Medical Education Training Research Innovation in Clinical care

A centre of excellence: establishing, developing and sustaining an Emergency Gynaecology Unit (EGU)

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Introduction

Emergency gynaecology units are essential to the optimal running of a complete acute gynaecology service in tertiary women's health. These departments serve to reduce patient waiting times and potentially improve accessibility for women to a dedicated team of specialized nurses and doctors skilled in gynaecology emergencies. They also encourage appropriate patients to be sent directly from primary care (***Figure 1***) and away from general emergency services in addition to providing a direct walk-in service to the local population. Hull and East Yorkshire Hospitals Trust has progressed one step further from this having already had two long established *"nurse-led"* Early Pregnancy Assessment Unit (EPAU) at Women and Children's Hospital and Castle Hill Hospital. The service described here has been visited by many other hospitals as a model of optimal delivery of acute care and potentially extendable to other services.

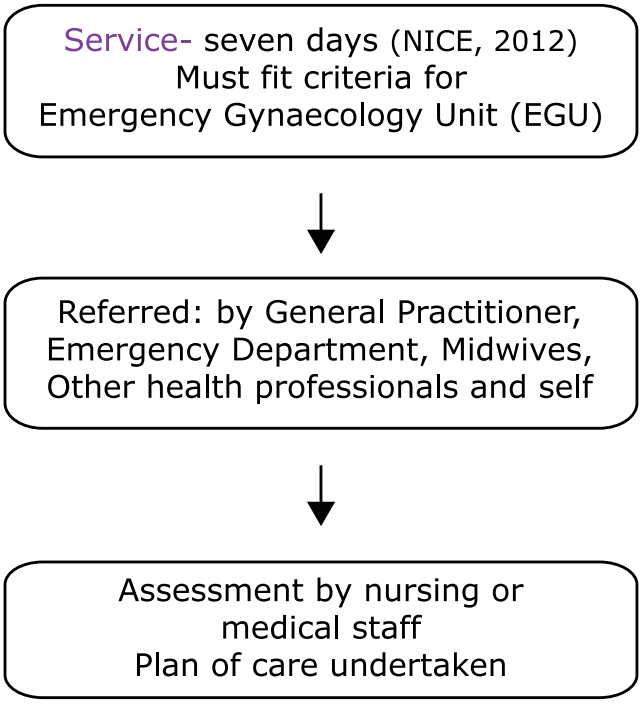

***Fig.1:* Patient pathway**

Service Development Rationale

The rationale for the development of the Emergency Gynaecology Unit started with the inability to control or predetermine the number of emergency patients which the inpatient gynaecology ward faced on a daily basis, a problem faced in many specialties. A new system to enhance the flow of patients on the gynaecology ward while improving care was therefore essential. Critical to this was the need to ensure that any new system would not only be beneficial to patients but

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also be accepted by and be of benefit to staff.

The vision to develop an Emergency Gynaecology Unit (EGU) was driven by the desire of the staff and the Health Group to place women at the centre of care, decrease waiting times for women with an emergency gynaecological problem and increase access and availability for women who had problems in early pregnancy. It was also hoped that this service development would decrease the risks of *"near incidents"* associated with late night operations on patients and, very importantly, ,standardise care by introducing a dedicated team of specialized nurses and doctors skilled in emergency gynaecology care.

In June 2009, the Royal College of Obstetricians and Gynaecologist (RCOG) issued good practice guidance on emergency gynaecology care[(1)]. The Emergency Services Standards of Practice and Service Organisation[(2)] document also supports the development of Emergency Gynaecology Units in all acute hospital trusts. The RCOG 2009 guidance lays down the principles for service organisation and delivery of high-quality emergency gynaecology care. These include:

1. Leadership – a senior clinical leader
2. Organisation – a good infrastructure including sufficient theatre capacity and manpower
3. Practice and training – adequate numbers and supervision of junior staff
4. Managerial and patient focus on emergency gynaecology services

Creation of service

The EGU at Hull and East Yorkshire Hospitals NHS Trust was established in April 2009 and this development was launched to health professionals who would be involved in referring into the unit and staff who would be working on the unit. However the process took a number of years to effectively implement.

The essential elements in this development were clinical leads, at HEY this was the Practice Development Nurse (PDN) for gynaecology and lead consultant, to progress the service and the engagement of the department. Other aspects to creating the service, in addition to planning and developing the service, included training and updating gynaecology nursing staff on different aspects of emergency gynaecology care and ensuring the unit functioned effectively. Ensuring staff received sufficient timely training and support while the *"process of change"* was being implemented was a key element to the successful implementation. One of the most essential changes was the introduction of new evidenced based clinical guidelines for the unit, under the supervision of a lead consultant. These were then cascaded to the medical and nursing staff to ensure the guidelines became embedded into practice.

The scaffolding for the structure of the service was in place but the foundations in delivery remained insecure. Therefore in

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2012 the gynaecology service transformation group decided that to ensure future service development needs would be met a permanent team of trained EGU nurses was essential. Hence nursing staff from the gynaecology ward joined existing members of the team of EGU nurses. An unexpected benefit of this symbiosis was that the ward nursing staff brought valuable additional skills to the group enhancing the future planning of the gynaecology services.

Key Objective in service creation

Having established a new team of trained nurses, three key objectives were identified in service progression:

1. expansion of the existing Early Pregnancy Assessment Unit remit to see more early pregnancy problems
2. approval and implementation of new revised guidelines of care incorporating nurse led roles
3. working in partnership with other clinical areas

1. Expansion of the existing Early Pregnancy Assessment Unit remit and see more early pregnancy problems.

The existing early pregnancy criteria were to see women who had mild or moderate pain or bleeding from 6 weeks to 14 weeks. The expansion of the service would be to see all pregnant women from four weeks of pregnancy to fifteen weeks with mild or moderate post virginal (PV) bleeding. Nursing staff would monitor those women requiring beta HCG monitoring, seeking medical staff advice when necessary. This movement of activity saw the reduction of women attending the gynaecology ward for monitoring.

Women who required medical treatment of an ectopic pregnancy would no longer have to attend the inpatient ward. They would be assessed, managed and their follow up monitoring would be carried out by the EGU nurses.

There is still a continuing movement of activity such as minor procedures from the inpatient gynaecology ward to the EGU. This is particularly so for bartholin abscesses which women would have previously gone to theatre to have them incised and drained. Now they are seen in the EGU for assessment and if appropriate incision and drainage under local anaesthetic rather than being admitting for treatment under general anaesthetic. Increasing the number of procedures carried out under local anaesthetic has benefits for both patients and the service.

2. Approval and implementation new revised guidelines and care incorporating nurse led roles

The publication of the new NICE guideline on Ectopic pregnancy and miscarriage: Diagnosis and initial management in early pregnancy of ectopic pregnancy and miscarriage in December 2012[3] led to two key changes in practice:

a. Approximately 20% of pregnancies miscarry and these miscarriages can cause considerable distress to women. The management of miscarriage is undertaken

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in a sensitive and patient centred manner. Management options are discussed with the women and, if possible, first line management strategy for women with a confirmed diagnosis of miscarriage should be expectant management for 7–14 days. The nursing staff have implemented this practice and the promotion of this management has reduced the number of women admitted to hospital for medical and surgical management.

Another significant practice change which was introduced into the Gynaecology Outpatients Department was surgical management of miscarriage using local anaesthetic. This new development saw women who would have previously been admitted to the gynaecology ward and taken to theatre to have a surgical evacuation of miscarriage under general anaesthetic, now have the procedure under local anaesthetic and in the outpatient setting. This again has benefits for the patients and the gynaecology unit. Women are in hospital for a shorter time and have a better recovery period. This has also seen a reduction in the number of inpatient admissions for surgical (GA) and medical management of miscarriage.

b. The new NICE guidance saw the expansion of the criteria for medical management of ectopic pregnancies. The current rate of ectopic pregnancy is 11 per 1000 pregnancies, with a maternal mortality of 0.2 per 1000 estimated ectopic pregnancies. The unit is now treating a higher number of women with medical management. Medical management being in the form of systemic methotrexate is offered if appropriate as first-line to those women who are able to return for follow-up.

3. Working in partnership with other clinical areas

The introduction of an outpatient hyperemesis treatment pathway in conjunction with the Antenatal Day Unit (ADU) was introduced in 2013. The outpatient hyperemesis treatment has seen a steady reduction in the number women requiring potential admission to hospital (***Figure 2*** *page 23*). This development led to the EGU nursing staff working in partnership with the midwives on the ADU. A new guideline of care was developed whereby women would be assessed by EGU, a management plan for outpatient treatment developed by medical staff and patients transferred to ADU. The benefits in addition to those realised by patients was a critical movement of clinical activity to the EGU and ADU.

Gynaecology service transformation

This gynaecology service transformation has subsequently allowed the further expansion of EGU and facilitated a closer working relationship with the Gynaecology Outpatient clinic, Antenatal Day Unit (ADU) and inpatient wards and a drive towards new ways of working and harmonisation of services. This development allowed the acute gynaecology inpatient ward to reduce to a 5 day service in October of 2013 with financial benefits for the Trust. In order to support the gynaecology service at weekends

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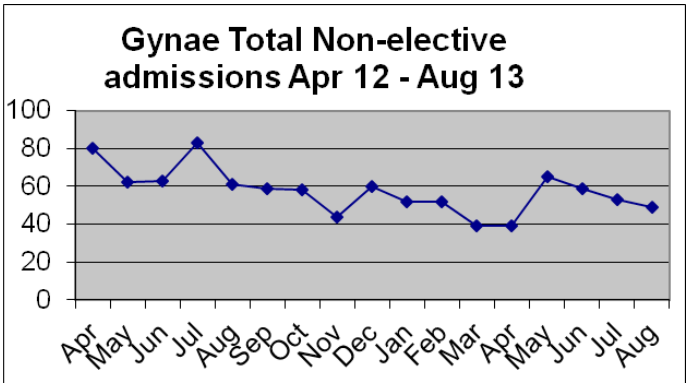
the inpatient gynaecology nursing team developed new ways of working such as using a triage nurse and expanding the nurse led roles. The continuing implementation of the latest NICE guidance on Ectopic Pregnancy and Miscarriage, will allow further reduction in inpatient care. The ability to perform minor procedures in EGU has also reduced the number of inpatient admissions (***Figure 2***) and hence has had benefits to the patient with reduced hospital stay and potentially faster recovery.

Summary

The direction and continued development of the EGU depends on all stakeholders taking this unit forward. In the current financial and political climate, we will have to stay focused on the objective we set ourselves. We must change and adapt as the unit develops and also as the political arena changes. We must strive to maintain quality gynaecology emergency services for women today.

Tools used in service transformation/ innovation

SWOT analysis
Transformation group Work
Process mapping
Action planning
Implementation / evaluation of projects



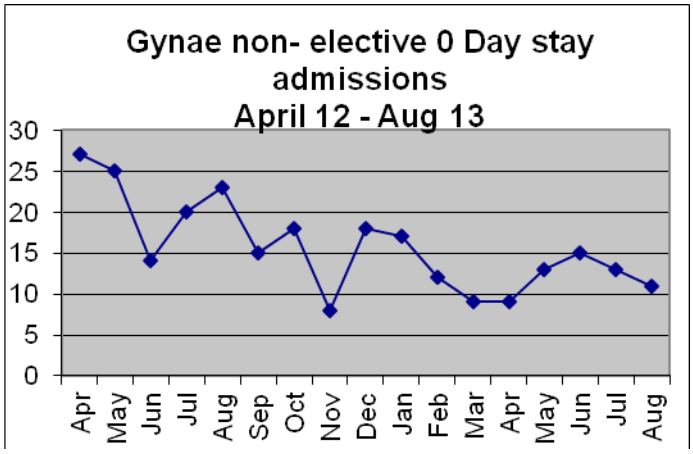


Fig.2:

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Possible barriers to service transformation / innovation
1..***'We've always done it like this'*** - a culture which creates a reluctance and resistance to change and sometimes it's at the top of the business!
2. ***No 'processes'*** - there are no formal processes to seek and generate ideas
3. ***Fear*** - staff are frightened of putting their head above the parapet and having their ideas and suggestions criticized
4. ***It's just about new products and services*** - there is a view that innovation is about coming up with new services rather than improving how we do it.
5. ***It's a 'management thing'*** - frontline staff's ideas and opinions don't count!
6. ***No 'rewards'*** - there's no 'incentive' to make it happen and even worse, the reward is 'more work '
7. ***What's the BIG idea?*** - the focus is on the 'next big thing' rather than lots of, or even just one small change can make a big difference
8. ***Silos*** - people do not interact or engage with other teams or departments
9. ***Insufficient time allocated or allowed*** - individuals are not encouraged to create specific time for 'innovation'
10. ***It's not on the agenda*** - a lack of 'strategic thinking' and consciously looking ahead at opportunities and threats, and encouraging others to do the same

References

1. Royal College of Obstetricians and Gynaecologists. Gynaecology: Emergency Services. Standards of Practice and Service organisation London: RCOG Press; 2009
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. NICE Ectopic pregnancy and miscarriage Diagnosis and initial management in early pregnancy of ectopic pregnancy and miscarriage 2012 clinical guideline 154 guidance.nice.org.uk/cg154

I would like to thank all the gynaecology staff who have been involved in the service transformation over the past 5 years. It has been challenging but we need to continue to develop and respond to the changing needs of our patients today and in the future.