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An Audit of Patient Satisfaction in an Outpatient Hysteroscopy Clinic Setting

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Abstract

Aims
We aimed to review experiences of women attending the outpatient hysteroscopy clinic (OHC) in University Hospital Kerry across five months in 2017.

Methods
Data collection was prospective and on-site. Green-top Guideline No. 59: Best Practice in Outpatient Hysteroscopy, published by the Royal College of Obstetricians and Gynaecologists (RCOG), was the standard used for comparison.

Results
There was a one hundred percent response rate (100%; 60/60). Six aspects of the service met the required standards, and five failed to meet the standards. Aspects that met the standards included convenience of service and staff assessment. Those that fell below the standards included ease of locating the clinic and comfort while waiting.

Conclusion
Despite the majority reporting mild to moderate pain, almost all the women (93.5%; 56/60) would recommend the clinic to a friend. Changes have been instituted since the audit, including installation of new signage to direct women to the clinic. A re-audit questionnaire has been developed to review the service. Outpatient hysteroscopy is a convenient and acceptable experience for women attending our gynaecology services.

Introduction

Outpatient hysteroscopy is carried out primarily for investigation of abnormal uterine bleeding[1-3]. It can also be used for office procedures such as guided endometrial biopsy, endometrial polypectomy, treatment of small submucous leiomyomas and retrieval of intrauterine devices[4-7]. It is safe, well tolerated, and obviates the need for general anaesthesia[8]. The Royal College of Physicians Ireland (RCPI) recommend that this service should be the standard of care for women accessing hysteroscopy services, as it has significant patient benefits and cost savings[9]. Benefits for women include reduced recovery time and faster return to work, as well as engagement with care. The RCOG recommends that all gynaecology units should be equipped with a dedicated outpatient hysteroscopy service[8].

However, outpatient hysteroscopy can also be associated with pain, embarrassment and anxiety[10-12]. Due to the clinical and economic advantages of outpatient hysteroscopy, it is important to ensure that women have a positive experience and are satisfied with this valuable service. Clinicians must ensure that discomfort is minimised through means such as operator expertise, the use of appropriate equipment, hysteroscopy patient information leaflets, appropriate techniques and pharmacological agents, pre-procedure counselling, and the use of the ‘vocal local’.

Cill Ide is University Hospital Kerry's (UHK) dedicated consultant-led outpatient hysteroscopy clinic (OHC). It opened in 2009 and treats more than 150 women per year. It offers diagnostic as well as operative procedures. Equipment includes five 30-degree three-millimetre diagnostic hysteroscopes, and two 30-degree three-millimetre operative alphascopes. A bipolar Gynecare Versapoint Bipolar Electrosurgery system is also used for operative procedures including treatment of endometrial polyps and submucous leiomyomas. Local anaesthetic is used for selected cases. Cill Ide is equipped with a waiting room, clinic room, doctor's office, and toilet facilities. It is staffed by a clinical nurse specialist or nurse and a secretary, and procedures are performed by either the consultant or a non-consultant hospital doctor under direct consultant supervision. Women are provided with written information pre- and post-procedure. Informal feedback to date has generally been positive, and in 2017 an audit was conducted to formally evaluate satisfaction with the service. The outcomes and implications of the audit are outlined below.

Methods

Data was collected over five months from July to December 2017. The target population was women attending the OHC during the specified time period. Data was collected prospectively and on-site, with a written questionnaire offered to women following their hysteroscopy and consultation. The questionnaire centred on the following themes: ease of getting to clinic; attendance at clinic; written information; recommendation to a friend or relative; pain; staff assessment and facility. Questions were either multiple choice, with the options of 'very good', 'good', 'fair' or 'poor', or yes/no. There was a visual analogue score for pain, and a space left for comments.

The RCOG Green-top Guideline No. 59, 'Best practice in outpatient hysteroscopy' was used as the standard for auditing the service. Standards were set at 80%. Consequently, for questions with a graded response choice, 80% of women were expected to respond with 'very good'. For yes/no questions, 80% of women were expected to respond with 'yes'. Data was collated in an Excel spreadsheet. Results were subsequently analysed by the chief researcher and reviewed by the supervising consultant.

Results

Sixty women were offered the questionnaire. There was a response rate of 100% (60/60), likely due to the on-site nature of data collection. Figures one to three represent patient responses to nine of the eleven aspects (two aspects not included: hysteroscopy information read prior to the procedure; would recommend to a friend or relative). Figure four represents pain assessment as measured by the women on a visual analogue scale (VAS).

Figure 1: Ease of getting to clinic.

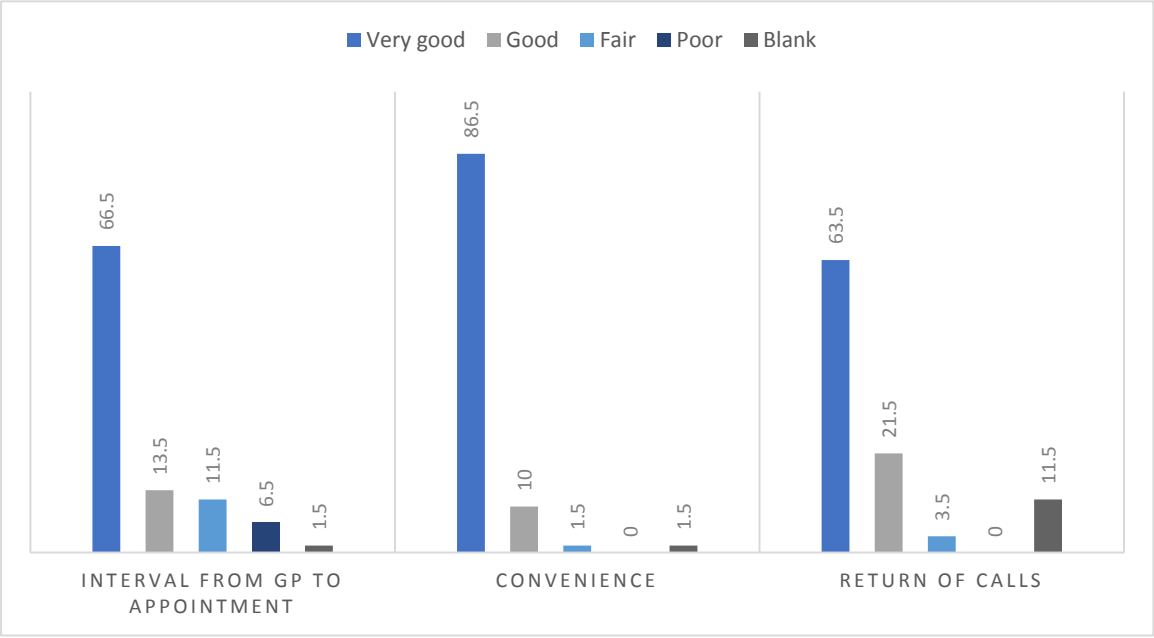


Figure 2: Facility.

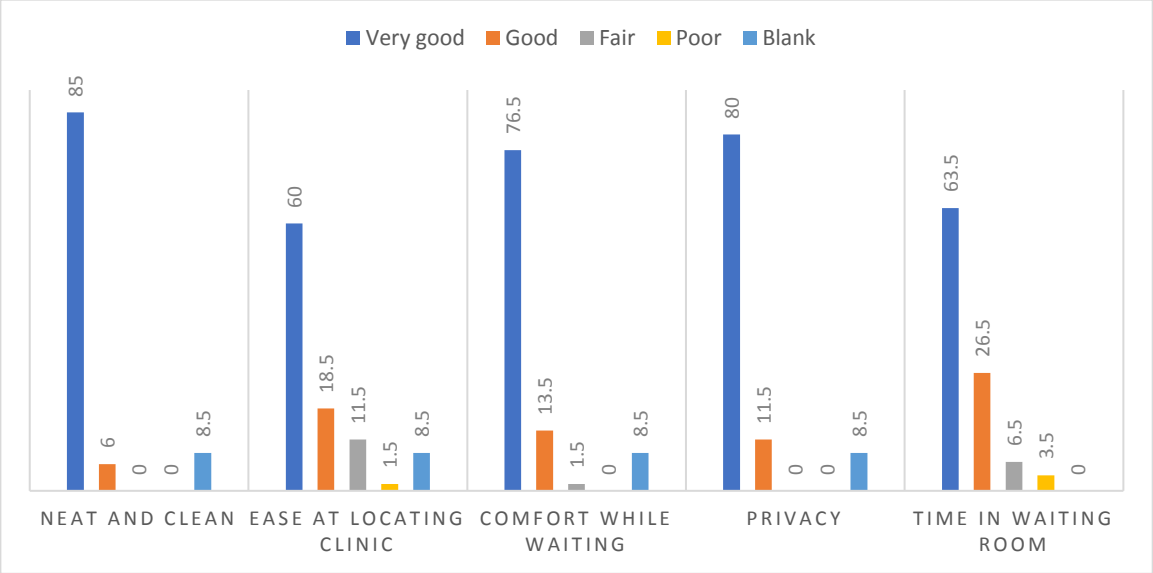


Figure 3: Staff assessment.

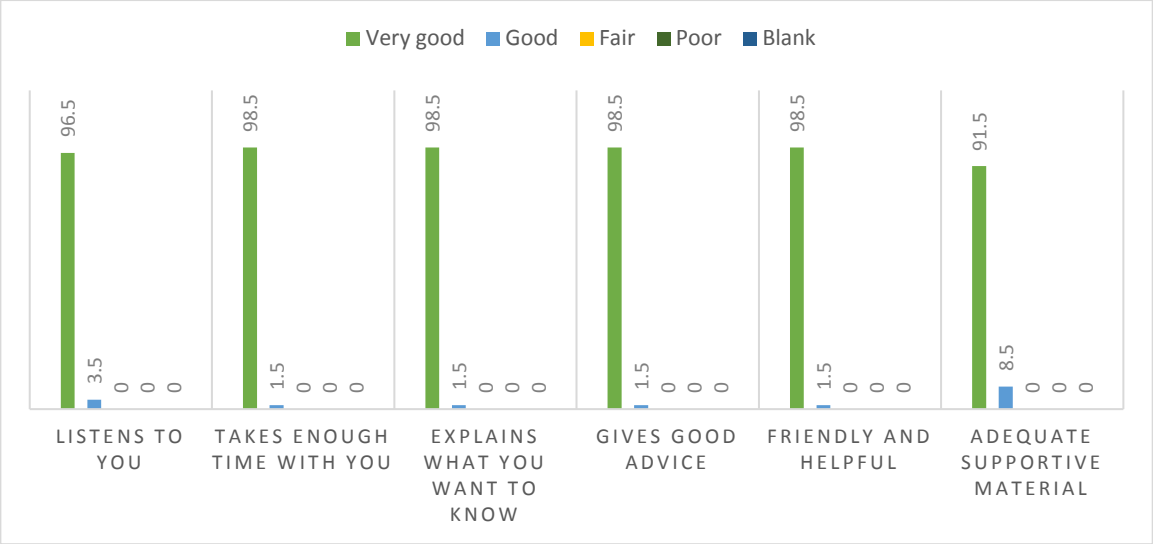
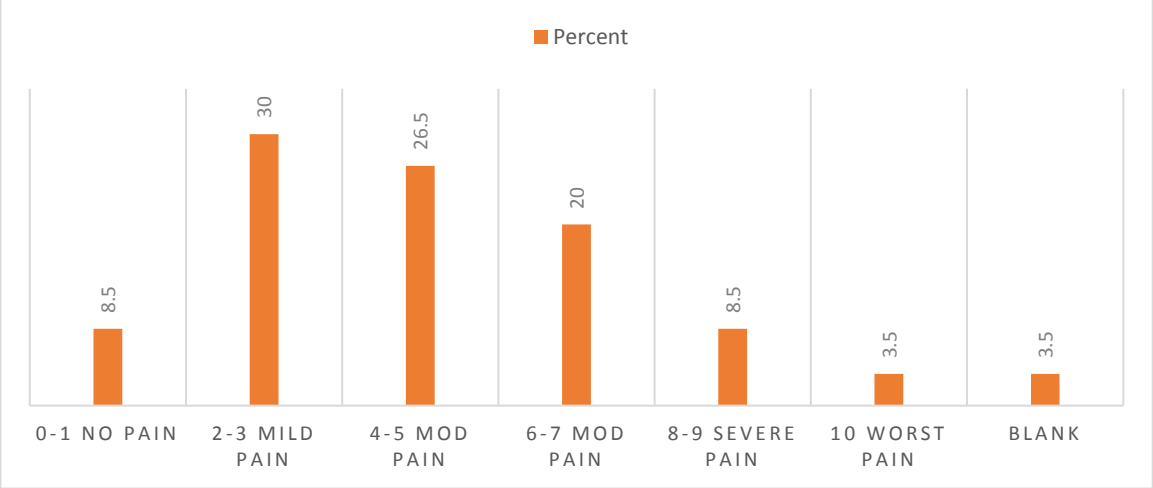


Figure 4: Overall experience by VAS (visual analogue scale).



Six aspects of the service met the expected standards, and five fell short of the standards. The majority of the women (86.5%; 52/60) felt that the service was convenient, and almost all of the women (93.5%; 56/60) would recommend the service to a friend. Most of the women (86.5%; 52/60) read the information leaflet in advance of their procedure. The staff met or excelled beyond the set standards on all aspects of care. Almost all of the women felt that the staff listened to them (96.5%; 58/60) and took enough time with them (98.5%; 59/60). Almost all of the women (98.5%; 59/60) felt that the staff explained what they wanted to know, gave good advice and were friendly and helpful. Most of the women (91.5%; 55/60) felt that the supportive material provided was adequate. The majority of women rated the facilities as neat and clean (85%; 51/60) and were satisfied with the level of privacy afforded (80%; 48/60).

Regarding the aspects of the service that fell short of the standards, only 40 women (66.5%; 40/60) were satisfied with the time interval between GP referral and appointment. Thirty-six women (60%; 36/60) felt that the clinic was easy to locate, and 38 (63.5%; 38/60) rated their time in the waiting room as satisfactory. Forty-six women (76.5%; 46/60) felt comfortable while waiting for their procedure.

The majority of women also experienced mild to moderate pain during the procedure (mild pain: 30%, 18/60; moderate pain: 46.5%, 28/60).

Eighteen women left comments on their questionnaire. Nine of these were comments expressing satisfaction with the service, with one suggesting that the option of 'excellent' should be added to the questionnaire. Two comments suggested better signage to locate the clinic. Two felt the waiting times were too long. Two women made comments about the information leaflet – one felt it was unclear and one suggested informing women of the need to provide a urine sample prior to the procedure. Two women provided suggestions for improving the waiting room by adding a TV, more magazines or a radio.

Discussion

The OHC reached audit targets in six out of eleven areas. Overall, patient satisfaction was very high, however areas for improvement were highlighted.

Regarding the interval between GP and appointment time, there may be a number of logistical barriers to a timely appointment. Ultrasound scan of pelvis (US pelvis) is booked for all women with abnormal uterine bleeding prior to OHC appointment. Due to radiology waiting lists, the time interval between GP referral and OHC appointment may be prolonged.

Regarding prompt return of calls, this relies on administration staff who are available only during working hours. To counter this issue, the telephone number of the gynaecology ward will be included in the new OHC patient information leaflet. This will provide women with access to the service out of hours.

Only 36 women (60%; 36/60) felt the ease of locating the clinic was 'very good'. One comment suggested improved signage, and following this finding, the team has installed a large sign outside the main hospital entrance to direct women to the clinic.

With respect to time spent in the waiting room, some suggestions in the comments section included requests for a television, magazines or a radio. During the audit period the TV in the waiting room was not working, but staff have since resolved this issue. Unfortunately, the magazines previously present have now been removed during the COVID-19 pandemic as per national guidelines for health and safety reasons. The women are asked to bring their own reading material while waiting.

Regarding pain during the procedure, the majority of women reported mild to moderate pain. However, most women (93.5%; 56/60) would still recommend the clinic to a friend or relative. This finding is in line with previous outpatient hysteroscopy satisfaction studies. Downes and Al-Azzawi[13] found that despite a six percent failure rate and a mean visual analogue score of 3.25/10 for pain, patient satisfaction was still 97%. Reflecting on this result, Kremer, Duffy and Moroney[14] commented that "patients still tolerate acceptable failure and discomfort and still remain satisfied" (p.281). Our study supports this theory. The RCOG recommends the use of non-steroidal anti-inflammatories routinely for women prior to outpatient hysteroscopy[8] and this advice is contained in our pre-procedure information leaflet.

Routine cervical preparation is not used in our clinic as it has not been shown to reduce pain and is not recommended by the RCOG[8]. Of note, there is no dedicated recovery area in the clinic post-procedure for the women, but there is a side room with a clinic bed if further recovery is required. This aspect of the service could be investigated in a future audit.

In conclusion, women reported high levels of satisfaction with the outpatient hysteroscopy service in UHK. Our audit also highlights areas for improvement. These areas include reduced time between GP referral and appointment, prompt return of calls, improved signage, and improved waiting room facilities. Some changes have already been made to improve the service, and other changes are in progress.

Our re-audit questionnaire has been designed to include an option of 'excellent' as recommended by one woman in the comments. Our re-audit will also include demographics such as age, parity and menopausal status to allow more in-depth analysis of experiences across groups.

Declaration of Conflicts of Interest:
No conflicts of interest.

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