Standard Operating Procedure

Same Day Discharge (SDD)

Vaginal Wall Repairs (VWR)

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Approved by	Gynae Governance Committee Anaesthetic Governance Committee
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Aim and scope of Standard Operating Procedure

This SOP is written with reference to other centres procedures to explicitly detail the steps in the pathway to ensure safe, consistent and well received care for patients undergoing Same Day Discharge (SDD) VWR. This SOP applies only for the SDD VWR.

It is essential that consistent information is given to the patient and carers from the preoperative assessment through to the post-operative period from all involved nursing and medical teams.

The safety of patients' clinical care of course overrides the SDD VWR pathway and patients must leave the pathway at any time where this is clinically indicated.

Target Staff Categories

This SOP is relevant for all patients who meet the careful criteria for SDD VWR and it should be followed by countywide gynaecology medical and nursing staff, preoperative assessment teams, day case surgery nursing teams and gynaecology surgeons and anaesthetists.

Contents

1. Background

SDD VWR is an important progression in our service development and will bring advantages to both patients and the Trust. The aims of this process can simply be summarised:

- Improve clinical outcomes
- Improve patient experience/satisfaction
- Reduce patient risk
- Increase the number of procedures/operative day and make better use of fixed resources
- Reduce length of stay
- Reduce risk of missing treatment targets
- Build resilience into the system and provide a more reliable service that is independent of stresses on the healthcare system (i.e., bed pressure)

Worcestershire Acute Hospitals NHS Trust are well placed to progress this project locally due to specific surgical, anaesthetic and nursing expertise and ambition. It is expected that SDD VWR rates will be in excess of 25% by September 2024.

Aligning nationally with Getting It Right First Time (GiRFT) and locally with WAHNHST Acute Surgical Reconfiguration (ASR) Project to split sites for hot and cold surgery, SDD VWR will be delivered from the Kidderminster Treatment Centre and the Alexandra Hospital in Redditch.

2. Eligibility Criteria to be checked in clinic when booking surgery

Pre-operatively (to be confirmed by the booking surgeon in outpatient clinic). Patients who are keen for SDD after VWR would be identified in GOPD when added to the waiting list.

It is essential that consistent information is given to the patient and carers from the preoperative assessment through to the post-operative period from all involved nursing and medical teams.

2.1 Patient Factors

- Adequate motivation, education and understanding
- BMI <40 – the final decision for same day discharge will rest with anaesthetist and operating surgeon
- ASA I/II.
- ASA III may be suitable if comorbidities are stable and optimised. Patient should have good functional status i.e., 4 METS or greater
- Alcohol: consumption <70u/week, no LFT derangement, no pancytopenia or cirrhosis, patient able to stop drinking without anxiety, no history of alcohol-related fits
- No cardiomyopathy.
- No recent ACS or CVA, no PPM, no 2 or 3-degree heart block
- RS: must be stable and well controlled, no OSA
- Diabetes: HbA1c <70, not insulin dependent. May be higher risk of overnight stay if BM unstable on day of operation.

- No known significant renal disease
- No liver disease
- Normal FBC with no bleeding disorder
- If history of difficult pain control with chronic pain- need to arrange early input from Chronic Pain Team, if required
- Total expected operating time less than 90 minutes

2.2 Social Circumstances

- Distance from Worcester Royal Hospital (which is the acute site for Worcestershire Hospitals NHS Trust in case of post-operative care need): must be within an hour by car
- Competent adult present in the home overnight following surgery
- Access to transport overnight if required
- Working phone at home to contact

If all the above preoperative criteria are satisfied:

- Leaflet on SDD VWR procedure given to patient
- Patient informed that they are suitable to be scheduled as a Same Day Discharge, if they wish
- Surgeon to complete waiting list form to include detail that surgery is to be done as day case/SDD

3. Pre-operative protocol- pre-admission to hospital

3.1 Pre admission nurse assessments

Pre-operative assessments should be carried out via Synopsis with a view to optimising comorbidities and should also include:

- Patient engagement through education, to manage and inform of the Same Day Discharge VWR pathway and what the expectations are for the discharge home later on the day of surgery.
- Pre-operative assessment staff should also inform the patient they will need a responsible adult to collect and care for them on discharge.
- Clear instructions i.e. *"We will plan to send you home after surgery. However, if you are not ready to go home it may be that you stay in hospital overnight. It will be useful if you come with an overnight bag just in case."*
- Given written information - the patient should be given the **'Having an operation'** leaflet with links to the video on gynaecology Enhanced Recovery Pathway (including physiotherapy exercises following your surgery), the **'Same Day Discharge Vaginal Wall Repair'** leaflet to help with patient expectations and **'Advice and exercises following major gynaecological surgery'** (WAHT-PI-0101)
- Education should be given around practising physiotherapy exercises BEFORE SURGERY to optimise recovery. This includes deep breathing exercises and getting in and out of bed.
- Explain there will be a requirement for patient to self-administer Enoxaparin injections on discharge and this will be explained before patient goes home.

- Helping the patient to understand their role in Enhanced Recovery which includes optimising their health and nutrition by stopping smoking, reduce alcohol consumption if >14u/week, and eating healthily.
- Pre-assessment staff should inform the patient of benefits of same day discharge - for example recovering at home in your own environment relieves anxieties of being on an unfamiliar ward and is far quieter; being discharged from hospital decreases exposure to potential infections; once at home the patients should not require opiate medication, meaning that recovery is optimised and allows bowel habits to return to normal.
- Fasting advice should be given in line with the Trust policy.
- Advise that nursing staff will follow up with discharge advice after surgery.
- Explain the patient will have access to emergency gynaecology care if needed at Worcestershire Royal Hospital
- Pre-op team to inform the operating consultant gynaecologist and secretary as soon as possible if there are any concerns that the patient is not suitable for SDD.

3.2 Engaging the patient through patient education

Patient education includes 3 aspects:

- Patient's role in enhanced recovery which includes optimising their health and nutrition by stopping smoking, reduce alcohol consumption if >14u/week, and eating healthily
- Practice physiotherapy exercises BEFORE SURGERY to optimise recovery. This includes deep breathing exercises and getting out of bed
- Managing patients' expectations and preparing them for same day discharge. Ensure there is a responsible adult with them on discharge until they are more than 24hrs post op

Benefits highlighted- i.e., resting at home more comfortable than in hospital- hospitals are noisy places; decrease exposure to nosocomial infections; encourage judicious use of opiates (optimising the recovery process by minimising nausea and speeding the return of normal bowel function).

3.3 Patient information leaflets

The above information should be supported by providing or signposting patients to the following leaflets:

- Same Day Discharge Vaginal Wall Repair
- Patient information leaflet on Gynaecology Enhanced Recovery
- Advice and exercises following major gynaecological surgery (WAHT-PI00101)
- Discharge Advice after Gynaecological Surgery
- Ward specific discharge leaflet

The leaflets are appended to this SOP.

3.4 Pre-operative protocol (Pre-admission)

- Enhanced recovery interventions
- Pre-operative information (verbal/written)
- Appropriate fasting: food= 6 hours, clear fluids until 2 hours preop.

4. Perioperative Anaesthetic and Analgesic protocol (NB Doses for pts >50kg)

4.1 Preoperative period

Fasting as per Trust guidelines:

- Patient should have no food after 6 hours before the start of the surgical list.
- Sips of water are allowed on the ward before surgery with any preoperative medications to be taken.
- All patients to be given ICIQ Urinary incontinence and ICIQ Vaginal symptoms questionnaires (ICIQ UI and ICIQ VS) *and BSUG consent form* to complete on arrival onto ward and these to be sent with patient to theatre.

4.2 Premedication

- Advise patients to continue other regular medications as per WAHNHST Guideline WAHT-KD-017 NBM and perioperative medicine use.

4.3 Intraoperative period

- General anaesthetic, Spinal anaesthetic or even pure LA are acceptable options. To be decided ideally pre-operatively.
- IV antibiotics before knife to skin.
- Antiemesis as per patient risk factors- ondansetron +/- cyclizine
- Aim for normothermia with warming likely to be necessary
- Aim for euvolaemia, 1 litre Hartmann's is typical
- Consider IV NSAID or PR towards end of surgery.

4.4 Recovery

- Ondansetron 4mg PRN
- Discontinue IVI asap

4.5 Post-op

- Regular paracetamol
- NSAIDS as adjuncts if required. Try and avoid codeine.
- Ensure there is a clear anaesthetic handover to recovery and the ward as to whether the patient is still suitable for SDD if all discharge criteria are met. If

now not suitable for SDD, this must be clearly handed over to recovery and ward staff and documented in operating notes.

4.6 Discharge medications

Patient to obtain own paracetamol and ibuprofen before admission. To be advised to take:

- Regular paracetamol 1g- 4-6 hourly (maximum 4g/24 hours)
- Regular or PRN ibuprofen- 400mg QDS maximum dose
- If posterior wall repair, then Macrogol laxative eg Laxido or Movicol 1 sachet bd to be dispensed from ward and patient advised to continue and avoid constipation.
- Enoxaparin to be dispensed from ward as required in line with Trust VTE prophylaxis guidance

5. Perioperative surgical protocol

5.1 Scheduling of patient

Pre-operative assessment appointment should be arranged early in the treatment pathway to facilitate patient education, manage expectations early and allow adequate time to optimise comorbidities in time for surgery.

Patients for SDD VWR should be done on the morning list to allow time for adequate postoperative care and assessment before discharge.

All patients to be given ICIQ Urinary incontinence and ICIQ**Vaginal symptoms questionnaires (ICIQ UI and ICIQ VS) and BSUG consent form to complete on arrival onto ward and these to be sent with patient to theatre**

Patients must be admitted to day case beds at Kidderminster Treatment Centre or the Birch Day Case Unit at the Alexandra Hospital. Patients are not suitable for inpatient wards such as 14, 17 or 18 at The Alexandra Hospital unless indicated in surgical operating notes that SDD is no longer planned.

5.2 Surgical technique

Surgical techniques will vary between operating surgeons and may be patient specific.

a) This SOP is not to guide surgical technique which is left at the discretion of the consultant

i) All patients to have local anaesthetic infiltration at the time of repair.

ii) All patients to be given intra-operative antibiotic prophylaxis with either 1.2G IV Augmentin (or Clindamycin 900mg IV if penicillin allergic). Dose may be altered in presence of altered renal function.

iii) All VWR procedures to have thromboembolism prophylaxis with TEDS for 28 days and (dependant on Trust risk assessment) either 7 or 28 days of clexane. (Dose weight dependant as per Trust guidance). Optimum timing for first dose

is at completion of surgery or up to 4 hours afterwards. Ward staff to teach self-administration prior to discharge.

iv) All patients to have a vaginal pack and foley catheter inserted at the end of the case.
Both to be removed together 2 hours following procedure completion- **surgeon to highlight time of removal on operating note**

v) Optimize pain relief- IV paracetomol + NSAID (unless contraindicated/allergic) intra-operatively. Codeine/opiates are a last resort and should be avoided if possible.

5.3 Operating Documentation

- The operating notes and electronic discharge summary (EDS) must be completed while the patient is in theatre suite
- Drugs to take home should be identified and prescribed at the earliest opportunity and included in the EDS
- **Laxatives/stool softeners as routine for posterior vaginal wall surgery**

- It is expected that patients with unexpected intraoperative complexity or complications will be advised to stay overnight for observation and this must be clearly documented in the operation notes

6. Postoperative recovery protocol

- Keep IV cannula flushed and in situ until patient ready for discharge home
- Patients should be observed with routine surgical recovery observations including heart rate, blood pressure, oxygen saturations, respiratory rate, pain score and PONV score with escalation and de-escalation as per NEWS guidance.

7. Post-operative nursing care protocol

- Multimodal analgesia is recommended to ensure patient comfort and optimal recovery. See above
- Keep IV cannula flushed and in situ until patient ready for discharge home
- Patients should be observed with routine surgical recovery observations including heart rate, blood pressure, oxygen saturations, respiratory rate, pain score and PONV score with escalation and de-escalation as per NEWS guidance.

- Encourage normal diet/fluids on return to ward.

Vaginal Pack and indwelling foley catheter to be removed 2hrs postop by ward staff. DO NOT REMOVE PACK AT 2HRS IF EBL OVER 250 ML – this indicates overnight stay and pack to be removed 7am.

BLADDER CARE PATHWAY AFTER VWR

- Monitor voiding- patient should pass urine within 4hrs of catheter removal. Voided volumes to be measured and PVR bladder scan performed within 15 minutes of void.

- **Voiding – the general rule for a <u>successful void</u>**

"Patients should pee more than they leave and leave <150ml on two occasions"
Each void should be a reasonable volume eg >150ml

- **Voiding problems**- any concerns can be discussed with the operating team who will be on site until 18-00hrs and will review all patients prior to leaving the site. After 18-00hrs then contact the on call team at WRH (either on 01905 761489 or ext 30425 or via bleep to Gynae Reg through switchboard..

- **Three categories in general of abnormal voiding- no void; poor void and borderline voiding:**

A) No void- If unable to void at all by 4 hours after catheter removed, then check PVR:
a) If PVR <400ml but no urge to void, encourage fluid and allow 2 further hours to pass the void test- If unsuccessful then proceed to re-insert indwelling foley catheter (IDC) and plan SDD with IDC for TWOC in GAU at 48– 72 hours.
b) If PVR >400ml or >300ml but uncomfortable/strong urge to void then proceed to re-insert foley catheter (IDC) and plan SDD with IDC for TWOC in GAU at 48– 72 hours.

B) If very poor voiding (small voids <100ml and residuals >200ml on two occasions)- insert foley catheter (IDC) and plan SDD with IDC for TWOC in GAU at 48– 72 hours as above.

C) If 'borderline' voiding- voids are reasonable (eg >150ml) but residuals higher eg 200ml, then suggest one in/out catheter (and measure residual) and await next void. If subsequent void and residual are satisfactory then void test is passed. If not, then IDC, plan SDD with IDC for TWOC in GAU at 48– 72 hours.

<u>Pathway for Management of Subsequent TWOC on GAU:</u>

After the TWOC, patients will fall into two categories:

Success
"Patients should pee more than they leave and leave <150ml on two occasions"

Each void should be a reasonable volume eg >150ml

– In which case discharge and ensure OPD F/up planned as per surgeons operating notes.

Failure
Categories A, B or C above repeated

- in which casereinsert further IDC and arrange reattendance to GAU for further TWOC 5 days later.
Cover with antibiotics on discharge - Nitrofurantoin 50mg QDS or Trimethoprim 200mg BD for 3 days (depending on allergy status)

Persistent issues with voiding on day 5-7/7 GAU review

GAU staff will liaise with on call consultant/Urogynaecology team if persistent voiding difficulty- senior input is essential.

Patient may require:
a) Take back to theatre for removal of bladder neck suture(s) (Anterior repairs only)
b) Further IDC and wait
c) CISC teaching and review

7.1 Enhanced recovery interventions

- Early oral fluids/diet (to prevent insulin resistance and a catabolic state and to encourage an anabolic state)
- It is essential to minimise nausea and ensure patient can eat and drink before discharge
- Minimise opiates
- Encourage to use oral analgesia as first line therapy, with an eye on same day discharge
- Early mobilisation- sitting, walking with minimal support
- **Follow bladder care pathway as above**
- Thromboprophylaxis: Clear details of the recommended regime should be documented in the surgical notes. VTE form must be completed. Nursing notes must document that patient has been educated about the method and need for self-injection at home.
- **Laxatives/stool softeners as routine for posterior vaginal wall surgery**
- Patients should be seen on the postoperative ward by the operating surgeon and anaesthetist as required.

7.2 Preparation for discharge

- Ensure nursing checklist criteria met- see below
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- Patient Information Leaflets should have been given at start of SDD VWR Pathway but before discharge please check patient still has information.
    - o Same Day Discharge Vaginal Wall Repair
    - o Patient information leaflet on Gynaecology Enhanced Recovery
    - o Advice and exercises following major gynaecological surgery (WAHT-PI00101)
    - o Discharge Advice after Gynaecological Surgery
    - o Ward specific discharge leaflet

- Ensure patient has Paracetamol and Ibuprofen ready at home

Ensure minimal/acceptable vaginal loss/bleeding and normal NEWS (0)

- Emergency gynaecology department contact details must be given to all patients. They can contact the unit directly on 01905 761489 24hours a day.

8. Clinical discharge criteria (nurse led) for Same Day Discharge VWR

(The patient should NOT be discharged by a nurse if non-compliant with any of the criteria unless reviewed and sanctioned by a member of the medical staff).

Discharge Criterion	Complied (tick box)	Actions, at earliest opportunity, if non-compliant
Uncomplicated surgery		
Surgery performed without complications (to be defined by surgeon). Postop plan mentions- for same day discharge		Contact surgeon to discuss whether safe for SDD
EBL <250ml (surgeon happy with haemostasis)		If EBL >250mls patient must remain in hospital overnight for observation and FBC day 1 post op. Remove pack and catheter at 07-00 following day DO NOT REMOVE AFTER 2 HOURS
No trauma to bladder or rectum.		The patient must remain in hospital overnight for observation SEE OPERATING NOTES FOR PACK/CATHETER MANAGEMENT
Post-operative observations[1]		
Complied with NEWS chart- stable and normal vital signs and ability to maintain oxygen saturation levels >94% on room air		Escalate to medical staff
Post-operative progress[1]		
Tolerated oral fluids and light diet without significant vomiting/nausea		Consider medical review
Adequate control of nausea and vomiting		Consider medical review
Adequate pain control with an oral regimen based upon paracetamol with/without adjunctive NSAID		Escalate to medical staff
Voiding spontaneously and meets 'Successful' bladder voiding pathway/ scan residuals (above)		Follow above pathway / Escalate to medical staff
Post-operative examination and tests		

Observation and NEWS score satisfactory. No significant fresh bleeding or constant ooze from vagina.		Escalate to medical staff
Medications to take home		
TTO's prescribed by the medical staff and given to patient with instructions for use		Escalate to medical staff to arrange TTOs
Routine analgesics- patient's own paracetamol 1g QDS, patient's own ibuprofen 400mg QDS (with food, from day **after** surgery unless contraindicated) Max 7 days		Escalate to medical staff to arrange TTOs
Routine stool softeners- laxido or Movicol Routine if posterior VWR		Escalate to medical staff to arrange TTOs
Exceptional (only if requested and prescribed by medical staff)- please tick all that apply: • Antibiotics • Hormone replacement therapy • Low molecular weight heparin (clexane/daltparin)- according to standard gynaecology VTE protocol		Ignore and strike through if no exceptional TTOs prescribed VTE prophylaxis as per VTE Trust Guidelines.
Post-discharge care		
Someone at home to act as a carer for the next 24-72 hours		Not suitable for SDD
Written patient information and emergency contact numbers given		

1. Minimal 6-hours post-operative observation. Escalate to medical staff if unsure or thought to be abnormal

9. Post-discharge (at home) protocol (patient instructions)

Patients should refer to the patient information leaflet WAHT-PI-0817 Discharge advice following your surgery.
They should contact the Emergency Gynaecology Assessment Unit on 01905761489 to access further advice in case of any queries or concerns.

9.1 Patient information leaflets

Patient information leaflets are to be given, but please check at post op discharge that patient still has leaflets on:

- Same Day Discharge Vaginal Wall Repair
- Patient information leaflet on Gynaecology Enhanced Recovery
- Advice and exercises following major gynaecological surgery (WAHT-PI00101)
- Discharge Advice after Gynaecological Surgery
- Ward specific discharge leaflet

10. Care After Discharge

Follow- up- all patients to be booked for 6 month face to face consultation with operating consultant unless specified differently by admitting / operating consultant.

11. Audit of SDD VWR

a) All patients to be entered onto BSUG database
b) Initial audit for one year suggested to assess feasibility, additional unplanned LOS, complications and re-admission rates.

12. References

Links to relevant departmental / Trust policies and procedures

NICE 123 (April 2019)
Worcestershire acute NHSST Prolapse treatment pathway (https://bit.ly/WorcsGynae)
Trust VTE

13. Appendices

Title	Link
Same Day Discharge VWR	To be drafted
Patient Information Leaflet on Gynaecology Enhanced Recovery	WAHT-PI-0882 Gynaecology enhance
Advice and Exercises Following Major Gynaecological Surgery	WAHT-P~1.PDF
Discharge Advice After Gynaecological Surgery	WAHT-PI-0817 discharge advice follc
Video On Gynaecology Enhanced Recovery Pathway (Physiotherapy Exercises Following Your Surgery)	TBC
Ward One Discharge Booklet	TBC
Ward One COVID SOP	Ward One Shielding patients from COVID !
Theatres COVID SOP	SOP Surgical Procedures COVID 19
Enhanced Recovery Document	Gynae Enhanced Recovery Pathway V3.
Patient Experience Audit Questions To be drafted / adapted for SDD VWR	SDD TLH Patient Experience Audit Questions v2
WAHNHST Guideline WAHT-KD-017 NBM	NBM and peri-operative medici

14. Table of abbreviations

Abbreviation	Meaning
VWR	Vaginal Wall Repair
SDD	Same day discharge
SOP	Standard operating procedure
GIRFT	Getting it right first time
ASR	Acute surgical review
WAHNHST	Worcestershire acute hospitals NHS trust
ACS	Acute coronary syndrome
CVA	Cerebrovascular accident
PPM	Permanent pacemaker
METS	Metabolic equivalents
BMI	Body mass index
ASA	American society of anaesthesiologists
LFT	Liver function tests
RS	Respiratory system
OSA	Obstructive sleep apnoea
HbA1c	Glycosylated haemoglobin
BM	Blood Glucose Monitor
FBC	Full Blood Count
QDS	To be taken 4 times daily
SR	Sustained Release
NBM	Nill by mouth
TIVA	Total intravenous anaesthesia
PEEP	Positive end expiratory pressure
BIS	Bispectral index
PNS	Peripheral nerve stimulator
PRN	Pro re nata (as required)
NSAID	Non-steroidal anti-inflammatories
MR	Modified release
VTE	Venous Thrombo-embolism
PONV	Post-operative nausea and vomiting
NEWS	National early warning system
EGAU	Emergency Gynae Assessment Unit
TWOC	Trial without catheter
EBL	Estimated Blood Loss
TTO	To Take Out (medications)
KTC	Kidderminster Treatment Centre
IDC	Indwelling Catheter