## CLINICAL PRACTICE GUIDELINE

### Vaginal Procedures

This document should be read in conjunction with the [Disclaimer](#).

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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 women shall be offered a chaperone during any intimate physical examination / procedure. This will be the patient’s choice. No assumptions should be made as to who is the most appropriate chaperone.
4. The patient may refuse a chaperone.
5. Health care providers performing a vaginal examination have the right to request another health care provider is attendance.
6. The chaperone shall sign the ‘Chaperone’ stamp in the woman’s medical records. If the offer of a chaperone is declined, this shall be documented in the woman’s notes.
7. The clinician and the chaperone shall discuss the role of the chaperone prior to the physical examination / procedure.

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.⁴

Cusco speculum
The Cusco speculum is classified as a bivalve speculum. It has been designed 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,³,⁴ 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.⁵ 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 women 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 and make 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 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 again at the appropriate angle.

If the cervix is not visible consider asking the woman to “bear down” during insertion, which may assist relaxation of the vaginal muscles. It may be beneficial to consider asking the woman to self-insert the speculum.

**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 appropriate sized speculum.
3. Ensure the bladder is empty.
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 skin conditions
   - lesions
   - vaginal discharge or bleeding
   - scar tissue
   - skin piercing
   - any evidence of 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 (not done if premature rupture of membranes is suspected) 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.
11. Slide the closed speculum into the vagina following the axis of the vagina (45º downwards). The Cusco’s speculum handle may face downwards if the woman’s position, the examination bed or lithotomy position allows. If the woman is lying flat, the handle may be kept superior, but care must be taken not to traumatise the urethra or clitoris.
12. Open the blades slightly to allow 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 any 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 upper blade, withdraw the speculum gently from the vaginal fornices, close the blades and remove by gently downward traction.

2. Note any abnormalities on the vaginal walls.

3. Offer the woman a pad or tissues.

4. Discuss any findings with the woman.

5. Document the procedure and any findings in the woman’s medical notes.

REFERENCES (STANDARDS)


National Standards – 11.4.1 Consumer / Patient Consent
Legislation - Nil
WNHS Patient Interview and Examination (2015)
Other related documents – Nil

RESPONSIBILITY

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<th>Policy Sponsor</th>
<th>Medical Director Obstetrics</th>
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Swabs: Low vaginal, high vaginal, endocervical & rectal

Quick reference guide

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

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

**Post-procedure:**
8. Provide privacy for redressing. 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 & plan.
10. **Send** specimens to pathology.

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

**Aim**
- To guide staff in the correct collection of vaginal and rectal specimens.

**Equipment**
- Adjustable light source
- Bi-Valve speculum if required
• Biohazard labelled bag
• Sterile swab & 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 &ECS)
• Unsterile examination gloves
• Patient identification labels
• Pap Smear equipment, if required
• Sterile plastic/wire shaft fine swab (PCR for chlamydia)

Procedure

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<thead>
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<th>PROCEDURE</th>
<th>ADDITIONAL INFORMATION</th>
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<tr>
<td><strong>1 Consultation</strong></td>
<td>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.</td>
</tr>
<tr>
<td>1.1 Obtain a medical / sexual history.¹ See also Clinical Guidelines: Gynae: STI.</td>
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<tr>
<td>1.2 Explain the procedure to the woman¹-³ explain confidentiality of results and counsel about the test(s) being performed.⁴</td>
<td>If symptomatic genital symptoms or suspected sexually transmitted infection, physical examination is best practice for diagnosis and treatment.⁴</td>
</tr>
<tr>
<td>1.3 Offer her the option of self-collection of LVS / rectal swabs if appropriate.⁴</td>
<td></td>
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<tr>
<td><strong>2 Consent</strong></td>
<td>If declined, explain the importance of the examination, offer a chaperone for support and if still declined, defer to another time or refer to another suitable practitioner and document plan.³</td>
</tr>
<tr>
<td>2.1 Obtain verbal consent before the procedure is commenced.¹-⁴</td>
<td>If initial consent is withdrawn during the procedure cease the examination, discuss concerns, defer to another time / practitioner and document plan.³</td>
</tr>
<tr>
<td>2.2 Record consent and include anyone else attending the examination (e.g. family, chaperone, medical students).³</td>
<td>If the woman is unable to provide consent, refer to the WA Health Consent to Treatment Policy. Providing a surrogate decision maker to consent to the examination and a familiar individual (such as a family member or carer) to accompany the woman, may be appropriate.³</td>
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</table>
Vaginal Procedures

**PROCEDURE**

2.3 Offer a chaperone to all women, irrespective of the gender of the examiner. Document the chaperone’s name and qualifications. See also NMHS Chaperone Policy.

It is recommended for practitioners conducting vaginal examinations or procedures to have another practitioner in attendance. See Clinical Guideline: Obstetrics & Midwifery: Antepartum Care: Antepartum Procedures-Maternal: Performing a Vaginal Examination

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.

- In addition, explicit consent should be gained if medical students are to examine the woman for education / training.

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.

- In addition, explicit consent should be gained if medical students are to examine the woman for education / training.

**ADDITIONAL INFORMATION**

If the offer of a chaperone is declined, document in the woman’s medical records. If the practitioner would like a chaperone but the woman does not consent, the practitioner does not have to perform the procedure, and may refer to another practitioner or defer to another time, where appropriate.

The chaperone / practitioner:

- is an impartial observer
- must be qualified (e.g. Registered or Enrolled Nurse or appropriately trained to support the woman)
- must be approved by the woman (& a gender approved by the woman or carer)
- maintains confidentiality and respects the woman’s privacy
- provides security for both the examiner and the woman
- may give assistance if required

**Preparation**

3.1 Ensure the bladder is empty. An empty bladder increases the woman’s comfort and allows a more accurate assessment of the pelvic organs.

3.2 Ensure the woman is adequately covered and comfortable. Provide privacy to undress & a sheet to cover herself.

3.3 Position for speculum examination with head on pillow, lying in a dorsal position with knees flexed & hips abducted. Lighting is required for adequate inspection.

3.5 Position the light.

3.6 Hand hygiene should be performed before and after patient contact. Put on gloves. If there is risk of splash, wear eye protection.

### PROCEDURE

#### ADDITIONAL INFORMATION

**4 Inspection**

Part the lips of the labia minora with the non-dominant hand and inspect the external meatus, and vulva.

Enables detection of:
- abnormal skin conditions
- lesions
- vaginal discharge or bleeding
- scar tissue
- skin piercing
- evidence of 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.

**6 Collection of the swabs**

6.1 **Low vaginal swab (LVS), High vaginal (HVS) & Endocervical swab (ECS)**

- Take a HVS and smear for pathogens.  
- Take a Pap Smear and/or pH if required.
- Clean away cervical mucous if necessary, then obtain an ECS
  - If PCR / NAAT place swab back into container with no transport medium
  - If culture (e.g. pus/ inflamed cervix) - obtain smear and swab into transport medium.

A smear and a swab must be collected when performing a LVS/HVS or ECS

Label all samples with the woman’s UMRN sticker, site (LVS, HVS, ECS), date and time of collection.

See Pap Smear section within this document.

Store at room temperature

**Smear**

Swab the area using the sterile swab. Gently roll the swab 2-3 timed in non-overlapping passes on to the middle of the 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
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<td>closing the slide carrier.</td>
<td>Non-symptomatic women may prefer noninvasive techniques such as first void urine and self-obtained LVS rather than a pelvic examination.</td>
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</table>

**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 (Low vaginal swab only), with instructions from the medical / midwifery / nursing staff. 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 Specimen Centre KEMH.

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. 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.

Allows easier insertion of the swab. See Clinical Guidelines, Obstetrics & Midwifery: Antepartum Care: Infections in Pregnancy: GBS Disease

8 **Post-Procedure**

Provide privacy for redressing and tissues if required.

Document procedure, findings, 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.

The samples should reach the pathology within 24 hours for optimal culture yield.
**PROCEDURE**

Slides) on swabs and pathology form, and plan.

Send specimens to pathology.

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**REFERENCES / STANDARDS**

6. Pelvic Examination Family Planning Western Australia Guidelines for Clinical Practice. Family Planning Western Australia. 2006.

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**RESPONSIBILITY**

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Papanicolaou (Pap) smear

Background Information

Procedure

Cervical Screening Recommendations - frequency of Pap smears

Interpreting Reports & Management

(Click on a hyperlink above to go directly to that section in the document)

Note: Changes to Australia’s National Cervical Screening Program are planned to occur 1 December 2017. For details, see http://www.cancerscreening.gov.au/

Aim

- To guide staff on the procedure of collecting a Pap smear, ensuring high quality specimen collection, and assisting to reduce the incidence of, and mortality from, cervical cancer.

Background information

Australia has the second lowest cervical cancer rate in the world amongst countries with comparable cancer registration systems. This has been largely attributed to the implementation and success of the National Cervical Screening Program (NCSP) in 1991. Cervical cancer is a largely preventable disease, as shown by a study in Victoria, where over 80% of women who developed invasive squamous cell cervical cancer in 2012 had no screening history or a lapsed screening history recorded in the Victorian Cytology Register. According to the Australian Institute of Health and Welfare (AIHW) Cervical Screening in Australia 2012-13: in 2011 there were 801 new cervical cancer cases diagnosed and in 2012 there were 226 deaths from cervical cancer.

Where Indigenous status data is collected, Aboriginal and Torres Strait Islander women are shown to have more than twice the cervical cancer rate and four times the mortality rate than that of non-Indigenous women. Reasons for the increased incidence and mortality rates among this population include lower cervical screening rates, and increased prevalence of residence in a remote location, as higher mortality is demonstrated in women residing in remote areas, where access to medical treatment could potentially be an issue.

Each Australian state and territory, as part of the National Cervical Screening Program, has a Cervical Screening Register, which keeps a confidential record of all cervical cytology, histology and more recently human papillomavirus (HPV) DNA results, taken on women residing within the jurisdiction. Unless the woman actively declines (the opt-off rate is less than 1%) it is compulsory for all laboratories to forward test results to the Register. The Register functions as a safety net, where women identified as overdue for routine cervical screening are provided a reminder in the form of a letter. Information held in the Register also supports women with
screen detected abnormalities that are overdue for their follow-up. In this case letters are directed to health care providers in the first instance. Other uses of Register information include statistical analysis and monitoring of cervical screening participation.  

Recent data has shown HPV is detected in 99.7% of cervical cancer cases\(^1\). HPV is spread during sexual activity, which includes any genital-skin to genital-skin contact. Infection with one or more types of HPV through adulthood is extremely common (peaks in young adulthood), but most healthy people will clear the virus within one\(^3\) to two years. In up to 10% the infection remains,\(^3\) and in rare cases where the virus persists and is undetected, it can lead to cervical cancer, although this may take up to 10-15 years from viral acquisition to develop.\(^1\),\(^3\) While virtually all cervical cancers are positive for HPV, other associated co-factors may include smoking, HIV co-infection, herpes simplex virus,\(^5\) multiparity (specifically >5 full-term pregnancies), young age at first full-term pregnancy, oral contraceptive use, and immune suppression\(^3\).  

In 2007 Australia introduced free national HPV vaccination.\(^4\),\(^6\) Although initially for girls, the Program now recommends vaccination to girls and boys in their first year of high school (aged 12-13 years),\(^6\) with the Gardasil vaccine. Gardasil\(^®\) and Cervarix\(^®\), the two HPV vaccinations available in Australia, have been shown to prevent acquisition of two HPV types that have oncogenic potential, HPV 16 and 18.\(^6\) HPV types 16 and 18 have been found in over 70% of cases of cervical cancer, thus vaccination could prevent these cases.\(^3\),\(^6\) As HPV vaccination does not protect against all HPV types, vaccinated women should continue having Pap smears.\(^6\)  

Gardasil\(^®\) also offers protection from two non-oncogenic types of HPV, 6 and 11, which are responsible for the majority (90%) of genital wart lesions\(^6\) and for some low grade squamous intraepithelial lesion Pap smear results. Gardasil\(^®\) is licensed for use in females aged 9-45 years and males aged 9-26 years,\(^6\) and the duration of immunity has been demonstrated up to nine years post vaccination.\(^6\) Cervarix\(^®\) has been approved for use in women aged 10-45 years.\(^6\) Women older than 26 should be provided with information to make an informed decision regarding the cost and benefit of vaccination.\(^6\)  

The HPV vaccine does not prevent persistent infection or cervical abnormalities in women who are already infected with these HPV types prior to vaccination.\(^6\) Thus, the decision to vaccinate women who have already initiated sexual activity needs to be on an individual basis following a thorough discussion of the benefits, risks and cost.\(^6\)  

Note: Gardasil\(^®\) and Cervarix\(^®\) are pregnancy category B2 (not recommended for use in pregnancy).\(^6\) If the woman has not completed the three dose course, remaining doses should be delayed until after pregnancy.\(^6\)
Cervical cancer complicating pregnancy occurs in about 0.05% of pregnancies. Pregnant women with low-grade cytologic abnormalities should be managed in the same way as for all women with low-grade squamous abnormalities. If a pregnant woman is found to have a high-grade lesion she will require early referral for colposcopy examination which is considered safe in pregnancy, to exclude the presence of invasive cancer.¹

Cervical screening in WA is the responsibility of physicians, nurses and midwives. The Department of Health WA Operational Directive (OD) 0555/14: Guidelines for the Credentialing of Pap Smear Providers recommends that nurses and midwives, registered with the Nursing and Midwifery Board of Australia, who perform cervical screening, apply for credentialing as a Pap Smear Provider (PSP). See OD 0555/14 for credentialing application details. The process of credentialing ensures quality assurance of smear taking and recognition of one’s skills and contributions to cervical screening. Pap smear provider courses are available through KEMH/WNHS: DNAMER (internal staff) and Sexual and Reproductive Health WA (formerly Family Planning WA).

**Procedure: Performing a pap smear**

**Equipment**

- Bi-valve speculum (plastic or metal)
- Jar containing fixative solution
- Cervex-Brush® / Cytobrush® / Spatula
- Torch or extension light
- 1 glass slide – labelled with the woman’s full name (surname & given name) in pencil (ink will dissolve due to the fixative)

**Procedure**

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<tr>
<td>1 Preparation</td>
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<tr>
<td>1.1 Inform the woman:</td>
<td>Prior to examination the provider should ensure:</td>
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<tr>
<td>- the purpose and importance of screening⁷</td>
<td>- the woman has been given enough information to ensure an informed decision, which may include declining examination and/or screening.⁷</td>
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<td>- the follow-up required for positive and negative results (including counselling and support services)</td>
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<td>PROCEDURE</td>
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| false positive findings  
- risks associated with screening including risks of treatment should it be required  
- any significant implications (medical, social, financial) of screening. | • verbal permission is obtained to conduct the procedure  
• privacy is ensured, and suitable covers are provided during examination  
• understanding of the role and benefits of the WA Cervical Screening Register (CSR), including the required and automatic transmission of results from laboratories to the CSR unless the woman declines (“opt-off” system) |

1.2 Ensure a chaperone is available to attend irrespective of provider gender.  
The chaperone signs the “Chaperone” stamp which is placed in the woman’s medical record after the examination.

1.3 Position the patient.  
The supine position is usually the best, with knees bent and letting the knees fall apart. The left lateral position may be used if the cervix is difficult to visualise e.g. an older women with a lax anterior wall.

1.4 Confirm patient identification and cervical screening history, complete relevant details on the pathology request form, and label the frosted section on the glass slide with a pencil with the woman’s full name (surname & given name).  
Place a patient identification sticker on the container that will hold the glass slide.  

2 Speculum insertion

2.1 Refer to Speculum Examination in this document.  
Provides instruction about performing a speculum examination.

3 Taking the Pap Smear

3.1 1. Insert the speculum.  
2. Inspect the cervix. Note if the squamous columnar junction (SCJ) is visible and whether the cervix appears normal, a variation of normal, or

Offering the woman a choice of positioning or self-insertion of the speculum may help reduce feelings of vulnerability and powerlessness. Moisten and warm the speculum. This may be done with warm water or a
PROCEDURE | ADDITIONAL INFORMATION
---|---
abnormal. | Lubricant. Lubricant may interfere with collection, however a small amount of water-soluble lubricant on the speculum does not reduce the quality of Pap smears and probably does not affect microbiologic results provided it is used sparingly and contact with the cervix is avoided.

3.2 If unable to locate the cervix:
- ask the woman to lift her buttocks and place a rolled towel under them, or place her clenched fists under her buttocks;
- withdraw the speculum, and palpate the position of the cervix with a gloved hand, moistened with water (not lubricant). Reinsert the speculum in the direction of the cervix.
- Use a different size speculum

If the lateral vaginal walls are bulging inwards, consider using a larger speculum or use of a condom over the speculum (cut off the reservoir of the condom).

4 Pap smear collection:

4.1 Take the smear from the ectocervix and the endocervical canal using implement(s) appropriate for the woman (Cytobrush®, Cervex-Brush®, spatula).

It is recommended a Cytobrush® should be used in conjunction to the Cervex-Brush® in the following circumstances:
- Premenopausal women who have undergone surgery for a previous cervical abnormality e.g. cone biopsy
- Women whose previous smears

The Cervex-Brush® is used to collect both endocervical and ectocervical cells, and is the preferred implement for most women. The Ayres Spatula is not commonly used or recommended unless more effective instruments are unavailable.

An optimal Pap smear sample has:
- Sufficient mature and metaplastic squamous cells to indicate adequate sampling from the transformation zone
- Sufficient numbers of endocervical cells, which indicate the upper
### PROCEDURE

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<th>have shown no endocervical cells</th>
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<td>• Post-menopausal women in order to increase likelihood of collection of endocervical cells.</td>
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<tr>
<td>• Where the SCJ is not visible.</td>
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### ADDITIONAL INFORMATION

- Limit of the transformation zone was sampled, ensuring screening for adenocarcinoma and its precursors.

### 4.2 Using the Cervex-Brush®

- Insert the centre of the brush into the endocervical canal
- Rotate the brush 3-5 times in the same direction, keeping bristles in contact with the ectocervix, ensuring the SCJ, if visible, is sampled. If a large ectropian is present, ensure that a sample of cells is collected from beyond the border of this area as well. If a large ectropian is present, ensure that a sample of cells is collected from beyond the border of this area as well.
- Transfer the cellular material onto the glass slide by sweeping the brush in one direction on one end of the side, turn the brush over and repeat the motion on the other end of the slide (note that if using Cervex-Brush® in conjunction with Cytobrush®, only transfer cellular material on one end or one side of the slide, reserving the remaining end/side of the slide for Cytobrush® cellular collection).
- Place the glass slide into a patient labelled jar with fixative solution.

### 4.3 Using the Cytobrush®

- Gently insert the brush into the cervical os
- Gently rotate the cytobrush® one quarter of a turn in the endocervical canal.
- Roll the cytobrush® on one end or one side of the slide. Place the glass slide into a patient labelled jar with fixative solution.
- It is recommended that the Cytobrush® not be inserted out of vision of the cervical canal. More rotations drive the desired cells deeper into the bristles and they may not be transferred to the glass slide.

### 4.4 Using the Spatula

- Place the end of the spatula in the
- If a large ectropion is present, ensure
<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>ADDITIONAL INFORMATION</th>
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</table>
| cervical os. | that a sample of cells is collected as well from beyond the border of this area.  
- Rotate the spatula three times keeping the shoulder of the spatula in contact with the ecto-cervix and ensuring the SCJ, if visible, is sampled.  
- Wipe spatula on one end or one side of the labeled slide. Place slide into jar with fixative solution. |

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<tr>
<th>5</th>
<th>Pap smear collection: OBSTETRIC</th>
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</table>
| 5.2 | Inform the woman that Pap smears can be performed in pregnancy.  
Women should be advised of the possibility of spotting or minor bleeding following collection and reassured that there is no risk to the fetus. Any heavy or sustained bleeding should be followed up. If concerned about the amount of bleeding, the woman should contact her health care provider. |
| 5.2 | Collect the smear using the **Cervex-Brush®** brush as described above.  
**Do not use the Cytobrush®** in pregnancy (>10 weeks).  
A smear may need repeating in 6-12 weeks if the sample is unsatisfactory. In these situations, liquid based cytology collection may be offered as an adjunct to the repeat conventional Pap smear.  
This may be due to cells that have been obscured by blood, inflammation, mucous, or there may not have been sufficient cells to provide adequate assessment. Also a smear that has not been properly prepared (e.g. a delay in fixation, leading to air drying of cells) may be inadequate.  
See also **Use of Liquid Based Cytology** below. |

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<tr>
<th>6</th>
<th>Follow up</th>
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</table>
| 6.1 | Inform women of recommendations for **future screening frequency**.  
Advise the woman that the Cervical Cytology Coordinator Nurse at KEMH will review all Pap smear results, and a letter documenting the result will be The Pap smear results for women attending Oncology and Colposcopy services are reviewed and managed by the attending doctor. |
Use of liquid based cytology (e.g. ThinPrep®, SurePath)
If the Pap smear slide in fixative is also accompanied by a liquid based cytology sample, then this should be noted on the Pathology request form including the rationale (e.g. previous unsatisfactory result due to inflammation, sample is heavily blood stained, etc.).

Interpreting reports & recommended management
Any abnormal symptoms not readily explained (e.g. post coital or intermenstrual bleeding or spotting) should be investigated regardless of Pap smear history or current result. Any abnormality noted upon visual inspection of cervix requires immediate colposcopy referral.

<table>
<thead>
<tr>
<th>PAP SMEAR REPORT</th>
<th>MANAGEMENT</th>
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<tbody>
<tr>
<td>Negative / within normal limits.</td>
<td>Repeat Pap smear in 2 years</td>
</tr>
<tr>
<td>Negative / within normal limits and no endocervical cells present.</td>
<td>Repeat Pap smear in 2 years</td>
</tr>
<tr>
<td>Negative with inflammation.</td>
<td>Repeat Pap smear in 2 years</td>
</tr>
<tr>
<td>Unsatisfactory</td>
<td>Repeat Pap smear in 6 – 12 weeks</td>
</tr>
<tr>
<td>Low-grade squamous intraepithelial lesion (LSIL)*</td>
<td>Repeat Pap smear in 12 months. If the woman is 30+ years, and has no negative cytology in the previous 3 years, either refer for colposcopy or repeat Pap smear in 6 months.</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td></td>
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<tr>
<td>Possible LSIL*</td>
<td></td>
</tr>
<tr>
<td>High-grade squamous intraepithelial lesion (HSIL)</td>
<td>Refer for colposcopy.</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td></td>
</tr>
<tr>
<td>Possible HSIL</td>
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</tr>
<tr>
<td>Glandular abnormalities, including adenocarcinoma in situ</td>
<td>Refer for colposcopy, which should be performed by a gynaecologist with expertise in suspected malignancies or by a gynaecologist/oncologist.</td>
</tr>
</tbody>
</table>
Invasive squamous cell carcinoma (SCC)  OR  Adenocarcinoma

Refer to a gynaecologist / oncologist

* Two LSIL results (including possible LSIL) within a three-year timeframe, even if intervening negative results, requires colposcopy referral

Special circumstances

- Abnormality in pregnancy – follow guidelines as for non-pregnant women. High-grade lesions require an early colposcopy referral to the KEMH colposcopy clinic.

- Immunosuppression (defined as a CD4 count of <400 in HIV positive women or transplantation with immunosuppressive therapy for >3 years) - refer for colposcopy at KEMH even if the lesion is a low-grade abnormality.

- Women exposed to diethylstilboestrol (DES) – annual cytological screening and colposcopy of the cervix and vagina performed in a specialist centre by an experienced colposcopist.

Cervical screening recommendations

The Australian National Cervical Screening Program recommends:

- Routine screening with Pap smears should be carried out every two years for women who have no symptoms or history suggestive of cervical pathology.³

- All women who have ever been sexually active (including any genital-skin to genital-skin contact) should commence having Pap smears between the ages of 18 – 20 years, or one to two years after first sexual activity, whichever is later.³

- This policy applies to women with no symptoms and normal Pap smear results who should be screened every two years. Women with abnormal smear results should be managed in accordance with National Health and Medical Research Council Guidelines (NHMRC) guidelines: ‘Screening to Prevent Cervical Cancer: Guidelines for the Management of Asymptomatic Women with Screen-Detected Abnormalities’ (2005).³ Available at: http://www.nhmrc.gov.au/publications/synopses/wh39syn.htm

- Women aged 70 years and over who have had two normal smears in the previous five years may cease having Pap smears. Women over 70 years who have never had a Pap smear, or who request a Pap smear, should be screened.³

- Pregnancy: Offer a Pap smear to all pregnant women who are due to screen, up to at least 24 weeks gestation.¹¹ Offer to perform a Pap smear up to at least 28 weeks, and for select women in the third trimester, if they are likely to have difficulty presenting in the postnatal period.⁸ This decision needs to be assessed on an individual case by case basis.

- Hysterectomy: Regular vault smears after hysterectomy should continue to be performed in the following circumstances¹⁴:
Vaginal Procedures

- Women who have had a subtotal hysterectomy (cervix still in situ) should continue to have Pap smears at the recommended intervals.13, 14

- Women who have had a total hysterectomy for benign reasons (e.g. menstrual problems or prolapse), with a history of normal Pap smears, histopathology of the cervix showed no neoplastic or premalignant changes, and who are asymptomatic - screening is no longer required.14

- Women who have had a hysterectomy that has completely excised a high-grade lesion (CIN2-3/ACIS) - ongoing annual screening is reasonable for five years, then reverting to the recommended screening interval.14

- Women who have had a hysterectomy for invasive gynaecological malignancy - ongoing screening recommendations are required to be at the discretion of a Gynaecologist/ Oncologist.14

- Women who have a history of LSIL on Pap smear or cervical biopsy and who returned to normal cervical cytology prior to hysterectomy - do not require vaginal vault smears unless symptomatic.14

- Women for whom the Pap smear history and/or the histology from the hysterectomy are unknown – obtain a baseline Pap smear from the vaginal vault at consultation. If normal, then further smears only as clinically indicated.13, 14

- Women who have been treated for vaginal intraepithelial neoplasia (VAIN)- continue to have pap smears or vaginal vault smears every one to two years or at the discretion of the treating specialist.14

See RANZCOG C-Gyn 08: Cytological Follow-up After Hysterectomy.

REFERENCES / STANDARDS


REFERENCES / STANDARDS cont.


National Standards – 1- Care Provided by the Clinical Workforce is Guided by Current Best Practice
5- Patient Identification and Procedure Matching

Legislation - Health Practitioner Regulation National Law (WA) Act 2010

Related Policies –
- Department of Health: OD 0555/14: Guidelines for the Credentialing of PAP Smear Providers (2014)
- KEMH Clinical Guidelines:
  - O&G, Patient Administration: Patient Identification
  - Gynaecology: STI; Gynaecological Cancers: Classification and Staging of Cervical Cancers

Other related documents –
- Australian Government: National Cervical Screening Program (includes patient brochures “In your language”); Cancer Australia: Cervical Cancer; Immunise Australia Program: Human Papillomavirus (HPV)
- Cancer Council Australia: Cervical Cancer Screening;
- Cancer Council WA: HPV Vaccination; & Cervical Cancer (patient information and support)
- Department of Health WA: WA Cervical Cancer Prevention Program
- Medical Services Advisory Committee (MSAC): National Cervical Screening Program Renewal (2014)
- Sexual and Reproductive Health WA (formerly Family Planning WA): Pap Smear Provider Course
- WNHS/KEMH: DNAMER: Continuing Professional Development: Pap Smear Provider Course (a pathway for WNHS/KEMH staff to become credentialed to perform pap smears on well women)

RESPONSIBILITY

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<td>Review date</td>
<td>Dec 2017 (National screening program changes due 1 Dec 2017)</td>
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Vaginal examination in girls and young women

Aim

- To guide medical and nursing / 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 / young woman’s best interest (their physical and psychological health and wellbeing) are paramount and should guide all decision making.¹ ²

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).¹

3. Examinations should be conducted so as to minimise discomfort and distress.¹

4. The girl’s / young woman’s dignity and privacy shall be maintained throughout the examination regardless of the presence of others. Provide privacy for disrobing and a suitable cover (e.g. gown or sheet) during examination.³

5. An appropriate adult witness, support person and/ or chaperone shall be present when examining a child.⁴

6. When examining a young woman, the presence of a support person and / or chaperone should be encouraged and available.¹ The person who is the chaperone shall be agreed to by the girl/ young woman.⁴ 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.⁴ 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.¹ ⁴ Document the chaperone’s name and qualifications.⁴

7. Ensure there is valid consent from the young person and / or their parent or guardian prior to conducting a vaginal examination.¹ Valid consent must be voluntary, informed and based on the capacity of the patient to consent.¹ If required, an interpreter should be used to ensure valid consent to examination². Practitioners should refer to state legislation regarding a child’s capacity to consent.¹ A girl’s / young woman’s capacity to consent is considered on an individualised basis and is not only related to age.¹ Children can consent to a procedure if they have the capacity to understand the information and the implications of the procedure.¹
8. Except in a medical emergency, vaginal examination should not proceed in the absence of valid consent.\textsuperscript{1-5}

9. When parents / guardians have consented on a girl’s behalf, Medical Officers should explain the procedure and proceed only with the girl’s / young woman’s consent.\textsuperscript{1} 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.\textsuperscript{2}

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.\textsuperscript{2}

11. Special considerations shall be given to obtaining consent from patients who are\textsuperscript{1}:
   - Intellectually impaired or mentally ill
   - Physically impaired or injured, in pain, or in shock
   - Drug or alcohol affected
   - Non-English speaking background
   - Sleep deprived
   - Unable to give valid consent.\textsuperscript{1}

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 ultrasound examination. If this does not reveal the required information and further examination is medically necessary, examination under anaesthesia, including vaginoscopy, may be indicated.

13. In pubescent or postpubertal girls, digital or instrumental examinations should only be performed with informed assent from the girl and the consent of their parent / guardian.

14. If a girl / young woman states that she is not sexually active, digital or instrumented vaginal examination is only rarely warranted.\textsuperscript{1}

**Indications for speculum examination**
- Papanicolaou (Pap) smear\textsuperscript{1}
- Endocervical swab for investigation of possible infection\textsuperscript{1}
- Endocervical swab for forensic investigation\textsuperscript{1}
- Assessment for abnormal vaginal bleeding\textsuperscript{1}
- Assessment for possible intra vaginal foreign body\textsuperscript{1}
- Assessment of 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 / 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 / young woman’s level of comprehension. An adequate explanation informs about the nature of the examination and the information it will provide.
- Ensure that the equipment used is appropriate for the size / age of the girl / 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/young woman to touch or hold it.
- Where possible use anatomical models, pictures and pamphlets to provide information.
- A familiar person (e.g. mother, relative) should usually be present during the examination. Additionally, ensure a qualified chaperone (e.g. Registered or Enrolled Nurse) is present that the girl / young woman is comfortable with. 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.
- Note: Be sensitive to the needs of the girl / young woman as she may feel embarrassed to undertake the examination in front of a relative.
- Encourage the girl / young woman to provide feedback to the examiner if they are not comfortable, either physically or emotionally. Be alert for non-verbal indications of distress and respect any requests to discontinue the examination. Document any withdrawal of consent and relevant discussions.
- Encourage the girl / young woman to empty her bladder prior to the examination.
- Conduct the examination in a calm environment, and ensure privacy. Unless the girl / young woman is having difficulty and requests assistance, do not assist with dressing or undressing.

Refer also to WNHS Patient Interview and Examination (2015) & NMHS Chaperone Policy (2015) as required.

The Clinical Guideline, Obstetrics & Midwifery, Antenatal Care, Antenatal Procedures: Vaginal Examination- Performing contains a quick reference guide, procedural information, and general considerations for all women, including further information on consent and chaperones applicable to all women.
REFERENCES / STANDARDS

National Standards – 1- Care Provided by the Clinical Workforce is Guided by Current Best Practice Legislation –
- Children and Community Services Act 2004
- Commonwealth Family Law Act 1975
- Guardianship and Administration Act 1990
- Health Act 1911

Related Policies –
- WNHS Patient Interview and Examination (2015); Language Services (interpreter use)
- NMHS Chaperone Policy (2015)
- Department of Health OD 0657/16: WA Health Consent to Treatment Policy (2016) (including section 4.3.2- Children and Young People : Mature Minors)
- DoH OD 0296/10 Interagency Management of Children Under 14 Who are Diagnosed With a Sexually Transmitted Infection (STI)
- DoH OD 0606/15 Guidelines for Protecting Children 2015
- DoH WA: Protection of Children Policy

Other related documents –
- KEMH Clinical Guidelines, O&M, Antenatal Care: Antenatal Procedures: Vaginal Examination
- Department of Health WA: Safety and Quality in Healthcare: Consent
- Department of Health WA (2013). Working with youth (assessment as mature minor)
- Department of Health WA: Mandatory Reporting of Child Sexual Abuse

RESPONSIBILITY
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Insertion and removal of a vaginal pack - Nursing care

**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
- 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**
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 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.

REFERENCES / STANDARDS

National Standards – 1- Care Provided by the Clinical Workforce is Guided by Current Best Practice;
Legislation -
Related Policies –
Other related documents –

RESPONSIBILITY

Policy Sponsor | Nursing & Midwifery Director OGCCU
Initial Endorsement | August 1999
Last Reviewed | March 2014
Last Amended |
Review date | March 2017
Insertion of a vaginal pack for uterine procedentia

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

Key points
1. This procedure may be performed by nursing / midwifery staff.
2. If the prolapse is unreducible the woman must be reviewed by the medical officer.
3. This procedure is usually performed for a predetermined time prior to definitive surgery.
4. The pack is usually replaced daily.
5. An indwelling catheter should be inserted for the duration of the pack being in situ.
6. The procedure is carried out using the principles of asepsis.

Equipment
- Sterile sponge holding forceps (optional)
- Sterile dressing pack
- Sterile scissors
- Sterile kidney dish
- Sterile gloves
- Gauze pack 4”
- Sanitary pad
- Prescribed lotion

Procedure
1. Explain the procedure and gain verbal consent.
2. Offer appropriate analgesia.
3. Place the woman in the left lateral or supine position on a continence sheet (bluey). Cover appropriately to maintain dignity.
4. Ensure there is adequate light to perform the procedure easily.
5. Tie the ends of the gauze together if more than one pack is required.
6. Soak the gauze in the prescribed lotion.
7. Using a gloved hand, gently replace the prolapsed uterus.
8. Insert the soaked pack using sponge holding forceps or a gloved hand.
9. Place a sanitary pad in position.
10. Document the procedure in the woman’s notes.

REFERENCES / STANDARDS
National Standards – T- Care Provided by the Clinical Workforce is Guided by Current Best Practice;
Legislation -
Related Policies / Other related documents –

RESPONSIBILITY
Policy Sponsor | Nursing & Midwifery Director OGCCU
Initial Endorsement | July 2010
Last Reviewed | March 2014
Last Amended | 
Review date | March 2017
Vaginal irrigation

Aim
The administration of a vaginal douche to:
- Irrigate and cleanse the vagina prior to surgery.
- Control odour in the presence of infection or offensive loss due to a tumour.

Equipment
- Irrigation as prescribed
- Irrigation administration set (non sterile)
- Jug
- Disposable gloves
- Continence sheet (bluey)
- Bedpan and cover
- Lubricating jelly

Procedure
1. Explain the procedure and gain verbal consent.
2. Ensure the woman’s bladder is empty prior to performing the procedure.
3. Place a continence sheet under the woman’s buttocks.
4. Place the woman on the bedpan with her knees flexed and legs abducted.
   Use a pillow for support. Cover the woman to maintain privacy.
5. Perform hand hygiene and don gloves.
6. Check the tubing and nozzle are securely connected.
7. Lubricate the nozzle.
8. Pour the solution into the irrigation bag. Prime the line, expel any air and clamp the tubing.
9. Gently part the labia and insert the irrigation nozzle approximately 5cm into the vagina.
10. Unclamp the tubing and allow all the solution to drain gently into the vagina.
11. When complete, reclamp the tubing and remove the nozzle.
12. Encourage the woman to cough or bear down to expel the fluid.
13. Remove the bedpan and clean and dry the woman.
14. Document the administration in the woman’s notes and care plan.

Flagyl vaginal irrigation
- Preparation as for vaginal irrigation.
- Run the Flagyl solution at low pressure into the vagina.
- Following administration, dry the area and cover with a clean sanitary pad or combine.
- Instruct the woman to remain supine for one hour.
- Document the administration in the woman’s notes and care plan.