Brighton and Sussex University Hospitals NHS Trust

Emergency Gynaecology Admissions & Gynaecology Assessment Unit (GAU)

Gynaecology Protocol: GP005

Date Agreed: May 2020

Guideline Reviewer:	Tosin Ajala
Version:	3.0
Approval Committee:	Women's Services Safety and Quality Committee
Amended Date:	May 2020
Review date:	May 2023

Contents

Key Principles

These guidelines and algorithms are aimed to assist in decision making. They are not designed to be prescriptive and you are not expected to use them in exclusion of discussions with senior colleagues.

These guidelines have been reviewed by all clinicians involved in emergency gynaecological care, including consultants, specialist and senior nursing staff.

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:

- All staff in Women's Directorate
- All members of the Women's Safety & Quality Committee (WS&QC)
- All members of the Protocol and Guideline Group

Responsibilities

Clinicians and Nurses:

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

Emergency Department Clinical Staff:

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

Management:

- 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

1 Introduction

1.1 Its aim is to support clinicians, nurses and careers in the delivery of safe and effective care to women with acute gynaecological conditions.

1.2 Women may present or be referred by one of the following;

1.2.1 GP referral

1.2.2 Emergency Department (ED)

1.2.3 1.3.2 Non –obstetric wards (other wards in the hospital)

1.2.4 1.3.3 Urgent Care Centre (out of hours GP)

1.2.5 1.3.4 Gynaecology Assessment Unit (GAU)

1.2.6 Early Pregnancy Assessment Unit (EPU)

1.2.7 Out-patient department

1.2.8 From another speciality

2 Women Presenting With Acute Gynaecological Conditions

2.1 All women must have a baseline set of observations taken which must include blood pressure, pulse, temperature, saturations and respiration with a NEWS2 recorded in the Acute Gynaecology Proforma.

2.2 A comprehensive history should be taken and recorded in the Acute Gynaecology proforma. The history is to include a safeguarding risk assessment and consider domestic abuse, sexual abuse and sexual exploitation.

2.3 Pregnancy testing must be offered to all women of child-bearing age with potentially pregnancy related condition. A urinalysis must also be performed for all women these must be recorded in the Acute Gynaecology Proforma.

2.4 Expected gynaecological conditions include:

- 2.4.1 Hyperemesis gravidarum
- 2.4.2 Severe heavy menstrual bleeding
- 2.4.3 Acute pelvic pain
- 2.4.4 Acute pelvic inflammatory disease
- 2.4.5 Abnormal vaginal bleeding
- 2.4.6 Ascites, secondary to known underlying gynaecological cancer
- 2.4.7 Bartholin's/ Vulval abscess/cyst
- 2.4.8 Post-operative complications within 30 days of procedure
  - 2.4.8.1 UTI
  - 2.4.8.2 Wound infection
  - 2.4.8.3 Wound break down
  - 2.4.8.4 Vaginal bleeding/ discharge
- 2.4.9 Retained products of conception
- 2.4.10 Abdominal pain
- 2.4.11 Uterovaginal prolapse
- 2.4.12 Acute urinary retention
- 2.4.13 Foreign body retention
- 2.4.14 Postnatal women over 10 days that have been discharge by the midwife

2.5 All women attending ED should be seen within the recommended 4 hour waiting time by ED and referred to the gynaecology registrar if specialist review is required.

2.6 All patients requiring admission MUST be seen by the registrar on call prior to admission.

2.7 Any patient that is discharged but requires follow-up such as a further review or elective procedure must be seen by the registrar and where appropriate discussed with the consultant on call.

3 Women Presenting With an Early Pregnancy Problem

3.1 All women presenting with an early pregnancy problem of less than 14 weeks gestation to ED/UCC should initially be assessed by the ED doctor. If clinically stable and does not require 'same day review' to be booked into the next available EPU slot.

3.2 If requires same day review the ED doctor should contact the on call Gynaecology Registrar by bleep and inform them of the patient history and ask them to review the patient.

3.3 EPU can see patients up to 14 weeks gestation if a booked appointment is made. Women over 14 week's gestation needing 'same day review' must be referred to DAU or the Labour Ward Triage.

4 Ectopic Pregnancy

4.1 Ectopic pregnancies must be managed according to EPU guidelines.

4.2 All women of childbearing age that present with unexplained abdominal pain must have a urine pregnancy test and ectopic pregnancy excluded.

4.3 All ED staff should be aware of the dangers of ectopic pregnancy and have an awareness of the atypical clinical presentations (up to 25% may present without a history of per vaginal bleeding).

4.4 Guidelines for the management of ectopic pregnancy should be included in all induction programs for all ED and Obstetrics and Gynaecology staff.

4.5 Haemodynamically stable suspected ectopic pregnancies for emergency surgery are category 2 (revised NCEPOD classification of interventions). This means that these patients must be operated on within a maximum of 6 hours of presentation. Between the hours of 22:00 and 08:00 decision to operate must be made by the consultant on call.

4.6 Haemodynamically stable confirmed ectopic pregnancies for emergency surgery are category 1.

4.7 Haemodynamically compromised patients are category 1 of the classification and must be operated on immediately.

4.8 Where there is a significant unavoidable delays with CEPOD the possibility of utilising elective gynaecology list must be explored by the Ward Manager in conjunction with the directorate Manager and on-call Consultant.

5 Clinical Management of Women with Acute Gynaecological Conditions

5.1 Women that present with other acute gynaecological conditions should be managed according to individual policy these include:

5.1.1 GP003 Pelvic Inflammatory Disease (PID)

5.1.2 GP002 Vomiting in pregnancy and Hyperemesis

5.1.3 GP006 Management of Bartholin's cyst/abscess and vulval abscess

5.1.4 GP007 Management of Ovarian Hyperstimulation (OHSS)

5.1.5 Early Pregnancy Unit

5.2 Suspected ovarian torsion for emergency surgery are category 2 (revised NCEPOD classification of interventions). This means that these patients must be operated on within 6 hours of diagnosis following Ultrasound scan.

6 Women Presenting To RSCH

6.1 Women presenting at the Royal Sussex County Hospital should be referred directly to Gynaecology Assessment Unit (GAU) via the Gynae registrar providing they are clinically stable.

6.2 GAU operational guidelines must be followed to ensure the referral and transfer is managed correctly. See appendix A & B.

6.3 The ward nurses must be informed of the referral and the patient's information must be written on the GAU expected white board.

6.4 The triage pathway is to be followed by the registrars when taking referrals.

7 Women Presenting To RSCH Requiring CEPOD

7.1 All women requiring emergency surgery must have a registrar review

7.2 The CEPOD form must be completed and booked with the CEPOD co-ordinator in theatre on Level 5

7.3 All patient are to have 2 group and saves blood samples taken prior to going to theatre and must be consented for the procedure

7.4 Consideration must be made for cases that could be managed on the fast track CEPOD pathway or on an elective day case list. Elective cases must be booked via the Patient Access Clerk on ext. 62863. Patients booked via the Fast-Track CEPOD pathway must have the checklist completed.

7.5 CEPOD Delays

7.5.1 Women requiring emergency surgery on CEPOD who have been postponed or delayed for more than 24 hours must be reviewed by a consultant.

7.5.2 Where there is a significant unavoidable delays with CEPOD the possibility of utilising elective gynaecology list must be explored by the Ward Manager and on-call Consultant this should include Day Surgery Lists and In-patient Lists.

8 Women Presenting To PRH

8.1 There is currently no CEPOD service at Princess Royal Hospital (PRH). Therefore, all patients that present to the PRH with a gynaecological emergency that may require surgery should be transferred to the Royal Sussex County Hospital (RSCH) unless their condition is immediately life threatening when surgery should be performed at the PRH. This is a surgical decision.

8.2 Emergency gynaecology procedures allowed at PRH

8.2.1 Life threatening conditions such as an unstable ectopic pregnancy

8.2.2 Life threatening post-operative complications

8.3 For these cases, the consultant anaesthetist and gynaecology consultant on call should be contacted initially.

8.4 Patients with a possible ectopic or any other acute gynaecological emergency that may require emergency surgery should NOT be admitted to PRH. They should all be sent to RSCH as soon as possible unless haemodynamically unstable requiring immediate transfer to the operating theatre.

8.5 Women who do not require transfer to RSCH must be seen and treated within the 4 hour ED standard. For Women requiring Hyperemesis management or follow up on Horsted Keynes must be discussed with the nurse in charge and arrangements are to be made for ambulatory treatment.

8.6 All ward attenders must be correctly coded on Medway within a 2 week period.

9 Transferring Women from PRH To RSCH

9.1 All stable gynaecology patients that require emergency surgery should be transferred from PRH to RSCH.

Prerequisites:

9.1.1 Patient should have a full clinical assessment by the gynaecology registrar on call at PRH

9.1.2 The transfer must be agreed by the consultant on call at PRH

9.1.3 The transfer must be discussed with the middle grade gynaecologist on-call at RSCH

9.1.4 If there is any doubt about the Cardiovascular stability or suitability for transfer then the case should be discussed between the PRH and RSCH consultants and where necessary to include the ITU anaesthetist (6010)

9.2 The Clinical Site Manager on bleep 6014 and the nurse in charge of the transferring unit (Horsted Keynes Gynaecology Ward/A&E) must be informed of the transfer. The CSM must confirm the bed location of the transfer; preferably L11 Gynaecology Ward

9.3 The transferring unit must book the transport and verbally handover to the receiving unit. The nursing transfer checklist must be completed and sent with the notes to the receiving ward. Medway must be updated once the patient has left the PRH.

9.4 A 'blue light' transfer with a paramedic crew must be booked for the transfer with Sussex Ambulance Control on ext. *8004

9.5 The patient should be stabilised in the appropriate holding area. All indwelling equipment must be secured and the level of monitoring should be determined by the potential problems anticipated.

9.6 Full discussion should occur between the transferring team and the receiving team at RSCH and the urgency of transfer should be specified depending on the urgency for the treatment at receiving end**.**

9.7 Documentation – BSUH transfer forms (2 forms): one for preparation of transfer and the 2nd for the actual transfer.

10 Gynaecology Admissions to other Hospital Departments

10.1 Gynaecology patients admitted outside of the gynaecology wards must have daily review by a registrar/consultant. The gynaecology ward co-ordinator must attend these ward rounds on either site if matron not present.

10.2 All outliers are to be written on the gynaecology ward white boards stating the location of the patient.

10.3 The ward co-ordinator must liaise with the Clinical Site Management team and repatriate to gynaecology ward as soon as able, prioritising with clinical need. If this is not possible the patient must be seen daily by the gynaecology team.

10.4 The patient must be provided with information as to why they are not nursed in the specialised areas and offered apologies. The co-ordinator must ensure the outlying ward team caring for the patients are happy with caring for the condition and are aware to contact either Horsted Keynes ward PRH or Level 11 RSCH for advice as required.

10.5 The patient must be provided with written information backed up with verbal support prior to discharge and contact details for the gynaecology ward should they have any further questions following discharge

10.6 The details of pregnant women admitted to other departments in the hospital must be written on the gynaecology white board and recorded in the outlier's book by the clinician who is first told of the admission. These women should be seen as above.

11 Gynaecology Assessment Unit (GAU) - Objective Standards

11.1 General Organisation

11.1.1 The Gynaecology Assessment unit is in Level 11 of the Tower Block, Royal Sussex County Hospital

11.1.2 It is operational 24 hours a day 7 days a week

11.1.3 The GAU will share its environment with L11 gynaecology 9 bedded ward allowing timely emergency admissions

11.1.4 There is a dedicated desk space for medical and nursing staff with an Medway terminal, printer for results and telephone (ext. 4013/4022).

11.1.5 PACS is linked to the ultrasound machine and must be used to report any ultrasound scan.

11.1.6 There is read only access to symphony to which must be monitored to identify gynaecology patients that are in ED. Arrangements must be made with ED to transfer patients where able.

11.1.7 The unit comprises of the following:

11.1.7.1 Ultrasound/Examination couch

11.1.7.2 Ultrasound machine with vaginal and abdominal probes, gel covers, antiseptic wipes

11.1.7.3 Examination lamp

11.1.7.4 Office/consultation room with PC

11.1.7.5 Fully kitted gynaecological trolley:

- Speculums
- Microbiology swabs
- Blood bottles and vacutainers
- Vaginal packs
- Repair/suture packs
- Silver nitrate sticks
- Local anaesthetics
- Dental needles and syringes
- Sponge holders
- Ring/shelf pessaries
- Pipelle
- Histology containers
- Bonano catheters and urine drainage bags
- Word catheter
- Urinary catheters
- Antiseptic

12 Services

12.1 Access to specialist nursing and medical teams

12.2 Diagnostic bloods and examinations as required

12.3 Diagnostic Ultrasound on arrival if trained practitioner available or by booked appointment in the main x-ray department on L5. If out of hours, access to fast track scanning the following day is available. The appointments are kept in a folder held at ED reception and are available to all specialities. Up to 1 gynaecology patient daily Monday – Friday if required may be booked into these appointments (excluding pregnancy related scans which are to be booked in the Early Pregnancy Unit).

12.4 Referral to appropriate clinics, treatment plans and referral to other specialties or safe and early discharge home

12.5 If required admission to L11 Gynaecology Ward.

13 Access Criteria

13.1 Access to the GAU will be via: (See Appendix A & Appendix B):

13.1.1 ED

13.1.2 Urgent Care Centre

13.1.3 Direct GP referral via Gynaecological SPR on call/telephone

13.1.4 Other specialities within the Trust

13.1.5 Prior arranged self-referrals (no walk in service available)

13.2 All haemodynamically stable non pregnant women with suspected sub-acute/acute gynaecological conditions, this including patients with hyperemesis Gravidarum

13.3 Early pregnancy cases presenting outside of EPU working hours (EPU Operational hours 08:00 to 18:00 hours week days except Fridays)

13.4 Exclusion Criteria:

13.4.1 Patients that are haemodynamically unstable with a NEWS2 score above 4 or have 3 or more in one parameter on the NEWS2.

13.4.2 Patients that will require stabilisation followed by immediate transfer to theatre, e.g. excessive vaginal bleeding

13.4.3 Women presenting under 14 weeks gestation should be referred to GAU. Women over 14 weeks gestation should be referred to DAU or Labour Ward Triage. The exact location of where the woman needs to be seen will depend on clinical circumstances (See Appendix C).

14 Patient Flow & Bed Management

14.1 Women that present in ED must be registered on symphony and triaged. Providing they fulfil the access criteria they should then be referred directly to GAU

14.2 The patient is transferred with a copy of their medical notes

14.3 Women who are experiencing problems with early pregnancy should be referred directly to the Early Pregnancy Unit (EPU) for the next available appointment and not the GAU unless unfit for discharge from ED or out of hours

14.4 The assessment process should be no longer than 2 hours from time of arrival to GAU and if requires admission should have a bed within 4 hours. Women requiring day treatment should stay no longer than 6 hours

14.5 The maximum length of stay will be 6 hours with admission straight onto the Gynae ward as required

14.6 Women who are assessed with no gynaecology cause found for their symptoms will be referred directly by the registrar to the appropriate speciality and the clinical site management (CSM) team informed for appropriate placement of the woman

14.7 If no beds available within the gynaecology ward on RSCH site bed utilisation will be explored in other areas of the Trust by the bed manager. It may be necessary to explore using Horsted Keynes PRH site or flexible use of beds on L12 ante/postnatal maternity ward. The CSM team will be contacted regarding appropriate placement for the woman.

14.8 If GAU is full and unable to accept patients and if it is required the on-call registrar will go and review the gynaecological patients in ED leaving the SHO L11/GAU

14.9 Ultrasound slots (1 slot per day) are available on Level 5 for patients seen out of hours who are clinically stable to be discharged. These scans are carried out the next day and the patient will be advised to return to GAU following the scan for review. Patients should not be advised to return to GAU for ultrasound scans as there are designated slots for ultrasound scans in the unit.

14.10 Were appropriate patients will be referred to other units/ specialities for further management such as-

14.10.1 CEPOD pathway or elective list

14.10.2 Chronic pain clinic

14.10.3 Gynae-oncology team

14.10.4 Urodynamics

14.10.5 Gynae-outpatient clinic

14.10.6 Endometriosis clinic

15 Financial Management

15.1 The Gynaecological Assessment Unit will be managed under a separate cost code with the Ward Manager responsible for managing the budget

15.2 The Directorate Manager will be responsible for coding reviews and commissioning arrangements.

16 Medical Management

16.1 The overall clinical lead for the GAU is the Clinical Lead for Emergency Gynaecology

16.2 The patients will be reviewed on arrival by the SHO/SPR on call for gynaecology on bleeps 8611 and 8618 respectively

16.3 The acute gynaecological proforma must be completed

16.4 The unit is consultant led, with the gynaecology consultant on call responsible for the care of the patients

16.5 All initial decisions for admission and discharge must be made at registrar level or above. This must include face to face review. Telephone consultations with the gynaecological registrar on call are not acceptable.

16.6 For patients that are admitted an estimated date for discharge must be clearly documented Nurse Led Discharge must also be documented in the notes and facilitated by the Ward Manager.

17 Nursing Management

17.1 The Ward Manager is responsible for the overall management of the area, including budget control, directly reporting to the Matron.

17.2 Guidelines have been formulated to assist the shift co-ordinator in their role.

18 Discharge Planning

18.1 All alternatives to admission that meet the patients' needs must be explored**.** An estimated *medically fit for discharge* date should be documented for all admissions.

18.2 TTO's should be written in a timely manner by the F2/ST1-2 who is on call and based in the GAU/L11.TTO's may be discharged from the ward or the use of Pharm@Sea

18.3 A discharge letter is to be formulated for direct discharge from GAU. They will not use the electronic discharge systems as not admitted as inpatients on Medway but as attenders

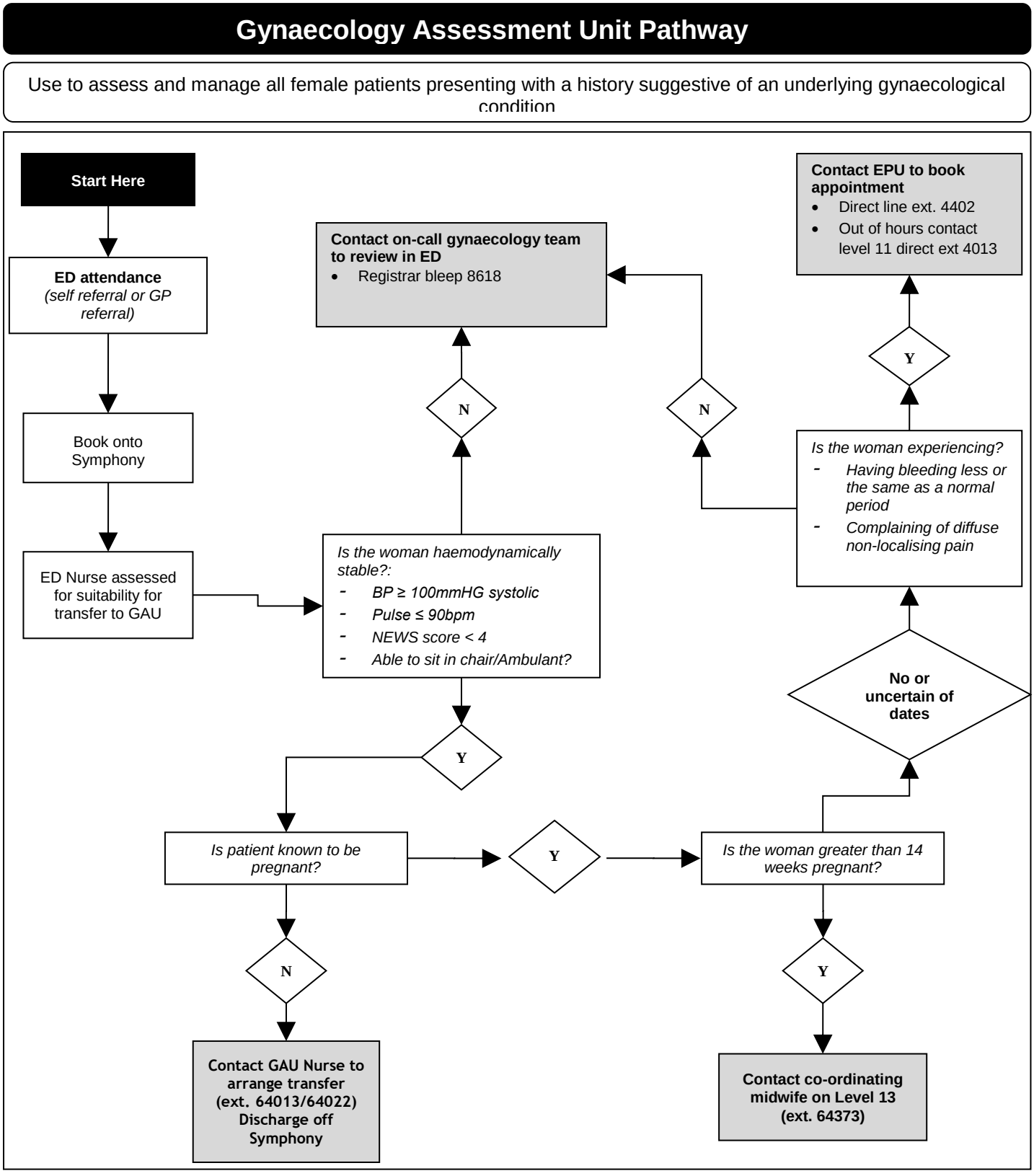
18.4 All patients to be coded by the Ward Clerk once discharged within a 2 week period.

19 Communication

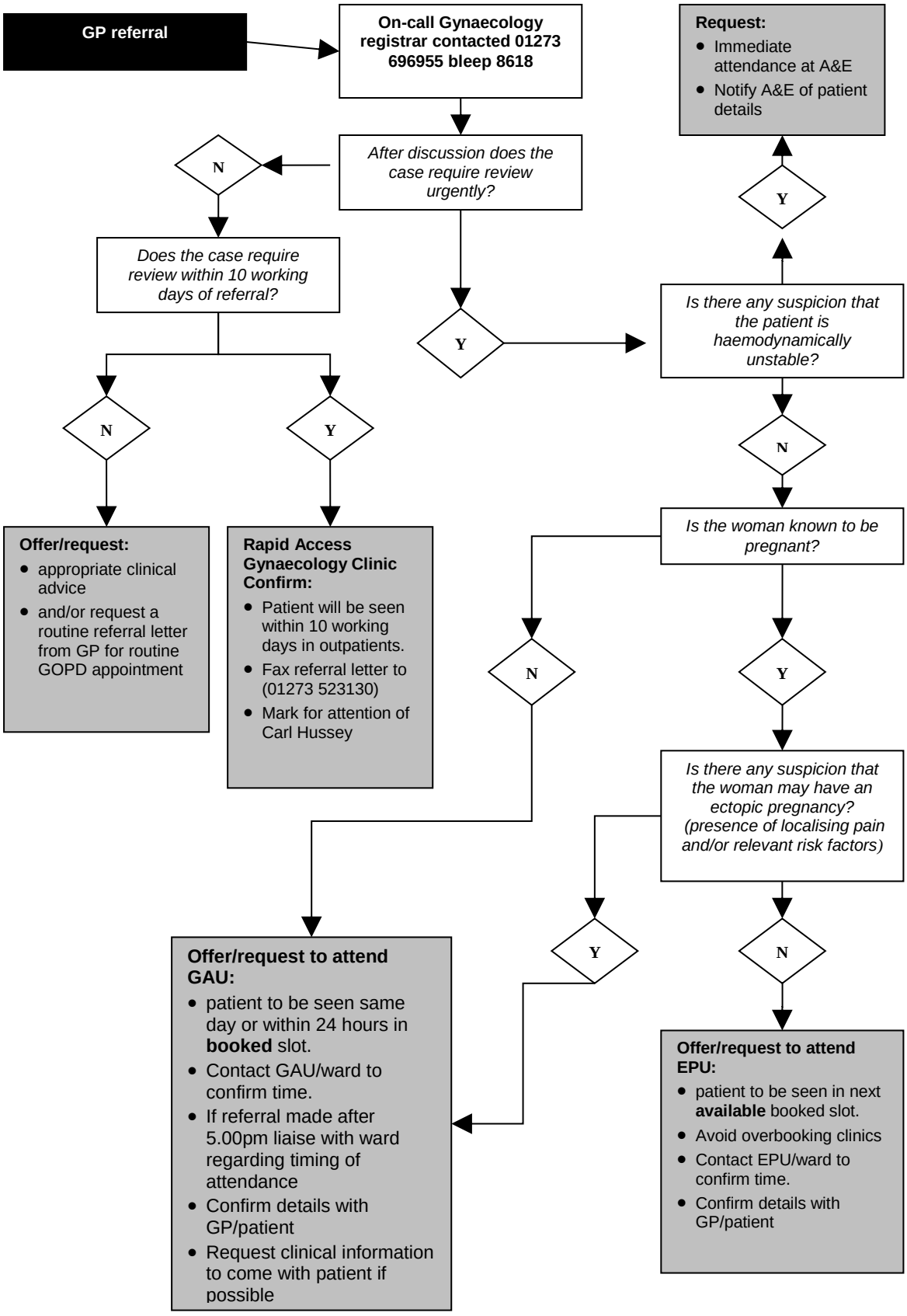
19.1 On arrival, literature is available to women and their families/carers outlining the philosophy of the unit and any gynaecological conditions.

19.2 The internal and external webpage will provide information to staff, patients, relatives and outside partners (GP's) which must be up to date.

20 Appendix A – ED Referral Pathway



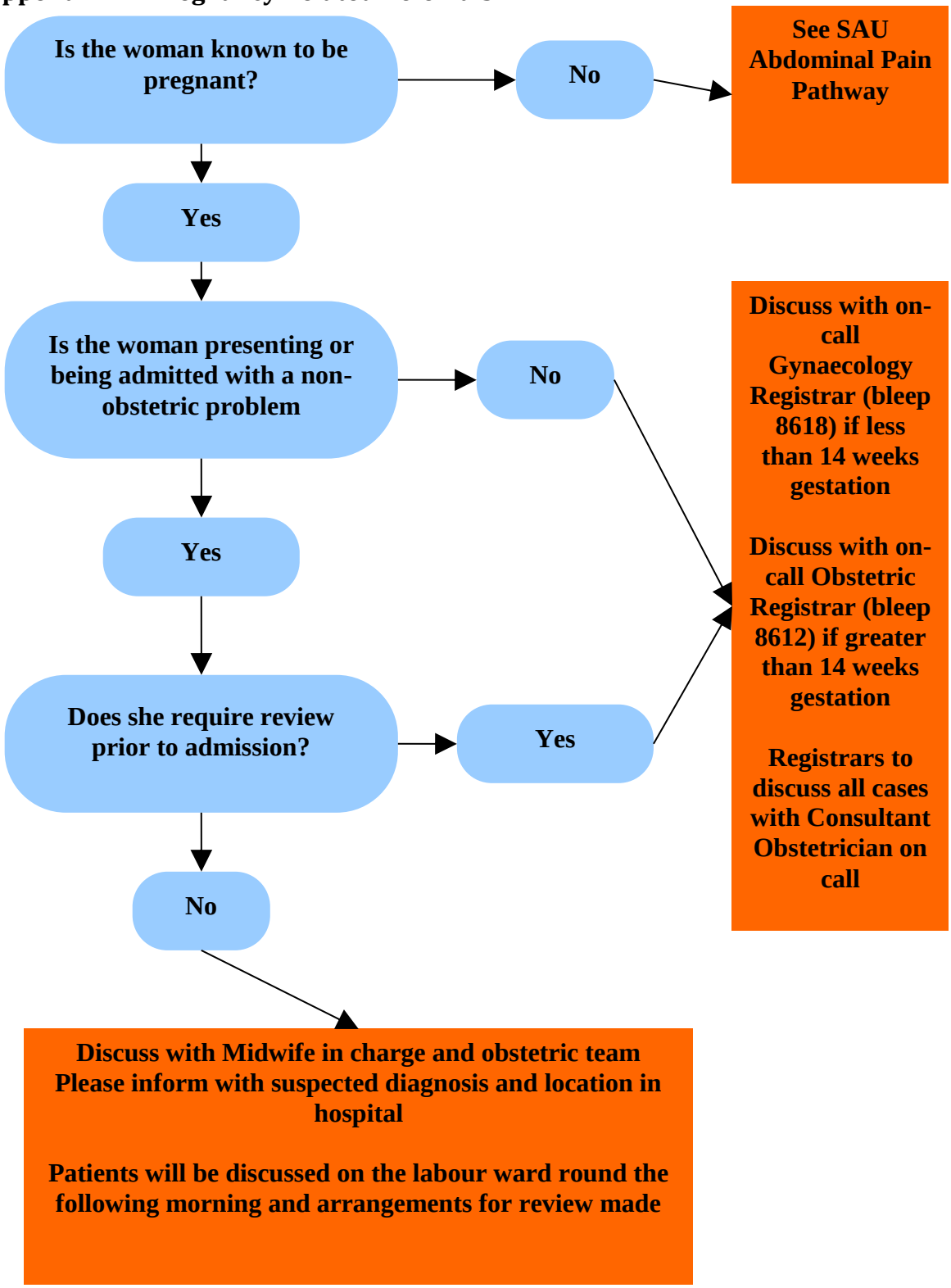
21 Appendix B – GP Referral Pathway



22 Appendix C – Pregnancy Related Referral Location

DAU	Triage/MAU	Labour ward	EPU	GAU
Minor PV bleeding >14 weeks	Minor PV bleeding >14 weeks (when DAU shut)	Significant PV bleeding >14 weeks	PV bleeding $^{<14}$ weeks - booked appointment	PV bleeding <14 weeks (out of EPU hours)
Abdominal pain in pregnancy >14 weeks (emergency)	Abdominal pain in pregnancy >14 weeks (emergency) when DAU shut or dependant on clinical condition	Abdominal pain in pregnancy >14 weeks (emergency) when DAU shut or dependant on clinical condition	Abdominal Pain ≤ 14 - booked appointment	Abdominal Pain <14 weeks (emergency)
No fetal heart audible >14 weeks	SROM (any gestation)	Obstetric emergencies		Hyperemesis under 14 weeks
Preterm pre-labour ROM (ongoing reviews)	Labouring women for assessment (any gestation)	Labouring women with birth imminent		
Reduced fetal movements		In-utero transfers		
Post dates > 40+12 declining IOL				
Itching / rash in pregnancy				
Raised BP/ PET				
Pre-op clerking for obstetric surgery				
Musculo-skeletal pain				
Suspected small for dates fetus				
Suspected malpresentation				
Suspected oligo / polyhydramnious				
Fetal heart rate irregularities				
Non-specific unwell women				
Suspected UTI or other infection				
Out-patient IOL using Propess				
GTT's (RSCH only)				
ANC referrals				

23 Appendix D – Pregnancy Related Referrals



24 Appendix E – Obstetrics & Gynaecology contacts

RSCH	Ext
Obstetric SHO	Bleep 8610
Gynae SHO	Bleep 8611
Obstetrics SPR	Bleep 8612
Gynae SPR	Bleep 8618
Please Note: SHO & SPR on call cover both Obstetrics and Gynaecology between the hours of 20:30 – 08.30 and weekends Obstetric and Gynaecological Consultants can be reached via switch board	
The Labour Ward	Ext 4373 or 4374
Can be contacted at all times for advice regarding all pregnant women and their babies	
The Day Assessment Unit	Ext 4392 or 7622
Can be contacted from 09:00 to 17:00 hours Mondays to Fridays	
Labour Triage	Ext 4793
For patients suspected to be in early labour 24 hours	
Early Pregnancy Assessment Unit (EPU)	Ext 4402
08:00 – 16:00 on Mondays - Fridays (for early pregnancy review/assessment up to 18 weeks gestation)	
Gynaecological ward/Gynaecology Assessment Unit (GAU)	Ext 4022 or 4013
Can be used to book patients into the EPU out of the hours stated above	

PRH	Ext
Obstetric SHO	Bleep 6035
Gynae SHO	Bleep 6037
Obstetrics SPR	Bleep 6036
Gynae SPR	Bleep 6223
Please Note: SHO & SPR on call cover both Obstetrics and Gynaecology between the hours of 20:30 – 08.30 and weekends Obstetric and Gynaecological Consultants can be reached via switch board	
Central Delivery Suite (CDS)	Ext 8485
Can be contacted at all times for advice regarding all pregnant women and their babies	
The Day Assessment Unit	Ext 5486
Can be contacted 08:30 to 18:00 Mondays to Fridays	
Labour Triage	Ext 8412
For patients suspected to be in early labour 24 hours	
Early Pregnancy Assessment Unit (EPU)	Ext 5685
Closed on Tuesday and Thursday	
Gynaecological ward	Ext 5685/5686
Can be used to book patients into the EPU out of the hours stated above	