Mid Essex Hospital Services NHS
NHS Trust

| | |
|---|---|
| **Colposcopy Service**<br>**Clinical Operational Service** | **Type: Policy**<br>**Register No: 08026**<br>**Status: Public once ratified** |

| | |
|---|---|
| Developed in response to: | NHSCSP20 3rd edition April 2016 |
| Contributes to CQC Outcome number: | 9 |

| **Consulted With** | **Post/Committee/Group** | **Date** |
|---|---|---|
| Anita Rao/ Alison Cuthbertson | Women's and Children's Clinical Directors | 25.07.2017 |
| Mr C Spencer | Consultant | 25.07.2017 |
| Alison Cuthbertson | Head of Midwifery/ Nursing | 25.07.2017 |
| Anne Powell | Matron Gynaecology | 25.07.2017 |
| Dr S Zamzam | Staff Grade Registrar | 25.07.2017 |
| Sarah Moon | Specialist Midwife for Guidelines and Audit | 25.07.2017 |
| **Professionally Approved By** | Mr C K Partington | 25.07.2017 |

| | |
|---|---|
| Version Number | 3.0 |
| Issuing Directorate | Women's and Children's Division |
| Ratified by: | DRAG Chairmans Action |
| Ratified on: | 11th September 2017 |
| Executive Management Board Sign Off Date | October 2017 |
| Implementation Date | 16th October 2017 |
| Next Review Date | August 2020 |
| Author/Contact for Information | Susannah Cotter, Colposcopy Clinical Nurse Specialist |
| Policy to be followed by (target staff) | Colposcopy Team |
| Distribution Method | Email, intranet & website |
| Related Trust Policies (to be read in conjunction with) | 04071 Standard Infection Control Policy<br>08086 Clinical Record Keeping Standards Policy<br>05118 Chaperone Policy<br>04001 Equality and Diversity<br>08034 Safeguarding Vulnerable Adults Policy |

**Document Review History:**

| **Review No** | **Reviewed by** | **Active Date** |
|---|---|---|
| 1.0 | Susannah Cotter | 8th May 2008 |
| 2.0 | Susannah Cotter | February 2014 |
| 2.1 | Carrie Farr – clarification to point 8.0, 19 and 20 | September 2015 |
| 2.2 | Susannah Cotter and Mark Howard | 6 Sept 2016 |
| 3.0 | Susannah Cotter, Colposcopy CNS | 16 October 2017 |

**Index**

## 1.0 Purpose

1.1 This document reflects. NHSCSP No20 Third Edition April 2016. Chapters 4 and 5 deal specifically with quality standards for Colposcopy clinics and diagnostic standards for Colposcopy and form the basis of best practice.

1.2.1 This document aims to set out how the Trust will meet the standards set out in NHSCSP No20 Third Edition April 2016. Appendix A and the follow Up Standards in Appendix B and follow up after Treatment in Appendix C

## 2.0 Introduction

2.1 The rationale for treatment of cervical pre cancer is the prevention of cervical cancer. Therefore any decision to treat or not to treat must address the fundamental question as to the risk of that individual developing cervical cancer balanced against the potential complications and problems of treatment.

## 3.0 Staffing and Training

3.1 Nurses and doctors undertake training; this will be conducted according to the requirements determined by the British Society of Colposcopy and Cervical Pathology. Colposcopists practising must see at least 50 new abnormal cytology referrals per year to maintain skills currency. All Colposcopists must attend at least one BSCCP recognised colposcopy meeting every three years.

3.2 The Diagnostic training programme is a trainer-led competency based structured theoreticaland practical programme that involves:-

- Direct supervision of 50 colposcopy cases (of which at least 20 must be new cases, of which 10 must be high-grade disease)
- Indirect supervision of 100 cases (of which at least 30 must be new cases, of which 15 must be high-grade disease)
- Completion of the log book
- Histopathological and Cytopathological sessions

3.3 LLETZ will be restricted to those who have sufficient training and experience in cervical treatment by this method.

3.4 Equipment Competency sheets will be signed and dated by all trainee and accredited Colposcopists.

## 4.0 Trust Service Targets

4.1 100%of women with abnormal test results should be seen in the Colposcopy clinic within 4 weeks of referral

4.2 100% of women with a test result of high grade dyskaryosis (moderate) or high grade dyskaryosis (severe) should be offered an appointment to be seen within 2 weeks of referral.

4.3 100% of women with Glandular abnormalities or more serious clinical presentations, to be seen within 2 weeks of referral.

## 5.0 Overview of the Trust Colposcopy Service Procedure

5.1 Appointment requests are received via email from the Cytology Laboratory daily.

5.2 The Trust also receives requests from GP surgeries, Family Planning Clinics, Sexual Health Clinics and gynaecological clinics within in Mid Essex Hospital Trust. These referrals are usually woman who have symptomatic cervical ectropion requiring treatment or those that have a suspicious looking cervix or clinical suspicion of cancer.

5.3 The result will be assessed by the nurse Colposcopist/senior Colposcopist and an appropriate appointment will be given.

5.4 Confirmation of receipt of the referral will be sent to the patients GP confirming date and time.

5.5 The patient is telephoned offering an appointment but if no reply a letter is then sent to the patient asking them to attend a Colposcopy examination.

5.6 All details are recorded on the data collection forms and on the Infoflex system. Direct entry is available to all Colposcopists and is to be entered on each patient in clinic.

5.7 The data collection forms remain with the patients notes and represent a backup for the computer based records.

5.8 There will be an initial colposcopic assessment. This will be followed by either/or

- Treatment
- Further Colposcopic Assessment
- Discharge from Clinic

5.9 See and Treat may also be offered.

## 6.0 Referral to Colposcopy

6.1 Referral of women for colposcopic assessment is achieved by a number of pathways including

- Direct referral by the Cytology Department
- By referral from a Consultant Gynaecological Clinic (clinically significant cervix)

- By referral from Sexual Health (clinically significant cervix)
- By referral from a General Practitioner (clinically significant cervix)

6.2 Direct Referral from Cytology Services is the most common of the pathways. The purpose of the HPV test in the "triage" format is to identify women into two groups:

- Those with low significant cytological changes and are high risk HPV positive who require Colposcopic assessment

- Those with **significant cytological abnormalities** (High grade dyskaryosis) moderate and above) will be referred for colposcopy at the first abnormal smear (as per current practice). Those having BNC [borderline nuclear changes] or low grade dyskaryosis will have a HR-HPV test carried out on the same sample. Women who have **low grade cytological** abnormalities and are "HR-HPV not detected" will be returned for routine screening in primary care at 3 or 5 years (i.e. routine surveillance). Women with **low grade cytology** and are "HR-HPV detected" will be referred for colposcopy at the first smear.

6.3 The referral pathway is:

- Low grade cytology low grade dysk, BNC) & HR-HPV not detected - Smear follow up 3 or 5 years (primary care)

- Low grade cytology (low grade, BNC) & HR-HPV detected - Referral to Colposcopy

- High grade cytology (High grade dyskaryosis ) moderate dysk and above) - Immediate referral to Colposcopy

6.4 The low grade cytology smears (normal, BNC, low grade dyskaryosis) with HR-HPV not detected are reviewed cytologically in three or 5 years (thereby removing the necessity of yearly cytology after treatment) for all age groups.

6.5 The low grade cytology smears (normal, BNC, low grade dyskaryosis) with HR-HPV detected will be re-referred for further colposcopic assessment.

6.7 Those treated women who have significant cytological abnormalities (High grade dyskaryosis) moderate and above) will be re-referred for further colposcopic assessment without the necessity of HR-HPV testing.

6.8 The post treatment pathway is:

- Cervical smear at 6 months post treatment: (complete and incomplete excision)

- Normal, BNC, low grade dyskaryosis and HR-HPV not detected 3 or 5 years cervical screening

- Normal, BNC, low grade dyskaryosis and HR-HPV detected Referral to Colposcopy

- Significant cytological abnormalities (High grade dyskaryosis )moderate and above) Referral to Colposcopy

- Incomplete excision suspected at the stromal/lateral margin to be discussed at Colposcopy MDT

This is following the NHS Cervical screening Programme HPV Triage and Test of Cure Protocol (Refer to appendix D)

## 7.0 Initial Colposcopic Assessments

7.1 There are essentially four outcomes at the initial visit (assuming a complete colposcopic examination is possible, i.e. the whole TZ seen, endocervical canal inspected and fornices examined) and this makes the assessment and management of the patient very simple using the new NHS Cervical Screening Programme 2012

- if no abnormality seen – review original and subsequent cytology, the patient will go back on to normal recall
- If only low grade changes are seen and it correlates with subsequent cytology, the patient can be discharged with a GP cytology follow up in 12 months.
- Uncertain about findings – take directed biopsy of seemingly most diseased portion of the suspected lesion.
  Treat if significant
- A definite lesion seen - more or less corresponding to the referring smear and requiring treatment. Arrange an **excision procedure** for diagnosis and treatment either as per **"see and treat"** protocol or at an arranged future appointment

## 8.0 Multidisciplinary Team Meetings – Minimum standard

8.1 The primary purpose of the meeting is to plan the management of the patients with discordant histology, cytology and colposcopic findings.

8.2 Frequency of meetings: Colposcopy MDT meetings should be held on the third Thursday of every month, depending on the amount of patients, they can be more frequent. Operational meetings should occur every 3 months to discuss protocols, audits and teaching – meetings to be chaired by the Lead Nurse Colposcopist.

8.3 Attendance: The meetings should be chaired by the Lead Nurse Colposcopist. The Colposcopy Coordinator should attend meetings as they are involved in the organisation of these patients. The following personnel should be present at the meetings: Laboratory personnel, including Consultant cytologists & Histopathologists; Colposcopy Lead and other Colposcopists, including trainees; Nurse Colposcopists; Colposcopy Administrators and Advanced Practitioners.

Attendance to at least 50% of these meetings as a minimum is required each year for all colposcopists– allowing for annual leave / study leave etc. Attendees to be noted on minutes for audit purposes.

8.4 Meetings Organisation: The meetings need to be formally minuted, with a log of who attends. The patients' notes should be available in the meeting in order to be able to refer to theme when necessary. Information regarding patients to be discussed should be circulated, with a brief summary and action points to be minuted for recording purposes. The action points for individual patients should then be put in the notes and letters sent to the GP and/or patient.

8.5 Cases for discussion:

- Discrepancy between smear and biopsy of at least two grades eg cytology high grade dyskaryosis (severe), biopsy CIN1.
- All ?Glandular Neoplasia cytology cases, and all cases of CGIN/SMILE or suspected CGIN/SMILE on histology.
- All cases of ?invasive cytology
- Cytology showing Borderline changes in endocervical cells with HR HPV detected.
- Women under the age of 24.5 years where treatment is contemplated
- When a 2nd LLETZ is being contemplated.
- Cancer cases, including micro-invasion, should be discussed at Colposcopy MDT meetings and also Gynae Cancer MDT meetings, and entered on the database for submission to the SQAS.
- Colposcopy, cytology and histology may also suggest colposcopy MDT discussion on any case where in their professional opinion a MDT discussion is warranted if complex patient management decisions are needed ,
- The clinicians running the colposcopy service should have the clinical freedom to discuss any cases that they feel are appropriate, which suit the local needs of the service
- Any out of programme HPV tests

8.6 Documentation:

- A register of attendees / apologies must be maintained
- Minutes of the meeting maintained.
- Actions agreed and filed in the patients notes with authorised signature confirming management plan

8.7 Audit:

- Audit of cases discussed at the Colposcopy MDT meetings and their subsequent management and outcome should be instigated on a regular basis, with evidence that the audit cycle has been completed.

## 9.0 Data Sheets

9.1 These have been designed to collect information for Clinical Management including sufficient record keeping to comply with the Trust Management Guideline on Medical Record Keeping. Data will also be entered directly into Infoflex by the clinician.

9.2 After each history/examination the likely outcome should be indicated. This is separate from the final outcome which will be determined after the results of any investigations are known. The likely outcome is usually one which will have been discussed with the patient before leaving the clinic. (If the final outcome decision is different it will be necessary to offer further and more detailed explanation in any correspondence as the patient's expectation is altered.)

9.3 The data sheets will remain part of the clinical notes (hard copy). The Colposcopy secretary will input patient's results onto Infoflex.

9.4 A diagram of the colposcopic findings will be drawn and it should be undertaken on every occasion. Digital image capture is also available.

9.5 Additional details not specifically related to Colposcopy can be included but time–consuming gynaecological consultations should be discouraged unless it is an urgent matter.

## 10.0 Investigations

10.1 HVS and Chlamydia swabs should only be taken if clinically indicated.

10.2 Cytology is optional depending on the clinical situation. There is an opportunity to obtain endocervical smears, in case there is a disease in the canal (you should be able to assess the ectocervical portion by Colposcopy) Cytology should not be repeated if taken less than three months prior to appointment.

10.3 Directed cervical biopsies should be taken at the discretion of the Colposcopist. There may be situations in which a LLETZ is indicated anyway and further biopsies are not required as a LLETZ sample is both diagnostic and therapeutic. If the patient is being managed on a see and treat basis there will be no requirement for a biopsy. Biopsies are invasive and sometimes unpleasant for the patient – it should NOT be considered a "routine procedure" for minor abnormalities.

## 11.0 Histological assessments

11.1 Important factors associated with the histological assessment include:

- Correlation with colposcopic and cytological assessment.
- Completeness of excision (ectocervical, endocervical and stromal/lateral margins).
- Exclusion of invasive disease.

11.2 If there is any uncertainty – it is essential to seek advice from the Lead nurse Colposcopist or lead Consultant

## 12.0 Results

12.1 After the Results are available:

- Check the results
- Decide whether treatment, follow up or discharge is appropriate
- Assign or dictate an appropriate letter to GP and Patient
- Arrange admission if relevant
- Arrange follow up (by clinic or GP)
- Assess whether colposcopy MDT is required and dictate letter appropriately

12.2 If there is any uncertainty – it is essential to seek advice from the Lead Nurse Colposcopist or lead consultant

## 13.0 Treatments

13.1 Available treatments:

- LLETZ (large loop excision of the transformation zone) under LA in the colposcopy clinic.
- LLETZ (GA) as a day case.
- See and Treat (LLETZ at first visit).
- Hysterectomy (in special circumstances).

13.2 The type of treatment selected depends on a number of factors including:

- Degree of CIN (LLETZ and See and Treat).
- Area of treatment (LLETZ, LASER GA).
- Cervical canal involvement (LLETZ, LASER, GA).
- Accessibility (GA).
- Patients with high anxiety (GA).
- Requirement for other investigations (i.e. hysteroscopy). (GA)

13.3 Having assessed the patient's cervix and having made the decision to treat the abnormality.

- A letter should be sent to the patient with an explanatory leaflet.
- A letter should be sent to the GP indicating the decision to treat.
- An appointment should be made with the clinic (if LA) or with the waiting list office (GA) within 4 weeks. A treatment or follow up Colposcopy appointment may be made in the clinic if the outcome is unequivocal or no results pending.

13.4 Suggested treatment scenarios

1. High grade disease (CIN 2 – 3 possible micro invasion) excision procedure.
2. Suspected invasive cancer – directed biopsy along with staging EUA. (discussed at Gynae Oncology MDT)
3. low grade disease (CIN1) – excision procedure or follow up with HR-HPV testing
4. Benign disease – (ectropion/chronic cervicitis) loop excision.
5. Pregnant with CIN – biopsy only when micro invasion or worse is suspected (MDT discussion).

Situations 1&2 above are fairly easy to determine. In situation 3 the management is less straightforward. Factors, which would tend to encourage treating low grade disease, include:

- Persistent mild disease.
- Large area of CIN.
- Discrepancy between Colposcopy and biopsy result.
- Patient wish.
- Potential for defaulting follow-up.
- If symptomatic as well.
- HR-HPV status

The decision whether to treat under local anaesthesia or general anaesthesia should take into account patients with anxiety, accessibility of the cervix, depth and area of treatment required and other surgical investigations.

## 14.0 See and Treat – LLETZ at first Colposcopy assessment

14.1 An option exists for some women to be assessed colposcopically and simultaneously treated by LLETZ thus saving additional appointment for treatment and reducing the waiting time for treatment.

14.2 Not all referrals will be suitable for see and treat for the following reasons:

- Patient anxiety may require GA.
- The lesion may not be serious enough to warrant treatment.
- Domestic and business reasons.
- The lesion may require treatment under GA.
- Other gynaecological conditions requiring GA treatment may prevail.
- Pregnancy.

14.3 Who should be offered see and treat?

- Patients with high grade cytology and high grade colposcopic appearance.
- Colposcopically low grade disease with large area of CIN.
- Patients who may default treatment at a later date.

13.4 This treatment may only be offered if the patient has been sent explanatory leaflets before attending. The patients will be considered as consenting for this treatment if they have read the leaflet and still avail themselves for Colposcopy /LLETZ and have discussed the procedure in the clinic. The patients may elect not to be treated in this way and revert to a more traditional timetable for treatment.

## 15.0 The Treatment Visit

15.1 Find out if any exclusion to Treatment exists:

- The patient should not be pregnant (except if suspicion of invasive disease is present)
- At the point of treatment she should have read the leaflet, had the procedure explained and given her verbal consent to the clinician who documents this in the patient's notes.
- The patient should not be about to go on holiday. Treatment may be performed after the holiday or the holiday postponed. This will be the patient's choice after informed discussion with the Colposcopist.
- Ensure that she is entirely happy with local anaesthesia treatment and has no previous problems with LA

15.2 The Colposcopy examination is repeated to confirm the previous assessment and histological correlation.

15.3 Local anaesthetic (Scandanest 3% plain) is injected subdermally around the ectocervix in the region that the excision is to take place (i.e. the transformation zone).

15.4 Once the anaesthetic is effective assemble the correct loop size for the treatment area.

15.5 Set the diathermy settings (i.e. cut 70 coag 70) and check the diathermy pad.

15.6 Carry out the excision, preferably in one motion (there will be some lesions so large that two or three portions will be taken). If taken in more than one piece it is important to explain how the pieces have been taken on the histology form and to draw a diagram if possible. This is so that the histologist can assess margins appropriately.

15.7 The specimen will encompass the transformation zone and certainly the ectocervical margins are easy to include (you can see them).

15.8 Cauterise the margins ectocervical and endocervical. (This will help haemostasis and will help treat any residual disease that you may have omitted in the loop).

15.9 There should be complete haemostasis before the patient leaves the examination couch.

15.10 Complete records as set out in para 6.

15.11 Follow up arrangements should be discussed (i.e. further colposcopy or cytology follow up depending on the histology results.

## 16.0 Follow up Arrangement

16.1 Follow up policy is now driven entirely by the "Test of Cure" (**ToC**) applied to the 6 months post treatment cervical smears. With HR-HPV not detected there is very little likelihood of any abnormality occurring as a consequence of residual disease and follow up smears at 3 years will form the basis of surveillance? Further disease may yet develop as a new event, but that is likely to take a long while and is not the concern of immediate follow up arrangements, rather the follow up cytological screening arrangements.

16.2 If incomplete excision is reported there still may not be any risk of immediate progression of the disease as the diathermy /laser thermal artefact may have influenced the histological assessment or may indeed have treated the residual disease. Again the follow up cervical smear and **ToC** will determine the follow up arrangements.

16.3 It is not possible to legislate for all eventualities but a rough guide is included and a number of basic principles apply.

- If there is no evidence of CIN – Colposcopy has no place in follow up.
- Full excision by and large, may be followed up cytologically (micro-invasive disease requires MDT involvement)
- If excision is considered incomplete at the stromal margin of the LLETZ specimen there is a chance of hidden residual disease after healing. The HPV **ToC** may help but these situations are subject to MDT consideration.

16.4 Treated with full excision reported:

- CIN only – Follow up with cytology in primary care with HR-HPV **ToC**.
- Micro-invasive lesion – patient to be seen after multidisciplinary meeting to discuss follow up.

16.5 Treated with incomplete excision reported:

- Ectocervical and Endocervical margin incomplete – HPV **ToC** at 6 months
- Micro/invasive lesion – patient to be seen after multidisciplinary meeting.

16.6 Mild abnormality untreated (borderline, CIN1)

- These women will be discharged and subject to follow up smears with HR-HPV

16.7 Pregnant Women

- If CIN 1 or less discharge patient to GP for a repeat smear 3 months post-partum.
- If CIN2/3 is suspected repeat Colposcopy at the end of the second trimester, then 3 months post-partum.
- Biopsy only if invasive disease is suspected.

16.8 Hysterectomy

- For patients having a hysterectomy for treatment of CIN (complete excision) Follow up is arranged by cervical cytology at six months and 18 months after surgery. We discharge from follow up if both samples are negative.
- For those women who have had incomplete excision of CIN either in treatment or found inadvertently during routine hysterectomy (for benign conditions) Follow up is continued by cervical cytology six and twelve months and for a further 9 years.

16.9 Immunosuppressed Women

Immune suppressed patients are seen as having a higher risk of progression of CIN therefore, treatment is offered early and follow up continues as per high grade lesions after treatment.

16.10 Glandular Abnormalities

Patients with glandular abnormalities or have had treatment for CGIN by cone biopsy/loop diathermy are followed up by cytology in accordance with the NHSCSP guidelines.

Patients who have had incomplete excisions of a glandular abnormality of the cervical canal are followed up at Colposcopy at six months unless there is suspicion of micro-invasive or invasive disease.

16.11 Suspected cervical cancer

If a cervical cancer is diagnosed after a Colposcopy patients are to be referred immediately to the Gynae Oncology team for further investigation and discussion at MDT.`

## 17.0 Communication with Patients

17.1 Appointments should not be made by the staff on the ward. The staff on the ward should arrange for the notes of all patients treated by LLETZ or laser be sent to the Colposcopy secretary for processing.

17.2.1 In other situations the consultant looking after that patient is responsible for documentation and follow up (i.e. in treatments of benign conditions).

17.3 Patient information leaflets are available for patients in the clinic area and waiting area. The appropriate leaflets are sent to the patients with their appointment letters.

## 18.0 Patients Failing to Attend

18.1 Depending on the urgency of the referral a further appointment will be sent to the patient with a letter. The General practitioner will also be informed.

18.2 The more urgent matters such as invasive disease, may require telephone communications

18.3 Failure to attend a second time requires that:

- The surgery will be informed again.
- The area health authorities receive specific notification (via the nurse Colposcopist).

## 19.0 Colposcopy Procedure Trolley Set-up

19.1 **Scope**

Local use

19.2 **Aim**

To minimise transmission of infection between patients.

19.3 **Introduction**

This guideline is intended to offer guidance to nursing staff assisting in the colposcopy
clinic. The colposcopy procedure is a ‘clinically clean’ procedure and aseptic technique
is not a requirement. However, it is of utmost importance to ensure that there is minimal risk to patients from contamination including spillage, spray or accidental contact by equipment to equipment.

19.4 **Undertaken by**

Applicable to all staff assisting in the colposcopy clinic and learners under the supervision of competent trained staff within this area.

19.5 **Key Recommendations**

- Hand Hygiene policy should be adhered to at all times (See Trust Clinical Documents)

- The procedure trolley must be cleaned thoroughly before the clinic. Between patients it must be cleaned using Sani – Cloth wipes

- An apron should be worn (See Trust document on Personal Protective Equipment PPE). They should be worn to protect clothing from contamination and removed once the patient activity is complete

- Gloves must be worn as single use items and removed once the patient activity is completed. Hands must be decontaminated after removal

- Disposable equipment should be used wherever possible

- Used, non-disposable instruments should be bagged and returned to HSDU

19.6 **Clinical equipment list**

Trolley

Impregnated wipes
Non sterile gloves
Plastic apron
Gallipots
Cotton wool balls
Swabs
Sponge holder
KY jelly

Other equipment should be available (not to be exposed to the patient or procedure) depending on the procedure to be undertaken.

19.7 **Method**

- Healthcare Workers are responsible for ensuring the procedure room is used in accordance with the hospital policy
- Prepare colposcopy procedure room
- Perform hand hygiene and put on apron
- Clean colposcopy trolley
- For each patient; open gallipot and pour in 5mls of Acetic Acid and 5mls of Iodine in disposable kidney dish
- For each patient; place cotton wool balls and cotton-tipped buds
- For each patient; use disposable sponge holders
- For each patient; ensure sterile speculum available in different sizes
- For each patient; ensure disposable kidney dish is in place on colposcopy couch Anyone using the room to carry out the procedure must ensure safe disposal of sharps and correct disposal of any equipment usedOn completion of the procedure the room should be left clean and tidy

### 19.8 **Monitoring the effectiveness of the Guideline**

- Process for Monitoring compliance and Effectiveness
  i. Audit and Review
  ii. Responsibility for conducting the monitoring/audit lies with the Lead Colposcopy Nurse
  iii. Frequency of audit on an annual basis or if concerns arise about an individual's clinical practice
  iv. Process for reviewing results and ensuring improvements in the service will be discussed at the Colposcopy Administration Meeting

## 20.0 Safe use of the Colposcopy Equipment

### 20.1 **Colposcope**

- Plug in the electricity supply. Switch on button on the main body
- To change bulb, slide cover from bulb housing, unhook bulb and change for a new bulb, recover housing
- Attach the camera system using the lead from the colposcope to the camera box. Ensure correct alignment before pushing the lead into the socket then apply screw cover
- Machine is to be cleaned before and after use with sani-cloth wipes. Store unplugged in treatment room.

### 20.2 **Diathermy Machine**

- Plug into the electricity supply. Use main switch on front of the unit to turn ON/OFF
- Insert diathermy pen point in sockets below setting dials.
- Insert diathermy pad point in socket below ON/OFF switch
- Use dials on front of machine to set to doctor's request
- Pen lead single use
- Pad lead clean before and after each use with a medi-swab
- Machine is left unplugged in treatment room. Clean before and after use with the medi-wipe
- Contact BME in case of a breakdown.

### 20.3 **Smoke Extractor**

- Plug into the mains electricity supply. Use main switch on back of machine for ON/OFF.
- Attach smoke tube one end of smoke tube and into exposed end of elephant trunking. Use new smoke tube for each patient
- Clean with sani-cloth wipes before and after use
- Contact BME in case of breakdown.

## 20.4 **Camera System**

- Plug into the electricity supply and switch ON in sequence:

    a) VDU – switch in bottom right-hand corner
    b) Photography box – switch on bottom left-hand corner
    c) Camera box – switch on bottom left-hand corner

- Attach camera lead for the colposcope to camera box. Ensure correct linage before pushing into the socket and securing with the screw cover
- Change paper for photography by pressing ‘open’ button on the front panel, change new for old cartridge, push cartridge unit back into box
- To alter image and white out use labelled buttons on front panel of camera box
- Wipe down with sani-cloth wipes before and after use. Store unplugged in treatment room.

## 20.5 **Resuscitation Trolley**

- There is no steering mechanism on the trolley currently in Gynaecology Out Patient Department.
- There is no locking mechanism on the trolley in Gynae Out Patient Department, apart from the securing tag on drawer 3 that must be pulled off before the drawer can be opened
- There is a defibrillator with the trolley
- The contents of each compartment of the trolley are as follows:-

    - Drawer 1 - Airway Management
    - Drawer 2 - Circulation Management
    - Drawer 3 - Medication, IV fluid and giving sets
    - Drawer 4 - Subsidiaries

- The exterior of the trolley should be checked daily and the drawers at least once every week and/or after every use
- The correct use of each item should be understood following statutory resuscitation training. If unsure, please refer to the Resuscitation Training Department for further education/training
- Spare stock is kept in the store cupboard within the department as well as on other wards and theatres
- All disposable items will be clearly marked on the appropriate packaging and, in some cases, the stock order sheets
- After each use, the trolley should be cleaned with appropriate wipes as per Infection Control Policy. All equipment used should be restocked immediately and never allow any item to be ‘borrowed’ from the trolley

- Report any trolley faults to BME Department and equipment faults to the Gynae Out Patient Department Manager. Complete Adverse Incident Report/Datix Report, if indicated
- No operator's manual is available for the trolley in Out Patients Department.

## 21.0 Infection Prevention

21.1 Use Aseptic Non-Touch Technique (ANTT). Hands to be washed before and after, each patient.

## 22.0 Audit and Monitoring

22.1 Quarterly audits are performed in this unit to comply with the statutory KC65 return.

22.2 All Colposcopists work will be monitored through the colposcopy office. Results will be checked with your colposcopic opinion. Quarterly reports are run on Infoflex to determine individual Colposcopists performance.

22.3 All Colposcopists to audit at least two different quality indicators a year as set out in appendix A, B and C.

22.4 All auditors will present their findings at the Obstetrics and Gynaecology Audit Meetings.
Consultants, doctors and nurses will be present. Recommendations or review of practice made from the audits will be taken to the Lead Consultant for review.

22.4 Key findings and learning points will be disseminated to relevant staff.

22.5 Datix forms are to be completed in the event of non-compliance in accordance with the Trust policy.

## 23.0 Incidents and Potential Incidents

Incidents and potential incidents should be managed with reference to "Managing Safety Incidents in Screening Programmes"

23.1 Identification of a cervical screening incident or potential incident

- If an incident is suspected in the colposcopy service the Hospital Based Programme Coordinator (HBPC) should be informed immediately.
  This will be by phone call to Mark Howard on 01638 569189 and by email to Mark.Howard@nhs.net (and cgeary@nhs.net – in case of absence)
- The HBPC and colposcopy department will gather the facts and complete a screening incident assessment form, found at:
  https://www.gov.uk/government/publications/managing-safety-incidents-in-nhs-screening-programmes

- The incident status will be indicated by SQAS and further actions recommended

23.2 Incident panels

Incident panels will include the lead colposcopist, clinical governance, women and childrens management, the HBPC and other Trust representation where appropriate

## 24.0 Equality and Diversity

24.1 It is to be recognised that patients attending colposcopy can be of different faiths and religions. We will meet all requests for a female Colposcopist.

24.2 Staff must be aware of the trust's Chaperone Policy and to arrange for a chaperone if required

23.3 If there are language barriers, contact the NHS Telephone Interpreting Service.

24.4 A vulnerable adult who has full mental capacity has the right to consent or refuse treatment and may make their own decision regarding the choice of chaperone. Their rights to decline any chaperone offered should be upheld. If the offer of a chaperone has been refused, the healthcare professional should decide whether it is appropriate to continue the examination. It is important to document that the offer was made and declined and what action taken.

## 25.0 Patient with Learning Difficulties (LD) /Autism

25.1 If the patient Is unable to consent to a procedure and a capacity assessment is required, the patient's GP is responsible for instigating the Mental capacity act 2005 (MCA) form for the patient's initial visit.

25.2 Under the Equality act 2010 it is understood that reasonable adjustments may need to be made in order that disabled people achieve equal health outcomes.

25.3 A period of preparation; or a pre-visit can be arranged based on the patients individual needs. Adjustments to the physical environment where possible should take place by considering lighting / noise / other people and remove unnecessary equipment.

25.4 LD/autism patients should be encouraged to bring a friend/Carer or relative with them. However A chaperone may be necessary, in this instance, as a third party to a clinical examination, whose aims will be to provide support and reassurance to the patient, witness the continuing consent to a procedure, and on occasion provide practical help to the clinician. They will also able to discourage unfounded allegations of improper behaviour, by acting as a witness to any procedures. Their role is therefore intended to offer safeguards to both patients with learning disabilities/autism and members of staff during consultation, examination, treatment and care and may provide additional

protection for the health care professional from patients with learning disabilities/autism who are known to present with behaviours which are challenging.

24.5 The time of the patient's appointment should be taken into consideration when booking i.e: first or last on the list in order to minimise waiting time. A double slot should also be booked to insure that the appointment is unhurried.

25.6 Aids such as pictures, photographs, videos and audios are available to use when communication is a barrier

## 26.0 Abbreviations

| | |
|---|---|
| GA | General Anaesthetic |
| BNC | Borderline Nuclear Changes |
| HPV | Human Papilloma Virus |
| HR-HPV | High Risk Human Papilloma Virus |
| CIN | Cervical Intraepithelial Neoplasia |
| CGIN | Cervical Glandular Intrepithelial Neoplasia |
| SMILE | Stratified Mucinous Intraepithelial Lesion |
| ToC | Test of Cure |
| TZ | Transformation Zone |
| LLETZ | Large Loop Excision of the Transformation Zone |
| MDT | Multi-Disciplinary Team |
| HBPC | Hospital Based Programme Coordinator |

## 27.0 References

Guidelines for the NHS Cervical Screening Programme
D Luesley and S Leeson
Publication: 20 April 2004

Managing Safety Incidents in Screening Programmes : October 2015
https://www.gov.uk/government/publications/managing-safety-incidents-in-nhs-screening-programmes

NHSCSP no 20, colposcopy and programme management, Third Edition March 2016
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/515817/NHSCSP_colposcopy_management.pdf

**Appendix A**

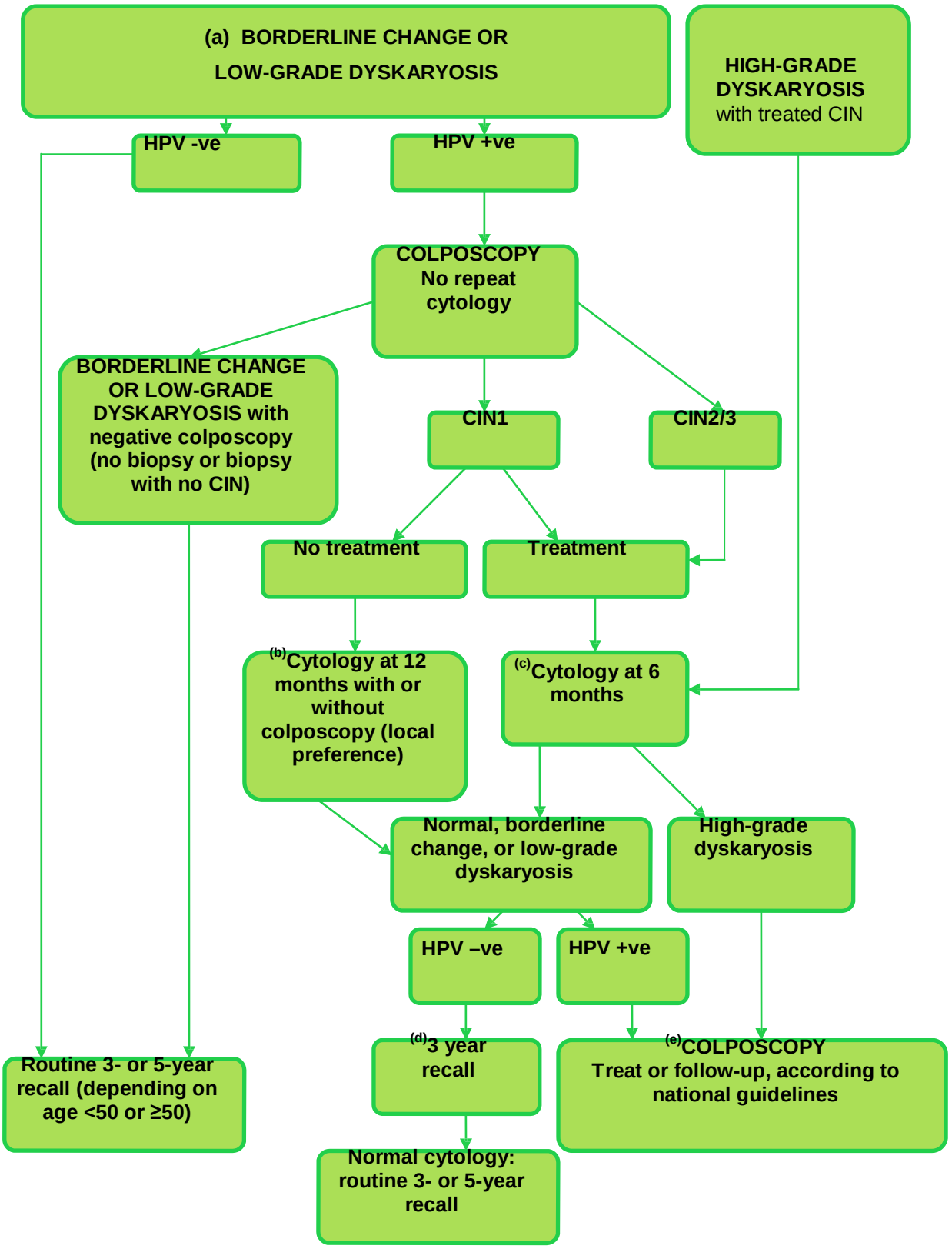
## NHPCSP Standards

- All women needing treatment must be informed that the treatment will be required and there consent , either written or verbal, recorded [100%]
- All women needing treatment must have had a colposcopic assessment [100%]
- All treatment must be recorded 100% [100%]
- All women must be treated in properly equipped and staffed clinics [100%}
- All women must have had their histological diagnosis established before destructive treatment
- The proportions of women treated at the first visit (see and treat) who have evidence of CIN on histology must be >90%
- The proportion of treatment associated with primary haemorrhage that requires a haemostatic technique in addition to the treatment method must be <5%
- Proportion of patients admitted owing to complications must be <2%
- When excision is used at least 80% should have the specimen removed as a single sample.
- Excision techniques involving the ectocervical lesions should achieve a depth of >7mm.
- Amongst women with CGIN, those wishing to retain fertility can be managed by local excision. Incomplete excision at the endocervical margin requires further excision procedure to obtain a clear margin and exclude occult invasive disease.[95%]
- The proportion of women managed as outpatients with local anaesthesia should exceed 80%.
- For women with completely excised CIN at hysterectomy, a smear should be taken from the vault at 6 and 18 months after surgery. If both negative, cease cytology follow up. For women on routine recall on the last 10 years prior to hysterectomy and no CIN in the sample, no vault cytology is required. For women with less than 10 years recall and no CIN in the histology a sample should be taken from the vault 6 months after surgery. If negative, cease recall. It is the consultant's responsibility to inform the GP of the hysterectomy histology.

**Appendix B**

## NHSCSP No 20: Summary of follow up standards

- All women remain at some risk following treatment and must be followed up [100%]
- Follow up should start at six months following treatment and not later than 8 months [>90%]
- all women who do not have negative test results after treatment must be recolposcoped at least once within 12 months[100%]
- The proportion of treated women with no dyskaryosis six months following treatment should exceed 90%
- The proportion of confirmed histological treatment failures should not exceed 5% within 12 months of treatment.
- biopsy should be undertaken in >95% of women with high grade abnormalities
- If at follow up a high grade cytological abnormality persists excision treatment is recommended
- Women referred with high grade (moderate) dyskaryosis or worse cytological abnormalities who have a colposcopically low grade lesion and who are not treated should have multiple biopsies.
- If a low grade lesion has not resolved within two years from referral to Colposcopy at least a biopsy is warrant


(a) BORDERLINE CHANGE OR LOW-GRADE DYSKARYOSIS
HIGH-GRADE DYSKARYOSIS with treated CIN
HPV -ve
HPV +ve
COLPOSCOPY No repeat cytology
BORDERLINE CHANGE OR LOW-GRADE DYSKARYOSIS with negative colposcopy (no biopsy or biopsy with no CIN)
CIN1
CIN2/3
No treatment
Treatment
(b) Cytology at 12 months with or without colposcopy (local preference)
(c) Cytology at 6 months
Normal, borderline change, or low-grade dyskaryosis
High-grade dyskaryosis
HPV –ve
HPV +ve
Routine 3- or 5-year recall (depending on age <50 or ≥50)
(d) 3 year recall
(e) COLPOSCOPY Treat or follow-up, according to national guidelines
Normal cytology: routine 3- or 5-year recall