Induction Pack for FY2, GP and ST1-7 Trainees

August 2021

Dear Trainees,

Welcome to Obstetrics and Gynaecology Dept.
Here is some information to help you acquaint and orient yourself to the Department.

Wards:
Obstetric wards: Delivery suite, Rusper ward (antenatal ward), ANDU (antenatal Day unit), Burstow ward (Postnatal ward)
Gynaecology wards: Brockham ward, Early pregnancy assessment unit (EPU) and Gynaecological Assessment unit (GAU).
Clinics: Aldrich Blake Unit

Working pattern description for FY2, GPST, ST1-2:
STD- standard day 08:00-17:00
1st on call- Obstetric on call 08:00-20:30
2nd on call - Gynae on call 08:00-20:30
Gynae 08:00-17:00 - Weekend and Bank Holidays
Night - 20:00-08:30
Lieu days for working on Bank Holidays

Responsibilities covered during out of hours:
Weekday Long Day Obstetrics: from 1700-2000- LW (including emergency CS), Triage, Burstow, Rusper, ANDU
Weekday Long Day Gynaecology: from 1700-2000- Brockham, EPU/GAU
Weekend Long Day Obstetrics: from 0800-2000- LW (including emergency CS), Triage, Burstow, Rusper, ANDU
Weekend Gynae 0800-1700: Brockham ward round, EPU/GAU. Usually helps with Burstow before ward round starts.
Nights: LW (including emergency CS), Rusper, Burstow, Brockham, EPU/GAU

Rota Co-ordinator

Responsibility of the setting of the weekly rota is currently being done by Mr Nnaemeka Onwudiwe (ST7). Helen George (Secretary, Admin support) on ext 6869, helen.george7@nhs.net. Her office is in the portacabin on the ground floor from 08:00-15:30 Mondays-Thursdays

The final copy of the electronic rota will be sent out to you by Friday for the following week only on your NHS.net email account so please ensure all of you have nhs.net account. Daily updates will also be sent on the WhatsApp group throughout the week.

If you notice any errors on the weekly or rolling rota please let us know asap.

Rota abbreviations

LSCS- c sections, TH – theatre, ANC- antenatal clinic, GOPD – Gynae clinic, FTC- Fast track clinic (cancer referrals)

The small letter lets you know if you are in Crawley or Horsham, if it has no letter it is in East Surrey.

The Letters stand for the consultant you will be working with HG - Hina Gandhi, SK - Sumit Kar, MG - Maha Gorti, JP - James Penny, ZA - Zahra Ameen, KJ - Karen Jermy, SSR - Shalini Srivastava, JA - Jean Arokiasamy, ZN - Zara Nadim, CW- Catherine Wykes, HN – Helen Nicks, CV – Cinzia Voltolina, SS – Sharmila Sivarajan, EG – Edmond Gaffrey, WY – Walied Youssef, AB- Avni Batish, NP- Naomi Page, RK- Ramesh Kuppusamy

Expectations from Junior doctors in Obs & Gynae

OBSTETRICS

Labour ward/Rusper ward (725 bleep):

- Attend at 08:00 for handover on Labour ward
- Very important to answer bleeps coming from Labour ward and Theatres Ext 6790/6791 and Maternity Theatre 7 Ext 1368/6034 and CEPOD theatre Ext 6033
- Attend ward round with Consultants and Senior trainee, which starts from Delivery suite and Rusper
- Cover ANDU in the morning 0800-1300
- Review patients as a priority when asked to ASAP
- Assist at Instrumental deliveries, CS, perineal tears suturing etc
- Common clinical scenarios are listed below with clinical assessment
- Team working with midwife, Obs team, anesthetic team for booking investigations, prescriptions etc
- Timely electronic discharge summaries and TTOs + bleep pharmacist on 557 if needing TTOs screened.
- ASK for midwifery and senior help in a timely manner if you do not know!

Antenatal day Unit ANDU:

- Normally covered by the Labour Ward SHO in the morning (bleep 725), Burstow SHO in afternoon (bleep 733)
- Answer bleeps ASAP. Inform midwife if delay in attending patient/s with a timeframe.
- Speculum examinations
- Always ask for chaperone. Show the cervix to midwife. Always write negative findings if significant.
- Common ANDU scenarios listed below
- Common policies - Hyperemesis and other on Intranet- Maternity policies
- Write clear plans in the notes and communicate to midwife
- Prescription for analgesics, IV Fluids, cannulation etc.
- Usually not many e-discharge/TTO due to documentation in handheld maternity notes
- If giving Boots prescriptions – these need to be collected from Boots here at SASH near main entrance. Boots closes at 18:00.
- Inform f/u plans to midwife and ask them to enter it in the ANDU book
- Book scans on Cerner. Midwife also can book. If in doubt, speak to lead sonographers in scan dept. Do not book scans for abdominal or bleeding PV, unless it is going to add to the management
- CTG and reduced fetal movements are usually midwife, SpR and consultant review.

Burstow ward: (SHO bleep 733)

- Answer bleep ASAP. Inform midwife if delay in attending patient/s with a timeframe.

- Go through the Red folder for tasks of the day. Since June 2021 there is now an extra consultant carrying out a gynae ward round who will aim to join you on Burstow ward to see any high risk postnatal patients such as HDU step downs or readmissions.
- Usual reviews are D1 post Instrumental delivery/LSCS perineum stitches, abdominal wound, lochia etc.
- Post-op complications such as bleeding, any medical complications post CS headache, paralytic ileus etc. Liaise with the right team such as anesthetist, Medical or Surgical
- e-discharge and TTO
- Jobs such as analgesia, Iron, Antibiotics, MMR vaccine, IV fluids, Clexane, blood collection, Ferrinject protocol etc
- Pathway for post natal pre-eclampsia management at discharge, TWOC , 3rd and 4th degree perineal tear policy and summary guide is being prepared by Ms DA
- Very important to understand the pathway for management of high risk cases such as Sepsis (policy of septic bundle), Severe pre-eclampsia, severe anaemia, PPH, VTE/PE (Doppler's , V/Q scans, discuss with radiology dept)

The ward computers have very useful documents under the folder "TTOs" which can be found on the desktop. These include all the information needed to perform a review for post-Caesareans, Instrumentals, and 3rd/4th degree tears. Also included are templates for speeding up discharge summaries, much of this can be copied and pasted in to the discharge summary which you will do when you review them on day 1.

GYNAECOLOGY

Brockham ward: (SHO bleep 719)

- Answer bleep ASAP. Inform if delay in attending patient/s with a timeframe.
- Keep the handover sheet updated every time a new patient is admitted and print the updated handover sheet of patients (for 08:00 and 20:00 handover)
- Please prepare a summary for all patients to be reviewed on the acute Gynae ward round and have all results available (night SHO)
- Ward round 08:30 onwards with Consultant and SpR and then do the jobs generated ie bloods, scans, discharge summaries etc.
- E-discharge, TTO. Nurses can print them.
- Book scan requests on Cerner. Discuss with sonographers if needed.
- Prescriptions - analgesia, antibiotics, IV fluids etc.
- Make clear plan of care and inform nurses. Don't just write it in the notes!
- Blood collection usually done by phlebotomist in the morning. You have to do them after if nurses don't or can't.
- Please liaise with nursing staff regarding if any theatre cases will be staying overnight to add onto the list.

EPU/GAU: (SHO 204 bleep)

The early pregnancy unit and gynaecology assessment unit is attached to Brockham ward. EPU: early pregnancy complications such as pain/bleeding. GAU manages referrals from ED.

- Answer bleep ASAP. Inform if delay in attending patient/s with a timeframe.
- EPU normal staffing is between 08:00-20:00 Monday to Friday. EPAU nurse bleep is 469
- Gestational age until 16 weeks is the cut off. >16w, go to AN ward
- Patients referred via GP/ED to SpR and self-referral
- Only stable patients are seen in EPU/GAU EWS<2
- Unwell patients are usually in ED and you will go to see them in ED either yourself or with SpR/Consultant
- Swabs - every patient seen by the on call team (even if they are admitted) who has a swab done will need their details entering onto Swabs list on Cerner.
- Need to solely attach yourself to GAU/EPU when allocated-be a visible presence.
- Provided no patients waiting 1st job is to check swab book. There is a folder of standard letters that can be posted to patient and GP, or you can do a discharge letter on cerner – print and send to patient or phone them with results and plan. Please "Endorse" these swabs results on Cerner in the EPU/GAU pool once checked and acted upon. Please note HVS swabs come back sooner than endocervical (chlamydia)-don't tick the patient off the list until both swabs back.

Seeing new patients in EPU/GAU

- All notes need to be documented on standard EPU/GAU proforma on Cerner.
- Gain consent and chaperone for intimate exams

If a patient needs theatre due to pain or bleeding:

- make them NBM
- bloods:G&S, clotting, FBC, U&E
- IV fluids
- online CEPOD form
- Review and consent by SpR(bleep 792) to consent
- inform theatre bleep 808 (theatre 8) and anaesthetist bleep 930.
- Please do VTE assessment on Cerner on anyone you admit.

Double swabs for most GAU patients:(pink)chlamydia/gonorrhea endocervical swab & a high vaginal swab (around cervix).
Ask women who have had an OP TVUS ordered for Gynae reasons to return to GAU for review.
Outpatient gynae scans are requested on Cerner "US pelvis (tranvaginal)".
If you are booking a Gynae inpatient scan that cannot be done in EPU call #6000 or #8917 to find out the time.

Miscarriage

- If you see products (pregnancy tissue) at the os that can be removed, place in orange topped specimen pot for histology containing formalin.
- A cremation form must be filled out by the patient for collected specimens sent to histology.
- If sending for Karyotyping also – please **do not** place these samples in Formalin – but in an dry empty pot.
- Miscarriage should not just be diagnosed on clinical examination alone. Please order a scan to assess fetal viability
- Do not promise scans to patients until confirmation
- There are **no** scans performed by the sonographer over the weekend

If reviewing a patient in EPU who does not need admission (i.e. light bleeding or low risk of ectopic):

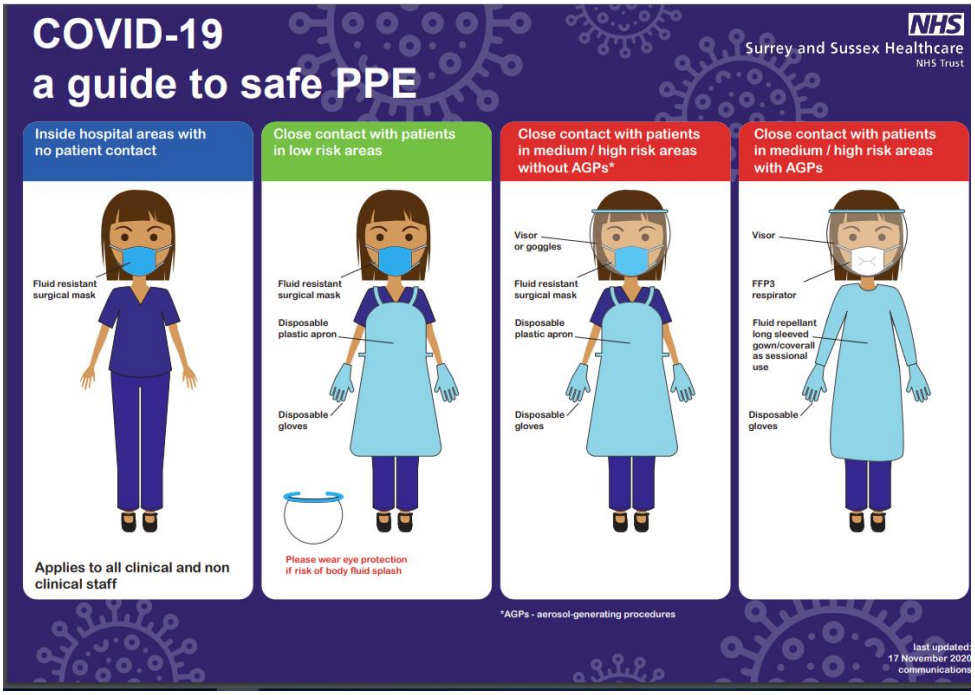
- d/c patient with an EPU scan next day
- Request scan on Cerner – the EPU nurses will phone patient with the time the next day.
- Do progesterone and HCG on all pregnant patients.
- EPU scans are requested on Cerner "US Obs (early preg)". During the day the EPU nurses can fit these patients in for scans – please liaise with nurses for time.
- EPU scan results are available on "Viewpoint" – login to EPU computers, start Viewpoint, (username: EPU DRS password: Ultrasound).

THEATRES

Theatre times: 08:00-13:00, 13:30-17:30/until it finishes.

If you are down to assist in **Theatre** aim to go to pre-assessment by endoscopy on the ground floor for 7.30am morning lists 1pm afternoon lists, you can see the patient's pre-op with the Consultant and read the notes.

PPE guidance: Please note the Trust guidance on use of PPE



Theatre in Crawley is either mornings or afternoons. Parking on Albany Road is a good idea as it is free and a short walk to the hospital. Follow the signs to Day Surgery and let staff know you are assisting, they will show you where to change etc. Evening lists can run late (until 7pm). The Consultant will usually organize the list so that you can leave at 17:30 i.e. LLETZ procedure's at the end. If your help is needed, please stay back and let the rota coordinator know to give you time off in lieu. If you choose to stay, you cannot claim time in lieu.

Elective caesarean sections

If you are doing Caesarean sections, these are in mornings (8am) or afternoons (at 13:30) at ESH. These women tend to come to Burstow ward, they will also need to be seen pre-op. Good to know what the history is, the Hb, blood group, position of the placenta. Attend pre-op theatre huddle/meeting.

Please start the discharge summaries between cases for an elective section list and leave the post op Hb ……. For the Burstow SHO to complete. Sign the EDS, but leave the "Complete" at end as "No". Burstow SHO can then amend, enter any new details and discharge.

If you are in posted in clinic/OPD, try and attend handover at 08:00 as interesting cases are discussed and you can then help on Burstow before OPD starts.

Clinic times: 09:00-13:00, 14:00-17:00/until it finishes.

IT information

VTE: There is a strict VTE assessment documentation policy. Please ensure that it is completed as soon as the patient is admitted to the ward or within 14 hours. VTE is completed on Cerner.

GAU swab /EPU Results: One junior grade will be allocated on the rota to review the results and act i.e. calling patients/GP surgery and arranging appropriate follow-up for any further investigations and/or treatment.

Cerner: Please familiarize yourself with requesting investigations, printing labels and reviewing results on **Cerner-Powerchart**.

Electronic Discharge summary: EDS is completed on Powerchart. Please write the discharge summary in details with all relevant important information to GP. A copy should also be kept in the patient's notes.

Policies:

Useful clinical guidelines can be found on the trust intranet in Document library. Please ask the staff if in doubt.

CEPOD:

Patients requiring emergency surgery need to be put onto the CEPOD list. This is done electronically this can be done in one of two ways:

1. CEPOD app can be accessed on intranet in Google Chrome platform.
2. CEPOD computer outside CEPOD theatre 8

Please inform the oncall Anaesthetist (930) and CEPOD co-ordinator (808)

Working at other sites:

Main hospital is East Surrey Hospital but trainees will also be posted at Crawley Hospital (ANC, DSU) and at Horsham Hospital (ANC).

Please check whether theatres and clinics are going ahead before you leave to go to Crawley and Horsham as sometimes, these activities may be cancelled at a short notice (after the rota is distributed). SHOs are not normally sent to Horsham! If the activity is cancelled, please assist your colleagues on wards or attend clinics at East Surrey Hospital for your learning.

Hand over:

Multidisciplinary team handover times are 08:00, 17:00 and 20:00 on Delivery suite. Please ensure the handover sheet is up to date at every handover.

Interesting cases, Emergency Caesarean section from previous 24 hours, interesting CTG are presented by the junior team to the on call Consultant at 08:00. Please ensure that the names of the cases for discussion are entered in the diary placed on Delivery suite.

Bleeps:

Individual bleeps will be handed over to you by Helen George. Please hand back the bleeps to her at the end of your post. The on-call bleeps (Obs Spr 722, Gynae Spr 792, Obs SHO 725, Gynae SHO 204 and Consultant 904) are baton bleeps. Burstow bleep 733. Gynae ward bleep 719.

Annual and Study Leave: Please familiarize yourself with the leave policy.

Minimum notice period is 6 weeks

It works on 'First come, first serve basis'. Your leave is not granted unless a signed form is received by Helen George. Email notification is not accepted.

NOT MORE THAN 4 Trainees (including FY2, GPST, ST1-2, ST3-7, Clinical Fellow) will be away on a day. If additional member of the team would like to apply, leave will only be granted in exceptional circumstances after discussion with Rota coordinator /Ms Gorti (Lead Clinician).

Send your completed forms to Helen George by email or post who keeps a record. Also please ensure that the name of the person covering your out of hour's duty is written on the form so that it can be entered on the Rota.

Sickness reporting: Please report to FirstCare service on 0333 321 8053. Also ensure that you inform the duty SpR/SHO/Consultant, Rota co-ordinator so that alternative arrangements can be made to cover your duties.

Some learning starters!

I understand that for some of you, the last time you learnt Obstetrics and Gynaecology was as medical students and in a lot different circumstances/ scenarios and that was a long time ago! I am providing you with some guidance on some common clinical scenarios to improve your understanding and make it less difficult for you all on the wards and in acute settings. Please be aware that this is only a basic introductory assessment and management of patients. Please seek senior's advice if there is any doubt!

Management of every case has following steps:

- History taking
- Clinical examination
- Diagnosis/Differential Diagnosis
- Investigations
- Treatment

Gynecological Cases:

History: Below is mentioned a framework for history taking in gynaecological cases.

Age

Obstetric history: G_P_. Details about pregnancy, outcome, complications

Presenting complaints:

LMP:

Menstrual cycle history: duration, interval, dysmenorrhea, menorrhagia, regularity, etc

Sexual history: contraception, dyspareunia etc

Cervical smear history: Note any abnormality

Past gynaecological medical or surgical history: e.g. Ovarian cyst, fibroid, laparoscopy/hysteroscopy/ hysterectomy

General Medical or surgical history:

Urinary symptoms:

Bowel symptoms:

Surgical history:

Medical history:

Drug allergy:

Socio-economic history: smoking/alcohol/drugs, family circumstances etc

Examination: (ALWAYS with chaperone)

Weight/BMI

Vital parameters

RS/CVS

Per Abdomen:

- Inspection: Look for distension, scars
- Palpation: soft/tenderness, lumps/mass
- Auscultation: where relevant for bowel sounds

Vulval examination: look for any abnormality

Per speculum: inspect vagina, cervix, os open/closed. Please take Triple swabs- high vaginal End cervical and Chlamydial (Cx) swab, wherever relevant. Look for prolapse.

Per vaginum examination: 2 finger digital examination. Please note the findings

Uterus Anteverted or retroverted, mobile/fixed, tender/non tender on deep examination or cervical excitation. Palpate the adnexae for any mass/cyst

Diagnosis or Diff diagnosis: ALWAYS, please mention diagnosis or differential diagnosis at the end of your examination. It may not be the exact diagnosis but it is useful for commencing the right investigations. If in doubt, please ask senior trainee or consultant for advice.

Investigations and Treatment: It will depend on the diagnosis.

Abdominal/ Pelvic pain (with negative urine pregnancy test)

Please take history as above and give the diagnosis or differential diagnosis:

Some common causes:

Gynaecological:

- Pelvic inflammatory disease
- Endometrioses
- Adenomyosis
- Ovulation pain
- Corpus luteal haemorrhage
- Ovarian cyst/mass
- Adhesions
- Irritable bowel syndrome
- Cystitis
- Musculoskeletal
- Psychological

Investigations:

- Triple swabs
- FBC, CRP
- Urine dipstick test. If +, for MSU
- Urine pregnancy test, if indicated and not already done in A&E
- Pelvis scan- TAS/TVS to exclude pelvic collection/mass/cyst
- MR, after discussion with consultant wherever indicated

Treatment: depending on the diagnosis, signs and symptoms.

- Analgesia
- For PID: Analgesia and PID Antibiotics regime (see policy)
- Condition specific management such as endometriosis, fibroid, ovarian pathology: may require Laparoscopy/Laparotomy but prior to that, seek senior input.

Abdominal/pelvic pain (with positive pregnancy test)

History
Check URINE PREGNANCY TEST report yourself
Note any previous pelvic/early pregnancy/obstetric scans, if done
Examination
Diagnosis:

- Ectopic pregnancy
- Missed miscarriage
- Threatened miscarriage
- Corpus luteum haemorrhage
- Other causes as mentioned above

Investigations:

- FBC, Serum Beta HCG, Serum progesterone
- Scan to exclude ectopic pregnancy

Inform seniors

MISSED MISSCARIAGE IN 1ST TRIMESTER

1. Expectant management to allow spontaneous miscarriage

Advantage: Avoids medical or surgical procedure

Disadvantage: May take up to few weeks, can result in incomplete miscarriage or bleeding requiring surgical management

2. Medical management (see policy)

Advantage: Very effective and successful,

Disadvantage: may require surgical management if heavy bleeding or incomplete miscarriage. Small risk of infection

3. Surgical management of miscarriage: Under local or general anaesthesia (See policy)

Advantage: Quick procedure (45mins), usually done at Crawley Hospital on Friday AM list *(currently at ESH due to COVID).*

Disadvantages: risk of GA, Surgical complications such as perforation, bleeding, infection

HYPEREMESIS GRAVIDARUM

History
Exam: General exam, PA
Inv: FBC, U&E, LFT
Treatment:

IV Fluids
Replace Potassium
Antiemetics (Cyclizine, Ondansetron, Metoclopramide)
Thiamine 50mg TDS
Folic acid (5mg OD)
TEDS and Clexane
Scan, if not already done for excluding Multiple or molar pregnancy

Obstetric cases (>16weeks)

DO NOT PERFORM DIGITAL VAGINAL EXAMINATIONS UNLESS YOU ARE CONFIDENT (YOU MUST CONFIRM ON SCAN THAT THE PLACENTA IS NOT LOW -LYING WHEN EXAMINING PATIENTS AFTER 20 WEEKS GESTATION)

History framework:
Age
Obstetric history: G_P_
LMP:
Gestational age in weeks:
Presenting complaint:
Also enquire about pain, contractions, bleeding PV, Liquor PV(suggestive of ruptured membranes, colour, odour of liquor etc), foetal movements, scar tenderness if CS.
Scans history: fetal growth, placental location
Medical history: Anaemia, DM, HT etc
Surgical history:
Ongoing treatment:
Allergy:
Social history: smoking/alcohol/drugs/family circumstances

Examination:
BMI
Vital parameters
RS/CVS
PA:
Symphysio fundal height (cms)
Lie
Presentation
CTG
PS:
Vulva
Vagina
Cervix: dilatation, length, os open/closed, ectropion+/-, discharge, bleeding, liquor

HVS

VE: (With chaperone): DO NOT PERFORM IF PLACENTA LOW LYING (covering os or <2cms from os)

Cx dilatation in cms, cx length in cms, position- anterior, mid posed, posterior, membranes +/-

Investigation and Treatment: depending on the findings

Suspected infection: FBC, CRP

If in doubt, please discuss with seniors

Reduced Foetal movements

Please note the history as above. Importance should be given to relevant maternal and foetal history such as DM, hypertension/pre-eclampsia, antepartum haemorrhage, Injury to abdomen (abruption), growth restriction, chromosomal or genetic condition in foetus, if known (usually in her hand-held notes)

Examination as mentioned above

Investigation:

CTG

Obstetric scan for fetal growth + umbilical, middle cerebral artery dopplers. If 2nd episode of reduced FM or any concerns with fetal growth, obstetric growth scans to be booked on Cerner and discuss with sonographers in the scan department Ext 6000/1605.

Seek senior advice for further management

High Blood pressure

History as above

Ask about symptoms of complications of pre-eclampsia: headache, nausea, vomiting, blurred vision and epigastric pain.

Be aware of complications of pre-eclampsia: (PEARL)

P-Pulmonary oedema which can lead to ARDS

E-Eclampsia

A-Abruption which can lead to DIC

R-Renal complications-renal failure

L-Liver- HELLP (Haemolysis, Elevated Liver enzymes, Low platelets)

Examination:

General exam, BMI

BP, proteinuria +/-

Per Abdomen

Check for patellar reflexes and Clonus

PS + VE (wherever indicated)

Investigations:

- Urine dipstick
- If + for infection, send MSU
- If Proteinuria, Urine Protein Creatinine ratio (PCR)
- CTG
- FBC, Clotting profile, Urea + Electrolytes, Liver function tests, Uric acid, Group and save (if relevant)
- Commence Labetolol or Nifedipine (if very high BP)- See policy

Discuss with seniors regarding management and transfer to Labour ward

Pregnancy with Antepartum haemorrhage

History

Relevant history: provoked or unprovoked bleeding - sexual intercourse, injury to abdomen, pre-eclampsia, low lying placenta (from earlier scans), contractions, amount of bleeding, duration of bleeding, recurrent bleeding, cervical smear, foetal movements details

Exam:

- General exam, BMI
- Vital parameters
- Urine dipstick for proteinuria
- PA
- CTG
- PS: amount of bleeding, colour, ectropion+/-, cervical os dilatation, liquor+/-
- VE: DO NOT PERFORM IF PLACENTA LOW LYING (COVERING OS OR <2CMS FROM OS)

Investigations: (See policy for details, if bleeding heavy, ask for senior help urgently)

- IV access
- FBC, Gp and save or cross match 4 units if bleeding heavy, Clotting profile, LFT, U&Es, Uric acid (if pre-eclampsia)

Discuss with senior for further management and transfer to Labour ward

Postpartum bleeding

History:

- Relevant details: duration since delivery, mode of delivery, amount of bleeding, passage of clots/placental tissue, breast feeding+/-

Examination:

- General examination, BMI
- Vital parameters
- PA: height of the palpable uterus
- PS: triple swabs, note the bleeding amount, colour, odour, clots/tissue
- VE: Os dilatation, palpable clots/tissue in the uterus

Investigations:

FBC, CRP, Gp and save or cross match (2-4 units if heavy bleeding)

Discuss with seniors before booking pelvic scan on Cerner to exclude retained products of conception

Treatment:

If RPOC/infection suspected, broad spectrum antibiotics Cefuroxime (if not allergic to Penicillin) + Metronidazole

Discuss with senior for definitive management.

Postnatal ward issues/care:

Day 1 Post CS

Routine post op check, palpate uterus (below the umbilicus), Check 1st void >250mls within first 6 hours of TWOC, enquire about lochia

Day 1 Post Instrumental delivery:

Routine postnatal check, ensure passed urine, check perineum if 3/4th degree tears

3rd/4th degree tears:

Check perineum, antibiotics 7 days, laxatives 14days, GOPD apt 12weeks, Physio referral and RCOG leaflet

Post natal HT/Pre-eclampsia care:

Stop Methyldopa as risk of postnatal depression

Avoid Labetolol in asthmatics and DM

Atenolol, Enalapril, Captopril – safe in breastfeeding mothers. Amlodipine, Ramipril contraindicated

GP/Community MIDWIFE to recheck BP regularly

Anti HT treatment to be managed by GP

C-sections:

Category 1: Crash. Run to theatre to assist, within 30min

Category 2: within 60min

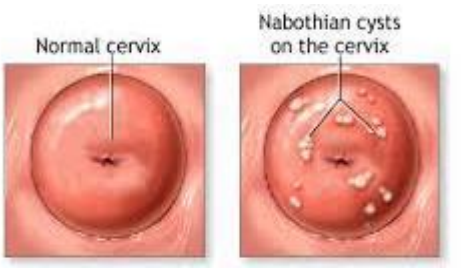
Category 3: semi elective

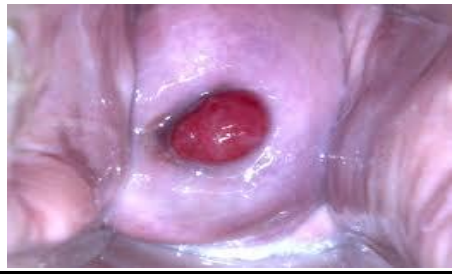
Category 4: elective

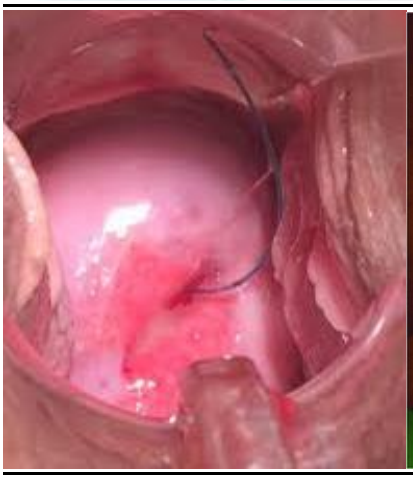
Trial in theatre: means trial of instrumental delivery which may fail and lead to CS. Go to theatre for assistance

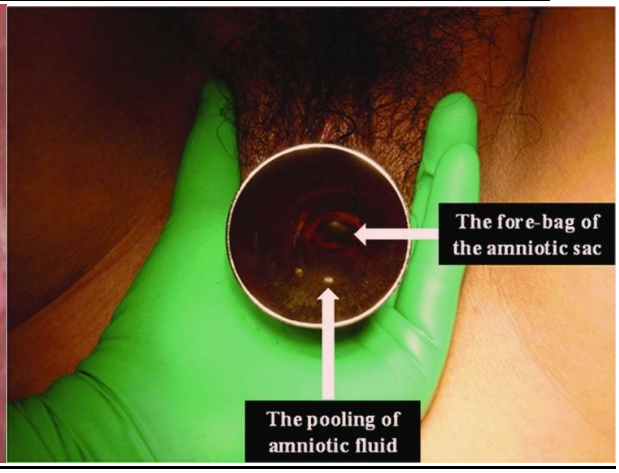
Speculum examination findings:

1. Nabothian follicles/cyst
2. Cx polyp
3. IUCD threads at Cx
4. Amniotic fluid at external os of cervix


Normal cervix
Nabothian cysts
on the cervix






The fore-bag of
the amniotic sac
The pooling of
amniotic fluid

TEACHING

Teaching: Remember, the onus of learning is on you! We as a team take great pride in teaching in our department.

Departmental teaching for FY2, GP ST, ST1-2 teaching in seminar room next to labour ward is held every Friday by Ms Zahra Ameen/Kopal Agarwal/ Ms Hala Ibrahim every Friday 13:00 in Training room on Neonatal unit. Teaching program will be sent out to you. If you cannot present the topic on the allocated days, it will remain your responsibility to swap with your colleague/s.

Mandatory GP Teaching: Information from PGEC Admin staff, Ext 2936. Depending on the mandatory teaching, a half /full study day should be taken and form handed to Helen George for record.

Mandatory FY2 Teaching: information with PGEC Admin staff Ext 1722. Depending on the mandatory teaching, a half /full study day should be taken and form handed to Helen George for record.

Other learning opportunities:

- Multidisciplinary hand over time 08:00-08:30 on Delivery suite
- Ward rounds, Clinics and theatres
- EPU/GAU teaching Every Tuesday 13:00-14:00
- Perinatal morbidity and mortality meetings: Joint meeting with Paediatric team every 4th Wednesdays of the month led by Mrs Sivarajan. Cases will be allocated to junior trainees for presentation. The notes will be with Ms SS's sec Alison Self. PLEASE ENSURE THAT YOU EMAIL YOOUR PRESENTATION TO MS SS ON THE DAY PRIOR.
- Audit meetings: There is a Trust rolling monthly Governance meeting chaired by consultants. Each trainee has a mandatory obligation to participate in audit or Quality Improvement project during their training period. Please approach your ES/CS or Audit Lead Shalini Srivistava, for a project.
- Joint Obstetric training (JOT): Multidisciplinary skills drills are held in PGEC. Timetable is available with midwife Sarah Prime, Ext 6432..
- Mandatory study days: CTG, Skills drills organized monthly at ESH, held in Burstow corridor staff room by midwife Sarah Prime, Ext 6432..
- Trust Grand rounds: Multi-specialty held every Thursday 13:00-14:00 in PGEC, Lecture theatre.

Regional Study days are organised by KSS Deanery for ST trainees

Appendices

On the Day 1 review – post C-section

-Document the reason for the section

-Estimated blood loss

-Post-delivery HB (if less than 100 will need ferrous sulphate and lactulose, if less than 80 may need Ferrinject or blood)- please refer to Ferinject Policy about postnatal anaemia management.

-Ensure the patient has passed her TWOC, ask about pain, Lochia (PV loss), SOB, eating and drinking, OB, Flatus (they will usually not open bowels prior to discharge)

Advise them that abdominal discomfort is expected for 6 weeks and they should avoid heavy lifting and driving, regarding driving they may need to check with the insurance company but as a rule should be able to do an emergency stop pain free. At 6 weeks post-delivery they see the GP for post natal check and contraception discussion. The dressing is changed at day 5, day 10 and then left uncovered. If they need iron supplements ask the GP to check HB and review in 4 weeks.

These women go home with lactulose and 10 days of clexane as standard. We screen the TTO's ourselves as they have ward stock of medications (unless 6 weeks of Clexane – this needs pharmacy screening).

Ensure that you do discharge summaries on day 1 when you review them as it makes life easier for whoever is covering Burstow the next day.

Blood pressure – chronic, gestational and PIH will need BP checked on day 1 and 2 post-delivery and again between days 3-5 post-delivery. If the BP is less than 130/80 stop the antihypertensive, if they are discharged on antihypertensive they will need to see the GP in 2 weeks to review the medication. BP tends to go up day 3-4 post-delivery.

Diabetic medication- if mothers have Gestational DM, medication is normally stopped after delivery. T1DM, T2DM carry on as per antenatal plan.

Patients are not discharged on Methyldopa due to mood disorder issues postnatally, Nifedipine can make people feel unwell with headaches.

3rd and 4th degree tears will need Gynae outpatient follow up in clinic, physio referral and laxatives for 2 weeks and antibiotics. Cefalexin 500mg tds and Metronidazole 400mg tds are the go to O&G antibiotics.

The Labour ward SpR on 722 is your senior support.

<u>Generic</u>
GX PX presented in labour at XX week's gestation. An Emergency/ Elective C-section/ SVD / Forceps / Kiwi was performed due to ___ with ___ mls EBL and delivery of live fe/male weighing XX Kg. Uncomplicated recovery. Observations and examination unremarkable and patient mobilising on ward.
Discharged with ferrous sulphate and 10 days of clexane.
Patient recovered well and was discharged home on iron supplements.

<u>GP advice</u>
Please check this lady's Hb in 3-4 weeks' time and consider if she needs to continue her iron supplementation.
Please arrange a 6/52 post-natal check and discuss contraception

<u>C section discharge advice</u>

Please complete 10 days of clexane injections and wear TED stockings for 4-6 weeks.
Please do not drive for 6/52 and lift weights no heavier than baby whilst recovering.

03 or 4th degree tear

A woman with a 3rd or 4th degree tear must have
1. Complete 1 week course of oral antibiotics
2. Continue laxatives for 2 weeks post delivery
3. Gynae OP clinic appointment in 3/12 to check the healing (book this with Ward Clerk) & print letter and give to patient.
4. Physiotherapy referral (complete paper referral in drawer on Burstow including Date of delivery. Either take referral downstairs to Therapies Area in Green Zone, or use internal post – to "Womens Physiotherapy")

Advice to patient with 3rd or 4th degree tear
You can resume activities (such as driving, exercise) when the pain is not distracting or restricting your movements. Please complete 10 days of clexane injections and 7 days of antibiotics with 14 days of laxatives. We have arranged a Physiotherapy referral and will see you in our Gynaecology outpatient clinic to review healing.

SVD
GX PX presented in labour at XX gestation and later had a SVD with the delivery of live fe/male weighing XX Kg with ___ mls EBL .
Uncomplicated recovery. Observations and examination unremarkable and patient mobilising on ward.

Safety Net
Please seek medical attention if abdominal pain worsens, bleeding worsens, fever or feel unwell.
Any concerns please discuss with your GP or midwife or contact Burstow ward.

A.3

Common prescription's
Labetalol 200mg po
Nifedipine MR 10mg po
Metronidazole 500mg tds IV /400mg tds po
Cefuroxime 1.5mg IV tds/Cefalexin 500mg tds po
Thiamine 25/50mg tds

Antiemetics :
- Cyclizine 50mg tds IV/PO
- Metoclopramide 10mg tds IV/PO (not licensed in under 19)
- Stemetil (Prochlorperazine) 12.5mg IM

Phenergan (Promethazine) 25 mg IM

Ondansetron 4mg TDS IV/PO

Analgesia:

Dihydrocodeine 30-60mg QDS PO

Codeine 30-60mgs PO QDS

Pethidine 100mg IM

Oxytocin:

Induction of labour: 5 units Oxytocin in 100ml 0.9% normal saline as per protocol

PPH: 40 units Oxytocin in 500mls 0.9% normal saline 125mls/hour (over 4 hours) (or routine post C-section).

Group B Streptococcus prophylaxis:

BenzylPenicillin 3gm IV stat, then 1.5gms 4 hourly until delivery

Clindamycin 900mg 8 hourly, if allergic to penicillin

INDUCTION FOR NEW DOCTORS EPU/GAU

Aug 2021

Welcome to the Early Pregnancy and Gynaecology Assessment Units (EPU/GAU).

The following members of staff:

EPU CONSULTANTS	Ms Catherine Wykes/Ms Naomi Page
MATRON FOR BROCKHAM/EPU/GAU	Sarah Mitchelmore
WARD MANAGER BROCKHAM	Sarah Barnes
WARD MANAGER EPU	Sami Gunning
SISTER EPU	Jeanette Hopper
SISTER EPU/PRACTITIONER	Maria Boutaba
SISTER BROCKHAM/EPU	Olga Cuevas Vera
SISTER OUTPATIENTS	Katie Davies
SISTER BROCKHAM	Shana Henry- Constantine
SISTER BROCKHAM	Soosy Paul
SISTER BROCKHAM	Aika Verzosa

EARLY PREGNANCY UNIT

Opening hours Monday-Friday 08:00-18:00

EPU telephone clinic Monday-Friday 09:00-13:00- patients have the facility to leave voicemails which are picked up if a Sister isn't available to answer.

The Early Pregnancy unit is primarily nurse led. We look after ladies who are up to 16 weeks pregnant with any unexpected symptoms in pregnancy such as pain and bleeding. Ladies who are over 16 weeks are seen on Rusper Ward by the midwives.

HUDDLE

We have recently started to have a huddle each morning before the ward round on Brockham. Attendees will be Matron, The Sister on EPU, Ward Manager/Sister on Brockham, the on- call Consultant, Registrar and SHO plus any other staff who are available and want to attend. It is a good

opportunity to discuss who is working and to discuss the agenda of the day. In-patient scans can be prioritised and booked as appropriate.

EPU is an emergency ectopic clinic and we scan approximately 20 ladies a day. We have strict criteria for booking scans as listed below:

- Women with pain/bleeding with positive pregnancy test must be scanned if an intrauterine pregnancy has not already been confirmed. Any ladies with bleeding and no pain are asked to monitor for 48 hours and to call back if the bleeding continues. Women with heavy bleeding should be advised to attend A & E.
- Women with previous ectopic pregnancy but asymptomatic should be scanned at 7 weeks in future pregnancies.
- Women who have experienced 2 consecutive miscarriages should be scanned at 8 weeks.
- Women with previous molar pregnancies should also be scanned at 8 weeks.

CLIP BOARD

We now have a clip board for Doctors to use out of hours (weekends and overnight) for scans that are needed. Any patients who are sent home and need follow-up scans must have their details and the reason for the scan documented clearly. Please include a contact number. The Sister working the following day will then check the list and prioritise the need for scans and book appointments where appropriate. Please do not promise patients' scans for the next day as this is not always possible and some patients may not need one depending on their symptoms.

PRODUCTS OF CONCEPTION

When removing products of conception from ladies who are potentially miscarrying please place the products in formalin unless they are having genetics test (in dry pot). The pots are kept in the sluice. It is paramount that the patient also completes a sensitive disposal form and the doctor should complete the LFD and histology forms which are sent with the products to histology.

GENETICS

Ladies who have had 3 consecutive miscarriages are offered genetics test and are then followed up in the recurrent miscarriage clinic. Products of conception must be put in a DRY pot as testing is <u>unable</u> to be done once they are exposed to formalin The forms will also need to be completed along with the relevant genetic forms.

GAU

GAU runs 24 hours a day and caters for any ladies referred by any other route including A & E or GPS. The EPU Sister can take some referrals and triage pregnant ladies however referrals should be accepted by the registrar. These patients must be stable and have EWS of 2 or below. Clinically unstable women and women require morphine should be seen in A & E. The SHO will then see the patient and make a plan which is discussed with the registrar. Any ladies who need admission will go to Brockham Ward so you will need to liaise with the ward about bed availability and let the EPU Sister know who will then put a bed request on Cerner and speak to the bed manager. Any ladies with hyperemesis are seen and admitted if ketones are 2 or above. They must have fluids in progress and an anti- sickness injection

given before coming to GAU. The two clinics run alongside each other so communication between staff and patients is paramount.

GAU DIARY

We have a diary in the clinic which we use daily to document what is happening each day. This may include blood tests, telephone calls and any follow ups. The diary is checked daily by the EPU Sister and is also for doctors to use to document any follow ups needed. Please liaise with the Sister.

PUL FOLDER

We have a folder for ladies who have had scans and are pregnancies of unknown location. Until a diagnosis has been made their notes will be kept in this folder and follow up bloods documented in the diary, as above.

METHOTREXATE FOLDER

There is a separate folder for ladies who have had methotrexate for either and ectopic or pregnancy of unknown location. They are followed up until their Serum BHCG is less than 5. Follow up bloods are documented in the GAU diary.

We are an extremely busy but friendly clinic and very keen to teach and answer any questions. We will orientate you to the clinic and explain things in more detail when you start working with us.