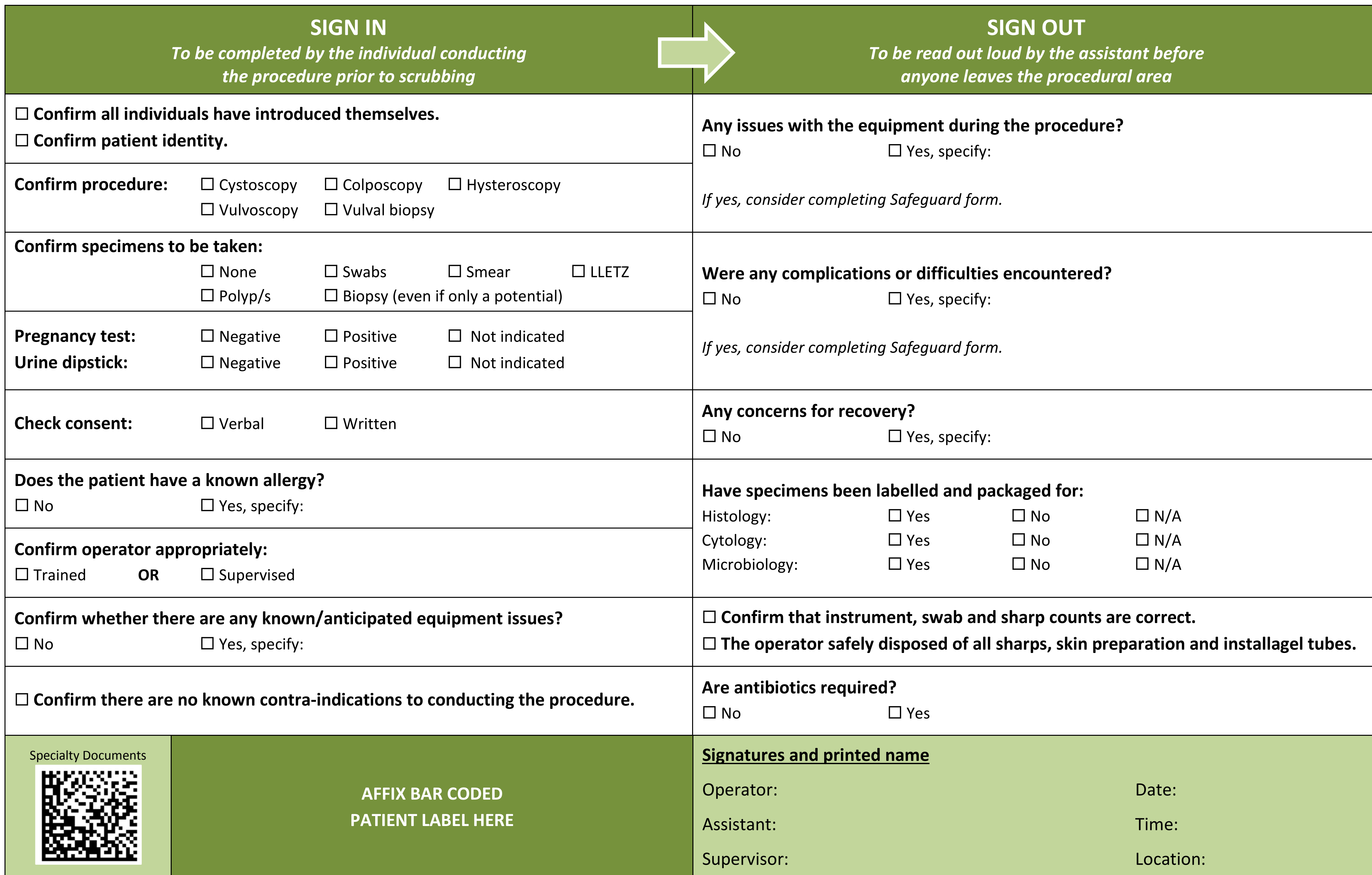
OUTPATIENT GYNAECOLOGY/UROLOGY ENDOSCOPY CHECKLIST



SIGN IN

To be completed by the individual conducting the procedure prior to scrubbing

☐ **Confirm all individuals have introduced themselves.**

☐ **Confirm patient identity.**

Confirm procedure: ☐ Cystoscopy ☐ Colposcopy ☐ Hysteroscopy ☐ Vulvoscopy ☐ Vulval biopsy

Confirm specimens to be taken:
☐ None ☐ Swabs ☐ Smear ☐ LLETZ
☐ Polyp/s ☐ Biopsy (even if only a potential)

Pregnancy test: ☐ Negative ☐ Positive ☐ Not indicated

Urine dipstick: ☐ Negative ☐ Positive ☐ Not indicated

Check consent: ☐ Verbal ☐ Written

Does the patient have a known allergy?
☐ No ☐ Yes, specify:

Confirm operator appropriately:
☐ Trained **OR** ☐ Supervised

Confirm whether there are any known/anticipated equipment issues?
☐ No ☐ Yes, specify:

☐ **Confirm there are no known contra-indications to conducting the procedure.**

Specialty Documents

AFFIX BAR CODED PATIENT LABEL HERE

SIGN OUT

To be read out loud by the assistant before anyone leaves the procedural area

Any issues with the equipment during the procedure?
☐ No ☐ Yes, specify:

If yes, consider completing Safeguard form.

Were any complications or difficulties encountered?
☐ No ☐ Yes, specify:

If yes, consider completing Safeguard form.

Any concerns for recovery?
☐ No ☐ Yes, specify:

Have specimens been labelled and packaged for:

Histology:	☐ Yes	☐ No	☐ N/A
Cytology:	☐ Yes	☐ No	☐ N/A
Microbiology:	☐ Yes	☐ No	☐ N/A

☐ **Confirm that instrument, swab and sharp counts are correct.**

☐ **The operator safely disposed of all sharps, skin preparation and installagel tubes.**

Are antibiotics required?
☐ No ☐ Yes

Signatures and printed name

Operator: Date:

Assistant: Time:

Supervisor: Location:

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This LocSSIP applies to all ambulatory gynaecological and urological endoscopy procedures undertaken in the outpatient setting. **Must-do procedural steps:**

1. To ensure compliance with best practice:
    a. CDDFT's Gynaecological and Urological Endoscopy procedural checklist must be used.
    b. The operator must dispose of all sharps before leaving the procedural area.

2. To eliminate the risk of losing or mis-labelling specimens:
    a. The procedure to be performed should be clearly stated at the Sign-In to all members of staff in order that the appropriate equipment and specimen sampling devices are ready and available during the procedure and the appropriate sample pots to hand.
    b. The specimens should be handed to the assistant and clearly stated, and immediately placed into the appropriate pot.
    c. The specimens should be checked, packaged into the appropriate forms, and signed for at the Sign-Out.

3. Cystoscopy:
    a. To reduce the risk of infection, the external urethra should be cleansed with either chlorhexidine or betadine.
    b. Lubrication should be used to aid with passing the cystoscope through the urethra, ideally with local anaesthetic gel (Instillagel). This is associated with reduced pain for the patient, and reduces the risk of trauma to the urethra.
    c. A variety of cystoscopes are available, but ideally a flexible cystoscope should be used in the ambulatory setting. This is associated with reduced pain for the patient.
    d. There is no evidence that antibiotic prophylaxis is necessary. This is therefore to the discretion of the operator.

4. Hysteroscopy (Associated guideline: RCOG Green-Top Guideline No 59 – Best Practice in Outpatient Hysteroscopy):
    a. The healthcare professional should have the necessary skills and expertise to carry out hysteroscopy.
    b. Routine use of opioid analgesia before hysteroscopy should be avoided as it may cause adverse effects.
    c. Women without contra-indications should be advised to take non-steroidal anti-inflammatory agents (NSAIDs) around 1 hour prior to their appointment slot, with the aim of reducing pain in the immediate post-operative period.
    d. Routine cervical preparation before outpatient hysteroscopy should not be used in the absence of any evidence of benefit in terms of reduction of pain, rates of failure or uterine trauma.
    e. Miniature hysteroscopes (2.7mm with a 3–3.5mm sheath) should be used for diagnostic outpatient hysteroscopy as they significantly reduce the discomfort experienced by the woman.
    f. There is insufficient evidence to recommend 0° or fore-oblique optical lenses (i.e. 12°, 25° or 30° off-set lenses) for routine outpatient hysteroscopy. Choice of hysteroscope should be left to the discretion of the operator.
    g. Blind cervical dilatation to facilitate insertion of the miniature outpatient hysteroscope is unnecessary in the majority of procedures. Routine cervical dilatation is associated with pain, vasovagal reactions and uterine trauma and should be avoided.
    h. Cervical dilatation generally requires administration of local cervical anaesthesia.
    i. Instillation of local anaesthetic into the cervical canal does not reduce pain during diagnostic outpatient hysteroscopy but may reduce the incidence of vasovagal reactions.
    j. Topical application of local anaesthetic to the ectocervix should be considered where application of a cervical tenaculum is necessary.
    k. Vaginoscopy reduces pain during diagnostic rigid outpatient hysteroscopy. Vaginoscopy should be the standard technique for outpatient hysteroscopy, especially where successful insertion of a vaginal speculum is anticipated to be difficult and where blind endometrial biopsy is not required.

5. Colposcopy:
    a. All colposcopists in the team must be certified through the BSCCP/Royal College of Obstetricians and Gynaecologists (RCOG) scheme. They must undergo the recertification process every three years in order to maintain levels of expertise and ensure that individuals are completing a sufficient caseload.
    b. Trainee colposcopists must be supervised by a certified colposcopist as per above (point a).