AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards

INFORMATION
for healthcare services

Heavy Menstrual Bleeding

Clinical Care Standard

The *Heavy Menstrual Bleeding Clinical Care Standard* aims to ensure that women with heavy menstrual bleeding are offered the least invasive and most effective treatment appropriate to their clinical needs and preferences and are able to make an informed choice from the range of treatments suitable to their individual situation.

The *Heavy Menstrual Bleeding Clinical Care Standard* contains eight quality statements describing the care that should be offered to women of reproductive age who are experiencing heavy menstrual bleeding.

This standard relates to care provided in primary and community healthcare settings including general practice, women's health, family planning and sexual health services and clinics, as well as in public and private specialist gynaecology clinics and practices, radiology clinics and hospitals.

A set of indicators is provided to support health services to monitor how well they are implementing the care recommended in this clinical care standard and to support local quality improvement activities. The definitions required to collect and calculate indicator data are specified **online**.

Monitoring the implementation of this clinical care standard will help organisations to meet some of the requirements of the National Safety and Quality Health Service (NSQHS) Standards (second edition) and the National Safety and Quality Primary and Community Healthcare Standards.

1 Assessment and diagnosis

The initial assessment of a woman presenting with heavy menstrual bleeding includes a thorough history, assessment of impact on quality of life, a physical examination (where clinically appropriate), and exclusion of pregnancy, iron deficiency and anaemia. Further investigations are based on the initial assessment.

In healthcare services involved in the assessment of patients with heavy menstrual bleeding, ensure that guidelines and protocols are in place to support:

- A thorough history, assessment of the nature of the bleeding and its impact on quality of life, a physical examination where appropriate, and exclusion of pregnancy, iron deficiency and anaemia
- Systematic assessment of the structural and non-structural causes of heavy menstrual bleeding based on history and presentation, with relevant investigations recommended according to this assessment
- Appropriate testing for bleeding disorders or thyroid dysfunction, cervical screening, and pelvic ultrasound; these are not routinely required
- Patients to see a particular type of clinician if that is their preference, for example someone of the same gender
- Referral and access to additional services that the patient may require, including counselling or other services to support their emotional wellbeing and mental health as appropriate.

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Cultural safety and equity

- Ensure that systems support the assessment of women in a way that is free from racism, bias and assumptions.
- Consider developing pathways and models of care that involve working collaboratively with Aboriginal Community Controlled Health Organisations and Aboriginal health workers or practitioners to improve access to care and continuity of care for women experiencing heavy menstrual bleeding.

Indicator for local monitoring

Indicator 1a: Proportion of patients with heavy menstrual bleeding who were tested for iron deficiency and anaemia.

2 Informed choice and shared decision making

A woman with heavy menstrual bleeding is informed about her treatment options and their potential benefits and risks. She is supported to participate in shared decision making based on her preferences, priorities and clinical situation.

Ensure that policies, protocols and procedures support informed choice and shared decision making. Specifically:

- Ensure that high-quality patient information resources are available in a range of formats and are clinically accurate, evidence based and easy to understand
- Ensure that resources provide information about both benefits and risks of relevant treatment options offered through referral, or by the service; consider making a decision aid available to support shared decision making
- Provide ready access to information for clinicians on the benefits, risks and probable outcomes of the various treatment options for heavy menstrual bleeding
- Provide clinicians with training and professional development to ensure they have the skills, knowledge and confidence to participate in, and support patients to participate in, shared decision making
- Put in place policies to facilitate referral and access to services that a woman may prefer, but which are not offered in the health service
- In rural and remote areas, adapt service delivery models to support patients to access appropriate care, for example through the use of telehealth and other models of care.

Cultural safety and equity

- Provide patient information about heavy menstrual bleeding in a variety of languages and formats appropriate to your service's patient population.
- Consider developing or adapting pathways and models of care that support women to access culturally safe and appropriate services and community supports in a timely way.
- Ensure that policies and procedures support the rights of women with disabilities. Make reasonable adjustments for women with disabilities to ensure their access to appropriate care and active participation in shared decision making about management of heavy menstrual bleeding.

3 Initiating medical management

A woman presenting with heavy menstrual bleeding is offered medical management, taking into account evidence-based guidelines, her individual needs and preferences and any associated symptoms. Oral treatment is offered at first presentation when clinically appropriate, including when a woman is undergoing further investigation or waiting for other treatment.

In primary health care and other services where patients first present for management of heavy menstrual bleeding, ensure that guidelines and protocols are in place to support:

- Medical management as the first treatment option in the absence of significant pathology
- Offering initial oral treatment to relieve symptoms and limit complications (such as iron deficiency) even if the patient is being referred for further investigations or awaiting other treatment
- Clinicians to access relevant evidence-based prescribing guidelines for the choice of therapy and dosing.

Indicator for local monitoring

Indicator 3: Proportion of patients with heavy menstrual bleeding who were offered medical management at their first presentation.

4 Quality ultrasound

When a woman requires an ultrasound to investigate the cause of her heavy menstrual bleeding, she is offered a pelvic (preferably transvaginal) ultrasound, which assesses all pelvic structures, including the uterus and endometrium, and is ideally performed in days 5–10 of her menstrual cycle.

In healthcare services that **refer** for pelvic ultrasound, ensure that protocols, procedures and pathways:

- Support transvaginal ultrasound as the preferred method when pelvic ultrasound is recommended and clinically appropriate
- Ensure patients are advised about how a transvaginal ultrasound is conducted and if they decline, or it is not appropriate for any other reason, then a transabdominal ultrasound only is requested
- Encourage patients to arrange for their ultrasound to be conducted in the first half of their menstrual cycle where possible, ideally on days 5–10, and clinicians to specify this in ultrasound requests
- Take into account any challenges patients may experience in accessing ultrasound locally
- Ensure patients are offered initial oral treatment where clinically appropriate while waiting for appointments.

In healthcare services **performing** gynaecological ultrasound, ensure that policies, protocols and procedures support:

- Appropriate high-quality transvaginal and transabdominal ultrasound (for example, see Australasian Society for Ultrasound in Medicine guidelines)
- Optimal scheduling of appointments so that scans are taken on days 5–10 of a patient's menstrual cycle where possible
- Women to make informed decisions and provide informed consent in relation to their ultrasound, based on timely and accurate information about the process, including an understanding of how transvaginal ultrasound is conducted
- High-quality reporting of ultrasound results, taking into account the need to accurately measure and report endometrial thickness (in millimetres), uterine dimensions, including volume, and the presence and location of structural abnormalities.

Indicators for local monitoring

Indicator 4a: Evidence of local arrangements to support appropriate referral for investigative pelvic ultrasounds for heavy menstrual bleeding.

The local arrangements should specify the process to:

- Encourage patients to arrange for their ultrasound to be conducted in the first half of their menstrual cycle, ideally in days 5–10
- Support clinicians to specify the expected timing of the ultrasound in requests
- Support discussions with patients about transvaginal ultrasound as the preferred method when imaging is recommended and clinically appropriate
- Assess adherence to the local arrangements.

Indicator 4b: Evidence of local arrangements for conducting investigative pelvic ultrasounds for heavy menstrual bleeding. The local arrangements should specify the:

- Protocol or guideline to check the appointment timing with the patient and ideally book the appointment in days 5–10 of their menstrual cycle
- Consent policy that ensures patients are supported to make informed decisions about pelvic ultrasounds, including specific requirements for transvaginal ultrasounds
- Process to assess adherence to the local arrangements.

5 Intrauterine hormonal devices

When medical management options are being considered, a woman is offered a 52 mg levonorgestrel-releasing intrauterine device if clinically appropriate, as it is currently the most effective medical option for managing heavy menstrual bleeding.

In primary health care and other services where medical management may be initiated, ensure that:

- Guidelines and protocols are in place to support patients being offered a 52 mg levonorgestrel-releasing intrauterine device (LNG-IUD) if it is clinically appropriate
- Arrangements are in place to provide the LNG-IUD, either within the service or through referral to an appropriate practitioner.

Indicators for local monitoring

Indicator 5a: Proportion of patients with heavy menstrual bleeding deemed clinically suitable for a 52 mg levonorgestrel-releasing IUD, who had one inserted or were referred to another clinician for insertion.

Indicator 5b: Evidence of local arrangements to refer or recommend patients with heavy menstrual bleeding to a clinician trained to insert levonorgestrel-releasing intrauterine devices. (Only applicable to services without a clinician trained in intrauterine device insertion.)

6 Specialist referral

A woman with heavy menstrual bleeding is referred for early specialist review when there is a suspicion of malignancy or other significant pathology based on clinical assessment or ultrasound. Referral is also offered to a woman who has not responded to medical management.

In primary healthcare services, establish protocols and pathways to ensure that:

- Patients with possible or suspected malignancy, or with significant pelvic pathology, are offered early referral to an appropriate specialist for review
- Patients who have not responded to medical management are offered referral to an appropriate specialist for assessment and treatment.

In secondary health services with referral protocols or criteria, use those protocols to advise referring clinicians of referral requirements and timeframes.

Indicator for local monitoring

Indicator 6a: Evidence of protocols or pathways to ensure timely and appropriate referral of patients with heavy menstrual bleeding.

The protocols or pathways should specify the process to:

- Offer early referral to an appropriate specialist when there is suspicion of malignancy or other significant pathology
- Offer a referral to an appropriate specialist when the patient has not had a satisfactory response to medical management
- Assess adherence to the protocols or pathways.

7 Uterine-preserving alternatives to hysterectomy

A woman who has heavy menstrual bleeding of benign causes and who is considering non-medical management is offered uterine-preserving procedures that may be suitable (such as endometrial ablation, uterine artery embolisation or surgical removal of local pathology). She is supported to make an informed decision and is referred appropriately.

In primary and secondary healthcare services where women are considering non-medical management of their heavy menstrual bleeding, ensure that protocols and pathways are in place to:

- Provide patients with access to appropriate uterine-preserving procedures, including endometrial ablation, hysteroscopic resection, myomectomy or uterine artery embolisation, as clinically appropriate, either within the healthcare service or by referral to an appropriately skilled clinician
- Support the provision of information about the benefits, risks and probable outcomes of potential treatments.

In healthcare services that provide surgical and non-surgical procedures to patients with heavy menstrual bleeding, ensure that protocols and pathways are in place so that patients can access uterine-preserving alternatives to hysterectomy as appropriate.

Indicator for local monitoring

Indicator 7a: Proportion of patients with heavy menstrual bleeding of benign cause(s) who received uterine-preserving procedural alternatives to hysterectomy.

8 Hysterectomy

Hysterectomy to manage heavy menstrual bleeding is considered when other treatment options are ineffective or are unsuitable, or at the woman's request. A woman considering a hysterectomy is fully informed about the potential benefits and risks of the procedure before making a decision.

In services where women may be considering their treatment options, ensure that systems and processes are in place to:

- Support the systematic consideration of less invasive alternatives to hysterectomy, as appropriate to a woman's clinical needs and preferences, in a way that is meaningful to her, so that she can make an informed choice about hysterectomy
- Provide women with information about the benefits, risks and consequences of hysterectomy, and about suitable approaches to hysterectomy
- For women who choose hysterectomy, support consideration of minimally invasive approaches (vaginal or laparoscopic) whenever clinically appropriate.

Overall Indicator for monitoring

Indicator 9a: Hospital rate of hysterectomy per 100 episodes.

Note: More information on calculation of this indicator is available on **METEOR** and the Commission's **website**.

Questions?

Find out more about the *Heavy Menstrual Bleeding Clinical Care Standard* and other resources. Scan the QR code or use the link **safetyandquality.gov.au/hmb-ccs**.

The Australian Commission on Safety and Quality in Health Care has produced this clinical care standard to support the delivery of appropriate care for a defined condition. The clinical care standard is based on the best evidence available at the time of development. Healthcare professionals are advised to use clinical discretion and consideration of the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian, when applying information contained within the clinical care standard. Consumers should use the information in the clinical care standard as a guide to inform discussions with their healthcare professional about the applicability of the clinical care standard to their individual condition.

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