OBSTETRICS AND GYNAECOLOGY

CLINICAL PRACTICE GUIDELINE

Vaginal procedures

(digital examination, speculum, swabs, insertion and removal of vaginal packs)

Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate staff
Scope (Area):	Obstetrics and Gynaecology Directorate clinical areas

This document should be read in conjunction with this Disclaimer

Contents

Chaperones, students and observers

- Follow NMHS Chaperone Policy (available to WA Health employees through HealthPoint) to ensure safety and comfort of both patients and staff.
- See also RANZCOG guideline (external website): 'Gynaecological examinations and procedures (C-Gyn 30)'
- All patients shall be offered a chaperone during any intimate physical examination / procedure.
- The chaperone must be a NMHS employed clinician governed by APHRA. Students are not eligible as a chaperone.
- If the patient declines a chaperone the clinician may choose not to undertake the examination or procedure, may postpone same and/or refer the patient to another clinician. The patient's decision and the subsequent plan must be documented.
- A person of the patient's choice may also be present but cannot undertake the role of a chaperone.
- **Documentation requirements** (there is a stamp available in outpatient clinics):
  - Confirmation the patient was offered a chaperone
  - The name and professional designation of the chaperone present
  - The name and professional designation of the clinician

Cervical Screening Test (previously Pap smear)

See WNHS Obstetrics and Gynaecology guideline: Cervical Screening Test

Speculum examination

Purpose

To provide guidance on the correct procedure to be followed when performing a speculum examination.

Key points

1. Hand hygiene shall be performed before and after patient contact.
2. Verbal consent shall be obtained before the procedure is commenced.
3. All patients shall be offered a chaperone during any intimate physical examination / procedure. Refer to NMHS Chaperone policy for details.

Types of speculum

Sims speculum

This speculum is designed to hold back the posterior vaginal wall allowing the anterior vaginal wall and the cervix to be visualised.[1] It is useful when vaginal wall prolapse is suspected[2], and for examination of an enterocele.[3] The woman is positioned in the left lateral position with her knees flexed i.e. Sims position.[2]

Cusco speculum

The Cusco speculum is classified as a bivalve speculum. It has been designed to hold back the anterior and posterior vaginal walls after opening so that the cervix may be visualised and has a screw for maintaining the 'open' position during examination. Modifications have resulted in various sizes,[3] [2] and the speculum is now made of steel or disposable perspex.[1] The handle can be rotated in a posterior or anterior direction.

Graves speculum

The Grave speculum is classified as a bivalve speculum. It has wide arched blades that curve markedly, a fixed handle and comes in a range of sizes, including paediatric. It is suitable for sexually active and multiparous women as the curved blades separate the vaginal wall better.[4] When using the Graves speculum the handle faces downward. The posterior blade is longer than the anterior blade allowing for positioning into the posterior fornix of the vagina.

Positioning

Dorsal position

The woman lies on her back with her head on one pillow. The knees are flexed and dropped to the sides.

Lateral position

The woman lies on her left side with both knees flexed.

Sims position

The woman lies on her left side, but the inner left leg is kept extended while the right knee (and leg) is flexed.

Lithotomy position

A modified ‘dorsal position’ where the feet are held in stirrups, the thighs are abducted and flexed.

Possible problems encountered during speculum examination

Vaginal wall laxity

If the vaginal walls are lax making visualisation difficult, consider using a wider or longer speculum.

A condom with the end cut off placed over the speculum may prevent the vaginal wall from collapsing. Ensure the woman has no history of a latex allergy.

Difficulty in locating the cervix

Withdraw the speculum, rather than continuing to manipulate it, and locate the position of the cervix with a gloved hand (moistened with water, not lubricant). Re-insert the speculum at the appropriate angle in the direction of the cervix.

If the cervix is not visible, consider asking the woman to “bear down” during insertion, which may assist relaxation of the vaginal muscles.

Equipment

- Speculum: may be metal or disposable
- Water based lubricant
- Unsterile examination gloves
- Adjustable light source
- Condom (if required)
- Long thick cotton swabs
- Sponge holding forceps
- Specimen collecting equipment (if required)

Procedure – Cusco speculum

Insertion

1. Explain the reason for the procedure and how it is performed. Offer the woman the opportunity to view the speculum and show her how it works.
2. Choose the appropriately sized speculum.
3. Ensure the bladder is empty. Consider pathogen PCR testing (i.e. chlamydia) of the urine before it is discarded.
4. Ensure the woman is appropriately covered and comfortable.
5. Position the light, perform hand hygiene and put on the gloves.

6. Part the labia minora with the non-dominant hand and inspect the external meatus and vulva.
7. Note the presence of:
    - abnormal appearing skin
    - discrete lesions
    - vaginal discharge or bleeding
    - scar tissue
    - skin piercing
    - female genital mutilation
8. If using a metal speculum, warm it in warm water if a pre warmed one is not available. Check the temperature on the gloved inner wrist and then on the woman's inner thigh.
9. Apply a small amount of the lubricant on the outer inferior blade of the speculum.
10. Using the non-dominant hand, part the labia minora with the thumb and forefinger and insert the speculum into the vagina. Ensure the blades are horizontal and remain together.[3]
11. Slide the closed speculum into the vagina following the axis of the vagina (normally 45º downwards).[3] The Cusco's speculum handle is designed to face downwards if the woman's position (lithotomy) or the examination bed allows. If the woman is lying flat or has a retroverted uterus and anterior cervix, the handle may be kept superior, but care must be taken not to traumatise the urethra or clitoris.[3]
12. Open the blades slightly to facilitate visual guidance towards the cervix.
13. Once the cervix is visualised, tighten the screw on the upper blade to retain the speculum in this position.
14. Observe the position and appearance of the cervix. Note the presence of inflammation, discharge, bleeding, lesions or any other abnormalities. The cotton swabs may be used to wipe away excess mucus or discharge that may obstruct clear visualisation of the cervix.
15. Perform any investigations as indicated.

Removal

1. Loosen the screw on the blade, withdraw the speculum gently from the vaginal fornices, allow the blades to close and remove by gentle downward traction.
2. Note any abnormalities on the vaginal walls.
3. Offer the woman a pad or tissues.
4. Discuss findings with the woman, normal or otherwise.
5. Document the procedure and findings in the woman's medical notes

Swabs: Low vaginal, high vaginal, endocervical & rectal

Quick reference guide

Quick Reference Guide

Pre-procedure:

1. **Consultation** (medical history, explain procedure and counsel, offer self-collection of low vaginal swab (LVS) / rectal swabs if asymptomatic)
2. Gain **consent and** offer a **chaperone**. Inform and gain consent for the presence of students and further consent if student is examining the patient.
3. **Prepare**: Empty bladder*, provide privacy, dorsal position, position light, attend hand hygiene and apply gloves and eye protection.

   *Consider pathogen PCR testing of the urine before discarding (i.e. chlamydia).

Procedure:

4. **LVS and Rectal** swabs: May be self-obtained by the woman if asymptomatic.
   - LVS: Insert swab 1-2 cm into vagina and place into transport tube (use charcoal medium tube for culture and a separate thin plastic/ wire shaft swab if PCR).
   - Rectal: Around/inside rectum just past external sphincter and place into charcoal tube.
5. **Inspect** the labia, external meatus and vulva; Insert speculum
6. **High vaginal swab (HVS)**: Swab, make smear on glass slide and place in charcoal medium.
7. **Endocervical swab (ECS)**: Cervical screening test first (if required), then clean mucous from cervix and take ECS PCR swab and place in tube. If pus/ inflammation of cervix, take ECS for culture, smear on glass slide and place in charcoal medium.

Post-procedure:

8. **Provide privacy** for re-dressing. Offer tissues as required.
9. **Document**: Procedure, consent, persons attending examination (e.g. chaperone, family), swab details (swab site, date, time, patient details- UMRN sticker or hand write with pencil on glass slides) on swabs and pathology form, findings and plan.
10. **Send** specimens to pathology.

Note: This QRG represents minimum care and should be read in conjunction with the full guideline. Additional care should be individualised.

Equipment

- Adjustable light source
- Biohazard labelled bag
- Sterile swab and glass slide in a slide carrier: one for each smear site (LVS, HVS, ECS)
- Transtube swabs (charcoal transport medium) - One per site swabbed (e.g. LVS, HVS and ECS)
- Bi-Valve speculum, if required
- Unsterile examination gloves
- Patient identification labels
- CST equipment, if required
- Sterile plastic/wire shaft fine swab (PCR for chlamydia)

Procedure

	Procedure	Additional information
1	**Consultation**	
1.1	Obtain a medical/sexual history.[1] See also Clinical Guidelines: Gynae: STI.	Assess if the woman has had previous pelvic examinations and her knowledge of the procedure. Explanation of the procedure, giving a chance for questions and responding sensitively eases anxiety and shows respect for the patient.[5]
1.2	Explain the procedure,[1, 5] explain confidentiality of results and counsel about the test(s) being performed.[6]	
1.3	Offer the option of self-collection of LVS / rectal swabs if appropriate.[6]	If symptomatic genital symptoms or suspected sexually transmitted infection, physical examination is best practice for diagnosis and treatment.[6]
2	**Consent**	
2.1	Obtain verbal consent before the procedure is commenced.[5] [6, 7]	If declined, explain the importance of the examination, offer the option to bring a support person of their choice to be present during the examination and, if still declined, defer to another time or refer to another suitable practitioner and document plan.[5]
2.2	Record consent and include anyone else attending the examination (e.g. family, chaperone, medical students).[5]	If initial consent is withdrawn during the procedure cease the examination, discuss concerns, defer to another time/practitioner and document plan.[5]
		If the woman is unable to provide consent, refer to the WA Health Consent to Treatment Policy. Providing a surrogate decision maker to consent

	Procedure	Additional information
		to the examination and a familiar individual (such as a family member or carer) to accompany the woman, may be appropriate.[5]
2.3	Offer a chaperone to all women, irrespective of the gender of the examiner.[1] Document the chaperone's name and qualifications.[5] See also NMHS Chaperone Policy and chaperone section at beginning of this document. It is recommended for practitioners conducting vaginal examinations or procedures to have another practitioner in attendance.	
2.4	The woman should be informed in advance of any students to be present and that they have the right to decline student attendance during any examination or consultation.[5] [7] • In addition, explicit consent should be gained if medical students are to examine the woman for education/training.[5] [7]	
3	**Preparation**	
3.1	Ensure the bladder is empty*.[1] *Consider pathogen PCR testing of the urine before discarding (i.e. chlamydia).	An empty bladder increases the woman's comfort and allows a more accurate assessment of the pelvic organs.[1]
3.2	Ensure the woman is adequately covered and comfortable.	Provide privacy to undress and a cover sheet to cover herself.[7]
3.3	Position for speculum examination with head on pillow, lying in a dorsal position[1] with knees flexed and hips abducted.	
3.5	Position the light.	Lighting is required for adequate inspection.[1]
3.6	Hand hygiene should be performed before and after patient contact. Put on gloves. If there is risk of splash, wear eye protection.[6]	See WNHS Infection Prevention and Management Manual: Hand Hygiene (available to WA Health staff through HealthPoint).

	Procedure	Additional information
4	**Inspection**	
	Part the lips of the labia minora with the non-dominant hand and inspect the external meatus, and vulva.[2]	Enables detection of[2]: • abnormal appearing skin • discrete lesions • vaginal discharge or bleeding • scar tissue • skin piercing • female genital mutilation
5	**Insertion of the speculum**	
	See Speculum Examination section above	The practitioner should be responsive to any patient expressing undue distress during an examination.[5]
6	**Collection of the swabs**	
6.1	**LVS, HVS and ECS** • Take a HVS and smear for pathogens[6] • Clean away cervical mucous, if necessary, then obtain an ECS[6] ➢ If PCR / NAAT place swab back into container with no transport medium[6] ➢ If culture (e.g. pus/ inflamed cervix) - obtain smear and swab into transport medium.	A smear **AND** a swab must be collected when performing an LVS/HVS or ECS. Label all samples with the woman's UMRN sticker, site (LVS, HVS, ECS), date and time of collection.[6] Store at room temperature.[6]
	Smear Swab the area using the sterile swab. Gently roll swab 2-3 timed in non-overlapping passes on to middle of glass slide. Discard this swab. Write the patient's name on the ground glass end of the slide with a pencil or use a patient ID sticker around the slide carrier. Allow the smear to dry in air before closing the slide carrier.	

	Procedure	Additional information
	Swab for culture Use the transtube swab. **LVS**: Insert the sterile swab 1-2cm into the lower entrance of the vagina and swab the sides of the vagina. The woman may prefer to collect her own (LVS only), with instructions from the medical/midwifery/nursing staff.[6] Insert the swab into the transport medium and label with the woman's identification sticker and indicate the site of collection. Place the slide and the transtube in a specimen bag with the request form in a separate pocket and send to the hospital Specimen Reception.	Asymptomatic women may prefer non-invasive techniques such as first void urine and self-obtained LVS rather than a pelvic examination.
6.4	**Rectal swab** Pre-moisten swab with transport medium. The woman may prefer to collect her own swab, with instructions from the medical/midwifery/nursing staff.[6] The swab is inserted into the rectum past the external anal sphincter and the specimen is collected. The swab is then inserted into the transport medium and labelled with the woman's UMRN identification sticker, the site of collection, date and time.[6]	Allows easier insertion of the swab. See Clinical Guidelines, Obstetrics and Gynaecology: GBS Disease
8	**Post-procedure**	
	Provide privacy for redressing[5] and tissues if required. Document procedure, findings, consent, persons attending examination (e.g. chaperone, family),[5] swab details (swab site, date, time, patient details: UMRN sticker or hand write with pencil on glass slides) on swabs and pathology form, and plan. Send specimens to pathology.	The samples should reach the pathology within 24 hours for optimal culture yield.[6]

Vaginal examination in girls and young women

Aim

- To guide medical, nursing and midwifery practitioners in relation to the indications for, and the conduct of, vaginal examination in girls and young women.

Key points

1. The girl's or young woman's best interest (their physical and psychological health and wellbeing) are paramount and should guide all decision making.[8]
2. Best practice includes effective communication. Medical Officers, nurses and midwives should take the utmost care in explaining the procedure to the girl or young woman (and parent/guardian). [8]
3. Examinations should be conducted so as to minimise discomfort and distress.[8]
4. The girl's or young woman's dignity and privacy shall be maintained throughout the examination regardless of the presence of others.[8] Provide privacy for disrobing and a suitable cover (e.g. gown or sheet) during examination.[7]
5. An appropriate adult witness, support person and/or chaperone shall always be present when examining a child.
6. When examining a young woman, the presence of an appropriate support person and/or chaperone should be encouraged and available.[8] The person who is the chaperone shall be agreed to by the girl/young woman.[5] If the girl/young woman is not comfortable with a particular chaperone, offer another chaperone. There should not be pressure to proceed if a suitable chaperone is not available.[5] The young woman has the right to decline the presence of a chaperone and the medical officer/nurse/midwife has the right not to perform the vaginal examination if they deem it inappropriate to examine the young woman without a chaperone.[5, 8] Document the chaperone's name and qualifications.[5] See also NMHS Chaperone policy and Chaperone section and beginning of this guideline.
7. Ensure there is valid consent from the young person and/or their parent or guardian prior to conducting a vaginal examination.[8] Valid consent must be voluntary, informed and based on the capacity of the patient to consent.[8] If required, an interpreter should be used to ensure valid consent to examination.[9] Practitioners should refer to state legislation regarding a child's capacity to consent.[8] A girl's or young woman's capacity to consent is considered on an individualised basis and is not only related to age.[8] Children can consent to a procedure if they have the capacity to understand the information and the implications of the procedure.[8]
8. Except in a medical emergency, vaginal or genital examination should not proceed in the absence of valid consent.[1, 5, 8]

9. When parents or guardians have consented on a girl's behalf, medical professionals should explain the procedure and proceed only with the girl's or young woman's assent.[8] Parental power to consent (or withhold consent) to treatment is limited that they may only validly consent to treatment that is in the child's best interests.[9]
10. Court authorisation for medical treatment of a minor is required if both the parents and the minor lack the capacity to consent in a non-emergency situation or if both parents refuse to consent to a necessary procedure.[9]
11. Special considerations shall be given to obtaining consent from patients who have or are[8]:
    - Living with an intellectual or physical disability
    - Experiencing mental health problems
    - Injured, in pain, or in shock
    - Drug or alcohol affected
    - Culturally and linguistically diverse
    - Sleep deprived
    - Unable to give valid consent
12. Digital or instrumental vaginal examination is very rarely indicated in prepubertal girls. Allegations of sexual abuse, vaginal bleeding, vaginal discharge or suspected genital malformation may require visual inspection of the vaginal vestibule and/or an ultrasound examination. If this does not provide the required information and further examination is medically necessary, examination under anaesthesia, including vaginoscopy, may be indicated.
13. In pubescent or post-pubertal girls, digital or instrumental examinations should only be performed with informed assent from the girl and the consent of their parent or guardian.
14. If a girl or young woman states that she is not sexually active, digital or instrumental vaginal examination are normally not indicated.[8]

Indications for speculum examination

- ECS for investigation of possible infection, when symptoms are present[8]
- ECS for forensic investigation[8]
- Assessment for abnormal vaginal bleeding[8]
- Assessment for possible intra-vaginal foreign body[8]
- Assessment for developmental abnormality (rarely)

If the Resident Medical Officer is unable to visualise the cervix, the Registrar/Senior Registrar must be contacted to complete the speculum and/or vaginal examination.

A result of the examination is to be documented in the patient's medical record MR 021/022.

Measures to minimise discomfort during pelvic examination

- Provide explanations tailored to the girl's or young woman's level of comprehension.[5, 8] An adequate explanation informs about the nature of the examination and the information it will provide.[7]
- Ensure that the equipment used is appropriate for the size or age of the girl or young woman.
- Discuss the use of any swabs or components (e.g. speculum) that will be used. Show any equipment to be used and provide the opportunity for the girl or young woman to touch or hold it.[10]
- Where possible, use anatomical models, pictures and pamphlets to provide information.[10]
- A familiar person (e.g. mother, relative[10]) should usually be present during the examination.[5] Additionally, ensure a qualified chaperone (e.g. Registered or Enrolled Nurse) is present that the girl or young woman is comfortable with.[5] The chaperone should be an impartial observer, which is different to a support person, though family may be used if there are no other options.[5]

Note: Be sensitive to the needs of the girl or young woman as she may feel embarrassed to undertake the examination in front of a relative.[5]

- Encourage the girl or young woman to provide feedback to the examiner if they are not comfortable, either physically or emotionally.[10] Be alert for non-verbal communications of distress and respect any requests to discontinue the examination.[5] Document any withdrawal of consent and relevant discussions.[5]
- Encourage the girl or young woman to empty her bladder prior to the examination.[1, 10]
- Conduct the examination in a calm environment, and ensure privacy.[5, 7] Unless the girl or young woman is having difficulty and requests assistance, do not assist with dressing or undressing.[5]

Refer also to NMHS Chaperone Policy as required for general considerations for all women, including further information on consent and chaperones applicable to all women.

Insertion and removal of a vaginal pack

Aim

The appropriate management and care of a woman during a vaginal pack insertion and removal.

Background

Vaginal packing is an emergency treatment for excessive bleeding per vagina, which can occur following cone biopsy, laser to cervix or trauma to the lower genital tract. It is also sometimes used for uterine prolapse. It is usually performed in the emergency centre, outpatient or theatre area.

If required on the ward, it is performed in the treatment room, with the patient placed on the examination couch in the lithotomy position.

Insertion

Equipment

- Assorted sterile speculums, Sims and Bi-valve, in various sizes
- Sterile scissors
- Sterile sponge holding forceps
- Gauze packs, 10cm radio opaque rolls. If more than one roll is required, ensure they are tied together securely
- Obstetric cream
- Normal saline
- Sterile gloves
- Long sterile cotton buds
- Monsell's paste/silver nitrate sticks

Procedure

For count requirements, follow WNHS Policy Procedural Count: Management and Procedure (available to WA Health employees via HealthPoint)

1. Ensure privacy.
2. Explain the procedure to the woman and reassure her.
3. Offer and administer appropriate analgesia.
3. Ensure woman's bladder is empty (catheterise if necessary).
4. Assist the Medical Officer as requested.
5. Following insertion, ensure the woman is dry, warm and comfortable.
6. Dispose of all equipment appropriately.
7. Check for further loss every 15 minutes for 1 hour and document findings.
8. Inform the Medical Officer of any continuing loss.

Removal of a vaginal pack

Vaginal gauze packing is removed as ordered by Medical Officer.

Check number of packs that were inserted. This will be documented in the patient's medical notes.

Equipment

- Disposable gloves
- Sterile sponge holding forceps
- Receiver
- Continence pad
- Personal protective clothing, including mask and goggles, if a splash is anticipated.

Procedure

1. Explain the procedure to the woman. Analgesia or anti-anxiolytic may be required, although generally this is not a painful procedure.
2. Position head on one pillow, if tolerated, and place the woman in the dorsal position and remove the bedclothes from the lower torso.
3. Remove the perineal pad.
4. Perform hand hygiene, don gloves.
5. Remove the vaginal gauze with sponge forceps or gather the gauze into the hand, gently drawing the visible end toward the perineum with downward and forward movements. Care must be taken withdrawing knotted strips. Apply a fresh perineal pad.
6. Record the removal on MR325 (report any discrepancy), Nursing Care Plan (MR286.01), the Observation Chart (MR 286) and the inpatient progress notes (MR 250).

   For count requirements, follow WNHS Policy Procedural Count: Management and Procedure (available to WA Health employees via HealthPoint)
7. Check and sign for the number of packs removed against number inserted in Operating Theatre on the operation record sheet MR 325. Report any discrepancy.
8. Check the pad for excessive bleeding every 15 minutes for half an hour.
9. The woman should remain in bed for 30 minutes after removal of the pack.
10. Excessive vaginal bleeding post pack removal should be reported to the medical officer. Rarely is it necessary for the vagina to be repacked (see previous page if required).
11. Remove the IDC as ordered.
12. Assist the woman to the shower.

Insertion of a vaginal pack for uterine procidentia

Aim

The insertion of a vaginal pack to replace a prolapsed uterus.

Key points

1. For count requirements, follow WNHS Policy Procedural Count: Management and Procedure (available to WA Health employees via HealthPoint)
2. This procedure may be performed by nursing/midwifery staff.
3. If the prolapse is unreducible the woman must be reviewed by the Medical Officer.
4. This procedure is usually performed for a predetermined time prior to definitive surgery
5. The pack is usually replaced daily.
6. An indwelling catheter should be inserted for the duration of the pack being in situ.
7. The procedure is carried out using the principles of asepsis.

Equipment

- Sterile dressing pack
- Sterile gloves
- Prescribed lotion / lubricant gel
- Sterile scissors
- Sanitary pad
- Packing gauze 10cm x2

Note: Usual regime is estrogen cream (e.g. ovestin) and clinigel ointment. Estrogen cream needs to be prescribed on medication chart, clinigel does not. Clindamycin is also sometimes prescribed.

Procedure

1. Explain the procedure and gain verbal consent.
2. Offer appropriate analgesia.
3. If it is the first time to insert the vaginal pack, first reduce the procidentia, insert IDC and then the vaginal pack(s).
4. On a daily basis, remove the pack prior to patient's shower then reinsert new pack after shower. It is optimal if patient has bowels open whilst pack is out.
5. Open dressing pack and prepare equipment including creams, packs, scissors and sterile gloves. Wash hands (aseptic hand wash) and don sterile gloves.
    a. For count requirements, follow WNHS Policy Procedural Count: Management and Procedure
    b. For 1 pack (if estrogen cream is prescribed) mix one full tube of estrogen cream with one full tube lubricant gel, use forceps to mix these together in the tray in dressing pack. If two or more packs are required, continue to use only one tube of Ovestin and two or more tubes of lubricant gel as required.

   c. If using two or more packs, tie firmly together prior to soaking and insertion into the vagina.
   d. Soak pack(s) in the mixture, ensuring coverage over the whole length
6. Place the woman in the left lateral or supine position on a continence sheet (bluey). Cover appropriately to maintain dignity.
7. Ensure that the bed is at the correct working height for you and that there is adequate light to perform the procedure.
8. If Clindamycin cream is prescribed, measure the dose out (usually one full applicator) insert ½ way into vagina using applicator and put the other ½ onto the tip of the pack and this tip will be inserted first.
9. Transfer the soaked pack/s in sterile tray close to woman's vagina.
10. Using a sterile gloved hand, gently replace the prolapsed uterus.
11. Insert the soaked pack(s) using gloved hand.
12. Place a sanitary pad and assist patient (as required) to a position of comfort.
13. Document the procedure in the woman's notes on MR 263 (Wound Management and Care Plan).

Note: If pack falls out within 24 hours, it needs to be replaced but Ovestin cream is only to be used once per day. For subsequent insertion of vaginal pack, only clinigel should be used.

References

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http://www.racp.edu.au/docs/default-source/advocacy-library/genital-examinations-in-girls-and-young-women-a-clinical-practice-guideline.pdf

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Related policies, legislation, resources

Legislation (external websites)-

- *Children and Community Services Act 2004*
- *Commonwealth Family Law Act 1975*
- *Guardianship and Administration Act 1990*
- *Health (Miscellaneous Provisions) Act 1911*
- *Health Practitioner Regulation National Law (WA) Act 2010*
- *Health Services Act 2016*
- *Privacy Act 1988*
- *Public Health Act 2016*

Related NMHS Policies –

- NMHS Chaperone Policy

Department of Health WA:

- Mandatory Policy: MP 0051/17 WA Health System Language Services Policy
- Mandatory Policy: MP 0166/21 Mandatory Reporting of Child Sexual Abuse Training Policy
- WA Health Consent to Treatment Policy (2016) (including section 4.3.2- Children and Young People: Mature Minors)
- Guidelines for Protecting Children 2020
- Website: Safety and Quality: Consent
- WA Youth Health Policy 2018-2023 Toolkit- Resources for Health Professionals and legal resource (2020) (external website, PDF, 3.88MB) (assessment as mature minor)
- HealthyWA website: Sexual Assault Resource Centre

Public Health:

- Silver book
- Nurse / Aboriginal Health Practitioner Initiated STI Treatment Code (2018);
- Self-collection patient information:
  - How to self-collect specimens to test for sexually transmissible infections (PDF, 729KB)

- Communicable Disease Control Directorate: Chlamydia: Testing and Clinical Management (self-obtained LVS instructions)

Related WNHS policies, procedures and guidelines

WNHS Clinical Guidelines, Obstetrics and Gynaecology:

- Gynaecology (Non-oncological): Care following a Simple / Radical Vulvectomy
- Perioperative: Preparation and Management
- Sexually Transmitted Infections (screening tests and specific STI information)
- Wound Care: Collection of a Wound Swab

WNHS Policies (available to WA Health staff through HealthPoint):

- Language Services (interpreter use)
- 'Pathology and Ultrasound: Ordering by Midwife/Nurse/NP' [moving to a WNHS policy]: including Antenatal Tests: Requesting; Swabs: LVS: Request; HVS: Request; ECS: Request; GBS Antenatal Screening: Request
- Patient Identification
- Procedural Count: Management and Procedure

Sexual Assault Resource Centre (SARC) (access to WA Health employees through HealthPoint) and SARC consumer website

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NSQHS Standards	☒ 1: Clinical Governance	☐ 5: Comprehensive Care	

(v2) applicable:	☒ 2: Partnering with Consumers ☒ 3: Preventing and Controlling Healthcare Associated Infection ☐ 4: Medication Safety	☒ 6: Communicating for Safety ☐ 7: Blood Management ☐ 8: Recognising and Responding to Acute Deterioration
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Version history

Version number	Date	Summary
1	Sept 2017	First version. Amalgamated these 7 individual guidelines (3 from section Gynaecology and 4 from O&G, dated from August 1999) into one document: 1. Speculum Examination [O&G] 2. Swabs: LVS, HVS, ECS, Rectal [O&G] 3. Papanicolaou (Pap) Smear [O&G] 4. Vaginal Examination in Children and Young Women [O&G] 5. Insertion of a Vaginal pack for Uterine Procedentia [Gyn] 6. Vaginal Irrigation [Gyn] 7. Insertion and Removal of a Vaginal Pack [Gyn]
2	Mar 2018	Full content review • The 'Pap smear' has changed to Cervical Screening Test. • Chaperoning –see NMHS chaperoning policy
2.1	June 2020	Fixed links and added link to new 'Procedural Count: Management and Procedure' WNHS policy
3	Feb 2022	Full content review. • Changes to CST screening ➢ All women 25 to 74 years should have transitioned to the renewed NCSP. If not, they are now overdue. ➢ Women of any age who have symptoms suggestive of cervical cancer require diagnostic testing and should be managed in accordance with NCSP guidelines, regardless of their cervical screening history. ➢ Add indigenous status, country of birth and language. ➢ **If a 12 month follow-up CST is HPV (not-16/18) detected,** with LBC prediction of negative, pLSIL or LSIL, the woman is regarded as **still at intermediate risk** and to have a second HPV follow-up test in a further 12 months' time (earlier if higher risk population- see below^). ➢ ^Women at higher risk of high- grade abnormality should have referral to colposcopy if HPV (any type) is detected at 12 months, regardless of result of reflex cytology. This includes the following groups: ○ Women ≥2 years overdue at time of initial screen ○ Women who identify as Aboriginal and / or Torres Strait Islander

		○ Women aged 50 years or older • Consider PCR testing of urine (chlamydia) before discarding • 'Vaginal Irrigation' removed- no longer performed • 'Insertion of a vaginal pack for uterine procidentia' procedure updated- read procedure. If pack falls out within 24 hours, it needs to be replaced but ovestin cream is only to be used once per day. For subsequent insertion of vaginal pack only clinigel should be used.
4	Nov 2022	• Cervical screening chapter removed – now standalone guideline • Minor other formatting • Updated chaperone section with NMHS Chaperone policy. ➢ A chaperone must be a NMHS employed clinician governed by APHRA. Students are not eligible as a chaperone. ➢ If the patient declines a chaperone the clinician may choose not to undertake the examination or procedure, may postpone same and/or refer the patient to another clinician. The patient's decision and the subsequent plan must be documented. ➢ Document: - That a chaperone was offered - Name and professional designation of the: Clinician AND the Chaperone present

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