Waitematā
District Health Board

Best Care for Everyone

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21 January 2020

[redacted]

Dear [redacted]

Re: OIA request – Informed consent

Thank you for your Official Information Act request received 3 December 2019 seeking information about informed consent practices at Waitematā District Health Board (DHB).

Your initial request contained the following:

> *RNZ requests WDHB reconsider its response to this OIA [i.e., previous request from you dated 21 October 2019]. In one case info has not been provided that should have been, I believe.*
>
> *In addition, my request was on reflection too limited, regarding the type of procedure/treatment I described (intimate, women) and who I referred to doing it (doctors/surgeons/nurses).*
>
> *I wish to ask Waitematā DHB to release all the info as I requested before, but to do with procedures or treatment on anyone without their consent, by anyone, including students. So this would cover any department, not just Obstetrics and Gynaecology.*
>
> *Please advise if Waitematā DHB wishes to make this a whole new OIA or provide the info more quickly than that, so we can include it in our reporting on OIA 19176.*
>
> *On some other specific matters RNZ requests info today without going to another OIA, re:*

- *Attachment 4 (of previous OIA response): This blanks out 2 examples of concerning procedures on page 5. It says in the cover letter these are redacted as out of scope. Nonetheless, the intent of the email writer is clear - to provide examples of students conducting procedures or taking part in treatment, without consent. It is in the public interest to know what these are, and what was done about it. Please provide.*
- *Attachment 5 (to previous OIA response): The 2018 email addressee field includes* [redacted] *My searches show she is New Zealand Nurses Organisation (NZNO). Yet I see no record in the OIA response of any other communications to* [redacted] *or from her about this. Is it possible she never got back to the Waitematā DHB to discuss this? The OIA request clearly covers any communications from her. All the correspondence with*

the union should have been released under the original request. Radio New Zealand (RNZ) asks for the full email chains. Please provide these in full forthwith.

- *I do not see any diary notes by nurses or others here. Were none written at all about any of this at any time? YES/NO …. Even by the nurse in Attachment 4 (of previous OIA response) who is concerned enough to go to the Medical Council and Auckland DHB?*

- *Have you released all and any attachments that went with these emails or other docs? If not please release.*

That same day you further clarified with the following:

Also please provide:

- *Numbers of how many students have performed VE's (vaginal exams) on patients and if there is written consent for all of these, since 2013.*

- *Re Attachment 6 (of previous OIA response), this shows requests to add info to the informed consent section. Please provide the before/and after versions of this document – before this August 2019 request was made, and after it, highlighting what has changed.*

- *Please comment on why Dr Ackerman sees the need to get this added in mid-2019, if Waitematā DHB had not had any concerns raised and had a fully formed policy and guidelines etc already.*

We advised your request would be lodged as an OIA, however, we also provided a media release for your immediate use (**Attachment 1**).

We also asked you to clarify the request and received clarification the following day, 4 December 2019 (detailed from page 3 onwards).

Before responding to your specific questions, it may be useful to provide some context about informed consent policies and work undertaken at Waitematā DHB in this regard.

Waitematā DHB has taken seriously and fully investigated all claims raised by the NZNO relating to informed patient consent. We have made significant changes to policies and education of staff around informed consent.

Last year Professor Ron Paterson was invited to undertake an external review of the DHB's approach to informed consent. His November 2019 report (legally privileged and confidential) to the Chair & CEO, found that overall, Waitematā DHB's informed consent process is of a good standard, consistent with legal and ethical requirements. The report notes that the DHB is appropriately emphasising and promoting the importance of informed consent, as evidenced by a wide range of activities and projects throughout the organisation which aim to ensure our processes and policies are robust and patient-focussed (please refer to pages 5 to 7).

The review confirmed that:
• the DHB's policies and documents meet New Zealand ethical and legal standards
• the DHB's response to specific concerns raised in the past six years have been appropriate and comprehensive.

Your questions and our responses to each are as follows:

To clarify by breaking this into three parts:

1. **the story we have now, based on the public interest into a bedrock of patient/medical interaction - informed consent**
2. **OIA 19176 and what we believe is missing from it, and asking all of that be released today**
3. **widening the story and inviting Waitematā DHB - outside the OIA, and in the public interest - to provide more info off its own bat, re: the cases of concern, and what's been/being done about them.**

1. **At present, we have a story where:**

- **concerns persist (2013, 2018, 2019) about procedures being done on patients without informed consent**
- **the DHB reports dealing with two cases since 2013**
- **the DHB has redacted examples of procedures of concern, saying these are outside the scope of RNZ's OIA. RNZ has asked for this info to be un-redacted regardless.**

Please see the un-redacted version of the email requested above (**Attachment 2**).

Please note it is not possible to investigate any concerns raised without an NHI number or any identifying clinical details for the patient. A number of the concerns raised by the nurse cannot be formally reviewed for this reason.

Please also could Waitematā DHB comment on why Dr Ackerman sees the need in mid-2019, to get these explicit instructions about medical students and informed consent added to the handbook? This seems odd if Waitematā DHB had not had any recent concerns raised and given it had worked on these since 2013.

As the SHO (Senior House Officer) Handbook was due for review senior clinicians within the Obstetrics and Gynaecology department took it as an ideal opportunity to add clarity to our orientation material. The Auckland University medical school's own manual has very clear guidance for students around informed consent and our review ensured the subsequent updates were in line with these.

2. There is solid evidence within OIA 19176 that there exists other information within scope that has not been provided in this OIA and which we ask be provided.

This pertains to the following:

PRIMARILY:

Attachment 5 (of previous OIA response), the December 2018 email from a theatre nurse:

- **It says "Again I ask why has nothing been done ...". So, the nurse indicates she has previously raised concerns and asked for action. Please provide.**

In response, we provide the following timeline of communications in which the nurse raised concerns and asked for action:

2013

In 2013 the nurse became concerned about informed consent in regards to teaching and approached Waitematā DHB's general counsel. Her concerns were taken seriously and relevant staff were asked to meet with her to discuss them.

2014
Meetings with the New Zealand Nurses Organisation (NZNO), the nurse and a senior manager took place. Extensive consultation and teaching sessions were held for clinical staff and students. A revised Informed Consent Policy was issued.

2015
A consensus statement was agreed between the Auckland and Otago medical schools, the DHBs, the NZ Medical Association and the Medical Council of New Zealand. This was published in the New Zealand Medical Journal (**Attachment 3**).

2016
In a letter from the NZNO to Waitematā DHB's CEO documented the previous concerns (prior to 2014) and raised on-going concerns from the nurse. However, details of the alleged breaches since 2014 were not provided.

The CEO replied to NZNO (**Attachment 4**), encouraging the organisation to bring any particular concerns to the immediate attention of Waitematā DHB's Chief of Surgery. NZNO did not do so.

A meeting was held with obstetrics and gynaecology Senior Medical Officers (SMOs) re-iterating the need to obtain express consent when students are involved in any procedure and to also make a patient aware of who will be performing their surgery.

2018
The nurse, who had been away from work for a period, returned to work and felt the informed consent policy was not being adhered to. She raised further concerns over September, October and December. Following her December 2018 email, referred to in your question above, the General Manager of Child, Women and Family Services, Stephanie Doe, the Clinical Director of Child, Women and Family Services, Dr Meia Schmidt-Uili, Director of Nursing Dr Jocelyn Peach and General Manager Surgery, Lyn Wardlaw met with the nurse . The general manager of Child, Women and Family wrote to the nurse on 19 December 2018 following this meeting to detail an action plan to address the concerns (**Attachment 5**).

It was agreed by senior clinical staff that the nurse had appropriately raised these concerns. Over this time, and since, there has been a large and comprehensive amount of work done in the area of informed consent, as detailed on pages 5 to 7.

- **It says "I look forward to some answers at our meeting on Tuesday". Where in the OIA info are the notes or communications around this meeting on Tuesday December 18, 2018? Please provide.**

Again, please refer to the follow-up letter of 19 December 2018 to the nurse outlining the details of this meeting (**Attachment 5**).

Attachment 5 (of previous OIA response):

- **The 2018 email addressee field includes NZNO's [redacted] The OIA does not provide any correspondence with the union re this, or the matter back to 2013, or since. RNZ asks for the full email chains.**

We have asked the relevant staff in this email chain to provide their records of emails. Please note, clinical staff do not necessarily retain all emails in every email chain. We are unable to find records of this particular email chain, but we have provided follow-up emails recording follow-up on this email (**Attachment 6**).

Attachment 4 and 5 (of previous OIA response):

- **The nurse is concerned enough to go to the Medical Council and ADHB; the other nurse says "Again I ask ..." . RNZ asked for diary notes by nurses re this. Are there none, even from these nurses?**

We are not aware of nurses keeping diary notes and there were no notes kept by nurses about this matter.

What has been done?

As previously mentioned, the DHB has undertaken significant work across the organisation and consulted widely both internally and externally on the matter of informed consent. Professor Ron Paterson's review (previously referred to) outlined that Waitematā DHB's policy and processes comply with legal requirements.

A Health and Disability Services Standards (HDSS) Audit, which is an independent national audit process for health care providers, was completed in December 2019. The draft report of that audit concluded that Waitematā DHB has the required policies and procedures relating to informed consent in place. It said clinical staff are knowledgeable about informed consent processes and could articulate the informed consent processes, including what to do if a patient lacks capacity to consent. In the surgical services, the patient records inspected by the auditors contained the required written consent, including procedural and anaesthetic consent. Mental health services also demonstrated informed consent processes that meet the patients' needs and the standards.

The HDSS draft report said that informed consent is, appropriately, an on-going process throughout the entire course of a patients' hospital journey and that both informal and formal consent is obtained. The independent reviewers undertook interviews with patients which also confirmed that, in addition to the rigour of the written consent process, verbal consent was obtained prior to any interaction/intervention that did not require written consent. Resources and information are provided to patients to enable informed decisions to be made regarding their care and treatment and information was presented in a way that patients understood.

Waitematā DHB's CEO and CMO wrote to the Director General of Health in December 2019 seeking national guidance on informed consent in the context of the training environment in public hospitals (**Attachment 7**).

Additional work undertaken to date includes:

- Internal reviews of informed consent policies and procedures with:
    - Waitematā DHB General Counsel
    - Chief Medical Officer and senior clinicians

  Institute of Innovation and Improvement (i3).
- Consultation with external parties such as:
    - other DHBs
    - New Zealand Nurses Organisation
    - Auckland and Otago medical schools
    - Medical Council of New Zealand
    - Waitematā DHB Consumer Council
    - Ministry of Health

Specifically, in terms of Obstetrics and Gynaecology the following projects have been undertaken by our Institute of Innovation and Improvement (i3):

- a process has been introduced so that all Registered Medical Officers (RMOs) receive a hard copy of the consent policy as part of orientation and sign off that they have understood it;
- update of orientation manual (SHO Handbook) that outlines information, policy and expectations of informed consent
- informed consent stickers (to be signed by the student and patient and placed in the paper chart) for intimate examinations where medical students are involved have been introduced.

During 2019, a working group undertook work in five work streams with some work on-going, as follows:

Work stream 1 – Informed consent process:

- guidance on informed consent for medical students at Waitematā DHB was sent to all SMOs and RMOs on 31 July 2019 [**Attachment 8**]. An updated memo regarding the Medical Council of New Zealand statement on informed consent and DHB policy was sent to clinical directors in December 2019. A copy of the email is enclosed although it is outside the scope of this request [**Attachment 8A**]
- an informed consent guidance documentation for healthcare industry representatives in theatre has been drafted and is now being reviewed.

Work stream 2 – Informed consent documentation

- review the informed consent policy, consent form and treatment without consent form[1] have been reviewed by the steering group and feedback provided by the Consumer Council
- minor changes have been made to definitions in the informed consent policy

Work stream 3 – Informed consent patient information

- current patient information available for key gynaecological procedures, including patient interviews of their experiences has been reviewed
- the patient information working groups is looking at where potential improvements can be made around the delivery of patient information provided to gynaecology patients.

Work stream 4 – Supervision in theatre

- An electronic platform has been developed, allowing the obstetrics and gynaecology team to have immediate visibility of the credentialed status for individual clinicians.

Work stream 5 – Education and training

- Multi-disciplinary theatre education sessions have been provided involving the CMO, General Counsel and Professor Ron Paterson
- a patient experience video has been created and relates to informed consent with DHB staff as the target audience. This was screened at an October 2019 education session and has the potential to be incorporated in to the "Welcome to Waitematā DHB" orientation agenda or in to clinical orientations

[1] This form is used in situations where patients lack the capacity to consent to a procedures and treatment is provided with the consent of an attorney under an enduring power of attorney, a welfare guardian or as permitted under Right 7(4) of the Code of Health and Disability Services Consumers' Rights.

- informed consent policy awareness posters for clinical staff are being updated and will be available within the first quarter of 2020
- in-service interactive training for theatre and surgical nurses has been created
- informed consent has been discussed with Senior Medical Officers (SMOs), led by CMO Jonathan Christiansen and i3 director Penny Andrew in obstetrics and gynaecology. The use of compulsory e-learning modules is being considered
- a prototype for an interactive e-learning module is being developed for surgical SMOs and registrars on specific informed consent issues, including medical students, teaching, team care, delegation and healthcare industry representatives.

SECONDARILY:
Attachment 6 (to previous OIA response)

- **This email stands in isolation. Please indicate if there were any other communications or actions around this and where in the OIA this info is. Please provide.**

The sender and the recipient of the email, who both have extremely busy clinical roles, do not recall any other emails around this matter and, if there were any such emails, they have not retained them.

- **The email asks for info to be added to a handbook. What happened next? Where in the OIA info is what happened next covered? Please provide.**

Dr Diana Ackerman's wording was subsequently added to the SHO Handbook, as per her request (**Attachment 9**).

Attachment 10 (to previous OIA response), July 2019 email from the chief medical officer:

- **He says "there has been some recent discussion about informed consent". It is reasonable to think some of this discussion might have been in recorded. Please provide.**

These discussions were not recorded. You will note that in Work stream 5 – Education and training above, we make mention of such discussions. In addition, many discussions come out of clinical education sessions – the attached plan gives an overview of the framework presented and topics covered (**Attachment 10**).

3. There is public interest in knowing more about Waitematā DHB's efforts or struggles to guarantee informed consent for patients, re all procedures.
My OIA was unfortunately limited to women, intimate procedures, and nurses/docs/surgeons.

So it is RNZ's request WDHB make more info about the overall experience and concerns avail, today or in a more timely way than under the OIA (two months due to Xmas).
Please see previous responses about the work undertaken across Waitematā DHB in relation to informed consent.

BUT, in addition, in this No. 3 section, I also ask for release of info under OIA on:

- **Numbers of how many students have performed VE's (vaginal exams) on patients and if there is written consent for all of these, since 2013.**

Over this time more than 100,000 patients have been treated in our hospitals and it is not possible to provide this information without reviewing tens of thousands of individual patient paper records to identify each patient who had a vaginal examination and whether there is a written consent for each examination.

To give context around the enormity of this task all paper charts would have to be retrieved from a storage facility and transported for review. Each chart would take an experienced clinician at least five minutes to review which would equate to 208 full-time days of clinician time or approximately a year of full-time work for a clinician.

We have considered whether charging for this or extending the time would assist us with providing the requested information but have concluded that it would not.

Therefore, we are declining this aspect of your request under Section 18 (f) of the Act on the grounds that substantial collation and research would be required to provide this information.

You have the right to seek an independent review of any of the decisions taken in providing this response by contacting the Office of the Ombudsman via www.ombudsman.parliament.nz.

The Waitematā DHB Informed Consent policy clearly outlines the requirements for students who undertake intimate examinations and prohibits multiple examinations on one patient by a group of students (please see excerpt below). Individual consent (which can be verbal for RMOs, registrars and SMOs) is required for all vaginal examinations.

2.3 Intimate Examinations

Such examinations are of critical importance and need to be properly learned by health professionals. The commonest cancers (prostate and breast) for both men and women are disclosed by such examinations.

Responsibility for eliciting the essential consent to teach these procedures rests with the supervising clinical teacher.

Multiple intimate examinations on one patient by a group of students is prohibited.

Intimate examinations by students under general anaesthetic require the same consent process i.e. the patient MUST consent for teaching BEFORE anaesthesia or pre-medication is given.

- Multiple examinations are, as in the general setting, prohibited.

Clinical teachers should use chaperones appropriately when teaching intimate examinations.

Patients have the right to have a support person present particularly during intimate examinations such as rectal or vaginal examinations.

- **Numbers of VEs performed by students since 2013 and records of any without fully informed consent.**

As above, it is not possible to provide this information without reviewing tens of thousands individual records. Therefore, we are declining this aspect of your request under Section 18 (f) of the Act due to substantial collation and research.

You have the right to seek an independent review of any of the decisions taken in providing this response by contacting the Office of the Ombudsman via www.ombudsman.parliament.nz.

- **Re: Attachment 6 (of previous OIA response), this shows requests to add info to the informed consent section. Please provide the before/and after versions of this document – before this August 2019 request was made, and after it, highlighting what has changed.**

We can provide the previous version of the booklet which was published on our staff intranet.

Dr Diana Ackerman, Clinical Director Obstetrics and Gynaecology, spearheaded a project to review and update this handbook as it was recognised that much of the information was already available on the staff intranet.

The 2015 version of the Obstetrics and Gynaecology Registrar and SHO Handbook is attached for your reference [**Attachment 11**].

- **to release all types of info (reports, communications etc) as I requested under 19176, but for procedures or treatment or examinations on anyone without their consent, or without fully informed consent, or where there were concerns there had not been fully informed consent, or where the activity was halted by concerns raised about this (as in the Dec 2018 case) by anyone, including students. So this would cover any department, not just Obstetrics and Gynaecology, of any part of Waitematā DHB.**

On 17 January, we advised you that we required an extension of time to 24 January to enable us to provide a response to this question. However, we provide our response in full below:

Waitematā DHB sees around 130,000 hospital admissions each year so the numbers of patients who receive care requiring some form of consent (procedural, blood, other) is very large. The information you have requested is not recorded in any routine or readily identifiable way.

However, we believe you are seeking information in relation to the concerns raised by the nurse in 2013 and again in 2018.

As outlined previously, we are only able to undertake a formal review of cases where patient NHI numbers are available.

In response to this request a clinical review of these cases has been completed and assessed according to guidelines set out in our Informed Consent policy (provided in previous response).

The reviewing clinician considered all consent forms, other documentation of consent, the anaesthetic records, nursing and lead maternity carer (LMC) notes, as well as the patient (baby) outcomes.

It was found that one case was inconsistent with our policy on consent. We are withholding the records relating to that case under section 9(2)(a) of the OIA in order to protect the patient's privacy.

You have the right to seek an independent review of any of the decisions taken in providing this response by contacting the Office of the Ombudsman via www.ombudsman.parliament.nz.

We accept however that there may be some public interest in the case and have, therefore, set out a summary of it below as follows:

A registrar obtained the patient's consent to a gynaecological procedure to be undertaken under general anaesthetic using a laryngeal mask airway. The patient signed the standard Waitematā DHB consent form. The consent form includes the statements:

> **I agree that:**
> I understand that my...care in occurring in a teaching hospital and there may be healthcare students (medical, nursing) present. I understand they will be appropriately supervised but at any time I can ask for them not to be present.

> I understand that no assurance can be given that a particular clinician will be performing my... procedure but that the clinician will be suitably qualified, and if in training, will be appropriately supervised by a senior clinician

During the procedure, the anaesthetist allowed a medical student to intubate the patient using a laryngeal mask airway. There should have been a clear and documented discussion seeking the patient's permission to the student undertaking the intubation. However, there is no mention in the patient's record of such a discussion occurring. The surgery was successful with no complications.

The outcomes of this event were as follows:

1. The incident was discussed directly with the anaesthetist responsible who was reminded of the informed consent policy.

2. The Quality Lead Senior Medical Officer (SMO) in Anaesthesia communicated to the department the importance of obtaining consent when medical students are actively involved and the consent policy was circulated to the SMO group.

In addition to these actions, the Chief Medical Officer (CMO), together with the Assistant Dean of Auckland medical school, sent a memo regarding informed consent and medical students to all SMOs (**Attachment 8**) which clearly outlined the situations in which documented consent is required. You will note the CMO included the 2015 NZ Medical Journal national guidelines which specifically include intubation as requiring explicit consent.

Auckland University's orientation process for medical students coming to Waitematā DHB (run by the Assistant Dean) also reinforced the guidance around consent for all students joining us – this is ongoing at each intake.

I trust that this information is helpful.

Waitematā DHB supports the open disclosure of information to assist community understanding of how we are delivering publicly funded healthcare. This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released.

If you consider there are good reasons why this response should not be made publicly available, we will be happy to consider your views.

Yours sincerely,

Dr Jonathan Christiansen
Chief Medical Officer
Waitematā District Health Board

Waitematā
District Health Board

Best Care for Everyone

4 December, 2019

Response to RNZ re informed patient consent

Waitematā District Health Board (DHB) takes any complaints about informed consent seriously and ensures they are properly investigated.

We welcome anyone raising issues about informed consent so we can ensure our policies are being followed as expected to protect the rights of people in our care.

As our recent OIA response to RNZ shows, a significant amount of work has occurred since 2013 to improve our policies and compliance with those policies, based on issues raised by a theatre nurse.

We have overhauled our policies and undertaken a range of work to ensure our patients are aware of their rights and that these are understood and respected by our staff, including forums attended by theatre staff.

We are working with our Consumer Council to look at any further changes that could be beneficial and the DHB also sought independent external assurances over our informed consent processes, the adequacy of our staff training and a review of our staff development and education programmes.

This was done to provide assurance that the DHB is following best-practice, in the absence of a national standard, and underlines how seriously we treat this issue.

This has confirmed that the DHB's policies and documents meet New Zealand ethical and legal standards and that the DHB's response to specific concerns raised in the past six years have been appropriate and comprehensive.

RNZ's OIA request related specifically to the unconsented intimate examination of female patients under general anaesthetic. Our response indicated the theatre nurse had raise two potential cases since 2013.

In the first case, insufficient information was provided for the DHB to properly investigate, although we were very active in trying to do so. In the second case, the intimate examination did not take place as the theatre nurse intervened. This was considered a near-miss.

These two events need to be seen within the context of Waitematā DHB managing more than 120,000 inpatient discharges per year. These are very rare events and, should they occur, they would be completely unacceptable and would be fully investigated.

The claims redacted in the OIA response were made in 2013 (six years ago) by the same theatre nurse and did not meet the definition set out in RNZ's OIA request. They related to concerns that junior doctors were part of the theatre clinical team when procedures had taken place. It is important that RNZ understands that the procedures have always been done with consent in place.

We note that RNZ received our OIA response two weeks ago and has given the DHB only a day to provide significant additional detail requested by way of follow-up. Available information will be provided in a timely manner but the short deadline provided by RNZ cannot be met.

Waitematā DHB has a sound track record of releasing information to RNZ but we believe the short turnaround time allowed on this occasion is unreasonable, given the period of time RNZ has held our OIA response and the historic nature of the issues concerned.

ENDS

Waitematā DHB Media Line: 09 487 1276

Jonathan Christiansen (WDHB)

From: Amanda Mark (WDHB)
Sent: Wednesday, 21 August 2019 14:29
To: Jonathan Christiansen (WDHB); Nigel Swain-Williams (WDHB)
Subject: FW: Consent Issues

Amanda Mark

General Counsel
Waitemata DHB

Ko tatou, tatou

15 Shea Terrace. Private Bag 93 503, Takapuna, North Shore 0740
mobile: 021 784 323 f: 442 7106

Ko tatou, tatou

www.waitematadhb.govt.nz

From: Sandra Mechen (WDHB) [mailto:Sandra.Mechen@waitematadhb.govt.nz]
Sent: Monday, 26 August 2013 7:46 a.m.
Subject: RE: Consent Issues

Jos

I see that Amanda initiated the issues that have lead to a review of the consent policy and has been copied in along the way therefore I will with Amanda.

Regards

Sandra Mechen **I Legal Advisor**
Legal Services I Waitemata DHB

Level 2 15 Shea Terrace, Private Bag 93503, Takapuna, North Shore 0740

p: 09 486 8920 Ext 3368 m: 021414628 f: 09 486 8924

Sandra.mechen@waitematadhb.govt.nz

www.waitematadhb.govt.nz

From: Jocelyn Peach (WDHB)
Sent: Sunday, 25 August 2013 17:58
To: Carolyn Czepanski (WDHB); Sandra Mechen (WDHB)
Subject: RE: Consent Issues

Sandra Mechen, Legal Advisor is the person I helped to update the document.
I need to understand what you're changin. You cannot make a change without the privacy Officer [Amanda Mark's] permission.
Jos

Jocelyn Peach *RGoN, MBS, PhD.*
Director of Nursing & Midwifery, Emergency Systems Planner
Waitemata District Health Board, P O Box 93- 503, Takapuna, Auckland 0740, New Zealand. Level 2, 15 Shea Terrace, Takapuna, Auckland, New Zealand.

Phone 09 488 4631 // Mobile 021 784 321// Fax 09 442 7106 // jocelyn.peach@waitematadhb.govt.nz
"The manner by which we treat people in our personal and occupational lives reflects or denies the truth of our commitment to human dignity and respect for individual worth."- Haim G. Ginott

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From: Carolyn Czepanski (WDHB)
Sent: Thursday, 15 August 2013 12:38
To: Jocelyn Peach (WDHB)
Subject: FW: Consent Issues
Importance: High

Hi Joc
FYI – I have also left a message on your phone regards this.
Kind regards
Caro

Carolyn Czepanski **I CNS Quality & Research (Acting)**
Dept of Anaesthesiology & Perioperative Medicine
Waitemata DHB
Shakespeare Rd, Private Bag 95-503, Takapuna 0622
p: 09 487 4941| Ext: 4941

From: Carolyn Czepanski (WDHB)
Sent: Thursday, 15 August 2013 07:52
To: Elizabeth Hollier (WDHB)
Cc: Tania Hunter (WDHB); Ian Harrison (WDHB)
Subject: RE: Consent Issues

Hi Liz
I will make a start on this by reviewing documents that are currently published.
Ian/Tania – have copied you both in FYI re this project.
Ian – I will try and catch up with you this am for an initial conversation.
Kind regards
Caro

From: Elizabeth Hollier (WDHB)
Sent: Wednesday, 14 August 2013 16:15
To: Carolyn Czepanski (WDHB)
Subject: FW: Consent Issues

Hi Caro,

Can you please head this project?

Liz

From: Cath Cronin (WDHB)
Sent: Friday, 2 August 2013 16:45
To: Penny Andrew (WDHB)
Cc: Elizabeth Hollier (WDHB); John Cullen (WDHB); Amanda Mark (WDHB)
Subject: FW: Consent Issues

Hi

We can assign the follow up and review of the consent policy and guidelines to Carolyn Cepanski as a project.

Who is the right person to work with from your team?

We will need to engage with Martin Connelly (assistant Dean), John Cullen/CD's, legal and Andrew Brant to get this completed. Perhaps Pat Alley can assist as well

I think we need to review the consent as well as ensure we have some information on there regarding teaching.

Liz will get similar docs from ADHB to see if they have this covered

We do need a tight timeline on this so that we can resolve the issue and ensure patients are receiving informed consent. Also to ensure that medical students and junior staff are only having strictly supervised and minimal access to anaesthetised patient unless we have specific consent

cath

Cath Cronin **I General Manager**
Surgical & Ambulatory Services I Waitemata DHB

Extension 7238, Direct Dial Phone: 09 4427238, Facsimile: 09 4868339
Email: Cath.cronin@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: Cath Cronin (WDHB)
Sent: Thursday, 1 August 2013 13:31
To: Andrew Brant (WDHB); John Cullen (WDHB)
Cc: Penny Andrew (WDHB)
Subject: RE: Consent Issues

Hi

We also seem to have a gap in our consent policy, guideline and consent form. We don't appear to outlines a process to discuss issues aligned with being teaching hospital and seeking informed consent from patients that we have students, house officers and other non- direct care (but WHDB) clinical staff in theatre and potentially involved in patient care (particularly pertinent when patients are under anaesthetic or sedation).

I haven't looked through the policies in detail but this has come to light during the first review. In my past role we had this documented clearly on the consent form

Penny – we may need some assistance and advice from your team

cath

Cath Cronin **I General Manager**
Surgical & Ambulatory Services I Waitemata DHB

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From: Andrew Brant (WDHB)
Sent: Thursday, 1 August 2013 07:43
To: Cath Cronin (WDHB); John Cullen (WDHB)
Subject: RE: Consent Issues

Hi

I suggest that we bring this to the attention of Martin Connelly, who is the assistant dean for the Waitemata campus for medical students, and together with surgery come up with a response. I would be suggesting that from Martin we need to outline the expectations of consent to the SMOs.

Cheers
Andrew

From: Cath Cronin (WDHB)
Sent: Wednesday, 31 July 2013 13:23
To: Leith Hart (WDHB); Elizabeth Hollier (WDHB)
Cc: Amanda Mark (WDHB); Andrew Brant (WDHB); John Cullen (WDHB)
Subject: RE: Consent Issues

Thanks

I acknowledge the RNs concerns and thank her for bringing this to our attention. I have very strong views on informed consent and we will immediately review our processes and ensure that we are meeting both medico/legal and patient expectations

As discussed please collect and email our current policy, any guidelines and consent form for us to review today.

I'll discuss with John this afternoon and will cc Andrew in to this FYI

Regards Cath

Cath Cronin **I General Manager**
Surgical & Ambulatory Services I Waitemata DHB

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From: Leith Hart (WDHB)
Sent: Wednesday, 31 July 2013 13:14
To: Elizabeth Hollier (WDHB)
Cc: Cath Cronin (WDHB); Amanda Mark (WDHB)
Subject: FW: Consent Issues

Hi Liz

I have spoken with Cath. Can you catch up with the nurse and let her know that we are taking this seriously and following this up.

We need to check the policy on patient consent and also look at the consent form. I can look at the policy, if you could ask Wendy to get a copy of the consent form. After reviewing both we can then plan next steps

Many thanks
Leith

From: Amanda Mark (WDHB)
Sent: Wednesday, 31 July 2013 11:42
To: Leith Hart (WDHB)
Subject: Consent Issues

Hi Leith

Further to our telephone conversation an issue has been raised with me by a theatre nurse under the Protected Disclosures Act relating to consent in theatres.

The nurse is concerned that students are conducting procedures (or parts of procedures) or taking part in treatment without the consent of the patient.

She provided several examples:

- An anaesthetist permitting a med student to put a laryngoscope down. When asked if the patient consented the anaesthetist is said to have replied that they didn't know consent was needed
- A registrar brought a House Officer in to do an examination of a woman's uterus with the stated purpose of teaching the size of the purpose. Patient was anaesthetised at the time. No patient consent.
- A male patient was catheterised by a med student under nursing supervision. No patient consent.

The nurse has raised her concerns with Liz but feels that she is not getting anywhere

The nurse has also discussed the issue with the Medical Council and with Andrew Keenan at ADHB.

She has also asked medical students what they understand re the requirements for consent. They have told her that they know they must get patient consent however they are reluctant to challenge SMOs who suggest they undertake a procedure even when they know the patient hasn't consented to their involvement.

I am very concerned at the possibility that procedures might be undertaken by students without patient consent. If there is a lack of clarity about the requirements for consent (and there should not be) then we should develop a policy which sets things out clearly and do some training/consciousness raising so that this doesn't occur.

I understand that you will inquire into these issues and come back to me. I need to let nurse know how we are going to deal with this issue.

Regards Amanda

Amanda Mark ***Legal Services Manager***
Legal Services Waitemata DHB

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Medical Students and informed consent:

A consensus statement prepared by the Faculty of Medical and Health Sciences of the University of Auckland and the University of Otago Medical School, Chief Medical Officers of District Health Boards, New Zealand Medical Students' Association and the Medical Council of New Zealand

Warwick Bagg, John Adams, Lynley Anderson, Phillipa Malpas, Grant Pidgeon, Michael Thorn, David Tulloch, Cathy Zhong, Alan Merry

ABSTRACT

To develop a national consensus statement to promote a pragmatic, appropriate and unified approach to seeking consent for medical student involvement in patient care. A modified Delphi technique was used to develop the consensus statement involving stakeholders. Feedback from consultation and each stakeholder helped to shape the final consensus statement. The consensus statement is a nationally-agreed statement concerning medical student involvement in patient care, which will be useful for medical students, health care professionals and patients.

The Code of Rights establishes the rights of consumers, and the obligations and duties of providers to comply with the Code. It is a regulation under the Health and Disability Commissioner Act. Nevertheless, there is evidence that the practice of seeking consent for the involvement of medical students in patient care is presently very variable. This consensus statement is an attempt to promote a pragmatic, appropriate, and unified approach to seeking such consent.

The document aims to deal with the potential (and at times actual) tension between the fundamental requirement to respect patients and their rights, and the obligation on the health system and health professional educators to provide learning opportunities for students. While these two requirements are by no means mutually exclusive, thoughtful care is required on both sides. Medical students learn in clinical environments and are legitimate and integral members of healthcare teams. The student learning covers a continuum of experiences and responsibilities, ranging from directly providing care to an individual patient to being part of a team providing care. As medical students transition from novices to junior doctors, patient interaction becomes an increasingly important part of their learning. Senior students (Trainee Interns) are integral members of the healthcare team providing care in hospital and general practices, and consent requirements need to reflect this.

However, before becoming involved in any patient's care, the consent of the patient must be obtained. Such consent should be informed: ie the patient (or another person as legally appropriate) should understand what he or she is granting permission for. This implies a conversation and communication, which includes listening to patients as well as giving them information. It is important to be sensitive to perceived or real imbalances in power between patients and healthcare providers. The process can usually be simple, verbal and

NZMJ 15 May 2015, Vol 128 No 1414
ISSN 1175-8716

www.nzma.org.nz/journal/subscribe

informal, particularly when the student's involvement is limited. When the risks are higher or the student's involvement greater, more information will be required and in some instances it would be prudent for explicit consent to be documented, or even obtained in writing, with a signature from the patient.

It is the spirit of informed consent that matters most: the important thing is to demonstrate respect and compassion for patients (and their families), in the context of their values, interests and vulnerabilities. Gaining and maintaining the consent of a patient is not a one-off event or simply an exercise in 'ticking boxes'. Rather, it is an ongoing process of communication and building trust, and patients must feel free to withdraw their consent at any time. Therefore, those involved (practitioners and students) should at all times remain sensitive to any change in each patient's sense of comfort over who is present or what is being done.

The aim of this consensus statement is to assist medical students, doctors and other registered health professionals responsible for supervising them to understand what is expected and required in relation to consent for students to be involved in patients' care.

Background

Medical students learn in an apprenticeship model under the supervision of registered healthcare professionals. Contact with patients occurs early in the journey towards becoming a doctor. Initially, this may be as an observer in a general practice, or in a class when a patient consents to being interviewed during a lecture. As learning progresses, students will be observers in surgical theatres, participate in the administration of anaesthetics, learn to undertake sensitive examinations, assist in the delivery of babies, and participate in many aspects of patient care in primary, secondary and tertiary care settings. The boundaries between observation and participation are sometimes blurred. Underpinning all these interactions is the trust of patients in those involved in their medical treatment and care. This trust is precious and must be respected.

Medical students become involved with patients in different ways, contexts and settings (see Table 1), and at different stages of their training. There are settings and contexts in which gaining consent is straightforward, and others where it is not. The relevant principles are not dependent on the setting or the context, but the way in which they are applied. These may vary and will require judgement.

Table 1: Some of the diverse settings in which students may become involved with the care of patients

Hospital care
• Clinics
• Emergency departments
• Intensive care units
• Neonatal units
• Operating rooms – in a surgical or anaesthesia context
• Psychiatry units
• Wards, adult or paediatric
Primary care or community care
• After-hours community clinics
• Air ambulances
• Ambulances
• Audiology clinics
• Community nursing clinics
• General practices
• Health care trusts
• Hospice
• Patients' homes
• Pharmacies
• Podiatrist clinics
• Private specialist clinics
• Rest homes
• Retinal screening clinics

On the whole, most patients welcome medical student involvement and understand the importance of training doctors (and other health professionals) for the future. The majority of patients say "yes" when they are asked about such involvement, and complaints about students are very rare.[1-3] Thus, the process by which consent is obtained can and should be proportional to the involvement of the medical student and the nature of the interaction and consequent risk or inconvenience to the patient. It is not appropriate

ISSN 1175-8716

to overstate the implications of the simple involvement of students, particularly as observers, and to do so may even have the perverse consequence of adding unnecessarily to the stress felt by some patients. Verbal consent obtained simply, politely and in the context of the general interactions between practitioners and patients is both adequate and appropriate for most situations.

The interactions between patients and medical students often occur in very busy settings in which clinical staff are under pressure, turnover of patients is rapid, and the opportunities to ask for consent are limited. Pragmatic solutions will be helpful in ensuring that the consent process is not unsettling or arduous for patients nor unworkably onerous for staff, but in the end the need to gain consent cannot be set aside on the grounds of inadequate time or resource. Irrespective of the context of the interaction, or the workload, patients should never feel coerced or pressured into providing consent.

There are some common principles about how consent should be obtained and by whom. These are outlined in the next section, and illustrated by examples and lists in boxes and tables.

Principles pertaining to informed consent for the presence of a medical student during the care of patients

1. Consent for the involvement of students in patient care is required by the Health and Disability Commissioners' (HDC) *Code of Health and Disability Services Consumers' Rights* ('the Code'—see Rights 5,6,7 and 9). It is also an important aspect of building rapport with patients, and of maintaining the trust and goodwill that exists between patients and the health professionals who care for them—including medical students.
2. Organisations that care for patients have a responsibility to ensure that appropriate consent is obtained for all aspects of patient management, including the involvement of medical students in the care of patients. Therefore, the workplace environment should facilitate the gaining of such consent. To this end, general measures should be implemented to promote awareness that the organisation is involved with teaching and that medical students might be involved in patient care (see Table 2).

Table 2. Some general measures to promote awareness that students might be involved in patients care. Some or all of these may apply in various settings, including (for example), hospital wards, general practices, and outpatient clinics.

- Policies
- Signage
- Pamphlets for patients (available or given on admission)
- An appropriate section on forms for consent to anaesthesia and surgery
- Informed in letters sent to patients about other matters, such as confirmation of outpatient visits
- The practice, by doctors and nurses, of routinely mentioning to patients the possibility that students may be involved in their care (at least as observers) and of the possibility that patients can refuse student involvement

3. The primary responsibility for ensuring that consent is obtained for the involvement of a medical student in a patient's care lies with the registered health professionals responsible for that patient at the time (see Box 1).
4. The HDC considers medical students who are providing care to be healthcare providers, and they are therefore also accountable for ensuring that consent has been given before they become involved in patients' care.

Box 1. Patients on wards and the responsibility for seeking consent

On ward rounds, students should be introduced to patients as part of the team (explicitly as *student* members of the team) by the doctor conducting the round. Students may also initiate introducing themselves to patients where appropriate.
Before students on wards seek out patients with educationally valuable presentations and take a history or perform an examination on them, they must seek permission from an appropriate member of that patient's healthcare team (doctor, charge nurse or nurse caring for the patient) to approach the patient. Once permission has been obtained to approach the patient, the student should gain verbal consent from that patient for history taking and examination. It may be prudent for the student to record this in the patient notes with an entry such as: "Bill Smith, Year 4 medical student, examined Mrs Jones – verbal consent obtained". An additional benefit of this approach is that the record would clearly indicate how many students had interacted with that patient, and be helpful in ensuring that a patient is not approached too often.
It should often be possible for a senior doctor, interested in teaching and keen to encourage students to see patients, to obtain permission from patients at a convenient time (eg, on a ward round) for students to seek consent to obtain histories or conduct examinations. Thus the burden of establishing which patients are open to such approaches need not be excessive.

5. Medical students should actively assess how comfortable patients and their family/whānau are with their involvement in care. If they perceive patients or their family/whānau to be uncomfortable, they should have a low threshold for disengaging. This is a matter of basic courtesy and ongoing sensitivity to the rights and comfort of patients.
6. Informed consent should be sought with respect and compassion for patients, taking into account their circumstances and vulnerabilities at the time (see Box 2).

Box 2. An example of a potentially difficult situation in seeking consent for a medical student's involvement in the care of a patient

A patient is unclothed and surrounded by the healthcare team, and asked to consent to a student examining her abdomen, with the student in the room.
Patients differ in their assertiveness and in how empowered and robust they feel at any particular time. It might be quite difficult for a patient in this situation to decline in the presence of a student. It may be better for the consultant to ask the patient privately, if they consent to students being present and, if the patient consents, to then ask if one (or perhaps two) of them could examine her abdomen during the round.

7. Patients need to know that they do have a choice about the involvement of medical students, and that they are entitled to change their mind at any time about such involvement, without any negative consequences for their care. The patient's right to refuse consent or withdraw consent takes precedence over the provision of training for students.
For many purposes, notably many instances of observation, it is appropriate to obtain (or confirm) consent verbally and informally; for other purposes it is prudent for the consent to be documented, or even obtained in writing, with a signature from the patient (see Point 16). Note that there is a legal requirement for signed consent for procedures under anaesthesia.
8. Language is key to communication: If a patient is not competent in English (eg, because this is not his or her first language) then a competent interpreter must be used to obtain consent for the involvement of medical students; this can often be done during the more general processes of patient care, which will also require an interpreter.
9. Patients need to understand clearly what a medical student is (see Box 3).

ISSN 1175-8716

Box 3. The need to explain what a medical student is

It may seem surprising, but many patients don't seem to understand the term 'medical student' unless it is explained. The term 'student doctor' is probably even less well understood, so 'medical student' is probably preferable. A brief clarification should be included in general informational material provided to patients, and this should be reinforced during conversations about medical students' involvement in patients' care. Name badges clearly indicating that the wearer is a medical student are also important.

10. As far as reasonably possible, patients should be informed about the proposed extent and nature of student involvement. There are three ways in which students may become involved in patients' care, although in reality the distinction is blurred, as any interaction with a student contributes to a patient's care (Box 4):
    a. Students may observe patients, or examine them, or carry out or assist with procedures on them for their educational benefit as students, or
    b. Bedside tutorials, when a senior doctor conducts a tutorial with a group of medical students, usually focused around examination of a patient the doctor may or may not be clinically involved with, or
    c. Students may contribute to the care of patients, under supervision (eg by taking blood, holding a retractor during a surgical procedure, or performing bag-mask ventilation under anaesthesia).
11. Patients who are temporarily or permanently incompetent to make an informed decision are particularly vulnerable (see Table 3 and Boxes 5 and 6). In such circumstances, consent should be obtained from the patient's legal representative if one exists and it is practical and possible. If no legal representative exists, then any views ascertained from the patient should be taken into account. If this is not possible, the views of other suitable, available persons who are interested in the patient's welfare should be taken into account. When there is no practical opportunity to obtain permission, student involvement under supervision may entail observation, history taking and general examination, unless the treating doctor decides that greater student involvement remains in the best interests of the patient. Judgement and experience is needed in respect of children under 16 years old. The consent process with children is complex. In some situations, the child may be able to consent for themselves. In other cases, the child's parent or guardian may need to make a decision for the child. Where this occurs, the assent of the child should also be obtained, as appropriate and possible. The principles remain the same, but in many cases eg, neonatal intensive care,

Box 4. Ways in which students may become involved with patients' care, and how they might explain this

An interaction with a patient on a ward might begin by a consultant saying something like "I have spoken with Mrs Jones in bed seven and she is willing to have one student listen to her heart and another student take some blood."
In case a) a student might say something like, "Hello Mrs, Jones. My name is Helen. I am a medical student. That means I am training to be a doctor. I am in my fourth year of medical training. I understand from Dr Smith that you have a medically important heart condition. Would you mind if I listened to your heart with a stethoscope and examined your heart and a few other things that might be affected by your condition, so that I can learn about it? Please feel free to say no if you prefer."
In case b) a student might say something like, "Hello Mrs, Jones. My name is Bill. I understand from Dr Smith that you need a blood test taken. I am a medical student. That means I am training to be a doctor. I am in my fifth year of medical training and have been taught how to take blood for blood tests. Do you mind if I take your blood sample, instead of the phlebotomist?
In either case the student should make a brief entry in the patient's notes documenting his or her involvement.

there may be a parental perception that their child is too vulnerable to be examined by anyone other than an expert. This requires particular sensitivity and reassurance. Often the consent will be for the teacher to examine the child in front of students, rather than hands on, and it is obviously important to invite the parents to be present if possible.

Table 3. Some examples in which a patient might not be competent to make a decision or give consent.

- Under anaesthesia
- On a ventilator under sedation in an Intensive Care Unit
- During sedation (including so called "conscious sedation")
- Very young patients
- Mentally or cognitively impaired patients or patients who are semi-conscious
- Patients impaired with alcohol and drugs
- Patients in shock, extreme pain or extreme distress
- Patients who are dying

Box 5. Patients in intensive care under sedation and/or on ventilators

It is important for intensive care units to have information available in the form of signage and pamphlets explaining that students may be present and may be involved in the care of patients. Given that most patients in intensive care units are very vulnerable, this is a situation where principle 11 applies. Except where it is possible and appropriate to obtain explicit consent for greater involvement, the role of medical students in intensive care units should usually be restricted to observation.

12. Some circumstances require a particularly high level of sensitivity to the potential vulnerability of patients and their families (See Table 4); in such circumstances meticulous care is required in seeking and documenting consent for the involvement of medical students.

Table 4. Examples of circumstances in which the potential vulnerability of patients or their families is increased, and in which extra sensitivity is appropriate regarding the need for informed consent for student participation

- Sensitive examinations (particularly under anaesthesia)
- Discussion of withdrawal of life support
- Discussion of organ donation
- The breaking of very bad news (which will be contextual for the patient)
- Catheterisation
- Patients with rare or particularly interesting conditions
- Patients who feel under obligation to their treating clinician
- Retrieval of patients from a referring hospital

13. Sensitive examinations (includes breast, rectal, vaginal examinations and those of the external genitalia) in competent awake patients require explicit consent. This can be verbal but should be documented in the patient's notes. It is essential that there should be no possibility for the consent to have any element of coercion (eg, it may make it harder for a patient to refuse if the patient is asked after undressing or in front of student. See Box 2).
14. Sensitive examinations under anaesthesia require formal written consent obtained in advance and signed by the patient. It is essential that there should be no possibility for the consent to have any element of coercion (eg, asking in front of a student may make it harder for a patient to refuse). Without such consent a student cannot undertake such activity.
15. A section should be included on the forms used to document generic consent for the involvement of medical students in observing or contributing to surgery, anaesthesia and other basic procedures undertaken in operating theatres, under direct supervision of an appropriate

Box 6. Some practical points about anaesthesia attachments

Students allocated to an anaesthetic run may anticipate attending a particular list with a particular anaesthetist, and that anaesthetist may obtain consent from the relevant patients. However, on the day there may be scheduling changes such that there is little educational value in this list, while a much more educationally rewarding list is occurring in one of the other theatres. In fact, the best utilisation of time may come from moving between lists during the day as opportunities present. Generic consent obtained from all patients at the time of their consent to surgery will facilitate this. Therefore it is ideal for such generic consent to be obtained at the same time as consent for anaesthesia and surgery, as a matter of routine.

It is important to recognise that some patients may decline permission for students to be present, and a system will be needed to ensure that these patients are clearly identified, and that students do not inadvertently transgress their wishes.

Table 5. Examples of things typically included (under direct supervision) and excluded from general consent for students to be involved in surgery and anaesthesia; the latter require explicit consent.

Included, basic procedures, such as:
• Observation
• Bag mask ventilation
• Holding a retractor
• Examining surgical pathology or normal anatomy
Excluded, more substantive procedures, such as:
• Any sensitive examination
• Endotracheal intubation (because there is a risk of damage to teeth or even of causing a sore throat)
• Insertion of an IV line or arterial line
• Closing wounds, including surgical incisions

Box 7. An unexpected surgical finding

Where a student on a surgical run is observing a surgical procedure, there may be an unexpected finding that he or she would benefit from scrubbing in and examining. It would be reasonable for generic consent to cover such a situation in most instances. However, it wouldn't be appropriate for multiple students to examine the finding in a single anaesthetised patient, and any examinations of a sensitive nature must be the subject of explicit consent, which must be in writing.

Box 8. Primary or community care

Health care providers in primary or community care settings agree to undertake student supervision through Clinical Access Agreements. In each case there will be a primary supervisor who has completed the Clinical Access Agreement and is responsible for ensuring appropriate consent is obtained for students to be involved in the care of patients.

As always, signage and pamphlets are important for informing patients about the likelihood that they will meet medical students in a particular practice or setting. For example, in general practice, a notice should be placed facing the patient waiting room, stating words to the effect that this is a teaching practice and students may be involved in the delivery of health care. A member of staff (such as the receptionist) should be expressly asked to draw the sign to the attention of patients when they arrive, and to check with them on each visit that they are comfortable with the presence of students.

Before the start of the consultation, the GP should ask the patient if he or she is comfortable for the medical student to be involved in the interview, observation or procedure. Opportunity for the patient to decline this request must be given, so this request should take place without the student present.

The principles of consent related to patients undergoing sedation or sensitive examinations are the same as for any other setting.

ISSN 1175-8716

registered health professional (note Right 7.6 of the Code). The important element of seeking such consent is, as always, the conversation between the doctor gaining consent and the patient.

16. Generic consent obtained under 15 should be understood as limited to observation and basic procedures and should not be taken as consent to conduct sensitive examinations while under anaesthesia or procedures with any material risk (see Table 5). Such examinations or procedures require explicit, and in some cases, including sensitive examinations, written consent.
17. In primary care settings (see Table 1 and Box 8), where students might accompany registered health professionals on visits to patients' homes or their rooms in a rest home, verbal consent for the student to enter the room or house should be sought from the patient and/or family/whānau who might be present. Where possible this should be done before the visit.
18. Patients' medical records are confidential and medical students should only access such records in line with a purpose that has been notified to the patient at the point of collection. There must be a genuine educational reason to do so, and with the permission of the health professionals responsible for the patient's care. It is reasonable to construe consent for a student to be involved in a patient's care as including consent for that student to read relevant patient records, but it would usually be courteous to mention this point to patients.
19. Students must respect the confidentiality of all information acquired by them in connection with patients. Under no circumstances should students disclose any information whatsoever on any form of social media about the patients they have been involved with, even in the absence of specific identifying information.

The above text is a consensus statement that was agreed by multiple stakeholders, after careful and considered consultation to provide a guideline. The paper is not intended to set standards but rather to outline New Zealand's existing legal and regulatory requirements in a practical way.

The paper is intended to provide guidance to medical students and supervising doctors in clinical settings. We have limited its scope to medical students for pragmatic reasons. Similarly, we have not attempted to cover every possible clinical situation where consent is required in relation to the training of medical students, but instead have chosen examples to illustrate the principles in some settings that we think may be particularly challenging. Notwithstanding these limitations, we hope this consensus statement will prove useful in clarifying expectations for informed consent in this context in New Zealand today.

We hope that this consensus statement will engender discussion within our hospitals and universities, and in the correspondence section of the *Journal*. This will inform a planned revision of the statement after it has been in use for a year. It may also be appropriate to expand its scope at that time.

ISSN 1175-8716

Competing interests: Nil

Note:

The NZMA Ethics Committee, MCNZ Consumer Advisory Group and HDC have been consulted.

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www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2015/vol-128-no-1414-15-may-2015/6534

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6 September2016

[redacted]
New Zealand Nurses Organisation
P O Box 8921
Symonds Street
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Dear [redacted]

Waitemata DHB Consent Policy

I write further to your letter dated 22 August in which you outline the issue of compliance with the consent policy and discussions since 2012. Thank you for bringing to my attention the concerns of your NZNO member.

The DHB takes the matter of informed consent very seriously and I have asked Amanda Mark, Legal Counsel, to confirm that our policy addresses all issues and that there is discussion and training of medical staff about policy requirements. She has assured me that the policy and requirements are up to date and that she provides regular training of medical staff about the expectations.

I have also asked Dr Andrew Brant, Chief Medical Officer, to discuss this letter with the Clinical Directors of the DHB. I have asked Andrew and Mr Michael Rodgers, Chief of Surgery, to confirm with the surgical specialists and anaesthetists that the senior medical staff know the policy requirements and review this with their teams.

Dr Jocelyn Peach, Director of Nursing and Midwifery is also engaging with nurses and midwives to remind them of the policy requirement and their role in advocating for their patients, escalating issues to the Charge Nurse Manager/Unit Manager. Jocelyn will ask the Theatre Manager to discuss the matter with the senior nurses in Theatres as well.

If the NZNO member you mention has any particular concerns please invite them to immediately contact Mr Rodgers. He will work with the member on any issues that might be identified.

Yours sincerely,

Dr Dale Bramley
Chief Executive
Waitemata District Health Board

cc: [redacted] NZNO [redacted]
Jos Peach, Director Nursing and Midwifery, Waitemata DHB
Mark Lennox, Employment Relations Manager, Waitemata DHB

Waitemata
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19 December 2018

[redacted]

Dear [redacted]

Thank you for meeting with Dr Meia Schmidt-Uili, Lyn Wardlaw, Jocelyn Peach and me yesterday. I appreciate you taking the time to meet with us. From our discussions I am aware that you have raised these issues for a number of years. I know that this has been a frustrating process for you and I apologise for the time delay. I am committed to working on addressing and resolving these issues with you. I have committed to Cath Cronin that we will achieve a sustainable way of working.

As we discussed, I have summarised the actions taken to date and the plan that we have in place below.

We initially met on 16 October 2018 where you outlined concerns about the way in which informed consent was being managed in theatre and, specifically, within the obstetrics and gynaecology theatre in which you work. You also expressed concerns about the oversight and supervision of junior medical staff working in the obstetrics and gynaecology theatres. At the meeting we agreed:

- You would send a list of patient NHIs that demonstrated your concerns
- Meia and I would meet with Dr Diana Ackerman (clinical director gynaecology) and Dr Helen Allen (acting clinical director obstetrics) to discuss your concerns
- Lyn and I would meet with Debbie Eastwood to discuss the broader theatre issues
- I would arrange a follow up meeting

On 17 October 2018 you sent me the list of patient's NHI numbers. I forwarded these through to Meia on 18 October 2018.

On 18 October 2018 I advised Cath Cronin, Debbie Eastwood and Dr Mike Rodgers that we had met and of your concerns.

On 23 October 2018 Lyn and I met with Debbie Eastwood to discuss your concerns about the way in which consent was being managed in theatre. At this meeting it was agreed that Lyn would undertake a review of the consent form to ensure that it was aligned with the Waitemata DHB informed consent policy and was auditable. This review is currently underway. Lyn will present the findings of the review and her recommendations at the February 2019 theatre leadership group meeting.

On 8 November 2018 Stephanie and Meia met with Helen Allen to discuss your concerns. Unfortunately Diana Ackerman was unable to attend, as she needed to cover an acute duty at short notice. Helen advised that she was aware of your concerns about the oversight of junior medical staff and had addressed a specific issue that had been escalated to her. Specifically, she had

reiterated the requirement for appropriate supervision and oversight and requested that the lead training supervisor follow up individually with the registrar involved. It was good to get your feedback today that there has been an improvement in the level of oversight and supervision that is being provided. Helen also stated that she felt there was an opportunity to improve the information being provided to women before they have an elective caesarean and that she had asked the midwife co-ordinator quality undertake a review.

As Diana was unable to attend the meeting, Meia talked with her separately about our discussions to date and the issues you had raised.

On 12 November 2018 we met to provide an update on actions taken to date and the plan in place. We also talked about the review of the patient information that Helen had requested and asked if you would like to be involved in this. Later that day I linked you in with the midwife co-ordinator quality who was leading the review. I understand from our discussion today that you have now met with Dee.

We agreed that we would meet again the week before Christmas (today's meeting) and that I would organise this.

Further to the above, Diana has advised that she has talked with you directly about your concerns. Following this she has suggested that Dr Adele Barr (who has just taken on the role of lead training supervisor) and she meet with you. Since then, Diana has written to Adele to advise her of your concerns. She has also met with the chief registrar.

Meia has also requested that Diana send a copy of the informed consent policy out to the team and highlight the informed consent requirements, including documentation. However, as discussed, and outlined below, we will be developing an informed consent orientation module for all staff (both new and existing).

There are a number of further actions that are underway and/ or planned. These are listed in the table below:

Action	Responsibility	Timeframe
Immediate action as per Director Hospital Services All RMOs working in Obstetrics and Gynaecology will be required to receive a hardcopy of the consent policy and will meet with Diana Ackerman (clinical director gynaecology) to ensure that the policy is clearly understood by the RMO. The RMO then signs a letter acknowledging this. This will be completed at handover (attach template of form for RMOs).	Diana Ackerman	19 Dec 2018
Organise a meeting between [redacted] Diana, Adele and Lyn. Stephanie will facilitate this – but date to be confirmed, as Adele is on annual leave this week.	Stephanie Doe	Jan 2019
Meia to meet with Diana to review the cases identified.	Meia Schmidt Uili	19 Dec 2018
Meet with Debbie Eastwood and Mike Rodgers to discuss the development of the informed consent training module and the opportunity to modify and implement this across all surgical specialities.	Lyn Wardlaw	Jan 2019

Action	Responsibility	Timeframe
Ensure that there is a clear and agreed process in place for the nursing team to escalate specific concerns about clinical practice, supervision or consent in theatre.	Lyn Wardlaw, Clinical Nurse Director Ulrike Gerstenberger (starts 7 January) and Adele Barr	Jan 2019
Meet with nursing team who work in the obstetrics and gynaecology theatres to discuss how they can support the consistent implementation of the informed consent policy and how they can escalate concerns.	Lyn Wardlaw and Ulrike Gerstenberger	Jan 2019
Complete the review of the consent form and present the recommendations to theatre leadership group.	Lyn Wardlaw and Ulrike Gerstenberger	20 Feb 2019
Develop an orientation and training package on informed consent. This will include information on the DHB policy, the consent form, documentation expectations and legislative requirements.	Diana Ackerman	28 Feb 2019
Commence auditing of informed consent.	Lyn Wardlaw	Apr 2019

As discussed yesterday, in addition to the specific actions listed above the Women's Health service has a number of work streams underway. These include: exploring the implementation of a new medical leadership structure (currently under consultation), strengthening clinical governance and mortality and morbidity processes in Gynaecology, reviewing junior and senior medical rosters and developing and reporting on agreed clinical outcome measures.

Cath has shown me the three incidents that you flagged with her today. I will respond to each:

14 December 2018 – vaginal examination about to be performed by a junior doctor without patient consent
This is not acceptable practice. Thank you for addressing this directly with the registrar at the time, which resulted in the examination not occurring. Diana is ensuring that all junior medical staff are aware of and will adhere to the Waitemata DHB informed consent policy.

24 September 2018– elective caesarean list on 29 August 2018
This incident was investigated by Helen Allen. The issues were addressed directly with registrar by Dr Alex Ivancevic (who was the lead training supervisor at the time). Helen also initiated a review of the patient information that is provided to women before they have an elective caesarean.

10 December 2018 – junior doctor performing an EVAC
This incident has been escalated to Diana Ackerman. Meia has a scheduled follow up meeting with her 19 December to discuss this case. Meia will ask Diana to provide feedback to you directly regarding the outcome of the review and the actions taken.

Thank you again for meeting with us yesterday. Meia and I will be closely monitoring the plan to ensure the timeframes are achieved. We will also be providing regular updates to Cath until these issues are fully resolved.

Please feel free to contact me any time on 021 246 2718.

Kind regards

Stephanie Doe
General Manager
Child, Women and Family

Cc: Cath Cronin, Director Hospital Services
[redacted] NZNO
Lyn Wardlaw, Operations Manager
Meia Schmidt-Uili, Division Head
Michael Rodgers, Chief of Surgery

Jonathan Christiansen (WDHB)

From: [redacted]
Sent: Friday, 14 December 2018 10:27
To: [redacted] Stephanie Doe (WDHB); Meia Schmidt-Uili (WDHB); Jocelyn Peach (WDHB); z_Lyn Wardlaw (WDHB)
Subject: lack of knowledge of WDHB informed consent policy

Dear All,

We have just finished the first evac on the list, the new reg and new house officer were scrubbed, the patient was draped the reg preformed a VE then stood back and told the H/O to do the same.

I quietly said to them that unless they have consent from the patient that under the informed consent policy they cannot use the patient as a teaching body.

The reg replied "but she is a doctor " I explained the policy includes teaching doctors and offered to get the reg a copy of the policy, the reg accepted this.

Again I ask why has nothing been done and look forward to some answers at our meeting on Tuesday.

Regards
[redacted]

From: Cath Cronin (WDHB) <Cath.Cronin@waitematadhb.govt.nz>
Sent: Wednesday, 16 January 2019 1:28 p.m.
To: Stephanie Doe (WDHB); [redacted] Jocelyn Peach (WDHB); Lyn Wardlaw (WDHB)
Cc: Meia Schmidt-Uili (WDHB)
Subject: RE: Informed Consent in Theatres

Thanks Steph

Happy for you to continue your work with the team and respond to the queries as we have agreed.

I am happy to receive recommendation regarding any change in SMO usual practice to discuss with Andrew Brant and division heads. We wouldn't implement changes to the consent process without further discussion. In my mind it was different for our junior workforce.

Happy to discuss

cath

Cath Cronin **I Director Hospital Services I RN**
Waitemata District Health Board

Extension 47238, Direct Dial Phone: 09 4427238, Facsimile: 09 4368339
Email: Cath.cronin@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: Stephanie Doe (WDHB)
Sent: Wednesday, 16 January 2019 12:12 p.m.
To: [redacted] (WDHB); [redacted] Jocelyn Peach (WDHB); Lyn Wardlaw (WDHB)
Cc: Cath Cronin (WDHB); Meia Schmidt-Uili (WDHB)
Subject: RE: Informed Consent in Theatres

Hi [redacted]
Yes – Diana has also distributed the policy to all the SMOs via email along with the expectations. She has also spoken to the SMOs about the requirements and expectations at the SMO meeting.
I am aware of a recent incident, which we are formally investigating, but have not yet been able to complete as the SMO is on leave until early Feb.
To date the SMOs haven't signed the form we developed – but we will follow this up with Diana when she is back from leave next week.
Also, work is commencing on the new orientation module next week (as I have a new staff member starting).
Just to note, I will be on leave from 18 Jan – 11 Feb, but please feel free to contact Meia during this time if there are any concerns. Alternatively you can contact Marianne Cameron, who is acting GM while I am away.
I will make contact with you when I am back from leave to touch base.
Kind regards
Stephanie

From: [redacted] (WDHB)
Sent: Wednesday, 16 January 2019 11:30 a.m.
To: Stephanie Doe (WDHB); [redacted] Jocelyn Peach (WDHB); Lyn Wardlaw (WDHB)

Cc: Cath Cronin (WDHB)
Subject: Informed Consent in Theatres

Dear All,

Thank you again Stephanie for your efforts so far in trying to address this matter.

As you will be aware by the riskpros submitted, lack patient consent for teaching is an issue for the SMO's as well as the RMO's.

Can the SMO's be made aware of the policy and be given the form to sign [the one you sent me]as they appear to be unaware or

unconcerned of the consequences/repercussions of not adhering to the policy.

Can you or someone else who has a clear understanding of it sit down and explain it to them, the organisational risk and the risks to themselves

should a complaint be made to the HD&C.

They do not have to agree with the policy, they need to adhere to it.

Until the consent / agreement to treatment form is amended to meet the policy, could the medical staff gain consent for the teaching/junior staff

performing the operation under supervision, and document it on the form where the operation is written so it is clear to all.

I look forward to discussing this at our meeting on Tuesday 22nd January.

Kind regards,
[redacted]

Denise Poole (WDHB)

From: [redacted]
Sent: Friday, 21 December 2018 10:37
To: Stephanie Doe (WDHB)
Subject: RE: Follow Up from Meeting

Thank you Stephanie, I really appreciate all your effort.

Kind regards
[redacted]

From: Stephanie Doe (WDHB)
Sent: Wednesday, 19 December 2018 4:38 p.m.
To: [redacted]
Cc: Cath Cronin (WDHB); [redacted]; Lyn Wardlaw (WDHB); Meia Schmidt-Uili (WDHB); Michael Rodgers (WDHB)
Subject: Follow Up from Meeting

Hi [redacted]
As promised yesterday, please see letter attached.
I have also attached a copy of the informed consent form that is referred to in the letter for your information.
Wishing you a very merry Christmas and happy New Year
Kind regards
Stephanie

Stephanie Doe I **General Manager**
Child, Women & Family Service I Waitemata DHB
m: 021 246 2718
www.waitematadhb.govt.nz

Waitemata
District Health Board
Best Care for Everyone

Waitematā
District Health Board

Best Care for Everyone

Waitematā DHB
Board Office
Level 2, 15 Shea Terrace, Takapuna, Auckland
Private Bag 93-503, Takapuna, Auckland 1332
Telephone: 09 441 8938
Facsimile: 09 486 8924

23 December 2019

Dr Ashley Bloomfield
Director General of Health

Cc: Hon Dr David Clark, Minister of Health
Dr Andrew Simpson, CMO
Dr Curtis Walker, Chair, Medical Council of New Zealand
Mr Anthony Hill, Health and Disability Commissioner

Dear Ashley,

RE: Informed Consent in a training environment

The Waitematā District Health Board is concerned about the lack of consistent national guidance on informed consent in the context of the training environment of public hospitals. We are asking the Ministry of Health to lead a process to achieve a consistent national consensus on the issue which aligns with the Code of Consumers' Rights and meets the team-based approach to delivery of health care in training hospitals.

The right of our patients to make an informed choice about the care they receive is fundamental to the work we do, and underpins the Code of Consumers' Rights. The DHB environment brings inherent challenges to the application of the Code. Healthcare is delivered by teams of clinicians, typically including registered medical, nursing and allied health practitioners in different stages of training and career progression. Questions have recently been raised about the requirements of informed consent in a modern hospital when members of the clinical team may commonly be participating in supervised learning.

The issue of informed consent in the context of training is particularly relevant to Resident Medical Officers (RMOs) who are employed as registered practitioners for the provision of clinical care, but are in most cases, pursuing further vocational training. The MCNZ has recently released its updated guidance on Informed Consent (September 2019) but this document does not provide specific guidance on consent for the training aspects of the clinical work our RMOs carry out.

Waitematā DHB has taken the view that there is generally no requirement to obtain consent to the participation of an RMO, who is employed as a member of the clinical team providing care. However, if an RMO is to undertake a procedure (under the supervision of an SMO), which the RMO is not yet qualified to do on their own, so far as reasonably practicable, the patient's consent to the RMO's participation should be obtained.

It is unclear whether Waitematā DHB's view of informed consent in relation to RMOs is consistent with that at other DHBs, or supported by regulatory and consumer bodies. Nor is it clear whether this view should extend to all healthcare professionals working and upskilling in training settings. We

are also mindful of the mobility of the healthcare workforce who may be in training pathways, and inconsistency of standards for informed consent between providers would raise concerns.

The Waitematā District Health Board, at its December meeting, discussed an external report on the informed consent issue undertaken by Professor Ron Paterson. The Board resolved to urgently request the Ministry of Health to provide national guidance on informed consent that covers training aspects of clinical work.

Yours sincerely,

Professor Judy McGregor
Chair WDHB

Dr Dale Bramley
CEO WDHB

From: Ann Young (WDHB)
To: # RMO House Officers WDHB 2019; # RMO Registrars WDHB 2019; # SMO ADU(WDHB); # SMO Anaesthetists (WDHB); # SMO CADS; # SMO Child, Family & Dental (WDHB); # SMO ED – Ext Prov(WDHB); # SMO ED - Specialists; # SMO ED (MOSS) - NSH (WDHB); # SMO ED (MOSS) - WTH (WDHB); # SMO Forensics (WDHB); # SMO Gen Med(WDHB); # SMO ICU (WDHB); # SMO Medicine (WDHB); # SMO Mental Health (WDHB); # SMO O & G (WDHB); # SMO OAHH (WDHB); # SMO ORL (WDHB); # SMO Orthopaedics (WDHB); # SMO Paediatrics (WDHB); # SMO Radiology (WDHB); # SMO Surgery (WDHB); # SMO Surgical Pathology Unit; # SMO Urology (WDHB)
Subject: INFORMED CONSENT FOR MEDICAL STUDENTS AT WAITEMATA DHB
Date: Wednesday, 31 July 2019 15:54:24
Attachments: Informed Consent NZMJ.128.1414[1].pdf

SMOS & RMOS

RE: INFORMED CONSENT FOR MEDICAL STUDENTS AT WAITEMATA DHB

There has been some recent discussion about informed consent in the involvement of medical students in patient care.

We thought it would be timely to summarise the national guidance on this (NZMJ publication 2015 as attached).

1. Waitemata DHB strongly supports the supervised apprenticeship learning of medical students in our healthcare facilities.

2. Patient consent is essential for the involvement of students in their care. Such consent should be informed and sensitively obtained, and **proportional** to the situation. The national consensus statement states that "**Verbal consent, obtained simply, politely and in the context of the general interactions between practitioners and patients is both adequate and appropriate for most situations**".

3. The **responsible clinician** (eg: SMO or RMO) **is accountable for ensuring consent is obtained** for the involvement of students. Students are responsible for ensuring that such consent has been gained by the responsible clinician.

4. Specific issues relating to the **operating theatres and procedural areas**:

    a. The generic statement on Waitemata's "Consent Form" regarding the involvement of students should be understood to be **limited** to observation and very basic procedures only.

    b. For a student to observe in theatre, or assist in a minor way (such as holding a retractor), Waitemata DHB's Consent Policy requires that the **responsible clinician obtain verbal consent** for the student's involvement.

    c. For a student to **actively** undertake aspects of a procedure (eg: suturing at closure in surgery) the **responsible clinician should document the patient's consent** to that involvement prior to the procedure.

    d. **Written consent is mandatory for students to undertake intimate examinations** (such as vaginal or rectal exams), and such examinations must be

directly supervised and limited to one student with a patient.

Dr Jonathan Christiansen
Chief Medical Officer
Waitemata District Health Board

Prof Martin J. Connolly
Professor of Geriatric Medicine
Assistant Dean, Waitemata Clinical Campus,
University of Auckland
Geriatrician,
Waitemata District Health Board

From:	Ann Young (WDHB)
To:	# Clinical Directors (WDHB); # Clinical Directors for Acute & Emergency Medicine(WDHB)
Subject:	Informed Consent: new Medical Council of New Zealand (MCNZ) guidance and DHB policy
Date:	Wednesday, 18 December 2019 09:20:42
Attachments:	Statement-on-informed-consent MCNZ 2019.pdf
Importance:	High

Dear CDs

Please could you discuss the following with your clinic teams including RMOs, and note the attachment from the MCNZ.

TO: All SMOs and RMOs

FROM: Dr's Dale Bramley (CEO) and Jonathan Christiansen (CMO)

Informed Consent: new Medical Council of New Zealand (MCNZ) guidance and DHB policy

Dear colleagues,

We wish to bring to your attention that MCNZ has updated its guidance on Informed Consent. This is attached for your reference.

The right of our patients to make an informed choice about the care they receive is fundamental to the work we do. The MCNZ notes key principles including: the need for agreement before treatment, the right of patients to make their own decisions, and that consent is an interactive process. The MCNZ highlights informed consent is "*more than signing forms and completing the paperwork*".

We can assist patients by building relationships based on trust and respect, providing information in a way they understand, communicating effectively, and ensuring there is the opportunity to involve whanau and others in the decision making.

Consent in the hospital – advice about RMOs and students.

In our hospitals care is provided by clinical teams whose members have differing levels of experience. RMOs are integrally involved in the process of informed consent and in providing treatment. The MCNZ guidance now contains a section on "**Delegating the patient's care to another doctor or health practitioner**". The principles outlined in sections 23 and 24 of the MCNZ document should always be considered when delegation of care occurs, such as that from SMO to RMO.

The MCNZ does not provide specific guidance on consent for the training aspects of the clinical work our RMOs carry out. Our DHB's policy on Informed Consent notes that "*Some teaching occurs within the clinical team as part of the optimal provision of care for that patient eg, … assistance with a procedure. Teaching is simply a secondary element of sound care provision. The basic provisions of common courtesy and respect apply, however specific patient consent is not required.*"

However please note our DHB policy also requires that: "*where teaching occurs that is additional*

to normal clinical requirements or involves someone not qualified to undertake the procedures on their own …. an explanation is to be given to the patient and explicit permission sought."

Therefore in summary there is generally no requirement to obtain consent to the participation of an RMO who is employed as a member of the clinical team providing care. However, if an RMO is to undertake a procedure (under the supervision of an SMO) which the RMO is not yet qualified to do on their own, so far as reasonably practicable the patient's consent to the RMO's participation should be obtained.

For surgical/procedural situations, we expect that an RMO should introduce themselves and explain their role. For example: *"I'm Dr Jones, I'm the doctor who will be undertaking your surgery today. I'm an advanced trainee in surgery and will be undertaking this procedure with the supervision of Dr Smith who is the consultant operating with me."* If an RMO is asked directly about their training level/competence by a patient or their whanau, they should respond honestly and appropriately.

The MCNZ document does provide clear guidance on the role of medical students and observers: permission should <u>always</u> be obtained for their involvement in the patient's care.

We encourage you all to discuss these points with your clinical teams on a regular basis, and to reflect on the MCNZ guidance and its relevance in your own clinical practice.

Regards

Dr Jonathan Christiansen
Chief Medical Officer

Dr Dale Bramley
Chief Executive Officer

Te Kaunihera Rata o Aotearoa
Medical Council of New Zealand

SEPTEMBER 2019 www.mcnz.org.nz

Informed Consent: Helping patients make informed decisions about their care

Key points about informed consent

The patient has the right to make an informed choice about their care and, in most instances, must give permission to proceed with treatment.

That permission is called informed consent. It is an interactive process between the doctor, the patient and sometimes those close to the patient, such as their family or whānau.

As the doctor, it is your responsibility to ensure informed consent is obtained, and to communicate and work with your patient to help them make the best decision for themselves (Code of Health and Disability Services Consumers' Rights 1996).

The doctor undertaking the treatment is responsible for the overall informed consent process.

The patient has the right to refuse treatment and withdraw consent.

All patients are presumed competent to give informed consent unless established otherwise.

About our statement on informed consent

What is informed consent?

Every time treatment is provided, a doctor must have permission to provide that treatment. The process of obtaining that permission is called 'informed consent'. Without informed consent, the treatment may be unlawful. To help the patient decide whether they want a treatment, they first need to be given information, such as the risks and benefits of their treatment options.

In this statement, we use the words 'treat' and 'treatment' to refer not just to one-off or specific clinical encounters and procedures, but also to ongoing care.

Who is this statement for?

This statement applies to all doctors, and sets out the standards of good medical practice when discussing options for treatment and obtaining consent from patients.

This statement may be helpful for patients and for other health practitioners who need to explain to patients what their rights to informed consent are and what they can expect from their doctors.

This statement may be used by the Medical Council, the Health Practitioners Disciplinary Tribunal and the Health and Disability Commissioner as a standard by which to measure your conduct as a doctor.

While we expect you to meet the standards set out in this statement, there are instances when you will need to use your judgement when applying this statement to the particular situations you face in your practice.

The key principles of informed consent

1 Trust is essential in the doctor-patient relationship. One way to build trust is to provide information openly and honestly to your patient.

2 You must comply with the Code of Health and Disability Services Consumers' Rights (the Code), which sets out what patients can expect when they use a health or disability service in New Zealand. Keep in mind the following points:

There must be agreement before going ahead with treatment

a In most instances, treatment may only take place if the patient agrees to have the treatment. (See Right 7(1) of the Code.)

The patient must be able to make decisions about their care

b Start from the position that every patient can make their own decisions unless there are reasonable grounds to believe otherwise. Recognise that a patient's capacity to make decisions can fluctuate and is specific to each decision the patient makes. (See Rights 7(2) and 7(3) of the Code.)

Consent is an interactive process, not a one-off event

c Obtaining consent is a process of shared decision-making where you help the patient understand their medical condition and the options for treating (or not treating) that condition. It is more than signing forms and completing paperwork. Take the time to ask questions so that you understand what matters to your patient, and what their concerns, wishes, goals and values are. (See Right 1(3) of the Code.)

How you can help your patient make informed decisions

Provide the information needed

3 You must give your patient the information they need to help them make a fully-informed decision. Share information that is relevant to them, in a way they understand, and allow reasonable time for the patient to make their decision. Think about whether there is anything else you can do to make it easier for your patient to consider the different options and make a fully informed decision. Cover the options available including those that you may not be able to provide yourself.

4 Be open and honest with your patient, and answer their questions accurately.

5 Provide information to your patient, such as an explanation of their condition, the options available, and the results of tests and procedures. (See Right 6 of the Code which lists several things to tell your patient.)

Communicate effectively

6 Effective communication is critical in the consent process. Establish what matters to your patient. Share information in a way that helps your patient understand what you are saying. This could include highlighting risks specific to your patient, and giving your patient pamphlets, brochures, or website links that provide more information about their condition. You may need to engage an interpreter if there are language barriers.[1] (See Right 5 of the Code on effective communication.)

[1] If you use an interpreter during the consent process, you should document this in the patient's records, along with the interpreter's name and status (professional interpreter, family member etc). If possible, ask the interpreter to acknowledge in writing that they believe the patient understands the information provided about their care and treatment. See also the chapter about 'Working with interpreters' in *Cole's medical practice in New Zealand.*

Treat your patient with respect

7 Treat your patient with respect. Being respectful includes taking into account your patient's cultural, religious, and social needs, and their values and beliefs. (See Right 1 of the Code on treating patients with respect.)

Involve others when making decisions

8 It is good practice to check with your patient whether they would like to involve others close to them in the informed consent process.

9 Sometimes, you may not have all the information required and may need another doctor or health practitioner to provide input on your patient's care. In those situations, you should explain to your patient that you need more information, and work with your colleagues to provide quality care. (See Right 4(5) of the Code about co-operation among providers.)

10 Sometimes, your patient may have difficulty making decisions about their care. Where that happens, the doctor obtaining consent should, with the patient's permission, include those close to the patient (such as their family/whānau[2]) in discussions about the patient's care. You must confirm with your patient their final decision before going ahead with treatment.

Factors to consider before going ahead with treatment

11 In most situations, treatment should only go ahead if:

a your patient has received all the information that is relevant to their decision, and

b you are sure that your patient understands that information and the consequences of their decision.

Questions to consider before going ahead with treatment:

- What is your patient's understanding of their condition and the outcome they are hoping to achieve?
- Have you (or another colleague) explained the different treatment options including the risks and benefits of each option, and the option of not treating (adopting a see what happens with time approach)?
- Have you given your patient relevant information that would influence how they would decide?
- If your patient is unsure about your advice or recommendations, are they aware that they can seek a second opinion?
- If a proposed treatment is new, experimental or lacks scientific evidence, have you explained this to your patient?
- Has your patient had enough time to ask questions and think about how they would like to proceed?
- Does your patient have additional needs (disability, language barriers, low health literacy) and need more support to make a decision?

12 If you are worried that your patient is making a decision that is not in their best interests, you should explain your concerns clearly to them and outline the possible consequences of their decision. Where possible, work with the patient (and those they are close to such as family members and whānau) to find a solution that works for the patient.

Documenting discussions during the consent process

13 You must keep clear and accurate patient records that note:

a the information that was discussed

b any specific risks that were highlighted

c any request or concerns expressed

d any decisions made and the reasons for them.

[2] Whānau refers to the extended family and family group.

14 Not every aspect of a consultation can be noted in a patient's records. You must record enough information to provide an accurate summary of your discussion with your patient. Check that what you record is enough to guide another doctor or health practitioner if they need to follow up with your patient.

15 If you give pamphlets, brochures, or leaflets to your patient, you should note these resources in your patient's records. You should also note any exceptions (to those resources) that relate to your patient. If at a later date your patient requests a copy of their notes, you should include a copy of the resources you provided (where this is practical).

When a patient declines information about treatment

16 If a patient tells you they do not want information about their treatment, you must record their decision in their notes. You should also explore with the patient why they are declining information about their treatment (including its risks and benefits), and record the patient's reasons in their notes. You should tell the patient that they can let you know if they change their mind, and to contact you in that event.

When a patient lacks capacity to consent

17 You must have reasonable grounds for deciding that your patient lacks capacity to make decisions about their care.[3] When your patient lacks capacity to make their own decisions, you should contact someone who has the legal right to make decisions on the patient's behalf (for example, a legal guardian or someone who holds a current enduring power of attorney for personal care and welfare) for their input on the patient's care.

18 If your patient lacks capacity to make their own decisions and there is no one to make decisions on their behalf, you may go ahead with treatment when:

- a that treatment is in the patient's best interests; and
- b reasonable steps have been taken to find out what matters to the patient; and
- c you believe that the treatment is what the patient would have wanted if they were able to decide for themselves; or
- d you have taken into account the input of others who have an interest in your patient's welfare if you have not been able to find out what your patient's views are.

(See Right 7(4) for more information.)

19 Before going ahead with treatment, you may want to discuss your decision with an appropriate colleague. You should document in your patient's records, the reasons for going ahead with the treatment, and the input you received from those you contacted about your patient.

Situations when immediate life-saving treatment may be needed

20 Sometimes, a patient may require immediate life-saving treatment because they are acutely unwell. In those time-critical situations, it may not be practical or possible to establish the patient's wishes or to communicate with the patient or their family/whānau before going ahead with treatment. You should take into account what is good practice, and what is in the patient's best interests. You should also document the treatment you provide and discuss it with the patient (and their family/whānau) at the earliest opportunity.

Your responsibilities

21 The doctor undertaking the treatment or procedure is responsible for the overall informed consent process. If you are the doctor treating the patient, you need to check that the patient is clear about their decision to have treatment before you go ahead with it.

[3] See also the chapter about 'Mental capacity' in *Cole's Medical Practice in New Zealand,* which discusses capacity assessments carried out to decide whether a person can make certain decisions.

22 In some situations, the doctor who obtains consent from the patient may not be the doctor who treats the patient. A doctor should only manage aspects of the informed consent process for which they have sufficient knowledge. It is not necessary that they are competent to perform that procedure.

Delegating the patient's care to another doctor or health practitioner

23 Sometimes, it could be practical to delegate a patient's care to another doctor or health practitioner. When deciding whether to delegate, you should consider:

a the nature of the treatment or intervention, and how any risks and complications will be managed

b your relationship with your patient, and how your patient would feel about having treatment with another doctor or health practitioner

c whether your patient or anyone else involved in the decision to delegate has been given enough information and time to think it over and to express their views.

24 You should also consider whether the person you delegate to:

a has the right skills and experience to treat your patient

b understands the risks and benefits of the treatment they are providing

c understands the patient's needs and their clinical history

d recognises that, in some situations, they should contact you or a senior colleague for advice

e is clear about which doctor or health practitioner is responsible for obtaining consent from the patient and for checking that the patient is clear about their decision.

Managing time pressures during the informed consent process

25 Managing competing demands is a reality for many doctors. However, time pressures do not remove your obligation to share information with your patient and to support them in making decisions about their care.

26 One way of managing time pressures is to consider:

a whether other doctors or health practitioners could play a part in explaining information and answering questions before or after you see your patient.

b what other sources of information and support are available that you could refer your patient to.

Special circumstances you may encounter

When your patient is a child or adolescent

27 The Code does not specify any minimum age for consent. It assumes that a patient is able to make their own decisions about their care and treatment unless there are reasonable grounds to think otherwise.

28 Legally, someone who is 16 years of age or older who consents or refuses consent to treatment is viewed as though they were an adult (of full age).[4] Someone under 16 is allowed to make their own decisions about their care. But whether they will be viewed as though they were an adult would depend on how mature they are to make their own decisions.

29 Generally, if a child or adolescent is able to understand what treatment or procedure they are having and why, along with what would happen if they did not have that treatment or procedure, then they are able to decide for themselves.

30 A female of any age has the right to accept or refuse any medical or surgical procedure related to ending her pregnancy.

[4] Care of Children Act 2004, section 36. See also section 4 of the Age of Majority Act 1970 that states that a person reaches full age when they turn 20.

When care is provided in a teaching environment

31 You must have a patient's permission in advance if students or observers attend the consultation or participate in the patient's care. Pay particular attention when sensitive issues are discussed. You must obtain explicit consent for any intimate examination.

Explain to the patient:

a the status and clinical experience of those attending

b the role and involvement of those attending (such as whether they will be observing, or participating in the care by taking a clinical history or examining the patient)

c what is expected of those attending

d that at any point in time, they have the right to refuse the involvement of those attending.

When a patient is anaesthetised

32 Sometimes, a patient under anaesthesia needs more investigation or treatment than they have consented to. You must use good clinical judgement and act in your patient's best interests. Sometimes, the treatment may need to be deferred.

33 If the situation is urgent, you should proceed on that basis, and discuss with your patient at the earliest opportunity.[5] You should consider discussing with a peer, a clinical head, or your Chief Medical Officer any unexpected findings you come across during the course of treatment. You should document these discussions.

When a patient participates in research

34 Before inviting a patient to participate in research, the research must first be approved by an accredited ethics committee. A patient must provide written informed consent before they participate in research (see Rights 6(1)(d) and 7(6)(a) of the Code). If any part of the research changes after the patient gives their consent, you must disclose this to the patient so that they can decide whether they still want to be involved.

35 If the treatment is part of research, the investigating and the treating doctors are responsible for taking all reasonable steps to help the patient understand the full implications of the treatment, especially the risks and uncertainties involved.

36 Patients may withdraw their consent to participate in research at any time.

When body parts or bodily substances are taken from a patient

37 A patient has the right to decide whether they want any body parts or bodily substances taken from them during a procedure to be returned or disposed of (see Right 7(9) of the Code). You should be guided by your patient's wishes.

38 Body parts or bodily substances removed or taken during a procedure or after death may only be stored, preserved, or used if:

a the patient consents; or

b the parts or substances are for research that an ethics committee has approved; or

c the parts or substances are for a professionally recognised quality assurance programme; an external audit of services; or an external evaluation of services (see Right 7(10) of the Code).

[5] See also the section on 'Unexpected events' in the chapter on 'Informed consent' in *Cole's Medical Practice in New Zealand*.

When a patient is enrolled in an immunisation or screening programme

39 You have a special duty of care when enrolling patients into immunisation or screening programmes. This includes making the person aware of any limitations of a screening programme and the uncertainties, in particular the chance of false positive and false negative results. Before obtaining consent you should explain, or give information to the patient that explains:

a the purpose of the screening or immunisation

b the risks and uncertainties

c any significant medical, social or financial implications for immunising against, or screening for that condition, and any follow-up provided, such as counselling and support services.

When you seek a declaration or Court order because there is disagreement about treatment

40 When the patient declines consent or lacks capacity to decide for themselves, this can sometimes cause disagreement between the doctor and patient (or their family/whānau). If that happens, you should ensure that your patient and their family/whānau are given the time, information and support they need to work through their concerns. You should also seek advice from your peers, senior colleagues, your organisation's legal adviser, or an ethics committee.

41 Where the disagreement between the different parties is likely to affect the patient negatively, you may need to seek (urgent) approval from the High Court. You may need to seek legal advice on the process for obtaining approval from the Court. Examples include:

a a blood transfusion or caesarean section to save life

b stopping treatment to allow the patient to die (for example, a patient in a persistent vegetative state)

c sterilisation of a patient who does not have the capacity to consent but for whom the family and other carers, supported by medical opinion, request the procedure to improve the patient's quality of life or to prevent the patient's physical or mental health from worsening

d a dispute between parents based on their views or religious beliefs about the treatment for their child.

If you need more advice

If you are unsure about any aspect of this statement, please contact us at the Medical Council. You may find it helpful to seek advice from a trusted colleague, your medical indemnity insurer, or your professional college or association.

Related resources that may be helpful

Medical Council of New Zealand

- *Good Medical Practice*
- *Cole's Medical Practice in New Zealand*
- *Managing patient records*
- *Disclosure of harm following an adverse event*
- *Safe practice in an environment of resource limitation*
- *Doctors and CAM (complementary and alternative medicine)*
- *Cosmetic procedures*
- *Advertising*
- *Telehealth*
- *When another person is present during the consultation*

Office of the Health and Disability Commissioner (HDC)

Code of Health and Disability Services Consumers' Rights

The HDC has issued several decisions on informed consent. These are available on https://www.hdc.org.nz/decisions/

Other organisations

Clinical images and the use of personal mobile devices: A guide for medical students and doctors (This is a joint publication by the New Zealand Medical Association and New Zealand Private Surgical Hospitals Association Inc.)

Legislation

Several laws set out requirements about rights and consent, and are available on http://www.legislation.govt.nz/

This statement was updated in September 2019. It replaces the March 2011 statement on *Information, choice of treatment and informed consent*. It is scheduled for review in September 2024. Any changes to the law before that review may make parts of this statement obsolete.

Code of Rights

1. **Respect**: the right to be treated with respect
2. **Fair treatment**: the right to freedom from discrimination, coercion, harassment, and exploitation
3. **Dignity and independence**: the right to dignity and independence
4. **Proper standards**: the right to services of an appropriate standard
5. **Communication**: the right to effective communication
6. **Information**: the right to be fully informed
7. **It's your decision**: the right to make an informed choice and give informed consent
8. **Support**: the right to support
9. **Teaching and research**: rights in respect of teaching or research
10. **Complaints**: the right to complain

Doctors in Difficulty

If you are worried about yourself or a colleague, please refer to the available under controlled documents.

http://staffnet/QualityDocs/Quality%20Documentation/O6%20Human%20Resources/%5BP%5D%20Prevocational%20Doctors%20in%20Difficulty%20-%20Management%20Process%20Sep18.pdf%search="difficulty"

Informed Consent: Definition

Informed consent may be defined as the process whereby someone who has the capacity and competence to consent to a given treatment or procedure, having been given sufficient information which he or she has understood, voluntarily arrives at a reasoned decision as to whether or not to agree to the proposed treatment or procedure. This should be a process which is responsible to the needs, wishes, capabilities and expressed concerns of the particular patient.

Informed Consent should be obtained in the following instances:

- The patients is to be placed under general anaesthetic or sedation
- There is a significant risk of adverse effects on the patient

- The procedure is experimental
- The patient is to participate in any research
- Body parts or tissue are to be removed [information provided must cover removal, retention, return or disposal]
- Blood components and products are to be used
- A student is to perform an intimate examination or the exam is part of clinical teaching and not an integral part of the procedure (see clinical teaching)
- When either party requests it.

Verbal consent should be noted in the clinical record for all other circumstances.

1. Medical students need explicit consent from the patient to be in theatre and the SMO or RMO need to get explicit (verbal ok) consent for them to participate in surgery (eg suturing).

2. All consent forms for gynae patients should include "vaginal exam under anesthesia" if this is part of the procedure.

Documentation

In clinic the consent can be verbal, whereas in theatre this needs to be clearly written on the consent form by the registrar or consultant.

Please refer to the policy for circumstances involving contentious issues of informed consent, if the patient does not consent or if the patient is either under the age of 16 or unable to consent.

Clinical Teaching – requires specific consent

Where teaching [including assessment, discussion or observation] occurs that is additional to normal clinical requirements, or involves someone not qualified to undertake the procedures on their own specific consent needs to be gained.

It should be documented that the trainee will be performing the procedure "with the SMO" or "under the supervision of the SMO"

Waitematā District Health Board

Best Care for Everyone

Education Plan: Informed consent

Prepared By:	Lisa Sue, Innovation and Improvement Project Manager
Input Provided By:	Penny Andrew, Director – Institute of Innovation and Improvement Kate Gilmour, ADON Surgical and Ambulatory Services Julie Bromley, Lead Anaesthetic Technician Cath Cronin, Previously the Director of Hospital Services
Approval required from:	Jonathan Christiansen, Chief Medical Officer
Document Changes:	v1. 5 July 2019 v2. 8 July 2019 v3. 13 Aug 2019 v4. 15 Oct 2019 v5. 21 Jan 2020

1. Introduction

In 2012, concerns were raised that procedures and protocols for gaining patient consent were not being adhered to within the Surgical Services. Failure to obtain informed consent according to these procedures and protocols is a serious issue: it is a breach to the patient's rights under the Code of Health and Disability Services Consumers' Rights 1996 (The Code of Rights), and a breach of health professionals' expected standards of practice. To protect patient rights and safeguard health care professionals, a review of the DHB's Informed Consent Policy and Agreement to Treatment / Consent Form was undertaken.

These documents were last updated in August 2018 to better meet the requirements in The Code of Rights. In particular:

- Right 6 - Right to be fully informed
- Right 7 - Right to make an informed choice and give informed consent
- Right 9 - Rights in respect of teaching or research

Since the updates to the policy and consent form in 2018, dissemination of education about the Informed Consent Policy, including its principles and process of obtaining informed consent, has been a departmental responsibility.

Variation in the application of the Informed Consent Policy across the Surgical Department provides the opportunity for a widespread programme of informed consent in surgery, with the aim of improving awareness of the principles of informed consent and consistency in the application of the Informed Consent Policy.

2. Objectives

All surgical health care professionals will:

- Understand the principles in the Informed Consent Policy
- Apply the principles of informed consent in day to day practice
- Recognise the importance of a properly carried out informed consent
- Have increased awareness of the implications when the informed consent policy is breached

3. Audience

All surgical health care professionals which include:

- Medical teams
- Nursing teams
- Anaesthesia teams
- Midwifery teams
- Trainees and Students

Across all surgical departments:

- General Surgery
- Orthopaedics
- Urology
- Gynaecology
- Obstetrics
- ORL

All roles are defined as per Informed Consent Policy. Please refer to Appendix 5.1 on page8.

4. Education Approach

There will be 5 approaches that will be used to promote awareness of the informed consent core principles. These are:

1. Friday theatre education sessions
2. Focus boards
3. In service teaching sessions – Interactive quiz and discussions (Nursing/Anaesthetic technician)
4. In service teaching sessions – Talks and discussions (Medical doctors)
5. E-learning module (Medical Doctors)

4.1 Friday Theatre Education Sessions

Target Audience	All health care professionals within Theatres and Surgical Wards. • Surgical consultants, registrars, house officers, trainee intern, medical students • Registered nurses, enrolled nurses, student nurses and health care assistants • Anaesthetist, Anaesthetic registrars, house officers, anaesthetic technicians, trainee anaesthetic technicians
Education content	**August 30th** • High level review of informed consent policy in terms of legal requirements and what is courtesy • 2 x Case scenario discussions **October 4th** • Patient perspective • Code of Health and Disability Services Consumer Rights and Medical Council guidance • Summary of guidance on students, teaching, team care and delegation • Further case scenario and discussion panel
Concept	Delivering education in a collaborative learning space; using methods such as problem based learning, case scenarios for simulation based education
Methods	• Case studies. These case studies be discussed in an open and interactive session • Policy and Code of Rights Discussion To provide guidance but allow audience to ask questions and discuss • Video or Guest speaker To have a different platform to engage the staff
Roles & Responsibility	**Governance:** Informed consent project steering group **30th August Discussion Panel:**

	Jonathan Christiansen, Amanda Mark, Penny Andrew and session is facilitated by Jay O'Brien. **4th October Discussion Panel:** Ron Paterson, Amanda Mark, Jonathan Christiansen. Also facilitated by Jonathan Christiansen.
Duration	2 x Friday Theatre Education Sessions 30 August – 60 minutes MDT session 4 October – 60 minutes MDT session

4.2 Focus Boards

Target Audience	All health care professionals within Theatres and Surgical Wards. • Surgical consultants, registrars, house officers, trainee intern, medical students • Registered nurses, enrolled nurses, student nurses and health care assistants • Anaesthetist, Anaesthetic registrars, house officers, anaesthetic technicians, trainee anaesthetic technicians • Midwifes, midwifery students • Medical radiation technicians
Education content	Informed Consent Policy, version August 2018 Section 1.2: What is informed consent? Section 1.5: Levels of consent - Implied, Verbal, or Written Section 1.6: Documentation of consent or written consent Section 1.7: What and How much information Section 1.8: Primary Responsibility for Information, consent, and delegation Section 2.0: Teaching, Students and Observers Section 2.1: Supervision
Concept	An eye catching and informative focus board to create awareness of the principles of informed consent in plain English.
Methods	North Shore Hospital and Elective Surgery Centre, posters distributed on ○ Theatre education focus board: Large poster A1 ○ Surgical ward education board: A3 posters for ward Short Stay, and Cullen. ○ PACU focus boards: 7 x A3 sized posters for Admissions Interview Rooms, Pre-Op, Day Stay, and Recovery.
Roles & Responsibility	**Governance:** Informed consent project steering group (See Appendix 5.1 on page 9 for details) **Design and implementation:** Cassie Khoo — i3 Design fellow Lisa Sue — i3 Project manager Chari An Bakkenes — Surgical Nurse Educator Kerlvin Ocado — Surgical Nurse Educator Grace Gannaban — PACU Nurse Educator

	Ara Cho	Theatre Nurse Educator
Duration	1 month. Posters were placed up in mid-September	

4.3 In service teaching sessions - Interactive quiz and discussions

Target Audience	Health care professionals across Surgical Wards and Theatre who are: • Registered nurses, enrolled nurses, student nurses and health care assistants • Anaesthetic technicians, trainee anaesthetic technicians
Education content	Informed Consent Policy, version August 2018 Section 1.2: What is informed consent? Section 1.5: Levels of consent - Implied, Verbal, or Written Section 1.6: Documentation of consent or written consent Section 1.7: What and How much information Section 1.8: Primary Responsibility for Information, consent, and delegation Section 2.0: Teaching, Students and Observers Section 2.1: Supervision
Concept	Delivering education through an interactive learning forum with the opportunity for collaborative feedback and discussion.
Methods	Each Clinical quiz is bespoke to the role of the target audience, i.e. Nurse focus and Anaesthetic technician focus. A core element of this approach is to have the facilitator direct critical thinking and discussion in a safe and open manner after each question. The quiz set up is to help engage staff and obtain greater involvement. In order to retain engagement of staff, there will be 8 questions per quiz and section 1 and 2 will be separated. • Clinical Quiz 1: The questions will be specific to the policy sections 1.2, 1.5 – 1.8 • Clinical Quiz 2: The questions will be specific to the policy section 2 Following each question, the answer will be revealed and there is an opportunity for the facilitator to discuss the answers with the audience. **Resources required include:** • Facilitator • TV screen or laptop • Prizes
Roles & Responsibility	**Governance:** Informed consent project steering group (See Appendix 5.1 on page 9 for details) **Design and implementation:** Lisa Sue — i3 Project manager Chari An Bakkenes — Clinical Nurse Educator – Surgical Kerlvin Ocado — Clinical Nurse Educator – Surgical

	Grace Gannaban	Clinical Nurse Educator – PACU
	Ara Cho	Clinical Nurse Educator – Theatres
	Julie Bromley	Lead Anaesthetic Technician
	Zoe Bunker	Anaesthetic Technician – Educator
Duration	All surgical services will have 2 x 30 minute in-service teaching sessions. **Nursing** • The forum of choice is after the AM-PM handover. • The schedule of the teaching sessions will be completed per service by the respective Clinical Nurse Educator. • These sessions will aim to be rolled out and completed over an 8 week period **Anaesthetic Technicians** • The forum of choice is Friday Theatre Education Sessions, once every 5 weeks • The schedule of the teaching sessions will be completed by Zoe Bunker • These sessions will need to be held at the start of each Friday Theatre Session for the remainder of the year to capture the cohort.	
Milestones	Concept approved	11 July 2019 – Steering group meeting
	Implementation	15 July to 6 September 2019 – Nursing 26 July to December – Anaesthetic Technicians

4.4 In service teaching sessions - Talks and discussions

Target Audience	All health care professionals within Theatres and Surgical Wards. • Surgical consultants, registrars, house officers, trainee intern, medical students • Anaesthetist, Anaesthetic registrars, house officers
Education content	Informed Consent Policy, version August 2018 Section 1.2: What is informed consent? Section 1.5: Levels of consent - Implied, Verbal, or Written Section 1.6: Documentation of consent or written consent Section 1.7: What and How much information Section 1.8: Primary Responsibility for Information, consent, and delegation Section 2.0: Teaching, Students and Observers Section 2.1: Supervision
Concept	Delivering education in problem based learning and discussion sessions.
Methods	To have a meeting to discuss with senior medical officers in Obstetrics and Gynaecology department their perception of informed consent and their understanding on expectations. Discussions with this cohort will be facilitated by Cath Cronin, Penny Andrew, and Jonathan Christiansen.
Roles & Responsibility	**Governance:** Informed consent project steering group

	Implementation: Jonathan Christiansen and Penny Andrew
Duration	1 hour To add to agenda onto existing departmental SMO meeting.

4.5 E-learning module

Target Audience	For consultants and registrars working within the provision of Surgical and Ambulatory Services
Education content	Informed consent topics relating to: <u>Medical students</u> National guidance (NZMJ 2015) Informed Consent Policy, version August 2018 Section 2.4 - Clinical teaching of students in training Section 2.5 – Supervision of student experience Section 2.6 – Consent for involvement of students Section 2.7 – Consent for all students in theatre / operating room / procedure room Reference to surgical department specific orientation manual <u>Team care and delegation</u> Code of Health and Disability Services Consumer Rights MCNZ Guidance (Proposed) Informed Consent Policy, version August 2018 Section 1.8 – Primary responsibility for information, consent, and delegation Section 1.10 – Team approach to providing information Section 1.11 – Team approach to obtaining consent Current Informed Consent e-learning module on Ko Awatea LEARN, Awhina <u>Teaching</u> MCNZ Guidance Informed Consent Policy, version August 2018 Section 2 – Teaching and Observers <u>Health care industry representatives</u> Informed Consent Policy, version August 2018 Section 2.10 – Observers not involved in clinical care
Concept	An online learning module to be placed on Ko Awatea LEARN – Awhina that is supplementary to the informed consent learning module already available. This particular module aims to provide further guidance on specific topics relating to informed consent.
Methods	***Method to be validated:*** To explore and design an e-module in the current education management system in Awhina. The aim is to create an interactive and engaging learning module.

	The content will be divided into 4 sections and each section will have their own learning objectives. Provisional learning objectives are: Medical students • Recognise scope of student involvement • Differentiate the appropriate levels of informed consent to be obtained for student involvement • Understand who is responsible for obtaining informed consent for student involvement Team care and delegation • Recognise who is responsible for obtaining consent and the basic consent principles • Understand in which situations it is appropriate to delegate the responsibility to obtain informed consent Teaching • Understand the different learning environments and distinguish which circumstances need informed consent obtained. Health care industry representatives in theatre • Identify who is responsible for obtaining informed consent for health care industry representatives in theatre
Roles & Responsibility	**Governance** Informed consent project steering group (See Appendix 5.1 on page 9 for details) **Design of prototype** *Content based on slides presented by Jonathan Christiansen during the October Friday Education Session.* Lisa Sue i3 Project manager Cassie Khoo i3 Design Fellow Keith Gulayan i3 Web Content Editor **Co-design prior to implementation** All clinical directors in surgical services will be presented the prototype for feedback
Duration	Approximately 30 minutes to 1 hour collectively; The course will be designed so that not all content needs to be read in one session, with to option to return to the module at any time.

5. Appendix

5.1 Informed consent project steering group

Name	Role
Jonathan Christiansen	Associate Chief Medical Officer
Penny Andrew	Director – Insititute of Innovation and Improvement
Michael Rodgers	Chief of Surgery
Kate Gilmour	Head of Division, Nursing – Surgical and Ambulatory Services
Diana Ackerman	Clinical Director, Gyanecology Acting Clinical Director, Obstetrics
Amanda Mark	Legal Counsel
Ulrike Gerstenberger	Clinical Nurse Director, North Shore Hospital Theatres
Morgan Edwards	Senior Medical Officer (Anaesthetist)
Ara Cho	Clinical Nurse Educator - Theatres
Lisa Sue	Innovation and Improvement Project Manager
Previoulsy involved	
Cath Cronin	Director of Hospital Services

Waitemata
District Health Board

Best Care for Everyone

Obstetrics & Gynaecology Registrar & SHO Handbook

What you need to know

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Welcome to WDHB

Kia Ora & welcome. We are delighted that you have chosen to come and work for our organisation. This workbook is designed to provide you with information and resources to smooth your orientation to Womens Health at WDHB. Below are the core values of our organisation and it is expected that these will guide you in your relationships with women, whanau and colleagues.

Code of Rights

The Health and Disability Commissioner has defined some important rights for health service users. These rights are:

1. To be treated with respect
2. To be treated fairly without pressure or discrimination
3. The right to dignity and independence
4. To receive a quality service and be treated with care and skill
5. To be given information that you understand and in a way that helps you communicate with the person providing the service
6. To be given the information you need to know about your health or disability; the service being provided and the names and roles of the staff; as well as information about any tests or procedures you need and any test results
7. To make your own decisions about your care and to change your mind
8. To have a support person with you at most times
9. To have all these rights apply if you are asked to take part in any research study or teaching session for training staff
10. You have a right to complain and have your complaint taken seriously

WDHB Maternity Services

Location

We have two maternity units, one in Takapuna on the North Shore and one in Henderson in West Auckland. (Location of hospitals is marked with red dots).

North Shore Hospital Maternity Unit
Around 3800 births per year, 10 birthing rooms, 3 birthing pools, 36 postnatal beds.

Waitakere Hospital Maternity Unit
Around 3000 births per year, 8 birthing rooms, 2 birthing pools and 26 postnatal beds.

Services provided

Both sites offer both primary and secondary maternity services however; there are some limitation to the secondary services at Waitakere due to the availability of resources. (Check this sentence with Emma Farmer)

WDHB employs a variety of staff to undertake the services provided – the birthing units are staffed by Midwives and the wards are staffed by Midwives, Nurses & Health Care Assistants. Both North Shore and Waitakere each have a team of Community and Diabetes Midwives. Waitakere also has a small team of case loading midwives.

Obstetric services are provided by both Specialist Obstetricians with North Shore also having Registrars. Anaesthetic & theatre services are available at both sites. Each site has its own Special Care Baby Unit, staffed by Neonatal Nurses, Credentialed Nurses and Paediatric Specialists & Registrars. Other services available include Lactation Consultants, Social Work and Physiotherapy.

WDHB Gynaecology Services

Location

Both North Shore & Waitakere sites have Gynaecology Outpatient and Colposcopy clinics. Women are seen at both North Shore and Waitakere Emergency Departments but inpatient gynaecology services are only available at North Shore Hospital and all women requiring inpatient care are transferred by ambulance from Waitakere to North Shore Hospital. Inpatients are usually admitted to ADU or Ward 4, and occasionally there are outliers on other wards.

Services provided

Gynaecology services at WDHB have almost 12,000 new patient contacts each year. In 2012, these contacts were made up of almost 6500 new referrals to Gynaecology Outpatients Clinic, over 2300 new referrals to Colposcopy, over 1000 new referrals to Early Pregnancy Clinic and over 2200 new presentations to the Emergency Departments at NSH and Waitakere.

Gynaecology services are provided by Specialist Gynaecologists, Registrars and House Officers. Gynaecology surgery is performed at both sites.

Key contacts

Women's Health comes under the WDHB Child, Woman and Family Division. If you have any queries relating to the service please contact the appropriate person below, either by phone or by email.

Title	Name	Phone
Clinical Director - Obstetrics	**Sue Belgrave**	**021 947 254**
Clinical Director - Gynaecology	**Peter Van de Weijer**	**021 412 683**
Operations Manager	**Michelle Wilson**	**021 411 677**
Women's Health Administrator	**Andrea Storry**	**ext 2957**
Women's Health Administrator	**Kathie Shoesmith**	**ext 3574**
Head of Division - Midwifery	Emma Farmer	021 220 7344
Midwife Manager - Facility NSH	Deb Pittam	ext 3837
Clinical Charge Midwife - NSH		ext 2415
Midwife Manager - Facility WTH	Helen Ngatai	ext 6607
Clinical Charge Midwife - WTK		ext 6655, 0212214264
Midwife Manager - Community	Sue Fitzgerald	ext 6548, 021 497 853
Antenatal clinic NSH	Ext 3393, Fax 2428	
Antenatal clinic WTK	Ext 6609, Fax 6619	
Gynaecology Outpatients & Colposcopy	Ext 3101, Fax 2405	
Early Pregnancy Clinic (EPC)	**021 243 9729 / Ext 3337** **Fax 486 8320 (external) 2320 (internal)**	
EPC CNS Susan Rae/Nurse	**021 243 9729**	
On-call Gynaecology Registrar	021 245 4591	
On-call Obstetric Registrar	7143	
On-call Obstetrician - NSH	Request on-call Obstetrician from operator	
On-call Obstetrician - WTK	Request on-call Obstetrician from operator	
Neonatal Lead (SCBU)	Jutta van den Boom	021 784 348
Paediatric Specialist - NSH	021 935 044	
Paediatric Specialist - WTK	021 242 8771	
RMO Advisor	Daisy Hunter, ext 2153	

Getting Started

This section guides you through the process to get an access agreement, an ID badge (which provides security access), and a parking swipe card and permit.

Identification and Security Access

Your ID card is valid for 2 years. The card is issued in your name. Every time you use the card, your entry will be recorded. If you use a card in an unauthorised area you will not be admitted but the attempt will be recorded.

The card will become invalid on the date printed on the card and will cease to work from this date, please make sure you apply for a replacement prior to the expiry date

If you lose your card, report it to security immediately 09 486 8920 ext 2010, they will deactivate it if not recovered in 7 days it will be deleted. There is a charge to get a replacement card

Parking

Vehicle access to Waitemata DHB hospital sites and car parks is via a parking access card. To obtain a card you need to complete an application form. When you receive your card you need to pre-load it with credit from one of the yellow parking machines. You can then swipe the card to exit the site. The charges are at the staff rate and you may come and go to either site multiple times on any day and will only be charged once in a 24hour period.

Parking regulations

- All vehicles must be parked in the correct designated area and display the appropriate permit and current WOF and Registration Certificate.
- You must not exceed the speed limit of 20kph. You must not park on grass, gardens, footpaths, on broken yellow lines, over fire hydrants or in NO parking areas and you must obey all signage.
- If you sell or change your vehicle you must notify Parking Services so that your details are kept up to date and you will receive a new sticker. Please discard the sticker on your old car before selling it. You do not need to complete a new form.

- If you change your car's registration plate (e.g. to a personalised one) you must notify parking services. Permit numbers issued must match registration plate numbers or you risk being issued a ticket and/or being towed away.
- Failure to park your car in accordance with WDHB policy will result in an Infringement Notice being issued and may result in the offending vehicle being towed away. Towed vehicles can be collected from Auckland Towing Co Ltd, 57 McKelvie Street, Ponsonby - payment approx $160.00.
- At Waitakere Hospital after 16.30, you can park closer to the hospital, provided that you leave before 8am. Generally this is in visitor car parks.

Information Systems

WDHB has a number of computer systems to make access to information easier for health professionals. Information held in our computer systems is confidential and subject to the health information privacy code. Access to computer information is monitored electronically though user passwords so make sure you log on and off using your own password.

Concerto

Concerto provides a repository of important clinical information; this includes laboratory results, radiology and scan results and summaries of clinic appointments, admissions, discharges and theatre procedures, including some from ADHB and CMDHB. You are encouraged to access concerto records fro all your clients and this is particularly important for those receiving secondary care.

You will be given a password to access to Concerto with your access agreement. Please ask the ward staff to sit down with you and help you navigate and become familiar with this system before you use it. Remember you may only access information for women who are currently your clients.

RISK Pro

Risk pro is the DHB incident reporting system, it tracks incidents so that they can be investigated and followed up and any trends can be identified. Please seek support from the Clinical Charge Midwife or Midwife Managers to facilitate risk pro reporting when an incident or concern has occurred.

Emergency calls

All emergencies calls are made via the WDHB operator, including fire and security events. **The number to call is 777.**

All "777" calls are answered promptly & are recorded. When the operator answers you should relay the following information.

- Who you are
- Type of emergency (e.g. Obstetric Code Red)
- Location (e.g. Room 4, Piha, Waitakere)
- Any other details e.g. alert theatre
- Wait for the operator to confirm the details before you hang up!

NB You must remember to say which hospital when giving your location as the operator takes emergency calls from both sites.

Do not be afraid to use the 777 call system. In any emergency it is always better to call for help and not need it than to wait for help when you do need it!

Types of emergency calls

The calls used can vary slightly from site to site so make sure you are familiar with the calls for the site you are working.

FIRE – WDHB has onsite response for fire incidents. The members of this team will co-ordinate any evacuation or relocation of patients & staff as well as assisting the Fire Service as necessary. As well as activation of the fire alarm it is important to call 777 as well. The e-learning package provides more information on fire procedures (see p.22)

CODE ORANGE – This is the team that is called for "security" emergencies. Each site has a team trained in "calming & restraint" techniques and they will respond to such emergencies. The Duty Manager will also come and they can issue a "Temporary Trespass Order" if necessary. WDHB has a "Zero Tolerance to Violence" incl. any aggression towards staff.

OBSTETRIC CODE RED – This team is called for all emergencies involving maternity clients (i.e. antenatal, intrapartum and postnatal).

NEONATAL RESUS TEAM – This team is called for any neonate requiring resuscitation (up to 28days of age). It is extremely important that you identify "NEONATAL RESUS" to ensure you get the right help!

ADULT RESUS TEAM – This team is used for all other emergencies in adult patients (i.e. over 16yrs of age), or in addition to an obstetric code red if medical assistance also is required. It may also be used for visitors or staff requiring emergency medical attention.

PAEDIATRIC RESUS TEAM – This call is only to be used for infants older than 28 days and children up to the age of 16. It will bring a person who are used to dealing with older children, rather than neonates. This call is only applicable to Waitakere site.

Remember to ask your Midwife Educator for a "pocket ref" for emergency calls at your site

WDHB StaffNet

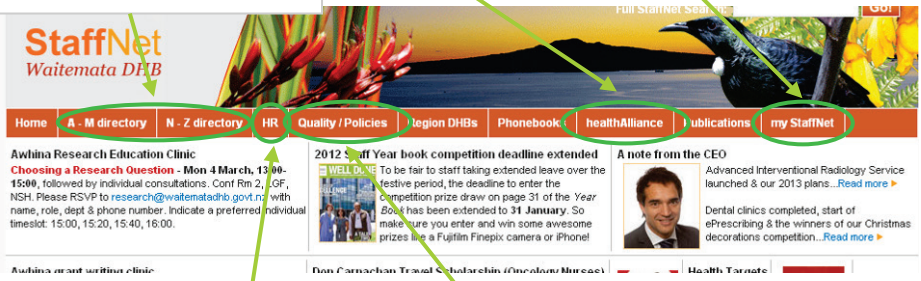
The StaffNet site can be found by clicking on Internet Explorer , and is the main portal for staff advice and communication. Take time to familiarise yourself with the site and the range of pages that can assist you in your work.

The sites includes:

BEIMS requests
Infection Control
Learning & development
Library
Midwifery / Nursing
Occupational Health
Traffic & Shuttle

Computer education

Email (outlook web access)
Employee Kiosk
Workforce Central (WFC)
Staff notice board
Work Perks



Human Resources

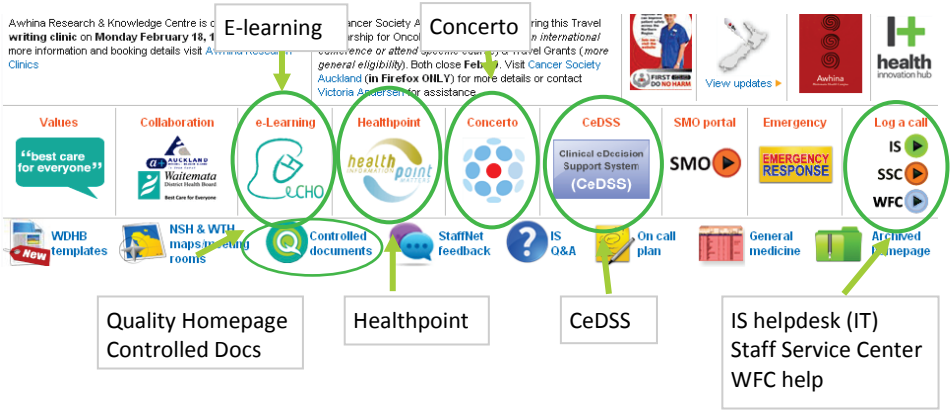
Quality Homepage
Controlled Docs
Incident Reporting

BEIMS requests – facilities maintenance, servicing and faults requests can be ordered online via BEIMs request.

Infection Control - information about Infection Control Services as well as some really useful resources and videos

Occupational Health & Safety – information on services, including the ACC Partnership Programme (Well NZ) Employee Assistance Programme (counselling services) and many more little known titbits.

Pharmacy - has really useful links such as “MIMS”. Other great resources such as ‘identifying foreign medicines’ (look under bookshelf) – great for finding NZ names for common drugs



Service desks – there are three service portals. IS helpdesk is for queries such as resetting password for Concerto/webmail. SSC (Staff Service Centre) is for pay queries or Employee Kiosk password reset. WFC (Work Force Central) is for any queries with WFC passwords/access/training.

Concerto – multifaceted programme which allows access to:

- Clinical documents and laboratory/radiology requests and results: viewed by NHI, from various Auckland sources (if job appropriate)
- Task manager: ability to order and view hospital orderly requests such as; patient assists, ice, linen, lab collections etc (clinical/non-clinical)
- Visit view: view of outpatient, inpatient and surgical appointments at various Auckland facilities

CeDSS – great resources with links to:

- Early Pregnancy Clinic; links to all EPC policies and patient information as well as useful information about how the clinic works
- Paediatrics; has a dedicated “neonatal” page with lots of useful resources

Work perks – WDHB arrangements with local providers to give employee discounts off services. For example, Event Cinemas offer staff $11 tickets.

Staff notice board & events calendar - useful for buying / selling surplus furniture amongst other things

Traffic Service - information about the inter-hospital staff shuttle (timetable & how to book) as well as parking information.

Clinical Guidelines

The service has a range of clinical guidelines. The role of these is to provide staff with up to date evidence based practice guidelines. Each guideline is reviewed every three years, if there is a significant practice change the guideline will be amended earlier.

It is important that you are familiar with the guidelines and use them to guide your practice. In the rare situation of a complaint or an adverse event these guidelines are often used as the standard of care by which your practice may be assessed. Staffs are welcome to write and / or contribute to guidelines – please discuss this with one of the Midwife Coordinators - Quality.

All policies and guidelines are now held electronically on the "StaffNet". There may be some paper copies in the clinical area – you should be aware that these may not be the latest version, therefore, it is important you that you know how to access the electronic copy.

Locating a clinical guideline or policy

Go to the StaffNet home page & locate "Controlled Documents" in the bottom bar. A single 'click' will open the "Controlled documents" home page in a new window. Click on "Policies/procedures" →"Child Woman & Family → then either Maternity or Gynaecology/Colposcopy.

If you know the name / partial name of the document, you can use the document search engine. From there you can scroll down to find the document you wish to view.

E-Learning

WDHB has a variety of online learning programmes, some of which are compulsory for all employees.

Select e-learning from the StaffNet homepage to bring up the eCHO homepage and register as a new user – you will need to know your WDHB email address and employee number. You cannot register using a private email address.

Compulsory e-learning modules are currently:

- Fire training
- Occupational Health & Safety
- Privacy of Health Information

Once you have created your account and clicked the confirmation link in your email, you will be able to login from any where via the WDHB external web page http://www.waitematadhb.govt.nz and login using the 'staff login' tab at the bottom right of the page.

Obstetrics & Gynaecology Team Structure

The 'teams' in O&G at NSH are Obstetrics, Gynaecology- Emergency & ADU, Ward, Theatre and EPC/OPD.

Acute patients are cared for by the on-call Registrar and Consultant of the day.

Handover

Hand over for Registrars and House Officers is held Mon-Fri 8am sharp in the Maternity Suite Seminar room. It is extremely important you attend these meetings as patient management and continuation of care is discussed. Weekend handover is usually SHO-SHO and there is no designated place for this. Call the on-call pager (93-1944) to see where they are.

Ward Rounds

The Gynae ward round is done by the SHO with help from the team Gynaecology Registrar for that day. This round includes all ward patients and those in short stay ward.

Patients still in ECC are reviewed by the ECC SHO that day and any queries directed towards the Gynaecology Registrar during office hours and the on-call Registrar our of hours.

The SHO on the postnatal ward covers maternity suite and directs queries to the on-call Obstetric Registrar.

The consultant doesn't usually do a ward round of all the patients, they are available for advice and input in more complex cases.

The continuity of care will often be with you for the patient's stay in hospital.

Setting up your Concerto personal settings

As there are many consultants in O & G and only 12 spaces in your personal clinical viewer the consultants that most often have inpatients are:

Paul Henderson	Steve Johns	Helen Allen
Abir Abed-Ali	Vijay Bhoola	Nilima Upadhyay
Sue Belgrave	Alex Ivancevic	Tom Wimbrow
Ammar Al-Abid	Raj Kumar	Shiu Kumar

Teaching Opportunities

O&G Teaching

There is teaching on Mondays at 1215hrs (on the Mondays when there are no morbidity or mortality case review meetings) and on Wednesdays at 1215hrs on practical topics. These provide excellent learning opportunities.

O & G Radiology Ultrasound Meeting

On the first Monday of each month at 8.30am there is O & G Radiology USS meeting in Radiology Conference Room on the ground floor.

Morbidity and Mortality Case Reviews

On every second Monday of each month usually at 12noon (this is occasionally subject to change) there is an obstetric morbidity and mortality case review session in conference room 1 on the lower ground floor. This is not compulsory but is always interesting.

Obstetric Morbidity and Caesarean Section Case Reviews

On the fourth Monday of each month usually at 12noon (this is also occasionally subject to change) the obstetric morbidity and caesarean section cases are reviewed in conference room 1 on the lower ground floor.

CTG Reviews

These are held with Midwives on a Friday lunchtime. Dates TBA.

Roster

Andrea Storry, Women's Health Administrator is responsible for the roster.

There is a copy of the weekly and monthly roster available on the shared drive. You can find it by going to the desktop and clicking "My Computer" then "G Drive" then "On Call Rosters" then "O&G Rosters''.

There is also a printed copy above the Gynae trolley on Ward 4 but *please be aware that this may not be the most up to date copy of the current roster*.

Duties are split into morning and afternoon sessions (usually 4 hours each) i.e. 8am-12, 12noon-4pm and 4pm-10pm.

SHO roster priorities

SHO roster priorities are as follows:

Mornings:

1. Morning Handover
2 ECC
3 Gynae Ward (Ward 4 and SSW but there may be other outliers in other wards/areas)
4 Maternity Suite

Afternoons:

1. ECC
2 Gynae Ward (Ward 4)
3 Early pregnancy clinic

Handover

Hand over for Registrars and House Officers is held Mon-Fri 8am in the Maternity Suite Seminar room. SHO's are responsible for updated colleagues regarding patient presentations at handover.

It is extremely important you attend these meetings. Weekend handover is usually SHO-SHO and there is no designated place for this. Call the on-call pager (93-1944) to see where they are.

House Officer Duties

Ward House Officer

Gynaecology patients are usually on Ward 4 but that there may be outliers on other wards. It is your job to see all the patients in the wards and in PACU2. Assessment & Diagnostic Unit (ADU) is covered by the ECC SHO.

The Ward 4 Charge Nurse is Sue Johnston. There is a white clip board by the door to the Charge Nurse's office which has a print out of all the Gynae patients. You should call the Gynaecology Registrar if there are problems. The on-call Consultant may also visit the ward to check on complex patients. If

your concern is urgent and the Gynaecology Registrar is unavailable call the Obstetric Registrar (mobile direct dial x7143) or the on-call Consultant. Remember the on-call Obstetric Registrar is often very busy in Delivery Suite and with LSCS's and so you should contact the on-call Consultant if you cannot make contact with either of the on-call Registrars.

It is best to prepare discharge summaries for all patients when you have time (e.g. in the afternoons) so that when they are discharged they are not delayed leaving the ward by waiting for discharge documentation. All patients should be discharged home with a complete copy of their discharge summary.

On Fridays' it is very useful to have a weekend plan for complicated patients. You also need to prepare the discharge summaries for patients who may go home over the weekend because the weekend SHO is usually very busy doing ward rounds and covering ECC.

If discharge summaries are not done in the ward or ECC the chart is sent to the Gynae room on Ward 4 – they need to be done promptly and returned to Ward 4 ward clerk.

Elective patients

Gynae elective patients may or may not require an anaesthetic review depending upon triaging of their self assessment questionaire. This process is administered by Gynaecology Booking & Scheduling Team.

When elective patients arrive on the ward you need to:

- Fill out the front of the A to D planner. This is extremely important so if the patient becomes unwell there is a record of medical problems and medications/allergies.
- Chart their regular medications.

ECC House Officer

The ECC House Officer has the on call pager (93 1944) during the day, then hands it over to the long-day House Officer at 4pm.

For problems relating to non pregnant and pregnant (<20 weeks gestation) call the Gynaecology Registrar and for problems related to women >20 weeks

gestation call the on-call Obstetric Registrar. If they are unavailable, call the on call Consultant.

After morning handover, your first task in the morning is to do a ward round and see all the patients left in ECC from the day before. Then you should start seeing new patients as they arrive.

O&G will only see patients that have been discussed with the appropriate on-call Registrar and accepted. Antenatal patients >20 weeks go straight to Birthing Suite Assessment area, but if they have UTI or vomiting and diarrhoea they may be seen in ECC.

All ECC patients who are discharged MUST have a discharge summary to take home. This is important because patients often come back the same night or in the next few days and the discharge summery is an electronic summary of events in the event you cannot locate old notes.

Registrars occasionally do an informal USS so they can send patients home. The scanner is the ADU one which is kept in the Gynae room on ADU, or if that's in use there is one in Delivery Suite (this must be returned immediately after use). You should make sure a photo of the scan is printed to stick in the notes along with an interpretation.

If the patient has a viable IUP on USS they should be discharged back to their GP or LMC for a follow up formal USS. If a viable IUP is not confirmed on USS the patient may need a formal USS at Early Pregnancy Clinic in addition to the portable USS.

Maternity Suite House Officer

The Postnatal House Officer sees all patients on Maternity Suite with YELLOW dots by their names on the whiteboard. The Charge Midwife, usually Pat Kelly, can help you. These patients are usually post LSCS or antenatal patients with GPH (we don't usually see these) etc or who have postnatal complications. In general, antenatal patients are seen by the on-call Obstetric Registrar and /or Consultant. The exception to this is simple cases such as 1st trimester hyperemesis.

Not all midwives have general surgical training. Be clear to the midwife caring for your patients about your plan of care and be sure that either you or the on-call Obstetric Registrar recheck anything you are concerned about later.

The on-call Consultant or on-call Obstetric Registrar need to see any antenatal, post natal or unwell patients you are concerned about.

You should do a brief discharge summary for Antenatal patients/Hyperemesis patients. A pre-pregnancy and discharge weight for must be included on the discharge summary of all patients with post-natal complications (including GPH post partum women going home on antihypertensive medication)

Over the weekend the on-call House Officer also covers acute problems on Maternity Suite. Notes for discharged patients will be kept in a box by the ward clerk's desk for discharge summaries to be done on Monday.

Night House Officer

The night house officer covers all ECC, Ward patients and Maternity Suite patients.

You collect the on-call pager at 10pm from the House Officer who has done the long day. You should page the on-call SHO on long day to find out where to meet them for handover.

If it is quiet you may be able to sleep in the Gynae room on Level 4. The Registrars have their own bed on Level 2 but are often busy on Delivery Suite all night. You may be asked to scrub in on difficult LSCS.

Morning handover is at 8am in the Maternity Suite Seminar room.

If you electronically requested an USS you want done during the weekend, you have to discuss this with the on-call Radiology Registrar who can be contacted through operator. You must request this as the **Weekend** House Officer

Weekend House Officer

The weekend House Officer works 8am-10pm on Saturday and Sunday**.**

You will need to do a ward round of the inpatients on the wards and in ECC. This can often mean you are quite busy as you will have to balance this with new admissions arriving in ECC. You will have to use your clinical judgement and information from the handover in order to prioritise which patients you will see first.

You are on-call with 1 registrar and consultant. If you have queries, talk to the on-call Registrar in the first instance.

Theatre

Consultants have a weekly, fortnightly or monthly theatre list theatre list that works on a two week rotating roster. Please refer this to the service roster and be aware that this is subject to change.

Antenatal Clinic

These are held on all weekdays as well as Monday and Wednesday afternoons on level 2. House Officers are not rostered to these clinics but are welcome to attend.

Gynaecology clinic

There is a roster for these clinics you can get from the G drive. They are held in the Gynaecology Outpatients clinic past Orthopaedic clinic on the ground floor. Again, House Officers are not rostered to these clinics but are most welcome to attend. Please ask if you would like to attend these clinics as we are more than happy to facilitate this.

Medical Students

Verbal consent must be obtained from the patient to have a medical student or other observer present during a physical/vaginal examination. This verbal consent must be documented in the notes to the effect of "*Vaginal*

examination with medical student (Name) present, verbal consent gained from patient for student to be present".

Please refer to Sections 2.6 and 2.7 on pages 14-15 of the Informed Consent Policy.

If you have any questions please discuss this with your supervisor.

Early Pregnancy Clinic (EPC)

For a quick link to all EPC policies and patient information go to "CeDSS" on the Intranet Homepage then click on "Women's Health" on the left side of the screen then click on "Early Pregnancy Clinic" under Gynaecology on the left side of the screen

This is held every afternoon at 1pm in the Gynaecology Outpatients Clinic past Orthopaedic Clinic on the Ground floor at North Shore Hospital.

Referrals

Early Pregnancy Clinic (EPC) sees externally referred women up to 19+6 weeks gestation with a *confirmed pregnancy loss* on ultrasound scan. EPC will take internal referrals for women up to 13+6 weeks gestation who are experiencing problems such as bleeding and/or pain or who have had a confirmed pregnancy loss on ultrasound scan, who have been seen in ECC or on the ward and who require follow up.

Non-pregnant women are not seen and women greater than 14 weeks gestation seen in ECC experiencing pregnancy problems should be referred to back their LMC to arrange follow up or to the non-urgent ante-natal clinic at North Shore or Waitakere Hospitals when LMC assessment is not possible.

Women requiring assessment of recurrent miscarriage (3 consecutive pregnancy losses) should be referred to Auckland District Health Board's Recurrent Pregnancy Loss clinic (RPLC) at Greenlane Clinical Centre. There are referral packs available in EPC which include all the blood tests which must be

completed by the woman and her partner prior to assessment at RPLC. See the end of this section for referral information.

The Nurse Specialist for the Early Pregnancy Clinic is Susan Rae. She works on Mondays, Wednesdays and Fridays. Susan is always happy to answer any questions you may have. You can contact her via her email Susan.Rae@waitematadhb.govt.nz or on 021 243 9729.

To book a patient seen in ECC or on the ward into the clinic or for phone follow-up by the Nurse Specialist you need to complete a yellow referral form and fax it to Early Pregnancy Clinic on fax 2320. If you have any questions regarding a referral please contact the Early Pregnancy Clinic phone on 021 243 9729. This phone is on between Monday – Friday from 9am – 4.00pm and is answered by Susan on the days she works or by a Staff Nurse from Outpatients on Tuesdays and Thursdays. All referrals are triaged by the Early pregnancy clinic nurse on the day the referral is received.

RCOG diagnostic criteria for a Missed Miscarriage/Early Pregnancy Failure

- Gestational sac with no fetus and mean sac diameter ≥25mm (anembryonic pregnancy/afetal sac/blighted ovum)
- Fetus present but no cardiac activity and mean sac diameter ≥25mm and crown rump length ≥7mm (missed miscarriage)
- Poor or absent growth over 1 week

Process for seeing a patient in EPC

1. Introduce self to patient
2. Ask patient what their understanding of the reason for their referral is?
3. Fill in the EPC Assessment Form (NB: ensure USS findings, BHCG & Blood group are clearly visible on this form)
4. Assess that the patient meets definition of early pregnancy failure
5. Discuss and confirm the diagnosis with the Registrar
6. Brief gesture/expression of empathy/sympathy
7. Discuss miscarriage/ almost certainly the woman has not caused this / >50% caused by random genetic event
8. Discuss the treatment options with patient
9. Give patient information leaflets about treatment options and miscarriage

10. Give the option of going away for a cup of coffee / home overnight to think about options and coming back later in pm / the next afternoon
11. Complete the consent form
12. Does the patient need Anti-D? If so, consent and chart same.
13. Does the patient have any questions that have not been answered during your consultation?
14. Notes to the nurse to arrange follow-up or treatment

Expectant and medical management of miscarriage

Refer to the WDHB "Miscarriage - Expectant Management" and "Miscarriage – Medical Management" policies.

The nurse will give the patient all the information they require for expectant and medical management.

It is important that the patient is discharged home aware of the following:

1. **Bleeding:** May be heavy for a period of time, peaking just prior to passage of products. Come into ED if changing pad >1hourly for >4 hours or if feeling lightheaded/dizzy/faint
2. **Pain:** Can be painful, but the pain should only last for a few hours. Peaks just prior to passage of products. May have some period-like abdominal cramps for 2-4 days after passing products. Take regular pain relief and come into ED is pain not controlled by analgesia
3. **May see products of conception. S**ome find this upsetting and some find this comforting/helpful.
4. **Where possible, products of conception should go to laboratory to rule out Molar Pregnancy**
5. **Bleeding may last for 10-14 days post passage of products**
6. **The EPC phone number r- 021 243 9729**

Surgical management of miscarriage - Evacuation

Refer to the WDHB "Miscarriage - Surgical management" policy.

Your discussion with the patient needs to include the risks of an Evacuation (bleeding, infection, anaesthetic risks and perforation amongst others) and that it is done under GA. You do not have to consent the patient but they need all this information to be able to make an informed decision.

When booking for an Evacuation there are 2 forms (a consent form and a drug chart) to be completed and write notes on clinical note paper attached to this form, and chart the Misoprostol (400mcg orally prior to procedure). They will then see the nurse who will do a height/weight/BP and give them all the

information they will require regarding where and when to attend and fasting instructions.

Other things followed in Early Pregnancy Clinic:

Molar pregnancy

Molar Pregnancies are followed up by the Nurse Specialist in EPC. She consults with the Dr Vijay Bhoola if she has concerns and refers to ADHB for follow up if necessary.

Pregnancy of unknown location

Refer to the WDHB "Pregnancy of unknown location" policy on the intranet.

Ectopic pregnancy

Refer to the WDHB "Ectopic Pregnancy" policy on the intranet.

Post TOP problems

Usually ongoing bleeding and/or pain. You will need to check for RPOC on USS and treat for Endometritis with oral antibiotics.

You may need to admit patients from Early Pregnancy Clinic to ECC for further assessment ie: a MTX ectopic follow up with pain or a woman with RPOC who is unwell with fever or pain/heavy bleeding for IV AB's. Discuss these women with the on-call registrar first.

There is usually a Registrar allocated to the clinic. Occasionally due to sickness etc there may be no Registrar. Susan Rae will help on the days she is present. If she is not at the clinic and you have queries then ring the on call Gynaecology Registrar or the on-call Consultant.

Early Pregnancy Clinic USS

There are 3 dedicated USS slots every week day – one at 11.30 and two at 1300 hrs. There is an USS appointment book in EPC. If your patient requires a f/up scan please fax a yellow internal referral form with a history and the date the scan is required. Follow instructions below for e-requesting an USS. The EPC nurse will ring patient and arrange date and time. Please tell you patient every care will be taken to book the scan at the requested date but that due

to triaging requirements and limited scan appointments this may not be possible.

To request an USS -follow these instructions:
There is a very particular way to request these ultrasounds. Select "inpatient" then "North Shore Hospital" then "ultrasound" then "specify date" then select today's date (even though the USS is not going to be today) then under the heading "Exam Suggested" you will need to write Pelvic USS -EPL CLINIC at (time) and (date) *this is really important to get correct or the scanning department will not receive the request*.

Recurrent Pregnancy Loss Clinic at ADHB

The referral criteria are as follows:

- Three (3) consecutive first trimester pregnancy losses
- Two (2) consecutive second trimester pregnancy losses
- Maternal age of younger than 40 years of age (at date of referral)
- Resident in Auckland, Counties-Manukau, Waitemata DHBs

NB – Pregnancy loss includes miscarriage, ectopic pregnancy and molar pregnancy and termination of pregnancy for fetal abnormality (but not for maternal mental health grounds ie: social).

The following tests are required:

- Maternal and paternal peripheral blood karyotyping
- Maternal Antenatal screen including Hep B, Hep C and HIV
- Lupus Anticoagulant Screen
- Anticardiolipin antibodies (IgG and IgM)
- APC Resistance and Prothrombin Ratio
- Thyroid Stimulating Hormone
- Day 2 or 3 FSH and Oestradiol level (please give this test on a separate form)

Please include a brief obstetric history on your referral as well as contact details, GP details and partners name and DOB. Please fax your referral to 631 0728. Once all the results have been received by RPLC they will make an appointment for the patient to be seen at the clinic. There is usually a 2-3 month waiting list for an appointment.

Anti-D immunoglobulin for Rh negative (-ve)

Rh-ve women require antenatal Anti-D within 72-hours of any of the following sensitising events in pregnancy:

- Vaginal bleeding
- Threatened miscarriage
- Spontaneous miscarriage
- Abdominal trauma

Need to get consent from patient on regular blood consent form.

There is a pamphlet in Early Pregnancy and in cubicles to give to the patient. Read it yourself so you can explain it properly.

PLEASE NOTE: new dose of Anti D for Miscarriage is now recommended for women who need anti-D prophylaxis – First trimester miscarriages for singleton pregnancies should received 250IU Rh(D), first trimester multiples pregnancies and all pregnancies beyond 12 weeks requiring Anti D prophylaxis get the standard 625 IU dose. Please specify lower dose on Anti D request to blood bank

Advising GPs about how to give Anti-D in the community

For GPs ringing about rhesus negative patient requiring Anti-D, there is a simple process you can follow to give women Anti-D in the community:

1. Fax a prescription for Anti-D 250iu to the Blood Bank either at North Shore or Waitakere Hospital.
   - The North Shore Hospital Blood Bank fax number is 486 8921.
   - The Waitakere Hospital Blood Bank fax number is 837 8855.

2. Give the woman the original prescription to take with them to collect the Anti-D from the appropriate blood bank. They can do this between 8am and 8pm, seven days a week. Hospital volunteers located in the main hospital reception area can direct the woman to the blood bank when they arrive.

- The North Shore Blood Bank is on Level 1.
- The Waitakere Hospital Blood Bank is on the lower ground floor, however women should present to the reception desk inside the main hospital entrance.

3. The woman will be issued with Anti-D to bring back to your rooms for administration.

4. The woman must wait for 20 minutes after the injection to observe for signs and symptoms of reaction. These are listed on the medication information sheet inside the Anti-D package.

Management of Typical ECC Presentations

Introduction

Gynae examination

This should be done on nearly everyone coming into ECC. Verbal consent must always be obtained prior to examination. *SHO's and Registrars can do Gynae examinations but trainee Interns and medical students must always be supervised*. Always ask a nurse to chaperone you.

All the equipment (speculum, light source, gloves, swabs, sponge forceps etc) are in the gynae trolleys. One at North end of Acutes, and one in Cubicles. Swabs – pink is endocervical for Chlamydia, purple is high vaginal for gonorrhoea and bacterial vaginosis. Red (with liquid growth medium) for viral herpes which is rarely done. There is a plain red swab – do not use this one.

General Gynae USS

- Out of hours requests for an USS for a Gynae inpatient (e.g. someone coming via ECC) – will not be done except in an emergency (may need Registrar to speak to them if you really want/need the scan).
-
- Non-urgent USS may wait several days.
- Outpatient USS (e.g. follow up 6-8 week USS) but please be aware that the real waiting list time for these scans is up to 13 weeks. They are done a little bit faster in Waitakere, so if you have a patient who lives out west you should consider requesting a Waitakere USS.

Miscarriage

Minimal PVB and no pain + closed Os →USS

Heavy PVB + open Os → confirm no fetal heart by formal USS before offering surgical/medical management

Heavy PVB + closed Os → USS

An expression of sympathy is important to recognise their loss. *"I'm sorry this has happened for you"*. Try to avoid use of words like 'foetus'.

Patient information regarding miscarriage

- Miscarriage is very common. 1:4 or 1:5 (20%) of all 'known' pregnancies miscarry, and maybe as many as up to 50% biochemical pregnancies.
- In the first trimester most miscarriages are due to "non-heritable" chromosomal abnormalities and were never going to progress normally. It can cause a lot of misunderstanding and concern to tell people they had a chromosomally abnormal pregnancy so the best way to explain this is to say that something did not work out right when the egg and the sperm got together and this is nature's way of sorting it out.
- Always ensure the woman is told that it is not their fault and they did nothing to cause this to happen and that there was also nothing that we could have done to prevent it.
- One miscarriage does not put them any more at risk of another miscarriage, most women who have one miscarriage go on to have a normal pregnancy after that.
- If they want to try again they should wait for a minimum of 1 normal period and that it may take 3 months for their periods to normalise after a pregnancy loss.
- Check rhesus status and give anti D if Rh negative.
- Give the miscarriage information pamphlet and point out the miscarriage support phone numbers. Explain that they and their family will feel sad about their loss- this is normal but if they think they are having trouble coping there is a miscarriage support group that can be helpful.

Types of Miscarriage

Threatened Miscarriage

Small amount of PV bleeding, Os closed, Live IUP (IUP = intrauterine pregnancy) on USS. Sometimes a portable USS can be done in ED for this. If the portable scan shows a live IUP discharge to GP/LMC to arrange a formal USS in community. Advise to return if bleeding increases or continues, 20% of pregnancies carried to term have some PV bleeding 1st trimester.

If a portable USS is not performed or doesn't show a live IUP the woman will require an Early Pregnancy Clinic USS booked if they didn't have a formal USS in ECC to check for viability and/or sub chorionic haemorrhage.

Inevitable Miscarriage

PV bleeding, open os, and no viable pregnancy on USS

If heavy bleeding or pain for evacuation on the acute list. Give Syntocinon infusion if the bleeding is heavy -30 units in 500ml of Normal Saline at 100-125mls/hr. If hosing, then give 1 ampoule of Syntometrine IM. Chart on both the fluid and drug chart.

If moderate bleeding book for USS at next available slot and keep in hospital overnight.

Incomplete Miscarriage

Retained products of conception (RPOC) confirmed on USS

- RPOC >2.5cm – book for Evacuation.
- RPOC <2.5cm + asymptomatic (ie not heavily bleeding) → expectant management with oral antibiotics with Early Pregnancy Clinic for review with repeat USS in a weeks time. Can use medical management (Misoprostol) if patient doesn't want Evacuation. *Refer to the WDHB "Miscarriage - Medical Management" policy.*

Missed Miscarriage/Non viable pregnancy/Early Pregnancy Failure

Intrauterine gestational sac with fetal pole but no fetal cardiac activity or no growth from previous scan > 7 days ago. Also includes anembryonic

pregnancy (previously called a 'blighted ovum') which is a sac with no fetal pole. Should be able to see cardiac activity at 5-6 weeks with a CRL (crown-rump length) of 5-7mm, if no activity seen on two USS 1-2 weeks apart, or >7mm CRL then this is confirmed missed miscarriage. Should also see fetal pole and cardiac activity with a gestational sac >20mm. Bhcg is useful for miscarriages but doesn't always fall – the placental tissue makes the Bhcg so even if there is a missed miscarriage it may still rise, but usually doesn't double like a normal pregnancy (in most cases the Bhcg will double every 48 hours but the lower end of the normal rise is 60% over 48 hours).

Complete Miscarriage

Products of conception (POC) passed, Os closed again. Patient can be discharged home if the bleeding has settled with GP/LMC followup to ensure decreasing symptoms (bleeding or pain).

Management of Miscarriage

1. Expectant/Conservative – Let the body pass the tissue itself. If missed miscarriage with no bleeding this is safe to do for up to four weeks (antibiotics not required) before review in EPC is required, with weekly phone follow up by EPC. If POCs not passed by 4 weeks consider Evacuation. If the patient is bleeding and wants expectant/conservative management, advise that it might take up to 10-14 days to completely resolve. *Refer to the "Miscarriage – Expectant Management" policy on the intranet.*
2. Medical – Misoprostol is given to help pass the products. This has just recently started to be offered in the EPC and is now done as an outpatient. *Refer to the "Miscarriage – Medical Management" policy on the intranet*.
3. Surgical – Evacuation. *NOTE: You cannot book Elective Evacuation from ECC they must go through Early Pregnancy Clinic. Refer to the "Miscarriage – Surgical Management" policy on the intranet*

Misoprostol

Misoprostol must be charted by a Registrar and must be co-signed by a second Registrar and only given to patients with an USS confirmed non viable pregnancy / miscarriage.

For subsequent doses only one Registrar signature is required. Ie: If medical management of miscarriage fails the first dose and the patient requires either a second dose or opts to have an Evacuation

Pregnancy of Unknown location

Refer to the "PUL" Policy on the Intranet

Ectopic Pregnancy

Refer to the "Ectopic Pregnancy" Policy on the Intranet

Diagnosis

Positive Bhcg / empty uterus +/-adnexal mass or free fluid +/- Bhcg not doubling as expected. Classic triad – missed period – pain – PV bleed. Should be able to see a gestational sac if Bhcg >2000 on TV USS.

Surgical Management

First line of treatment in a proven ectopic pregnancy is surgery.

If unstable, needs laparotomy and if stable, then for laparoscopy. However, only in well-selected cases sometimes another treatment plan might be chosen.

Conservative management of ectopic

For tubal abortions or a pregnancy of unknown location with falling Bhcg and pain which has settled, Bhcg must be <1000 needs weekly follow up in Early Pregnancy Clinic until Bhcg <5.

Medical management of ectopic

For stable ectopics with Bhcg <3000 Needs Consultant approval. Need to discuss all side effects (see below), risks (including risk of rupture and surgery),

and follow up (requires regular bloods tests and attendance at clinics). Also should not get pregnant for 3 months. If there are social concerns or concerns about patient reliability or they want to try and conceive again sooner then not for MTX. *Refer to the Ectopic Pregnancy Policy on the Intranet.*

Methotrexate (MTX)

Single IM injection into the buttock. Need to chart on a special Cytotoxic Drug Form. This must be administered by either the EPC CNS or, by yourself or the Registrar. It's really hard to get anyone to give it on the weekend or after hours in ECC. *Don't give it if you are pregnant or want to become pregnant in the next 3 months.*

Before giving MTX:

- There is a Methotrexate Checklist in the EPC which can be affixed in the patient notes and is useful in ensuring all points have been covered.
- You need written informed consent, and must discuss alternative management options to the patient.
- Ensure patient has a patient information handout on Ectopic Pregnancy and Methotrexate. These are available in the Ectopic Pregnancy Folder in the Gynae trolley's in ECC.
- Patient needs to be reliable for and aware of the importance of follow up and have a current home and mobile number they can be contacted on.
- Patient must be aware of all the side effects (read up on these yourself, basically MTX kills all rapidly dividing cells in the body so can cause nausea, irritation of bowel lining, skin, urinary tract, etc). Most common side effecting for MTX for ectopic is nausea and occasionally mouth ulcers,
- Patient needs to be aware of the risk of rupture exists until bhcg = <5 and to come immediately to EDif they have pain or symptoms suggestive of rupture (shoulder tip diaphragmatic or rectal pain, dizziness etc) and possibility of need for surgery in this circumstance.

- Patient should not have sexual intercourse until bhcg <5 due to the risk of rupture.
- Patient needs to be aware that she should avoid getting pregnant for 3 months and why, and that she cannot take folic acid again until Bhcg is <5.
- There are a set of MTX guidelines in Cubicles, the Gynae Trolley and Early Pregnancy Clinic (and online). There are also instructions on how to administer it online.
- Dose: 50mg/m2 of body surface area Surface Body Area:

$$\text{Body Surface Area } (m^2) = \sqrt{\frac{\text{Actual Body Weight (kg) x Height (cm)}}{3600}}$$

Afterwards:

Follow up in Early Pregnancy Clinic (all info is there).

- Day 4 repeat Bhcg, expect it may go up slightly.
- Day 7 repeat Bhcg, LFTs and FBC, expect Bhcg to drop by at least 15% between day 4 and day 7. If not consider a second dose of methotrexate or laparoscopy.
- Need to follow the Bhcg until <5 (by phone weekly after initial review in Clinic).
- Pain may be the tube expelling the pregnancy sac, but remember that there is still a risk of rupture.

Hyperemesis

Follow hyperemesis guideline on the intranet

Basic examination – don't need to do PV unless there is a particular indication. Weight (current and pre pregnancy) and level of dehydration are the most important indicators.

While treating for hyperemesis, need to exclude other causes of vomiting e.g. UTI, appendicitis etc.

Ask whether they have had an USS to confirm single, normal pregnancy (not multiple or molar) – if they haven't had an USS then order one (non-urgent).

Check MSU and urine for Ketones.

Replace fluids – 1000mls normal saline over 30minutes, then review and adjust to include potassium as required by electrolyte results, up to 4 litres in 24 hours.

Oral supplements: Pyridoxine (Vitamin B6) 25mgs orally 8 hourly and Thiamine (Vitamin B1) 100mgs daily, and routine pregnancy supplements: Folic acid 5mg daily, and Iodine 150mcg daily if tolerated.

Anti-emetics:

1st Line: Metoclopramide 10mg IV 8hourly and Cyclizine 25-50mg IV 8hrly or

2nd Line: Prochloperazine (Rectal dose 25mg, followed by 20mg oral 6 hours later if required, or Oral dose 20mg initially, then 10mg two hours later. Prevention dose is 5-10mg orally 2-3 times a day) or

3rd Line: Ondansetron 4mg IV 6hourly (only with senior clinician advice)

Reflux: Chart Ranitidine 150MG PO OD or 50MG IV BD. TDS if they have reflux symptoms. Give it to everyone, it helps.

Refer to dietician fax x3940 (usually Angie sees the patients on Maternity Ward). Weight is essential for the dieticians. A significant weight loss (>5-10kg) need to think about alternative forms of feeding such as NG/NJ (NGs are fine bore and placed without CXR check for placement, NJs are placed endoscopically by Gastro and are a bit of a hassle, only done if NGs fail x3, TPN is last resort and considered usually in 2nd trimester with ongoing weight loss).

Plan (is usually):

- IV fluids and anti-emetics
- Review dehydration and response to initial treatment
- May go home to care of GP or LMC if well hydrated and responding to anti-emetics
- Admit to maternity if vomiting intractable and >10% weight loss
- Discharge once the patient is eating and drinking.

Listeriosis

If patient has a temperature and nausea and vomiting +/-diarrhoea, and you suspect listeriosis, do a rectal swab and blood cultures requesting listeria culture for both.

Treat with **Amoxycillin.**

Abnormal Uterine Bleeding

Happens throughout the reproductive life-span of women but occurs more often after menarche, around the menopause, while breastfeeding, in women diagnosed with PCOS or who are obese. If the menstrual cycle is irregular the most likely cause is not ovulating. Can present with with massive menorrhagia lasting for weeks at a time. This is because the endometrium keeps thickening up under the influence of oestrogen, but because there's no ovulation, there is no corpus luteum to secrete progesterone to maintain the endometrium and then to cause a period when the corpus luteum degenerates. So the endometrium gets thicker and thicker until it eventually spontaneously breaks down with a big gush.

- Check Beta HCG (to exclude pregnancy),Hb, Group and Hold and Iron studies
- Examine abdomen, speculum, PV exam, signs of PCOS

- They may need a transfusion or Ferrogradumet (or iron infusion as outpatient if cannot tolerate oral iron, is done through Ambulatory Day Stay). In O&G, we only transfusion when Hb is <75 or symptomatic.

Short-term management

- Tranexamic acid (Cyclokapron) 1g PO QID while bleeding (only for 3-4 days at a time).
- Norethisterone (NET) to stop bleeding: use high doses – start with 20 mg stat then 5 mg tds until bleeding settles or max dose 80 mg reached. Once bleeding has settled continu Norethisterone 5 mg tds for at least 10 days, preferably 20 days to allow Hb to recover etc. It is important to explain that once they stop the tablets they will get a withdrawal bleed one or two days later. Patient may require an Outpatient Gynae clinic appointment and an USS at some point.
- Provera (medroxyprogesterone acetate) is a mild progesterone and is good for getting regular cycle control (10 mg a day for two weeks of every month).

Management of Sexually Transmitted Infections

Chlamydia

Testing in females

- A cervical swab if undertaking a speculum examination (symptoms or clinical scenario dictates).
- Self-collected vaginal swab if asymptomatic, examination declined and no other tests required.
- **Note:** A first catch urine has lower sensitivity in females than cervical or vaginal swabs.

Treatment

- Azithromycin 1g stat – pregnancy category B1.
- **OR** doxycycline 100mg twice daily for 7 days **(NOT in pregnancy).**
- **OR** amoxicillin 500mg 3 times daily for 7 days – alternative in pregnancy.

Advise to use condoms or abstain from sex for 7 days after initiation of treatment or until 7 days after all sexual contacts have been treated.

Partner Notification

- Be clear about language: 'partner' implies relationship – all sexual contacts in the last 2 months should be advised so they can have a sexual health check and treatment.
- Contact(s) should have a sexual health check and if asymptomatic treat empirically for chlamydia with azithromycin 1g stat.
- Contacts should be treated without waiting for their test results; if positive, then refer to specific guideline.
- Most choose to tell contacts themselves, giving written information is helpful.
- Notifying all contacts may not be possible e.g. if there insufficient information or a threat of violence.

Follow Up

- By phone or in person, 1 week later.
- No unprotected sex in the week post treatment?

- Completed/tolerated medication?
- Notifiable contacts informed?
- Any risk of re-infection?
- Test of cure only needed if pregnant or if a second line treatment has been used.
- Diagnostic tests can detect traces of dead organisms – wait at least 5 weeks before retesting.
- Re-infection is very common; offer repeat sexual health check in 3 months.

Reference: *Sexually Transmitted Infections Summary of Guidelines 2013 Published by the New Zealand Sexual Health Society*

Gonorrhoea

Testing in females

A cervical swab if undertaking a speculum examination (culture/NAAT) or a self-taken vaginal swab if asymptomatic (or examination declined) and no other tests required (NAAT testing only).

Treatment

- **If antimicrobial susceptibilities not available or Ciprofloxacin resistant or pregnant or breastfeeding**: Ceftriaxone 500mg im stat (make up with 2ml lignocaine 1% or as per data sheet) PLUS azithromycin 1g stat (both drugs category B1).
- **If isolate is Ciprofloxacin sensitive:** Ciprofloxacin 500mg po stat PLUS azithromycin 1g stat.
- If clinical PID, treat as per PID guideline.

Advise to abstain from sex until abdominal pain has settled and to abstain or use condoms until 7 days after all sexual contacts have been treated.

Partner Notification

- Be clear about language: 'partner' implies relationship – all sexual contacts in the last 2 months should be advised so they can be tested and treated.

- Contact(s) should have a sexual health check and if asymptomatic treat empirically for gonorrhoea with ceftriaxone 500mg im stat (make up with 2ml lignocaine 1% or as per data sheet).
- Contacts should be treated without waiting for their test results
- Most choose to tell contacts themselves; giving written information is helpful.
- Notifying all contacts may not be possible, e.g. if there is insufficient information or a threat of violence.

Follow Up

- By phone or in person, 1 week later.
- No unprotected sex for 1 week post treatment?
- Completed/tolerated medication?
- All notifiable contacts informed?
- Any risk of re-infection? Re-treatment necessary if re-exposed to untreated contact.
- Test of cure is only needed if symptoms don't resolve. Re-test by culture in 3 days.
- Re-infection is very common; offer repeat sexual health check in 3 months.

Reference: *Sexually Transmitted Infections Summary of Guidelines 2013 Published by the New Zealand Sexual Health Society*

Management of Pelvic Inflammatory Disease

Testing in females

- Endocervical swab for chlamydia and gonorrhoea
- High vaginal swab for bacterial vaginosis and trichomoniasis.
- Bimanual examination.
- Urine pregnancy test or beta HCG and urinalysis dipstick.
- Serology for HIV and syphilis.
- Full blood count (FBC) and C-reactive protein (CRP) (*for severe cases or diagnostic uncertainty*).
- Vital signs: Temperature, pulse, blood pressure.

Treatment

- **Ceftriaxone 500mg** im stat (make up with 2ml lignocaine 1% or as per data sheet) PLUS
- **Doxycycline 100mg** twice daily for 2 weeks PLUS
- **Metronidazole 400mg** twice daily for 2 weeks. *(Metronidazole may be discontinued at review if not tolerated.)*
- Advise treatment may take time to work.
- Advise to abstain from sex until abdominal pain has settled and to use condoms until 7 days after all sexual contacts have been treated.

Partner Notification

- Be clear about language: 'partner' implies relationship – all sexual contacts in the last 2 months should be advised so they can have a sexual health check and treatment.
- Contact(s) should have a sexual health check and if asymptomatic treat empirically for chlamydia with azithromycin 1g stat.
- Contacts should be treated without waiting for their test results; if positive, then refer to specific guideline.
- Most choose to tell contacts themselves. Giving written information is helpful.
- Notifying all contacts may not be possible, e.g. if there is insufficient information or a threat of violence.

Follow Up

72 HOUR FOLLOW-UP FOR MODERATE /SEVERE PID

- Repeat bimanual exam to assess resolution of signs and refer if not improved.
- No unprotected sex?
- Tolerated medication?
- Notifiable contacts informed?
- Any risk of reinfection? Will need further treatment if re-exposed to untreated contact.

1 TO 2 WEEK FOLLOW-UP FOR MILD PID (PHONE OR IN PERSON)

- As above – bimanual where practical or where symptoms not improved.
- Re-infection is common; offer repeat STI check in 3-6 months.

Reference: *Sexually Transmitted Infections Summary of Guidelines 2013 Published by the New Zealand Sexual Health Society*

Tubo-ovarian abscess

This is an inflammatory mass involving the fallopian tube, ovary and occasionally the adjacent organs (ie Bowel). Usually presents in word of reproductive age and usually as a consequence of upper genital tract infection.

Treatment of acute presentation is with broad spectrum antibiotics. Sometime surgical management or interventional radiological drainage will be required.

Once IV antibiotics have improved symptoms and patient is afebrile long courses (6 weeks) of oral antibiotics are often needed on discharge. Interval surgery is the definitive treatment if long courses of oral antibiotics are insufficient.

Management of Typical Ward Cases

Total Abdominal Hysterectomy (TAH)

Normal post-op cares

- Eating D1 usually
- IDC out when mobile (D1-2)
- TEDS +/-Clexane (will be in op note)
- Discharge D5, D4 if doing well, and D3 if the Consultant says so
- GOPC 6/52
- Discharge advice: no heavy lifting 6/52, no driving 4/52, no sexual intercourse 6/52, no tampons/baths/swimming pools/ spas for 10/7or until bleeding stopped. Explain that many have a small vault haematoma which discharges spontaneously 10 to 14 days after surgery)

Vaginal Hysterectomy

- Pack and IDC out D1,
- Discharge D3
- GOPC 6/52,
- Discharge advice: no heavy lifting 6/52, no driving 2/52, no sexual intercourse 6/52, no tampons/baths/swimming pools/ spas for 10/7or until bleeding stopped. Explain expect a heavy PV bleed loss day 10-14 (explain that many have a small vault haematoma which discharges spontaneously 10 to 14 days after surgery)

LSCS Patient

Daily ward round: ask about pain, nausea/vomiting, passed flatus yet, amount of lochia, passed urine (if IDC already out)

O/E: Temperature, Abdo – Soft nontender, fundal height relative to the umbilicus, uterus contracted, Wound – Amount of ooze on the dressing, Calves – Soft, nontender Urine output PV loss

Plan – if no problems:

- Remove IDC (D1)
- Eat and drink

- Oral analgesia (pain team will stop PCA)
- Mobilise
- Transfer to LMC care (need to put the stamp in the clinical notes and sign it)

Uro-Gynae Surgery

Prolapse repair (Native tissue)

Plan – if no problems:

- Eat and drink
- Oral analgesia (pain team will stop PCA)
- Mobilise
- Vaginal pack and IDC out on day 1

Prolapse repair (Mesh repair)

Plan – if no problems:

- Eat and drink
- Oral analgesia (pain team will stop PCA)
- Mobilise
- Vaginal pack and IDC out on day 1
- ***Need post void residuals (PVRs). Aim for 2 PVRs <200 mls***

TOT (Trans Obturator Tape)

Plan – if no problems:

- Eat and drink
- Oral analgesia (pain team will stop PCA)
- Mobilise
- Vaginal pack and IDC out on day 1.

Antimicrobial Prophylaxis in Surgery

Procedure	Antimicrobial	Duration	Alternative for patients with beta-lactam allergy
Caesarean Section	Cefazolin	Single dose - administer within 60 minutes prior to incision	Clindamycin OR Vancomycin PLUS Gentamicin
Hysterectomy +/- Bilateral Salpingo-oophorectomy	Cefazolin AND Metronidazole	Single dose Single dose	Clindamycin PLUS Gentamicin
Urogynaecology Procedures	Cefazolin (Need for prophylaxis should be reviewed on an individual basis, according to the invasiveness of the specific procedure)	Single dose	Vancomycin OR Clindamycin PLUS Gentamicin
Trans-cervical surgery (including hysteroscopic surgery, loop excision, hysterosalpingogram, IUD insertion), endometrial biopsy and induced abortion/dilation and evacuation, exploratory or diagnostic laparotomy.	Prophylaxis not routinely indicated		
There is an existing protocol for Group B Streptococcal Prophylaxis During Labour			

Anaerobic cover with metronidazole may be required in selected high risk patients/procedures, e.g. patients with bowel adhesions, history of PID

Please refer to the WDHB policy Antimicrobial Prophylaxis in General Surgery for more detailed information.

Referral of patients to Gynae-Oncology MDM at ADHB

The following minimum set of investigations must be completed prior to referral:

Carcinoma of the vulva	Biopsy result: CT abdomen and pelvis: CXR:
Carcinoma of the Vagina	Biopsy result: CT abdomen and pelvis: CXR:
Carcinoma of the cervix	Biopsy result: UECS < Renal Function, FBC: CXR:
Endometrial Carcinoma	Histology (pipelle or curettings): MRI pelvis and abdomen: CXR:
Pelvic Mass	RMI (risk of malignancy index) score: Abdominal pelvic imaging (CT or MRI): CA125, CEA: If age < 40 AFP, HCG: UEC, LFT, albumin:

Cervical Screening

Management of Women with normal cervical smears

If the cervical smear report is negative for squamous or glandular epithelial lesion or malignancy then recall for cervical smear in 3 years ***unless*** it was their first smear, or more than 5 years have elapsed since the previous smear, in which case you recall for cervical smear in 12 months.

Management of Women with unsatisfactory cervical smears

If the cervical smear report is unsatisfactory, repeat the cervical smear within 3 months. If the patient has had 3 consecutive unsatisfactory smear reports, refer for Colposcopy.

Management of Women with ASC-US and LSIL (Low-grade Squamous Abnormalities)

Women aged 20 – 69 years with an abnormal smear report within the last 5 years -Refer to Colposcopy.

Women aged 20 – 29 years with no abnormal smear reports within the last 5 years- Repeat cervical smear in 12 months.

Women aged 30 years and over who have an ASCUS and LSIL smear will have automatic reflex Hr HPV typing performed by the laboratory

1. If the reflex HrHPV test is negative, repeat cytology in 12 months. If the repeat cytology is negative, return to normal screening.
2. if the HrHPV test is positive, refer to Colposcopy.

12-month repeat smear report after ASC-US/LSIL

If the 12-month repeat smear is reported as:

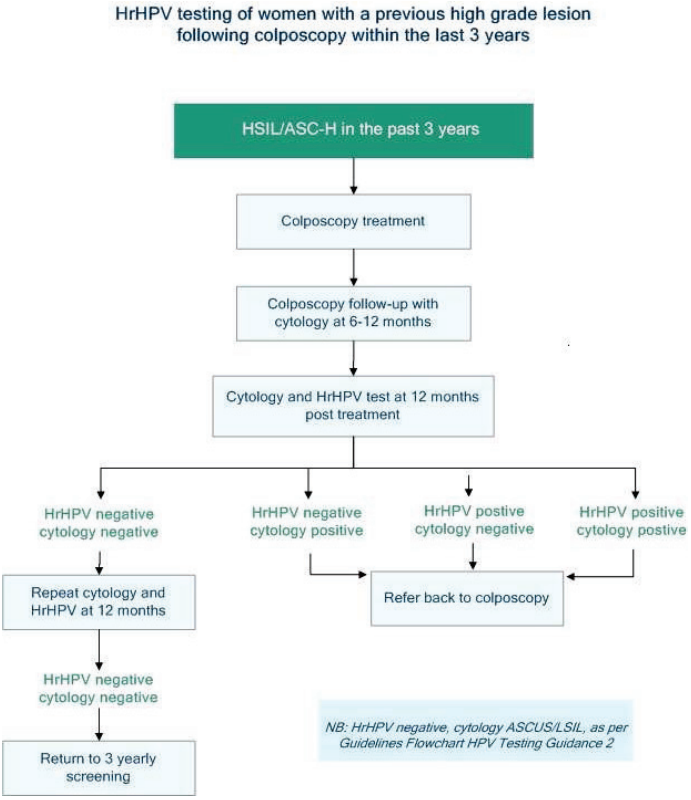
- HSIL or ASC-H, refer to Colposcopy
- ASC-US/LSIL, refer to Colposcopy
- negative, repeat the smear in 12 months (ie, 24 months after the index smear).

Management of Women with ASC-US and HSIL (High -grade Squamous Abnormalities)

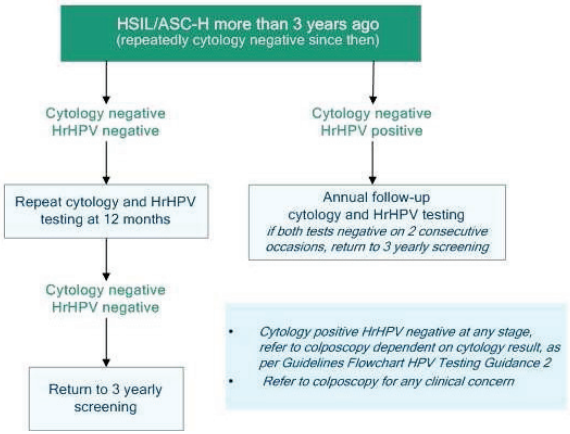
If the smear is reported as HSIL or ASC-H, the patient should be referred for Colposcopy

Reference: *Guidelines for Cervical Screening 2008 Published by National Cervical Screening Programme 2008*

HrHPV Testing



HrHPV testing of women with a high grade lesion more than 3 years previously, with subsequent repeated negative cytology tests (historical testing)



Please refer to the Guidelines for Cervical Screening in Gynaecology Outpatients & Colposcopy Clinics for further information.

Reference: *Guidelines for Cervical Screening 2008 Published by National Cervical Screening Programme 2008*

Screening in Pregnancy

Ante-natal & HIV screening

All women with ongoing pregnancies should have 1st antenatal bloods performed. These include blood group and antibody screening, HIV, Hep B antigen status, syphyllis, and rubella screening.

HIV screening is now offered to all women as part of routine antenatal care. Translated versions of the information leaflet are available on the National screening unit website: *http://nsu.govt.nz/Current-NSU-Programmes/1319.asp*. Anna Saunders is the Midwife Co-ordinator-Screening and she will provide advice and support to you should your receive a positive or equivocal HIV test result. Anna.Saunders@WaitemataDHB.govt.nz ☐021 223 8400

Down Syndrome screening

First or second trimester screening is now available. For more information go to National screening unit: *www.nsu.govt.nz/current-nsu-programmes/2781.asp* New Zealand Down Syndrome Association: www.nzdsa.org.nz, 0800 693 724

Family Violence screening

Screening for family violence is a section 88 requirement, training is available. Contact Margaret Devlin, Family Violence Prevention Coordinator: Margaret.Devlin@WaitemataDHB.govt.nz, 09 486 8920 ext 6359. Any woman who screens positive can be referred to the Women's Health social worker for support and advice or the local support agencies below:

Waitakere ☐09 386 1987 or 027 492 9940 (24 hour Crisis)
North Shore ☐09 410 6736 or Rodney District ☐0800 321 361 (24hour Crisis)

Smoking support

All women must be screened for smoking; the ABC methodology should be used: **A**SK about smoking, **B**RIEF ADVICE about risks, and refer to **C**ESSATION support. Please refer women who smoke to the free smokefree pregnancy support service.

☐Smokefree Communities: 09 448 0013

Smokers must be informed that WDHB is a non-smoking site. Women can be prescribed nicotine patches during their stay if they are not able to stop smoking and suffer cravings.

There is free online education for you around asking women about smoking using the ABC approach: https://smokingcessationabc.org.nz/.

Maternal Mental Health

All women should be screened for mental health problems, including past history of psychiatric admission or antipsychotic medication – For queries or concerns contact Lorrie Bennett 09 488 4634 ext 3598. For acute mental health presentations contact the WDHB switchboard and ask for the CATT Crisis Team North or West.

Referral to secondary services

Anaesthetic Consultation referral

Referral should be made if a woman has:

- BMI >35 (at booking), or excessive weight gain in pregnancy
- concern related to epidural, spinal or general anaesthesia
- women who decline blood products
- any anaesthetic risk factors

The women should complete an **Anaesthetic Self Assessment form**; the LMC completes the top grey box, with EDD, height, weight, BMI, BP and reason for referral. Please send as soon as possible with Maternity Facility Booking Form to antenatal clinic for anaesthetic triage.

Diabetes in pregnancy referral

Clinics and support are available on both Waitakere and North Shore sites. LMCs remain the lead carer and the diabetes in pregnancy service provides the specialist services and works collaboratively with the LMC to manage the diabetes in pregnancy.

Complete a **yellow WDHB referral form** (or referral on letterhead) and fax to NSH – 09 489 0550 or WTH - 09 838 1737

Physiotherapy Consultation referral

Physiotherapists will review women with back or pelvic pain, dyastasis symphysis pubis, and other musculo-skeletal problems. They may be able to arrange TENS hire although this can be done directly at www.natalcarenz.co.nz. Postnatally they will see women who have had a third degree tear or substantial perineal damage. Fax a **yellow WDHB referral form** (or referral on letterhead) to antenatal clinic.

Dietician Consultation referral

Dieticians will see women with significant dietary restrictions; women with hyperemesis; weight loss; and morbid obesity. They will counsel women with allergies about appropriate infant formula if they are not planning to breastfeed. Referral on a **yellow referral form** (or referral on letterhead) to Faxed to NSH – 09 441 8940 or WTH - 09 837 8825

Social Work Consultation referral

Women's Health Social workers can provide advice and support about a range of problems arising out of pregnancy. They can also provide support and counselling for family violence or child protection issues. They provide bereavement counselling for termination and perinatal loss. Referral on a **yellow referral form** (or referral on letterhead) to antenatal clinic

Te Aka Ora Advisory forum – (vulnerable families) referral

Any person identifying a vulnerable family can refer to the forum for support and advice. Forums are held every Wednesday 10 - 12noon at either Waitakere or North Shore sites. Terms of reference explaining forum and referral criteria are on the intranet under controlled documents.

Fax a **yellow referral form** (or referral on letterhead) to Sue Fitzgerald – Midwife Manager – Community, Fax 09 837-6619 Waitakere or Fax 09 486-8928 North Shore.

Child protection concerns

If you have any child protection concerns, or are looking for additional advice and support contact the WDHB CYF Liaison on 029 650 1337.

Eligibility Team

If you have concerns regarding a patients eligibility for funded healthcare you can contact the Eligibility Team on Ext 8920.

Cultural support

Cultural and linguistic diversity training is available free to LMCs. WATIS (Waitemata Auckland Translation and Interpreting services) offer translation and interpreting services in hospital and in the community: ☐09 442 3211 or www.watis.org.nz/main/index.php

Maori support services on ☐09 486 8324 ext 2324 then send referrals by fax to 09 441 8971

Asian support services ☐09 488 4663 ext 2314 or 3863 (NSH) or 09 837 8831 ext 6831 (WTH) on line referral http://www.asianhealthservices.org.nz/

Pacific Island support services – please fax a **yellow referral form** (or referral on letterhead) to 09 8376619 Galuafi Lui 021 286 1686

Waitemata DHB – November 2013

Any amendments or alterations to Womens Health Administration