Women's Health College
New Zealand Nurses Organisation
Tōpūtanga Tapuhi Kaitiaki o Aotearoa

Standards for Hysteroscopist Training and Clinical Training Programmes Recommendations for Nurses 2022

Next Review 2023

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Introduction

Ko Te Tiriti O Waitangi te tuhinga motuhake o Aotearoa. Tautoko ana ngā Neehi Whakahaere o Aotearoa me Te Rūnanga Neehi Māori o Aotearoa hoki, i tēnei tuhinga Motuhake, ā, ka whakanui, ka whakapiki hoki tātou, kia rite te tunga o te tangata whenua me ngā Neehi Whakahaere o Aotearoa.

Te Tiriti o Waitangi is the founding document of Aotearoa/ New Zealand (NZ). The New Zealand Nurses Organisation (NZNO) and Te Rūnanga o Aotearoa acknowledges the great importance of this living document and will continue to respect and promote the equal standing of Tangata Whenua o Aotearoa. The NZNO/ Tōpūtanga Tapuhi Kaitiaki o Aotearoa specifically Section 6.1.3[1] which gives effect to Te Tiriti o Waitangi partnership.

The NZNO/ Tōpūtanga Tapuhi Kaitiaki o Aotearoa is the leading professional organisation for nurses - nēhi. The Women's Health College (WHC), NZNO provides professional guidance for nurses - nēhi working in women's health and aims to support advanced nursing practice. Historically, this has included the nurse colposcopist standards and now the development of nurse - nēhi hysteroscopy training.

In Aotearoa, NZ, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises diverse people with different levels of advantage require different approaches and resources to achieve equitable health outcomes. These standards are committed to a reconfiguration of health service to deliver high quality health care that meet the health needs of Māori and all women in Aotearoa. Māori wāhine aged over 25 have total cancer mortality rates almost twice that of non-Māori wahine (1).

Recognition and endorsement of the Waitangi Tribunal WAI 2575 Report 2019 is acknowledged and will align health outcomes with the proposed Māori Health Authority. This is designed to give Tino Rangatiratanga for Māori and offer more equitable outcomes (1).

The nurse hysteroscopy standards for nurses nēhi commenced development in NZ in 2020. They align with the principles of the Cancer Action Plan 2019-2029 which includes being equity led, knowledge driven, outcome focused and whānau centred and are based on the British Society for Gynaecological Endoscopy (BSGE) standards for hysteroscopy.

Please note that where the term women/ woman is used in this document, this includes gender diverse people.

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Background

Endometrial cancer is the most common gynaecological cancer in NZ and Australia. The rate of endometrial cancer is increasing in NZ (2). Fundamentally endometrial cancer is caused by chronic unopposed oestrogen. Risk factors include obesity, nulliparity, diabetes, early menopause and late menarche, chronic anovulation (e.g. PCOS) and certain genetic factors such as hereditary nonpolyposis colorectal cancer (HNPCC, or Lynch syndrome).(3) Hysteroscopy is considered gold standard in the diagnosis of endometrial abnormalities.

In NZ, Pacific women have the highest incidence of endometrial cancer and there is an upward trend in younger women.(4) Between 1996 and 2012, age-standardized incidence rates increased in all women and significantly in the < 40, 40-49, and 50-74 age groups (annual percentage change [APC] 9.22, 3.56, and 1.65 respectively). Incidence rates were highest in Pacific women and increased most rapidly in those under 50 years of age (APC 9.36). Conversely, age-standardized mortality rates decreased in all women and significantly in the 50-74 and 75 + age groups (APC - 5.25 and - 5.06 respectively), with the highest rate observed in Pacific women. A further Auckland study from 2000-2014 of 588 women identified that Pacific, followed by Māori, women had the highest incidence of endometrial cancer relative risk = 5.11 and 2.47, respectively). Also of note, disease-specific survival was worse in Pacific, and to a lesser extent, Māori women.(5) It has been identified that with early detection related to symptoms of abnormal vaginal bleeding or discharge, that endometrial cancer can be cured in about 80% of women. Prompt detection of endometrial abnormalities is invaluable.(5)

Nurses in NZ are encouraged to practice to their extent of their scope and increasingly have taken on clinical roles that were traditionally the domain of the doctor, for example colposcopy. The proposed NZ hysteroscopy training program for nurses aims to support the hysteroscopy services already established and contribute to improved access for women. This will assist in a reduction of waiting times, ensuring maintenance of a two week wait time for suspected gynaecological cancers, improved patient cancer journey and continuity of care for patients with endometrial cancer. It will also reduce patient waiting times for non-urgent/ benign hysteroscopy indications. Literature from the United Kingdom (UK) has demonstrated high levels of patient satisfaction with nurse led hysteroscopy services and low rates of complication.(6)

The proposal to train nurses in hysteroscopy in NZ is underway with a nurse practitioner on a pilot programme with support from the Waikato District Health Board and the Nursing Council New Zealand (NCNZ). Nurse training and implementation of nurse led hysteroscopy is already

well established in the UK demonstrating positive outcomes including increased service capacity and continuity of care(7)

This proposal to train nurses in hysteroscopy and develop nurse led hysteroscopy clinics is supported by The Ministry of Health (MOH) which has advised the Health Workforce Directorate of the planning for an academic course (to underpin the acquisition of technical skills needed to provide this service). Nursing workforce development is a priority with a focus to grow Māori and Pacific staff, and the development of roles for a whānau centered and holistic approach. Importantly, nurse led clinics will assist in the performance of the cancer care system as outlined in the NZ Cancer Action Plan (8) and expand services that are responsive to the needs of all people affected by cancer.

Women's Health College NZNO Position Statement

The WHC, NZNO recognises and supports appropriately skilled and qualified nurses to undertake hysteroscopy training for nurses. The WHC, NZNO recommend the hysteroscopy role for nurses is established in women's health services which have volumes sufficient to meet the training requirements of hysteroscopy patients and can provide appropriate trainer and trainee support.

It is recommended that hysteroscopy training is undertaken over a 12-18 month period however this time frame will vary according to individual circumstances.

The standards outlined in this document provide recommendations for training. While the WHC recommends the minimum standards outlined in this document, we assume no responsibility for a nurse's individual practice. Nurses are required to function within legislative requirements and adhere to professional standards and institutional policy.

Hysteroscopy service development

The aim of training nurses to undertake hysteroscopy in NZ is to provide them with the knowledge and skills to assess and diagnose potential causes of abnormal uterine bleeding (AUB) and to undertake minimally invasive hysteroscopic interventions within their scope of practice and level of expertise. Hysteroscopy will be undertaken both in the outpatient clinic setting under local anaesthesia, and under general anaesthetic in operating theatre. Nurses will also have the skills to provide women with information and education about the woman's condition including options for treatment. The hysteroscopy role for nurses includes.

- Assessment, diagnosis, treatment, and referral to appropriate services
- Coordination of the patient's care plan
- Coordination of patient communication with members of the team
- Assist in the development of clinical guidelines and protocols in line with clinical governance
- Involvement in establishing service provision development
- Coordination within a multidisciplinary team involving doctors, nurses, managers and support staff
- Project planning and management
- Involvement in education and training and supervision of trainees as appropriate depending on level of skill and experience

Training entry requirements

A nurse who applies to undertake hysteroscopy training must meet the following entry criteria

- Be a NZ registered nurse who meets the NCNZ criteria for expanded practice for registered nurses (9) OR a NZ Nurse Practitioner
- Hold a current Annual Practicing Certificate (APC) with the NCNZ
- Registered cervical smear taker in NZ is desirable but not essential to entry
- Certificated intrauterine contraceptive (IUC) inserter (including the levonorgestrel IUC: Mirena) is desirable but not essential to entry
- Have two years concurrent post registration women's health/ gynaecology experience within the last three years.
- Registered nurses must be a minimum of proficient on the Registered Nurse Professional Development & Recognition Programme (PDRP) (or equivalent for those working outside of Te Whatu Ora).
- Hold professional indemnity insurance (example – member of NZNO)
- Have completed a postgraduate qualification which includes an advanced health assessment paper.

Internationally qualified nurses who are hysteroscopists and seeking credentialing in NZ should first apply to NCNZ for NZ registration.

Hysteroscopy competencies

The following competencies must be achieved by the nurse in order to become a hysteroscopist. These will be assessed in a variety of ways

1. Demonstrate knowledge and rational of protocol, guidelines for practice, legal aspects and professional accountability
2. Demonstrate knowledge of the relevant female reproductive tract
3. Demonstrate knowledge of the uterine pathology
4. Demonstrate knowledge of the staging and grading of uterine tumors
5. Demonstrates an understanding of the need to verify patient identity, explanation of the procedure and informed consent by the nurse hysteroscopist
6. Demonstrate an understanding of the correct use of equipment (i.e., stacking system/ endoscopes instrumentation/ light source)
7. Demonstrates knowledge of aseptic technique and its importance while carrying out a hysteroscopy.
8. Demonstrate the importance of correct handling and prepping of the patient
9. Demonstrate knowledge of infection control, cleaning disinfection and sterilization
10. Demonstrates care in the introduction of the hysteroscope while minimizing discomfort to the patient and recognizing complications and safe withdrawal of the hysteroscope after inspection of the uterine cavity
11. Demonstrates ability to recognize uterine landmarks and a complete examination of the uterine cavity
12. Accurately record assessment on the appropriate documents plus digital photography
13. Gives full explanation of results to patient, allowing time for patient to ask questions
14. Gives clear instructions for follow-up care
15. Recognizes importance of coding and audit capacity
16. Demonstrate knowledge of complications following hysteroscopy
17. Demonstrate understanding of importance of ultrasound prior to hysteroscopy and interpretation of report to guide assessment and management
18. Demonstrate ability to take endometrial sampling for hysteroscopy

Training protocol for hysteroscopy

The aim of training is to ensure an approved registered nurse/ clinical specialist nurse/ nurse practitioner is suitably skilled and experienced to undertake diagnostic and therapeutic hysteroscopy in outpatient hysteroscopy and in the operating theatre**.** The training is undertaken in the clinical setting and is a trainer led competency based structured theoretical and practical program. Theory training runs concurrently to clinical training.

The trainee should have a primary mentor who may be a consultant gynaecologist or experienced nurse trained in hysteroscopy, plus one other experienced hysteroscopist. The training programme is led by the primary mentor.

Theory training

The theory component of the training is composed of a 60 point course provided by Te Pukenga – Ara and covers the topics as outlined in Appendix A.

Observation

19. To observe 10 hysteroscopy procedures as a supernumerary in clinic/ theatre
20. To observe introduction and to listen to the explanatory discussion/ counselling to patient
21. To observe patient positioning, draping, sterile technique
22. To observe initial examination of patient; bimanual exam, speculum exam, exposure/ direct visualization of cervix
23. To observe local anesthetic techniques
24. To observe the introduction of the hysteroscope under general anesthetic and outpatient hysteroscopy (both direct visualisation and vaginoscopy) and troubleshooting techniques to gain access through the cervical canal
25. To observe the anatomy and endoscopic appearances at rigid hysteroscopy
26. Handling of the endoscope while in the uterine cavity for full cavity assessment
27. To observe the correct and safe withdrawal of the hysteroscope
28. To listen to and observe the post examination explanations and advice to the patient

Practical/ clinical training experience

- Perform 50 cases managed under direct supervision with 80% of cases to be supervised in outpatient hysteroscopy clinic. Initial cases to be observed and done under general anesthetic then proceed to outpatient hysteroscopy clinic with local anaesthetic
- Perform 50 cases managed under indirect supervision or until both student and trainer are confident of competency. The decision to move from direct to indirect supervision should be a joint decision made between trainer and trainee
- Attendance at histology laboratories for a minimum of one day (can be from prior experience)
- 40 hours experience in a Sexual Health or Family Planning clinic (can be prior experience)
- Regular attendance (at least 50%) at multidisciplinary meetings (MDM) and lead case reviews
- Clinical audit of practice and or hysteroscopy service

Assessment

The assessment of the trainee should be on agreed competencies. Assessment includes the following material

- Completed log-book of a minimum of 100 hysteroscopic examinations (direct and indirect supervision) (Appendix B)
- 10 case discussions with the clinical trainer
- 10 written case studies of 500 words
- 10 clinical evaluation assessment
- Clinical audit of practice and/ or hysteroscopy service
- Provide a letter of competency signed off by their training supervisor
- Use of an evaluation rubric – for an example see Appendix (C)
- Observed Structured Clinical Examination (OSCE)

Case discussions should include the following aspects:

- Clinical record keeping
- Clinical assessment
- Clinical investigation and reference to NZ and international guidelines and best practice literature
- Treatment
- Follow up and future planning
- Professionalism
- Overall clinical judgement
- At least three of these case discussions will include the cultural implications of caring for Māori women and the nurse will demonstrate a working knowledge of cultural support services within the service and wider community
- It is highly recommended that case discussions will include cases from other high-risk populations, e.g., Pasifika and women from high socioeconomic deprivation groups. This will enable the trainer to assess the trainee's ability to discuss their management strategies for individual cases.

Clinical evaluation assessments

Clinical evaluation assessments enable the trainer to assess the trainee on their clinical skills in history taking and physical examination. Clinical evaluation assessments must include the following:

- History taking
- Physical examination skills
- Communication skills
- Clinical judgement
- Professionalism
- Organisational skills/ efficiency
- Overall clinical care

Final assessment OSCE

Final assessment should be undertaken as a summative observed structured clinical examination (OSCE) and undertaken by an independent qualified hysteroscopist. It is recommended the assessment should take place after a period of 12-18 months of practice or at the request of the individual nurse or supervising consultant.

It is essential that the principles of consent and privacy are adhered to (as per the Health and Disability Commission) for the above assessments. Guidelines on these themes are available in

the NZNO position statement entitled “Privacy, confidentiality and consent in the use of exemplars of practice and journaling” (2005). See NZNO website Guidelines for Nurses and Midwives, Privacy, Confidentiality and Consent in the Use of Exemplars of Practice and Journaling 2005,[i]

See NCNZ Code of Conduct http://nursingcouncil.org.nz/Nurses/Code-of-Conduct

Ongoing clinical requirements

Collaborative Practice

Collaborative practice is an essential component of nurse hysteroscopist role. Second opinions and multidisciplinary review will be sought with any clinical concerns.

Maintaining Accreditation and Professional Development

All nurses who perform hysteroscopy must have access to ongoing professional development including supervision following the completion of their training. The nurse hysteroscopist will be assessed as part of a PDRP or an employer’s credentialing programme and as part of the councils recertification audit. Registered nurses must demonstrate and document how they meet the additional competencies for expanded practice when they apply for their APC.

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Appendix A

Theory topics:

1. **The Normal Uterus – Anatomy and Physiology**
    - Anatomy of the pelvis
    - Physiology of the menstrual cycle
    - Physiology of the menopause
    - The endometrium in the normal cycle

2. **The Abnormal Uterus**
    - Abnormal endometrium
    - Effect of Tamoxifen on the genital tract
    - Fibroids
    - Endometrial polyps
    - Congenital abnormalities

3. **Cervical Abnormality**
    - Polyps
    - Erosion
    - Early cancer
    - Advanced cancer

4. **Menorrhagia**
    - Pathophysiology of menorrhagia
    - Role of scanning
    - RCOG guidelines
    - Treatment options:
        - Medical management
        - Endometrial ablation/ resection: 1st generation
        - Endometrial ablation: 2nd generation
        - Mirena
        - Hysterectomy

5. **Pelvic Pain**
    - Differential diagnosis
    - Endometriosis
    - Pelvic Inflammatory Disease
    - Diagnostic Laparoscopy
    - Treatment Options

6. **Infertility**
    - Primary infertility
    - Secondary Infertility
    - Polycystic Ovarian Syndrome
    - Recurrent Miscarriage

7. En**dometrial Pre-malignancy and Malignancy**

- Endometrial hyperplasia
- Endometrial cancer
- Management of pre- malignant and malignant disease
- Cervical pre- malignancy and malignancy

8. Evidence based Practice

- Sources of evidence
- Critical appraisal of evidence
- Developing protocols
- Developing guidelines

9. Medico legal and Ethical considerations

- Nurse Consent
- Nurse Prescribing

10. Menopause and HRT

- Management of menopause
- HRT prescribing
- Preparations and routes of administration
- Abnormal bleeding on HRT

11. The Equipment

- Hysteroscopes
- Camera systems
- Distension media
- Sampling devices
- Principles of sterilisation of hysteroscopy equipment
- Use and safety aspects of local anesthesia

12. Histology

- Preparations of specimens
- Principles of histological diagnosis
- Normal endometrium
- Abnormal endometrium
- Effects of Tamoxifen on the genital tract
- How medication can alter histological interpretation

13. Analgesia and Anesthesia

- Pain management
- Safe use of local anesthesia

14. Miscellaneous

- Managing the difficult patient
- Stress Management
- Time management
- How to teach
- Presentation skills

Appendix B: Logbook

Hysteroscopy Logbook (Student Name)

	Date	NHI	Indication	Procedure	Observed only	Supervised	Unsupervised	Clinical Opinion	Outcome Complication comments	Logged Histology	Future plan
1											
2											
3											
4											

Appendix C: Evaluation Rubric

Kathy Lasater Clinical Judgement Rubric				
Dimension	**Expert**	**Proficient**	**Competent**	**Novice**
Effective noticing involves				
Focused observation	Focuses observation appropriately: regularly observes and monitors a wide variety of objective and subjective data to uncover any useful information	Regularly observes and monitors a variety of data, including both subjective and objective: most useful information is noticed: may miss the most subtle signs.	Attempts to monitor a variety of subjective and objective data but is overwhelmed by the array of data: focuses on the most obvious data, missing some important information	Confused by the clinical situation and the amount and kind of data; observation is not organized and important data is missed, and/ or assessment errors are made
Recognising deviations from expected patterns	Recognizes subtle patterns and deviations from expected patterns in data and uses these to guide the assessment	Recognises most obvious patterns and deviations in data and uses these to continually assess	Identifies obvious patterns and deviations, missing some important information: unsure of how to continue assessment	Focuses on one thing at a time and misses most patterns and deviations from expectations; misses opportunities to refine the assessment
Information seeking	Assertively seeks information to plan intervention: carefully collects useful subjective data from observing and interacting with the patient and family	Actively seeks subjective information about the patients situation from the patient and family to support planning interventions occasionally does not pursue important leads.	Makes limited efforts to seek additional information from the patient and family: often seems not to know what information to seek and/ or pursues unrelated information	Is ineffective in seeking information; relies mostly on objective data; has difficulty interacting with the patient and family and fails to collect important subjective data

Effective interpreting involves				
Prioritising data	Focuses on the most relevant and important data useful for explaining the patient's condition	Generally focuses on the most important data and seeks further relevant information but also may try to attend to less pertinent data	Makes an effort to prioritize data and focus on the most important, but also attends to less relevant or useful data	Has difficulty focusing and appears not to know which data is most important to the diagnosis; attempts to attend to all available data

Making sense of data			In simple, common, or familiar situations, is able to compare the patient's data patterns with those known and to develop or explain intervention plans; has difficulty, however, with even moderately difficult data or situations that are within the expectations of students; inappropriately requires advice or assistance	Even in simple, common, or familiar situations, has difficulty interpreting or making sense of data; has trouble distinguishing among competing explanations and appropriate interventions, requiring assistance both in diagnosing the problem and developing an intervention

Calm confident manner			Is tentative in the leader role; reassures patients and families in routine and relatively simple situations, but becomes stressed and disorganized easily	Except in simple and routine situations, is stressed and disorganized, lacks control, makes patients and families anxious or less able to cooperate
Clear communication			Shows some communication ability (e.g., giving directions); communication with patients, families, and team members is only partly successful; displays caring but not competence	Has difficulty communicating; explanations are confusing; directions are unclear or contradictory; patients and families are made confused or anxious and are not reassured
Well-planned intervention flexibility			Develops interventions on the basis of the most obvious data; monitors progress but is unable to make adjustments as indicated by the patient's response	Focuses on developing a single intervention, addressing a likely solution, but it may be vague, confusing, and/ or incomplete; some monitoring may occur
Being skilful	Shows mastery of necessary nursing skills	Displays proficiency in the use of most nursing skills; could improve speed or accuracy	Is hesitant or ineffective in using nursing skills	Is unable to select and/ or perform nursing skills

Effective reflecting involves				
Evaluation/ self-analysis	Independently evaluates and analyses personal clinical performance, noting decision points, elaborating alternatives, and accurately evaluating choices against alternatives	Evaluates and analyses personal clinical performance with minimal prompting, primarily about major events or decisions; key decision points are identified, and alternatives are considered	Even when prompted, briefly verbalizes the most obvious evaluations; has difficulty imagining alternative choices; is self-protective in evaluating personal choices	Even prompted evaluations are brief, cursory, and not used to improve performance; justifies personal decisions and choices without evaluating them
Commitment to improvement	Demonstrates commitment to ongoing improvement; reflects on and critically evaluates nursing experiences; accurately identifies strengths and weaknesses and develops specific plans to eliminate weaknesses	Demonstrates a desire to improve nursing performance; reflects on and evaluates experiences; identifies strengths and weaknesses; could be more systematic in evaluating weaknesses	Demonstrates awareness of the need for ongoing improvement and makes some effort to learn from experience and improve performance but tends to state the obvious and needs external evaluation	Appears uninterested in improving performance or is unable to do so; rarely reflects; is uncritical of himself or herself or overly critical (given level of development); is unable to see flaws or need for improvement.