Certification in Urogynaecology (CU)
Directly Observed Procedural Skills (DOPS)
Hysteropexy

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Excellence in Women's Health

Formative □ ..Summative □

Trainee Name: ..... Date: .....

Assessor Name: ..... Training Supervisor □ Consultant □

Second Assessor Name ..... Training Supervisor □ Consultant □
(If applicable, for example preoperative and operative assessors)

CU Year Level of Training: Year 1 □ Year 2 □ Year 3 □

Hospital: .....

Clinical Details:

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Case Complexity: Low □ Medium □ High □

Number of times previously performed this procedure: 0-3 □ 3-6 □ 6-10 □ 10+ □

Please indicate how you rate this Trainee by ticking the appropriate box.

Procedural skills under observation:	Performance Scale				
	1	2	3	4	N/A
	Able to perform the skill(s) under supervision	Able to perform the skill(s) with minimal supervision (needed occasional help)	Competent to perform the skill(s) without supervision (required help when complication arose)	Competent to perform the skill(s) without supervision (did not require help when complication arose)	
Patient selection; demonstrates understanding of contra-indications to uterine-preserving surgery for prolapse and is able to select cases where such an option is safe and reasonable.					
Pre-operative counselling for informed consent; can accurately discuss benefits and risks of proposed surgery. Can discuss any additional future issues that may arise with uterine and cervical preservation.					
Ensures that appropriate theatre set-up in place for chosen procedure; patient positioning, availability of necessary equipment, disposable materials, medications and blood-products if required. Discusses details of procedure with surgical assistant and completes surgical checklist at start of case.					
Performs a thorough EUA at start of procedure, confirming the surgical plan. Catheterises bladder if necessary (may leave IDC in for duration of the case).					
For a vaginal approach, infiltrates vaginal wall and then performs an incision/dissection to identify either the utero-sacral ligaments or the sacrospinous ligament(s), depending on the choice of procedure. For abdominal approach, either makes an appropriate incision (midline or pfannenstiel) or gains safe laparoscopic entry andplaces secondary operating trochars/ports to carry out the surgery.					

For a vaginal uterosacral plication, both ligaments are visualised/palpated. Places sutures into both ligaments which are then tied in midline to plicate/shorten the ligaments and elevate the uterus. Performs cystoscopy to confirm ureteric patency before closing the vaginal incision. For sacrospinous hysteropexy, either one orboth sacrospinous ligaments are palpated and cleared of overlying tissue to enable safe suture placement into the ligament(s) at least 1.5cm medial to the ischial spine. Distal ends of these sutures are then secured to the cervix, usually at the back. Commences vaginal skin closure before tying the suspension sutures and elevating the uterus. Checks rectal examination to rule out an injury before closing the vaginal incision.					
For abdominal sacro-hysteropexy (byeither route) safely opens the peritoneum overlying the sacral promontory and continues this opening in a caudal direction through the cul-de-sac and up to the back of the cervix. (Takes care to avoid the right ureter laterally and the rectum medially). Places an appropriate mesh which is either sutured to the back of the cervix or passed through an opening in the broad ligament(s) and sutured to the cervix anteriorly. Lays the other end of the mesh 'strap' upward through the opened peritoneum and sutures it to the pre-sacral ligament at the level of the sacral promontory, after appropriate tensioning with the assistance of a vaginal probe. Closes the peritoneum with a running suture, avoiding excessive ureteric tension or bowel injury. For an abdominal Uterosacral ligament plication, identifies the ligaments behind the cervix and places sutures to either shorten each ligament longitudinally, or to plicate the two ligaments together in the midline. Carefully inspects the course of the ureters and if necessary does an intra-operative cystoscopy before closing the abdomen. Checks haeamostasis and rectal injury.					
Safely closes the laparotomy incision or removes laparoscopic trochars with any necessary closure of rectus sheath layer before closing the skin. For vaginal procedure, then checks haemostasisbefore closing the vaginal incision.					
If not already done, performs a cystoscopy to confirm ureteric patency, checks for haemastasis as well as a rectal examination to confirm that no bowel injury has occurred. If an abdominal procedure has been performed, any necessary concomitant vaginal prolapse repairs are carried out. Places an indwelling catheter if not already in-situ.					
Outlines suitable post-operative management plan with appropriate attention to bladder and bowel function, infection prevention and thrombo-prophylaxis.					

Global rating (Overall impression of professional behaviours) ** The global rating is separate to the procedural skill score	Below Expectation	Just Meets Expectation	Meets Expectation	Well Above Expectation

Aspects of the procedure that were performed well:

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Aspects of the procedure where improvement is required:

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Recommendations:

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☐ Please tick this box if the trainee is deemed competent.
(Trainee must achieve a score of 3 or 4 against each of the listed criteria and a minimum Global rating of 'Meets Expectation' to be deemed competent)

Assessor signature: …… . Date: ……..…..

Trainee signature: …….. Date: ……..……