Developing a direct access outpatient hysteroscopy service

This article describes the development and running of an outpatient hysteroscopy service. The authors highlight the reasons why the service was seen as feasible and the benefits which patients and staff have found since its inception.

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Endoscopic visualisation of the uterine cavity, or hysteroscopy, is now recognised as being a more accurate diagnostic procedure than dilatation and curettage (D&C) for abnormal uterine bleeding. According to Lof-fer (1989): 'The usefulness of D&C as a diagnostic tool has been repeatedly questioned.'

Recent developments in endoscopic equipment have allowed outpatient hysteroscopy to be performed without the need for general anaesthetic, making the investigation acceptable to most patients. This facility is associated with minimal risk, increased diagnostic accuracy and reduced costs. It also encompasses many recommendations of The Patient's Charter (DoH 1992).

DEVELOPMENT OF THE OUTPATIENT SERVICE

Development of the direct access hysteroscopy service in Bradford began in 1994 when a working group of six GPs and two consultant gynaecologists was formed to consider provision of the service. Protocols and guidelines were devised, together with a patient-held record booklet.

It was envisaged that the service would be used mainly by women over 35 with a range of menstrual problems, such as:

- Menorrhagia
- Inter-menstrual bleeding
- Post-menopausal bleeding
- Unscheduled bleeding during hormone replacement therapy (HRT)
- As assessment for endometrial resection.

All GPs in Bradford were invited to workshops to be given a detailed briefing on how the service would work, prior to them being able to refer patients.

In order to carry out hysteroscopy successfully in the outpatient setting, appropriate equipment for sterilisation of the instruments and carrying out of the procedure were required. Similarly, staff providing the service needed the requisite knowledge and skills.

Nursing input was from theatre staff who met with nurse/midwife managers. From these meetings protocols and procedures were developed. A six-week training programme was devised for the clinic’s nursing staff. Meetings were also held with the central sterile supplies manager to discuss the content of the instrument trays and what the expected demand for trays would be.

PREPARING FOR PRACTICE

A camera system and hysteroscopes, measuring 1.0mm (2.5mm with sheath), were supplied. It was decided that using Nu-Cidex would be the most appropriate way to disinfect the hysteroscopes, as an extraction cabinet is not needed and it is a safer alternative to glutaraldehyde (Johnson and Johnson 1994). Staff involved in the procedure do not wear theatre clothing as this was thought unnecessary; patients would only remove the necessary clothing and wear a gown or dressing gown. The procedure room floor is thoroughly cleaned after each session and the room is damp dusted according to the Bradford Hospitals NHS Trust theatre procedure.

To make the room less clinical, pictures and mobiles have been placed within view and music is played. Attractive dressing gowns are also provided. The aim is to make the clinic as welcoming and friendly as possible.

THE NURSE FACILITATOR

A G grade nursing post has been created to fulfil the nurse facilitator role. This involves liaising with the hospital and community trusts, and acting as a contact person providing a link between GPs, the hospital-based service and the patients. Advice and information is given and the nurse facilitator acts as a named nurse for patients in accordance with The Patient’s Charter (DoH 1992).

Attributes essential to the post are:

- Counselling skills
- Teaching and assessing qualification
- Community awareness skills
- Knowledge of health promotion.

The authors currently hold the post jointly, and since being in post, they have undertaken a number of projects including:

- Visiting and supporting GPs and practice nurses as

KEY WORDS

- WOMEN'S HEALTH
- OUTPATIENT SERVICES

These key words are based upon work undertaken by the RCN Library.

This article has been subject to double-blind review.
Table 1. Reasons for patient referrals in the first year.

<table>
<thead>
<tr>
<th>REASONS FOR REFERRAL (N=255)</th>
<th>NUMBER</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Menstrual problems</td>
<td>113</td>
<td>44.3</td>
</tr>
<tr>
<td>Post-menopausal bleeding (PMB)</td>
<td>97</td>
<td>38.0</td>
</tr>
<tr>
<td>Unscheduled bleeding on HRT</td>
<td>22</td>
<td>8.6</td>
</tr>
<tr>
<td>Assessment for transcervical resection of the endometrium (TCRE)</td>
<td>19</td>
<td>7.5</td>
</tr>
<tr>
<td>Others</td>
<td>4</td>
<td>1.6</td>
</tr>
<tr>
<td><strong>WOMEN WITH POST-MENOPAUSAL BLEEDING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empty uterus</td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>Endometrial polyps</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Malignant appearance (carcinoma confirmed in two cases)</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Fibroids</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Pyometra</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Endocervical polyp</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Cervical stenosis</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Failed attempts (cervix could not be viewed due to obesity)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>WOMEN WITH MENSTRUAL PROBLEMS</strong></td>
<td>113</td>
<td></td>
</tr>
<tr>
<td>Normal cavity</td>
<td>92</td>
<td></td>
</tr>
<tr>
<td>Endometrial polyps</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Submucosal fibroids</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Hyperplasia (confirmed in one case)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Endocervical polyps (carcinoma confirmed in one case)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>WOMEN WITH UNSCHEDULED BLEEDING ON HRT</strong></td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Normal cavity</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Endometrial polyp</td>
<td>3</td>
<td></td>
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<tr>
<td>Fibroids</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Malignant appearance (carcinoma confirmed)</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

they begin to use the service

- Developing and facilitating workshops aimed at practice nurses because they are involved in preparing patients for the procedure
- Visiting and informing community staff, family planning nurses and their managers to enable them to provide information for women
- Examining the problems facing Bradford’s multi-cultural population. Liaison with community development and health education services has enabled the authors to speak at Asian women’s health groups. Information leaflets which have been developed have also been translated into Urdu, and the production of an audio cassette for Asian women informing them what happens at the clinic is underway.

ATTENDING THE CLINIC

Referral procedure Referral to the hysteroscopy clinic is through the patient’s GP. Once a patient has been assessed according to the guidelines, any necessary investigations are arranged, and the GP will carry out a vaginal examination to establish that the patient is suitable for outpatient hysteroscopy.

An appointment is made directly by telephone and the hysteroscopy will be performed within three weeks, or within one week in cases of post-menopausal bleeding.

On arrival at the clinic, the patient is welcomed by the nurse facilitator. The patient is usually well prepared after pre-hysteroscopy counselling by her GP or practice nurse. Diazepam 5mgs and Ponstan 500mgs are offered to be taken one hour prior to the procedure.

Time is spent checking the patient’s record booklet, providing reassurance and answering any questions. It has been shown that careful counselling, assessment and information giving can help preparation and improve recovery (Boore 1978, Franklin 1974, Powell 1992, Walsh 1993, Wilson-Barnett 1981). Consent is then obtained by the consultant. The patient may have a relative or friend with her throughout the procedure.

The cervix is infiltrated with local anaesthetic to exclude discomfort when it is grasped with the volsella forceps, and saline is used to distend the uterus. A biopsy may be taken, as according to Taylor and Gordon (1992): ‘Endometrial hyperplasia and malignancies can be identified by obtaining visually directed biopsies using a pipelle suction sampler.’

Post-hysteroscopy, the patient is able to relax in a comfortable room with a drink, and in this environment results and advice are given. Recommended treatment is discussed and explanatory leaflets on this are provided. Evidence has proved that providing leaflets in addition to verbal information enhances patient knowledge (Moran 1995, Roter et al 1988).

The patient is given any information about the results of the procedure immediately, so that she is able to leave the clinic aware of the likely diagnosis or reassured that no treatment is needed. She is asked to fill in a questionnaire before returning to her GP in three weeks time to discuss treatment and results. The patient is able to leave the clinic approximately half an hour after the procedure.

Record keeping A care plan has been devised by the nursing staff to review, evaluate and document nursing care throughout the patient’s attendance at the clinic. This is in accordance with the UKCC’s Standards for Records and Record Keeping (1993), and shares similarities with Orem’s self-care model (1980) which: ‘Encourages nurses to act in a complementary way with individuals, their families and significant others to enable self-care to be achieved.’

EVALUATION

Over 300 hysteroscopies were performed in the first year and it is estimated that 500-600 patients per year
Box 1. Advantages to the patient.
- Assessment and counselling by someone the patient knows
- Only one hospital visit
- Fast service
- Consultant-led service
- No general anaesthetic
- Involvement in choosing management of care
- Continuity of care
- Direct referral to surgical waiting list if required
- Minimal disruption to family and work

Box 2. Advantages to the inpatient service.
- Reduced waiting times in hospital-based gynaecology outpatient clinic
- Altered case mix in theatres (more major surgery performed)
- Reduced waiting lists
- Reduced inpatient and day case costs

Box 3. Advantages to GPs.
- Continuity of care
- Job satisfaction and patient satisfaction
- Personal development
- Reduced consultations and prescribing

Box 4. What the service provides.
- Continuity of care
- Principle provision of care for patient from GP
- Reduction of inpatient and day case costs
- Decreased use of general anaesthetics
- Benefits from joint working between GPs and consultants.

could benefit from this service (Chew 1995). The reasons for patient referrals in the first year are contained in Table 1.

The consultants, nurse facilitators and clinic staff nurses believe in the team approach to care. Good communication is essential and, therefore, regular meetings are held. Outcomes of clinics are discussed and changes and improvements to practice are decided.

Information is cascaded to members of the wider team, the senior nurse manager and members of the original working group.

The members of the nursing team chose to work in the service and were instrumental in the planning of the clinic. Their views are sought when changes are proposed, and consequently, staff morale is high because they know their opinions are valued. The team also provides mutual support. Within this environment, the nurses are encouraged to develop their roles and gain the confidence to effect change.

**Continuing evaluation** Nursing care is said to be incomplete unless it is evaluated systematically (Irvine 1991, NHS Management Executive 1994, Samuel et al 1993). Continuing evaluation has enabled the team to formulate plans and objectives for the future.

Patient satisfaction questionnaires were evaluated from the first 124 returned (response rate=99 per cent). Overall, the evaluation showed that 98 per cent were very satisfied with the service. Suggestions made by patients have been acted on, for example, identifying the locality of the clinic and free supply of pre-medication (which previously had been paid for by the patient). Some of the advantages for both the patient, the inpatient service and the GPs in the area can be found in Boxes 1, 2 and 3, and an assessment of what the service provides is contained in Box 4.

**CONCLUSION**

This is a unique service developed by purchaser and provider working together. It is highly acceptable to both women and GPs providing continuity of care in the primary care setting. The service is fast and vital for women with post-menopausal bleeding, where there could be a diagnosis of endometrial malignancy.

The hysteroscopy team is committed to a specific interest in women’s health, and its philosophy is to give women informed choices to enable them to take charge of their own health. They work together as a team providing mutual support, clarity of purpose and commitment to an idea.

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