Royal College of Obstetricians and Gynaecologists

Setting standards to improve women's health

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GYNAECOLOGY: EMERGENCY SERVICES STANDARDS OF PRACTICE AND SERVICE ORGANISATION

1. Purpose

Gynaecology is a major surgical specialty and it therefore follows that gynaecological emergencies are one of the most common indications for surgery. This document lays down the principles for service organisation and delivery of emergency gynaecology. These principles apply to units where patients with emergency gynaecological conditions are clinically assessed, investigated and treated.

2. Introduction

Gynaecological emergencies can arise at any time of the day. The introduction of early pregnancy units (EPU) has led to an organised assessment of women with complications of early pregnancy, the most common cause of emergency assessment. Thus, most of these women are seen within working hours. However, some women have severe symptoms, which cannot wait until an EPU opens, and others have non-pregnancy-related conditions.

As a result of the introduction of EPUs and following National Confidential Enquiry into Patient Outcome and Death recommendations, most gynaecological emergency surgery should take place within the working day.[1] This allows for better consultant availability for teaching and supervision of trainees. However, given that emergencies also arise out of hours, when trainees are likely to be the only doctors in the hospital, the need for consultant presence or distant supervision will always remain.

Waiting list targets for elective surgery create a priority for elective surgery, which is sometimes at opposition to the priority for emergency cases during daytime operating lists.

Standards for emergency gynaecology need to encompass all of these factors.

3. Standards

Many of the standards set out in this document are also supported by the RCOG working party report *Standards in Gynaecology*, published in June 2008.[2]

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4. Organisation of a high-quality emergency gynaecology service

The delivery of a high-quality emergency gynaecology service requires:

- leadership – a lead senior clinical leader
- organisation – a good infrastructure including sufficient theatre capacity and manpower
- practice and training – adequate numbers and supervision of junior staff
- managerial and patient focus on emergency gynaecology services.

4.1 Leadership

Each unit must have a named lead consultant who is responsible for the emergency gynaecological service. This responsibility includes clinical organisation, standards of practice, governance and directing the most effective use of resources in the emergency gynaecology service.

This responsibility should be reflected by dedicated time in the named consultant's job plan based on the size of the unit and its volume of activity.

The named consultant should work within a team, including a senior nurse or matron and the directorate manager. They must hold quarterly multidisciplinary risk management meetings, including nurses, anaesthetists and theatre staff involved in the provision of the emergency gynaecological service.

Clinical reviews of difficult cases and root cause analyses of significant clinical incidents must take place regularly. The frequency of these meetings will depend upon the size and activity of the service but should be held at least monthly. These meetings should report through the departmental and Trust governance structures.

4.2 Organisation

There should be a policy stating at what point there must be direct consultant input into the management of emergency gynaecological cases. The consultant on-call must ensure that emergency patients are reviewed at least once every 24 hours, including at weekends. If the volume of activity is high, the service will require an appropriate level of presence from the consultant on-call.

It is essential that there is ready and timely access to the following:

- **Diagnostic support services** – ultrasound, radiology including magnetic resonance imaging and computed tomography, haematology and biochemistry.
- **Operating theatres** – there must be adequate theatre provision for gynaecological emergencies in working hours. Although surgical evacuation of the uterus for miscarriage is often seen as a minor procedure, the risks of delay should be recognised (infection and bleeding). In addition, it is appropriate that these women should expect timely and sensitive care at an emotionally vulnerable time. Clearly, in cases of medical emergency (for example, ruptured ectopic pregnancy with haemodynamic instability) the clinical features will determine the priority to be given in relation to other surgical emergencies.
- **Critical care facilities** – complex cases may need access to a critical care facility (for example, severe ovarian hyperstimulation syndrome). Ideally, these facilities should be on the same hospital site. However, where this is not the case, an effective care pathway for ready access to a nearby critical care facility is essential. If patients are transferred to another site, the name of the consultant gynaecologist in charge should be clearly discussed and documented.
- **Specialist or tertiary level services** – In a small number of emergencies, access to specialist or tertiary level services will be needed. Again, a robust care pathway must be in place for these women.

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- **Psychological support services** – some women may need psychological support. Suitable care pathways and services must be in place for those women who need extra support, especially following pregnancy loss.
- **Governance** – a full range of governance systems and processes must be in place and working to identify and register risks associated with the emergency gynaecological service. Emergency gynaecological surgery must be the subject of regular audits of clinical processes and outcomes.

4.3 Practice and training

Guidelines must be in place for the most common emergencies and updated on a regular basis.

Trainee doctors must be able to get advice and support from a senior doctor at all times. The level of support will depend on the trainee's level of experience. Training in the management of emergencies must be given priority. This must include operative skills.

Modified Early Warning Score charts and scores should be used to assess patients. These charts enable an accurate assessment of the patients' current state and to trigger action in patients who are deteriorating before they reach a critical point.

Procedures must be in place for the effective handover of care between the changing shifts of doctors. This must include an accurate assessment of the patient's current condition and a suggested time for review by a gynaecologist (specialist registrar or above).

4.4 Patient focus

Patients' views must be taken into account when developing emergency gynaecological services. Trusts have a variety of mechanisms for gathering patients' views about services and these should be used to assess emergency gynaecological services.

Patient information leaflets should be available covering the common emergency gynaecological conditions. Good quality national leaflets are available, such as those produced by the RCOG.[3] These should be supplemented by local information, such as where to find help (contact telephone numbers and so on), especially for those patients being managed in the outpatient setting.

Ward areas must be organised and equipped to maintain patient dignity at all times. This means ensuring complete privacy during consultations and examinations.

References

1. National Confidential Enquiry into Patient Outcome and Death. *Who Operates When? II: the 2003 Report of the Confidential Enquiry into Patient Outcome and Death*. London: NCEPOD; 2003 [**www.ncepod.org.uk/2003wow.htm**].
2. Royal College of Obstetricians and Gynaecologists. *Standards for Gynaecology: Report of a Working Party*. London: RCOG Press; 2008 [**www.rcog.org.uk/womens-health/clinical-guidance/standards-gynaecology**].
3. Royal College of Obstetricians and Gynaecologists. [**www.rcog.org.uk/womens-health/patient-information**].

This good practice guidance was produced on behalf of the Professional and Clinical Standards Committee by **Mr D Churchill FRCOG, Wolverhampton; Dr T Mahmood, FRCOG, Kirkcaldy; Mr SK Vyas FRCOG, Bristol**.

It was peer reviewed by the Professional and Clinical Standards Committee and clinical directors of obstetrics and gynaecology before being finally approved by the RCOG Standards Board.

The RCOG will maintain a watching brief on the need to review this guidance.

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