Standard Operating Procedure: Ambulatory Hysteroscopic Gynaecology Unit

University Hospitals of Leicester NHS Trust

Trust ref: C16/2020

Contents

1. Introduction

The Ambulatory Gynaecology unit has been set up and running since October 2014. The unit offers the following Hysteroscopic procedures under local anaesthetic.

- Hysteroscopic polypectomy /resection of submucous fibroid and directed biopsies of the endometrium under vision
- Hysteroscopic retrieval of lost/embedded IUCD/IUS
- Insertion of IUCD/ IUS following the above procedures
- Endometrial ablation

Scope:
This SOP is intended for the use of clinicians and nursing staff who are involved in providing the Ambulatory Operative Hysteroscopic Service. This document will facilitate a dedicated women centered ambulatory service for the above procedures.

Standard 1: Scheduling and listing

Procedure referrals are to be accepted from Gynaecology **outpatient, 2 week** wait clinic or **hysteroscopy** clinics, on a standard referral form which includes referral source, patient's name, procedure, comorbidities and other relevant information (appendix 1).

The referring consultant retains overall responsibility for the patient's ongoing care and responsibility for reporting results, arranging any subsequent treatment, intervention or follow up.

Inclusion Criteria: Following criteria should be met at the time of initial referral.

- **Inclusion criteria:**
- Removal of intracavity/canal lesions:
    - Endometrial polyp confirmed at hysteroscopy
    - Endocervical polyp confirmed at hysteroscopy
    - Symptomatic submucous fibroid (G0 / G1 / G2) in premenopausal women - be aware that fibroids >3cm and / or G2 SMF are unlikely to be removed completely in one sitting and patient may present as emergency with prolapsing fibroid between procedures
    - Biopsy of SMF with recurrent PMB or suspicious features suggestive of sarcoma
    - Recurrent or persistent symptomatic RPOC following failed MMM and SERPC under USS guidance especially post partum (not first line)

- Targeted/global biopsies (usually via MDT)
    - with genuine concern about the appearance of endometrium - vascular / cystic /cobblestone appearance/Incongruous, suspicious USS and OPH findings
    - Equivocal pipelle biopsy suspicious of atypia or malignancy
    - Surveillance of atypical hyperplasia where patient unsuitable for definitive surgery (under oncology oversight)
    - Endocervical biopsy of suspected adenocarcinoma of the cervix (at request of oncology team)
- Retrieval of Lost IUCD/S – only after failed attempt with thread retriever

- Patients should be listed for an ambulatory procedure only if they can tolerate vaginal examination, hysteroscopy and pipelle biopsy in the outpatient setting. They should have been offered the choice of having procedure in outpatient setting versus in theatre with sedation/regional/general anaesthetic as appropriate clinically

- Patients with suspected polyps or submucous fibroids confirmed at outpatient hysteroscopy or PMB clinic. Patients will have undergone a diagnostic procedure to **confirm** the presence of the intracavity lesion and assess ability to tolerate an outpatient procedure

- Patients will not be listed for an ambulatory procedure on the basis of an ultrasound

scan alone unless discussed with the ambulatory team.

Inclusion criteria: Minitouch Endometrial Ablation

- Patients choosing ablation procedure for the control of heavy menstrual period and who have undergone outpatient hysteroscopy and endometrial biopsy to rule out significant pathology. A diagnostic hysteroscopy must have been performed previously to confirm tolerance of an ambulatory approach and that the uterine cavity is relatively regular in shape, not too small or large. Cavity length {sound length MINUS cervical length} should be between 4cm and 8cm {only top 6.5cm of cavity will be treated}) and without significant submucous fibroids.
- The cavity length less than 4 cm is a contraindication for the procedure.

Inclusion criteria: Mirena IUS insertion/removal/replacement

- Mirena IUS may be fitted with specific consent from the patient following directed endometrial biopsies, resection of polyps or fibroids for the following indications
- Licensed indications for IUS:
    - Contraception
    - Treatment of heavy /problematic periods
    - For endometrial protection alongside estrogen hormone therapy
- Unlicensed uses of IUS include:
    - Treatment of Endometrial hyperplasia (recommended in RCOG GTG 67)
    - Endometriosis or Adenomyosis
    - May be considered for high risk patients with recurrent endometrial polyps
    - Confirmed or suspected endometrial cancer and atypical hyperplasia – on the advice of the oncology MDT

Exclusion Criteria: The following patients will not be suitable for ambulatory procedures
General exclusions:

- Pregnancy/risk of pregnancy has been excluded:

Healthcare practitioners can be reasonably certain that a woman is not currently pregnant if any one or more of the following criteria are met and there are no symptoms or signs of pregnancy:

- She has not had intercourse since the start of her last normal (natural) menstrual period, since childbirth, abortion, miscarriage, ectopic pregnancy or uterine evacuation for gestational trophoblastic disease.
- She has been correctly and consistently using a reliable method of contraception.

(For the purposes of being reasonably certain that a woman is not currently pregnant, barrier methods of contraception can be considered reliable providing that they have been used consistently and correctly for every episode of intercourse.)

- She is within the first 5 days of the onset of a normal (natural) menstrual period.
- She is less than 21 days postpartum (non-breastfeeding women). She is fully breastfeeding, amenorrhoeic AND less than 6 months postpartum.
- She is within the first 5 days after abortion, miscarriage, ectopic pregnancy or uterine evacuation for gestational trophoblastic disease.
- She has not had intercourse for >21 days AND has a negative high-sensitivity urine pregnancy test (able to detect hCG levels around 20 mIU/ml).

- Known uncontrolled epileptic (LA may precipitate seizure)
- Severe mobility issues (unless pre-arranged with ward and operating clinician and double slot booked)
- Weight exceeding limits of couch (200kg) (BMI >40 may be booked if speculum was feasible and referrer was able to visualize the cervix)
- It may be feasible to perform the procedures even if there are some relative contraindications, but please refer these patients to the ambulatory team members for opinion in case of any deviations and these patients should not be directly listed.

Myosure Exclusions:

- Submucous Fibroids larger than 4 cm (>3cm may require 2 procedures and patients should be warned of this). G2 SMF larger than 4cm are unlikely to be removed sufficiently to achieve symptom control so alternative treatment options are usually preferable. There is no limit with size of polyps
- Uncontrolled Congestive cardiac failure (risk of fluid overload). Limit fluid deficit to 1500ml where cardiac problems increase the risk of fluid overload

Minitouch Endometrial Ablation Exclusions:

- Significant uterine cavity distortion – (septum (subseptate acceptable), bicornuate / unicornuate, fibroids significantly distorting the cavity)
- Cavity length {sound length MINUS cervical length} is less than 4cm {risk of cervical thermal damage} and greater than 8cm {only top 6.5cm of cavity will be treated}
- Cavity width <2.5cm at the fundus.
- Less than 3 months failed medical therapy

- Family not complete
- Suspected or confirmed uterine malignancy or hyperplasia within preceding 5y
- Proven endometrial hyperplasia
- Untreated CIN
- Patient unwilling to use non-hormonal contraception
- Active or suspected sexually transmitted pelvic infection or PID or evidence of systemic infection (eg pyrexia)

Increased failure rates are seen with:

- women under 40y so should be avoided
- Symptomatic endometriosis and/or suspected adenomyosis (increased cyclical pain)

Booking Process

1. The premedication form should be signed by the referrer or nurse prescriber on the reverse of the booking form. A nurse hysteroscopist can obtain a doctor's signature from a doctor in the adjacent clinic or forms should be sent to ambulatory team along with the drug history and any contraindications esp to NSAIDs or Opiates.

2. The patient should be provided with the appropriate information leaflet which will be posted to the patient along with their appointment.

3. If a patient requires two different ambulatory procedures, only one will be carried out at one time. Myosure will be carried out prior to ablation if the patient needs both the procedures. This allows for the exclusion of hyperplasia in a polyp prior to ablation which would otherwise then be contraindicated, and it is possible that symptoms may improve following removal of the polyp negating the need for ablation. Patients should be encouraged to have a Mirena IUS in this circumstance.

4. The lists are to be scheduled in accordance with CMG policy of the waiting lists. The patient notes should be made available for the procedure and procedures should not be performed without a proper and sufficient record available.

5. A bridging plan is NOT USUALLY REQUIRED for patients on anticoagulants for Ablation or Myosure removal of polyps unless they appear particularly vascular, nor for fibroids in postmenopausal women. It is usually sufficient to ask women to omit a single dose of anticoagulant prior to the procedure and if all goes well, can resume normal treatment the same day, after the procedure. Near patient testing of the INR on the day of the

procedure is recommended for patients on warfarin and the procedure should be postponed if the INR >3.

Premenopausal women who are on anticoagulants with vascular looking submucous fibroids are more likely to bleed heavily than postmenopausal women so consideration for a bridging plan should be given for these women.

6. The list should be appropriately published including patient name, hospital number, procedure and any extra information as additional comments e.g. latex allergy or medical comorbidity.

Standard 2: Procedure: Personnel and equipment

- The ambulatory Gynaecology procedures are to be performed in a dedicated area appropriately staffed with trained practitioners or supervised trainees.
- There is a minimum of four personnel during the procedure. These include one skilled practitioner, assisted by one scrubbed staff member with appropriate training (SN, AP) for the service, one health care assistant as a runner for managing equipment and one health care assistant as patients' advocate and support. In case of diagnostic hysteroscopy there should be three personnel including Hysteroscopist, scrubbed practitioner and person providing patient support.
- The procedure should be performed by a competent practitioner adequately trained to perform these procedures or a trainee under the direct supervision of a competent practitioner.
- The preparation of treatment room should be in line with cleaning of theatre guidelines regarding infection control.

Standard 3: Pre-procedure checks

- Appropriate skill mix of workforce is to be confirmed prior to the start of the list. The patient notes, premedication charts, appropriate set of adequate hysteroscopes and devices, vaginal trays, prepacked drapes and supplies need to be confirmed prior to the list commencing. An extra operative hysteroscope and diagnostic hysteroscope should be available on standby for the list.

- A team briefing should be completed prior to the start of each procedure in accordance with the LocSSIP checklist. (Appendix 3). Additional procedures will be discussed to ensure equipment availability (e.g. smears, swabs, IUS)

- Throughout the procedure, patient's privacy and dignity is to be maintained. It should always be remembered that patient is awake and all the conversation should be appropriate and confidentiality is to be maintained all the time. At any time, the procedure should be abandoned if patient is unable to tolerate the procedure or becomes unwell and concerns may be raised by any member of the team.

- The patient's name, date of birth and address will be confirmed with the patient prior to labeling the specimen pot and histology form.

Standard 4: Patient pathway:

1. Meet and greet: the patient is received by a member of nursing staff, is given analgesia after checking the records. Her observations are recorded and urine sample taken for a pregnancy test on all women who are sexually active with a man unless she has at least 12 months amenorrhoea (post-menopausal).(see general exclusions above) Patients with latex allergy will be highlighted and preparations to the treatment room will be in accordance with the Latex Allergy Policy (appendix4)
2. The patient returns to the waiting area for 45 -60 minutes, to allow the analgesia to take effect prior to the procedure.
3. Patient is then seen by the medical practitioner for pre-procedure consultation and consenting. If an XL device will be required this must be communicated to the whole team. If a Mirena IUS is to be fitted or any other additional procedures anticipated, specific consent will be obtained and this will be communicated to the whole team.
4. The setup of all equipment for the procedure should be completed prior to the arrival of the patient in the treatment room.
5. Patient is taken to the changing room to change into a hospital gown
6. Patient will be invited into the treatment room and the team will be introduced.
7. Patient's name date of birth and address are confirmed for the histology sample pot and form. The procedure is confirmed with the patient including any additional procedures. Patients may bring a friend or relative into the treatment room for support at the operator's discretion.

8. The patient will be seated on the procedure couch and the couch adjusted into the best position for the doctor and patient, maintaining her dignity.

9. Sterile drapes are used (operator preference) and plastic water collection bag is used for Myosure procedures. The perineum and/or cervix are cleaned with antiseptic solution as necessary.

10. The procedure is carried out under local anesthesia (Intracervical or Paracervical block) for procedures where dilatation is required. A vaginoscopic approach should be performed whenever possible and local anaesthetic may not be required if dilatation is not needed. Choice of the anesthetic agent is at the individual preference of the operating practitioner and dependent upon comorbidities.

    a. Lignospan/Cytonest with a dental syringe provides easier administration and higher volumes of local Lidocaine can be used with adrenaline.

    b. Adrenaline can increase the risk of unwanted side effects. Lidocaine without adrenaline is available for use with a standard syringe and blue/orange needle and allows for aspiration to avoid inadvertent intravascular injection.

11. Adrenaline should be avoided in patients with cardiac arrhythmia or epilepsy.The maximum volume of local anaesthetic which may be administered is dependent on the weight of the patient, the concentration of the anaesthetic and whether or not adrenaline is used

Drug	Concentration (mg/ml)	Maximum dose (mg/kg)	Maximum volume (ml)								
			35 kg	40 kg	45 kg	50 kg	60 kg	70 kg	80 kg	90 kg	100 kg
Lidocaine **1%**	10 mg/ml	**3 mg/kg**	10.5	12	13.5	15	18	20ml (200mg)			
Lidocaine **2%**	20 mg/ml		5.25	6	6.75	7.5	9	10ml (200mg)			
Lidocaine **1%** *with Adrenaline (1:200000)*	10 mg/ml	**7 mg/kg**	24.5	28	31.5	35	42	49	50ml (500mg)		
Lidocaine **2%** *with Adrenaline (1:200000)*	20 mg/ml		12.25	14	15.75	17.5	21	24.5	25ml (500mg)		
Prilocaine **1%**	10 mg/ml	**6 mg/kg**	21	24	27	30	36	40ml (400mg)			

12. Entonox is available for all patients requiring additional analgesia as required. Its actively encouraged for pateints undergoing minitouch ablation.

13. The appropriate device is selected by the operating practitioner and opened by the runner (Myosure: Lite, Reach or XL; Minitouch)
14. Standard operating pressures for outpatient hysteroscopy are between 80-100mmHg. Occasionally pressure may need to be increased to reduce bleeding but should never exceed 140mmHg. The practitioner will be mindful of the pain experienced by the patient and if excessive at higher pressures, either reduce the pressure, give Entonox or abandon the procedure.
15. Plastic speculums will not be broken in the vagina - can lead to vaginal trauma
16. All the specimens are appropriately labeled with the patient sticker. The patient details will be confirmed with her by the HCA (runner) before attaching the sticker to the pot and verified with the operating practitioner. The operating practitioner completes all histology forms and addresses them to the patient's original referring Gynaecology consultant who will maintain overall responsibility for the patient's ongoing care.
17. Digital photographs will be taken, clearly marked with the patient details and date and attached securely in the patient notes in accordance with CMG policy.
18. The traceability stickers for the device and operating sets are attached to the documentation sheet.
19. Documentation of the procedure will be completed on the pro forma and will include any abnormalities, concerns or recommendations.
20. Once the patient is ready, she will be escorted back to the changing room to re-dress and thence to the consultation room.
21. Her observations will be rechecked and documented in the notes
22. The operating practitioner will debrief the patient following the procedure along with any further management options.
23. The ICE discharge letter is prepared by the operating practitioner along with a DIT3 letter to the referring consultant. The referring consultant retains overall responsibility for the ongoing care of the patient and will write to the patient with her results. However, the operating practitioner has their own duty of care to ensure the results are actioned upon where necessary
24. The HCA will escort the patient back to the waiting room or recovery rom and offer her refreshment. The patient will wait for 10-15 mins before leaving the department to ensure she is fully recovered from the procedure.
25. If the patient, requires a longer stay she may be admitted to the inpatient ward once the ambulatory suit closes for the evening.
26. Patient will be given contact numbers in the case of emergency and a copy of her ICE discharge letter
27. The patient can be discharged anytime when she feels ready.

Standard 5: Monitoring During Anaesthesia

All patients undergoing a local anaesthetic procedure are monitored at according to the Royal Association of Anaesthetist and Department of Anaesthetist guidelines.

	ACTION	**RATIONALE**
(a)	All patients will have vital signs recorded prior to commencement of procedure	To ensure the patient does not have any adverse reactions and following the Association of Anaesthetist guidelines.
(b)	Patients undergoing **Local anaesthetics and Endoscopy procedures** will have the following parameters measured: • Blood Pressure • Pulse oximetry • Height • Weight All of the above other parameters must be available within the department	All patients undergoing local and regional anaesthesia will require the same standard of care and monitoring, ensuring any adverse reactions are identified and acted upon immediately.

Standard 6: Care of equipment and treatment room

- Reusable equipment is to be sent to the sterilization hub or the sterilization services department (SSD) for offsite cleaning, in preparation for use again.
- Equipment is to be appropriately audited (completed information sheet allocated to the item) /wrapped/ bagged and labeled, then transported to the SSD hub for collection.
- Clean items are to be collected from SSD from the allocated shelving
- Single use items are disposed of according to hospital policy
- All hard surfaces used are to be cleaned with the chlorclean between each case
- Camera head and light leads are cleaned with high grade disinfectant wipes between each case

Standard 7: Transport of Laboratory Specimens from the Ambulatory Hysteroscopy Service to histopathology laboratory

HCA Runner must ensure that:

- The tissue sample pot is correctly labeled after demographics verification with the patient (or her representative if does not have mental capacity), confirming that this correlates with the label on the pathology request form.
- The details of all the samples sent are recorded in the clinic book
- Ensure the pathology pot contains sufficient preservative (formalin) to preserve the tissue sample. This must cover all the tissue.
- Secure containers with fluid and tissue tightly for transportation to avoid leaks.
- Place label on the container and not on the lids
- Use a bio hazard label on any container that may be potential harmful to the laboratory team
- Mark pathology request forms for urgent (2WW) processing with red “2WW” ink stamp and place in ORANGE bag
- Ensure samples are collected by UHL porter service.

Standard 8: Management of unexpected events

A Hysteroscopy is a very safe procedure. However, complications can and do occur which include:

A. Fainting or dizziness (vasovagal reaction)

B. Extreme pain discomfort while performing the procedure

C. Confirmed or suspected uterine perforation, bowel, bladder or blood vessel injury

D. Fluid overload

A. Vasovagal Episode

1. Cervical manipulation or dilation can result in vaginal stimulation of the parasympathetic system. This results in bradycardia and vasodilatation causing fall in blood pressure and fainting. Vasovagal rates are approximately 1-1.7% & during OPH.

2. Remove scope immediately reassure patient. Most patients recover in a few seconds.

Lower head and raise legs to increase venous return from the legs

3. Call for additional assistance

4. Check BP, Pulse, Respiratory Rate and oxygen saturation

5. Consider oxygen, IV access and a 12 lead ECG if effects of vasovagal prolonged.

6. Look for adverse signs:

   Systolic BP<90

   Heart rate<40

   Ventricular arrhythmia

7. If persistent adverse signs present: Start oxygen

8. Obtain IV access

9. Medical Staff to administer Atropine 500mcg IV stat and start IV fluids

10. If no satisfactory response call Resuscitation Team and follow algorithm

11. In rare cases where effects of vasovagal are profound or prolonged follow:

    Adult Bradycardia Algorithm

B. Extreme pain

- If patient experiences severe pain during administration of local anaesthetic, stop injection and allow pain to settle as the injection takes effect. Reassure patient. Further injections are likely to be less painful. If patient continues to find this excessively painful – offer patient Entonox or abandon the procedure.
- If patient finds cervical dilatation painful stop dilatation – infiltrate further Lidocaine 1% into the cervix up to maximum dose – See chart in main guideline. Allow time for the Lidocaine to take effect
- If the patient finds the pressure if the saline painful (cramping pain) – consider reducing the intrauterine pressure. Standard operating pressures are between 80-100 mmHg. Occasionally pressure may need to be increased to reduce bleeding but should never exceed 140mmHg. The practitioner will be mindful of the pain experienced by the patient and if excessive at higher pressures, either reduce the pressure, give Entonox or abandon the procedure.
- If at any point the patient requests for the procedure to stop – the practitioner will do so.

C. Confirmed or suspected uterine perforation, cervical, vaginal, bowel, bladder or blood vessel injury

- If uterine perforation is suspected the procedure will be abandoned, a full assessment undertaken and set of observations and consideration will be given to the need for admission for observation/further investigation
- If there was no evidence of bowel, bladder or blood vessel injury at the time of the perforation, the patient is well and reasonably comfortable, she need oral broad

spectrum antibiotics and analgesia as required

- Where vaginal or cervical injury occurs, this may be managed conservatively if minor or with sutures or packing of the vagina and admission with antibiotic cover or transfer to theatre as appropriate.
- Where visceral damage is suspected or confirmed – admit for observation and discuss further management with the on call general surgical or urological team.
- Where vascular damage is suspected or confirmed – admit for resuscitation, observation and treatment as required, liaising with the vascular or interventional radiology team if necessary.

D. Fluid overload

It is recommended that fluid deficits should be monitored continuously throughout the Myosure procedure with that aim of not causing fluid overload. As saline is the only distension medium used in our clinic, the limit of fluid deficit for most patients is 2500ml. If patients have Congestive Cardiac Failure or Pulmonary Hypertension a reduced limit of fluid deficit is used dependent on the severity of the disease (eg 1500ml or lower still if the woman has severe cardiac failure – eg 750ml) will be used and consideration to admission for post-procedure admission for observation given.

Where the limit of fluid deficit is exceeded, the patient will be admitted for a period of no less than 4h for observation. Any derangement in her observations from normal values will prompt consideration of the following:

- **Strict fluid balance chart**
- **Blood tests (FBC and U&E as minimum),**
- **CXR,**
- **IV Furosemide 20mg if clinical evidence of pulmonary oedema**
- **Referral to the Medical registrar on call or ITU Outreach team for advice**

Standard 9: Privacy and Dignity

Staff must respect a patient's privacy and dignity at all times. All patients have the right to individualised care when undergoing treatment.

	ACTION	RATIONALE
(a)	• Local Anaesthetic Patients may retain dentures, spectacles, wigs, false limbs etc.	• This protects patient's dignity when they are feeling vulnerable.

	All information regarding the above must be documented on the patient care plan and the procedure team informed.	The team will be made aware of any potential hazards.
(b)	Patient's religious and ethnic culture must be respected and their wishes granted when practicable.	All patients are to be treated equally irrespective of their religion or ethnic culture.
(c)	Patients will not be left unattended in the treatment and resting area.	To provide support and protect the patient from any misadventure.
(d)	In Treatment Room • The patient's clothing and / or sheet is to remain in place until the last possible moment. • Skin exposure must be kept to a minimum but sufficient to allow appropriate skin preparation and draping.	To protect the patient's dignity when they are unable to do so for themselves.

2. Monitoring Compliance

It is recommended that the service undertake regular audit, service evaluation and patient satisfaction questionnaires to assist in assessing the quality of the service.

3. Education & Training

None

4. Supporting References

1. Best Practice in outpatient hysteroscopy RCOG/BSGE joint guidelines March 2011 (accessed December 2023) https://www.rcog.org./gtg59hysteroscopy.pdf
2. UHL theatre guidelines
3. UHL infection prevention guidelines

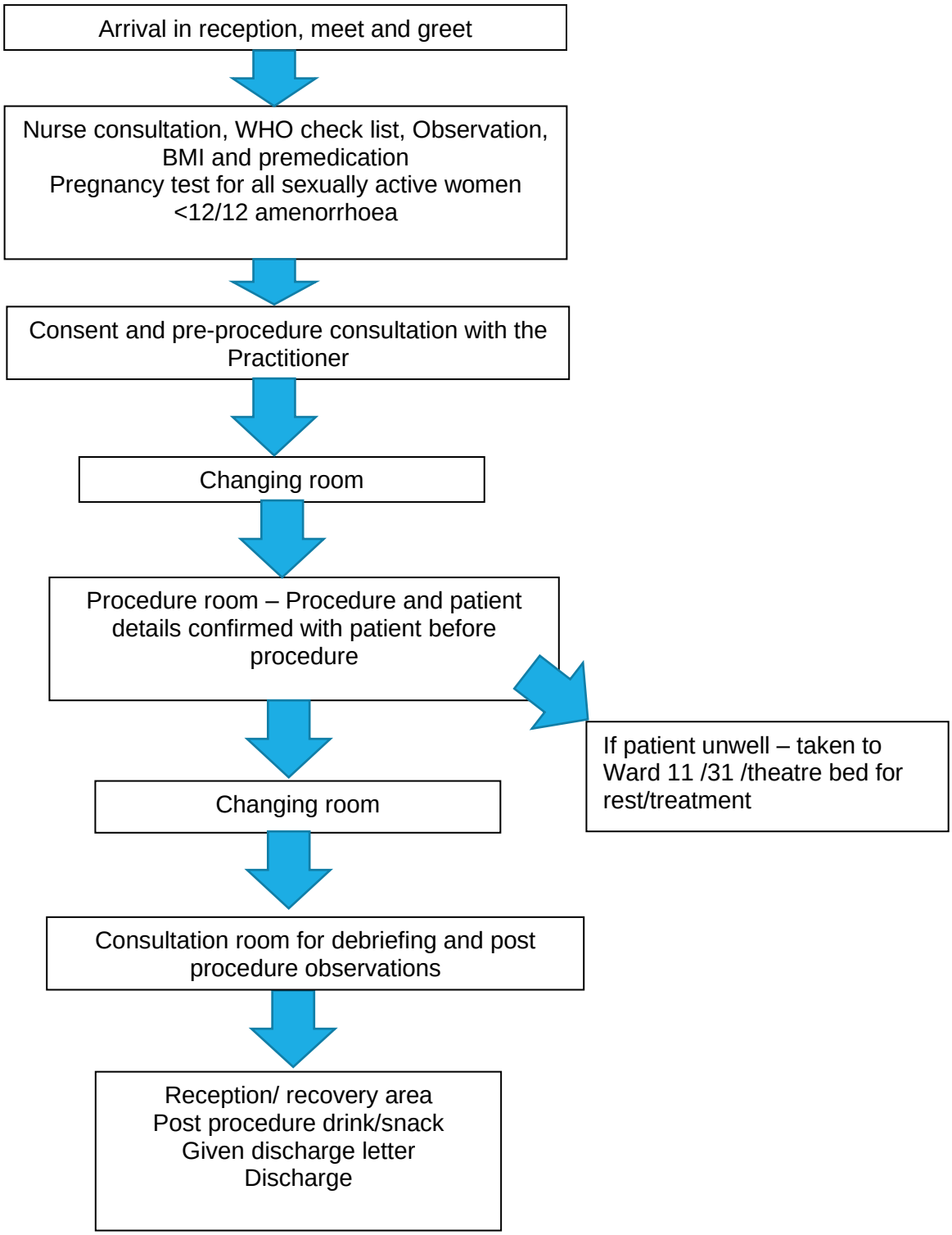
5. Key Words

Hysteroscopy

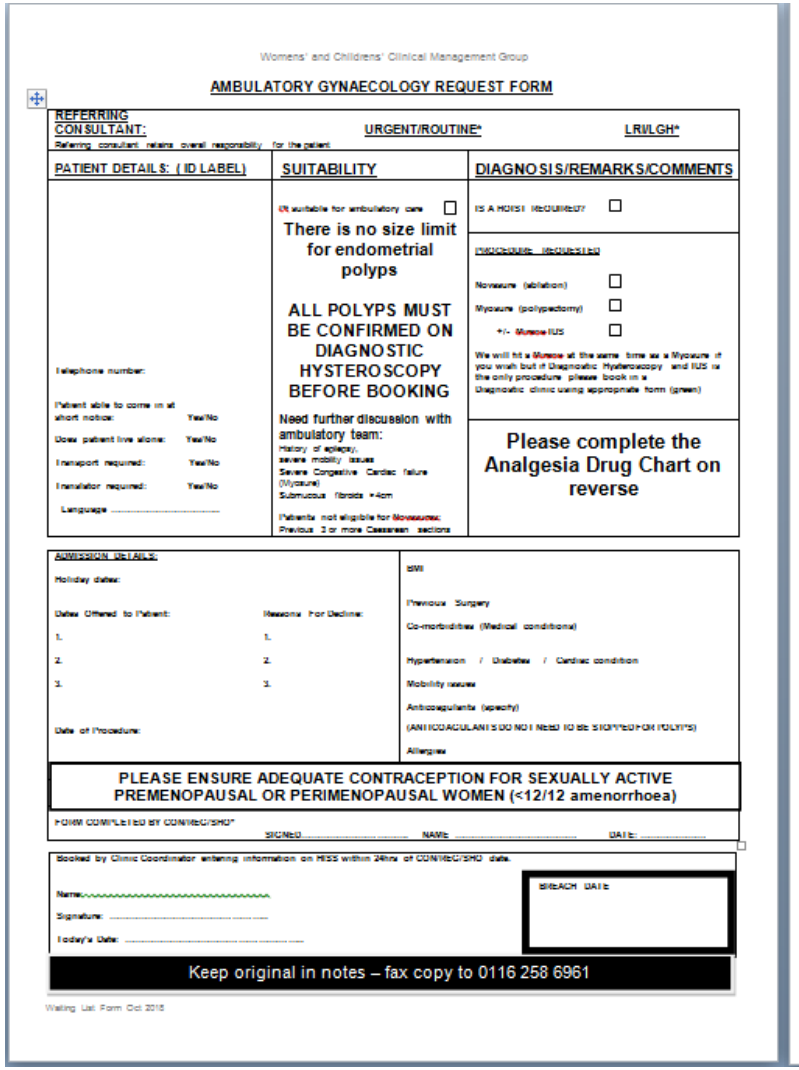
The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality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

CONTACT AND REVIEW DETAILS			
SOP Lead (Name and Title) Olivia Barney - Consultant			**Executive Lead** Chief Nurse
Details of Changes made during review:			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
November 2019	**1**		**New document**
December 2023	**2**	**Olivia Barney Gynaecology Governance Committee UHL Women's Quality & Safety Board**	Updated pregnancy exclusion criteria

Appendix 1: Patient flow pathway



Appendix 2: Referral form (peach form) + Premedication chart



Womens' and Childrens' Clinical Management Group

AMBULATORY GYNAECOLOGY REQUEST FORM

REFERRING CONSULTANT: URGENT/ROUTINE* LR/LGH*

Referring consultant retains overall responsibility for the patient

PATIENT DETAILS: (ID LABEL)

Telephone number:

Patient able to come in at short notice: Yes/No

Does patient live alone: Yes/No

Transport required: Yes/No

Translator required: Yes/No

Language .....

SUITABILITY

Pt suitable for ambulatory care ☐

There is no size limit for endometrial polyps

ALL POLYPS MUST BE CONFIRMED ON DIAGNOSTIC HYSTEROSCOPY BEFORE BOOKING

Need further discussion with ambulatory team:

History of epilepsy,
severe mobility issues
Severe Congestive Cardiac failure
(Myosure)
Submucous fibroids >4cm

Patients not eligible for Novasure:
Previous 3 or more Caesarean sections

DIAGNOSIS/REMARKS/COMMENTS

IS A HOIST REQUIRED? ☐

PROCEDURE REQUESTED

Novasure (ablation) ☐

Myosure (polypectomy) ☐

+/- Mirena IUS ☐

We will fit a Mirena at the same time as a Myosure if you wish but if Diagnostic Hysteroscopy and IUS is the only procedure please book in a Diagnostic clinic using appropriate form (green)

Please complete the Analgesia Drug Chart on reverse

ADMISSION DETAILS:

Holiday dates:

Dates Offered to Patient: Reasons For Decline:

1. 1.
2. 2.
3. 3.

Date of Procedure:

BMI

Previous Surgery

Co-morbidities (Medical conditions)

Hypertension / Diabetes / Cardiac condition

Mobility issues

Anticoagulants (specify)

(ANTICOAGULANTS DO NOT NEED TO BE STOPPED FOR POLYPS)

Allergies

PLEASE ENSURE ADEQUATE CONTRACEPTION FOR SEXUALLY ACTIVE PREMENOPAUSAL OR PERIMENOPAUSAL WOMEN (<12/12 amenorrhoea)

FORM COMPLETED BY CONMEC/SHO* SIGNED..... NAME..... DATE:.....

Booked by Clinic Coordinator entering information on HISS within 24hrs of CONMEC/SHO date.

Name:.....

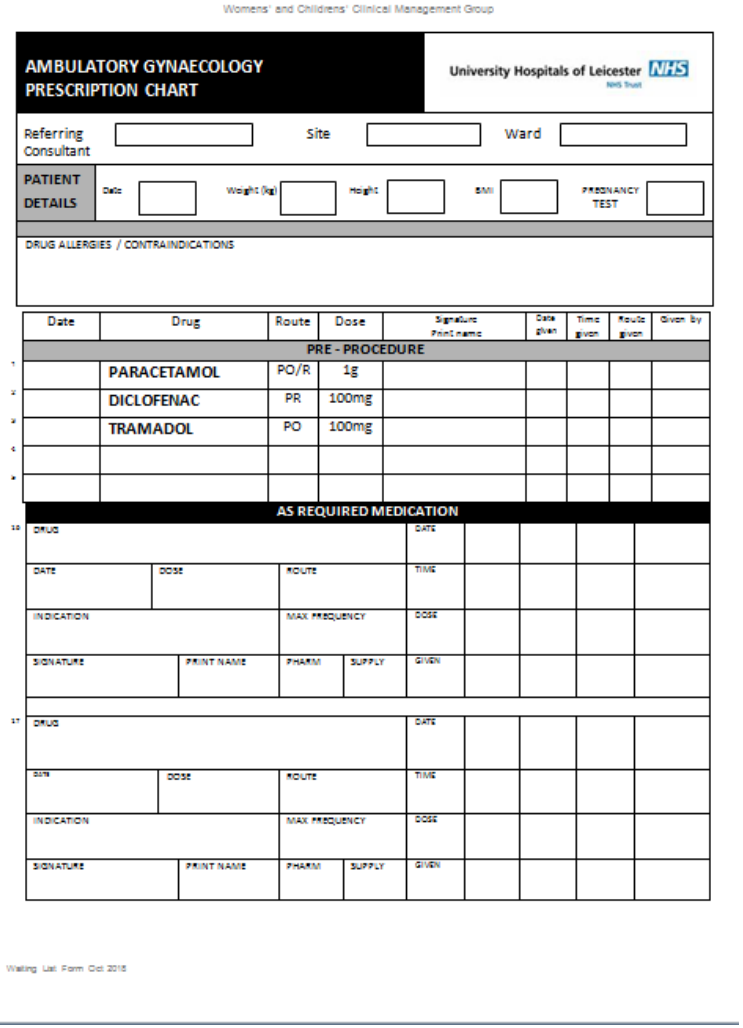
Signature: .....

Today's Date: .....

BREACH DATE

Keep original in notes – fax copy to 0116 258 6961

Waiting List Form Oct 2015



Womens' and Childrens' Clinical Management Group

AMBULATORY GYNAECOLOGY PRESCRIPTION CHART

University Hospitals of Leicester NHS

Referring Consultant | Site | Ward

PATIENT DETAILS: Date | Weight (kg) | Height | BMI | PREGNANCY TEST

DRUG ALLERGIES / CONTRAINDICATIONS

	Date	Drug	Route	Dose	Signature Print name	Date given	Time given	Route given	Given by
		PRE - PROCEDURE							
1		PARACETAMOL	PO/R	1g					
2		DICLOFENAC	PR	100mg					
3		TRAMADOL	PO	100mg					
4									
5									

AS REQUIRED MEDICATION

10 DRUG | DATE

DATE | DOSE | ROUTE | TIME

INDICATION | MAX FREQUENCY | DOSE

SIGNATURE | PRINT NAME | PHARM | SUPPLY | GIVEN

17 DRUG | DATE

DATE | DOSE | ROUTE | TIME

INDICATION | MAX FREQUENCY | DOSE

SIGNATURE | PRINT NAME | PHARM | SUPPLY | GIVEN

Waiting List Form Oct 2015

Appendix 3: LocSipps check list
– on all hysteroscopy pro formata

LocSSIP: TO BE COMPLETED BY RUNNER BEFORE COMMENCING PROCEDURE

Confirm pregnancy test performed: YES / N/A
Confirm patient details with patient: YES
Affix same checked sticker to sample pot and histology form: YES
Written consent confirmed: YES **Sign_____**

Appendix 4: Care of Patients with Latex Allergy
Latex allergy patients will receive optimal care within a latex free environment.

	ACTION	RATIONALE
(a)	All staff caring for a patient with latex allergy will be made aware This information will be included on the procedure list.	To allow preparation of the peri-operative environment for this patient.
(b)	Staff involved with patients with a latex allergy will have access to information in the following areas: • Latex free folder OPD There should be a nominated latex advisor in each area.	All staff are to have access to latex free information and product guidelines.
(c)	Latex allergy patients should be first on the procedure list. If this is not possible then the area must be prepared following the guidelines below.	To allow for the preparation of the area environment reducing the risk of latex particles being present.
(d)	It is not necessary to empty the treatment room (TR) of fixtures and fittings. During preparation of the TR staff must wear latex free gloves. Preparation must include: • Removal of any visible latex products e.g. gloves or items to be covered with a latex free sheet. • TR should be cleaned in the approved manner. • Damp dust trolleys and bed. • Operating table pads and patient supports that contain latex (or when it is not certain that items are latex free) must have a latex free cover such as bubble wrap. This should be secured with a latex free tape. • Access to TR should be restricted and latex allergy awareness notices must be placed around the area.	To provide a latex free environment in compliance with the Trust's latex allergy policy. To inform staff that the TR is designated latex free.
(g)	Following procedure Patient to resting area prepared for the patient's latex allergy status.	All staff involved to be aware of allergy.