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 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.

EQUIPMENT

Assorted sterile speculum – Sims and Bi-valve, various sizes
Sterile Scissors
Sponge 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

1. Ensure privacy.
2. Explain the procedure to the woman and reassure her. 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 antianxiolytic may be required, although generally this is not a painful procedure.

2. Position on one pillow, if tolerated, and place the woman in the dorsal position and turn the bedclothes down.

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 movement. 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).

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 it is necessary for the vagina to be repacked, see page 1 if required.

11. Remove the IDC as ordered.

12. Assist the woman to the shower.

Do not keep printed versions of guidelines as currency of information cannot be guaranteed. Access the current version from the WNHS website

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