effects on such treatment and adjust dosage and/or change treatment as required. The combined Formulary includes guidance on how to proceed with treatment, in line with Nice Guidelines on Urinary Incontinence in Women.

3 Free Flowmetry and Residual Volume Clinic

3.1 Occasionally, some patients may require free flowmetry and/or residual urine volume estimation, rather than full urodynamic assessment. These can be done by the Urogynaecology Specialist Nurse. Residual urine volume is usually estimated using portable bladder ultrasound scanner to measure the post-void bladder volume. In exceptional circumstances, it may be necessary to pass an in/out urinary catheter, following aseptic technique and with patient consent.

3.2 The free flowmetry and bladder scan generate a print out that should be kept in the notes, with the patient details and date printed on it.

3.3 In most circumstances, such tests are carried out as confirmation of normal or ruling out of abnormality, when patients can be re-assured and discharged, according to their clinical features. Occasionally, patients may need to be reviewed by a medical practitioner, for example upon the detection of high residual urine volume.

4 Telephone Urinary Incontinence Follow Up Clinic

4.1 Patients on conservative measures for stress incontinence of urine and/or overactive bladder can be followed on the phone, saving them the need to attend in person, which can be inconvenient.

4.2 Ideally, this option should be explored with patients during their first consultation, either in the Urogynaecology Clinic or the Triage Clinic. It might be better to document this in the notes and obtain the patient consent for it.

4.3 The time interval at which patients can be followed up varies from patient to patient and this applies to telephone follow up just as it applies to telephone follow up. It is customary to offer follow up at 6 months, so as to ensure that patients had a chance to get to see the

Physiotherapist and allow enough time for Pelvic Floor Muscle Training and bladder drill to achieve maximum benefit and also allow time to try medication with dose adjustment and/or change of medication before proceeding to invasive tests, such as Urodynamic Assessment and/or Cystoscopy.

4.4 Telephone follow up consultations should be booked as a clinic slot, with agreed time slot, to be booked at the end of the first consultation, as for a standard follow up appointment.

4.5 Telephone follow up consultations should be carried out by the Urogynaecology Specialist Nurse whilst alone in an office, to ensure patient confidentiality.

4.6 Telephone follow up consultations should be carried out with the patient notes available, to ensure that information about the patient condition as well as previous care are available and documentation can be made during the consultation in the notes.

4.7 Patient identity should be verified at the start of the telephone follow up consultation, for example by checking the date of birth, address and hospital number or name and address of General Practice.

4.8 Patient consent should be obtained / checked after that, and documented in the notes.

4.9 The actual conservative measures tried should be verified and documented in the notes. This includes first visit as well as subsequent visits to the Specialist Female Pelvic Floor Physiotherapist, doing Pelvic Floor Muscle Training and Bladder Drill, use, effect, or lack of it, and side effect(s) of medication(s) used, dose and dose modification(s) and change of medication.

4.10 Patients who had improvement in their symptoms and quality of life and are satisfied with the outcome can be discharged back to their General Practitioner. They should be advised to continue with the conservative measures and contact their General Practitioner, if they have any problems. They should be made aware that re-referral can be arranged, if and when required.

4.11 Patients who suffer from problems, gain inadequate relief of their symptoms and/or are unhappy with the outcome should be booked to be reviewed in the Urogynaecology Clinic or booked for Urodynamic Assessment, as appropriate.

4.12 The follow up sheet (Appendix A) should be used for the telephone consultation and a letter should be dictated to be posted to the General Practitioner, with a copy to the patient.

5 Pessary Replacement Clinic

5.1 Whenever possible, pessary replacements should be carried out in General Practice, so as to save patients the need to attend in clinic. Shelf and Gellhorn pessaries might be more difficult for General Practitioners to change and might therefore be booked for pessary replacement in clinic.

5.2 Ring, shelf and Gellhorn pessary replacements can be carried out in the Urogynaecology Specialist Nurse-led Clinic.

5.3 Patient symptoms and her satisfaction with and intention to continue with pessary treatment should be checked and documented.

5.4 The pessary is them removed and the vagina checked for any ulceration, using Cusco's speculum. In the presence of vaginal ulceration, the pessaries should not be replaced. Patients should be counselled about the nature of such ulceration and local oestrogen cream prescribed for use to help healing of the ulcer(s). Patients should be offered another appointment in 2-4 weeks, to allow time for healing of the vagina, when speculum examination should be repeated to check for this healing. If healing is complete, then a new pessary can be inserted. If not, then a new pessary should not be inserted and another appointment should be offered in 2-4 weeks. An additional local oestrogen prescription should be provided, if required. Patients with slow healing, suspicisous and/or recurrent ulceration should be seen in the Urogynaecology Clinic to check the reason and rule out the remote possibility of fistula and/or malignancy.

5.5 It may become necessary to increase or decrease the size of the pessary or change its type as time passes. Patients should counselled about this and their consent to the change should be obtained and documented.

5.6 The follow up duration after pessary replacement varies from patient to patient. It is customary to offer the replacement at 6 monthly intervals.

5.7 The pessary replacement sheet (Appendix B) should be used for documentation.

6 Post-operative Follow Up Clinic

6.1 Post-operative follow up is vital to audit the safety and effectiveness of surgery. This should be documented on the national database for Urogynaecological surgery (www.bsug.net).

6.2 Post-operative follow up is usually carried out at 8 weeks after surgery for stress urinary incontinence and 12 weeks after surgery for pelvic organ prolapse. Patients can be seen earlier if there are any problems. Such patients with problems may be better seen in the Urogynaecology Clinic.

6.3 Patients should be provided with the quality of life questionnaires on the day of surgery to bring back with then for follow up. If these questionnaires were not provided or were not completed and brought with the patient, they should be provided for completion before the patient is seen.

6.4 The patient consent to have her data added to the national database for Urogynecological Surgery (www.bsug.net) should have been obtained with her consent for surgery. If this was not carried out, then it should be obtained at the follow up consultation.

6.5 The post-operative follow up sheet (Appendix C) should be used to complete the patient symptom check and quality of life evaluation, as well as examination, as to be filled on the national database for Urogynecological Surgery (www.bsug.net). Examination includes checking for mesh complications, where mesh was used, including exposure, infection and/or tenderness. Such complications should be rated according to the International Urogynecological Association classification. The examination also includes grading of pelvic organ prolapse on the Pelvic Organ Prolapse-Quantification (POP-Q) system.

6.6 If there is any problem, then advice should be obtained from a medical practitioner or arrangement should be made for the patient to be seen in the Urogynaecology Clinic as soon as possible.

7 Trial Without Catheter (TWOC) Clinic

7.1 Patients who fail their Trial Without Catheter (TWOC) following surgery are discharged home with a catheter to come back for a fresh attempt after a varied duration between few days to a week).

7.2 Attendance at the Trial Without Catheter (TWOC) Clinic is better than attendance on the ward, where busy nursing staff may not be able to attend to patients as required and the busy ward environment may not offer patients the appropriate privacy and comfort.

7.3 Patients who attend for Trial Without Catheter (TWOC), they should have their catheter removed and they are encouraged to drink and mobilise normally. They should use the disposable measuring pot to measure the volume voided and provide to the Specialist Nurse as soon as they void, so that a Post-void Bladder Volume can be estimated using portable bladder scan.

7.4 Patients who pass more than 100ml with <100ml Post-void Bladder Volume can be discharged. Otherwise, management should be individualised. Patients with reducing Post-void Bladder Volume can try again. Those keen on another period of catheterisation can have a new urethral catheter inserted under sterile and aseptic conditions. Otherwise, patients can be taught Clean Intermittent Self Catheterisation.

7.5 The trial without catheter (TWOC) sheet (Appendix D) should be used for documentation and kept in the notes.

8 Posterior Tibial Nerve Stimulation (PTNS) Clinic

8.1 Patients with overactive bladder symptoms that do not improve on conservative measures, including 2 different medications (antimuscarinic or beta 3 receptor agonist) should have Urodynamic assessment, to confirm Detrusor Overactivity.

8.2 Patients with refractory detrusor overactivity should be offered a choice between Botulinum Toxin “A” bladder wall injection and Percutaneous Tibial Nerve Stimulation (PTNS). Patients who wish to have Botulinum Toxin “A” bladder wall injection can have this carried out at the same time as having cystoscopy, to rule out local pathology in the bladder.

8.3 The plan to go for Percutaneous Tibial Nerve Stimulation (PTNS) should be discussed at the Multi-disciplinary Team (MDT) Meeting, in line with Nice Guidelines on Urinary Incontinence in Women.

8.4 Percutaneous Tibial Nerve Stimulation (PTNS) can be carried out trained Urogyanecology Specialist Nurse. The Percutaneous Tibial Nerve Stimulation (PTNS) sheet (Appendix E) should be used.

9 Intra-vesical Instillation Clinic

9.1 Patients with painful bladder syndrome may need intravesical instillation treatment. Patients have first, repeat and top up instillations as required by their clinical conditions. The currently used preparation is hyacyst. Other preparations may be used in individual cases.

9.2 The hyacyst sheet (Appendix F) should be used.

10 Risk Management

10.1 Patients with complications or particular circumstances may need to be seen by a medical practitioner.

10.2 Documentation will be kept and audit will be carried out. Training and support will be provided as required.

10.3 Any unusual features should be discussed with the Consultant. Patients remain under the care of their Consultant and may need discussion in the Multidisciplinary Team Meeting (MDT) as for all cases.

11 Training

Training in the role of Urogynaecology Specialist Nurse was provided and additional help, training and support will be provided as required, including visits to other units if and when necessary.

12 Audit

12.1 Audit will be required to ensure safe and effective practice as well as achievement of the goals of establishing the clinics.

12.2 Audit will be maintained through good documentation to be kept on databases for regular audit without the need to retrieve the notes.

12.3 Audit will be presented at the Departmental Clinical Governance Meeting on regular basis, as part of the Urogynaecology Audit.

13 Research

13.1 The new role of Urogynaecology Specialist Nurse offers opportunities for research and this will be organised, as appropriate.

13.2 Patients involved in research may need data collection and this will be completed as required. The Good Clinical Practice Certificate will be completed and updated, as required for all those involved in research activity.

14 Monitoring compliance:

Please refer to the Monitoring and Auditing document for details on monitoring compliance for this protocol.

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Appendix A: Telephone Follow

Department of Obstetrics and Gynaecology

Urogynaecology Telephone Follow Up Sheet

Hospital : RSCH / PRH / LVH Consultant: AG / SI / VW

Brighton and Sussex University Hospitals NHS

Date : ...../...../..... Time : ..... : ..... AM / PM..... Grade :	Address label
ID check: Yes /	**Consent:** Yes / .....
Problem: SUI / OAB / Mixed	**Duration:** ..... weeks / months.....
Measure(s)	Fluid advice ..... Smoking cessation ..... Weight loss ..... Pelvic floor muscle training Yes (how regular .....) / No Seen by specialist physiotherapist Yes (number of visits .....) / No ..... Bladder drill ..... Medication(s) tried, dose, duration, side effects..... ....
Outcome	Cured / Improved / No change / worse .....
Plan	Discharge / Continue conservative measures / Urodynamics ..... Advice to see GP / Follow up clinic / telephone .....

.....

Name .....Signature: .....

Brighton and Sussex University Hospitals NHS Trust

Appendix B: Pessary Replacement Sheet

Date : ...../...../..... Staff : ..... Grade :	Address label
Symptoms	None Bleeding / Discharge / Bulge / Pressure / Falling out / Bowel problems / Urinary problems / Pain / Sexual dysfunction .....
Pessary removal	No problems. Impacted / painful / bleeding / tear(s) / forceps use / assistance .....
Speculum examination	Healthy. Ulcer(s) /.....
Pessary insertion	Same one cleaned and reinserted / new one / Assistance Ring.....mm / Shelf ...../ Gell horn..... Change in type.....to...../ size.....to.....
Follow up	GP / Pessary clinic / GOPD / UG Clinic in..... Weeks / Months.
Surgery	Declined / booked.....

.....

Name .....Signature: .....

Appendix C: Urogynaecology Post-operative Follow up sheet

Brighton and Sussex University Hospitals NHS Trust

Location: PRH / LVH / RSCH Telephone Postal GP

Patient Details	
Name : ……..	Op Date: …./……../……..
Hospital No. : ……..	FU Date: …./……/……..
D. O. B. : ……/……/……	Interval : ……wks

Peri-operative Review		**Procedure:**
Return to theatre <72 hrs	Y/N	…….
Return to Hospital <30 days for procedure related event	Y/N	…….
ISC/Catheter > 10 days	Y/N	**Catheter use**
		Pre-op Post-op

Morbidity eg. UTI / Visit to GP / Visit to Hospital / Visits by health care staff/ Antibiotic use

Details of above: ……

……..

Follow-up assessment

QoL Scores: ICIQ – UI: /21 ICIQ – VS: /53 ICIQ – SM: / 58

Global Impression of Outcomes

	Greatly Worse	Moderately Worse	Slightly Worse	No Change	Slightly Improved	Moderately Improved	Greatly Improved
Incontinence							
Prolapse							

Changes in Urinary incontinence

	Worse	No Change	Improved	Cured
Stress incontinence				
Urgency Incontinence				

Symptom Check:

Urinary	Stress I, Urgency, Urge I, Frequency D / N ----------,
	Voiding dysfunction, Haematuria, UTI ……
Prolapse	Bulge, dragging sensation, pressure
Bowel	Urgency, Urge I, Frequency, Anal I (Flatus/Loose Stools/Solid Stools),
	Obstructed Defecation, Bleeding
Sexual	SA Y/N, reason……., Dyspareunia, Male discomfort, PCB
Pain	Bladder / urethra / vagina / perineum

Notes……

……

Examination:

Healing / Erosion / Exposure / Tissue softness / Flexibility

POP-Q			**B-W**				
Aa	Ba	C	Ant Vag Wall	I	II	III	IV
GH	PB	TVL	Post Vag Wall	I	II	III	IV
Ap	Bp	D	Cx / Cuff	I	II	III	IV

Notes……

.....……...

Plan:

Physio Discharged Medication……..…...

FU……../……...

Waiting list for

…….……..

……

Seen By: ……..**Grade:**……..…….

Appendix D: Trial without Catheter

Brighton and Sussex University Hospitals NHS Trust

PATIENT DETAILS

Name…….

Date of Birth……

Hospital Number…….

Trial without Catheter

Date……..

Time……..

Date Catheter Inserted……

Type/Size of Catheter……

Reason for catheter

……

……

Relevant medical history

……

……

Medications

……

……

Trial without catheter (TWOC)

Consent obtained Y/N Chaperone offered Y/N Declined / Requested

Time Catheter Removed…… Mls in balloon……

Comments on Removal

……

……

……

Volume of Urine Passed

Time	Volume of Urine Passed	Residual (bladder scan)	Urinalysis

- **Urinalysis on 2nd void.**
- **Residual on 3rd void.**
- **Consider CISC or catheterisation if residual greater that voided volume or residual greater than 150mls.**

Failed Trial without Catheter

CISC

……
……
……

Re-insertion of Catheter:

Size……Type……

Mls in balloon……Lot No……Expiry Date……

Comments……
……
……

Management Plan
……
……
……

Order with Charter Y/N
……

Referral to Community Nurses Y/N
……

Follow up appointment……

Signature……..

Print……

Designation……

Contact Details……..

Appendix E: Percutaneous tibial nerve stimulation

Brighton and Sussex University Hospitals NHS Trust

Date Consultant Doctor	Name Hospital Number Date of birth

Urodynamically proven detrusor overactivity Yes / No

Normal cystoscopy Yes / No

Tried

- Fluid advice Yes / No
- Bladder drill Yes / No
- 2 different anticholinergics Yes / No

.....
.....

Contraindications: Yes / No

- Neurological disease interfering with posterior tibial nerve or pelvic floor function.
- Pregnancy or planning pregnancy within 12 weeks treatment schedule.
- Having a pace maker in place, or planned insertion during treatment 12 weeks schedule.
- Having any electric / electronic monitoring or treatment device attached to the body.
- Use of any inflammable or explosive gas, including oxygen for respiratory disease.
- Inflamed or damaged skin around the needle insertion area.
- Bleeding tendency.
- No planned vacation or admission to hospital during 12 weeks treatment schedule.
- More than one non-attendance during 12 weeks treatment schedule.
- Needle phobia.

Signature:.....

Brighton and Sussex University Hospitals NHS Trust

Date	No.	QoL Score	Ankle used	Setting	Response	Problems	Signature
	1		Rt / Lt		Toe flexion/ foot sensation		
	2		Rt / Lt		Toe flexion/ foot sensation		
	3		Rt / Lt		Toe flexion/ foot sensation		
	4		Rt / Lt		Toe flexion/ foot sensation		
	5		Rt / Lt		Toe flexion/ foot sensation		
	6		Rt / Lt		Toe flexion/ foot sensation		
	7		Rt / Lt		Toe flexion/ foot sensation		
	8		Rt / Lt		Toe flexion/ foot sensation		
	9		Rt / Lt		Toe flexion/ foot sensation		
	10		Rt / Lt		Toe flexion/ foot sensation		
	11		Rt / Lt		Toe flexion/ foot sensation		
	12		Rt / Lt		Toe flexion/ foot sensation		

Twelve weeks follow up visit:

Date:

FVC:

Quality of life score:

Subjective assessment:

Signature:……

Name:……

Appendix F: Hyacyst Sheet

Lewes Victoria Hospital

Brighton and Sussex University Hospitals NHS Trust

Urogynacology Unit Consultant: AG / SI / VW

Date : ……/……/…….	Name
Doctor : ……..	Hospital Number
Grade : ……	Date of birth

Urodynamics: Yes / No Result:……..

Cystoscopy:……..

Treatment tried:……..

Visit	No.	Date	Name	Grade	Signature
Weekly / 2 weekly	1	……/……/…….			
	2	……/……/…….			
	3	……/……/…….			
	4	……/……/…….			
Monthly	1	……/……/…….			
	2	……/……/…….			
	3	……/……/…….			
	4	……/……/…….			
	5	……/……/…….			
	6	……/……/…….			

12 weeks follow up visit / Telephone: Date: ……/……/……..

Outcome: Better / same / worse /……

Plan: Discharged / Top up / ……

……

……

Name ……..

Signature:……..