South Eastern Sydney Local Health District

WELL WOMEN’S HEALTH PROGRAM
Activities, Interventions and Resources

Handbook
SESLHDHB/017
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Preface

The Women’s Health Nurses handbook is an electronic, interactive document that provides guidance and resources at the point of care. This document is a result of the review of previous Women’s Health Nurses Clinical Policies and Procedure Manuals. The review process involved broad consultation with stakeholders from women’s health, sexual health, domestic violence, and child protection services.

This document supports National and State Policy, Procedures and Guidelines by providing direct links to current documents and complements directives with guidance for implementation in the local setting. It seeks to provide a framework that ensures consistent clinical practices and regulation of the information provided to women. Additionally this document has the capacity to be readily updated to maintain currency with national, State and local policies, procedures, guidelines and business rules.

The guiding principles, frameworks and organisational requirements that underpin the Well Women’s Health Program and mould the roles and professional responsibilities of the Women’s Health Nurse can be found in Sections 1, 2, and 3.

Section 4 provides local operational information that supports the delivery of clinical services and operational activities in various settings. This section provides information on the practical delivery of clinical care at Well Women’s Health clinics including equipment storage and use, waste management, universal referral and follow-up procedures and record management.

Section 5 provides details of the basic well women’s health check, including the how to complete women’s health physical examinations and screening tests, and section 6 provides guidance for specific conditions.

Throughout Sections 5 and 6 the information is provided using the same framework:

- Background - specific information related to the condition or examination
- Specific history - additional specific questions to assist accurate assessment
- Education and resources - the essential information required to enable the woman to be able to provide informed consent and internet links to printable material that may be provided
- Intervention – details how to perform assessments and referrals
- Follow-up – specific considerations when planning the follow-up of the woman
- Specific documentation – details of the essential information to be documented
- References – the source of the information provided with internet links where possible.
Sections 7, 8 and 9 provide guidance for broader issues including violence, quality activities and infection protocols.

This document may be used as a resource to assist with the orientation of newly appointed Women’s Health Nurses. The hyperlinks in the document enable efficient access to recognised websites to obtain resources for women during a consultation. Service provision is further enhanced by the ready access to these resources in a range of languages.

This document is the property of the South Eastern Sydney Local Health District (SESLHD). The ongoing review and updating of the document is the responsibility of the Women’s Health Nurses under the coordination of their team leader. New items and change in practice will be tabled at the monthly meetings. The responsibility of updating the document is the Women’s Health Nurse Team or delegate. The date of revision is maintained in the footer and hard copies are not recommended as it prevents updating as well as access to information and resources.

The development of this document was initiated by the former South Eastern Sydney Illawarra Health Service (SESIAHS) and may be used as a template by other Women’s Health services external to SESLHD acknowledging SESLHD within the credits.
1 BACKGROUND

1.1 Policy Statement
This section of this document provides guidance of the interventions performed by Women’s Health Nurses in SESLHD.

1.2 Background
This document has been developed as a resource for Women’s Health Nurses (WHN) employed by and delivering services in SESLHD. It describes the organisational management structure and professional lines of responsibility as well as supporting a uniform and consistent approach by providing clear descriptions of the role of Women’s Health Nurses, including the underlying philosophy and principles of care, and interventions to guide clinical practice. Additionally this document provides direct links to resource material and references where possible.

1.3 Responsibilities

Employees will:

- Perform interventions according to the guiding principles in this document and in the manner described in this section.
- Where the guidelines cannot be followed due to concerns raised by the employee, the situation will be discussed with the line manager.
- Identify modifications to reflect changes in evidence and report to the line manager.

Line Managers will:

- Implement the document for use by the Women’s Health Nurses.
- Coordinate audits to evaluate use.
- Ensure reviews performed in a timely fashion to reflect changes in services and developments in evidence.

Managers/Service Managers will:

- Provide the resources to enable implementation, access and ongoing review of the document.

Medical staff will:

- Provide consultation in the review of the interventions.
1.4 Organisational Management Structure

The Well Women’s Health Program is well supported within the Child, Youth, Women’s and Family Health in the Ambulatory and Primary Health Care Directorate. The Women’s Health Nurses are co-located and have close affiliations with other programs within the unit, especially the Violence and Abuse Prevention Program (VAAP), Community Projects (CP), and the Early Parenting Program (EPP).

1.5 Lines of Accountability

The Women’s Health Nurses are mobile between various locations across SESLHD including the Prince of Wales Hospital, Rockdale Community Health Centre, Engadine Community Health Centre, Community Health, Caringbah (The Sutherland Hospital), Menai Community Health Centre, Matraville Medical Centre, and the Caringbah Women’s Health Information Centre. Table 1.5 – Lines of Accountability describes line management and clinical supervision.

The Women’s Health Nurses are occasionally required to provide services outside usual working hours to engage with some populations, or participate in local initiatives that affect women. The Women’s Health Nurse is to adhere to the Local Health District policies and procedures when required to work after hours to provide necessary education sessions within the community. Approval and accrual of Time in Lieu is to be gained from the Manager, Child, Youth, Women’s and Family Health.

<table>
<thead>
<tr>
<th>Women’s Health Nurse</th>
<th>Line Management</th>
<th>Clinical Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Nurse Consultant 1.0 FTE</td>
<td>Manager</td>
<td>Gynaecological Oncologist</td>
</tr>
<tr>
<td>Randwick</td>
<td>Community Health Randwick</td>
<td>St George Hospital Kogarah</td>
</tr>
<tr>
<td></td>
<td>Support provided by the Child, Youth, Women’s and Families Health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Darlinghurst</td>
<td></td>
</tr>
<tr>
<td>Clinical Nurse Consultant Team Leader 1.0 FTE</td>
<td>Manager</td>
<td>Gynaecological Oncologist</td>
</tr>
<tr>
<td>Rockdale Community Health Centre</td>
<td>Child, Youth, Women’s and Families Health</td>
<td>St George Hospital Kogarah</td>
</tr>
<tr>
<td></td>
<td>Darlinghurst</td>
<td></td>
</tr>
<tr>
<td>Clinical Nurse Consultant 0.43 FTE</td>
<td>Manager</td>
<td>Gynaecological Oncologist</td>
</tr>
<tr>
<td>Engadine Community Health Centre</td>
<td>Child, Youth, Women’s and Families Health</td>
<td>St George Hospital Kogarah</td>
</tr>
<tr>
<td></td>
<td>Darlinghurst</td>
<td></td>
</tr>
<tr>
<td>Clinical Nurse Specialist Grade 2 (CNS2)</td>
<td>Manager</td>
<td>Gynaecological Oncologist</td>
</tr>
<tr>
<td>0.57 FTE</td>
<td>Child, Youth, Women’s and Families Health</td>
<td>St George Hospital Kogarah</td>
</tr>
<tr>
<td>Community Health Caringbah</td>
<td>Darlinghurst</td>
<td></td>
</tr>
</tbody>
</table>
2 THE WELL WOMEN’S PROGRAM

2.1 Program framework and guidelines

The Well Women’s Health Program is based in the community and works within a primary health care framework. It complements existing health services provided for women by developing initiatives for specific populations of under serviced women to meet their identified health needs. The Program aims to increase women’s access to health information which focuses on early detection and illness prevention, as well as providing health screening and referral to appropriate services. The program direction is derived from the following documents:

- NSW Women’s Health Framework for NSW 2013
- National Aboriginal and Torres Strait Islander Women's Health Strategy
- Women’s Health Plan 2009-11
- The National Women’s Health Policy (2010)
- NSW Health and Equity Statement: In all Fairness (2004)
- Women’s Health Outcomes Framework (2002)
- Strategic Framework to Advance the Health of Women (2000)

2.2 Target populations

Whilst the Well Women’s Health Program provide services for all women, we do recognise the difficulties that some women face in accessing services and encourage women from a number of different backgrounds to access our services. These include:

- Aboriginal and/or Torres Strait Islander women
- Women from culturally and linguistically diverse backgrounds
- Newly arrived refugee women
- Women with a mental health diagnosis
- Women who have a disability or mobility issues
- Women who experience violence
- Women who are geographically isolated
- Women who are carers
- Women who are socially and economically disadvantaged

The Women’s Health Nurse provides early detection services for breast and cervical cancers and provides health information and resources to women who, for whatever reason, do not attend mainstream services.

2.3 Service development

Integral to the program is the development of partnerships with health staff, community organisations, and women. The development of collaborative partnerships with health service providers in both the government and non-government sectors assist with the provision of
appropriate services for populations of women at risk of poor health outcomes and the greatest burden of disease.

Effective partnerships support the development and delivery of acceptable, affordable and appropriate community based services to improve health outcomes for women who do not access existing services. Key strategies include the development of services for specific populations which include the following strategies:

- build effective partnerships with the community and service providers
- support community development initiatives to develop sustainable outcomes
- provide professional development for health staff
- provide community education
- provide Well Women’s Health clinical services.

2.4 Principles

The well women’s services identify suitable preventative strategies to support women to optimize their health. This includes providing a health screening service for well women and women who, for whatever reason, do not attend mainstream services and therefore are not receiving screening services. The program specifically aims to provide services for women who do not attend screening for cervical and breast cancer, women living with undiagnosed health conditions such as hypertension or depression, and women who live with domestic violence.

Women’s Health Nurses are committed to delivering relevant, accessible, and responsive services that are based on the principles of primary health care. These principles are:

- that the health of women is influenced by a broad range of factors – environmental, economic status, ethnicity, disability, location and environment
- that services need to be relevant to the local community and based on evidence
- to ensure services are affordable to the women
- to maintain collaborative relationships and develop effective partnerships to provide services to women who do not use existing services
- to maintain a focus on women most in need including women who identify as Aboriginal or Torres Strait Islanders, newly arrived refugee women, women from culturally diverse backgrounds, disabled women, and geographically isolated women.

To meet these principles the Women’s Health Nurse provides initiatives that are appropriate, affordable and acceptable for specific populations of women that always:

- demonstrate respect and maintains each woman’s dignity
- ensure consent for clinical procedures is well informed and understood
- include a comprehensive and relevant medical history
• include necessary physical examinations
• provide education, information and written resources to inform choices
• include completion of Health Care Records.

The Women’s Health Nurse will utilise her skills of active listening, feedback and clarification when interacting with women to provide a supportive and non-judgemental environment where women:

• are free to express their opinions and feelings
• are able to explore a range of options in reaching health care decisions
• feel secure that their confidentiality and privacy will be respected
• know their safety and comfort will be assured and maintained at all times.
3 THE WOMEN’S HEALTH NURSE

3.1 Professional Organisation

3.1.1 Australian Women’s Health Nurse Association

Women’s Health Nurses are committed to quality services which are safe and provide optimal care to all women. To do this the Women’s Health Nurse Practice is guided by the women’s health peak organisation, the Australian Women’s Health Nurse Association (AWHNA).

This organisation provides leadership and support for Women’s Health Nurses as well as the annual appraisal for all Women’s Health Nurses titled the Advanced Practice Standards (APS).

3.2 Specific Requirements for Women’s Health Nurse Employment

Women’s Health Nurses in SESLHD meet the criteria as defined by the Public Health System Nurse and Midwives (State) Award, detailed below.

3.2.1 Clinical Nurse Specialist Grade 1

A Registered Nurse who applies a high level of clinical nursing knowledge, experience and skills in providing complex nursing care directed towards a specific area of practice, a defined population or defined service area, with minimum direct supervision.

A Clinical Nurse Specialist Grade 1 shall satisfy the following minimum criteria:

- Relevant post-registration qualifications and at least 12 months experience working in the relevant clinical area of their post-registration qualification; or
- Four years post-registration experience, including three years experience in the relevant specialist field.

A Clinical Nurse Specialist Grade 1 is distinguished from an 8th Year Registered Nurse/Midwife by being required to satisfy the following criteria:

- Actively contributes to the development of clinical practice in the ward/unit/service;
- Acts as a resource and mentor to others in relation to clinical practice; and
- Actively contributes to their own professional development.

Clinical Nurse Specialist Grade 1 is a personal grading.

3.2.2 Clinical Nurse Specialist Grade 2

A Registered Nurse appointed to a position classified as such with relevant post-registration qualifications and at least 3 years experience working in the clinical area of their specified post-graduate qualification. The Clinical Nurse Specialist Grade 2 classification encompasses the Clinical Nurse Specialist Grade 1 role criteria and is distinguished from a Clinical Nurse Specialist Grade 1 by the following additional role characteristics:
• Exercises extended autonomy of decision making;
• Exercises professional knowledge and judgment in providing complex care requiring advanced clinical skills and undertakes one of the following roles:
  o leadership in the development of nursing specialty clinical practice and service delivery in the ward/unit/service; or
  o specialist clinical practice across a small or medium sized health facility/sector/service; or
  o primary case management of a complete episode of care; or
  o primary case management of a continuum of specialty care involving both inpatient and community based services; or
  o an authorised extended role within the scope of Registered Nurse practice.

Incremental progression to the second year and thereafter rate shall be upon completion of 12 months satisfactory full-time service (or pro rata part time service).

3.2.3 Clinical Nurse Consultant Grade 1
A Registered Nurse appointed as such to a position approved by the public hospital or public health organisation, who has at least 5 years full time equivalent post registration experience and in addition who has approved post registration nursing qualifications relevant to the field in which he/she is appointed, or such other qualifications or experience deemed appropriate by the public hospital or public health organisation.

3.2.4 Clinical Nurse Consultant Grade 2
A registered nurse appointed as such to a position approved by the public hospital or public health organisation, who has at least 5 years full time equivalent post registration experience, with at least 3 years full time equivalent experience in the specialty field. In addition the employee must have approved postgraduate nursing qualifications relevant to the field in which he/she is appointed or such other qualifications or experience deemed appropriate by the public hospital or public health organisation. An employer may also require a higher qualification in the specialist nursing field where such a qualification is considered essential for the performance of the individual position.

3.2.5 Clinical Nurse Consultant Grade 3
A registered nurse appointed as such to a position approved by the public hospital or public health organisation, who has at least 7 years full time equivalent post registration experience, with at least 5 years full time equivalent experience in the specialty field. In addition the employee must have approved postgraduate nursing qualifications relevant to the field in which he/she is appointed or such other qualifications or experience deemed appropriate by the public hospital or public health organisation. An employer may also require a higher qualification in the specialist nursing field where such a qualification is considered essential for the performance of the individual position.
3.3  Role of the Women’s Health Nurse

The Women’s Health Nurse develops strategies to address specific women’s health issues and engages in planning, research and evaluation often in liaison or partnership with other services. A feature of Women’s Health Nurse Practice is the ability to be responsive and flexible. The development of collaborative partnerships with health service providers in both the government and non-government sectors assist with the provision of appropriate services for populations of women at risk of poor health outcomes and the greatest burden of disease.

Clinical functions are undertaken in the context of nursing practice that enhances women’s knowledge. Providing information, developing effective problem solving skills, exploring options, and providing opportunities to discuss health concerns enables the woman to be the coordinator of her own health.

All Women’s Health Nurses provide one off counselling and support as part of their clinical service. In these sessions they respond to the woman’s immediate needs and make appropriate referrals to a range of services and practitioners in consultation with the woman. The scope of this aspect of the service will be determined by service management according to local health service need, and/or the skill of the individual.

To provide these clinical services and enhance the health of women the Women’s Health Nurses work in partnerships with community organisations and service providers to address disadvantage and dissolve barriers that prevent women from using mainstream services.

3.3.1 Essentials of Care

- Women’s Health Nurses embrace the Essentials of Care (EoC) framework and the Domains for Women’s Health are currently under development.
- NSW Ministry of Health Nursing and Midwifery office/special projects Essentials of Care Program
- More information can also be found on the ARCHI website

3.4 Clinical Leadership

The Women’s Health Nurse is responsible for providing clinical leadership by:

- providing education for health care workers, clinical supervision of students and involvement with preceptor programs
- supporting and performing research and quality activity
- undertaking health promotion activities and developing and distributing appropriate resources
- contributing to clinical service planning and management
- participating in ongoing professional development activities
• participating in Local, State and National Committees that advance the practice of Women’s Health Nursing
• providing direct services to women through well women’s clinics, community development initiatives and education forums.

3.5 Practice informed by evidence

The Women’s Health Nurse is responsible for ensuring that clinical practice, service development and health promotion initiatives are supported by appropriate and robust evidence. Individual professional development and the opportunity to identify and apply new learning provides the Women’s Health Nurse with the ability to be accountable for the implementation and evaluation of their practice initiatives, and have responsibilities for the dissemination of the evidence to the community, other health employees, and peers.

3.6 Professional Practice

The Women’s Health Nurse is required to maintain National Nursing Registration recommendations for professional development including maintenance of a professional portfolio and a reflective journal. Nurses may be audited at any time by the Australian Health Practitioner Regulation Agency (APHRA).

Women’s Health Nurses are also encouraged to participate in the activities of professional bodies such as the Australian Women’s Health Nurse Association, to monitor research, and to attend conferences, seminars and professional updates. All Women’s Health Nurses maintain a professional portfolio to provide evidence of professional practice.

3.6.1 Performance Appraisal

Annual performance appraisals offer an opportunity to gain guidance from senior Women’s Health Nurses and gain management support for service delivery as well as identifying service gaps and developing services to address unmet needs of specific populations. The annual performance appraisal also offers an opportunity to assess the Women’s Health Nurses developmental and training needs.

3.6.2 Advanced Practice Standards

Peer review assessment against the Women’s Health Advanced Practice Standards (APS) is to be undertaken by all Women’s Health Nurses. The assessment provides the benchmark for best practice, provides a tool for enhancing and supporting effective practice, and affirms competence in women’s health nursing. The Standards guide practice and inform professional development against the following domains:

• professional specialty education
• community development and advocacy
• clinical leadership and health promotion leadership
• implementing current evidence-based practice
• professional leadership.
3.6.3 Clinical Supervision

Women’s Health Nurses are responsible for the establishment of clinical supervision in the workplace. Women’s Health Nurses attend monthly clinical meetings, the Terms of Reference for these meetings are provided in Appendix A - Well Women’s Health Program Clinical meetings. Each meeting provides opportunity for peer review, service planning and skills update and development. The meeting is minuted and clinical discussions and decisions are documented in the appropriate client health care records. The SESLHDGL/027 Guidelines for Clinical Supervision for Nurses and Midwives is used.

Three Clinical Nurse Consultants and one Clinical Nurse Specialist form the Women’s Health Nurse team across SESLHD. The definitions of the Clinical Nurse Consultant and the Clinical Nurse Specialist roles can be found in Section 3 – Women’s Health Nurse. The Clinical Nurse Consultants / Specialists are actively involved in a peer support and review process across the other programs within Women’s Health.

3.6.4 Professional Development

Women’s Health Nurses attend education in order to enhance clinical practice. Funding and leave is negotiated with the Manager, Child, Youth, Women’s and Family Health. A total of five days per annum is expected for FTE’s and for part time employees the ration is determined by the number of hours they work per week. The Learning and Development form with a copy of the course outline is to be completed and appropriate leave described on the timesheet (short course, conference, etc).

Relevant education opportunities may include:

- computer skills, research, management skills, training and development programs
- mandatory training and e-learning modules provided by the Organisational Learning Unit
- conferences and seminars
- professional development
- updates on issues relevant to women’s health held at health and associated facilities.
4 OPERATIONAL ACTIVITY

4.1 Clinics

Women’s Health Clinics are provided in a health facility or community setting, they need to be readily accessible by public transport, have available car parking and disabled access to the clinic. Considerations for sight impaired women will be assessed on a regular basis to ensure safe access. The room will need to house an examination couch, lamp, desk and chairs, suitable space for clinical equipment and hand washing facilities.

An ideal clinic will have the following facilities:

- located on the ground floor or has lift access, and is close to toilet facilities
- clean with a comfortable/controllable temperature
- blinds/curtains/screen and a lockable door for privacy
- an electrical power point
- a table or desk and access to a minimum of four chairs,
- safe, secure and convenient place to load clinic equipment to and from car
- telephone access and/or duress alarms or other methods to mobilise support.

Well Women’s Clinical services are held at several sites as listed in Table 4.1 – Clinical Activity.

<table>
<thead>
<tr>
<th>Well Women’s Clinic</th>
<th>Frequency</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rockdale Community Health Centre</td>
<td>Monday / Tuesday each week</td>
<td>WHN Ph: 9087 8300 9382 8694</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Appointment Ph: 9087 8300</td>
</tr>
<tr>
<td>Engadine Community Health Centre</td>
<td>Wednesday / Thursday- twice a month</td>
<td>WHN Ph: 9548 4300</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Appointment Ph:9520 4644</td>
</tr>
<tr>
<td>Caringbah Women’s Health Information Centre</td>
<td>Thursday monthly</td>
<td>WHN Ph: 9520 4644</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Appointment Ph: 9525 2058</td>
</tr>
<tr>
<td>Community Health, Caringbah (The Sutherland Hospital)</td>
<td>Clinic for specific projects only</td>
<td>WHN Ph: 9522 1060 0457 881 350</td>
</tr>
<tr>
<td>Menai Community Health Centre</td>
<td>Monday afternoon weekly</td>
<td>WHN Ph: 9543 1111 0457 881 350</td>
</tr>
<tr>
<td>Matraville Medical Complex</td>
<td>Thursday - monthly</td>
<td>WHN Ph: 9382 8321</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Appointment Ph: 8347 4444</td>
</tr>
</tbody>
</table>
4.2 Managing Equipment and Waste

4.2.1 Material Resources Department

The Women’s Health Nurse is responsible for ensuring the availability of plastic bags, contaminated waste bags, and sharps containers in order to collect waste in the appropriate receptacles. They can be ordered from the Material Resources Department at the local hospital through the Office Manager (Ph: 9382 8156).

4.2.2 SEALS

Glass slides and container, Thin prep containers, cervical sampling brushes, disposable speculums, specimen containers, plastic bags for clinical slides, and pathology request forms are all provided under contract by NSW Pathology, SEALS, Randwick Campus (Microbiology Manager 9382 9100).

The SEALS collection manager is to be informed when and where specimens are to be collected. SEALS provide a courier service to collect specimens however the Women’s Health Nurse may deliver the specimens to SEALS laboratories depending on the location of the clinic. The collection details are provided in Table 4.2.2 - Collection of Pathology.

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Collected from</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matraville Medical Complex</td>
<td>WHN delivers to SEALS at POW Hospital</td>
<td>Prince of Wales (POW) HospitalPhone: 9382 9128</td>
</tr>
<tr>
<td>Rockdale Community Health Centre</td>
<td>Reception</td>
<td>Northern Network Manager, SEALS Phone 9382 9140 for courier to collect specimens the following morning</td>
</tr>
<tr>
<td>Engadine Community Health Centre</td>
<td>Reception at Engadine Community Health Centre</td>
<td>Phone courier 4222 5008 to collect specimens the following morning</td>
</tr>
<tr>
<td>Caringbah Women’s Health and Information Centre</td>
<td>Reception at Engadine Community Health Centre</td>
<td>Phone courier on 4222 5008 to collect specimens the following morning</td>
</tr>
<tr>
<td>Community Health, Caringbah</td>
<td>Reception Community Health, Caringbah</td>
<td>SEALS onsite and delivered to SEALS</td>
</tr>
<tr>
<td>Menai Community Health Centre</td>
<td>Reception Community Health, Caringbah</td>
<td>SEALS onsite and delivered to SEALS</td>
</tr>
</tbody>
</table>

4.2.3 CSSD

The Women’s Health Nurse is responsible for arranging the delivery of metal speculums to the CSSD department accompanied by the completed CSSD form for autoclaving as described in Table 4.2.3 - CSSD Collection. All metal speculums are sterilised at the local CSSD department. Diaphragms are gassed (not autoclaved).
Used metal speculums and diaphragms are to be soaked for a minimum of twenty minutes in a clean bucket of water with approved detergent at clinical venues, after which the water is poured down toilet (wear disposable gloves and safety glasses to avoid contamination from splashing), then place the speculums in double plastic bags.

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Collected from</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matraville Medical Complex</td>
<td>Women’s Health Nurse delivers used items to CSSD, Prince of Wales Hospital</td>
<td>Prince of Wales Hospital CSSD Ph: 9382 0670/1</td>
</tr>
<tr>
<td>Rockdale Community Health Centre</td>
<td>Courier delivers and collects used speculums in a white bucket supplied, place in the mail room for collection</td>
<td>St George Hospital Ph: 9113 1111 and ask for CSSD</td>
</tr>
<tr>
<td>Engadine Community Health Centre</td>
<td>Women’s Health Nurse delivers used items to CSSD with completed CSSD form (please keep a copy) Collection of clean speculums is required by WHN</td>
<td>Sutherland Hospital CSSD Ph: 9540 7111</td>
</tr>
<tr>
<td>Caringbah Women’s Health and Information Centre</td>
<td>Women’s Health Nurse delivers used items to CSSD with completed CSSD form (please keep a copy) Collection of clean speculums is required by WHN</td>
<td>Sutherland Hospital CSSD Ph: 9540 7111</td>
</tr>
<tr>
<td>Community Health Caringbah</td>
<td>Women’s Health Nurse delivers used items to CSSD with completed CSSD form (please keep a copy) Collection of clean speculums is required by WHN</td>
<td>Sutherland Hospital CSSD Ph: 9540 7111</td>
</tr>
<tr>
<td>Menai Community Health Centre</td>
<td>Women’s Health Nurse delivers used items to CSSD with completed CSSD form (please keep a copy) Collection of clean speculums is required by WHN</td>
<td>Sutherland Hospital CSSD Ph: 9540 7111</td>
</tr>
</tbody>
</table>

### 4.2.4 Sharps Containers

All Sharp items are handled in accordance to the ‘Sharps Management’ District Procedure SESLHNPD/121 and waste management may be managed as described in Table 4.2.4 – Sharps Collection. All sampling equipment for disposal is also placed in sharps containers.

Orders for Sharps containers are processed through Office Manager (Ph: 9382 8686).
Table 4.2.4 – Sharps Collection

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Collected from</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matraville Medical Complex</td>
<td>Matraville Medical Complex</td>
<td>Ph: 8347 4444</td>
</tr>
<tr>
<td>Rockdale Community Health Centre</td>
<td>WHN takes to St George Hospital Waste Management Department</td>
<td>St George Hospital Ph: 9113 1111 Ask for Waste Management Department</td>
</tr>
<tr>
<td>Engadine Community Health Centre</td>
<td>WHN takes to Sutherland Hospital CSSD and places in contaminated waste bin in the Waste Management Department</td>
<td>Sutherland Hospital Ph: 9540 7111</td>
</tr>
<tr>
<td>Caringbah Women’s Health and Information Centre</td>
<td>WHN takes to Sutherland Hospital CSSD and places in contaminated waste bin in the Waste Management Department</td>
<td>As above</td>
</tr>
<tr>
<td>Community Health, Caringbah</td>
<td>WHN takes to Sutherland Hospital CSSD and places in contaminated waste bin in the Waste Management Department</td>
<td>As above</td>
</tr>
<tr>
<td>Menai Community Health Centre</td>
<td>WHN takes to Sutherland Hospital CSSD and places in contaminated waste bin in the Waste Management Department</td>
<td>As above</td>
</tr>
</tbody>
</table>

4.2.5 Linen

Linen is obtained from the Linen service at the nearest designated hospital and returned to the linen service when used as described in Table 4.2.5 – Linen Delivery and Collection.

The Cost Centre number is required by the Linen Department.

Table 4.2.5 – Linen Delivery and Collection

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Cost Code</th>
<th>Collected from</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matraville Medical Complex</td>
<td>150126</td>
<td>WHN collects and returns to POW Hospital Linen department</td>
<td>POW Hospital Linen department Ph: 9382 2808</td>
</tr>
<tr>
<td>Rockdale Community Health Centre</td>
<td>181084</td>
<td>Courier delivers and collects dirty linen from the mail room within centre</td>
<td>St George Hospital Ph: 9113 1111</td>
</tr>
<tr>
<td>Engadine Community Health Centre</td>
<td>181084</td>
<td>Women’s Health Nurse collects and returns to Sutherland Hospital</td>
<td>Sutherland Hospital Ph: 9540 7111</td>
</tr>
<tr>
<td>Caringbah Women’s Health and Information Centre</td>
<td>181084</td>
<td>Women’s Health Nurse collects and returns to Sutherland Hospital</td>
<td>As above</td>
</tr>
<tr>
<td>Community Health, Caringbah and Menai Community Health Centre</td>
<td>181084</td>
<td>Women’s Health Nurse collects and returns to Sutherland Hospital</td>
<td>As above</td>
</tr>
</tbody>
</table>
4.2.6 Other Waste

Disposable speculums are placed in a yellow contaminated waste bag and disposed of with the other waste. They are not reusable. The yellow contaminated waste bag is left at designated areas for collection as described in Table 4.2.6 – Waste Bag Collection.

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Collected from</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matraville Medical Complex</td>
<td>Managed by commercial service at Matraville Medical Complex</td>
<td>Matraville Medical Complex Ph: 8374 4444</td>
</tr>
<tr>
<td>Rockdale Community Health Centre</td>
<td>WHN takes to St George Hospital Waste Management Department</td>
<td>St George Hospital Ph: 9113 1111Ask for Waste Management Dept.</td>
</tr>
<tr>
<td>Engadine Community Health Centre</td>
<td>WHN takes to CSSD at Sutherland Hospital and places in contaminated waste bin</td>
<td>Sutherland Hospital Ph: 9540 7111</td>
</tr>
<tr>
<td>Caringbah Women’s Health and Information Centre</td>
<td>WHN takes to CSSD at Sutherland Hospital and places in contaminated waste bin</td>
<td>As above</td>
</tr>
<tr>
<td>Community Health, Caringbah</td>
<td>WHN takes to CSSD at Sutherland Hospital and places in contaminated waste bin</td>
<td>As above</td>
</tr>
<tr>
<td>Menai Community Health Centre</td>
<td>WHN takes to CSSD at Sutherland Hospital and places in contaminated waste bin</td>
<td>As above</td>
</tr>
</tbody>
</table>

4.3 Client Follow Up

The Women’s Health Nurse will ensure that women are provided with reminders for follow up appointments at an agreed timeframe. The follow up phone calls may be indicated, but not exclusively, for high or low blood pressure, Papanicolaou tests, emergency contraception, and referral to other service providers.

For repeat Papanicolaou tests the notification should be one month prior to the recommended time frame in the preceding Papanicolaou result. This is to provide ample time for the woman to access her choice of service provider. If the woman plans to attend a different service she will be asked to request that the Women’s Health Nurse is provided with a copy of the repeat Papanicolaou test results.

4.4 Broken Appointments

Whilst Women’s Health Nurses encourage women to take responsibility for their own health, broken appointments raise duty of care issues. The manner in which broken appointments are addressed will be determined by the reasons for the initial appointment being made:

- **Self referral** - A broken appointment may indicate that a woman has changed her mind or forgotten the appointment. In this case, no further action is required.
• **Health worker referral** - If referred by another health care worker the Women’s Health Nurse will notify the referring person that the woman has failed to attend.

• **Women’s Health Nurse Follow-up** - The Women’s Health Nurse will contact the woman by telephone. If she is not easily contacted the process described in 4.5 - *Inability to contact a woman* will be followed.

4.5 **Inability to Contact a Woman**

If the Women’s Health Nurse is unable to contact a woman by telephone on at least two occasions, or the woman does not respond to a message, the Women’s Health Nurse is to commence issuing the appropriate standard letters *(see Appendix C)* to the address given at the time of the previous consultation. The letter should be sent by *registered mail* if the reason for follow up is a pathology result classified as “high risk”.

If the woman does not respond to the letter the Women’s Health Nurse will issue a letter with copies of the pathology results to the General Practitioner indicated in the women’s health care records (unless permission to contact the General Practitioner has been denied).

The designated Clinical Support Advisor will be advised of the result and attempts to contact the woman. The Clinical Support Advisor may make recommendations to:

• Return the reports to Pathology / Pap Test Register stating that woman has not given consent to contact the GP and the Women’s Health Nurse has not been able to make contact, or /and

• Close the file if there is no contact from the woman within one month of telephone calls and mail correspondence.

4.6 **Referral Process**

The Women’s Health Nurse may identify a need to refer women to local doctors, authorised service providers of emergency departments, public physiotherapist, continence nurse program, sexual health clinics, or mental health services.

A referral may be required for the following reasons:

• blood pressure not within normal range limits especially if there are associated symptoms such as a headache

• for hormonal contraception

• treatment for poor pelvic floor tone

• breast masses

• cervix is tender on rocking, or if there is pain in adnexa/fornices

• offensive vaginal discharge
abnormal vaginal bleeding particularly in post menopausal women.

The Women’s Health Nurse may precede the referral by telephoning the service to advise of the imminent referral, particularly if the referral is urgent. If necessary, the woman may be directly referred to the Emergency Department. If a woman does not have a General Practitioner the Women’s Health Nurse will discuss with an authorised medical officer or refer directly to the Emergency Department. It may be necessary for the Women’s Health Nurse to organise transport such as a taxi or ambulance.

The Women’s Health Nurse will provide clear, concise and uniform referral information to ensure continuity of care for women where their health requires medical or other methods of management. The Women’s Health Nurse will complete a referral letter as described in Appendix C using approved letterhead stationery either by hand or typed and include all details as per NSW Health Medical Discharge Referral Reporting Standard (MDRRS) (GL2006_015). A copy of the letter is kept in the woman’s health care record.

If a woman is required to make a self referral, for example to the continence nurse, she will be provided the intake phone number as provided in Table 4.6 - Intake Phone Numbers. If required the Women’s Health Nurse will assist the woman with the phone call and completion of the appropriate documentation. The woman will be advised she will need her Medicare, Centre link and/or Veterans Affairs numbers available.
<table>
<thead>
<tr>
<th>Geographical Area</th>
<th>Service</th>
<th>Phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prince of Wales (POW), Randwick Community Health Services</strong></td>
<td>Northern Network Access and Referral Centre (NNARC)</td>
<td>Ph: 9369 0400</td>
</tr>
<tr>
<td></td>
<td>Mon- Friday 8.30am – 4.30pm</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Domestic Violence Hotline</td>
<td>Ph: 1800 65 64 63</td>
</tr>
<tr>
<td></td>
<td>(Toll free, 24hrs a day, 7 days a week)</td>
<td>TTY: 1800 67 14 42</td>
</tr>
<tr>
<td></td>
<td>Rape Crisis Centre</td>
<td>Ph: 1800 424 017</td>
</tr>
<tr>
<td></td>
<td>( Rape /Sexual Assault)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Drug and Alcohol Langton Centre</td>
<td>Ph: 9332 8777</td>
</tr>
<tr>
<td></td>
<td>(targets CUPS, Methadone and Welfare)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kirketon Road ( targets at risk young people, sex workers, people who inject drugs)</td>
<td>Ph: 9360 2766</td>
</tr>
<tr>
<td></td>
<td>Mental Health</td>
<td>Acute care Ph: 9366 8611</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Crisis team Ph: 9382 2479</td>
</tr>
<tr>
<td></td>
<td>Dental</td>
<td>Ph: 9293 3333</td>
</tr>
<tr>
<td></td>
<td>(Sydney Dental Hospital or attend an emergency dept)</td>
<td></td>
</tr>
<tr>
<td><strong>St George District Intake service</strong></td>
<td>Nursing (Continence)</td>
<td>Ph: 9113 3999</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fax:9113 3388</td>
</tr>
<tr>
<td></td>
<td>Allied Health</td>
<td>Ph: 9113 2495</td>
</tr>
<tr>
<td></td>
<td>(Physiotherapist, Domestic Violence Counsellors)</td>
<td>Fax: 9533 2908</td>
</tr>
<tr>
<td></td>
<td>Mental Health</td>
<td>Ph: 9113 4444</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fax: 9113 1540</td>
</tr>
<tr>
<td></td>
<td>Dental Service</td>
<td>Ph: 1300 134 226 (8.30 – 4.30pm)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adults must be in receipt of a Govt Health care card or pension concession card</td>
</tr>
<tr>
<td><strong>Sutherland Shire Intake service</strong></td>
<td>Nursing (Continence)</td>
<td>Ph: 9540 7540</td>
</tr>
<tr>
<td></td>
<td>Allied Health</td>
<td>Ph: 9540 8300</td>
</tr>
<tr>
<td></td>
<td>(Domestic Violence counsellor)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental Health</td>
<td>Ph: 9540 7800</td>
</tr>
<tr>
<td></td>
<td>Dental Service</td>
<td>Ph: 1300 134 226 (8.30 – 4.30pm)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adults must be in receipt of a Govt Health care card or pension concession card</td>
</tr>
</tbody>
</table>
4.7 Documentation

The Women’s Health Nurse is responsible for ensuring that the consultation, all procedures, interventions, referrals and follow-up are recorded in a legible and concise manner using the NSW Ministry of Health approved medical terminology and Clinical Abbreviations District Procedure SESLHDPR/281 and Clinical Abbreviations List

All details of referrals and the appropriate follow-up of referral are to be recorded in the woman’s health care record.

All attempts to contact the woman and discussions with Clinical Support Advisor and GPs are to be documented in the heath care record and copies of all letters are to be filed in the health care record.

Written permission must be obtained prior to the transfer of any information from the woman’s medical record to a second person or agency as directed in the NSW Ministry of Health Privacy Manual (Version 2).

The current electronic database CHIME is used to record client health information, procedures, activity data including the Cancer Institute NSW Cervical Screening online reporting tool for Pap tests.

4.7.1 References

- Healthcare Record Documentation and Management
- Privacy Manual (Version 2) PD2005_593 NSW Ministry of Health
- Guidelines on Documentation and Electronic Documentation, Annual Conference (2010) NSWNMA

5 WELL WOMEN’S HEALTH CHECKS

5.1 Assessment

When women present to the clinic the Women’s Health Nurse performs an overall visual assessment in the first instance, including assessing the woman’s general appearance, anxiety/mood levels, movement, gait, and use of mobility aids. The Women’s Health Nurse will introduce herself to the woman and any persons accompanying the woman (health care worker, case manager, partner, relative, friend, child or interpreter) and assesses her language skills and health literacy.

The Women’s Health Nurse systematically assesses the woman in line with the flow chart details in Appendix B – Women’s Health Nurse Flowchart of Clinical Management for the Well Women’s Check and ensures the consultation covers issues addressed on the Health Care Record (internal) form.

5.2 Taking a History

The Women’s Health Nurse identifies the service the woman is seeking and provides the appropriate health information and offers information about the range of health care options, supports, and
other services available. The Women’s health Nurse will use reflection and enquiry to ensure the woman understands the questions and the information provided. On occasion when a woman reports several issues the Women's Health Nurse may need to prioritise, in which case the woman will be involved in identifying the priorities and additional appointments may be made to cover issues of concern in a timely manner.

At each appointment the health care record should be reviewed prior to the consultation. All pathology results will be reviewed and the results will be filed in the woman’s health care record. The Women’s Health Nurses Clinical Record Form provides a logical sequence to history taking and assists in the gathering of relevant information.

5.3 Blood Pressure

5.3.1 Background

According to the Heart Foundation the normal awake blood pressure is <135/<85 (link). The Heart Foundation also provides guidance on recording blood pressure and recommendations for intervention for elevated blood pressure see Table 5.3.1 a) – Heart Foundation Classification and Follow–up of normal blood pressure and Table 5.3.1 b) – Heart Foundation - Classification and Follow–up of Hypertension. The Heart Foundation has resources for Aboriginal and Torres Strait Islander peoples on this site.

<table>
<thead>
<tr>
<th>Diagnostic category*</th>
<th>Systolic (mmHg)</th>
<th>Diastolic (mmHg)</th>
<th>Follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>&lt; 120</td>
<td>&lt; 80</td>
<td>Recheck in 2 years (or earlier as guided by patient’s absolute cardiovascular risk) †</td>
</tr>
<tr>
<td>High-normal</td>
<td>120–139</td>
<td>80–89</td>
<td>Recheck in 1 year (or earlier as guided by patient’s absolute cardiovascular risk) †</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostic category*</th>
<th>Systolic (mmHg)</th>
<th>Diastolic (mmHg)</th>
<th>Follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>&lt; 120</td>
<td>&lt; 80</td>
<td>Recheck in 2 years (or earlier as guided by patient’s absolute cardiovascular risk) †</td>
</tr>
<tr>
<td>High-normal</td>
<td>120–139</td>
<td>80–89</td>
<td>Recheck in 1 year (or earlier as guided by patient’s absolute cardiovascular risk) †</td>
</tr>
<tr>
<td>Grade 1 (mild) hypertension</td>
<td>140–159</td>
<td>90–99</td>
<td>Confirm within 2 months</td>
</tr>
<tr>
<td>Grade 2 (moderate) hypertension</td>
<td>160–179</td>
<td>100–109</td>
<td>Reassess or refer within 1 month</td>
</tr>
<tr>
<td>Grade 3 (severe) hypertension</td>
<td>&gt;=180</td>
<td>&gt;=110</td>
<td>Reassess or refer within 1–7 days as necessary</td>
</tr>
<tr>
<td>Isolated systolic hypertension</td>
<td>&gt;=140</td>
<td>&lt; 90</td>
<td>As for category corresponding to systolic BP</td>
</tr>
<tr>
<td>Isolated systolic hypertension with widened pulse pressure</td>
<td>&gt;=160</td>
<td>&lt;=70</td>
<td>As for grade 3 hypertension ‡</td>
</tr>
</tbody>
</table>

† See Absolute cardiovascular risk assessment in hypertension management ‡ In middle-aged and elderly patients with cardiovascular risk factors or associated clinical conditions, isolated systolic hypertension with large pulse pressure indicates high absolute risk for cardiovascular disease.
5.3.2 Specific History

History of Blood Pressure anomalies are to be recorded in the health care record including the medication prescribed by her local doctor.

<table>
<thead>
<tr>
<th>Special Considerations – Hypertension in Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>The mandatory directive is to be followed if a woman is pregnant at time of examination</td>
</tr>
</tbody>
</table>

**PD2011_064 Maternity – Management of Hypertensive Disorders of Pregnancy**

<table>
<thead>
<tr>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic blood pressure greater than or equal to 140mmHg, and/or Diastolic blood pressure greater than or equal to 90mmHg (Korotkoff 5)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recording the Blood Pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure the woman is positioned correctly</td>
</tr>
<tr>
<td>Record BP on both arms at the first recording, thereafter the left arm</td>
</tr>
<tr>
<td>The diastolic is to be recorded at the point of silence (Korotkoff 5). Muffling (Korotkoff 4) is acceptable only where Korotkoff 5 is absent</td>
</tr>
</tbody>
</table>

5.3.3 Education and resources

The Women’s Health Nurse discusses the advantages of checking blood pressure, the procedure is explained and verbal consent obtained.

5.3.4 Intervention

The blood pressure is taken. If it is not within normal ranges at the initial examination then:

- ensure the correct size of cuff has been used
- check blood pressure on alternative arm, give the option to lie down on the bed/couch on their left side
- repeat 20 minutes later to exclude “white coat syndrome”
- reduce anxiety by providing support and information.

If the blood pressure remains outside normal limits the Women’s Health Nurse will refer the woman to her local doctor or emergency department for further assessment and management as described in 4.6 Referral Process. This will include telephoning the doctor or triage if the woman has symptoms including but not restricted to faintness, nausea, headache, and visual disturbances.

5.3.5 Follow up

Agreement for review and follow-up is reached with the woman, and implemented as detailed in 4.3 Client Follow up.
5.3.6 Specific Documentation

History of Blood Pressure anomalies are to be recorded in the health care record including the prescribed medication.

5.3.7 References

- Heart Foundation

5.4 Breast Palpation and Awareness

5.4.1 Background

Women are encouraged to be aware of any changes in their breasts and it is helpful to have an awareness of how a normal breast looks and feels. The National organisation Cancer Australia makes the following statement:

“There is no evidence of any additional benefit of clinical breast examination for women who are already attending for regular screening mammography. For women who are not participating in regular mammographic screening, regular clinical breast examination may offer some benefit”.

5.4.2 Specific History

The woman’s history is taken including breast surgery, history of masses, cysts or tumours, family history of breast cancer, previous mammogram results, pain, or changes in appearance of breasts.

5.4.3 Education and resources

The Women’s Health Nurse discusses the advantages of regular breast awareness and an annual breast palpation by a health practitioner. The role of screening and/or diagnostic mammography and breast ultrasound for women in specific risk groups will be discussed if appropriate.

The procedure is explained and verbal consent obtained. During the procedure the woman will offered information on how to notice changes in her own breasts and written material may be provided from Cancer Australia website. Cancer Australia provides specific resources for Aboriginal women and the Jean Hailes website has a range of resources for Indigenous women on the Indigenous Women’s Health portal.

5.4.4 Intervention

The Women’s Health Nurse washes and warms hands and ensuring privacy, asks the woman to remove all clothing from the thoracic region. The Women’s Health Nurse, in a good light will:
- Position the woman either sitting or standing with arms by her sides and visually inspect the breasts and chest wall noting scars, skin conditions and texture especially puckering or dimpling, nipple retraction, difference between nipples or size of breasts, any overt nipple discharge, or if the woman has breast implants.

- Request the woman to raise arms above her head followed by pressing her hands on hips and roll shoulders forward, contracting pectoral muscles all the while continuing visual inspection checking the lateral sides of breasts and chest wall, the symmetry in breast and nipple elevation and that there is no related skin retraction.

- Request the woman to relax shoulders and with hands on hips bend forward from the waist and to then slowly stand upright and note whether breasts fall freely from chest wall, then palpate the supraclavicular and axillary regions for lymph nodes.

- Request the woman to lie down and place a small pillow under the scapula of the side being examined and place the hand of the side to be checked beneath the head and palpate the breast tissue superficially and deeply by varying the pressure whilst using the flat of the fingers of the outstretched hand, and maintaining contact with the breast tissue. Ensure a systematic examination of the breast, nipple, and chest wall by using one of the methods outlined in Table 5.4.4 - Systematic Examination of the Breast.

- Repeat the examination on the other breast using the same technique, followed by assisting the woman to the upright position so she may dress.

<table>
<thead>
<tr>
<th>Table 5.4.4 Systematic Examination of the Breast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vertical</td>
</tr>
<tr>
<td><strong>Vertical palpation</strong> of the chest wall and breast tissue</td>
</tr>
</tbody>
</table>

Referral to a General Practitioner or other appropriate service is required if any unusual findings are detected which require further assessment and management. The referral will be made as described in 4.6 Referral Process.

5.4.5 Follow up

If anomalies are found during the breast examination, an agreement for referral and follow-up is reached with the woman and implemented as detailed in 4.3 Client Follow up.

5.4.6 Specific Documentation

If an abnormality is present the Women’s Health Nurse will provide a clearly labelled diagram including size, shape, consistency, mobility, tenderness, fixation, and exact position in the health care record.

The Women’s Health Nurse documents in the health care record if the woman declines the
5.4.7 References

Cancer Australia (Breast and Ovarian Cancer)

- Reproductive and Sexual Health: an Australian clinical practice handbook 2nd Edition (2011)
- Australian Women’s Health Nurse Association Inc

5.5 Examination of the Reproductive System

5.5.1 Background

A physical examination of the reproductive system is performed if indicated in the history. This may include all or some of the examination listed in Table 5.5.1 - Anticipated findings from physical examination. These examinations seek to detect masses, infections, skin conditions, FGM, pregnancy, poor muscle tone, and prolapse.

<table>
<thead>
<tr>
<th>Type of examination</th>
<th>What may be detected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower abdominal</td>
<td>Masses, Infections</td>
</tr>
<tr>
<td>External genital and vaginal</td>
<td>Vulval conditions, Foreign bodies, FGM, Prolapse</td>
</tr>
<tr>
<td>Speculum</td>
<td>Infections, Cervicitis</td>
</tr>
<tr>
<td>Bimanual</td>
<td>Masses, Pregnancy, Infections, Prolapse</td>
</tr>
<tr>
<td>Pelvic floor</td>
<td>Poor tone, Incontinence. Prolapse</td>
</tr>
</tbody>
</table>

5.5.2 Specific History

The Women’s Health Nurse notes any significant history including LMP, previous Papanicolaou test history, contraceptive history, and hormone use.

5.5.3 Education and resources

The Women’s Health Nurse explains the procedure and demonstrates the examination with use of a pelvic model if necessary and verbal consent is obtained.

5.5.4 Intervention

The Women’s Health Nurse washes hands and prepares necessary equipment according to the NSW Ministry of Health Infection Control Policy Directive PD2007_036. The Women’s Health Nurse provides the opportunity for the woman to empty her bladder, requests the woman to undress from waist down, and provides a drape to ensure privacy.

Throughout all phases of physical assessment, the Women’s Health Nurse is alert for facial or verbal expressions of pain, discomfort or distress, and responds appropriately – halts the examination, checks with patient, and if necessary ceases the examination.
a) Lower abdominal examination

The Women’s Health Nurse requests the women to lie on examination couch in the supine position with her head resting on one pillow, arms by her side and feet resting on bed.

The Women’s Health Nurse observes for signs of tension and provides an opportunity to discuss concerns and may offer relaxation techniques prior to proceeding with the examination which includes:

- visual inspection - observe and record scars, lesions, skin conditions, and
- palpation - palpate suprapubic, right iliac fossa and left iliac fossa regions to identify masses, pain, tenderness, guarding or rebound, and check if groin lymph nodes palpable.

### Special Considerations – Lower abdominal examination

<table>
<thead>
<tr>
<th>Post partum assessment</th>
<th>Examine abdomen for tenderness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assess uterine involution</td>
</tr>
<tr>
<td></td>
<td>Assess separation of abdominal rectus sheath muscle</td>
</tr>
<tr>
<td></td>
<td>Assess caesarean section scar (if indicated)</td>
</tr>
</tbody>
</table>

b) External genitalia and vaginal examination

With the woman remaining in the supine position the woman is requested to bend her knees and then allow them to fall apart to expose the external genitalia. The Women’s Health Nurse positions the examination light appropriately, re-washes hands and puts on gloves. She then observes for:

- skin conditions or lesions, erythema, excoriation, distribution of pubic hair, introital bleeding or discharge, masses, prolapse, linear fissures, evidence of female genital mutilation (FGM/C),
- dryness or atrophy, especially in lactating and postmenopausal women,
- foreign bodies such as tampon or condom, and
type of discharge - amount, colour and odour.

### Special Considerations - External genitalia and vaginal examination

<table>
<thead>
<tr>
<th>Post partum assessment</th>
<th>Assess lochia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assess Perineum – note bruising, swelling or grazing of the vulva and vagina. Episiotomy and perineal tears usually heal in 2-3 weeks although the site may remain tender in a significant proportion of women for some months</td>
</tr>
<tr>
<td></td>
<td>Observe for signs of infection or scarring with painful ridging or narrowing of the introitus. These may cause pain on penetration, involuntary tightening of vaginal muscles and a loss of arousal and lubrication</td>
</tr>
</tbody>
</table>

| Female Genital Mutilation | The nurse must be familiar with the definition of types of FGM, the short and long term effects of FGM that may impact on a woman’s uro-gynaecological health, and potentially the woman’s overall physical and mental health |

Female Genital Mutilation
c) **Speculum examination**

- **Choosing the speculum**

  Choose a speculum size appropriate to the woman; most women will find a narrow blade more comfortable. A longer, wider speculum may be necessary for women of multiple parity or poor vaginal muscle tone. If the vaginal walls still intrude and obscure the cervix, a condom with the end removed may be placed over the speculum blades before insertion. The condom then supports the vaginal walls and enables access to the cervix.

  A metal or plastic speculum may be selected and preparations for these differ, see Table 5.6.4 c) - Speculum preparation.

<table>
<thead>
<tr>
<th>Table 5.6.4 c) - Speculum preparation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metal speculum</td>
</tr>
<tr>
<td>Rinse under warm running water to warm</td>
</tr>
<tr>
<td>Leave wet to lubricate</td>
</tr>
<tr>
<td>Check temperature on inside of gloved wrist, then after informing the woman check again on the inner aspect of her thigh</td>
</tr>
</tbody>
</table>

- **Inserting the Speculum**

  The Women’s Health Nurse will insert the speculum by:

  - using thumb and forefinger to part labia minora
  - sliding the speculum slowly and gently into the vagina guided by the posterior vaginal wall and ensuring blades remain horizontal and together
  - opening the blades of the speculum to be guided visually to locate the cervix and bring it into view.

  When the cervix is difficult to locate the speculum may need to be repositioned by allowing the blades to close before moving the speculum in the vagina.

  If the cervix is not located the speculum will be withdrawn and:

  - the position of the cervix will be palpated with a gloved hand moistened with water and once the position of the cervix has been identified the speculum can then be inserted at the appropriate angle
  - if the cervix remains “out of view” then withdraw the speculum, ask the woman to “bear down” and then re insert the speculum
○ adjust the woman’s position depending on the position of the cervix, for instance, placing a small pillow/roll/cushion under her buttocks, this may assist in visualising the cervix by altering the angle of her pelvis.

When the cervix is visualised with the speculum blades positioned in the anterior and posterior fornices, tighten the screw of the upper blade to self-retain the speculum in the vagina.

- **Visual assessment**

Once the Speculum is secured the Women’s Health Nurse will perform a visual assessment and:

○ note the appearance of the vagina, presence of inflammation, friability of tissue, presence of a foreign body, discharge or visible lesions in the vagina,

○ observe the position and appearance of the cervix and note the presence of inflammation, colour and consistency of any discharge, bleeding, cervical ectropion, lesions, ulceration or polyps, presence or absence of contact bleeding, columnar epithelium on the ecto-cervix; and

○ note the colour, number and length of intrauterine device (IUCD) strings (if present).

- **Collection of specimens**

The Women’s Health Nurse will collect the required specimens based upon the history as outlined in Table 5.6.4 c) - Indicated tests, and ensure they are labelled and transported according to SEALS guidelines, and are accompanied by the completed pathology form ensuring the specimen and form are in the correct pockets of the plastic bag. Urine should be bagged separately from other specimens.

<table>
<thead>
<tr>
<th>Table 5.6.4 c) – Indicated tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
</tr>
<tr>
<td>Sexually active women aged &lt;=70 years</td>
</tr>
</tbody>
</table>

- **Removing the speculum**

The speculum is removed by loosening the upper blade screw, withdrawing the speculum slightly and gently from the fornices to avoid pinching the cervix before allowing the blades to close and completely withdrawing the speculum using slight downward traction.
d) **Bimanual examination of the pelvis**

With the woman remaining in the supine position with knees bent to expose external genitalia the Women’s Health Nurse will apply lubricant to two gloved fingers of her examining hand (vaginal hand) and:

- part the labia minora using the thumb and forefinger of the unlubricated gloved hand (abdominal hand) to visualise the introitus
- slide the lubricated forefinger of the vaginal hand into the vagina, pressing downward slightly to assess the levatores
- without causing discomfort, insert a second finger and follow the posterior vaginal wall until the cervix is palpable (on occasion only one finger may be inserted into the vagina to perform the examination, particularly if the woman is post menopausal or has a narrow introitus)

<table>
<thead>
<tr>
<th>Special Considerations - Bimanual examination</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Women with female genital mutilation (FGM)</strong></td>
</tr>
<tr>
<td>Depending on the degree of FGM the examination may not be possible, or only one finger may be inserted into the vagina</td>
</tr>
</tbody>
</table>

- turn the examining hand palm upwards and palpate the cervix, noting the position, size and consistency of the cervix and cervical os

<table>
<thead>
<tr>
<th>Special Considerations - Bimanual examination</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diaphragm fitting</strong></td>
</tr>
<tr>
<td>To estimate the size of the required diaphragm assess the:</td>
</tr>
<tr>
<td>- position of the cervix</td>
</tr>
<tr>
<td>- distance from the posterior fornix to the posterior aspect of the pubis symphysis</td>
</tr>
<tr>
<td>- the presence of a distinct palpable notch behind the pubic bone</td>
</tr>
</tbody>
</table>

- place the abdominal hand mid position above the symphysis pubis and press down to stabilise the pelvic organs. Elevate the cervix with the fingers of the vaginal hand and palpate the position of the uterus by noting the position of the fundus with your abdominal hand as described in Table 5.6.4 d) - Identifying the position of the uterus
  - If the fundus is not located, relocate the abdominal hand to the left or right of the central position; following location of the uterus note the position, size, shape and mobility by palpating the fornices.

<table>
<thead>
<tr>
<th>Table 5.6.4 d) - Identifying the position of the uterus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anteverted position</strong></td>
</tr>
<tr>
<td>The fundus is palpated anterior to the axis of the vagina</td>
</tr>
<tr>
<td><strong>Retroverted</strong></td>
</tr>
<tr>
<td>Vaginal fingers placed in the posterior fornix enables palpation</td>
</tr>
</tbody>
</table>
mid position

The fundus is not usually palpable

- Identify any masses or tenderness by:
  - displacing the cervix laterally by placing a finger on each side of the cervix and rocking gently
  - palpating the adnexa by moving the abdominal hand and vaginal fingers to the relevant lateral fornix and applying gentle pressure between your hands
  - palpating the Pouch of Douglas with vaginal fingers in the posterior fornix.

### Special Considerations - Bimanual examination

| Large women | Normal ovaries may not be palpable |

#### e) Pelvic Floor Muscle Tone Assessment

This examination is usually performed following a bimanual examination to assess the tone and functioning of the pelvic floor muscles.

### Special Considerations – Pelvic Organ Prolapse

- Examination for pelvic organ prolapse should be performed in the dorsal lithotomy position at rest and then with maximal valsala or cough.
- Re-examination in the standing position may be necessary if physical finding do not correspond to symptoms or if maximal extend of the prolapsed cannot be confirmed.
- Assessment for vaginal atrophy and a rectovaginal examination to evaluate the posterior compartment and the perineal body are important.
- A retractor or the posterior blade of a bivalve speculum is a useful aid

The Women’s Health Nurse, with gloved fingers located centrally in the vagina, will ask the woman to ‘contract’ or ‘pull up’ her pelvic floor muscles and hold the contraction for as long as possible (up to 10 seconds) and grade the strength of the contraction as described in table 5.6.4 e).

<table>
<thead>
<tr>
<th>Table 5.6.4 e) – Muscle tone gradient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muscle contraction</td>
</tr>
<tr>
<td>Nil - If no contraction is felt then determine if the abdominal or gluteal muscles are being contracted erroneously.</td>
</tr>
<tr>
<td>Flicker only with muscles stretched</td>
</tr>
<tr>
<td>A weak squeeze. Two second hold</td>
</tr>
<tr>
<td>A fair squeeze (where the contraction can be felt to move in an upward inward direction)</td>
</tr>
</tbody>
</table>
A good squeeze, good hold and lift
The contraction MUST be able to be repeated a few times to be graded as 4

If a contraction is felt ask the woman to relax and tighten the muscles again, the strength of contraction and degree of pelvic lift is noted. Also assess the strength of the second contraction in comparison to the first and grade according to Table 5.6.4 e) – Muscle tone gradient.

Following the pelvic floor tone assessment the Women’s Health Nurse will:

- provide information about how to perform pelvic floor exercises including the regime as per the National Continence Management pamphlet/resources. Brochures in a range of language are available from the National Continence Foundation.
- a review will be offered within three months if the pelvic floor muscle tone is assessed as below Grade 3.

If muscle tone grading remains weak at the follow up assessment the options for further assessment and management will be discussed, these may include referral to the continence nurse advisor, physiotherapist, or local doctor as described in 4.6 Referral Process.

### Special Considerations - Post partum assessment of pelvic floor muscle tone

Pelvic floor muscles may be stretched following childbirth; this may impact on the quality of sexual activity by creating loss of sensation and arousal for both partners.

Assess for any urinary/faecal incontinence

f) **Completion of examination**

The Women’s Health Nurse removes all items used for the examination from the vagina and disposes of according to [NSW Ministry of Health Infection Control Policy Directive PD2007_036](#) and [Waste Management Guidelines for Health Care Facilities PD2005_132](#), and assists the woman to sit up, offers tissues or pad and ask her to dress.

#### 5.5.5 Follow up

Follow up is dependent on the assessment and findings and an agreement for review and follow-up is reached with the woman, and implemented as detailed in 4.3 Follow up.

#### 5.5.6 Specific documentation

If specimens are to be taken the required pathology forms are completed, glass slides are labelled in pencil with woman’s name and date of birth. If liquid-based cytology is to be performed the specific
medium is labelled, and the woman is required to complete and sign SEALS “Consent for payment” pathology form.

The Women’s Health Nurse records in the health care record if the woman declines some or all of the components of the examination.

5.5.7 References

- Family Planning Victoria Service Coordination Guide
- NSW FGM Education Program Brochure
- RANZCOG FGM/C general information
- Australian College of Midwives and Australian College of Nursing joint project on FGM learning resources
- FGM Clinical Management Guidelines A Self Directed learning package for health professionals (2000) NSW Education Program on Female Genital Mutilation. Family Planning NSW
- National Continence Foundation
- PD2007_036 Infection Control Policy NSW Health
- Hand Hygiene Policy
- Child Wellbeing and Child Protection Policies and Procedures for NSW Health
- Reproductive and Sexual Health: an Australian clinical practice handbook. 2nd edition (2011) Family Planning NSW
- Screening to prevent cervical cancer, guidelines for the management of asymptomatic women with screen detected abnormalities (May 2006), National Health and Medical Research Council
- Take Control an initiative of the National Continence Management Strategy Bladder and Bowel Website. Australian Government Department of Health and Ageing
- The Cancer Council Diethylstilbestrol (DES) and Cancer Position Statement (2013) DES and Cancer - Position Statement
6 WELL WOMEN’S HEALTH CLINICS – SPECIFIC INTERVENTIONS

6.1 Contraception

6.1.1 Background

The World Health Organisation endorses criteria for contraceptive use. The anticipated outcomes are a reduction in unplanned and unwanted pregnancy, and a decrease in the morbidity and mortality from sexually transmissible infections.

Contraceptive methods used in Australia are:

- Hormonal – combined oral contraceptive pill (COCP), Progesterone only pill (POP), estonogestrel implants (Implanon), Mirena IUCD, Depo provera injection, and Nuva-ring
- Post coital contraception – Postinor, prescription medication including Yuzpe regimen, or the copper based intrauterine device (IUCD), Barrier methods– diaphragms and condoms
- Fertility awareness basal methods - calendar, temperature, Billings ovulation method, symptothermal and standard days method
- Sterilisation – tubal ligation, essure procedure, and vasectomy
- Breast feeding
- Coitus interruptus
- Spermicide.

6.1.2 Specific History

Prior to discussing contraception it is necessary to exclude a current pregnancy by history, recent use of contraception and sexual activity, and date of last menstrual cycle. Other factors that will influence identifying suitable contraception options include the woman’s:

- age
- parity - including recent births and if currently breast feeding
- physical health – including history of hypertension, thrombo-embolism, migraine, cancer, diabetes, HIV, and drug reactions
- current medications
- known allergies - especially latex and rubber
• previous methods of contraception - effectiveness, acceptability and problems.

### Special Considerations – Contraception

| The combined contraceptive pill is not recommended for women who are breast feeding |
| A diaphragm used prior to birth will no longer fit and refitting will be necessary |

### 6.1.3 Education and resources

All women are provided with information that is woman focused and evidence-based to enable them to make an informed decision about which method of contraception is preferred to prevent pregnancy.

The Women’s Health Nurse will discuss all methods of contraception as required, incorporating efficacy, mode of action, contraindications, side effects and cost. Choice of a method by an individual may be influenced by efficacy, reversibility, health risks, side effects, user-friendliness, accessibility and cost. Additionally it will be determined if there is a need to use additional methods such as condoms between the consultations and when efficacy of the chosen method will be established.

Written material from [Family Planning NSW](#) or [Natural Family Planning Services](#) may be provided.

### 6.1.4 Intervention

The intervention is dependant on the impression gained from the assessment and may include:

a) **Emergency post coital contraception**

   Where Emergency post coital contraception is indicated the medication can be obtained from a pharmacy, [Sexual Health Clinic](#), and some [Youth clinics](#). The supply is regulated by state laws.

b) **Suspected Pregnancy**

   If the history indicated a possible current pregnancy a pregnancy test will be performed as described in 6.11 Pregnancy testing.

c) **Barrier Methods**

   If the woman chooses a diaphragm the Women’s Health Nurse will provide written material from [Family Planning NSW](#) and gain verbal consent to perform a vaginal examination as described in 5.5.4 d) Bi manual examination – fitting a diaphragm. The woman may then purchase the diaphragm from the local pharmacy and is invited to return for an educational consultation for insertion.

   If the woman chooses condoms the Women’s Health Nurse will demonstrate how condoms are applied, disposed of, and options if the condom fails.
d) **Hormonal and IUCD**

Women’s Health Nurses are not authorised to prescribe hormonal contraception or insert IUCDs and will refer women to a General Practitioner (GP) or an authorised service as described in 4.6 Referral Process.

### 6.1.5 Follow up

If the woman accesses emergency post coital contraception an agreement for review and follow-up is reached with the woman, and implemented as detailed in 4.3 Client follow up.

### 6.1.6 Specific Documentation

Assessment for current pregnancy, the methods of contraception discussed, any procedures performed, information given, copy of referral letters and outcome of referral.

### 6.1.7 References

- Contraception: an Australian clinical practice handbook Third edition FPA Health/Family Planning NSW 2012
  
  Family Planning NSW (FPNSW) and Talk line phone number 1300 658 886 [www.fpnsw.org.au](http://www.fpnsw.org.au)
- [Natural Family Planning](http://www.naturalfamilyplanning.org.au)
- Sexual Health & Family Planning Australia November 2008 Contraception: an Australian clinical practice handbook, second edition

### 6.2 HIV Pre-Test Discussion/Consent/Testing

#### 6.2.1 Background

Women’s Health Nurses follow the NSW Ministry of Health ‘[HIV – Management of People with HIV Infection who risk infecting others’ Policy Directive PD2009_023](http://www.fpnsw.org.au)' and the National Testing Policy for HIV using the HIV Informed consent resource for testing. Women’s Health Nurses do not perform this test but can refer the woman to the appropriate service, such as the local GP or sexual health clinic.

#### 6.2.2 Specific History

The Women’s Health Nurse will take a sexual history to identify risk behaviours.

#### 6.2.3 Education and resources

The Women’s Health Nurse will assess the woman’s current knowledge and build on this to provide an understanding of:

- differences between HIV and AIDS
- reasons for testing
- how HIV is transmitted
strategies that reduce or prevent transmission

- the three month delay in the development of antibodies following exposure to the virus

- the implications of a positive test and the mandatory notification requirements

- the policy directives concerning confidentiality

- how results are obtained

- services available to improve health outcomes if the result is positive, such as sexual health services, immunology or infectious diseases physicians, and local support networks.

Fact sheets from Family Planning NSW may be provided. Information for women is also on the ACON website.

### 6.2.4 Intervention

Referral to a General Practitioner or other appropriate service is required if the woman wishes to be tested for HIV. The referral will be made as described in 4.6 Referral Process.

### 6.2.5 Follow up

Agreement for review and follow-up is reached with the woman, and implemented as detailed in 4.3 Client follow up.

### 6.2.6 Specific Documentation

Specific documentation in the woman’s health care record including the discussion/consent, information given, copy of referral letters and outcome of any referrals is retained in the Health Care Record.

### 6.2.7 References

- NSW HIV Strategy 2012-2015 A New Era
- National HIV Testing Policy2011Informed consent for testing
- Ashm Testing Portal
- HIV Antibody Testing - Counselling – Guidelines, PD2005_048 NSW Health
- ACON website

### 6.3 Menopause

#### 6.3.1 Background

Menopause is a natural part of every woman’s life. It is the last menstrual period, marking the end of a woman’s reproductive years. Most women reach the age of menopause between the ages of 45 and 55 years.
Menopause symptoms can begin gradually over two to six years before the last menstrual period. Peri menopause, or menopause transition, is the time over which periods fluctuate until they stop. How women experience the menopause is very individual. 20% of women have no symptoms, 60% have mild symptoms, while 20% suffer severe symptoms. As hormone levels fluctuate, women may begin to experience some physical and emotional symptoms that can have an effect on body image and interpersonal relationships. These symptoms include hot flushes, night sweats, generalised aches and pains, headaches, vaginal dryness, urinary frequency, reduced libido, tiredness, irritability, depression, sleeping difficulties, forgetfulness, low self-esteem, or crawling or itching sensations under the skin.

6.3.2 Specific History

The woman’s menstrual history is taken including the symptoms of menopause she is experiencing and how they affect her quality of life.

6.3.3 Education and resources

Women who seek education on the management of menopause have a right at every age to receive accurate, objective, understandable information on the relevant medical options and evidence-based complementary therapies available. Reduction in menopause related symptoms will improve the women’s quality of life.

The Women’s Health Nurse will assess the woman’s current knowledge and build on this to provide an understanding of reproductive physiology and changes that occur around the time of menopause, including the benefits of continued participation in health programs such as two yearly cervical, breast and bone density screening.

Information on healthy ageing, bone health, and nutrition (including dietary phytoestrogens) will be provided, and healthy lifestyle choices will be discussed including regular physical activity, joining local support groups, avoiding smoking, and limiting alcohol intake.

Written material may be supplied from Jean Hailes concerning peri-menopause and menopause. Information in other languages may also be provided from Jean Hailes website

6.3.4 Intervention

Medical and complementary options may be discussed and the woman may be referred according to 4.6 Referral Process for ongoing management. The importance of informing the General Practitioner of any complementary therapies being used will be emphasised, and women will be further advised to ensure they see only ‘accredited practitioners’.

6.3.5 Follow up

Agreement for review and follow-up is reached with the woman, and implemented as detailed in 4.3 Client follow up.
6.3.6 Specific Documentation

Specific documentation in the woman’s health care record including assessment, findings, information given, copy of referral letters and outcome of any referrals.

6.3.7 References

- Australasian Menopause Society
- Jean Hailes Foundation The Jean Hailes Foundation for Women’s Health - Home
- Family Planning NSW
- Reproductive and Sexual Health: an Australian clinical practice handbook. 2nd edition (2011) Family Planning NSW

6.4 Menstrual Problems (excluding vaginal bleeding)

6.4.1 Background

Menstruation is the periodic discharge of blood and tissues from a non-pregnant uterus through the vagina. Menstruation occurs every 28 days or so between puberty and menopause, except during pregnancy, but may also cease during times of ill health, stress and starvation. The length and flow of the menstrual cycle will vary from woman to woman.

6.4.2 Specific History

The women’s history is taken including the date and nature of last menstrual period, physical and emotional symptoms, treatments taken, and the effect on her quality of life.

6.4.3 Education and resources

The Women’s Health Nurse will assess the woman’s current knowledge and build on this to provide accurate information to dispel myths.

Written material may be provided concerning premenstrual syndrome from Family Planning NSW, and Jean Hailes Foundation for polycystic ovarian syndrome and endometriosis.

6.4.4 Intervention

If indicated the Women’s Health Nurse may:

- explore the options to manage menstrual cycle difficulties such as dysmenorrhoea, menorrhagia, polycystic ovary syndrome (PCOS) premenstrual syndrome (PMS), including medications, natural therapies, diet, exercise and general lifestyle changes
- encourage participation in local support groups
- explore referral options to General Practitioner for assessment, investigations, or if medication is indicated
• recommend non prescription medications emphasising the adherence to the instruction and dosage instructions provided
• recommend advising their General Practitioner if taking any systemic treatments as they may affect the efficacy of prescription medications.

6.4.5 Follow up
Agreement for review and follow-up is reached with the woman, and implemented as detailed in 4.3 Client follow up.

6.4.6 Specific Documentation
Specific documentation in the client’s health care record including assessment, findings, information given, copy of referral letters and outcome of referrals.

6.4.7 References
• Family Planning NSW
• Jean Hailes Foundation Website
• Reproductive and Sexual Health: an Australian clinical practice handbook. 2nd Edition (2011) Family Planning NSW

6.5 Osteoporosis

6.5.1 Background
Osteoporosis is a condition in which the bones of the body become fragile and brittle, increasing the risk of fractures. Osteoporosis is the condition where bones lose minerals, such as calcium, more quickly than the body can replace them leading to a loss of bone mass or density. As a result bones become thinner and less dense and are therefore more prone to serious fractures. These are known as fragility or minimal trauma fractures.

All bones can be affected by osteoporosis, which is diagnosed using a DEXA (X-Ray) scan to measure bone density. The most common sites are the hip, spine, wrist, ribs, pelvis and upper arm. Osteoporosis is often called the “silent disease” as it usually has no signs or symptoms until a fracture occurs. It is essential that osteoporotic fractures are identified and treated as quickly as possible to stop the “fracture cascade”. Osteoporosis Australia states one in every two women in Australia will have an osteoporotic fracture; therefore it is essential to increase health promoting strategies that educate women about preventing osteoporosis and in turn reduce the risk of fractures.

6.5.2 Specific History
The Women’s Health Nurse takes a comprehensive history from the woman to identify risk factors for osteoporosis:

• poor calcium intake in the diet and likelihood of vitamin D deficiency
• physical inactivity
• family history of osteoporosis
• late onset of menarche (after age 15-16yrs) or early menopause (under age 45yrs)
• chronic health conditions such as rheumatoid arthritis, thyroid disease
• malabsorption disorders, chronic liver disease and chronic kidney disease
• long term use of certain medications, such as corticosteroids, anticonvulsants, heparin, insulin, thyroid supplements, or chemotherapy
• cigarette smoking
• alcohol - more than two standard drinks per day
• excessive caffeine intake - >5 cups per day.

6.5.3 Education and resources

The Women’s Health Nurse will provide individual information on life style changes to protect against osteoporosis; this information is detailed in Table 6.5.3 - Risks and protective actions for osteoporosis.

Written material may be supplied from Osteoporosis Australia, where fact sheets are available in a range of languages. Information is also available on the Jean Hailes Foundation website - Bone Health for Life.

<table>
<thead>
<tr>
<th>Identified risk</th>
<th>Protective action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor calcium intake</td>
<td>Eat a varied diet which includes plenty of:</td>
</tr>
<tr>
<td></td>
<td>– fresh fruit and vegetables</td>
</tr>
<tr>
<td></td>
<td>– whole grains</td>
</tr>
<tr>
<td></td>
<td>– canned fish with edible bones for example sardines</td>
</tr>
<tr>
<td></td>
<td>Consider referral to an accredited dietician</td>
</tr>
<tr>
<td>Low Vitamin D levels</td>
<td>Vitamin D levels are increased with sun exposure, it is recommended to have 10-15 minutes of sun exposure to arms and face daily, without sunscreen and before 11am or after 3pm</td>
</tr>
<tr>
<td>Cigarette smoking</td>
<td>Avoid smoking, participate in QUIT programs</td>
</tr>
<tr>
<td>Alcohol consumption</td>
<td>Limit alcohol consumption</td>
</tr>
<tr>
<td>Caffeine consumption</td>
<td>Limit caffeine intake to less than three cups per day of cola, tea or coffee</td>
</tr>
<tr>
<td>Lack of physical activity</td>
<td>Participate in regular weight bearing and strength training activities, for example 30 minutes of walking, jogging, tennis, dancing 3 – 4 times a week</td>
</tr>
<tr>
<td></td>
<td>Exercise also maintains bone strength and balance so falls are reduced</td>
</tr>
<tr>
<td></td>
<td>Make contact with local support groups and programs that promote strength training</td>
</tr>
</tbody>
</table>
6.5.4 Intervention

If the woman has a low level of vitamin D diagnosed, supplements may be recommended to assist with the absorption of calcium. The recommended daily intake of dietary calcium is:

- Adolescents – 1,300mg calcium per day
- Women under 50 - 1,000mg calcium per day
- Post menopausal women - 1,300mg calcium per day.

If a woman is identified at risk of osteoporosis the Women’s Health Nurse may refer to a General Practitioner or other appropriate service for investigation and management. The referral will be made as described in 4.6 Referral Process.

6.5.5 Follow up

Agreement for review and follow-up is reached with the woman, and implemented as detailed in 4.3 Client follow up.

6.5.6 Specific Documentation

Specific documentation in the woman’s health care record including assessment, findings, information given, copy of referral letters and outcome of referral.

6.5.7 References

- Dieticians Association of Australia
- Jean Hailes Foundation The Jean Hailes Foundation for Women's Health - Home
- NSW Health website – CIAP (Clinical Information Access Program) for medication manual MIMS and the Natural Medicines comprehensive database
- Osteoporosis Australia website - National toll free phone number is 1800 242 141,

| Family history, long term use of certain medications, such as corticosteroids and chronic health conditions | Remain aware of osteoporosis and reduce risk by performing protective actions Access regular bone density assessments Discuss the impact of chronic health conditions and medications on bone density with treating doctor |
| Falls | Falls are a risk for people with osteoporosis so it may be necessary for women to see a physiotherapist and/or occupational therapist to provide assistance with walking aids and ensure their home environment is safe |
6.6 Papanicolaou Tests

6.6.1 Background

The National Cervical Screening Program is a joint health initiative of the Commonwealth and State and Territory Governments and is auspiced by the Cancer Institute. The screening program only applies to asymptomatic women.

There are two additional methods of testing, liquid based cytology as described in Table 6.6. Liquid Based Cytology (Thin Prep), and Human Papilloma Deoxyribonucleic Acid (HPV DNA) Testing, and Table 6.6.1 - Human Papilloma Deoxyribonucleic Acid (HPV DNA) Testing.

Women’s Health Nurses do not routinely perform Thin Prep unless indicated by their designated Clinical Supervisor.

If the Women’s Health Nurse has a pathology request for the HPV DNA form signed by the supervising clinician they need to:

- complete the Medicare portion with the patient's Medicare card number and reference number (the number on the left hand side of the patient name on the Medicare card)
- annotate eligible for Item#69486 on the pathology request form
- obtain the patient’s signature on pathology request form.

If the patient does not own a Medicare card, then they would have to pay for this test. The Women’s Health Nurse will write "Medicare Ineligible, Bill the patient" on the request form.

<table>
<thead>
<tr>
<th>Table 6.6 - Liquid Based Cytology (Thin Prep)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale</strong></td>
</tr>
<tr>
<td>Liquid Based Cytology is commonly used as an additional test to conventional cytology with any cells remaining on the sampling instrument after preparation of the slide being transferred to a liquid based collection system – the “split sample”</td>
</tr>
<tr>
<td><strong>Evidence</strong></td>
</tr>
<tr>
<td>A recent review of published work to assess the performance of liquid based cytology compared to conventional cytology found “no evidence that liquid based cytology reduced the proportion of unsatisfactory slides or detected higher grade lesions in high quality studies, than conventional cytology.” Lancet 2006; 367:122-32</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
</tr>
<tr>
<td>When a woman requests Thin prep, or it is ordered by the Clinical Supervisor, the woman is required to pay for the cost of this test and sign the approved SEALS Pathology request form (See Appendix D – Consent – payment of Thin Prep test)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 6.6.1 - Human Papilloma Deoxyribonucleic Acid (HPV DNA) Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale</strong></td>
</tr>
<tr>
<td>Women previously treated for a high grade squamous intraepithelial lesion (HSIL) are encouraged to undergo Human Papilloma Deoxyribonucleic Acid (HPV DNA) testing to monitor the effectiveness of the treatment</td>
</tr>
<tr>
<td><strong>Evidence</strong></td>
</tr>
<tr>
<td>NH&amp;MRC Guidelines - Screening to prevent Cervical Cancer (2005)</td>
</tr>
</tbody>
</table>
**Cost**

HPV DNA is a test that can be claimed from Medicare. However, in order to do this, there are requirements set out by Medicare that need to be followed. If these requirements are not followed fines will/can occur to both SEALS and the person/department requesting the test.

### 6.6.2 Specific History

Age and sexual activity will identify if a Papanicolaou testing (Pap Smears) is indicated as follows:

- **All women who have ever had sex should start having Pap smears between the ages of 18 and 20 years, or two years after first having sex - whichever is later.**

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

- In women aged over seventy years, the Papanicolaou tests may cease if there has been two or more normal results in the preceding five years. For women aged over seventy who have never been screened, are symptomatic or request a Papanicolaou test should be screened irrespective of age.

Women with symptoms such as bleeding or pain require referral to their doctor for further investigation. A Pap smear may be taken and a copy must be sent to the doctor as this may expedite the process of investigation.

<table>
<thead>
<tr>
<th>Special Considerations - Papanicolaou Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>During normal menstruation</td>
</tr>
<tr>
<td>During abnormal vaginal bleeding</td>
</tr>
<tr>
<td>During pregnancy</td>
</tr>
<tr>
<td>Vaginal or cervical infection</td>
</tr>
<tr>
<td>Douche or vaginal creams</td>
</tr>
<tr>
<td>Post menopausal and breast feeding</td>
</tr>
<tr>
<td>Lesbians and women who have sex with women</td>
</tr>
</tbody>
</table>
| Women after a hysterectomy | Continue with either a Papanicolaou or vaginal vault smear if:  
  - the cervix was not removed at the time of hysterectomy  
  - the exact reason for the hysterectomy is not known  
  - previous test results are not known  
  - there is a history of genital warts, HPV changes, high or low grade epithelial squamous lesions that required investigation/treatment or follow-up  
  - there is a history of invasive gynaecological malignancy  
  - the woman is immunosuppressed due to therapy or disease |
| Women exposed to Diethylstilboestrol in utero | Offer both cervical and vaginal cytological screening annually  
Also perform a careful visual inspection and palpation of the entire vagina and an internal pelvic examination  
May also include iodine staining of the vagina and cervix (normal tissue stains brown) Further procedures may then be necessary, such as colposcopy and biopsy |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Genital Mutilation (FGM) women</td>
<td>Consider a paediatric speculum; however it may be difficult or impossible to perform a Papanicolaou test. A thorough history, including gynaecological history, medical and surgical intervention, and bladder problems will enable appropriate referrals</td>
</tr>
</tbody>
</table>

**6.6.3 Education and resources**

The woman is advised of the benefits of Papanicolaou screening and information concerning the Pap Register will be provided. Obtaining the results will be discussed and permission to advise their GP of the result will be sought. The procedure is explained and verbal consent is obtained. The National Cancer Screening website provides information on the ‘frequently asked questions’ page.

**6.6.4 Intervention**

Papanicolaou screening requires a speculum examination as described in 6.6.4 c) Speculum examination. The following steps are performed to collect the sample of loose cells and fix to the glass slide. However for liquid-based cytology the sampling devices should simply be vigorously moved around within the supplied medium.

**Step 1** 
Insert the centre of the cervix sampler brush into the cervical os and rotate the brush a minimum of three times in the same direction.

**Step 2** 
Remove the brush carefully and transfer the cellular material thinly and in one direction on the labelled slide. If a cytobrush is used in conjunction with the cervix sampler, transfer the cellular material to half the slide only.

**Step 3** 
Insert the cytobrush into the endocervical canal and rotate.

**Step 4** 
Remove the cytobrush and transfer the material onto the clean half of the slide by rolling the cytobrush across the slide.

**Step 5** 
Dispose of the cervical sampler/cytobrush into a Sharps container.

**Step 6** 
Prevent the sample from air-drying by applying spray fixative from a distance of 5-10cms ensuring the entire slide is covered.

**6.6.5 Follow up**

All women must be informed of the result of their Papanicolaou test within one month of the test being performed. The woman will be contacted and depending on the result the woman may be
asked to attend a clinic appointment or the result may be provided over the phone. Occasionally a home visit may be required.

Agreement for review and follow-up is reached with the woman, and will be further influenced by the pathology results and recommendations as described in table 6.6.5 – Intervention following abnormal results for Papanicolaou test.

When advising the woman of the results the Women’s Health Nurse will ensure that:

- clear and accurate information on the significance of the report will be provided, and the woman’s choices for further management will be discussed
- adequate time is allocated to address any questions and to discuss any anxiety about the significance of the abnormality and the necessary referral pathways
- Interpreter Services will be used for women who have identified and accepted the need for an Interpreter. Special care needs to be taken to ensure that they have understood the information. If referral is necessary an interpreter booking is organised
- written material in the appropriate language to support the information provided verbally will be provided. The NSW Cervical Screening Program provides information in range of languages

| Table 6.6.5 – Intervention following abnormal results for Papanicolaou test |
|---------------------------------|---------------------------------|
| **Result**                     | **Action**                      |
| Unsatisfactory                 | Repeat test in 6-12 weeks after correction of the problem (if possible) which resulted in the unsatisfactory test |
|                                | If postmenopausal consider use of vaginal oestrogen for seven days before repeating the test. Ensure three days between last application and the test to reduce the excess cream in the vagina |
| Endocervical material or cells absent | If negative/within normal limits repeat Papanicolaou test in 2 year |
| Negative with inflammation    | Repeat in 2 years               |
| Bacterial vaginosis           | Refer to GP for treatment if symptomatic, pregnant or prior to instrumentation of the upper genital tract |
| Normal endometrial cells present in postmenopausal women | Normal endometrial cells should not be reported in an asymptomatic woman (NHMRC) Symptomatic women require investigation irrespective of their Papanicolaou test result |
| Possible/definite low grade squamous intraepithelial lesions (LSIL) | Under 30 years of age - Repeat Papanicolaou test in 12 months Over 30 years of age – no negative cytology in the preceding two to three years - repeat cytology within six months or perform an early colposcopy to facilitate diagnosis of any occult high grade squamous intraepithelial lesion (HSIL). This decision is dependent on clinical judgement |
Possible/definite high grade squamous intraepithelial lesions (HSIL) | Refer to General Practitioner (GP) or authorised medical officer for referral to a specialist gynaecologist or other suitable colposcopist as described in paragraph 4.6 Referral Process
If the woman does not have a GP, the Women’s Health Nurse is to seek advice from Clinical Supervisor and follow recommendations

<table>
<thead>
<tr>
<th>Management after treatment for HSIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period elapsed since treatment</td>
</tr>
<tr>
<td>4-6 months</td>
</tr>
<tr>
<td>12 months</td>
</tr>
<tr>
<td>24 months</td>
</tr>
</tbody>
</table>

Invasive squamous cell carcinoma (SCC) or adenocarcinoma | Referral to G.P. or authorised medical officer as described in paragraph 4.6 Referral Process to refer the woman to a Gynaecological Oncologist

### National Cervical Screening Program review process

The Federal Government (Department of Health and Ageing) is reviewing the research, technology and practices linked to the screening program, to ensure it continues to be as effective as possible in preventing cervical cancer in Australia. This process is referred to as the National Cervical Screening Program Renewal.

The Renewal will examine screening tests and practices, screening intervals, the at-risk age group, systems of collecting tests and providing results, data collection and Pap test register management. The first meeting of the Renewal Steering committee was held November 2011 and the Renewal process is expected to be complete in mid 2014.

Information and updates are on the [National Cervical Screening Program Renewal](#) website

### 6.55 Specific Documentation

Specific documentation in the client’s health care record including assessment, findings, information given, copy of referral letters and outcome of referral and indicate consent given or withheld for the Pap Test Register.

### 6.6.6 References

- Screening to prevent cervical cancer, guidelines for the management of asymptomatic women with screen detected abnormalities (May 2006), National Health and Medical Research Council
- The National Cervical Cancer Screening program Frequently asked questions
- National Cervical Screening Program Renewal
Reproductive and Sexual Health: an Australian clinical practice handbook. 2nd Edition (2011)
Family Planning NSW

6.7 Pelvic Inflammatory Disease (PID)

6.7.1 Background

Pelvic inflammatory disease (PID) is associated with ascending infection from the vagina and cervix to involve the endometrium, fallopian tubes and pelvic structures. Infection due to the endogenous flora and the lower genital tract is known as ‘endogenous PID’ whereas PID caused by sexually transmissible pathogens such as Neisseria gonorrhoea and Chlamydia trachomatis is termed ‘STI associated PID’.

The genital Mycoplasma’s, iatrogenic infection and gynaecological procedures are also implicated in the aetiology of PID. The true incidence and prevalence are not known due to the inaccuracy of diagnosis.

6.7.2 Specific History

The Women’s Health Nurse will take a sexual history and clarify the symptoms the woman is experiencing especially the duration and type of any pelvic pain, dyspareunia, energy levels, and odour, colour and quantity of vaginal discharge.

<table>
<thead>
<tr>
<th>Special Considerations – Pelvic inflammatory disease and IUCD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IUCD in situ with cervicitis or pelvic inflammatory Disease</strong></td>
</tr>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

6.7.3 Education and resources

The woman is advised of the likely cause of the discharge depending upon the history, the bimanual examination and swabs (if indicated) will be explained and verbal consent obtained. The need for sexual partners to be told may be discussed and strategies to approach them will be discussed.

6.7.4 Intervention

The Women’s Health Nurse will assess the woman’s temperature and perform a bi-manual pelvic examination as described in 5.6.4 d) bimanual examination of the pelvis. Diagnosis is difficult on clinical grounds but is likely when any three of the following features are present:

• pelvic pain of less than three weeks duration
• appearance of cervicitis and leucocytes in vaginal secretions
• mucopurulent discharge from external os
• pain on rocking of cervix
• fundal and adnexal tenderness with bimanual palpation
• adnexal masses
• fever (38°C or higher).

The Women’s Health Nurse will refer the woman to her GP or sexual health clinic for further assessment and management as described in 4.6 Referral Process. If the woman is acutely ill a referral to the local emergency department will be made, which may include telephoning triage and organising appropriate transport.

6.7.5 Follow up
Agreement for review and follow-up is reached with the woman, and implemented as detailed in 4.3 Client follow up. The Women’s Health Nurse may inform the woman of adjunctive measures to improve her health whilst on antibiotics, with emphasis on the important of completing the course, the interaction of alcohol with antibiotics, and strategies to reduce risk of Candida infection. Safe sex practices may be discussed and the woman will be encouraged to attend follow-up appointments.

6.7.6 Specific Documentation
Specific documentation in the woman’s health care record including assessment, findings, information given, copy of referral letters and outcome of referral.

6.7.7 References
• Reproductive and Sexual Health: an Australian clinical practice handbook (2006) FPA Health/Family Planning NSW

6.8 Pelvic Organ Prolapse

6.8.1 Background
Pelvic organ prolapsed refers to the descent of one or more of the:
• Anterior vaginal wall
• Posterior vaginal wall
• Apex- uterus/cervix or vaginal vault after hysterectomy.

The presence of any such sign should be correlated with relevant symptoms. It is estimated that fifty percent of parous women have pelvic organ prolapsed, however many are asymptomatic.
Aetiology is complex and multifactorial. Risk factors include aging, pregnancy, childbirth, connective tissue abnormalities, denervation of pelvic floor, hysterectomy, menopause, increased abdominal pressure e.g. chronic constipation, chronic obstructive pulmonary disease and smoking. Prolapses may present as:

- **Apical prolapse**: Observation of descent of the uterus/cervix or vaginal vault after hysterectomy
- **Anterior vaginal wall prolapse**: Observation of the descent of the anterior vaginal wall. Most commonly this would be due to bladder prolapse (cystocele – either central, paravaginal or a combination). Higher stage anterior vaginal wall prolapse will generally involve uterine or vaginal vault descent. Occasionally, there might be anterior enterocele (hernia of peritoneum and possibly abdominal contents)
- **Posterior vaginal wall prolapse**: Observation of descent of the posterior vaginal wall. Most commonly, this would be due to rectal protrusion in to the vagina (rectocele). Higher stage posterior vaginal wall prolapse can involve the uterus or vaginal vault (after hysterectomy) and/or enterocele.

### 6.8.2 Specific History

Ask about symptoms that may include the awareness of a bulge or protrusion (that may need to be reduced by the woman to urinate/defecate), dragging sensation, pelvic heaviness, pelvic pain, back ache or bladder/bowel/sexual problems.

### 6.8.3 Education and resources

Conservative therapy including lifestyle measures such as weight loss, prevention of constipation, avoiding heavy lifting and pelvic physiotherapy. Resources are available from the Continence Foundation website.

### 6.8.4 Intervention

Assessment of the stage of prolapse according to the Pelvic Organ prolapse qualification scale (POPQ) see table 6.8.2 – Staging System and possible referral to a local doctor, pelvic floor clinic/specialist for assessment and further management.

<table>
<thead>
<tr>
<th><strong>Table 6.8.2 Staging System</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The Pelvic organ prolapsed quantification scale (POPQ) staging system established by the International Continence Society (ICS) uses the hymen as the fixed reference point:</td>
</tr>
<tr>
<td><strong>Stage 0</strong></td>
</tr>
<tr>
<td><strong>Stage I</strong></td>
</tr>
<tr>
<td><strong>Stage II</strong></td>
</tr>
<tr>
<td><strong>Stage III</strong></td>
</tr>
<tr>
<td><strong>Stage IV</strong></td>
</tr>
</tbody>
</table>
6.8.5 Follow up
Agreement for review and follow-up is reached with the woman, and implemented as detailed in 4.3 Client follow up.

6.8.6 Specific Documentation
Specific documentation in the woman’s health care record including assessment, findings, information given, copy of referral letters and outcome of referral.

6.8.7 References
- Continence Foundation of Australia website.
- Take Control An Initiative of the National Continence Management Strategy Bladder and Bowel Website. Australian Government Department of Health and Ageing.

6.9 Postnatal Assessment

6.9.1 Background
The “six week” post natal visit is to ensure that the woman’s body has returned to the pre-pregnant state. It provides the opportunity for the woman to discuss concerns, access information, and plan the management of her sexual and reproductive health, as well as enabling an assessment of the woman’s adaptation to parenthood and also provides an opportunity to identify any difficulties in resuming sexual activity.

After the birth of a child, there is wide variation in the time until a woman may feel ‘ready’ for sexual activity. The role of hormones in influencing libido is not well understood and is very variable. Decreased oestrogen (from the circulation of prolactin in amenorrhoeic lactating women) causes vaginal atrophy, which may result in pain and discomfort during penetration for about 2-3 months in non-lactating women. Approximately 50% of women report a return of sexual desire within 2-3 weeks. The remainder will experience delays lasting from weeks to many months. The return of menstruation and cessation of breastfeeding may also influence the return of libido. Cultural restrictions will also influence the time period that the woman abstains from sexual activity following the birth of a child.

The difficulties experienced are influenced by a large number of factors including:
- The physical and physiological effects of childbirth and the postnatal period, including extreme tiredness, vaginal thinning, slower and less profuse lubrication, painful vaginal penetration
- Emotional issues and fear such as fear of harming the perineum, fear of waking baby if sleeping in the same room, fear of unplanned pregnancy, fear of sexual unattractiveness due to change in body shape and increase in weight, post natal depression
- Family and relationship issues due to changes in role, less assertiveness in negotiating decisions
• The pre-pregnancy sexual response pattern.

6.9.2 Specific History
The Women’s Health Nurse will record the pregnancy and birth history and:

• identify any urinary or faecal incontinence
• discuss breast health and identify any feeding problems
• discuss resumption of sexual intercourse and address any specific concerns
• discuss contraception as described in 6.1 Contraception
• ascertain the woman’s choice of health practitioner to monitor her baby’s health, and refer to appropriate services if the woman has not already accessed services, or if she raises concerns for the baby’s well being during the consultation

enquire if the woman has any support systems (partner/family/friend) discuss her emotional and social health and wellbeing

6.9.3 Education and resources
Some women may experience breast tenderness and sensitivity after child birth and may need reassurance that the letdown of milk during arousal and orgasm is a normal event. This letdown may be reduced or prevented by breastfeeding before sexual activity. Women may need reassurance that arousal and/or orgasm during breastfeeding is a normal physiological response.

The physical examination will be discussed and verbal consent obtained.

The Women’s Health Nurse may provide the following recommendations or referrals:

• encourage rest/sleep when the baby is asleep
• promote developing a supportive network
• discuss use of lubricants and varied positions to aid comfortable sexual activity
• provide information on vaginal oestrogen cream or pessaries
• provide overview of Centrelink services if there are financial concerns
• provide overview of relationship counselling services
• written material may be provided from Beyond Blue website

6.9.4 Intervention
The Women’s Health Nurse will:

• check blood pressure
• perform a physical assessment
• offer a Papanicolau test if appropriate
• complete the Edinburgh Postnatal Depression Scale (EPDS)
• refer to appropriate services for management for contraception, incontinence, and emotional health. If the EPDS score is equal or greater than 10, and/or ‘YES’ to question 10 a referral, as described in 4.6 Referral Process is to be made to an appropriate health care provider for ongoing management.

6.9.5 Follow up
Agreement for review and follow-up is reached with the woman, and implemented as detailed in 4.3 Client follow up.

6.9.6 Specific Documentation
Specific documentation in the woman’s health care record including assessment (including the Edinburgh Postnatal Depression Scale score), findings, information given, copy of referral letters and outcome of any referrals.

6.9.7 References
• Beyond Blue Website Clinical Practice Guidelines 2011
  Edinburgh Postnatal Depression Scale
• Reproductive and Sexual Health: an Australian clinical practice handbook. 2nd edition (2011)
  Family Planning NSW

6.10 Pre-conception Assessment

6.10.1 Background
It is important for women to be as healthy as possible when planning to conceive as a healthy body and lifestyle means the woman can optimise her health for pregnancy and provide a healthier start for the baby.

6.10.2 Specific History
The Women’s Health Nurse will take a full history especially concerning diet, exercise, dental health, if health screening is up to date, medications, childhood illnesses, family history, and current health status and risk taking behaviours. Some women may express that they are having problems conceiving and the Women’s Health Nurse will explore the length of time trying to conceive, sexual activity, menstrual and infection history.

6.10.3 Education and resources
The Women’s Health Nurse will assess the woman’s current knowledge and build on this to provide accurate information to dispel myths and ensure optimum health for pregnancy.
Written material may be provided on planning a pregnancy from State-wide service Mothersafe, NSW Ministry of Health, or Family Planning NSW.

Mothersafe is based at the Royal Women’s Hospital (RHW), Randwick. Phone numbers for the Medications in Pregnancy and Lactation Service are: (02) 9382 6539 Sydney Metropolitan and 1800 647 848 for Non-Metropolitan

**6.10.4 Intervention**

The Women’s Health Nurse may provide the following recommendations to women who are planning a pregnancy:

- Eat a diet rich with fresh fruit and vegetables, and avoid foods potentially infected by Listeria such as unpasteurised soft cheeses, cold pressed meats, raw and smoked seafood, pre-prepared salads, soft-serve ice-cream, and paté
- Develop an exercise routine
- Maintain a Body Mass Index (BMI) between 20-25
- Attend health checks including dental, skin and breast assessments and ensure Papanicolau test is up to date
- Quit smoking, drinking alcohol and recreational drugs
- Reduce caffeine intake
- Engage with a General Practitioner (GP), even if this is a second or subsequent pregnancy
- Actively manage known medical conditions with GP or medical specialist
- Discuss all “across the counter” medications, herbal medicines, homeopathy products, and vitamin and mineral supplements (Folate / Folic Acid, Iodine, Calcium, Vitamin D) with GP
- Optimise immunity to illnesses that could be harmful to a pregnancy (rubella, diphtheria, tetanus, pertussis, varicella, and influenza) by having a blood test and updating immunisations
- Discuss family and obstetric history that would indicate consideration for genetic testing, such as previous birth defects, foetal anomalies, miscarriage or stillbirth
- Discuss the need for other tests including thyroid function testing, fasting blood sugar levels, HIV blood test, hepatitis B, hepatitis C, syphilis, iron levels, thalassemia screening, and rhesus factor. Both parents/partner may require some of these tests.
If conception has not occurred within an acceptable period of time the Women’s Health Nurse will discuss options to increase fertility and consider referral to GP or fertility specialist services as described in 4.6 Referral Process.

6.10.5 Follow up
Agreement for review and follow-up is reached with the woman, and implemented as detailed in 4.3 Client follow up.

6.10.6 Specific Documentation
Specific documentation in the woman’s health care record including assessment, findings, information given, copy of referral letters and outcome of any referrals.

6.10.7 References
- Pre-Conception Health Information Checklist August 2009 Mothersafe/RHW Intranet
- Reproductive and Sexual Health: an Australian clinical practice handbook. 2nd edition (2011) Family Planning NSW
- NSW Ministry of Health December 2012. Having a Baby
- Sex Matters: Fact sheets, Pre-Pregnancy Planning, January 2008. FPA Health/Family Planning NSW Family Planning NSW
- Thinking of having a baby-planning a pregnancy and becoming pregnant, NSW Health SHPN 080346
- NH&MRC Clinical Practice Guidelines, Module 1, 2012
- Jean Hailes website, Health for women, Fertility/Thinking of having a Baby

6.11 Pregnancy Testing

6.11.1 Background
A healthy woman may miss periods for a variety of reasons including stress, progesterone only contraceptives, significant weight loss, thyroid disease, or heroin use. Irregular or skipped periods may be normal for the woman with polycystic ovarian syndrome (PCOS). If a sexually active woman misses two successive periods, the most likely diagnosis is pregnancy.

A pregnancy test detects a hormone called Beta Human Chorionic Gonadotrophin (Beta hCG) which is produced by the developing embryo and may be detected in the urine or blood of a woman who has conceived.

Most urine pregnancy tests detect Beta Human Chorionic Gonadotrophin at levels between 25 and 50 mIU/ml and the majority of pregnancies can be detected by the first day of the missed period as 90% of implantations have occurred by this time. By 7 days after the first day of the missed period 97% of pregnancies have implanted.

6.11.2 Specific History
The Women’s Health Nurse takes a social, sexual and menstrual history from the woman especially the date and nature of last menstrual period (whether it appeared “normal” and whether it was at
the expected time to exclude an implantation bleed or other bleeding during early pregnancy). Other signs of pregnancy will be explored, such as:

- **Breast changes**: occur early in pregnancy. Breasts may enlarge and become firm or fuller. Women may complain of throbbing, tingling or prickling sensations, tenderness or soreness. The nipples enlarge and become more prominent, and the surrounding areola becomes darker. The veins under the skin become more apparent.

- **Morning sickness**: nausea, sometimes accompanied by vomiting, usually occurs between six weeks of pregnancy until the third or fourth month.

- **Frequent urination**: usually occurs during the first 3 or 4 months of pregnancy, resolves, and then often reappears during the later months as the growing uterus presses on the bladder.

- **Other signs**: skin pigmentation changes, foetal movements, snoring and gastrointestinal symptoms.

### 6.11.3 Education and resources

The Women’s Health Nurse will provide information about the pregnancy test including the potential for false negatives if adequate time has not elapsed, and false positives for up to two weeks following a miscarriage or termination.

The procedure will be described and verbal consent obtained.

### 6.11.4 Intervention

A urine test is performed according to the manufacturer’s instructions.

- **Negative result** - If the pregnancy test result is negative and pregnancy is suspected the test will need to be repeated in one week to rule out a false negative or insufficient time for the Beta hCG to be detectable in the urine.

- **Positive result** - If the pregnancy test result is positive the Women’s Health Nurse provides a supportive non-judgemental environment to allow the woman to freely express her reaction to the result and discuss a range of alternative courses of action if necessary.

The Women’s Health Nurse will provide information concerning a range of pregnancy services in the community, including those providing emotional support, financial assistance, practical assistance, antenatal care, birthing services and termination of pregnancy.

### 6.11.5 Follow up

Agreement for review and follow-up is reached with the woman, and implemented as detailed in 4.3 Client follow up. At the follow-up appointment after a negative result if there are other symptoms of pregnancy present the Women’s Health Nurse will organise a referral to a GP as described in 4.6 Referral Process for further investigation and serum Beta Human Chorionic Gonadotrophin.
6.11.6 Specific Documentation

Specific documentation in the woman’s health care record including assessment (including symptoms of pregnancy and test result), findings, information given, copy of referral letters and outcome of referral.

6.11.7 References

- Reproductive and Sexual Health: an Australian clinical practice handbook. 2nd edition (2011) Family Planning NSW
- Termination of Pregnancy A resource for health professionals (2005), The Royal Australian College of Obstetricians and Gynaecologists

6.12 Sexually Transmissible Infections

6.12.1 Background

A sexually transmissible infection (STI) is an infection that is transferred by sexual contact (oral, vaginal or anal intercourse, shared sex toys). Signs and symptoms vary depending on the possible infection as described in Table 6.12.1 - Signs and symptoms of sexually transmissible infections.

<table>
<thead>
<tr>
<th>6.12.1 Signs and symptoms of sexually transmissible infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms/signs</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Purulent discharge +/- pelvic pain</td>
</tr>
<tr>
<td>Intermenstrual or post coital bleeding</td>
</tr>
<tr>
<td>Green, frothy, odorous discharge with inflammation</td>
</tr>
<tr>
<td>Inflammatory test result</td>
</tr>
<tr>
<td>Unprotected sex &gt; 3 in 3/12</td>
</tr>
</tbody>
</table>

6.12.2 Specific History

The Women’s Health Nurse will take a thorough sexual history to exclude vaginal infections not transmitted sexually if an infection is suspected or signs of an infection are reported. The detailed history includes the:

- type of discharge (thick, thin, colour, odour, itching, stinging, dysuria, dyspareunia) and the association of symptoms with menstrual cycle
- use of possible allergens or irritants e.g. soaps, deodorants, bubble bath, spermicides, vaginal lubricants, hair dyes, perfumes, and hygiene products
6.12.3 Education and resources

The Women’s Health Nurse will provide clear concise information about the transmission of the infection, possible treatments and how long abstinence is recommended. In most situations the woman should be advised to abstain from intercourse for 1 week after treatment and notify partners for tests and treatment if indicated.

The woman will be given the option of seeing their GP or Sexual Health Clinic for treatment, and privacy and confidentiality will be discussed.

The physical examination is described and verbal consent obtained. Fact sheets may be provided from the NSW Sexually Transmissible Infections Programs Unit and Sydney Sexual Health clinic website.

Information for general public is also available from the Sexual Health Infoline 1800 451 624 Monday to Friday between 9am and 5.30pm.

6.12.4 Intervention

The Women’s Health Nurse will refer the woman to her GP or sexual health clinic for further assessment and management as described in 4.6 Referral Process. Strategies on how to advise partner will be explored and if required the woman may be referred to the sexual health counsellor for further support and help in relation to contact tracing/partner notification as described in 4.6 Referral Process.

6.12.5 Follow up

Agreement for review and follow-up is reached with the woman, and implemented as detailed in 4.3 Client follow up.
6.12.6 Specific Documentation
Specific documentation in the woman’s health care record including assessment, findings, information given, copy of referral letters and outcome of referral.

6.12.7 References
- National Management Guidelines for Infections (7th Edition), Sexual Health Society of Victoria (SHSOV) 2008
- New South Wales Sexual Health Services Standard Operating procedures 2011. Chapter for Women’s Health nurses page 178
- Sydney Sexual Health clinic website
- ASHM testing portal website—supporting the HIV, Viral Hepatitis and Sexual Health workforce

6.13 Vaginal Bleeding (excluding menstrual problems)

6.13.1 Background
Abnormal vaginal bleeding is any vaginal bleeding between periods, after sex, during pregnancy or after menopause.

Contact bleeding from the cervix is relatively common when taking a Papanicolau test with a cytobrush from the endocervix.

6.13.2 Specific History
The Women’s Health Nurse takes a thorough history including:

- current age
- description of current bleeding, frequency and factors associated with bleeding
- age at menarche, pattern of menstrual cycles, last normal menstrual period and past history of bleeding
- sexual activity, contraceptive history
- current medications, especially use of hormonal therapy
- previous history of sexually transmissible infections
- previous Papanicolaou tests and abnormal results.
6.13.3 Education and resources

The Women’s Health Nurse discusses the possible causes of bleeding taking into account the individual needs of the woman (young, fertile or postmenopausal) and offers a physical examination, including a speculum and a bimanual pelvic examination.

The intervention and any examination will be described and verbal consent obtained.

6.13.4 Intervention

The Women’s Health Nurse will assess the woman as indicated by the history as follows:

- **6.3 Menopause for suspected menorrhagia**
- **6.10 Pregnancy testing for suspected pregnancy**
- **6.11 Sexually Transmissible Infections for suspected infection.**

If the woman could be having a miscarriage they should consult a doctor or attend the nearest hospital for assessment and management. The signs of threatened miscarriage may include one or all of the following:

- severe pain in the lower abdomen
- cramping
- vaginal bleeding.

<table>
<thead>
<tr>
<th>Special Considerations – Vaginal Bleeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remember that Chlamydia is a common cause of vaginal bleeding in young women</td>
</tr>
<tr>
<td>Early pregnancy problems such as Ectopic pregnancy or a Miscarriage need to be considered, assessed and if appropriate referred</td>
</tr>
<tr>
<td>If infection and pregnancy are excluded a Papanicolaou test may be performed</td>
</tr>
</tbody>
</table>

If required the Women’s Health Nurse provides a referral to the woman’s GP, local Sexual Health Clinic or the authorising medical officer for further assessment, management and investigations as described in 4.6 Referral Process.

6.13.5 Follow up

Agreement for review and follow-up is reached with the woman, and implemented as detailed in 4.3 Client follow up. It may be necessary to perform a Papanicolaou test at a follow up appointment if a Pap test has not been taken in the previous two years.

6.13.6 Specific Documentation

Specific documentation in the woman’s health care record including assessment, findings, information given, copy of referral letters and outcome of referral.
6.13.7 References

6.14 Vaginal Discharge

6.14.1 Background
A woman may report unusual vaginal discharge which will require assessment by the Women’s Health Nurse. Vaginal discharge varies in response to the hormones of the menstrual cycle, the woman’s age and health status.

6.14.2 Specific History
The Women’s Health Nurse will take a thorough sexual history to exclude a sexually transmissible infection. This detailed history includes:

- type of discharge (thick, thin, colour, odour, itching, stinging, dysuria, dyspareunia) and association of symptoms with the menstrual cycle
- use of possible allergens or irritants e.g. soaps, deodorants, bubble bath, spermicides, vaginal lubricants, hair dyes, perfumes, hygiene products
- attempts to self-treat, or use of antibiotics recently
- the last sexual contact, relationship duration and status (regular partner, new partner or multiple partners), partner’s sexual history (including any overseas contact), sexual orientation and risk behaviours
- previous STI, the treatment and follow up of both the woman and the partner
- any risk behaviours – recreational use of drugs (pattern type of drug and frequency), intravenous drug use (IVDU) for self or partner, tattoos, body piercing
- previous blood transfusion including year and country
- choice of contraception, particularly barrier methods
- date of last menstrual period (LMP).

6.14.3 Education and resources
The Women’s Health Nurse will provide clear concise information about vaginal discharge, possible causes and treatments.

The physical examination is described and verbal consent obtained.

Written information may be provided from NSW Ministry of Health or Family Planning NSW.
6.14.4 Intervention  

a) Sexually transmissible infection
If a sexually transmissible infection is suspected the Women's Health Nurse will continue assessment as described in 6.12 Sexually transmissible infections.

b) Vaginal infection not sexually transmissible
The Women's Health Nurse undertakes a physical examination including a visual vulva and speculum examination of the vagina and cervix, and a bi-manual pelvic examination as described in 5.5 Examination of the Reproductive System.

6.14.5 Follow up
Agreement for review and follow-up is reached with the woman, and implemented as detailed in 4.3 Client follow up.

6.14.6 Specific Documentation
Specific documentation in the woman’s health care record including assessment, findings, information given, copy of referral letters and outcome of referral.

6.14.7 References
- Bacterial Vaginosis fact sheet Sexual Health - NSW Ministry of Health
- Family Planning NSW website
- National Management Guidelines for Infections (7th Edition), Sexual Health Society of Victoria (SHSOV) 2008

6.15 Vulval Conditions (including itching)

6.15.1 Background
The two most common vulval conditions are Dermatoses and Lichen Sclerosis. Either may be reported by a woman or noticed during the physical examination. It is essential that Lichen sclerosis is recognised and treated to prevent significant atrophy and distortion of the genital area. It is also associated with squamous cell carcinoma of the vulva. Other vulval conditions are Genital warts and Genital herpes. These require referral to their general practitioner or a local Sexual Health Clinic for assessment and management.

The condition affects skin anywhere on the body but most commonly affects the skin of the genital area and it is more common in post-menopausal women and with increasing age.

Other common causes of vulval conditions are irritants and allergens as described in Table 6.15.1 - Common causes of vulval conditions.
### Table 6.15.1 - Common causes of vulval conditions

<table>
<thead>
<tr>
<th>Irritants</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soap, bubble baths, panty liners, powders, commercial lubricants, spermicides, antifungal creams, tea-tree oil, sweat and urine.</td>
<td>Use water or soap substitutes such as QV bar, QV wash or Cetaphil</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Common allergens</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body jewellery, nickel, local anaesthetics, perfumes, and dyes, preservatives in medication such as antifungal preparations and spermicides and latex (condoms).</td>
<td>Tampons/ menstrual cups are preferred to sanitary pads, and all patients should be prescribed a bland moisturiser to prevent fissuring. Cotton pads may be used as these are less irritating than synthetic ones.</td>
</tr>
</tbody>
</table>

### 6.15.2 Specific History

The Women’s Health Nurse takes a history including:

- description of symptoms/soreness and presence of dysuria or dyspareunia
- all preparations used on the vulva (soaps, deodorants, bubble baths, spermicides, vaginal lubricants) and of exposure to heat and friction to the vulva
- personal or family history of atopy and psoriasis, other skin or oral disease and known drug sensitivities
- medical history and current medications
- gynaecological and obstetric history - including oestrogen status, menstrual cycles, sexual history, vaginal discharge, vaginal infections, and treatments
- urological history - incontinence, anal surgery.

### 6.15.3 Education and resources

The Women’s Health Nurse will provide clear concise information concerning vulval conditions, and obtain verbal consent for the visual examination.

### 6.15.4 Intervention

The Women’s Health Nurse undertakes a visual examination of the vulva to detect any anomalies as described in Table 6.15.4 – Symptoms of vaginal conditions.
<table>
<thead>
<tr>
<th>Condition</th>
<th>Symptoms</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatoses and Lichen sclerosis</td>
<td>an itch which is often intense</td>
<td>Refer to GP or specialist through authorising medical officer</td>
</tr>
<tr>
<td></td>
<td>dysuria, dyspareunia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>whitened sclerotic skin often in a “keyhole” or figure-of-eight patterns on the vulval/anal area</td>
<td></td>
</tr>
<tr>
<td></td>
<td>epidermis finely wrinkled or scaly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bruises, purpura and petechial haemorrhages</td>
<td></td>
</tr>
<tr>
<td></td>
<td>skin splits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>pain is secondary to excoriation or fissuring</td>
<td></td>
</tr>
<tr>
<td>Lichen planus / erosive vulvitis</td>
<td>shiny flat-topped papules on the skin but causes non-specific erosions on mucous membranes</td>
<td>Refer to GP or specialist through authorising medical officer</td>
</tr>
<tr>
<td></td>
<td>painful erosions and ulcers, (may be limited to, or alternate between, the vaginal or oral cavity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>heavy purulent discharge and superficial bleeding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a white reticulate (fine network) pattern may be noted</td>
<td></td>
</tr>
<tr>
<td></td>
<td>May also be purple thickened lesions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lichen planus may result in severe scarring, adhesions and vaginal stenosis</td>
<td></td>
</tr>
<tr>
<td>Lichen simplex</td>
<td>thickened leathery skin with enhanced skin markings</td>
<td>Refer to GP or specialist through authorising medical officer</td>
</tr>
<tr>
<td>Psoriasis</td>
<td>greyish plaques to glossy red plaques Less scaly than psoriasis on non-genital skin</td>
<td>Refer to GP or specialist through authorising medical officer</td>
</tr>
<tr>
<td></td>
<td>check for other sites on physical examination, e.g. scalp/nails</td>
<td></td>
</tr>
<tr>
<td>Dermatitis</td>
<td>itch</td>
<td>Irritant contact dermatitis - reduce exposure to irritants</td>
</tr>
<tr>
<td></td>
<td>excoriation and fissuring causing pain and dyspareunia erythema, scaliness, fissuring</td>
<td>Allergic contact dermatitis – remove common allergens</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Corticosteroid induced - refer to GP and review prolonged use of topical steroids on the vulva</td>
</tr>
<tr>
<td>Condition</td>
<td>Symptoms</td>
<td>Management</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Atrophic vaginitis</td>
<td>vaginal dryness and thinning, irritation and discomfort predispose to secondary infection</td>
<td>Usually responds well to topical vaginal oestrogen</td>
</tr>
<tr>
<td>Cyclic vulvovaginitis</td>
<td>cyclic vulvovaginitis is when a woman suffers from recurrent or persistent thrush that worsens just before or during a menstrual period every month</td>
<td>Swabs for Candida species (both albicans and non–albicans) from a low rather than high vaginal swab</td>
</tr>
<tr>
<td>Candida (Thrush) most common Candida albicans</td>
<td>erythema/itch, white plaques</td>
<td>Vulval or high vaginal swab, Transswab (blue) Transport or Stewart’s medium</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Antifungal creams or pessaries over the counter at pharmacy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assess for associated factors, pregnancy, diabetes, antibiotics, and/or the oral preparation for severe/recurring cases</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assess use of topical products such as soap and perfume - recommend no soap on vulval skin, no douching, cotton underwear, no lycra next to skin</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Refer to GP if Candida persists for further investigation</td>
</tr>
<tr>
<td>Vulvodynia</td>
<td>generalised vulval pain without any specific signs</td>
<td>Referral to GP or Sexual Health clinic</td>
</tr>
<tr>
<td></td>
<td>vestibulodynia is a subset of vulval pain that occurs when the vestibular skin is touched.</td>
<td></td>
</tr>
</tbody>
</table>

If required the Women’s Health Nurse provides a referral to the woman’s GP, or the authorising medical officer for further assessment, management and investigations as described in 4.6 Referral Process.
6.15.5 Follow up

Agreement for review and follow-up is reached with the woman, and implemented as detailed in 4.3 Client follow up.

6.15.6 Specific Documentation

Specific documentation in the woman’s health care record including assessment, findings, information given, copy of referral letters and outcome of referral.

6.15.7 References

- The Vulva, a Clinician's Practical Handbook (2009) Family Planning NSW
7 ADDITIONAL CONSIDERATIONS

7.1 Infection Control


7.2 Work, Health and Safety

Women’s Health Nurses are to work in a safe workplace therefore all planned activities are enacted within legislative and legal requirements and in line with the Work Health and Safety (formerly Occupational Health and Safety) legislation. The ‘Safety when working offsite Handbook’ provides further guidance to this.

Each month Work Health and Safety is discussed at the Child, Youth Women’s and Family Health meeting. Monthly site inspections are performed and Women’s Health Nurses are responsible for reporting any risks in the workplace to the Manager, Child, Youth, Women’s and Families Health. This ensures the team are constantly vigilant about potential risks and are empowered to rid the environment of risk (See also 4.1 Clinics). Women’s Health nurses may also be required to participate in site inspections at Community Health centres they are located at.
8 ENHANCING SERVICE DELIVERY

8.1 Health Language Services

The Health Language Service (HLS) is available 24 hour a day, 7 days a week, to assist in communication with culturally and linguistically diverse women and deaf women. Where possible the appointments are booked in advance and may request a female Interpreter. The Women’s Health Nurse will follow the directives of the NSW Ministry of Health ‘Interpreters – Standard Procedures for working with Health Interpreters’ PD2006_053. Bookings are made for community clinical or educational sessions. The Interpreter Service requires information in writing on their relevant forms which are available on the intranet (fax/post/email) about the topics for discussion to ensure appropriate interpreter, especially if the content of the information is of an intimate nature as with Papanicolaou tests and breast screening.

The Health Language Service
Phone: 9828 6088
Fax: 9828 6090 (4 weeks in advance)
Email: Interpreters.bookings@swahs.nsw.gov.au

For hearing impaired women
TTY 02 8752 4360

For emergency situations a telephone interpreter may be accessible through the Healthcare Interpreter Service.

If the Health Language Service cannot provide service – or the woman has expressed concerns about use of the service due to personal reasons – for example a member of family is a worker at the service, the Telephone Interpreter Service (TIS) may be engaged. This service is also available 24 hours, 7 days a week, however the Interpreters are not specifically health care trained.

Telephone Interpreter Service (TIS)
Phone No. 1300 655 030 or 131450

- There is a cost which starts from $26.40 (July 2013) per fifteen minutes to Child, Youth Women and Family Health. The National TIS website has a detailed Interpreting list of charges for after hours, prebookings and other services. A code number will be requested for billing purposes see Table 7.2 - Codes for TIS.

<table>
<thead>
<tr>
<th>Site</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prince of Wales Hospital</td>
<td>C024360</td>
</tr>
<tr>
<td>St George Public Hospital</td>
<td>C024459</td>
</tr>
<tr>
<td>Sutherland Hospital</td>
<td>C193703</td>
</tr>
</tbody>
</table>
8.2 Domestic Violence Screening

Domestic Violence – Violent, abusive, emotional abuse or intimidating behaviour carried out by an adult against a partner or former partner, adult, child or a carer.

Routine screening involves asking all women aged 16 years and over who attend Health Services about recent experiences of domestic violence. Screening for domestic violence should not take place in the presence of a partner or a child over the age of 3 years or if the woman is not physically or mentally well enough to answer questions. The woman must be 16 years or older.

8.2.1 Background

Women attending a Women’s Health Nurse individual consultation will be screened for domestic violence regardless of whether or not there are signs of abuse, or whether domestic violence is suspected. All Women’s Health Nurses will receive orientation/training using the Implementation Package prior to undertaking screening for domestic violence.

8.2.2 Specific history

Domestic violence screening is part of the history taking for new women during face – to face contact. This is a six-stage process involving:

- reading the preamble that explains the screening
- asking the woman the domestic violence screening questions
- taking action according to the outcome
- offering all women an information card
- documenting the outcomes on the NSW Health Screening for Domestic Violence form and in the woman’s health care record
- providing follow up as necessary.

8.2.3 Education and resources

Routine screening for domestic violence allows Women’s Health Nurses to identify violence and educate women with options for their safety. Routine screening can reduce the severity of injury, promote help-seeking behaviour and provide opportunities to encourage and support women who are at risk of domestic violence.

8.2.4 Intervention

Routine screening may be carried out in accordance with the guidelines in the Routine Screening for Domestic Violence in NSW Health: An Implementation Package. The screening questions are:
1. Within the last year have you been hit, slapped or hurt in other ways by your partner or ex-partner?

2. Are you frightened of your partner or ex-partner?

If the woman answers no to both questions, give the information card to her and say: Here is some information that we are giving to all women about domestic violence.

If the woman answers yes to either or both of the above questions, continue to questions 3 and 4.

3. Are you safe to go home when you leave here?

4. Would you like some help with this?

Then proceed to questions 5, 6 and 7

5. Do you have children? (If so) have they been hurt or witnessed violence?

6. Who is/are your children with now? Where are they?

7. Are you worried about your children’s safety?

Referral to specific Domestic Violence services may be required; this can be by the Women’s Health Nurse as described in 4.6 Referral Process, or by the woman herself.

Women may disclose sexual assault (current or past) to Women’s Health Nurses. Women’s Health Nurses need to ascertain when the assault occurred and make contact with the Sexual Assault Service to refer the woman as described in 4.6 Referral Process if appropriate.

If the woman is in fear of her own safety and particularly if she has children and has concerns for their safety then the police are notified immediately.

8.2.5 Follow up

An agreement for review and follow-up is reached with the woman, and implemented as detailed in 4.3 Client follow up.

<table>
<thead>
<tr>
<th>Special considerations - Domestic Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contacting the woman in a manner that she has not approved may compromise her safety.</td>
</tr>
</tbody>
</table>

8.2.6 Specific Documentation

The Women’s Health Nurse completes the NSW Health Screening for Domestic Violence form including signature, files this in the health care record. The action taken is documented and appropriate follow-up procedures are discussed and agreed with the woman.

If disclosure of sexual assault occurs during a clinic consultation, the disclosure and action taken must be documented in the woman’s health care record.
8.2.7 References

- NSW Ministry of Health Policy and Procedures for Identifying and Responding to Domestic Violence, March 2003 Revised 2006

8.3 Child Wellbeing and Child Protection

8.3.1 Background

Child abuse is a term commonly used to refer to different types of maltreatment inflicted on a child or young person. It covers a wide range of behaviours and includes assault (physical and sexual), ill treatment, and exposing the child or young person to behaviour that might cause psychological harm.

Risk of significant harm (ROSH) refers to the likelihood that a child or young person may suffer physical, psychological or emotional harm as a result of what is done (physical, emotional, sexual abuse) or not done (neglect). Risk of significant harm may also result from environmental factors e.g. homelessness or self-harming behaviours such as injecting drugs, self inflicted harm i.e. cutting.


<table>
<thead>
<tr>
<th>Special considerations - Children and Young Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Young Persons</strong></td>
</tr>
<tr>
<td><strong>Homelessness</strong></td>
</tr>
</tbody>
</table>

8.3.2 Mandatory Reporter Guide

All NSW Health staff should use the Mandatory Reporter Guide (MRG) to assist in deciding whether concerns for the safety, welfare and wellbeing of children and young people meet the risk of significant harm threshold (ROSH).

The MRG will assist health mandatory reporters in their decision to report matters. Options include:

- Contacting the Child Protection Helpline immediately when your concerns constitute suspected imminent risk of significant harm
- Contacting the Child Protection Helpline within 24 hours when your concerns constitute suspected risk of significant harm
• Contacting the Health Child Wellbeing Unit (CWUs) when your concerns about the child or young person’s safety, welfare and wellbeing are below the statutory threshold or you are uncertain about whether your concerns meet the statutory threshold.

It is essential to document your concerns and if appropriate continue working with the woman/young person if your concerns are not at a level which requires a Child Protection Helpline response or contact with the Child Wellbeing Unit.

8.3.3 Making a Report

a) Risk of Significant harm identified

If after completing the MRG mandatory reporters reasonably suspect that their concerns meet the threshold of risk of significant harm, they are legally bound to contact the Child Protection Helpline to report their concerns. This obligation is contained in the Commission for Children and Young People Act 1998.

To make a report to Community Services Child Protection the Women’s Health Nurse must contact:

Community Services Helpline on 133 627 (24hrs/7 days)

The report should include the:

• date and time of the report
• name of the officer who was spoken to
• nature of the concerns reported
• reference number allocated
• response of Community Services (if known).

The report must be documented in the health care record and a copy given to the Women’s Health Nurse immediate supervisor.

b) No risk, or inconclusive risk, of significant harm identified

If after completing the MRG the significant risk of harm is not identified, or the Women’s Health Nurse is in doubt of the appropriate action the Child Wellbeing Unit may be contacted. To make a report to the Child Wellbeing Unit:

Greater Eastern and Southern Child Wellbeing Unit,
Telephone 1300 480 420, Fax 02 4228 3507
Email: GESCUE@sesiachs.health.nsw.gov.au

Health Child Wellbeing Units will take calls between
8.30am and 5.30pm Monday to Friday, excluding public holidays.

If the above is unavailable locally then contact the Tertiary Child Protection Service
• Sydney Children’s Hospital Network, Randwick Campus Child Protection Unit on 02 9382 1412 or after hours on 02 9382 1111
8.3.4 References

Child Wellbeing and Child Protection Policies and Procedures for NSW Health

Child Wellbeing & Child Protection – NSW Interagency Guidelines This also provides a link to the NSW legislation

8.4 Other Related Policies

Child Protection Issues for Mental Health Services - Risk of Harm Assessment Checklist NSW Health PD2006_003: This policy aims to direct mental health clinicians assessing pregnant women and carers of children (parents and others) in recognising and responding appropriately to specific risk factors associated with symptoms of mental illness.

Child Related Allegations, Charges and Convictions against Employees NSW Health PD2006_025: This policy directive sets out the mandatory requirements for responding to any allegation, charge or conviction against a NSW Health employee where it involves children.

Consent to Medical Treatment – Patient Information NSW Health PD2005_406: Requirements for the provision of information to patients and obtaining consent to medical treatment.

Criminal Allegations Charges and Convictions against Employees NSW Health PD2006_026 This policy directive sets out the mandatory requirements for responding to any allegation, charge or conviction against a Health Service employee where it involves a criminal matter.

Drug & Alcohol Treatment Guidelines for Residential Settings NSW Health GL2007_014 These guidelines provide recommendations for residential treatment of people with drug or alcohol dependence. In particular section 11.2 deals with people with children in these programs.

Maternal & Child Health Primary Health Care Policy NSW Health PD2010_017: The NSW Health / Families NSW Supporting Families Early package brings together initiatives from NSW Health’s Primary Health and Community Partnerships Branch and Mental Health and Drug & Alcohol Office. It promotes an integrated approach to the care of women, their infants and families in the perinatal period.


Privacy Manual (Version 2) - NSW Health PD2005_593: Provides operational guidance for health service staff to the legislative obligations imposed by the Health Records and Information Privacy Act 2002. (section 15.3 ’Child protection issues’)

8.5 Education Programs

To ensure community education sessions are of high quality the Women’s Health Nurse reviews all resources (pamphlets, leaflets, flyers) for currency before distribution, and all session plans are created with the inclusion of culturally sensitive activities and interpreters as required. The Women’s Health Nurse further assesses participant’s language skills to guide their use of language (speed, word choices, and medical terminology) during the sessions.

Each education session is evaluated by the:
• participants
• requesting service
• reflection and critical thinking of the Women health Nurse providing the session.

The information from session evaluations (surveys/questionnaires) is collated and discussed at the Women’s Health Nurse meeting and used to guide the ongoing development of session plans.

8.6 Women with an Intellectual Disability

8.6.1 Background

“Women with disabilities often lack opportunities to engage in preventative health care activities, reporting biases and prejudice in accessing reproductive and sexual health care. Women with disabilities often do not receive the regular preventative physical examinations that are required to maintain optimal health”

(Preventative Women’s Health Care for Women with Disabilities Guidelines for General Practitioners)

8.6.2 Specific History

Women who have an intellectual disability and attend a community well women’s clinic may require additional assistance during the consultation. Additional history may include exploring and acknowledging the woman’s expertise in managing the disability. The complexity of language used will need to be modified in response to the demonstrated understanding by the woman.

The Women’s Health Nurse will assess the ability of the woman to provide valid and informed consent. Additional enquiry regarding carers and guardianship orders will be explored to determine if the woman’s is able to provide valid consent.

8.6.3 Education and resources

The Women’s Health Nurse will assess the woman’s current knowledge and build on this to provide accurate information to dispel myths. Clear descriptions will be provided regarding procedures and examinations.

Written material specifically for women with intellectual disability is available from NSW Ministry of Health, the Centre for Developmental Disability, Victoria or Family Planning NSW fact sheets /Disability.

8.6.4 Resources

Family Planning NSW fact sheets /Disability
NSW Ministry of Health internet/intranet – Being a healthy woman
Centre for Developmental Disability website (Victoria)
8.6.5 References

- Working with people with Intellectual Disabilities
- New South Wales Cervical Screening program

8.7 Women with a Spinal Cord Injury

Women’s Health Nurses working in isolation will refer women with spinal cord injury above the sixth thoracic level (T6) to a venue where there are backup facilities that can manage autonomic dysreflexia which is a potentially life threatening condition.

Other considerations are environmental modifications to improve accessibility to the clinic room, bathroom and examination couch.

8.7.1 References

- New South Wales Cervical Screening program
- Spinal Cord injury website
- ACI Health NSW Spinal cord injury and resources

9 QUALITY ACTIVITIES

9.1 Organisational Accreditation

Women’s Health Nurses participate in the LHD quality activities and incorporate the National Safety and Quality Improvement Guides and Accreditation Standards 2012 in their role; it involves a self-assessment process and systematic external peer review to assess the achievement of nominated standards. The focus of the standards are on customers/clients; building effective systems through ongoing improvement; and measuring and evaluating outcomes. The standards provide a framework for establishing and maintaining quality care and services across the organisation.

9.2 Quality Activity and Assurance

Women’s Health Nurses provide continuous health services (Well Women’s Health Clinics) and time limited projects (community development projects). The structure, process, and outcomes of activities are assessed against standards of best practice ensuring that all interventions are underpinned by research, are under continual review and improvement, and provide the highest standard of care.

Quality Activities measure performance, identify opportunities for improvement in the delivery of care and service, and include action, follow-up and evaluation of small to medium activities.

Quality Assurance / Control (QA) is a planned and systematic approach to monitoring, assessing and improving the quality of health services on a continuous basis within the existing resources.
9.3 Short Term Initiatives

All short term project activities are designed using a cycle of four stages, this is described in the ‘PDSA’ cycle as ‘Plan Do Study Act’:

**Plan**  Women’s Health Nurses complete project proposals that identify purpose, background, goals, aims, objectives and costs. Measurable objectives are identified and strategies are described to enable both process and impact evaluations.

**Do**  Women’s Health Nurses review each project stage to ensure effective progress of the project. Evaluations performed during the program may be both qualitative and quantitative, and aim to ensure the implementation of problem solving strategies where unexpected challenges arise.

**Study**  Projects are evaluated for process, outcomes, cost and sustainability and recommendations and plans are made for the future of the project.

**Act**  The Women’s Health Nurses collate feedback and reports through the peer review processes at team meetings, and if necessary additional consultation may be sought to provide guidance. Strategies may be identified and implemented, including extending, developing, transferring management, or closure of the program.

9.4 Work Plans

The Well Women’s Health Program projects are documented in a work plan (See Appendix I) and are reviewed quarterly and reported upon at the end of the financial year. Quarterly reports are compared to the annual work plans which are formulated at the beginning of each financial year.

9.5 Activity Reporting

The Women’s Health Nurse records the Occasions of Service in CHIME data base, and the results of evaluations of programs and other initiatives undertaken such as client satisfaction and site surveys. The collated statistics and findings are used for quarterly and annual reports provided to the Manager of the Child, Youth, Women’s and Families Health and discussed at the Women’s Health Nurse clinical meetings, Child, Youth, Women and Families Health Unit meetings and Peer review meetings.

The team of Women’s Health Nurses provides activity reports to the NSW Cervical Screening program (NSW Cancer institute). The Cervical Screening online reporting tool is to be completed. The clinical statistics include:

- Number of pap tests performed
- Number of abnormalities detected
- Number of under screened and previously unscreened women.

The NSW Cervical Screening Program provides quarterly reports from across NSW which enables peer comparison of screening rates by age and geographical area. This identifies populations who
are under screened, and supports the development of specific projects to increase screening rates within those populations. Additionally these reports provide the opportunity to compare individual reports and explore reasons for differences in rates and results between team members. South Eastern Area Laboratory Service (SEALS) also provide a clinical quality management process which provides each Women’s Health Nurse with information of their adequacy in the collection, capture of endo-cervical material and report of lesions detected.

The Women’s Health Nurses perform annual audits of health care records to monitor the accuracy of documentation, assess compliance, and support the delivery of safe and effective care and services. The results of all audits are reported through the Women’s Health Nurse meetings.

9.6 Incident Information Management System (IIMS)
Adverse advents, complaints and near misses are reported through the NSW Incident Information Management System (IIMS) database and a Severity Assessment Code allocated which determines the action required.
10 ADMINISTRATION

10.1 Health Care Records

All Health Care records (paper or electronic) are to be kept according to the NSW Ministry of Health Health Care Records – Documentation and Management Policy Directive PD2012_069. South Eastern Sydney Local Health District procedure for ‘Clinical Abbreviations’ and ‘List of Clinical Abbreviations’ should also be followed. Health care records required to be stored outside Medical Records departments must be stored in a locked filing cabinet within the facility.

When transporting Health care records between facilities they are to be locked in a briefcase and preferably placed in the boot of the car. The health care record is to be recorded on the relevant records database at the facility where the health records are to be kept.

In community health centres, medical records are stored in accordance with the community health centre medical records centralised system. Client follow-up files maybe kept in a locked filing cabinet in the Women’s Health Nurse office/clinic.

All health care records must be kept for seven years from the last visit or until the woman is 25 years of age whichever is the longer time period.

Women’s Health Nurses are in the process of working towards using electronic Health Care Records only on CHIME database.

10.1.1 References

- Health Care Records and Management PD2012_69
- SESLHD Procedure for Clinical Abbreviations
- SESLHD Clinical Abbreviations List
- Guidelines on Documentation and Electronic Documentation, Annual Conference (2010) NSWNMA
- CHIME

10.2 Administrative Support / Office Manager

The daily activities of the Women’s Health Nurse’s are supported by the office manager and includes fleet management, timesheets and Kronos entry, organisation of equipment for meeting and teleconferencing, and ordering supplies and resources.

To purchase clinic equipment that is not supplied by Material Resources the Women’s Health Nurse provides quotes and product information from the relevant companies. This information is then provided to the Manager, Child, Youth, Women and Families Health for approval prior to being processed by the Office Manager.
# 10.3 Revision and Approval History

<table>
<thead>
<tr>
<th>Date</th>
<th>Revision No.</th>
<th>Author and Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2012</td>
<td>1</td>
<td>Approved and posted on intranet SESLHD site under “W” Review, insertion of updated and new polices</td>
</tr>
<tr>
<td>October 2012</td>
<td>2</td>
<td>links relinked, new WHN position inserted and update WHU from Randwick to Darlinghurst</td>
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<tr>
<td>January 2013</td>
<td>3</td>
<td>Rehyperlinking of several internal and external links</td>
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</table>
| July 2013             | 4            | Rehyperlinking of several internal and external links Addition of new policies/documents  
- Child Wellbeing and child protection policy  
- National Safety and Quality Health Service standards (September 2012)  
- ASHM testing portal  
- The Women’s Health Framework in NSW 2013  
- Renaming Unit title Families instead of Family  
- Update of new polices and relinking of rescinded links within document |
| September 2013        | 5            | Update of new polices and rehyperlinking of rescinded links within document  
- Engadine Community Health centre new telephone number in Section 4  
- Menai Community Health centre added to Women’s Health Nurses clinics including, pathology collection, linen and waste management) in Section 4 |
| October to February 2014 | 6            | National Aboriginal and Torres Strait Islander Women’s Strategy and link inserted on page 9  
- The Heart Foundation [resources for Aboriginal and Torres Strait Islander peoples](#) on page 26  
- Preconception page 59 – reference added Jean Hailes website information on fertility/Thinking of having a baby  
- Jean Hailes Indigenous women’s health resources portal on page 28/9  
- [ACI Health NSW Spinal cord injury and resources](#) page 80  
- [SESLHDGL/027 Guidelines for Clinical Supervision for Nurses and Midwives](#) page 15  
- Jean Hailes Foundation Anxiety resource portal |
<table>
<thead>
<tr>
<th>link page 25</th>
</tr>
</thead>
<tbody>
<tr>
<td>The CEC Health Literacy Guide resource link page 25</td>
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<tr>
<td>Family Planning Victoria Service Coordination Guide page 37</td>
</tr>
<tr>
<td>NSW FGM Education Program Brochure</td>
</tr>
<tr>
<td>RANZCOG FGM/C general information</td>
</tr>
<tr>
<td>Australian College of Midwives and Australian College of Nursing joint project on FGM learning resources</td>
</tr>
<tr>
<td>National TIS Interpreting service – code numbers and charges updated and hyperlinked</td>
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<tr>
<td>Links inserted throughout document for example Youth services within LHD</td>
</tr>
<tr>
<td>All references checked, several hyperlinks rehyperlinked</td>
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</table>
11 APPENDICIES

Appendix A   Well Women’s Health Program Clinical Meetings

Clinical Terms of Reference

Child, Youth, Women’s and Families Health
Well Women’s Health Program (WWHP)
Clinical Meetings

MEMBERSHIP
The membership of this meeting includes those staff employed and managed in the Well Women’s Health Program (WWHP) within the Child, Youth, Women’s and Families Health.

The clinical service meeting has been developed as a forum to assist Women’s Health Nurses to:
- maintain good practice,
- share information,
- maintain uniformity of clinical practice,
- peer support and problem solving.

Members:
- have a responsibility and right to ensure that meeting is meaningful and meets its stated Role and Terms of Reference,
- are encouraged to actively participate in setting the agenda, participating and presenting at the meeting,
- will have the opportunity to plan and facilitate components of the meeting.

OFFICERS IN ATTENDANCE
Manager / delegated staff member, Team Leader, Well Women’s Health Program.

QUORUM REQUIREMENTS
Meeting will be postponed if less than 50%+1 members are in attendance.

ROLE
The role of the WWHP meeting is to assist the Team Leader and the Manager with the management, communication, planning and reporting of program and project activities.

This meeting provides a focused time for the WWHP staff to develop their knowledge, share ideas, solve problems and exchange information about the work in which they are engaged.

The outcomes of this meeting contribute to the development of the annual program plans, reports and review.

TERMS OF REFERENCE
- to discuss issues arising from clinical practice within their District,
- to discuss, review and update clinical protocols and work program plans in accordance with the National Health and Medical Research Council (NH&MRC) Guidelines 2005, the NSW Cervical Screening Program, NSW Health State plans, Local District Health plans and the Australian Women’s Health Nurse Association (AWHNA).
FREQUENCY OF MEETINGS
- meetings to be conducted 1st Wednesday of the month which are linked to team and management meetings as per roster,
- meetings will be conducted face to face with option to teleconference into meeting,
- meetings will be at an agreed location, – room venues are booked by nurse located at the venue,
- calendar dates to be determined at the last meeting of the year for the following calendar year.

MEETING SPONSOR
- Meeting sponsor is the Manager of Child, Youth, Women’s and Families Health.
- The WWHP team Leader takes responsibility for ensuring the meetings are held regularly.

SECRETARIAT
- Chair- Team Leader/Line Manager
- Agenda: Rotated between WWHP as per roster. The Women’s Health Nurse’s will set the agenda. The agenda is to be saved on the shared drive/Well Women’s Health Meetings folder. The agenda will have a standard format with projects and outcomes. The template is located on the intranet.
- Minutes: Rotated between the WWHP team as per roster. The Minute taker will distribute minutes to other members within two weeks of meeting, and save minutes on the shared drive folder/Well Women’s Health/Meetings folder.

METHOD OF EVALUATION
- Attendance rates of members recorded
- At the end of each year the Role and Terms of Reference of the meeting are reviewed and updated, staff will be asked to participate in this review.

WWHP MEETING DATES
Monthly following Team meeting

<table>
<thead>
<tr>
<th>Date</th>
<th>Locations</th>
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</thead>
<tbody>
<tr>
<td>1st Wednesday of month</td>
<td>Child, Youth, Women and Families Health, Meeting Room,</td>
</tr>
<tr>
<td></td>
<td>Darlinghurst CHC, 301 Forbes St, Darlinghurst. NSW 2010.</td>
</tr>
<tr>
<td></td>
<td>Phone 9382 8686 (office manager).</td>
</tr>
<tr>
<td>11.30am – 1.00pm</td>
<td>Teleconferencing option can be used</td>
</tr>
<tr>
<td>following Unit meeting</td>
<td></td>
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</table>
# Women’s Health Nurse Flowchart Guide of Clinical Management for a Well Women’s Health Check, SESLHD

The flowchart aims to provide the Women’s Health Nurse with a generic framework in clinical assessment to enhance consistent clinical practice.

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Clinical History</th>
<th>Physical Examination</th>
<th>Investigations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Complete Women's Health Care Record from Explore situations with women using active listening open ended questions clarification of concerns empathy, non-judgemental</td>
<td>Blood Pressure Abdominal examination Genital examination Pelvic examination Pelvic Floor Muscle assessment Clinical Breast Examination</td>
<td>Pap test (smear) – conventional slide Thin Prep if required – client to sign consent form for payment if requesting this test Pregnancy testing – Urine HCG HPV DNA “Test of Cure” if indicated</td>
</tr>
</tbody>
</table>

Guidelines used to support clinical decision making are: The Australian Women’s Health Nurse Association Clinical Guidelines, FPA Health Clinical Guidelines (Sexual and Reproductive Health/ Contraception), the National Management Guidelines for Sexually Transmissible Infections, Cancer Australia (Nations Breast and Ovarian Council Guidelines), the National Heart Foundation Guidelines, the National Cervical Foundation Guidelines, the NHMRC Guidelines for Pap test screening and follow-up. The program influences include the NSW Pap Test Register and the NSW Cervical Screening and BreastScreen programs. Mandatory policies include Routine Domestic Violence Screening and the Child Wellbeing and Child Protection, Young Persons policies. The National Safety and Quality Health Service Standards 2012.

<table>
<thead>
<tr>
<th>Management</th>
<th>Non pharmacological interventions</th>
<th>Consider conditions for referral</th>
<th>“Across the counter” medication for women is available for certain conditions i.e vaginal /vulval health</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Information Woman led decision making Supportive counselling Referral</td>
<td>Breast mass/abnormality Pap Test result requiring further investigation/ Colposcopy Abnormalities detected on examination Medical conditions Psychosocial issues Suspected sexually transmissible infections</td>
<td></td>
</tr>
</tbody>
</table>

Provide information, education and language specific resources (if available) on alcohol and other drugs, breast health, contraception, cardiac risk awareness/ health, domestic violence, diet/nutrition, exercise, falls prevention, heart health, menstrual problems, premenstrual symptoms (PMS), menopause, osteoporosis, preconception, postnatal care, reproductive issues, safe sex/sexual health, stress management, smoking cessation, vulval/vaginal health and other services available for women within the community.

<table>
<thead>
<tr>
<th>Client education</th>
<th>Referral and follow-up</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All clients who are referred will be provided with a written letter by the Women’s Health Nurse with relevant information for the service provider. Copy is kept in Women’s Health Care Record file. Follow-up and review is determined as per client need.</td>
<td>Women’s Health Care Record, SEALS Pathology form, clinical register, record statistics on CHIME database.</td>
</tr>
</tbody>
</table>
Appendix C - Women’s Health Nurse Notification Letters

Letter 1  Normal Test results
Letter 2  Repeat Papanicolaou test
Letter 3  Requires further management
Letter 4  Request for woman to contact Women’s Health Nurse
Letter 5  Letterhead for referrals

Letter No 1 - Normal Test results

Use cut off slip and self ink stamp

Letter No 2 - Repeat Papanicolaou test

Dear (name),

Just a short note to let you know that as a result of your recent visit to the Women’s Health Nurse Clinic, the Pathologist recommends that you need to have your Pap test repeated. You are due again in __________

Enclosed are copies of your results for you and your doctor (I have kept the original report) with the Pathologist’s recommendation.

However, if you have any unusual pain, bleeding or discharge, please consult a doctor.

Yours sincerely,

(name)
Women’s Health Nurse
Ref: Jan 2014 (2)

Letter No 3 - Requires further management

Dear (name),

Enclosed are copies of your results for you and your doctor following your recent attendance to the Women’s Health Nurse Clinic with the Pathologists recommendation. I have kept the original report in your file.

The recommendation is that you require further management. You will need to see your doctor and follow his/her advice. Please take letters and copies of your report to your doctor.

Yours sincerely,

(name)
Women’s Health Nurse
Enc.
Ref: Jan 2014 (3)
Letter No 4 - Request for woman to contact Women’s Health Nurse

Dear (name),

I have tried to contact you without success. I wish to talk to you regarding

________________________________________________________________________

________________________________________________________________________

Could you kindly telephone me on (phone number) or (phone number) so that I can speak with you. If I am not there please leave a message and your contact telephone number and I will return your call as soon as possible.

Yours sincerely

(name)
Women’s Health Nurse
Ref: Jan 2014(4)

Letter 5 – Referral letter to another service

The NSW Health Medical Discharge Referral Reporting Standard (MDRRS) GL2006_015, 25-Oct-2006 Guideline is followed with an example templates on page 26 and a template below to be used on SESLHD letterhead
An example letter of referral to contain the following:

Friday, 6 September 2013

Name of intended recipient
Organisation
Address line 1
Address line 2
Suburb State and postcode

Dear Name of intended recipient,

Re: Client's name, Client's address
Best phone number for contact, Interpreter needed Yes / No (if yes enter preferred language)

Client's name, a female aged age in years (if <12 enter years and months)(DOB dd/mm/yyyy), attended the Women’s Health Clinic at place of clinic (not full address) on enter date for reason for appointment. During the consultation it became apparent that Client's preferred name requires further assessment and management for reason for referral.

Free text to include assessment findings

Free text to include relevant history

Free text to include test results

Client's preferred name is currently Choose an item reason for medication and name/dose/frequency (if none press "delete")

Client's preferred name states she Choose an item name of allergen and reaction. (If none press "delete")

Please do not hesitate to contact me on the above phone number if I can furnish you with further details, or to discuss the ongoing management for Clients preferred name.

Choose an item

Choose an item
Women’s Health Nurse
Ref Sep-13 (referral) Client's name, DOB (dd/mm/yyyy)
Client's address, Best phone number for contact.
Appendix D - Consent Payment of Thin Prep Test

CONSENT FOR PAYMENT OF THIN PREP TEST

The Thin Prep Test is a new method of examining a pap smear. It improves the quality and quantity of the sample making it easier to identify abnormal cells from the cervix.

***

I understand that the Thin Prep Test for my cervical smear is not covered by Medicare and I consent to pay $45 for this service.

Signed ...................................................... Date ............................

ANATOMICAL PATHOLOGY
Level 4, Campus Centre, Prince of Wales Hospital, Barker St, Randwick N.S.W 2031
Telephone: 9382 9126
Fax: 9382 9037

SEALS
North Randwick / Sydney
Central Kogarah / Sutherland
South Wollongong / Nowra / Shellharbour

New Thin prep consent form_2013
Appendix I - Example Work Plan

Women’s Health

Well Women’s Health Program
Work Plan
July 01 2013 – June 30 2014

Prepared by:
Date:
Introduction to program

Background/Rationale

Approach/Method

Main project areas (titles)

1. Project title
2. Project title

Resources

<table>
<thead>
<tr>
<th>Project</th>
<th>Title</th>
<th>Estimated cost ($)</th>
<th>Actual cost ($)</th>
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<tbody>
<tr>
<td>1</td>
<td>Project title</td>
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<td>Total</td>
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Monitoring and evaluation

Sustainability

Communication strategy
Annual Program Review

Key achievements

Review of progress

Implementation

Quality

Impact

Conclusions

Critical success factors

Challenges

Enablers

Future directions
Project 1 - Title

Introduction

Background/Rationale

Approach/Method

Project Goal / Health Outcome

Project Aims
a)
b)
c)

Resources

<table>
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<tr>
<th></th>
<th>Estimated Cost</th>
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<tbody>
<tr>
<td>1. FTE's</td>
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<tr>
<td>2. Overheads</td>
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Objectives and impact indicators

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<th>Indicators (Impact evaluation)</th>
<th>Baseline</th>
<th>Progress</th>
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<td>1.2</td>
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Click to return to index
Project 2 - Title

Introduction

Background/Rationale

Approach/Method

Project Goal / Health Outcome

Project Aims

a)

b)

c)

Resources

<table>
<thead>
<tr>
<th></th>
<th>Estimated Cost</th>
<th>Actual Cost</th>
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<tr>
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<td>2. Overheads</td>
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Objectives and impact indicators

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Other activities

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<th>Annual report</th>
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<td>Capacity building activities</td>
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<tr>
<td>Enabling community development</td>
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<tr>
<td>Administrative responsibilities and Unit</td>
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<tr>
<td>representation</td>
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<tr>
<td>Professional development activities</td>
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</tbody>
</table>

Resources

1. Capacity building activities
2. Enabling community development
3. Administrative responsibilities
4. Professional development activities

TOTAL

$0       $0

Click to return to index
Work plan – **Strategies Section**

To be used as needed on a regular basis for monitoring progress –

This section can be detached and taken to supervision sessions
1. Project 1 - Title

**Objective 1.1**

<table>
<thead>
<tr>
<th>Strategies Actions - What you are going to do</th>
<th>Indicators (process evaluation) How you will know its been done</th>
<th>Responsibility Who will do it</th>
<th>Timeframe (eg Jan-Mar 11)</th>
<th>Quarterly Progress</th>
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**Objective 1.2**

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<th>Timeframe (eg Jan-Mar 11)</th>
<th>Quarterly Progress</th>
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**Objective 1.3**

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<th>Responsibility Who will do it</th>
<th>Timeframe (eg Jan-Mar 11)</th>
<th>Quarterly Progress</th>
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1. Project 2 - Title

**Objective 2.1**

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<th>Responsibility</th>
<th>Timeframe (eg Jan-Mar 11)</th>
<th>Quarterly Progress</th>
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<td>How you will know it's been done</td>
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**Objective 2.2**

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**Objective 2.3**

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