Guidelines for gynaecology Pre-assessment by senior gynaecology nurses.

University Hospitals of Leicester NHS
NHS Trust

Trust ref: C38/2007

Contents

1. Introduction and who the guideline applies to:

This document sets out the Women's Service guideline for history taking and clinical examination of Pre-assessment gynaecology patients. This guideline gives directions for the safe and effective taking of clinical histories and general clinical examination and sets out guidelines for practice, training, audit and evaluation.

Guidance Definition:

Pre-operative assessment is an assessment of the patient's physical fitness for surgery and anaesthesia. It also provides an opportunity to give information to enable the patient to be mentally as well as physically prepared for theatre.

The pre-operative assessment process is intended to ensure that the patient is fully informed and wishes to undergo the procedure. (NHS Modernisation Agency, Theatre Programme)

2. Background:

Developments in healthcare delivery have highlighted the need for nurses to develop greater autonomy and accountability in specific areas of clinical practice.

The NHS Plan (DoH 2000) and Making a Difference (DoH 1999), endorsed these changes to ensure delivery of modern patient centred services. The NHS Modernisation Agency also proposes the sharing of skills by the introduction of multi-skilled practitioners.

Senior Nurses working in an expanded role are required to develop skills of history taking, clinical examination, anaesthetic risk assessment and communication skills within the context of their professional role, ensuring optimal patient care within the multidisciplinary team.

3. Accountability:

All nurses undertaking this role must identify as a:

- Level 1 registered adult nurse
- Be employed as a Senior Nurse (6 or above) or Nurse Specialist within the Women's Perinatal and Sexual Health Directorate
- Successfully completed training and assessment as set out in this document
- Assessed as competent and hold a statement of competence to practice the skill
- Verification of each competence must be kept in the individuals personal file
- Accept accountability for their practice
- Be aware of and adhere to:
  - NMC The Code
- Have a designated medical mentor able to provide teaching, support, supervision and assessment

4. Consent:

Verbal consent should be obtained from the patient in line with the UHL Trust Consent Policy (UHL 2016). The Pre-Assessment Nurse should explain their role and scope of practice at the start of the consultation and use this opportunity to offer the patient a chaperone, (record the response).

5. Exclusion Criteria:

- The POA Nurse will not undertake clinical history or physical examination under the following situations:

  - The patient requests to have a doctor perform the history and examination
  - The POA Nurse recognises that the patient's medical condition is outside their scope of practice (NMC The Code 2015)

6. Record Keeping and Documentation:

NMC: The Code 2015 states 'that record keeping is an integral part of nursing practice… that should help the care process.'

Documentation will be in line with Trust Policy and NMC Guidelines

- All documentation should be legibly written in indelible black ink.
- Designation clearly documented at the end of the patient's clerking.
- All entries must be signed, timed and dated.
- The individuals name should be clearly printed underneath the signature.
- The individuals bleep, pager or extension number must be recorded.
- All documentation should have the patient's name, hospital number, date of birth, hospital site and consultant recorded at the top of the page.
- Patient confidentiality shall be safeguarded at all times. (Data Protection Act 1998).
- Abbreviations should not be used.
- An entry, once made, should always remain as part of the record. If this is an error, it should not be made illegible (scribbled out) it should be marked through with a single line, any addition unwanted should not be disguised
- Clinic notes should be made at the time of consultation, investigation or treatment or as soon as possible afterwards.
- The practitioner must ensure that this expanded role is recorded on the UHL register of Advanced Practitioners.

7. Confidentiality:

NMC The Code 2015 states that a registered nurse must;

> *'as a nurse/midwife you owe a duty of confidentiality to all those who are receiving care. This includes making sure they are informed about their care and that information about them is shared appropriately'*

8. Audit and Evaluation:

Each senior nurse will be responsible for their individual practice and will carry out regular audits of their practice in accordance with clinical governance activities (NMC 2015).

During the first three months of autonomous practice, a doctor will review the history taken, clinical examination and fitness for surgery of all patients. This process is undertaken by doctors to evaluate their competence to practice.

After this period, if the senior nurse is considered competent, an evaluation audit will be undertaken every six months in order to evaluate the safety, effectiveness and appropriateness of the practitioner's history taking, clinical examination and selection of investigations. This will normally take the form of retrospective review of case notes and will be conducted by a senior member of medical staff, using the audit tool in Appendix IX. This process of evaluation is in line with current practice for doctors in training.

The senior nurse will be able to provide a list of all patients seen and the patients selected for the audit will be randomly selected from this list.

Any adverse events must be reported and an incident form completed in line with Trust policy.

9. Education and Training:

Formal assessment of competence is mandatory prior to the unsupervised clinical history taking and examination of patients. To complete the assessment registered nurses will need to have undertaken the following training:

- Pre-assessment history taking and clinical examination course for nurses covering all systems.
- Theoretical course covering routine blood results and their implications for health management.
- Level 3 accredited module based on Gynaecology Nursing (30 credits)
- Teaching and subsequent assessment by a consultant or ST3/4 grade within the Women's Clinical Management group(CMG), in the following body systems
    - Respiratory system
    - Cardiovascular system
    - Gastro-intestinal system
    - Female Genito-urinary system

10. Competency:

Prior to working unsupervised in the skills and role the POA nurse must have the following

- A record of 8 Assessed as competent in all the Pre-operative Assessment Competencies

- Have their Key Skill/Protocol record authorised by a competent authorised person
- A completed portfolio of competences with supporting evidence of learning
- A record of all, signed off the required skill competencies
- Invest in the opportunity to work towards an Accredited Course in the appropriate field

11. Supporting References

1) Data Protection Act 1998
2) DoH Pre-operative Assessment Guidelines (July 2003)
3) Making a Difference (DoH 1999)
4) NHS Modernisation Agency, Theatre Programme
5) NICE guideline Acute kidney injury: prevention, detection and management www.nice.org.uk/guidance/cg169
6) NICE guideline Routine Pre-operative Tests for elective surgery www.nice.org.uk/guidance/ng45
7) NICE guideline Patient experience in adult NHS services: improving the experience of care for people using adult NHS services www.nice.org.uk/guidance/cg138
8) NMC The Code 2015 (NMC 2015)
9) The DoH Pre-operative Assessment Guidelines for both Day Surgery and Inpatient Surgery
10) Human Rights Act 1998
11) The NHS Plan (DoH 2000)
12) UHL Trust Consent Policy (V10 – April 2016)
13) Pre-operative measurement of adult blood pressure and management of hypertension. Association of Anaesthetists of Great Britain and Ireland & British Hypertension Society. www.aagbi.org/sites/default/files/Pre-operative
14) ASA Physical Status Classification System
15) http://www.asahq.org/resources/clinical-information/asa-physical-status-classification-system
16) Neuraxial anaesthetic and anticoagulants and antiplatelet agents#; the ESA guidelines. June 2010 http://www.esahq.org/~/media/ESA/Files/Refresher%20Courses/2010/Neuraxial%20anaesthesia%20anticoagulant%20and%20antiplatelet%20agents%20the%20ESA%20guidelines%202010.ashx

12. Keywords

Clinical examination, Consent, History taking,

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

Development and approval record for this document		
Author / Lead Officer:	A Whitton	**Job Title:** Clinical Nurse Specialist Gynaecology Pre-Assessment
Reviewed by:	A Whitton and N Salmon	

REVIEW RECORD			
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December 2017	V1	A Whittton	No Change
January 2021	V2	A Whitton N Salmon	Various wording, best practice chaperone
April 2024	V3	M Ostler, D Stewart and K Sutton	Various wording, best practice around skills including ePOA assessment.

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UHL NHS Trust

Appendix I: Core competencies: Communication and Information Giving

Rationale

The nurse in pre-assessment needs advanced communication skills to facilitate a comprehensive assessment of the patient's medical, social and psychological needs. It is vital to provide appropriate information to enable the patient to make informed choices and prepare for surgery.

Specific Learning Objectives

Knowledge: The Pre-Operative Assessment (POA) nurse will be able to:

- Discuss with the patient/carer their planned admission and surgery, including:
  - Date & Time of admission
  - Expected length of stay
  - Type of operation with risks and benefits
  - Fasting times
  - Pre-operative preparation
  - What to bring into hospital
  - Discharge arrangements and aftercare needs
  - Time required off work
  - How to access to electronic patient information
  - Triaging the patient
  - ePOA
- Provide clear, easy to understand information in an appropriate format and at a level accessible to the patient/carer to reinforce the above points
- Ascertain the patient's level of understanding and the amount of detail they wish to know
- Identify any concerns the patient/carer may have and address them
- Have a comprehensive knowledge of the manifestations of anxiety in patient's behaviour, and a repertoire of skills to combat negative behaviour
- Have the communication skills to address a patient's sensory impairment appropriately
- Give patients the opportunity to ask questions

Skills: The POA nurse should be able to demonstrate:

- The use language appropriate to each patient
- Effective communication with patients whose first language is not English via Language Line or a suitable interpreter
- An ability to create a rapport and develop a short term relationship with the patient
- The ability to communicate appropriately with patients who have sensory impairment
- Interviewing skills that enable the gathering of information, demonstrating the use of open and closed questioning
- Listening skills and the ability to explore and clarify implied questions
- The ability to identify verbal and non-verbal responses and react appropriately
- The ability to use language that is understood by the individual patient and explain in terms they will understand

- The ability to use problem solving and decision making abilities, based on the information available
- The ability to identify behaviour resulting from anxiety and to diffuse confrontational or aggressive responses

Assessment criteria:

- The nurse is observed with a minimum of 8 patient pre-operative assessments during which he/she demonstrates all of the points above

Attitudes: The POA nurse should:

- Demonstrate empathy, knowledge and understanding of issues surrounding women's health and surgical procedures in gynaecology

I certify that the above skills have been assessed and competency demonstrated.

Assessor signature

Print Name

Designation

Date

POA Student Signature

Print name

Appendix II: Core competencies: Pre-operative assessment history taking

Rationale

The ability to obtain an accurate history and perform a physical examination is fundamental to providing comprehensive care to adults. The POA nurse needs to collect and document all necessary information to ensure the patient's medical, social and psychological needs are met in order to promote a safe admission, surgical procedure and prompt discharge.

Specific Learning Objectives

Patient History

- The POA Nurse will interview and assess the patient using the communication skills outlined in Key Skill 1
- The POA Nurse should ensure at all times that the environment provides:
    - Confidentiality
    - Privacy
    - Reassurance
- The POA Nurse will ensure that:
    - All documentation is prepared prior to appointment
    - Appropriate information is available
    - He/she is fully aware of the medical history and reason for surgery/procedure
    - Any sensory or physical disability needs are addressed
- The POA Nurse must introduce themselves to the patient and carer explaining their role and the purpose of the clinic
- The POA Nurse will act in a manner that is both professional and friendly to promote patient confidence

Obtaining a History

The POA Nurse should be able to:

- Obtain a patient's history in a logical, organised and through manner, covering
- Intended operation/procedure
- Past medical history (including)
    - Childhood and adult illnesses
    - Injuries
    - Surgical procedures
    - Obstetric history
    - Psychiatric problems
    - Hospital admissions
    - Transfusions
    - Anaesthetic history
    - Medication history (including any herbal therapies), checking compliance and interactions with surgery
    - Previous infections
- Social and family history
    - Smoking
    - Alcohol

- Recreational Drugs
- Family history of illnesses (eg IHD, Asthma, Diabetes, Thrombosis sickle cell) – Occupation

- Obtain, where necessary, supplemental historical information from other sources, such as significant others, GP or previous physicians
- Assess and plan for the patients discharge including:
  - The patients independence and home support provision
  - Have they any dependants – Transport on discharge

Assessment criteria

The POA nurse is observed at a minimum of 8 patient pre-operative assessments during which he/she follows all of the points above

Attitudes

The POA Nurse should:

Demonstrate empathy, knowledge and understanding of issues surrounding women's health and pre-operative anxieties

I certify that the above skills have been assessed and competency demonstrated.

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Appendix III: Core competencies: Pre-operative assessment clinical examination

For Respiratory System
Cardiovascular System
Gastro-intestinal System
Genito-Urinary System

Rationale

The POA Nurse will undertake a physical examination allowing a full assessment of the patient pre-operatively to optimise the patients physical condition for surgery. The POA Nurse, in conjunction with the consultant gynaecologist and anaesthetist, will take appropriate action if any abnormalities are found on examination.

An essential element prior to performing a physical examination is to ensure that consent has been obtained. Valid consent should be obtained either verbally or written prior to any examination. It is the responsibility of the POA nurse to ensure that the rights of the patient as set out in the articles of The European Convention of Human Rights are upheld.

The POA Nurse should also ensure that the patient's privacy and dignity are maintained at all times.

Specific Learning Objectives

Clinical Examination

- The POA Nurse should be able to describe the four methods of physical examination
  - Inspection
  - Palpation
  - Percussion
  - Auscultation
- Including where and when to use them, their purpose and the findings they illicit
- The physiological mechanisms that explain key findings on examination

The Process

- Introduce self to patient and explain reason for clinic appointment.
- Maintain privacy and dignity
- Observe race, age, body shape (tall, short, clear deformity), grooming
- Neurological state - Alert, orientated, moving normally
- Nutritional state - Normal weight for height, obese, cachexic
- Skin - Colour, pigmentation, texture, lesions
- Vital signs

Assessment of the Respiratory system

- Analysis of Signs & Symptoms (History)
  - Chest pain
  - Breathlessness
  - Oedema
  - Cough, sputum

General Inspection

  - Respiratory Rate – pattern, depth and effort
  - Obesity – may cause dyspnoea
  - Peripherally – finger nails for clubbing and cyanosis
  - Centrally – lips and oral mucosa for cyanosis
  - Chest - use of accessory muscles, skeletal deformities

- Palpation – where appropriate
  - **Technique** - Check symmetry of expansion. Palpate each rib and all positions of the chest wall with firm pressure
  - Trachea
  - Chest expansion
- Percussion
  - **Technique** — aim to compare one side of the chest with the other. Start at the apices, work down the upper, middle and lower lobes, front & back and axilla
  - Resonant
  - Dullness
  - Hyper-resonance
- Auscultation
  - **Technique** – Use diaphragm of stethoscope. Listen to back altering left and right parallel points moving from apices to bases. Repeat on front.
  - Normal breath sounds – vesicular
  - Abnormal breath sounds – bronchial or bronchial vesicular
  - Added sounds – rales, rhonchi, wheezes, crackles, crepitations
- Knowledge – clinical interpretation
  - Indications for a CXR – discuss with junior medical staff
- Knowledge – relating to anaesthetic risk
  - Chest infection, sputum, asthma, COPA, Pulmonary Embolism
  - O_2 saturation levels pre-op

Assessment Criteria

• The POA Nurse will be able to

  - Describe normal respiratory system anatomy and physiology – Describe normal and abnormal breathing sounds
  - Perform a full respiratory assessment as detailed above
  - Indications for lung function tests
  - Be aware of when to contact senior staff for further assessment
  - Discuss the documentation of the clinical findings

I certify that the above skills have been assessed and competency demonstrated.

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Assessment of the cardiovascular system

- Analysis of Signs and Symptoms (History)
  - Chest pain
  - Breathlessness
  - Pitting Oedema
  - Palpitations
  - Blackouts and dizziness

- General Inspection
  - Head, neck, hands, legs, feet & chest
    Peripheral cyanosis, clubbing, koilonychia, leukonychia, splinter haemorrhages, spider naevi, conjunctiva, glossitis, corneal arcus, mouth ulcers, pitting oedema, breathlessness, scars in the precordial area
  - Palpate radial pulse checking for rate, rhythm and volume. Confirm that they are equal and synchronised in both wrists

- Palpation – where appropriate
  - **Technique**: Palpate the apex beat (the point furthest to the left and downwards at which a definite cardiac impulse is felt) by using the flat of the hand and the fingertips with the pt lying at 45°. It normally lies within the 5th intercostal space and within the mid-clavicular line
  - Ventricular enlargement
  - Chest deformity
  - Mitral stenosis (beat described as tapping)

- Percussion
  - Not beneficial to percuss over the precordium

- Auscultation
  - **Technique** – standing at the right side of the patient and using first the diaphragm and then the bell of the stethoscope identify the first and second heart sounds (S1 and S2).
  - S1 is the first of the paired heart sounds. It is deeper and longer than S2. Carotid pulse maybe used to time S1 - it occurs after S1. Identify rhythm as regular, irregular or regularly irregular.
  - Auscultate the apex for low-pitched diastolic murmur of mitral stenosis and the pan systolic murmur of mitral regurgitation
  - Slowly move stethoscope towards left sternal edge to listen for tricuspid murmurs – ask patient to inhale – note any splitting of S2. Continue to listen as patient exhales: does splitting disappear?
  - Slowly move stethoscope to left 2nd intercostal space to listen for pulmonary murmurs
  - Then to right 2nd intercostal space to listen for aortic murmurs
  - Repeat process with bell of the stethoscope to listen for Mitral Stenosis

- Assess the Jugular Venous Pressure (JVP), report abnormalities and act accordingly

- Knowledge – Clinical Interpretation
  - Indications for a 12 lead ECG
  - Identify normal and abnormal in adult
  - Identification of common abnormal ECG morphology
  - Indications for a CXR
  - Indications for a cardiac echo

- Knowledge – relating to anaesthetic risk
  - Newly diagnosed heart murmur
  - Ischaemic Heart Disease (IHD) and previous Myocardial Infarction (MI)
  - Hypertension
  - Hypotension
  - Palpitations
  - Previous heart surgery
  - History of Rheumatic Fever
  - Hyperlipidaemia
  - Heart Failure
  - LBBB known or newly diagnosed

Assessment Criteria

The POA Nurse will be able to:

- Describe the normal cardiovascular anatomy, including the cardiac cycle, blood circulation, conduction systems and chest wall landmarks.
- Describe the normal heart sounds and how these can be assessed
- Describe abnormal heart sounds
- Perform a full cardiac assessment as detailed above
- Discuss the documentation of the clinical findings
- Be aware of when to contact senior staff for further assessment

Discuss the documentation of the clinical findings

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Assessment of the Gastro-intestinal System

- Analysis of Signs and Symptoms (History)
  - Haematemasis/Maleana – Nausea and vomiting
  - Unexplained weight loss
  - Change in bowel habits
  - Dysphagia – Jaundice

(Abdominal examination not routinely undertaken in Gynaecology Pre-assessment)

Sanitize or wash hands before and after examination

- General Inspection
  - Always ask permission to examine the patient and offer a chaperone. The patient must be positioned comfortably, the room should be warm and privacy maintained at all times. Ensure opportunity has been given to empty bladder.
- Observe abdomen from above and the side
  - Look for distension (masses, dilated bowel, ascites or organomegally
  - Note any scars (old, new, keloid, hypertrophic)
  - Striae (silver/purple)
  - Jaundice (scratch marks – puritis)

- Palpation
  - **Technique** – performed with the right hand predominately, with the examiner kneeling or sitting next to the patient and the arm horizontal. Always enquire about pain and tenderness before examining. Look at the patient's face throughout to ensure you are not causing pain.
  - Start by gently palpating in the four quadrants – making note of any obvious tender areas or masses.
  - Note any abnormalities with liver, spleen, bladder, kidneys

- Percussion
  - Used to detect the presence of ascites by 'shifting dullness' and 'fluid thrill' **Technique** – *shifting dullness* – percuss the abdomen from the midline towards the flanks, until the note becomes dull. Keep the hand in the same position and ask the patient to roll towards you, then continue to percuss in that position. If the area where the dullness was confirmed has become resonant, this suggests free fluid in the abdomen.
  - *Fluid Thrill* – ask an assistant to place his/her hand longitudinally along the midline. Then flick the flack beneath the area of dullness, with the other hand on the opposite side as if at the other end of a diameter of a circle. If there is a fluid thrill, it will be felt shortly after the flick, as a flutter.
  - Percuss lightly in all four quadrants
  - Tympany – gas/distended abdomen – Dullness – fluid/solid structures Auscultation
  - Normal abdomen reveals peristaltic sounds that are gurgling and bubbling in character

- Intestine mechanically obstructed reveals high-pitched tinkling sounds (usually in association with colicky pain)

- Knowledge – clinical interpretation
  - Relevance of constipation
  - Relevance of diarrhoea / malaena
  - Indigestion, reflux, haematemesis NSAID's
  - Jaundice

Assessment Criteria

The POA Nurse will be able to:

- Describe the normal Gastro-intestinal anatomy.
- Perform a full abdominal examination as detailed above
- Describe any abnormalities
- Discuss the documentation of the clinical findings
- Be aware of when to contact senior staff for further assessment
- Discuss the documentation of the clinical findings

I certify that the above skills have been assessed and competency demonstrated.

Assessor signature

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Assessment of the Nervous system

- Analysis of Signs and Symptoms (History)
  - Current Problems – include duration of the symptom, its development, and its subsequent course
  - Headache
  - Visual disturbance
  - Unconsciousness, faints or fits
  - Problems with speech
  - Memory loss
  - Muscle weakness
  - Difficulty in performing simple tasks (eg fastening buttons) - Difficulty in walking (reels from side to side)

- General Function
  - Ability to perform normal functions such as sitting and standing
  - Gait
  - Use of walking aids

- General Cerebral Functions - General behaviour
  - Conscious level
  - Intellectual performance
  - Emotional status
  - Thought content
  - Cerebral integration
    - Re-organise objects by hearing or touch
    - Carry out skilled purposeful movements
    - Understand and communicate written speech and writing

- Motor System
  - Mass – looking for wasting
  - Tone – look for spasticity, rigidity and flaccidity
  - Involuntary movement
  - Strength – test flexion, extension and other movements through major joints, first without resistance and then with examiner offering resistance. Compare each side, grade as normal, decreased or absent

- Knowledge – anaesthetic risk
  - Epilepsy
  - Motor Neurone
  - Multiple Sclerosis
  - Parkinsons Disease

Assessment Criteria

- The POA Nurse will be able to:

  - Show an understanding of the nervous system
  - Have an understanding of the risk associated with anaesthetics
  - Be aware of when to contact senior staff for further assessment
  - Discuss the documentation of the clinical findings

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Appendix IV: Core competencies: Ordering and interpretation of investigations required for pre-operative assessment

Aim

To provide a framework to enable the POA Nurse to order appropriate Trust approved investigations, thus ensuring that appropriate actions are taken in the case of abnormal results.

Entry Key Skill Criteria

RN's undertaking Pre-operative Assessment with a minimum of 3 years' experience within gynaecology.

Have completed and assessed as competent in Key Skills 1-3 of the Pre-operative Assessment Competencies.

Standard:

- The POA Nurse will work within The DoH Pre-operative Assessment Guidelines for both Day Surgery and Inpatient Surgery, the NICE guidelines on Pre-operative Investigations and Directorate guidelines to ensure appropriate investigations are ordered.

- Prior to ordering the investigations the POA nurse will obtain verbal consent from the patient as outlined in the DoH Pre-operative Assessment Guidelines (July 2003)

- The POA Nurse will take responsibility to follow up and record the results in the patients medical notes and if appropriate to contact the patient.

- The POA Nurse will check all results for abnormalities, if results fall outside the normal ranges then appropriate action must be taken, refer to algorithms

- The Pre-operative Assessment Unit is responsible for all communication with the patient prior to their admission to the ward. This includes checking the results of all investigations and ensuring that any abnormal results are acted upon to avoid later cancellations.

The following Core Investigations can be ordered in the following circumstances. Investigations can be ordered outside these guidelines as per NHS Operating Theatre & Preoperative Assessment Programme following consultation with patient's clinician.

Investigation	Patient	Action Required
Blood pressure	All patients attending PAC	If B/P is > 140/90 but < 180/110 GP needs to be informed but surgery not cancelled. Patient to have their B/P repeated by GP or home monitoring. If B/P ≥180/110 any non-urgent surgery should be postponed, however urgent surgery must almost always proceed but the patient needs to be aware of the risks.
Pulse	All patients attending PAC	If tachycardic (>100) or Bradycardic (<50) or irregular with unknown cardiac history then inform the anaesthetist. Will require an ECG
Pulse oximetry	All patients attending PAC	If < 94% then discuss with anaesthetist.
Respiration Rate	All patients attending PAC	Spirometry may be required. Discuss with anaesthetist if necessary
BMI	All patients attending PAC	If >40 then inform anaesthetist. If weight over 150kg (23½stone) then inform ward and theatres re theatre table. If BMI >50 then patient needs to attend high risk clinic
Urinalysis	All patients attending PAC (as per directorate guidelines)	If glycosuria then perform Capillary Blood Glucose (CBG) If leucocytes and urinary symptoms, then send MSU If nitrites present then send MSU
MRSA screening	All Major and Laparoscopy patients	If MRSA isolated then treatment to be arranged. If surgery urgent then discuss with surgeon who can take advice from microbiology
CRO screening	Any patient who has been an inpatient within the last 12 months	If isolated then inform surgeon and discuss with infection prevention
Pregnancy test	Any patient that is late with their period.	Inform surgeon if positive and cancel surgery, refer back to GP for further care
Sickle Cell test	Any patient with a family history of sickle cell, or those of afro-Caribbean descent	Inform anaesthetist if positive
Capillary Blood Glucose	Any patient with glycosuria	Perform CBG, if raised then perform random lab glucose and HbA1C May need to refer to GP if results raised If surgery urgent then need to discuss results with anaesthetist and surgeon
Spirometry	Patients with significant COPD, asthma or SOB. Follow guidelines from high risk	Inform anaesthetist

	clinic	
ECG	Any patient with any of the following: over 60 years, cardiac history, uncontrolled hypertensive, on diuretics, diabetic neuropathy, foot disease, renal surgery, BMI ↑45 Undiagnosed hypertensive	Discuss with anaesthetist if abnormal
Echocardiogram	Newly diagnosed heart murmur (no previous echo performed) Newly diagnosed LBBB on ECG Patient showing signs and symptoms of heart failure.	ECG must be performed before an echo is ordered. Discuss the results with the anaesthetist.

Blood Tests

Surgery grades (not an exhaustive list)

Surgery Grade	Example
Minor	Hysteroscopy Bartholins Excision of vulval lesion
Intermediate	Laparoscopy Vaginal Repairs
Major or complex	Total Abdominal Hysterectomy Laparotomy Robotic Hysterectomy

The ASA (American Society of Anaesthesiologists) Physical Status Classification System is a simple scale describing fitness to undergo an anaesthetic. The ASA states that it does not endorse any elaboration of these definitions. However, anaesthetists in the UK often qualify (or interpret) these grades as relating to functional capacity – that is, comorbidity that does not (ASA 2) or that does (ASA 3) limit a person's activity.

ASA Classification

ASA Classification	**Definition**	**Examples, including, but not limited to:**
ASA 1	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA 2	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30 <

		BMI < 40), well-controlled DM/HTN, mild lung disease
ASA 3	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents.
ASA 4	A patient with severe systemic disease that is a constant threat to life	Examples include (but not limited to): recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis

Minor Surgery

Test	ASA 1	ASA 2	ASA 3 or ASA 4
FBC	Not routinely	Not routinely	Not routinely
Clotting	Not routinely	Not routinely	Not routinely
Renal Function (U/E's)	Not routinely	Not routinely	Consider in patients at risk of AKI (Acute Kidney Injury)
Group and Save	Not routinely	Not routinely	Not routinely
ECG	Not routinely	Not routinely	Consider if no ECG results available from past 12 months

Intermediate Surgery

Test	ASA 1	ASA 2	ASA 3 or ASA 4
FBC	Not routinely	Not routinely	Consider for patients with cardiovascular or renal disease if any symptoms not recently investigated

Clotting	Not routinely	Not routinely	Consider in patients with any of the following • chronic liver disease • If patient taking anticoagulants need modification of their treatment regime then make an individualised plan in line with local guidance • If clotting status is required before surgery use point –of-care testing
Renal Function (U/E's)	Not routinely	Consider in patients at risk of AKI	Yes
Group and Save	Not routinely		
ECG	Not routinely	Consider in patients with cardiovascular, renal or diabetes comorbidities	Yes

Major or complex surgery

Test	ASA 1	ASA 2	ASA 3 or ASA 4
FBC	Yes	Yes	Yes
Clotting	Not routinely	Not routinely	Consider in patients with any of the following • chronic liver disease • If patient taking anticoagulants need modification of their treatment regime then make an individualised plan in line with local guidance • If clotting status is required before surgery use point –of-care testing
Renal Function (U/E's)	Consider in patients at risk of AKI	Yes	Yes
Group and Save	Yes	Yes	Yes
ECG	Consider in patients aged over 65 if no ECG available from past 12 months	Yes	Yes

Assessment Criteria

The POA nurse can explain for each investigation:

- Why it is required
- Contraindications
- Consequences of an abnormal result
- The normal and abnormal range of each investigation

The POA nurse can:

- Explain how the test is performed
- Ensure that informed consent is obtained from the patient and document as necessary
- Demonstrate how the results are monitored and ensure that appropriate action is taken
- Demonstrate, in the advent of an abnormal result, when and from whom to seek advice eg Anaesthetist, Surgeon or GP.
- Documents the ordering, results and action taken appropriately.

I certify that the above skills have been assessed and competency demonstrated.

Assessor signature

Print Name

Designation

Date

POA Student Signature

Print name

Appendix VI: Altering medication to maximise surgical safety

Aim

To optimise surgical safety specific medication may need to be reduced or stopped to ensure adequate safe patient preparation for surgery. This will also enable same day or day prior to surgery admission.

Standard

Background knowledge

- The POA nurse is knowledgeable of the action and consequences of the listed medications in terms of the patients surgery
- The POA nurse is aware of new therapies and is able to assess the impact they will have on the patients surgery, or is aware of where to obtain this information
- The POA nurse is aware of their knowledge limitations, and knows when and whom to contact, to seek further medical or pharmacy advice when unclear of the compatibility or consequences of medication in the preparation for surgery

Communication with the patient

The POA nurse will:

- Explain to the patient, in terms they can understand, why the medication needs to change, what they need to do and when.
- To check understanding, ask the patient to repeat the information.
- Provide the patient/carer with clear written notification of the change.
- Document any change in the patients medication appropriately and safely.

Medication Therapy:

- The POA nurse will follow the Trust Drug Policy
- The POA nurse will arrange further investigations, as appropriate, to ensure the patients safety when reducing or stopping medication eg INR
- The POA nurse will undertake a risk assessment when reducing or stopping medication to ensure the safety of the patient

Medication that can be stopped or reduced in Pre-Assessment clinic:

Drug	Pre-operative Action	Rationale
Hypoglycaemics Gliclazide Glibenclamide Metformin	Refer to hospital guidelines Usually omit morning of surgery for morning list.	Risk of hypoglycaemia in fasting patients Monitor blood sugar levels pre-operatively
Insulin	Refer to UHL guidelines Ensure an alert on ORMIS Plan for 1st on list	Risk of hypoglycaemia Monitor blood sugar levels May require VIII on admission
Anticoagulant Warfarin Apixaban Rivaxaban	Establish reason for anticoagulation Ie AF, PE/DVT, Heart Valves, Hereditary Thrombophilia Refer to UHL guidelines for haemostasis plan	Increased risk of haemorrhage with surgery
Antiplatelet	Establish reason for medication	Increased risk of bleeding with surgery. Obtain further advice for patients that have cardiac stents inserted for < 1 year.
Aspirin	Stop only if significant risk of bleeding	
Clopidogrel	Omit 7 days prior to surgery	
Dipyridamole	Omit 24 hours prior to surgery	
Prasugrel	Omit 7 days prior to surgery	
Ticagrelor	Omit 48 – 72 hours prior to surgery	
Ticlopidine	Omit 10 days prior to surgery	
Contraception COP	Discontinue 4 weeks prior to major surgery	Increased risk of DVT/PE Ensure alternative contraception is arranged, document in notes

Assessment criteria:

The POA nurse will be able to:

- Demonstrate knowledge of all medications listed above with particular reference to its effect on the patient's surgery and anaesthetic
- Explain the consequences of reducing or stopping the medication
- Demonstrates communication strategies as outlined in Key Skill 3 to ensure patient understanding
- Show awareness of knowledge limitations and when to contact medical or anaesthetic staff

I certify that the above skills have been assessed and competency demonstrated.

Assessor signature

Print Name

Designation

Date

POA Student Signature

Print name

Appendix VII: Gynaecology knowledge

Aim

To ensure that patients receive up to date and consistent information regarding their surgery and condition

Standard

The POA nurse is knowledgeable on all gynaecology surgery offered at LGH and is able to discuss each operation in detail.

- Knowledge of the female reproductive system
- Pre and post-operative care for each gynaecological operation
- Specific information required for an operation
- Discharge information
    - Recovery period
    - Bleeding & Pain
    - Time required off work
    - Exercise – Driving

Assessment Criteria

The POA nurse will be able to demonstrate

- Completion of the Pre Assessment Course
- Knowledge of all gynaecology surgery offered at UHL
- Awareness of the information patients required about individual operations
- Communication strategies as outlined in Key Skill 3 to ensure patient understanding
- Awareness of knowledge limitations and when to contact medical staff

I certify that the above skills have been assessed and competency demonstrated.

Assessor signature

Print Name

Designation

Date

POA Student Signature

Print name

Appendix VIII: Clinical skills of Pre-assessment nurses

- Venepuncture
- Advanced clinical history taking
- Physical examination
- 12 lead ECG
- Ordering and interpretation of Pre-operative investigations (excluding X-rays)

Appendix IX: Theoretical and practical experience gained in first six months in post

- Hospital Induction Day
- Directorate Induction Day
    - 3 day course on Pre-assessment covering
        - Assessment, diagnostic and patient Management Skills
        - Fundamentals of taking a patient history and performing a social and psychological assessment
        - Performing a physical examination
        - Interpreting blood results (covered briefly)
- ECG training for qualified nurses run by UHL ½ day LRI
- Shadowing junior doctors in Pre-assessment clinic

Appendix X: Audit tool for clinical history taking and physical examination of adult patients seen by the senior nurses in gynaecology Pre-assessment clinic

Directorate of Women's, Perinatal and Sexual Health Services University Hospitals of Leicester NHS Trust

Documentation

Legible		
Black Ink		
Date/Time of Clerking		
Patient details completed in full:	Name	
	Address	
	D.O.B.	
	UHL Number	
Senior Nurses signature, designation, printed name clearly recorded at the end of the clerking		

History Taking

Past History	Medical	
	Surgical	
	Anaesthetic	
	Logical	
	Appropriate	
	Any omissions	
Drug History	Generic Name	
	Dose	
	Frequency	
Drug Allergies	Recorded in medical records, nursing records and drug chart	

Clinical Examination

Pulse	
Blood Pressure	
O_2 Saturation levels	
Respiration Rate	
Urinalysis	
General Examination	
Abdominal Examination	

Appropriate investigations ordered

	Rationale	Abnormal Y/N	If abnormal – acted upon
Blood Tests			
MSU			
ECG			
CXR			
Echo			
Lung Function			

Assessed as suitable for admission **YES/NO**

IF NO

Case discussed with SHO
Consultant
Anaesthetist
Other – state

Any omissions?

_____

Outcome:

Operation went ahead **YES/NO**

If not, reason for cancellation _____

Comparison with Anaesthetic /Consultant review:

History _____

Examination _____

Fitness for operation _____

Signature of auditor _____

Designation _____

Date _____

Appendix XI: Audit record

Date	Mode of Audit	Comments	Signature
	Random sampling of 10 patients		

Appendix XII: Competency certificate

University Hospitals of Leicester NHS Trust
Directorate of Women's, Perinatal & Sexual Health Services

This document certifies that _____Senior Nurse, has undergone formal assessment and is deemed competent to carry out advanced history taking, physical assessment and order routine investigations, as outlined in the policy, for women admitted to the gynaecology pre-assessment clinic at Leicester General Hospital.

Lead Clinician

I support _____ to undertake history taking and physical examination of patients attending gynaecology pre-assessment and that their post is one in which they have the need to do so.
Signature _____ Date _____

Print name _____

I agree to act as designated mentor/clinical audit Consultant

Signature _____ Date _____

Print name _____

Gynaecology Services Manager

I support _____ to undertake history taking and physical examination of patients attending gynaecology pre-assessment and that their post is one in which they have the need to do so.
Signature _____ Date _____

Print name _____

Head of Nursing and Midwifery

I support _____ to undertake history taking and physical examination of patients attending gynaecology pre-assessment and that their post is one in which they have the need to do so.
Signature _____ Date _____

Print name _____