Clinical Practice Guidelines for Nurses Undertaking Cervical Screening in Victoria

Section One:
Principles underpinning clinical practice for nurses undertaking cervical screening in Victoria

Section Two:
Clinical practice guidelines for nurses undertaking cervical screening

www.papscreen.org.au

www.cancervic.org.au

Exit
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PREFACE

The guidelines provide nurses with access to uniform high quality standards related to a broad range of clinical practice settings. Use of these guidelines provides high standard benchmarks which are relevant for continuous quality improvement.

The guidelines are designed for use by nurses providing cervical screening across a range of service areas.

The guidelines are based on current evidence and opinions of best practice, and are consistent with the Family Planning Australia New South Wales Clinical Practice Guidelines (2003) and the Australian Women’s Health Nurses Association Inc’s Women’s Health Nurse Clinical Practice Guidelines, Protocols and Procedures (2003).
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PRINCIPLES UNDERPINNING CLINICAL PRACTICE FOR NURSES UNDERTAKING CERVICAL SCREENING IN VICTORIA

1. INTRODUCTION

1.1 Purpose of Clinical Practice Guidelines for Nurses Providing Cervical Screening

The purpose of the guidelines is to facilitate a high standard of clinical practice for nurses providing cervical screening throughout Victoria. The guidelines aim to:

• Guide practice in the area of women’s health, including cervical screening
• Clarify some of the broad standards of practice
• Assist in a coordinated approach to women’s health service provision from a health promotion framework.

1.2 The Provider

In these guidelines, the definition of a women’s health nurse is a Division One Registered Nurse, educated for advanced practice, the characteristics of which would be determined by the context of their practice. The term ‘women’s health nurse’ will be used throughout the guidelines and incorporates a range of roles such as:

• Nurse Pap test provider
• Practice nurse
• Sexual health nurse
• Sexual and reproductive health nurse
• Adolescent sexual health nurse
• Community health/women’s health nurse.

The above is not an exhaustive list, but acknowledges that nurses provide cervical screening work in a variety of settings (private, public and non-government) with often multiple roles such as clinical practice, health promotion, education, research and management.

The women’s health nurse will have:

• Current registration as a Division One Registered Nurse with the Nurses Board of Victoria (if practising in Victoria)
• A certificate in a Pap test provider course, which is accredited by the Royal College of Nursing, Australia or equivalent. Current accredited Victorian courses are available at:
  
  **The University of Melbourne Department of General Practice**
  ‘Pap Test Training for Practice Nurses’
  03 8344 7276  [www.gp.unimelb.edu.au](http://www.gp.unimelb.edu.au)

  **The University of Melbourne School of Population Health & Melbourne Sexual Health Centre**
  ‘Clinical Sexual and Reproductive Health for Nurses’
  03 9341 6249  [www.sph.unimelb.edu.au](http://www.sph.unimelb.edu.au)

  **Family Planning Victoria**
• Current credentialling status as a nurse Pap test provider with the Royal College of Nursing, Australia
• An appropriate professional indemnity insurance cover.

The role and functions of the women’s health nurse should be documented in their current job description. Sample women’s health nurse job descriptions are available from the Melbourne Sexual Health Centre website at www.mshc.org.au

1.3 The Role of the Women’s Health Nurse

Women’s health is a specialised area of advanced nursing practice that provides a holistic woman-centred approach with an emphasis on primary health care prevention. The role often encompasses health promotion, screening and direct clinical services, support, advocacy and referral. Services are provided across a woman’s lifespan and are not solely concerned with reproduction.

The women’s health nurse in this context aims to provide:

• Advanced practice in the areas of women’s health which is underpinned by a health promotion framework
• Clinical assessment and cervical screening
• Breast examinations and sexually transmitted infections; asymptomatic screening may be incorporated into this role depending on individual competency based training

• Sexual and reproductive health information, education and counselling on a range of sexual and reproductive health issues across the lifespan with a focus on ‘well women’
• Information/education on general health issues such as:
  - Smoking
  - Relevant immunisation
  - Nutrition
  - Physical activity
  - Healthy lifestyle
• Appropriate referral networks with other health care providers and other organisations, and to establish collaborative relationships.

The women’s health nurse should only undertake clinical procedures within their scope of practice for that specific health care setting. Any abnormality(s) suspected or determined by the women’s health nurse should be discussed with the client and a referral should be made to a general practitioner or another appropriate health professional.

1.4 Practice Background and Boundaries of Practice

The women’s health nurse should acknowledge:

• The Australian Nursing and Midwifery Council National Nursing Competencies, which were accepted in 1990 by Australian nurse regulatory authorities as the minimum competencies to be demonstrated by nurses for entry to the practice of nursing (ANMC 2000)
• The Australian Competency Standards for the Advanced Nurse (ANMC 1997), which aim to reflect the total practice of the advanced nurse
• The Code of Professional Conduct for Nurses in Australia (ANMC 1995), and the Code of Ethics for Nurses in Australia (ANCI 1993)
• The competencies identified within the National Standards for Nurse Pap Smear Providers (RCNA 1997)
• Victorian Credentialling and Re-credentialling Policy for Nurse Pap Smear Providers (Registered Division 1 Nurses) (RCNA 2003)
• The National Guidelines for Cervical Screening (CDHFS 1998) and the National Guidelines for the Management of Women with Screen-detected Abnormalities (NHMRC 2005) provide a framework for cervical screening.

1.5 Credentialling

Credentialling for nurse Pap test providers aims to provide a process of recognition of an individual nurse’s areas of practice and provides a mechanism to:
• Recognise expertise
• Ensure the quality and standard of the cervical screening service
• Demonstrate accountability for practice.

The Royal College of Nursing, Australia website www.rcna.org.au provides details on:
• Information about credentialling and re-credentialling
• Credentialling application form

• National standards for nurse Pap smear providers
• Policy and guidelines for nurse Pap smear providers
• Additional location application
• New organisation location application.

The college website provides forms for demonstration of continuing competence such as:
• Self-assessment tool
• Quality of practice statement
• Women’s satisfaction survey
• Pap test statistical record
• Reactivating credentialling number.

The credentialling application form and further information is available from the Credentialling Secretariat, Royal College of Nursing, Australia, free call 1800 061 660.

The Victorian Cytology Service provides nurses with a ‘practice’ number on the condition they meet and maintain their credentialed status. The service only reports Pap tests collected by nurses who are credentialled. This access allows credentialled nurses to sign the cytology request forms and receive results. It is a process to assist nurses in a visible cervical screening service and, through access to their own clinical reports, ensures that a high standard of practice is maintained.

1.6 Professional Indemnity

It is recommended that all women’s health nurses have personal indemnity insurance. In the workplace, nurses may have additional professional indemnity insurance
provided by the employer, however it is the nurse’s responsibility to ensure that they have an appropriate level of insurance cover for their scope of practice.

In general practice, a general practitioner’s procedural insurance covers the practice against vicarious liability that may arise from the actions of the nurse.

There is still the potential for the nurse to be sued individually by an aggrieved client and in this instance individual professional insurance is preferred. This is also particularly relevant if the nurse acts as a contractor or is self-employed.

The Australian Nursing Federation offers professional indemnity insurance to members who are employed by a health facility. Insurance is also available through the Royal College of Nursing, Australia and Guild Insurance Limited on free call 1800 810 213.

1.7 Organisational Philosophy

The women’s health nurse generally works within health care settings that aim to provide quality women’s health services that will benefit their clients’ health and well being. They have a commitment to:

- Provide the best possible client care using current evidence based practices
- Advocate for the rights of all individuals to achieve holistic health
- Facilitate informed choice and participation in all aspects of health care
- Deliver services in an accepting and non-judgmental fashion.

1.8 Rights and Needs of Clients

The Nurses Act 1993 (Vic) enabled the establishment of the Nurses Board of Victoria, which has many responsibilities. The board has a responsibility to protect the public by providing registration for nurses. If a complaint about professional conduct and fitness to practise as a registered nurse has been lodged, then investigation will be undertaken by the board.

1.9 Health Promotion

Health promotion provides enormous potential for public health improvement. Internationally, the World Health Organization has guided health promotion development. The Declaration of Alma-Ata (ICPHC 1978) provided a platform for the development of health promotion, which was further defined in the Ottawa Charter for Health Promotion (FICHP 1986). The Ottawa Charter defines health promotion as:

... the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change and cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living ...
with relevant integrated health promotion networks are critical to this role.

A social model of health, which includes an awareness of the inter-relationship between the biological, psychological, social and spiritual needs of the client, should underpin practice. The women’s health nurse should be concerned with enabling clients to remain healthy and should address the complexity and uniqueness of the whole person in a culturally sensitive manner.

2. CONSUMER RIGHTS

2.1 Confidentiality and Privacy

Confidentiality and privacy are important considerations in the relationship between the client and the women’s health nurse. Key components include:

Privacy Legislation

The Privacy Act 1988 (Cwlth) regulates the way health care settings collect, keep secure, use and disclose personal information. The introduction of the Privacy Amendment (Private Sector) Act 2001 (Cwlth) has been a catalyst for the National health and Medical Research Council to review the Act and further details are available via its website.

www.nhmrc.gov.au/about/privacy.htm

This Act gives the client a right of access to personal health information held about them throughout Australia.

The Health Records Act 2001

The Health Records Act 2001 (Vic) aims to protect the privacy of an individual’s health information and how this information is managed. The Act applies to the Victorian Government sector, Victorian Government funded services, private health services within Victoria and any other organisations within Victoria that holds health information.

The Freedom of Information Act 1982 (Vic) and the Health Records Act give the client a right to access information about their health care held in the public and private sectors. If access is denied by the health care setting’s policy (public sector), then the client can access their medical records under the Freedom of Information Act.

Health (Infectious Diseases) Regulations 2001

Under the Victoria Health (Infectious Diseases) Regulations 2001, doctors and laboratories are required by law to notify the Department of Human Services of diagnoses of specified infectious diseases. The Regulations stipulate the information that must be provided. This includes demographic data, clinical history, the disease diagnosed, risk factors, suspected modes of transmission and clinical comments.


All medical records should be confidential. Confidentiality, privacy and ethical behaviour are
crucial to client care (Section 63 of the Health Records Act). The women’s health nurse will provide respectful care at all times and under all circumstances, with recognition of clients’ personal dignity regardless of sex, age, religion, ethnicity, sexual preference or medical condition.

Confidentiality has an ethical, a legal and a statutory basis. Confidentiality should be maintained at all times. There can be a:

- **Verbal** breech of confidence (e.g. discussion of the clients’ conditions with staff members, families, friends and others)
- **Visual** breech of confidence (e.g. clients’ files left in full view of any other party)
- **Auditory** breech of confidence (e.g. client matters discussed in a loud and unprofessional manner in hearing range of others nearby).

Client consultations and examinations should be carried out in surroundings designed to ensure privacy. Client consultation rooms should ensure visual and auditory privacy. Individuals not directly involved in client care should not be present during consultations without the consent of the client.

### 2.1.1 Mandatory Reporting

Under Section 64(1c) of the *Children and Young Person’s Act* 1989 (Vic), any person may notify any instance of possible or known child abuse. Professionals who are gazetted and legally required (mandated notifiers) to report child physical injury and sexual abuse are:

- Legally qualified medical practitioners, registered nurses, and members of the Victorian police force (refer [Children’s Protection Australia 2002](#)).
- Primary school and secondary school teachers and principals (refer [Children’s Protection Australia 2002](#)).

The women’s health nurse, under Section 63 and 64 of the *Children and Young Person’s Act*, will notify the Child Protection and Family Service Office of the Department of Human Services if they form a belief, based on reasonable grounds, that a child has suffered or is likely to suffer significant harm as a result of physical injury or sexual abuse and if the child’s parents or caregivers have not protected or are unlikely to protect the child from harm of that type.

Under the Children and Young Person’s Act, the identity of the notifier will remain confidential, except in certain circumstances.

The penalty for a mandated notifier who does not notify is an offence under the Mandatory Reporting amendment and incurs a $1000 fine.

An effective response to child abuse and neglect requires an approach of shared responsibility between statutory child protection bodies and people working in other community and human service organisations. Nurses can play a very significant role in protecting children from harm.

Although only mandated notifiers have a legal responsibility to report physical and sexual abuse,
everyone has a moral responsibility to report all types of possible or known child abuse.

**Child Protection Crisis line 13 1278**
**Toll free 24 hours**

2.1.2 Negligence

The women’s health nurse, along with other health care workers, will exercise a duty of reasonable care towards their clients. If the women’s health nurse carelessly neglects this duty then this may constitute negligence. The women’s health nurse will be accountable and responsible for their own actions within nursing practice.

2.1.3 Duty of Care

Health care settings have a duty of care to protect people working in or visiting the setting from harm, and also to protect the privacy and confidentiality of all people in the health care setting.

2.1.4 Anti-discrimination

Specific legislation at both Commonwealth and State/Territory level prohibits discrimination on a number of grounds, including sexuality and impairment (including physiological, psychological and intellectual disabilities).

2.2 Informed Consent

2.2.1 Principles

Important decisions that clients make about their own lives, particularly medical decisions, should be both voluntary and uncoerced. The women’s health nurse has a moral and legal duty of care to obtain a valid, informed consent. Informed decision making takes into account language and jargon barriers to ensure that a client understands. Consent can be implied from conduct, verbal and/or in writing. O’Sullivan (1993) cites Sagell and Reed as saying there should be five components to consent. The client should:

- Understand the nature of their condition
- Understand the nature of the proposed treatment or procedure
- Be aware of possible alternative courses of action
- Be acquainted with the risks of the proposed and the alternative courses of action
- Be informed of the chances of success or failure of the proposed and alternative procedures.

Therefore, when a client consents to a Pap test, the above principles of consent will be adhered to. The client will be informed that the Pap test is a screening test and not diagnostic.

Some clients may be incapable of informed consent, for example minors, those incapacitated by illness and some people with intellectual or psychiatric disabilities.

Although a client below the age of 18 years should be a ‘minor’, they may be able to give informed consent to medical treatment. This will depend on the client’s comprehension ability and maturity, which are only partly linked to the young person’s age. Protection of the young person through paternal rights will only exist for as long as they are needed.
It was held by the Australian High Court (Department of Health and Human Services v. JWB and SMB [Marion’s Case] [1992] CLR 218 FC 92/010) that:

... Parental power to consent to medical treatment on behalf of a child diminishes gradually as the child’s capacities and maturity grow. A minor is capable of giving informed consent when he or she achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed ...

The women’s health nurse will not disclose information regarding a minor. The women’s health nurse will not give any person information regarding a minor as this may leave the women’s health nurse liable in an action for breach of confidentiality.

The women’s health nurse will facilitate and support education, which fosters responsible decision-making by the minor. The women’s health nurse must be satisfied that the provision of the service is necessary to promote the minor’s physical and mental health.

The women’s health nurse and other health workers will check whether an agent has been appointed under a medical enduring power of attorney in the situations where a person becomes not competent due to injury or illness to provide informed consent (Medical Treatment Act 1988, Vic).

2.2.2 Menhennitt Ruling

The client’s medical records will reflect the Menhennitt ruling when they request a termination of pregnancy, as Section 65 of the Crimes Act 1958 (Vic) prohibits unlawful abortions. Consent for a termination of pregnancy must be freely given and demonstrate that on reasonable grounds, the termination was necessary to preserve the women from serious danger to her life or physical or mental health.

3. HEALTH AND SAFETY

3.1 Occupational Health and Safety Regulations

Both employer and employees have a responsibility in relation to occupational health and safety. Under the Occupational Health and Safety Act 2004 (Vic), which replaces the Act from 1985, the employer must provide and maintain, so far as reasonably practicable, a working environment that is safe and without risks to the health of staff and clients. The Act provides a framework for consultation between the employer and employees in the health care setting regarding health and safety. The Act or the summary can be downloaded from www.workcover.vic.gov.au

The framework should have two levels for consultation:

- Health and safety representative(s)
- Occupational health and safety committee(s).

A health care setting must elect its own health and safety representative(s) as provided under the Occupational Health and Safety Act. The women’s health nurse is encouraged to participate in an occupational health and safety committee established in their health care setting. The management representative must be appointed and the employee representative must be elected to this committee.
In accordance with legal responsibilities placed on employees under the legislation, the women’s health nurse must comply with the health care setting’s health and safety policies and procedures, provided such policies and procedures have been developed in consultation. The employer must provide appropriate equipment, training, and other measures, which support and encourage compliance with the health care setting’s health and safety policies and procedures.

3.2 Injury in the Health Care Setting

All responses to injuries/incidents in the health care setting must comply with the Occupational Health and Safety Act. All injuries/incidents will be reported to the chief executive officer or head of the organisation and an injury/incident record sheet completed within 24 hours of the incident (or as per protocol by the individual health care setting).

3.3 Equal Opportunity, Discrimination and Harassment

Discrimination and harassment can occur in relation to race, colour, politics, religion, gender and sexuality. Any member of the health care setting who considers themselves to have been, or believes a client has been, subjected to any form of sexual harassment or bullying should not hesitate to report this to a senior manager or the chief executive officer.

The health care setting policies should recognise that bullying and harassment is unacceptable. Instances of bullying can be unlawful as per:

Victorian legislation
- Racial and Religious Tolerance Act (2001)

Commonwealth legislation
- Equal Opportunity for Women in the Workplace Act (1999)
- Workplace Relations Act (1996)
- Disability Discrimination Act (1992)

A report of any harassment should be treated seriously and systematically, and investigated thoroughly within as short a timeframe as practicable.

4. INFECTION CONTROL

4.1 Principles

This section provides a basic overview of infection control and have been based on the Infection Control Guidelines for the Prevention of Transmission of Infectious Diseases in the Health Care Setting (DHA 2004). Each health care setting has specific infection control guidelines.

Successful infection control is based on good hygiene around a range of practices that arise from identifying hazards and implementing risk management for the
hazard. Health care settings should develop detailed protocols and policies that cover:

- Basic principles of infection control strategies
- Quality management practices
- Developing effective work practices and procedures
- Managing infectious disease in the health care setting
- Identifying infection control strategies in specialised health care settings.

Refer to the Department of Health and Ageing website at for a copy of the guidelines, which have been endorsed by the Communicable Diseases Network Australia, the National Public Health Partnership and the Australian Health Ministers’ Advisory Council.

### 4.1.1 Standard Blood and Body Fluid Precautions

Standard precautions have been defined in Australian Standard 4187 as:

... work practices which require everyone to assume that all blood and body substances are potential sources of infection, independent of perceived risk. Such precautions involve the use of safe work practice and protective barriers and the safe disposal of body substances and soiled material ...

Standard precautions are work practices required for the basic level of infection control and should be used at all times to ensure both the safety of the women’s health nurse and the prevention of transmission of infection from client to client, client to women’s health nurse and women’s health nurse to client. The women’s health nurse and other health professionals must assume that the blood and body substances of ALL clients are potential sources of infection independent of diagnosis or perceived risk.

Standard precautions are recommended for the care of all clients, regardless of their perceived or confirmed infectious status, and in the handling of:

- Blood (including dried blood)
- All body fluids, secretions and excretions (excluding sweat), regardless of whether they contain visible blood
- Non-intact skin
- Mucous membranes.

Standard precautions should include such things as:

- Thorough washing and drying of hands before and after client contact
- Use of personal protective equipment such as gloves, aprons, masks and eye protection
- Appropriate handling and disposal of sharps and waste
- Use of aseptic techniques.

### 4.2 Strategies for Infection Control

Strategies for infection control are based on the aetiology of the infections involved and the most effective ways to control them. Standard precautions are work practices required to achieve a basic level of infection control. Pivotal for standard precautions for infection control in the health care setting are:
• Aseptic technique, including appropriate use of skin disinfectants
• Personal hygiene practice, particularly hand washing before and after all significant client contacts
• Use of personal protective equipment, which may include gloves, impermeable gowns, plastic aprons, masks/face-shields and eye protection
• Appropriate handling and disposal of sharps and other clinical waste
• Appropriate reprocessing of reusable equipment and instruments: includes appropriate use of disinfectants
• Environmental controls, including design and maintenance of premises, cleaning and spills management
• Appropriate provisions of support services, such as laundry and food services.

Implementing standard precautions minimises the risk of transmission of infection from person to person and should be implemented at all times. Additional precautions are tailored to the particular infectious agent.

To successfully control transmission of infectious agents, it is necessary to:
• Identify hazards
• Assess, classify and manage risks
• Develop risk management protocols and communication strategies to effectively minimise the risk.

4.3 Quality Management Practices
The health care setting should have a strategic plan for infection control which includes a comprehensive infection control procedures manual that specifies performance standards for routine work practices and procedures. The health care setting should develop, implement and document effective policies in line with national minimum standards and infection control principles. A system of infection control management (such as a committee) should meet regularly to consider and resolve current infection control issues that affect the working environment.

The implementation of effective infection control strategy depends on:
• Clear understanding by all health care setting employees on the methods of preventing cross-infection
• Full cooperation between health care setting employees and the client.

The women’s health nurse should respect the client’s right to privacy and confidentiality at all times. However on some occasions, other professional colleagues may require the provision of information regarding the infectious status of a client on a ‘need to know’ basis and such incidences must be approached with great caution.

4.4 Effective Work Practices and Procedures
For detailed information regarding infection control and prevention in the health care setting, refer to the Victorian Government website.

4.4.1 Design and Maintenance of Health Care Setting

All aspects of the health care setting must be monitored and maintained to ensure that it meets current standards, codes and regulations. The way the setting is designed is fundamental to infection control and takes into account such factors as workflow, which should be from clean to contaminated areas.

Within a health care setting, all employees must be educated in infection control. As with all processes involved in providing health care, infection control must be evaluated and updated regularly to maintain quality outcomes. These outcomes need to be fed back to employees on a regular basis with discussion regarding the methods / effectiveness of specific procedures.

4.4.2 Hand Washing

Hand washing should be considered as the most important measure to prevent the spread of infection. Hands must be washed in an identified hand washing sink:

- Before significant contact (physical examination, undertaking venipuncture or delivery of an injection, before and after routine use of gloves, after going to the toilet) with any client
- After activities likely to cause contamination (handling equipment/instruments soiled with blood or other body substances).

The correct procedure of routine hand washing includes:

- Duration: 10 to 15 seconds
- Routine: Hands should be thoroughly wet and lathered vigorously using neutral pH liquid hand wash. Rinse under running water, but do not touch taps with clean hands
- Drying: Disposable paper towel to pat hands dry, clean cloth towel or fresh portion of a roller towel. Do not touch taps with clean hands. If elbow or foot controls are not available, paper towel should be utilised to turn off taps.

Suitable hand basins and hand washing equipment are essential and readily available and should comply with Australian Standard 1730. Cleaning and reprocessing areas need to comply with Australian Standard 4031 and Australian Standard 4261.

4.4.3 Personal Protective Equipment

The health care setting should provide personal protective clothes and equipment that complies with relevant Australian Standards. The women’s health nurse should wear gloves whenever there is a risk of exposure to blood or body substances and wear protective eyewear during procedures where there is potential for splashing or spraying of blood or body substances Australian Standard 4011 and Amendment 1 (1998).

Single-use Examination Gloves

General purpose utility gloves should be used when cleaning contaminated instruments. The gloves can
be reused, but must be discarded if damaged. Sterile gloves should be worn during any surgical/invasive procedure involving penetration of the skin or mucous membrane and/or other tissues.

A gown or apron should be worn during procedures that are likely to cause the splashing or splattering of blood or other body substances onto employee clothing.

4.4.4 Handling and Disposal of Sharps

- Sharp medical devices must be immediately disposed of in a yellow, rigid, plastic, labelled container according to Australian Standard 4031.
- The person who has used the sharp must be responsible for its immediate safe disposal following use, preferably at the point of use
- Needles should NOT be recapped into their original sheath unless an approved recapping device is used. Used disposable syringes, needles, scalpel blades, cytobrushes and other sharp instruments should be placed into an Australian Standard 4031 specified, disposable sharps container immediately after use and at the point of use
- Clearly marked sharps containers should be placed as close as practicable to the areas where sharps are being generated
- Sharp instruments must not be passed by hand between health care workers. Specified puncture-resistant sharps trays to be used for transfer of all sharp items (RACS 1998).

4.4.5 Disposal of Clinical Waste


- Waste should be segregated at the point of generation, using appropriately colour-coded and labelled containers. Standard precautions should apply when handling clinical waste
- Clinical waste (placed in yellow containers) includes:
  - Discarded sharps
  - Laboratory and associated waste directly associated with specimen processing
  - Human tissues, including material or solutions containing free-flowing blood
  - Animal tissue
- A registered waste management company (approved by the Environmental Protection Authority) should routinely collect and dispose of all waste
- The National Guidelines for Waste Management in the Health Care Industry (NHMRC 1999) recommends that organisations generating such waste must ensure its safe identification, packaging, labelling, storage, transport, treatment and disposal, from the point of generation to the point of final disposal. In office practices, small volumes of blood, urine or faeces can be disposed of via the sewerage system, although disposal of any large volume of waste should follow local regulations.
4.4.6 Single Use Equipment

Wherever possible, single-use, sterile, disposable equipment should be used to avoid cross-contamination between clients. Instruments or equipment intended for single use and labelled ‘single-use’ by the manufacturer should be disposed of after use.

To avoid cross-infection, items such as ointments, lubricants and creams should be used for individual clients only. The Australian Standard 4187 universally condemns the practice of reuse of single-use items and states that they should be discarded at the point of use.

4.4.7 Reprocessing of Reusable Instruments and Equipment

The health care setting must use appropriate facilities and procedures for cleaning, disinfection and decontamination of the work environment. For the reuse of all medical equipment, Australian Standard 4187 must be adhered to.

Validation of the cleaning and sterilisation process of re-usable invasive devices is a legal requirement for clients receiving treatment with this equipment.

Health care settings should have systems in place that allow key items (for high-risk procedures) of equipment to be tracked. The system should show individual instruments, client details, details of reprocessing strips and process validation proof.

4.4.7.1 Surfaces

Surface disinfectants and sterilants are regulated by the Therapeutic Goods Administration. Heath care settings should provide comprehensive training for health care workers about the safe handling of chemicals.

Neutral pH detergents should be used for cleaning tables, chairs, floors and walls in client care areas. Such environmental surfaces are not associated with transmission of infections to health care workers or other clients.

Clinic equipment such as couch, footstool, light and light stand, pillow, plastic waste bucket, equipment table top, trolley, hand basin and taps should be cleaned after each session or when visibly soiled. Warm water and neutral pH detergent should be used for surface disinfection in accordance with manufacturers’ instructions and the Australian Standard 4187.

Paper towelling, cotton wool, disposable gloves or any other items used for cleaning should be disposed of as for infectious (clinical) waste.

4.4.7.2 Manual Cleaning of Instruments

After use, all instruments should be rinsed under warm running water to remove any debris such as blood and serum. Thorough cleaning of all instruments (scrubbing with a clean brush in a designated sink) should commence as soon as practicable in warm water and detergent in order to remove blood and other debris. Instruments
cannot be sterilised (or disinfected) if they have not been adequately cleaned to eliminate potentially infective organic materials prior to the sterilisation process. The use of hot water may result in coagulation and adherence of protein matter to surgical instruments. Manual cleaning should comply with the Australian Standard 4187. The use of an enzyme based detergent is recommended for cleaning blood stained instruments. All instruments should be rinsed in warm water after cleaning. General purpose utility gloves, eye protection and plastic aprons should be used for protection while cleaning instruments and should comply with Australian Standard 1337.

4.4.7.3 Sterilising Instruments

The Australian Standard 4187 sets out procedures for the cleaning, disinfection and sterilisation of reusable medical and surgical instruments and equipment, and maintenance of associated environments in health care settings. Refer to the Royal Australian College of General Practitioners website www.racgp.org.au, under ‘Your Practice’, for details about validation of the sterilisation process.

The standard states that:

• Gloves should always be worn when handling used non-disposable equipment
• All used non-disposable equipment that has come into contact with any potential infectious material must be thoroughly cleaned and sterilised before reuse
• All single use items should be discarded at point of use
• Various sterilisation procedures may be used, depending upon the type of equipment and the material of which it is made.

The preferred option for sterilising metal instruments should be:

• Autoclaving (steam under pressure) at 121 degrees Celsius to 134 degrees Celsius
• Packaged items should only be processed in an autoclave, which has a built-in drying cycle and meets the Australian Standard 2192.

Cleaning and sterilising diaphragms and fitting rings (used for fitting and practice purposes) should:

• Occur immediately after diaphragm fitting. The diaphragms should be rinsed under warm running water to remove any debris such as blood, serum or other materials containing protein. The fitting diaphragms should be thoroughly washed with soap and water, sonicate for a few minutes and allowed to dry
• Include the sterilisation (autoclaving) of fitting diaphragms at 134 degrees Celsius for three minutes.

4.4.7.4 Correct Loading

• The steriliser should be correctly loaded as per Australian Standard 4187. Steam must be able to circulate effectively around all instruments and all
surfaces must be accessible and exposed to the steam
• When the packaged items are unloaded, the items should be dry, not torn and have intact seals.

4.4.7.5 Monitoring the Sterilisation Process
All steam sterilisers must meet the requirements of relevant Australian Standards 2192, 1410 or 2182 and be operated according to Australian Standards 4187 and 4815. Australian Standard 1079 provides details of different types of packaging material suitable for use in health care settings. The sterilisation process needs to be checked on a daily basis. The autoclave should be fitted with a physical monitor to measure time, temperature and pressure, and this should be checked periodically to comply with the manufacturer’s specifications. All bench top autoclaves should have a print-out facility. The steriliser should be calibrated at least once a year by a qualified service technician who is approved by the National Association of Testing Authorities.

Colour change strips (chemical indicators) must be used on packages to indicate that the package has been through the steriliser. A positive result is required and recorded for each load. A negative result must also be recorded and the load re-sterilised.

Each week the actual killing power of the steriliser must be tested with bacterial spores. A sample of spores should be placed with the load to be sterilised, then incubated with a control (unsterilised spore sample) according to the manufacturer’s instructions.

Documented evidence of commissioning, ongoing maintenance, calibration and daily procedures must be maintained within the health care setting.

4.4.8 Blood and Body Fluid Spills Management
Standard precautions apply where there is risk of contact with blood or body substances. All body fluid spills (sputum, vomit, faeces, urine, and blood or laboratory culture) should be handled immediately and with extreme care. Standard cleaning equipment (solutions, water buckets, cleaning cloths and mop heads) should be readily available for spills management.

4.4.8.1 Spot Cleaning
• Blood and/or body fluid spots should be wiped immediately with a damp cloth, tissue or paper towel(s) and discarded in accordance with state regulations and hands washed after spot cleaning.

4.4.8.2 Spills
• Blood and body substance spills should be immediately wiped up as soon as possible
• Disposable gloves should be worn during blood and body fluid spill management procedures
• Eye wear and plastic apron should be worn when there is a risk of splashing occurring
• The area should be cleaned with warm water and neutral pH detergent. If the spill occurs on carpet, then this should be shampooed as soon as possible.

4.4.8.3 Collection of Specimens

• Gloves must be worn when collecting specimens of any body fluid

• After collection, specimens must be placed in a well constructed container, sealed tightly and transported to the pathology department in a leak-proof bag

• Requirements for specimen collection, transport and storage should comply with the Accreditation Requirements in Medical Testing (NATA/RCPA 2004) (refer to www.nata.asn.au). For transport of specimens between institutions, the packaging should comply with standard postal or courier regulations.

4.4.9 Linen

All used linen can potentially be contaminated with infectious organisms and therefore should be treated as infectious. The following statements should apply in the handling of linen in a health care setting:

• All hospitals or commercial linen services should have documented policies and procedures for the collection, transport, processing and storage of all linen and need to comply with the Australian Standard 4146

• All linen should be treated as infectious and should be placed in a standard linen bag. Appropriate personal protective equipment should be worn when handling soiled linen

• Wet/moist linen should be placed in a linen bag with a plastic liner to prevent handlers from contamination

• Gloves should be worn when bagging infectious linen.

4.4.10 Immunisation Guidelines for Health Care Professionals

Women’s health nurses may be exposed to, and transmit, vaccine-preventable diseases (VPDs). Maintenance of immunity to VPDs of women’s health nurses and other health care workers helps prevent VPDs’ transmission. Health care settings employing women’s health nurses and other health care workers should initiate staff vaccination programs in accordance with the Australian Immunisation Handbook (NHMRC 2003).

Further information can be obtained from the Victorian Government Health Information website: www.health.vic.gov.au, which provides such information as:

Immunisation provider information: resources, policy/procedure documents and reports

Fact sheets provider resource: The disease, immunisation type and side effects

Fact sheets in your language: in 19 different languages
Frequently asked questions: immunisation myths and realities, vaccine information and immunising newly arrived immigrants

Local councils: a list of local councils which provide immunisation services

Links to related sites

4.4.10.1 Vaccination Program

Immunisation for Health Care Workers (DHS 2004) recommends that health care settings should have a vaccination register which contains details of staff vaccine preventable disease history, vaccination, antibody results, record of vaccines consented/refused and should be maintained by a designated staff member. The government guidelines for health care workers can be downloaded from www.health.vic.gov.au (under ‘Public Health’).

Health care workers should be encouraged to maintain their own personal immunisation status on the nationally endorsed health screening card for health care workers.

4.4.10.2 Refrigerators

Vaccines and other medications should be stored in accordance with the manufacturer’s instructions and the ‘cold chain’. (NHMRC 2003)

Vaccines requiring refrigeration should be stored in a designated refrigerator(s). Refrigerator(s) used for storage of vaccines should have their temperatures monitored and recorded at least weekly on a vaccine refrigerator temperature chart

Refrigerators used by staff for food storage should not be used to store vaccines and clinical specimens.

4.4.11 Needle Stick Injury and Other Blood or Body Fluid Incidents

All health care settings must develop their own infection control protocols for communicable diseases, including appropriate action to take in the event of needle stick and other blood or body fluid incidents. Any needle stick injury should be reported to the manager and an incident/injury form completed as soon as possible. The protocols should also include details for prompt reporting, evaluation, counselling, treatment and follow-up of occupational exposures to blood borne viruses.

4.4.11.1 Immediate Management

• If the skin is penetrated, the area should be washed with soap and water (an antiseptic could also be applied). Any affected mucous membranes should be flushed with large amounts of water

• If the eyes are contaminated, the area should be rinsed gently but thoroughly, with water or normal saline while the eyes are open. The Australian Immunisation Handbook (NHMRC 2003) should be consulted for further details

• A medical practitioner must assess if the injury is high or low risk
• The client should be informed of the exposure and followed up with appropriate explanation and counselling.

• The health care setting must maintain confidentiality, and the health and safety protocols should be adhered to, which includes appropriate serologic testing for evidence of:
  - HIV antibody (informed consent required)
  - Hepatitis B surface antigen (HbsAg)
  - Hepatitis C antibody (Anti-HCV)

• Blood samples should be collected as soon as possible after the incident and processed urgently.

• Post exposure prophylaxis may be recommended depending on the circumstances of exposure to HIV.

• The client should be asked for permission to be tested for HIV and Hepatitis B and C. Follow-up blood tests should be provided as necessary. (DHS 1997).

5. QUALITY ASSURANCE

Quality assurance processes within a health care setting should consist of education and evidence based practice, which maintains a high professional standard.

5.1 Accountability of the Women’s Health Nurse

All women’s health nurses are accountable for their practice. In the exercise of this practice, the women’s health nurse will act in such a manner as to enhance the general health and harmony of the community, justify public trust and confidence, enhance the reputation of the profession and safeguard the interests of the client. The women’s health nurse is responsible at all times for their own acts and must function within their scope of practice and parameters within the health care setting.

The credentialling process for nurse Pap test providers in Victoria provides a process based on quality assurance to maintain high standards of practice and also supports reflective practice.

The national standards and the code of ethics and professional conduct for nurses in Australia are available through the Australian Nursing and Widwifery Council [www.anmc.org.au](http://www.anmc.org.au)

5.2 Continuing Education

The women’s health nurse will participate in ongoing, relevant professional education and training that will maintain competencies of practice.

5.3 Client Care Standards

The women’s health nurse will be expected to exercise a reasonable standard of care towards the client. If a women’s health nurse unintentionally but carelessly neglects the duty of reasonable care that he/she should exercise towards the client, this can constitute negligence. (Refer to ‘consumer rights’ in Section One of these guidelines.)

5.4 Client Feedback

Client feedback will be encouraged within the health care setting through various strategies such as client survey forms.
5.5 Investigation of Complaints

Under Section 20 of the Nurses Act 1993, anyone can make a complaint about a registered nurse to the Nurses Board of Victoria. A client under the Health Services Act can complain to the Health Services Commissioner. It is important to note that:

- The health care setting will acknowledge and respond to client complaint(s) within an appropriate timeframe
- Each complaint will be taken seriously and acted upon according to each health care setting’s policy
- The women’s health nurse coordinator/manager will be encouraged to make an initial assessment of any client complaint. Where the complaint involves a question of clinical practice, the appropriate women’s health nurse will be informed of the complaint and appropriate action taken
- Complaints and action taken about the practice of any nurse Pap test provider is monitored as part of the recredentialling process.

5.6 Client Records and Audits

Accurate client medical records are an essential component of client care. The women’s health nurse must keep comprehensive, accurate and legible medical records by law. The medical records will contain objective and factual information and store clinical data for use by the women’s health nurse and other health professionals involved in the client’s management. The confidentiality of the medical records is fundamentally important to the health care setting, the women’s health nurse and the client.

Medical records will be:

- Compiled for each client and contain appropriate clinical information
- Completed by the appropriate health care professional and include documentation about:
  - Each consultation
  - Date
  - Reason for consultation
  - Outcome of consultation
  - Outline of the review process/health care plan
- Contain the name and position (printed) and signature of person making the entry
- Be stored within the health care setting in designated filing cabinets, which will remain locked when the women’s health nurse or other health care professionals are not in attendance. Medical records required for home visits will be transported in a locked cabinet in order to ensure client confidentiality
- Protected and not stored or left in areas where members of the public have unrestricted access.

It is important to note that:

- The women’s health nurse should cross out their inaccuracies in the medical record, initial and date them and enter a marginal note as to the reason for the correction(s) as soon as practicable
- The client may request access to their medical records. This process of access should be a matter of individual negotiation between client, the women’s
health nurse and the health care setting’s policy in line with Freedom of Information Act requirements.

- Information concerning the client contained within their medical records should be released on request to the concerned client according to the health care setting’s specific policies
- If the client requests (preferably in writing) that their medical records should be made available to another medical service, medical practitioner, etc, reasonable consideration should be given to the request. The women’s health nurse should be under no obligation to provide the original record, as the specific health care setting should retain this information. A copy of the client’s record or a health summary should be satisfactory in most circumstances
- Prior to giving out information to clients, in particular over the telephone, the identity of the client should be ascertained. Confidentiality of the client will be maintained over the telephone by the women’s health nurse checking verbally the name and date of birth of the client against the appropriate medical record. Some health care settings may utilise a pass word system and/or issue each client with their medical record number to assist in maintaining confidentiality
- Only the women’s health nurse, general practitioner and authorised staff employed by the health care setting will provide pathology/cytology results and other clinical information contained in client medical records
- Administrative staff will only have access to basic client data recorded on the front of the client’s medical record
- Tracer cards should be utilised when the client’s medical record is removed from the main filing system. Tracer cards (details of where, when and who) should be utilised by the authorised person who removes a medical record from the main filing system
- The health care setting should have an adequate computerised database to maintain accurate client information. Computer passwords should be used to protect unauthorised access to client information.

5.7 Referral

An appropriate referral process will assist the client who requires a referral within the health care setting. In case of emergency or other unusual circumstances, a telephone referral may be appropriate, but followed up as soon as reasonably practicable with written documentation.

The referral to a medical specialist from a women’s health nurse may be coordinated by the client’s nominated general practitioner in consultation with the women’s health nurse. When the client does not nominate a general practitioner, individual health care setting referral policies will guide this referral process.

The referral letters should:

- Be legible (and preferably typed)
- Contain relevant background history
- Contain problem, key examination findings
- Include reason(s) for referral and expectations of referral
- Be on appropriate health care setting stationery.
The health care setting will acknowledge the rights of the client to refuse any treatment, advice or procedure. Refusal by the client to follow the course of action suggested by the women’s health nurse will be carefully assessed and alternative avenues documented. Refusal may not absolve the women’s health nurse of the duty of ensuring the client’s continuing care through appropriate referral to another provider.

The women’s health nurse will acknowledge and, if requested, facilitate the right of the client to seek a further opinion.

5.8 Disposal of Documents

Medical records, according to the Freedom of Information (Amendment) Act 1993 (Vic), need to be retained for a minimum period of seven years. Medical records, if no longer required, will be stored as hard copy or in an electronic media and destroyed by means that ensure no identifiable contents are retrievable. Medical records can only be destroyed according to the binding standards set by the Health Privacy Principles (DHS 2002?) or by other laws such as the Public Records Act 1973 (Vic), which apply to state public sector organisations. Refer to the Public Health Services Patient Information Records General Disposal Schedule, which can be accessed through www.dhs.vic.gov.au/privacy.

5.9 Storage of Pharmaceuticals

The women’s health nurse should comply with the Drugs, Poisons and Controlled Substances Act 1981 (Vic) and the Drugs, Poisons and Controlled Substances Regulations 1995. The Drugs and Poisons Unit (DPU) at the Department of Human Services states that failure to comply with the legislation renders a person liable to prosecution, but compliance with the legislation does not necessarily ensure compliance with other professional standards (DPU 1999).

Storage facilities for Schedule 4 poisons and Schedule 8 poisons must be secure and remain locked to prevent access by an unauthorised person at all times, except when it is necessary to open it to carry out an essential operation in connection with the poison stored in it. The following documents provide summaries of key notification requirements required by health professionals under the Drugs, Poisons and Controlled Substances Act 1981 (Vic), and the Drugs, Poisons and Controlled Substances Regulations 1995.

A nurse (Division 1, 3 or 4) is authorised to possess and administer those S4 or S8 poisons necessary for a patient under the care of that nurse in accordance with the:

- Instructions and authorisation of a medical practitioner (or dentist) for that patient
- Condition of a health service permit issued by the Department of Human Services
- Approval of the Secretary of the Department of Human Services in specified circumstances.

Nurses are not authorised to supply scheduled poisons. Each health care setting is issued with a health services permit and an approved copy of their poisons control plan. Further details are also available on the Victorian Government Health Information website for drugs and poisons on www.dms.dpc.vic.gov.au
5.10 Equipment Maintenance

Medical equipment and resources will be appropriate and adequate to ensure comprehensive primary care. The health care setting will be expected to document their regime for maintenance checks on such items as the steriliser and resuscitation equipment.

5.11 Security

All employees will comply with individual health care setting policies and procedures for employee safety and security.

5.12 Smoking Policy

The women’s health nurse should support no smoking policies within organisations and health care settings.
6. PREVENTATIVE HEALTH CHECKS

6.1 Guidelines for General Consultation by the Women’s Health Nurse

Reason(s) for the client’s presentation to the service often directs the consultation. The depth of enquiry will be greatly influenced by the reason the client has presented and therefore the following points are a consultation guide.

Establish Rapport and Establish Purpose of Consultation

Client Rights

General Health Status
Includes age; relevant medical/surgical history; psychological and psychiatric conditions; history of blood transfusions, body piercing/tattooing; allergies; current non-prescription and prescription medication.

Social/Lifestyle
Includes smoking, alcohol and other recreational drug use; social networks and living conditions; exercise/recreation; diet/weight; sleeping pattern.

Family
Relevant family history includes heart attack/stroke, hypertension, thromboembolic disease, diabetes, breast cancer, ovarian cancer.

Sexual and Reproductive Health History

- Includes risk factors for STIs (sexual behaviours/activities); sexual partner(s), regular and casual; gender of sexual partner(s); last sexual contact with partner(s); type of sexual activity (oral, vaginal, anal, toys); safer sex practices (condoms/dams); overseas sexual contact; sexual difficulties; past history of STIs; history of sexual abuse

- Immunisation status

- Menstrual history, includes: last menstrual period; age of menarche; length of cycle and duration of bleeding; heaviness of flow (number of tampons or pads, degree of soaking, flooding, clots); dysmenorrhoea (onset, duration, distribution, intensity, type of pain, medications); premenstrual symptoms; dyspareunia; abnormal bleeding specifically post coital and intermenstrual bleeding

- Gynaecological and obstetric history, includes number of pregnancies (number of live births, type of delivery(s); miscarriage(s), terminations); discharge; dysuria’ pruritus/lumps/lesions; micturition (continence, cystitis); rectal symptoms

- Breast history, includes last mammographic screening (if in screening group); previous breast problems

- Pap test history, includes date of last Pap test; previous history of an abnormal result

- Contraceptive history, includes current method(s) of contraception; level of satisfaction and possible side effects; correct usage review.

Client Education and Discussion

Health Check(s)
Referral

Document Findings

- Ensure client registration or authorisation form including emergency contact details is completed as per health care setting policies and procedures.
- Ensure a comprehensive sexual history is documented. Sometimes a sexual history proforma is useful and an example is available in Resource C.
- All examinations and clinical findings on examination are clearly documented.

6.2 Pap Test

Cervical cancer is one of the most preventable of all cancers. The Pap test is a reliable form of cervical screening test, although, like all screening tests, it is not 100% accurate. With regular two yearly screening, up to 90% of the most common form of cancer of the cervix can be prevented. Early detection of cervical abnormalities and cancer improves outcomes. Refer to Resource A for the National Policy for the Prevention of Cervical Cancer (CDHFS 1998) and Resource B for the Guidelines for the Management of Asymptomatic Women with Screen-detected Abnormalities (NHMRC 2005).

The national policy provides guidelines on which women need screening and how often Pap tests should be taken. It states:

- Cervical screening should be carried out every two years for women who have no symptoms or history suggestive of cervical pathology.
- All women who have ever been sexually active should commence having Pap tests between the ages of 18 and 20, or one to two years after sexual intercourse, whichever is later. In some cases, it may be appropriate to start screening before 18 years of age.
- Pap tests may cease at the age of 70 for women who have had two normal Pap tests within the last five years. Women over the age of 70 who have never had a Pap tests, or who request a Pap test, should be screened.

The women’s health nurse who provides a cervical screening service (primarily targeting clients who are unscreened or underscreened) cannot work in isolation and will complement the role of the General Practitioner(s) working within the geographical area.

These guidelines apply ONLY to clients who have no symptoms or history suggestive of abnormal cytology. Clients with symptoms require further investigation by the general practitioner irrespective of Pap test result.

Follow Guidelines for ‘General Consultation’

Refer to Section 6.1

Explain

- Incidence and aetiology of squamous cell carcinoma.
- The role of the Pap test, which is to detect pre-cancerous or early cell changes which, if left untreated, may develop into cancer.
- Major risk factors for developing cervical cancer such as human papilloma virus and smoking.
- Limitations of screening, such as false negatives/false positives.
- Reasons for having two-yearly screening.
• Pap test timing (not menstruating, no marked vaginal infection, no vaginal creams/pessaries within the last 24 hours and client preferably more than 12 weeks post-partum)
• Age of commencement and cessation of screening
• New cervical screening technologies (liquid based cytology, computer assisted re-screening, optoelectronic screening such as TruScreen, and HPV DNA testing)
• Clinical procedure for taking the Pap test
• Role of the Victorian Cervical Cytology Register.

Discuss
Discuss the process of Pap test notification with the client during the consultation. It is important to obtain an address or telephone number where the client can be contacted within the subsequent two to four weeks, in case there is an abnormality. The client notification process will include contact:

- With the client regarding the ‘normal’ Pap test result within two to four weeks via the post, over the telephone and/or in person as per the health care setting policy
- Via telephone, mail or other agreed method, if the Pap test result is abnormal. Contact initially via telephone is the preferred method of contact for an abnormal Pap test result. Refer to Resource E for guidelines on the notification of Pap test results (normal and abnormal) (FPV 2005).

Question
• If the woman has experienced a past painful or uncomfortable Pap test and determine why

Provide Written Information as Required, about:
• Cervical screening and the Pap test registry
• New cervical screening technologies (downloaded from the PapScreen Victoria website at www.papscreen.org.au)
• HPV, using the pamphlet or fact sheet from PapScreen Victoria (www.papscreen.org.au).

Document Findings
• Document all details of history-taking assessment (refer to Resource C for a cervical history proforma) and note key cervical screening history feedback such as:
  - Appearance of the cervix (colour, ectropian, atrophy, pus, scarring, nabothian follicles, intra-uterine device strings)
  - Contact bleeding
  - Abnormal vaginal discharges*
  - Any pelvic pain, dysmenorrhoea or dyspareunia*
  - Abnormalities of the cervix, including cervical polyps*
  - Presence of pelvic mass, tenderness or symptoms, which are not in the range of normal*

* These require consultation with a general practitioner for management and referral.
Follow Procedure for Taking a Pap Test

- Refer to Resource G and Resource H
- Prepare all equipment and undertake the Pap smear as per Victorian Cytology Service guidelines contained in Resource F
- Examine the external genitalia
- Insert speculum (disposable or warmed metal speculum)
- Visualise and inspect the cervix and vaginal walls
- Choose appropriate sampling equipment
- Perform the Pap test
- Apply sample to glass slide as per the Victorian Cytology Service guidelines. Refer to Resource F for further details regarding Pap test sampling technique
- Maintain correct sampling and fixation process for conventional Pap test and additional cervical screening technologies if requested.

Regular quality assurance checks will take place to ensure all women are notified of their results

- Adhere to Pap test notification and recall health care setting policy. Resource D and Resource E provide a standardised process for Pap test notification and recall of results.

Consider Special Considerations Such As Pregnancy

- An endocervical brush should not be used in pregnant women and therefore the cervix sampler is recommended.

Postmenopausal women

In some postmenopausal women, due to atrophy, it can be difficult to take an adequate sample of cells for a Pap test, as the squamo-columnar junction can be located within the cervical canal. Vaginal oestrogen cream/pessaries is recommended for 10 to 14 days before the Pap test when a client presents with atrophy of the genital tract. The vaginal oestrogen cream should assist with sampling technique. (Victorian Cytology Service Newsletter 1997).

Hysterectomy

- The National Policy for the Prevention of Cervical Cancer (CDHFS 1998) indicates that the client who has not had her cervix removed after a hysterectomy should continue to have cervical screening at the recommended two-yearly intervals. The client who has had a hysterectomy (cervix removed) should have vaginal vault tests if there has been:
  - A significant abnormality detected on a Pap test
  - A history of invasive gynaecological cancer
  - No Pap test history
- Refer to Resource A for a summary of the national policy, for the indications for cervical screening and vault test for the client who has undergone a hysterectomy.

Vault test

- A vault test should be performed on the client who has been identified as being at a higher risk for the development of vaginal cancer
• A vault test should in general be taken yearly, according to the national policy (Resource A). The cervex sampler is the preferred (use several sweeping motions across vaginal vault).

Uncertainty about presence of cervix

• If the client is uncertain about the type of hysterectomy performed, the women’s health nurse should advise the client to seek the relevant information from their general practitioner and/or the surgeon who performed the procedure.

• If the client’s general practitioner has no record about the type of hysterectomy and has not undertaken further investigations, then the women’s health nurse should undertake a bi-manual examination to establish the presence or not of the cervix. During this examination the women’s health nurse should obtain a baseline Pap test from the vaginal vault or cervix as indicated by the woman’s history.

Lesbians

• Women who have had any sexual activity should be offered cervical screening.

• Any woman, regardless of sexual orientation, requires cervical screening.

• Some studies have indicated an increased prevalence of hepatitis C and bacterial vaginosis and similar rates of abnormal cervical cytology in women who have sex with women. (Fethers et al 2000, Marazzo et al 1998, Ferris et al 1996). Woman to woman transmission of human papilloma virus during sexual activity can be possible and therefore this precipitating factor supports the importance of regular cervical screening for lesbians (O’Hanlan, Crum C 1996). PapScreen’s website www.papscreen.org.au provides cervical screening resources for health professionals and women regarding lesbian issues.

Culturally and Linguistically Diverse Communities

• The way information is communicated and provided will be influenced by client characteristics, cultural background and understanding of spoken and written English. If the client’s first language is other than English, all reasonable steps should be taken to ensure that a qualified interpreter is present during the consultation. The women’s health nurse should be aware that a bilingual staff member, unless appropriately accredited, should not be presumed to have the necessary skills to act as an interpreter. The health care setting should provide access to independent trained interpreters, ideally in person, or via an accredited telephone interpreting service such as the Translating and Interpreting Service (TIS) 131450.

Indigenous Women

• The report Barriers to and Appropriate Delivery Systems for Cervical Screening in Indigenous Communities in Queensland (Kirk et al 1998) identified that many existing services failed to meet the cultural, linguistic and geographical needs of many Indigenous women. The barriers outlined in the report documented that many Indigenous women do not access screening services and do not seek appropriate follow-up care for abnormalities detected. The Principles of Practice, Standards and Guidelines
for Providers of Cervical Screening Services for Indigenous Women (DHA 2004) highlights the lack of culturally safe and culturally effective support and counselling services and outlines five key principles for best practice.

**Women with disabilities**

- All women, regardless of ability, who have ever been sexually active, should have a Pap test every two years.
- A disability impacts not just the physical aspect of sexuality, but also the emotional, psychological and social elements of a woman’s self-image as a sexual being. The lack of access to reproductive health care for women with disabilities has been well documented.
- The report, Screened Out! Women with Disabilities and Cervical Screening (Johnson et al 2002) suggests that women with disabilities have lower rates of cervical screening, due to a range of social barriers and barriers relating to life circumstances and how women see themselves.
- All reasonable steps should be taken to ensure that information provided to women with disabilities is appropriate and accessible and informed consent for the Pap test is obtained. Practitioners should also be sensitive to possible issues relating to sexual abuse.
- A listing of accessible Pap test service providers is available on PapScreen’s website: [www.papscreen.org.au](http://www.papscreen.org.au) or by calling 13 11 20. Searches can be performed for services offering disabled parking, ramped entry, wide doorways, disabled toilets, adjustable beds and hoists.

### 6.2.1 Pelvic Examination/Bi-manual Examination

The bi-manual examination should not be routinely carried out as part of a Pap test. The value of the bi-manual examination is questionable as a screening strategy in view of the low incidence of ovarian cancer in healthy women and the relatively high prevalence (1.5%) of relatively unimportant adnexal abnormalities (Grover & Quinn 1995).

**Indications for Bi-manual Examination**

- Pelvic inflammatory disease (PID)
- STI screening
- Painful intercourse
- Masses
- Assess pelvic floor related symptoms (Gallo, Fallon & Staskin 1997).

**History Taking and Assessment**

- Obtain clear, relevant history.

**Discuss**

- Relevance of bi-manual procedure.

**Explain Procedure**

- For pelvic examination clinical procedures, including bi-manual examination, refer to [Resource F], [Resource G], [Resource H], [Resource I], [Resource J] and [Resource K] for cervical screening.

**Document Findings**
6.3 Preceptorship

6.3.1 Preceptorship Program

Preceptorship during the clinical practice component of the Pap test provider course for nurses is integral to knowledge and skill development. A professional peer (called a preceptor) provides supervision and review of clinical practice for the nurse undergoing the course. Preceptees include:

- Division One Register Nurses who are undertaking an accredited nurse Pap test provider education course throughout Australia
- Other registered nurses who have been accepted for clinical experience in women’s health.

To ensure uniformity, a minimum set of standards for preceptors has been developed by the Cancer Screening Services of the Victorian Department of Human Services (DHS 2004).

The preceptor, a voluntary role, can be either:

- A registered general practitioner with a minimum of 100 hours experience in taking Pap tests
- A Division One Register Nurse who:
  - is a credentialled Pap test provider with the Royal College of Nursing, Australia and has a Victorian Cytology Service ‘User Number’
  - has a minimum of 100 hours experience in taking Pap tests
  - undertakes ongoing professional development
  - has completed a course held in relation to taking a Pap test that is recognised by the Royal College of Nursing, Australia
  - has a letter of support from their employer.

The women’s health nurse requires informed consent for the involvement of the preceptee during client consultations. Ideally the client’s consent is obtained from the client prior to the presence of the third party/preceptee in the consultation room. This process may be regarded as general courtesy, but also enables consent to be openly obtained. When permission has been given by the client, then the women’s health nurse should briefly leave the consultation room to locate the preceptee. The women’s health nurse should introduce the preceptee to the client and state clearly their status and envisaged role throughout the consultation.

6.3.2 Contractual Arrangement

A formal preceptorship arrangement between the health care settings and the training institution/university is required for student clinical supervision or preceptorship.

Further details regarding standards for cervical screening clinical preceptors are available from:

Program Manager
Cancer Screening Services
Department of Human Services
Floor 17, 120 Spencer Street
MELBOURNE VIC 3000
03 9616 7777
6.3.3 Professional Support

Ongoing professional peer support is available through membership of professional bodies such as the Women’s Health Nurse Association of Victoria, Australian Practice Nurses Association and Australian Sexual Health Nurses Association Inc. Formal and informal individual peer support programs provide another option to the women’s health nurse.

6.4 Breast Health and Screening

Breast cancer is the most common cancer in Australian women and the most common cause of cancer death for Australian women. Most of the established risk factors for breast cancer (including increasing age, a previous cancer diagnosis, reproductive history and a genetic predisposition) cannot be modified. Therefore, the potential for prevention is limited, though exercise and preventing obesity is considered valuable. At this stage, early detection remains the major strategy for reducing death and illness from this disease.

6.4.1 Clinical Breast Examination (CBE)

Clinical breast examination (CBE) is not recommended as a screening method for the early detection of breast cancer. CBE as a screening method refers to breast examination by a health professional looking for breast cancer in women without symptoms. It differs from physical examinations used by health professionals to investigate identified breast symptoms.

Systematic reviews have found no direct evidence of the effectiveness of population-based screening with CBE in reducing deaths from breast cancer. No randomised controlled trials have compared CBE to no CBE. Studies comparing the combined effects of mammography and clinical breast examination with the effects of mammography alone as a population-based screening tool have shown no difference in the number of deaths from breast cancer in the two groups after more than 15 years of follow-up. Thus, there is no evidence of any additional benefit of CBE for women who are already attending for regular mammography screening.

For women who are not participating in regular mammographic screening, regular CBE may offer some benefit.

CBE should only be carried out by the women’s health nurse who is competent in this technique and clear about boundaries of practice. The women’s health nurse must have undergone specific training in CBE.

Follow Guidelines for ‘General Consultation’

Refer to Section 6.1

History Taking and Assessment

Discuss

• Normal breast changes (hormonal, pregnancy)
• The importance of breast screening in detecting early signs of cancer
• Recommendations for screening mammography, which include:
  - Women aged 50 to 69 years are encouraged to have a free mammogram every two years through BreastScreen (ph: 13 20 50)
- Women aged over 40 years may choose to attend BreastScreen
- Women aged over 70 years may choose to continue having free mammographic screening through BreastScreen
- Mammography is not recommended for women aged less than 40 years

Risk factors for breast cancer include increasing age, previous breast cancer and a strong family history. High-risk women can discuss relevant screening options with their general practitioner. These may include:
- Annual mammograms
- Breast ultrasound
- Regular clinical breast examinations by a general practitioner

The importance for each woman to be ‘breast aware’ by familiarising herself with the normal look and feel of her breasts. Women should be encouraged to see a doctor if they notice any unusual changes, including:
- A lump, lumpiness or thickening in the breast or armpit
- Skin changes: dimpling, puckering or redness
- Changes in the nipple: inverted, a change in direction or unusual discharge
- An area that feels different from the rest
- Unusual pain.

**Explain Procedure**
- For clinical breast examination procedure, refer to Resource L. Resource M provides a clinical breast examination sheet proforma, which may be included in the client’s medical records.

**Document Findings**
- The women’s health nurse should:
  - Map all breast changes in the client’s medical records. The clinical breast examination proforma in Resource M may be useful.
  - Document all breast health education (including leaflets) provided. It may be appropriate to provide written information in different languages or in an appropriate medium for some clients with disabilities or where English is not their preferred language.

The latest national and international evidence with breast cancer is available at www.breasthealth.com.au (consumer friendly website), the National Breast Cancer Centre (NBCC) at www.nbcc.org.au, or The Cancer Council Australia at www.cancer.org.au

The National Breast Cancer Centre provides free clinical newsletter research updates via the e-alert.

**6.4.2 Breast Awareness**
- There is no evidence according to World Health Organization that the promotion of breast self examination (BSE) has any benefits in terms of reducing deaths from breast cancer. Women are encouraged to know the normal look and feel of
their breasts and to report any changes to their general practitioner as soon as possible (Clark 1997).

● In Australia, even with a fully established mammographic screening program, more than half of all breast cancers are found by the woman or her general practitioner after noticing a change in the breast (NBCC 1999). Although screen detected breast cancers are typically smaller, the majority of non-screen detected breast cancers are found at an early stage and treated conservatively. This supports efforts to promote early detection beyond the mammographic screening program.

● It is recommended that women (regardless of whether they attend for mammographic screening), are aware of how their breasts normally look and feel and report any new or unusual changes promptly to their general practitioner.

● The women’s health nurse should talk to the client about being breast aware. The following suggestions may help (not based on evidence that they will reduce breast cancer risk or mortality) and include encouraging the client to feel:
  - The breasts from time to time and view them in the mirror. It should only take a few minutes and could be done while in the shower or bath, while dressing, or while lying down
  - The breast tissue, from the collarbone to below the bra line, and under the armpit
  - Near the surface and deeper in the breast with the flats of the fingers and the finger pads.

● The women’s health nurse will:
  - Facilitate open discussion with the client regarding breast concerns
  - Document all health education provided
  - Refer a woman to a general practitioner without delay if they notice any unusual breast changes
  - Inform the woman of the range of tests that maybe needed to investigate the breast change(s).

6.5 Screening for Sexually Transmissible Infections (STIs) for Asymptomatic Women

The women’s health nurse with appropriate training and supervision can provide STI counselling and asymptomatic screening in line with specific policies for the health care setting. The women’s health nurse must have current knowledge of STIs and have a sensitive and non-judgmental approach to provide effective STI counselling and screening.

Follow Guidelines for ‘General Consultation’
Refer to Section 6.1

History Taking and Assessment

● The sexual history should include:
  - Last sexual contact with a regular or casual partner
  - Relationship duration
  - Number of sexual partners and risks of sexual partners over the last six to 12 months. Record
sexual practices (oral, anal, etc.) including barrier usage (always, never, inconsistent)

- Sexual orientation (Don’t presume a client’s sexual orientation and therefore questions need to be open ended such as ‘Have you ever had sex with a woman/man?’)

- Recent overseas travel in an area with a high prevalence of HIV and enquire about sexual activity

- Possible symptoms that indicate an STI

- Explore contraceptive history

- Explore medical/surgical/obstetric/immunisation history.

• Explore client’s STI risk factors such as:
  - Alcohol and drug usage
  - Previous STIs
  - Pregnancy risk and history
  - Hepatitis status
  - Risk for blood-borne viruses.

• Appropriate test(s) should be determined on STI risk factors.

Discuss

• Risk factors for transmission of STIs: past history of intravenous drug user, sexual contact with an intravenous drug user, blood transfusions, tattoos, sex overseas, homosexual/bisexual contact, sex with commercial sex worker, sexual contact with carrier of HIV, hepatitis B, hepatitis C or other STI

• Sexual concerns such as issues around sexuality, previous sexual assault, domestic violence

• Strategies for safer sex practices. Refer to Section 7.1.9 for further information on barrier methods of contraception and safer sex practices

• Confidentiality

• Costs associated with pathology test(s)

• Three to six months window period with testing

• Follow up for results.

Provide Health Education

• Incidence, transmission, symptoms, diagnosis and indications for testing and treatment of common STIs. It is important to note that chlamydia is the most common sexually transmissible bacterial pathogen in Australia and if often asymptomatic. As many as 70% of women with chlamydia may be asymptomatic (Dayan 2000)

• Importance of hepatitis B vaccination. Refer to resource D for STIs for the hepatitis B vaccination authorisation Proforma

• Safer sexual practices:
  - Barriers and lubricant usage
  - Assertiveness
  - Abstinence and alternative forms of pleasuring
  - Relevant lifestyle changes, which may be adopted to help prevent the transmissions of STIs. Refer
Provide an STIs Clinical Examination

- Follow clinical practice guidelines for general consultation and pelvic examination contained in Resource E and Resource F for cervical screening.

- Undertake a thorough pelvic examination specifically noting abnormalities of the vulva; vagina and presence of any abnormal discharge; cervix or any tenderness on rocking, and/or any adnexal mass or tenderness (describe size and consistency).

- Take specimen(s) appropriately according to health care setting protocols and procedures for pathology collection.

- If a Pap test is required, then this usually done before the STI screening.

- If a client is asymptomatic, but clinical signs of infection are identified on examination, consult with the general practitioner for advice on further management. Refer to Resource N on the protocols for management of a client who presents with symptoms or a history that indicates possible STIs.

- For HIV counselling, the women’s health nurse must have attended an accredited HIV counselling course. Details of the accreditation program in HIV Antibody Test Counselling (hepatitis C related issues included) are via course co-ordinators at Melbourne Sexual Health Centre or La Trobe University.

Asymptomatic STI Pathology

Depending on the health care setting protocols, an STI screen may include:

1. Blood tests syphilis serology; hepatitis B and C (if direct risk such as intravenous drug user); HIV antibody test.

2. Endocervical swabs (urine sample can also be done) endocervical swab for chlamydia (PCR); endocervical swab for gonorrhoea.

3. High vaginal swab trichomonas vaginalis (swab taken from the posterior fornix and placed in bacterial transport medium) (Donovan et al 1998).

Refer to Resource N for an example of a protocol for the case management of the client who presents with symptoms or a sexual history that may indicate possible STIs. If the client is asymptomatic, a first pass urine specimen for PCR chlamydia may be indicated, but a speculum examination facilitates visual inspection of the genitalia.

Chlamydia specimen for PCR may include:

- Urine
  - The first 20ml of any voided urine is collected into sterile urine container
  - The client should not have urinated for two hours prior to the test (male or female)
  - Store/transport at room temperature
• Endocervical sample
  - Insert endocervical swab from the PCR kit into cervical canal (leave in canal for approximately fifteen seconds) and rotate swab for two full turns for approximately 15 seconds
  - Withdraw endocervical swab without touching any vaginal surfaces and place into collection container (Garland et al 1997).

Document Findings

Provide Appropriate Pamphlet(s)

Assess the Need for Follow-up Screening

• Discuss the implications of positive results such as medical, psychological and social
• Discuss the importance of notification and contact tracing.

Referral

• For a client who is both asymptomatic and does not exhibit clinical signs of infection, consult with a general practitioner to confirm the appropriate testing and documentation on a pathology request form under Department of Human Services guidelines
• Consult and refer to general practitioner if the client is symptomatic for further management
• Refer to Resource N and Resource O regarding protocols for the management of the client who presents with symptomatic or asymptomatic history or clinical signs and symptoms of STIs and/or vaginal discharge.

Arrange Follow-up Appointment or Other Option(s) for the Client to Obtain Results

• Ensure client understands the importance of how to obtain test results
• The Health (Infectious Diseases) Regulations 2001 replaced the outdated legislative provisions relating to notification of STI. Notification is vital in efforts to prevent or control the spread of infection. Information is available on the Victorian Government website under ‘Public Health’ www.health.vic.gov.au. It provides information about what to notify, how to notify and privacy legislation.

Refer to

• The National Management Guidelines for Sexually Transmissible Infections (SHSV 2002) for an outline of current guidelines for the screening of STIs.
• The Melbourne Sexual Health Centre website www.mshc.org.au for a copy of these STI guidelines. This website provides detailed policies and procedures for the women’s health nurse. It includes a section called ‘making a diagnosis’ which provides clinical hints for diagnosing some of the more common genital infections, suggestions for specimen collection for laboratory diagnosis and links to specific treatments and other aspects of management. It also includes women’s health nurses’ resources, notification forms and fact sheets for doctors. Patient information in other languages, pamphlets and many useful links to other websites are available.
7. CONTRACEPTION

7.1 Methods of Contraception


Refer to www.ippf.org for a copy of the IPPF Medical and Service Delivery Guidelines. This newly updated publication offers evidence-based guidance on a range of sexual and reproductive issues, including family planning. The selected practice recommendations for contraceptive use is one of the World Health Organization’s two evidence-based guidelines on contraceptive usage. The document provides guidance on the safe and effective use of a wide range of contraceptive methods, and is the companion guideline to WHO’s Medical Eligibility Criteria for Contraceptive Use. These guidelines can be downloaded from www.who.int/reproductive-health/publications/mec

The World Health Organization has attempted to classify the medical eligibility criteria of contraceptive methods into four classes.

**WHO 1** – method is always usable and has no associated risk

**WHO 2** – method is broadly usable and benefits outweigh risk

**WHO 3** – method may be used with caution as the risk may outweigh the benefit

**WHO 4** – unacceptable health risk.

7.1.1 Combined Oral Pill (COP)

The combined oral contraceptive pill (COP) contains the synthetic versions of two female sex hormones, oestrogen and progesterone. There are three types of COP: monophasic, biphasic and multiphasic.

The women’s health nurse is not authorised to prescribe medications under the Victorian Health (Drugs and Poisons) Regulation 1995, but can provide ongoing oral contraception providing that:

- There are ongoing written orders from the general practitioner
- The client has been initially assessed and prescribed hormonal contraception by a general practitioner
- The women’s health nurse clinical practice guidelines on the combined oral contraceptive pill and the progestogen-only pill are adhered to

Follow Guidelines for ‘General Consultation’
Refer to Section 6.1

History Taking and Assessment
• Obtain clear, relevant history
• Determine client’s current level of knowledge about contraceptive options
• Check blood pressure.

Discuss

Indications
• Choice
• Motivation
• Benefits from one or more of the ancillary protective health effects of COP usage
• No contraindications.

Effectiveness
• If taken according to instructions, the COP has a failure rate of about 0.1% for the ‘perfect’ user (misses no pills and follows instructions perfectly) (Wysocki 1998). Therefore, only about 1 in 1000 women is expected to become pregnant within the first year. Since the efficacy is so user-dependant, the ‘typical’ use of the COP is 95% effective (Trussell & Kowal 1998).

Mode of COP action
• Ovulation suppression
• Thickening of cervical mucus to prevent sperm from entering the uterus, and
• Alteration of the endometrium to prevent implantation.

Advantages
• Continuous contraceptive coverage if used according to correct instructions and is reversible
• High efficacy if used correctly
• Increases protection from cancer of the uterus and ovaries
• Improvement in many menstrual symptoms:
  - Menstrual periods will be regular
  - Menstrual periods may be lighter and shorter
  - Menstrual period pain may be reduced
  - Cycle control and flexibility
• Can help improve acne (if present)
• If there are no contraindications and with annual follow up, it can be used by clients up to menopause.

Absolute Contraindications (WHO 4 Classification)
• History of thrombo-embolism, cerebrovascular or coronary artery disease
• Known thrombogenic mutation
• Systolic blood pressure ≥ 60 or diastolic ≥ 100
• Breast malignancy
• Focal migraines (migraine with aura) with neurological symptoms
• Migraine requiring ergotamines
• Smoker ≥ 15 cigarettes per day if over 35 years of age
• Active liver disease (use in mild well controlled hepatitis B and C is possible)
• Lactation ≤ six weeks post partum
• Prolonged immobilisation.

**Strong Relative Contraindications (WHO 3 classification)**
- Postpartum < 21 days
- Lactation during the six weeks to six-month period
- Smoker (< 15 cigarettes per day) who is over the age of 35 years
- BP: systolic 140–159 or diastolic 90–99
- Treated hypertension where BP is < 140 systolic and < 90 diastolic
- Migraine without focal neurological symptoms > 35 years
- Suspected pregnancy
- Past history of breast cancer with no recurrence in five years
- Liver enzyme inducing drugs
- Gall bladder disease, (untreated or medical management)
- Severe hyperlipidaemia.

**Relative contraindications (WHO 2)**
- Severe headaches starting with pill and non-focal migraine < 35 years
- Age > 40 years
- Smoking and < 35 years
- Body mass index > 30
- Diabetes < 20 years duration and no vascular disease
- > Six months post partum & breast feeding
- Hypertension of pregnancy
- Major surgery without prolonged immobilisation
- Superficial thrombophlebitis
- Mild hyperlipidaemia
- Family history of hyperlipidaemia and early myocardial infarctions
- Uncomplicated valvular disease
- Cervical intraepithelial neoplasia (CIN) and dysplasia
- First degree relative with a past history of thromboembolism.

**Disadvantages**
- Transient side effects during the first three months should be discussed with the client (referral back to general practitioner if symptoms persist), and include:
  - Breast tenderness
  - Nausea or vomiting
  - Bleeding or spotting between periods, especially in the first two months of pill taking (called break-through bleeding)
- Decreased libido
- Mild headaches
- Skin problems (acne, hirsutism, chloasma)
- Slow weight gain
- Amenorrhoea/absence of withdrawal bleed

- Major side effects:
  - Cardiovascular
  - Gastrointestinal
  - Cancer
- A client requires high motivation to remember to take the pill every day
- In rare cases, a client may suffer serious side effects (Weisberg 1997).

**Side Effects**
- Oestrogenic, progestogenic and androgenic effects.

**Health Education and Counselling**
- Provide the client who is starting the COP regime information on:
  - Seven-day rule
  - Events that reduce the effectiveness of the COP (forgetting the pill more than 12 hours, diarrhoea, vomiting and some medications, including St John’s Wort)
  - The theoretical advantage of low dose COP such as loette and microgynon 20 ED

- Emergency contraception
- Barriers methods of contraception to protect against STIs
- Baseline observations
- Possible side effects
- Follow up (Guillebaud 2004).

**Women’s Health Nurse COP Guidelines**
- Ongoing preventative health checks
- Check for absolute and relative contraindications and notify general practitioner if any changes in clinical status or assessment
- Take or check the sexual health assessment and follow up with individualised counselling, reflecting any specific contraindications or issues
- Discuss the types of COP
- Use sample material such as a COP packet to guide and instruct the client on effective pill administration procedures
- Discuss advantages, disadvantages and possible side effects of COPs
- After the first, but before completing the fourth cycle of pill use, check blood pressure and weight. Check for any side effects and re-emphasise correct pill taking. Discuss advantages of tricycling packets (client continuously takes the active COP pills during a three-month period, and thereby skips the inactive pills for this period)
• All women during the reproductive age group should be advised to take a folate supplement. It is recommended by the National Health and Medical Research Council and Public Health Association that a 0.4-0.5 mg supplement up to the twelfth week of pregnancy should be taken by women in this target group (Mazza 1999)

• Advise the client on the safer sex message and encourage regular cervical screening.

If a general practitioner is available within the health care setting, the women’s health nurse will:

• Check that the client has been initially assessed by a general practitioner working within the health care setting as a suitable candidate for oral contraception
• Elicit any problems with side effects and discuss possible complications
• Record findings and ensure signed authorisation as per health care setting policy is completed for ongoing contraception
• Recommend to the client that she needs to be reviewed by a general practitioner at least yearly whilst on COP.

7.1.2 Progestogen-only pill (POP)
The progestogen-only pill, also known as the mini-pill, is an oral hormonal contraceptive containing only progestogen.

Follow Guidelines for ‘General Consultation’
Refer to Section 6.1

History Taking and Assessment
• Obtain clear, relevant history
• Determine client’s current level of knowledge about contraceptive options
• Check blood pressure.

Discuss
• The POP may be suitable contraception in women who:
  - Choose this low dose method
  - Have had oestrogen-related side effects or complications such as nausea, weight gain, headaches
  - Are breastfeeding where the baby is older than six weeks
  - Are needing immediate post-partum contraception and are not breastfeeding
  - The POP may be suitable contraception, but requires discussion with a general practitioner, in women over 35 years of age who smoke and have hypertension plus other cardiovascular disease, migraine with aura, liver disease, previous thromboembolism, or prolonged immobilisation (Guillebaud 2004).

Effectiveness
• Highly effective with a failure rate of 0.03 to 4% depending on study. However the efficacy is slightly less than that of COPs, especially in younger
women. In the first year of use, the probability of pregnancy among typical users is 5%

- Under perfect use, only 0.5% of women would become pregnant. In lactating women, the POP is nearly 100% effective because of the contraceptive effect of breastfeeding. The POP’s efficacy is similar in breastfeeding clients to women 35 to 40 years of age on COPs (Weisberg 1999).

**Mode of POP action**

- The POP may prevent pregnancy by changes in:
  - Cervical mucus – thickens cervical mucus
  - Endometrium and tubal mobility
  - FSH/LH feedback (may cause anovulation and in some cases interferes with luteal phase).

**Advantages**

- If there are no contraindications, and with regular follow up, the POP can be used until menopause
- Effective after 48 hours of commencement of first tablet
- Can be started anywhere in the cycle
- Suitable for clients who have had side effects from the oestrogen component of COPs
- Can often be used when oestrogen is contraindicated
- Unlikely to affect lactation.

**Absolute Contraindications (WHO 4 classification)**

- Breast cancer.

**Strong Relative Contraindications (WHO 3 classification)**

- Lactation < 6 weeks
- Current thromboembolic disease
- Develops cardiovascular disease, migraine with aura, or thromboembolism whilst using the method.
- Liver enzyme inducing drugs
- Acute liver disease with abnormal liver function tests.

**Relative contraindication (WHO 2)**

- Women with undiagnosed abnormal vaginal bleeding
- Women with past history of ectopic pregnancy
- Hypertension
- Multiple risk factors for cardiovascular disease.

**Disadvantages**

- May cause changes in menstrual bleeding such as:
  - Spotting between menstrual periods
  - Irregular pattern of menstrual periods
  - Prolonged menstrual periods
  - Amenorrhoea
- Must be taken at the same time daily (or within three hours).
Breastfeeding and POP

- Ideally, the client should wait till the sixth week post-partum before commencing the POP. However, there are some clients who will want to commence earlier because of their concern about preventing pregnancy (Weisberg 1999).

Women’s Health Nurse POP Guidelines

- Provide the client with appropriate counselling before and after selecting POP
- Take or check the sexual health history and follow up with individualised counselling, reflecting any specific contraindications or problems noted
- Provide instructional material such as a sample POP packet when informing the client about usage. Encourage the client to repeat the basic POP instructions in order to check for correct understanding
- Provide advice about precautions to be taken if the POP is missed greater than three hours
- Discuss advantages, disadvantages and possible side effects
- Discuss the best time to take the POP, with consideration given to normal sexual pattern
- Advise the client to consult a health care setting if pregnancy is suspected, if she has further questions regarding use of the POP, or if she experiences any unusual side effects.

Follow-up

- Three months after starting the POP, the client should return for a check-up to monitor blood pressure and weight. Re-emphasise correct pill taking and discuss any problems she has with the POP
- If the client has been amenorrhoic for two to three months, a urine pregnancy test should be performed
- Advise the client to return for an annual examination with the general practitioner
- Advise that acute vomiting and/or diarrhoea interferes with the effectiveness of the POP. In these cases, the use of additional contraceptive protection for at least 48 hours after the last episode may be required.

7.1.3 Emergency Contraception

When discussing contraception methods with the client, the women’s health nurse should highlight the availability and importance of emergency contraception (ECP). ECP should be discussed with all clients who are at risk of pregnancy. Since January 2004, ECP has been available over the counter at pharmacies throughout Australia.

Follow Guidelines for ‘General Consultation’

Refer to Section 6.1

History Taking and Assessment

- Obtain clear, relevant history
- Explore level of knowledge about emergency contraception.
Discuss

- Indications for emergency contraception – sexual contact at a time in the cycle when conception is possible
- Progestogen-only as the preferred regime. In July 2002 the first commercially packaged post-coital regime (Postinor-2) was released in Australia
- Different forms such as:
  - ‘Progesterone-only’ or Levonorgestrel method
  - ‘Combined pill’ or Yuzpe method
  - Copper intrauterine device (IUCD) within five days of unprotected sexual intercourse or estimated day of ovulation (Foran 2002).

Effectiveness

- Progesterone only – 83% (Trussell, Rodriquez & Ellertson 1998). Shown to be up to 95% effective when used in the first 12 hours (Von Hertzen et al 2002)
- Yuzpe – 75% (Hertzen & Van Look 1998)
- Intrauterine device – 99% (Trussell, Rodriquez & Ellertson 1998).
- Both hormonal methods are most effective when given as soon as possible after unprotected intercourse, and effectiveness decreases as time elapses (Foran 2002).

Contraindications

- The World Health Organization and the International Planned Parenthood Federation have stated that there are no absolute contraindications for ECP. The use of the levonorgestrel method is preferable for women with a past history of venous or arterial thromboembolism or with complicated migraine present at the time of request for post-coital contraception.

Mode of oral emergency contraception action

- Action depends on the stage in the cycle at which it is taken. For example, if the emergency contraception is given:
  - Before ovulation, it appears to delay ovulation in that cycle
  - After ovulation, it may prevent implantation of the blastocyst.

Levonorgestrel only method

Two doses of 750 micrograms of levonorgestrel 12 hours apart (manufacturer’s advice), but new evidence has been published that supports the use of a single dose of two tablets (1.5mg levonorgestrel) as equally effective and can be taken up to 120 hours after unprotected sex. This is the Family Planning Victoria recommendation.

An alternative, where cost is a consideration, is:

Two doses of 25 microval/microlut tablets 12 hours apart (25 minipills are equivalent to a dose of 750 micrograms of levonorgestrel) and commenced within 72 hours of unprotected intercourse.
Advantages of Levonorgestrel Method (Postinor-2)

- Nausea and vomiting are uncommon (routine cover with anti-emetics is not indicated)
- Can be 95% effective in preventing a pregnancy if taken in the first 24 hours. Its effectiveness decreases to around 85% when taken between 24 and 48 hours, and when taken 48–72 hours afterwards, the effectiveness falls to 58%. There is some effectiveness for up to five days after unprotected sex (Von Hertzen et al 2002).

Disadvantages

- May experience disturbance in the pattern of subsequent menses
- May be a more suitable alternative in breastfeeding women who require emergency contraception (Guillebaud 2004).

Yuzpe method

This method entails 100 ug ethinyl oestradiol and 500 mg levonorgestral (four tablets of either Nordette or Microgynon 30 ED or five tablets of Loette or Microgynon 20) and commenced within 120 hours of unprotected intercourse. Dose is repeated 12 hours later (prescribed with an anti-emetic (10 mg maxalon/5 mg stemetil), and begun within 120 hours of intercourse (Guillebaud 2004).

Disadvantages

- Nausea (50% of users) and vomiting (20% of users)
- Disruption of menses (normal occurrence of menses – 60%, early menstruation – 30% and late menstruation – 10%)
- Breast tenderness (Trussell, Rodriquez & Ellertson 1998)

Women’s Health Nurse Emergency Contraception Guidelines

- The women’s health nurse will consult with the general practitioner for authorisation of ECP. Please refer to attached ECP authorisation form in Resource Q for contraception and Resource R for the women’s health nurse protocol for emergency contraception
- The client should return to the health care setting for a pregnancy test after the levonorgestrel-only method if:
  - Period is delayed for more than one week
  - Bleeding is lighter than usual or intermittent
  - There is pelvic pain
  - ECP was given more than once in a cycle
  - Hormonal contraception was commenced immediately
  - The woman develops symptoms suggestive of an STI
  - STI screening may be indicated. (It is often pragmatic to screen for chlamydia at the time of presenting for ECP as there is a high non-attendance rate for review.)
### 7.1.4 Depo Provera

Depo provera (DMPA) is a long-acting progestogen-only injectable contraceptive containing 150 mg medroxyprogesterone acetate in a 1 ml solution. It is an intramuscular injection (do not massage deltoid or gluteal muscle injection site) every 12 weeks, plus or minus seven days.

**Follow Guidelines for ‘General Consultation’**

Refer to Section 6.1

**History Taking and Assessment**

- Obtain clear, relevant history
- Explore client’s current level of knowledge about DMPA and other forms of contraception
- Check blood pressure.

**Indications**

- The client with:
  - Lactation
  - Oestrogen-related side effects
  - Non-compliance issues with regards to remembering the oral contraceptive pill
  - Malabsorption syndrome
  - Menstrual problems that have been appropriately investigated.

**Effectiveness**

- Highly effective with a pregnancy rate between 0.1–0.6% in the first year of use (Guillebaud 2004).

**Mode of action of DMPA**

- Prevention of ovulation by suppression of hypothalamic pituitary ovarian axis
- Changes in cervical mucus, making it more impenetrable to sperm
- Changes in the endometrium, making it unsuitable for implantation.

**Advantages**

- Long acting, coitus independent, effective contraception
- Reduction in menstrual loss, anaemia prevention
- Suitable for use if oestrogen not tolerated
- Unlikely to affect milk production or quality
- Can be used to treat clients with menstrual problems
- May be used in some situations where oestrogen is contraindicated.

**Disadvantages**

- Cannot be rapidly reversed
- Menstrual disturbance and initially, bleeding may be irregular and spotting is common, but heavy bleeding is rare
- Delay in fertility return; it may take up to 18 months for regular menses to return
- Weight gain, which is variable, relates to appetite
- PMS-like symptoms, such as headaches, mood changes, bloating
• Decreased libido

• There is controversy about the effect on bone density and whether long-term use that suppresses baseline oestradiol levels results in loss of bone density (Weshoff 2002). Currently, the World Health Organization recommends that women who are aged 18 to 45 years can use DMPA without restriction (WHO Category ‘1’). For women aged less than 18 or greater than 45 years, the benefits of using DMPA and NET-EN generally outweigh the known or theoretical risks (WHO Category ‘2’).

**Contraindications**

*Absolute Contraindications (WHO 4)*

• Breast cancer

*Strong Relative Contraindications (WHO 3)*

• Lactation < six weeks
• Current thromboembolic disease
• Past history of cardiovascular disease
• The woman develops migraine with aura, or thromboembolism whilst using the method
• Multiple risk factors for cardiovascular disease
• Hypertension with systolic ≥ 160 or ≥ 100
• Women with undiagnosed abnormal vaginal bleeding relative contraindication (WHO 2)
• Hypertension, systolic 140–159, diastolic 90–99
• Liver enzyme inducing drugs
• Past history of DVT.

**Instructions on use**

*First injection of DMPA*

• During first five days of menstrual cycle – no additional contraceptive cover required

• Any time of cycle if pregnancy can be confidently excluded

• Preferably four weeks post-partum (can be used in breastfeeding), but ensure lochia has ceased

• Contraception sustained for 12–14 weeks.

*Late administration of DMPA*

• If it is more than 13 weeks from the first injection and the client wishes to continue DMPA use, it is important to exclude pregnancy

• If intercourse has occurred within the last three weeks, the client should be advised to use condoms or a POP for three weeks from the last unprotected intercourse, prior to having a pregnancy test

• If the test is negative (intercourse has not occurred in the last three weeks) DMPA may be prescribed by the general practitioner.

*Repeat injections of DMPA*

• The women’s health nurse can administer DMPA if the authorisation sheet has been completed by a general practitioner. Please refer to resource C for contraception for a sample DMPA authorisation sheet (requires adequate medical practitioner back up and support)
Preventative health checks

A relevant and clear client history must be undertaken prior to administration of DMPA

Blood pressure checked annually and their weight recorded at each repeat DMPA injection (Guillebaud 2004)

DMPA can be administered up to one week early and one week late to maintain efficacy

Reviewed annually/PRN by a general practitioner.

Women’s Health Nurse DMPA Guidelines

The women’s health nurse will consult with the general practitioner for DMPA authorisation (Refer to Resource S for contraception copy of DMPA authorisation form)

General practitioner to be consulted if:
- Client/women’s health nurse requests
- Bleeding heavier than a period or like a period but more often than monthly
- Spotting more than 20% of days
- Excess weight gain of four kilograms or more
- More than 13 weeks have elapsed since last dose (Kaunitz 2002)
- Changes in clinical status or assessment

Management of bleeding problems:
- Reassurance and explanation – 50% of clients will be amenorrhoeic at 12 months
- Treatment of irregular bleeding is rarely needed
- General practitioner to be consulted for all abnormal bleeding problems. Bleeding is usually due to endometrial atrophy and it will usually respond (although this practice is unlikely to make any long-term difference to bleeding) to daily prescribed dose over 21 days of:
  - 1.25 mg conjugated oestrogen (premarin) or
  - Combined oral contraceptive pill.

7.1.5 Implanon

Follow Guidelines for ‘General Consultation’
Refer to Section 6.1

Provide Appropriate Pamphlets and Information

- Guillebaud (2004) provides adequate information regarding subdermal implants such as implanon

Discuss

- Plastic subdermal rod contains a progestogen which is released into the bloodstream over three years
- Insertion (40 mm x 2 mm rod inserted by an applicator into the upper arm under local anaesthetic) usually day one to day five of the client’s natural cycle

Indications

- The client with contraindications to oestrogen (smoker over 35 years of age, epilepsy on medication affected by oral contraceptives, migraine, hypertension)
**Effectiveness**

- Effectiveness is less than 0.1% pregnancy rate (Guillebaud 2004).

**Mode of action of DMPA**

- Primarily works by ovulation inhibition but also has cervical and endometrial effects.

**Advantages**

- Is a long acting, coitus independent, very effective contraception
- Is suitable for use if oestrogen contraindicated or not tolerated
- Provides long lasting contraceptive cover
- Is cheap.

**Disadvantages**

- Changes in menstrual pattern
- Unpredictable vaginal bleeding may occur from complete amenorrhoea to frequent and/or prolonged bleeding.

**Refer to general practitioner Who Is Specifically Trained to Insert Implanon**

- Organon (Australia) Pty Limited provides health education resources and training in insertion and removal of implanon across the state. For further information see [www.organon.com.au](http://www.organon.com.au)

7.1.6 *Intrauterine Devices (IUD)*

**Follow Guidelines for ‘General Consultation’**

Refer to Section 6.1

**Provide Appropriate Pamphlets**

**History Taking and Assessment**

Provide information and discuss attitude to pregnancy, advantages and disadvantages, and procedure for fitting, checking and follow-up appointment.

**Discuss**

**Indications**

- The client who:
  - Has completed her family
  - Wishes to space pregnancies
  - Is unable to use steroidal contraception
  - Wishes to use for emergency contraception.

**Effectiveness**

- Failure rate of a consistent diaphragm user (perfect users) within one year would be 4–8% in the first year, but range in the world literature is 6–20% (Guillebaud, 2004)

**Mode of action of IUD**

Various hypotheses include:

- Sterile inflammatory response of uterine lining
- Reduces the number and viability of sperm reaching the egg
- Reduces fertilisation of the egg
- Impedes movement of eggs into the uterus
- Types of IUDs
Advantages
• Readily reversible
• Discreet
• Cheap
• Compliance is not an issue post-insertion.

Disadvantages
• No protection against STIs
• Client advised to check strings after each menstruation
• Copper IUDs may increase period pain and cause heavier menstrual bleeding.

Demonstrate IUD Fitting Procedure Utilising the Pelvic Model

Provide Appropriate Pamphlets
• Ensure client has appropriate written information.

Documentation
• Refer to general practitioner if client requests IUD insertion.

7.1.7 Sterilisation (Female/Male)

Follow Guidelines for ‘General Consultation’
Refer to Section 6.1

Provide Appropriate Pamphlets

Discuss
• Reason for request
• Permanency of procedures

Advantages
• Both partners’ feelings about male and female sterilisation and dispel any myths
• Other siblings in the relationship and extended family.

Indications
• The client who has completed her family or has medical problems which are incompatible with pregnancy.

Effectiveness
• The lifetime failure rate is about 2:2000 (CREST ‘model’ using Filshie clip method for women) compared to 1:2000 (vasectomy) for men (Guillebaud 2004).

Mode of Action of Sterilisation

Advantages
• Permanent
• No effects on menstrual cycle or sexual functioning
• Discreet.

Disadvantages
• Not readily reversible
• A surgical procedure that carries risk of complications
• Requires specialist referral.

Documentation
• Refer to general practitioner if requested or requesting a referral. The client needs to be
referred to a gynaecologist specially trained in this procedure

- For further reading on sterilisation, refer to the RCOG evidence-based guideline available online from RCOG website [www.rcog.org.uk](http://www.rcog.org.uk)

7.1.8 Barriers (Diaphragm/Cap)

**Follow Guidelines for ‘General Consultation’**

Refer to Section 6.1

**History Taking and Assessment**

- Provide information and discuss:
  - Failure rate: in a consistent diaphragm user (perfect users), failure within one year would be 4–8% in the first year, but the range in the world literature is 6–20% (Guillebaud 2004)
  - Attitude to pregnancy
  - Advantages and disadvantages
  - Procedure for fitting, checking and follow-up appointment.

**Discuss**

- The clinical procedure for a bi-manual examination as per [Resource K](#) for cervical screening
- Types of diaphragms: coil, arcing spring
- Types of caps: Dumas, Prentif and Vimule
- Importance of additional spermicide to be inserted into the vagina via an applicator if the diaphragm has been in situ for more than three hours prior to sexual intercourse
- Instructions for use (the diaphragm should be left in place for a minimum of six hours after sexual intercourse; the diaphragm needs to be inserted every time prior to sexual intercourse)
- Care and storage of barrier
- Emergency contraception
- Cost
- Trial diaphragm (approximately one week prior to follow-up)
- Diaphragm check approximately every year with regular use and advise on occasions when to seek an earlier review such as:
  - Increase or decrease in weight by five kilograms
  - Six weeks post-partum
  - Post-gynaecological surgery.

**Provide Health Educations and Counselling**

- Effectiveness
- Advantages/disadvantages
- Spermicide
- Male and female condoms and dams.

**Demonstrate Diaphragm Fitting Procedure Utilising the Pelvic Model**

- Refer to clinical procedures for diaphragm fitting procedure in [Resource T](#) for contraception.

**Provide Appropriate Pamphlets**

- Ensure client has appropriate written information about diaphragms and emergency contraception.
7.1.9 Barriers (Condoms)

Follow Guidelines for ‘General Consultation’
Refer to Section 6.1

Discuss

- Method effectiveness (female and male condoms)
- Importance of communication in sexual relationships
- ‘NO’ means ‘NO’
- Risks associated with unprotected intercourse such as STIs, pregnancy, violence, harm and exploitation.
- Barrier methods of contraception
- Abstinence if genital/anal sores and/or discharges
- Alternative forms of pleasuring, e.g. massage / masturbation
- High-risk behaviour
- Vaccinations
- Screening

Assessment of Risk Factors
Assess and Discuss Need for Follow up Screening

Condom Demonstration
- Utilise appropriate pamphlets and resources

Procedure for Condom Breakage

- Emergency contraception
- STI screening indications as per Resource C, Resource N and Resource O for STIs
- Sexual health information telephone line – advice and information: Melbourne Sexual Health Centre 03 9347 0244

7.1.10 Natural Family Planning Consultations

Periodic abstinence (natural family planning or NFP) is the means of preventing pregnancy by avoiding sexual intercourse during the fertile phase of the menstrual cycle. Fertility UK www.fertilityuk.org provides comprehensive and objective information for health professionals and the general public on all aspects of fertility awareness. Fertility charts and completed sample charts can be printed out from this site.

Types of natural family planning methods include:

- Calendar–rhythm method
- Temperature method
- Ovulation or mucus method (Billings)
- Symptothermal method

Discuss

Indications

- Religious restrictions/teachings/beliefs forbid the use of artificial contraception
- Unexpected pregnancy would not be undesirable
- Experience unacceptable side effects or contraindications to other family planning methods
Effectiveness

• Although theoretical calculations may suggest these techniques can be relatively effective, in practice the failure rates are high. Failure rates in the first year of use vary between one and 25 pregnancies per 100 women.

• Efficacy depends on behavioural factors as well as the accuracy of the techniques used to assess the onset and end of the fertile period (IPPF 1995).

How it works

• The fertile phase is determined by observing/monitoring and recording the body’s natural physiological signs and symptoms that indicate that ovulation has occurred. Sexual intercourse is avoided during this phase.

• These various methods work only if the couple understands the basic physiology of menstrual cycle and has a strong commitment to follow method instructions. If, for any reason, sexual abstinence during the fertile period cannot be practised, the additional use of barrier methods is recommended.

Advantages

• It is a ‘natural’ method, and does not require use of devices, consumption of hormones or involve surgical procedures.

• It is inexpensive (only charts, calendars and/or thermometers are necessary).

• The method can be taught by the women’s health nurse who has undertaken additional training within this area. After initial training and follow-up, some clients may be encouraged to undertake further comprehensive training such as the accredited Billings ovulation method training program.

• Responsibility for this method is shared by both partners.

• It has the approval of certain religious groups that do not support the use of other methods to avoid pregnancy.

• It is aesthetically more acceptable for some couples compared with coitus-related methods such as condoms.

• Training in the methods increases awareness and knowledge of reproductive functions and thus may help couples to achieve pregnancy if this is their desire.

• Couples who are afraid of possible side effects from artificial methods of contraception can use NFP.

Contraindications

• Partner’s cooperation may not be predictable.

• Unplanned pregnancy would have serious implications.

Disadvantages

• NFP will not be successful without strong commitment and cooperation from both partners. A partner may not agree to comply with the necessary periods of sexual abstinence if natural family planning is the only method used. Sexual abstinence may in turn cause marital difficulties and psychological stress.
• It requires the client to have detailed knowledge of her own body changes during her menstrual cycle and ability to identify the fertile period. Can be more challenging for clients with irregular menstrual cycles
• It is less effective in preventing pregnancy than most other family planning methods
• An extended period of initial instruction on recording the client’s menstrual cycle and ongoing counselling is required
• It requires daily monitoring of bodily functions and usually charting of signs and symptoms. This may be bothersome or difficult for some clients/couples.

*Other options*

Discuss other options to natural family planning such as:

• Brown’s meter, which is an ovulation prediction meter/monitor (preventing/achieving pregnancy)
• ClearPlan (to detect luteinising hormone (LH) surge).

7.1.11 *Lactational Amenorrhoea*

The lactational amenorrhoea (LAM) method is the informed use of breastfeeding as a contraceptive method by a client who fulfils the following three criteria:

• Amenorrhoeic
• Baby is not receiving supplements
• Less than six months post-partum.

**Follow Guidelines for ‘General Consultation’**

Refer to Section 6.1

**Discuss**

• Method effectiveness (protection is 98% when all three of the above criteria are fulfilled)
• How the methods works
• Indications
• Advantages and disadvantages
• Criteria for maximum effect (Gross & Burger 2002).

**Assess and Discuss Need for Follow-up**

• Return of fertility
• Planning post-partum contraception.

8. GENERAL WOMEN’S HEALTH ISSUES

8.2 *Other Women’s Health Issues*

8.2.1 *Pre-Conceptual Care*

**Follow Guidelines for ‘General Consultation’**

Refer to Section 6.1

**Discuss**

• Physiology of conception
• Issues relating to conception
• Rubella testing/rubella vaccination
• Varicella testing/vaccination
• Pap test/breast examination
• Folate – most women need 0.5 mg folate daily, which ideally is commenced at least one month
before conception and continued for three months during the ante-natal period
• Nutrition, exercise and weight control
• Smoking and alcohol risks
• Environmental issues (occupations)
• Listeriosis
• Genetic concerns such as thalassaemia
• Age risk – amniocentesis/cardiovascular disease
• Ante-natal testing such as Downs syndrome risk
• Birthing options
• Signs of pregnancy and indications for pregnancy testing
• Risk of infection from partner such as herpes or hepatitis B.

**Document Findings**

**Provide Pamphlets and Resources as Indicated**

**Refer to General Practitioner if Indicated or Requested**

8.2.2 Sub-Fertile Couple

**Follow Guidelines for 'General Consultation’**

Refer to Section 6.1

**Discuss**

• Physiology of conception
• Issues relating to conception
• Normal variants of human fertility

• Investigations and treatment options for both male and female sub-fertile couple
• Natural family planning methods
• Ovulation detection.

**Refer to General Practitioner if Indicated or Requested**

• On identifying a history of subfertility and after discussion with the client/couple, the women’s health nurse will refer to a general practitioner for further investigation.

8.2.3 Continence (Bladder or Bowel Incontinence Issues)

**Follow Guidelines for 'General Consultation’**

Refer to Section 6.1

**History Taking and Screening**

• High-risk groups include female clients who are:
  - Peri- and post-menopausal
  - Younger and who have had children
  - Overweight
  - Diabetes, stroke, heart conditions, neurological disorders, post-surgery, with chronic respiratory conditions or prostate problems

• Perform a bi-manual examination to note presence/absence of:
  - Urethral and/or vaginal atrophy
  - Prolapse of bladder, uterus and/or rectum
  - Stress incontinence with coughing
- Urge incontinence
- Pelvic floor muscle contraction
- Vaginal moisture
- Pelvic masses (Gallo, Fallon & Staskin 1997).

Discuss
- Signs and symptoms
- Lifestyle and cultural issues
- Sexuality and psychological issues
- Previous management.

Client Education and Counselling
- Diet, exercise and lifestyle
- Pelvic floor exercises
- Bladder diary and training
- Skin care, vaginal health and hygiene products
- Support groups/resources/library
- Methods of treatment
- Key organisations such as the Continence Foundation of Australia. The National Continence Helpline 1800 330 066, staffed by a team of continence nurse advisors, provides confidential information and free brochures about bladder and bowel control problems
- Useful websites include www.continence.org.au

Provide Pamphlets as Indicated
- Provide appropriate written material such as:
  - Pelvic floor muscle exercises
  - Bladder training
  - Lower abdominal muscle exercise leaflets.

Weight and Urinalysis

Referral
- Refer to appropriate health professionals (nurse continence adviser, continence physiotherapist, general practitioner and so on).

Documentation

8.2.4 Menopause

Follow Guidelines for ‘General Consultation’
Refer to Section 6.1

History Taking and Screening
- Obtain clear, relevant history
- Menopause status
- Current level of knowledge about the peri-menopause and the menopause
- Concerns and needs
- Contraindications to some treatment options
- Assess if investigations are required, if any.

Discuss
- Signs and symptoms
- Cultural issues
- Previous management
- Myths and misconceptions about the menopause (hormone replacement therapy, complementary therapies, osteoporosis, etc)
- Contraception, if required.
Client Education and Counselling
- Diet and importance of phytoestrogens
- Weight bearing exercise
- Lifestyle
- Family history
- Self care management
- Complementary therapies
- Stress management
- Pelvic floor exercises
- Vaginal health and indications for natural lubricants or oestrogen cream
- Support groups/resources/library
- General preventative health care (Pap test/mammogram/bone density)
- Outline options for management:
  - Risks/benefits
  - Side effects.

Provide Pamphlets as Indicated
- There are a number of useful books and websites for clients such as the Jean Hailes Foundation at www.jeanhailes.org.au

Websites for health professionals include
British Menopause Society www.the-bms.org, and Australasian Menopause Society www.menopause.org.au

Blood Pressure and Weight
Referral
- Refer to appropriate health professionals (naturopath, social worker, general practitioner, incontinence nurse adviser and so on).

Document Findings
8.2.5 Vaginal Health
Follow Guidelines for ‘General Consultation’
Refer to Section 6.1

Obtain Relevant Information
- Onset and frequency of symptoms
- Vaginal discharge (for an example of a flow chart for the management protocol for vaginal discharges by the women’s health nurse, refer to resource C for STIs)
- Pain/tenderness in genital area
- Dyspareunia
- Pruritus
- Continence
- Other symptoms or concerns
- Previous investigations and treatments, if any
- Lifestyle

Discuss
- Vaginal health
- Prevention of cross-infection to partner(s)
- Possibility of STI screening or other investigations
- Possibility of the need to treat partner(s)
Give Appropriate Written Material

Document Findings

Referral to general practitioner may be required

8.2.6 Common Gynaecological Conditions

Common gynaecological conditions include such issues as:

- Common vulvo-vaginal conditions
- Urinary incontinence
- Premenstrual syndrome
- Polycystic ovarian syndrome
- Menorrhagia
- Endometriosis
- Dysmenorrhea
- Uterine fibroids

Follow Guidelines for ‘General Consultation’

Refer to Section 6.1

Review

- Sexual health assessment
- Contraception
- Signs and symptoms
- Previous management.

Discuss and Provide Health Education

- Aetiology
- Prevalence
- Diagnosis
- Treatment options
- Complementary therapies
- Diet
- Exercise
- Stress management
- Support groups
- Resources/library

Document Findings

Provide Pamphlets

Refer to General Practitioner or Other Health Professional if Indicated or Requested

9. COUNSELLING

9.1 General Counselling Consultations

Women’s health nurse consultations should be varied and may include such issues as:

- Mental health and wellbeing
- Domestic violence
- Sexual assault
- Sexuality
- Relationship issues
- Pregnancy options
- General counselling and advice on women’s health issues

In order to do justice to these extensive complex areas and given the limitations of these clinical practice guidelines, the women’s health nurse should develop...
guidelines for the individual health care setting with
regards to some of these above-mentioned issues.

9.2 Pregnancy Testing for Planned and Unplanned Pregnancy

Follow Guidelines for ‘General Consultation’

Refer to Section 6.1

Document Findings

Obtain Specific Information from the Client

• Missed/overdue period
• Date last menstrual period (LMP) – normal / abnormal
• Contraception
• Signs and symptoms of pregnancy
• Previous pregnancy test
• Preferred option in response to positive or negative
test result

Explain Procedure (including Confidentiality Policy) for
Pregnancy Testing

• Collect urine specimen for Human Gonadotrophin
  (HCG) testing
• Explore possibility of blood test
• An ultrasound may be required if doubts with
  gestation

Give Test Result and Discuss Indications for

• Repeat pregnancy test and include timeframe
• Follow-up appointment(s)
• Counselling

Refer to General Practitioner or Other Health Professional
if Indicated or Requested

• Such as abnormal bleeding or rhesus factor

9.3 Pregnancy Counselling for Unplanned Pregnancy

Unplanned pregnancy does occur. All clients should
have the right to access reliable information and
compassionate counselling. The women’s health nurse
that provides counselling recognises that it is the client’s
right to control their own fertility and reproductive
choices.

To support clients with an unplanned pregnancy,
the women’s health nurse/pregnancy counsellor will
provide objective and supportive counselling which
is non-directive and facilitates an informed personal
choice. The service will be responsive and sensitive to
client needs, including pregnancy testing, counselling,
emergency contraception, post-termination of pregnancy
counselling and counselling of effective contraceptive
options.

The women’s health nurse is strongly recommended to
undertake specific education and training in pregnancy
options and counselling. The women’s health nurse will
be informed about the current termination of pregnancy
legislation within Australia and preferably internationally.

Follow Guidelines for ‘General Consultation’

Refer to Section 6.1
History Taking and Assessment
• Obtain clear, relevant history, including:
  - General history
  - Obstetric history
  - Menstrual history
  - Sexual and gynaecological history
  - Contraceptive history
  - Pap test history
  - Lifestyle
  - Social history

Provide Appropriate Pamphlets

Document Findings
• Documentation in the client’s medical record must reflect the Menhennitt ruling (Section 65 of the Crimes Act 1958, Victoria) when clients are requesting a termination of pregnancy
• Refer to Section 2 ‘Consumer rights’ for further details on the Menhennitt ruling and other medico-legal issues regarding termination of pregnancy and informed consent.

Women’s Health Nurse Pregnancy Counselling Guidelines
• Refer to the general practitioner:
  - For confirmation of the uterine size if required due to ambiguity with dates
  - Features suggestive of an abnormal pregnancy or any other abnormalities
  - The client requests

Discuss Options (Continuing with Pregnancy, Adoption and Termination of Pregnancy)
• Explore the client’s attitude towards a possible pregnancy or non-pregnancy
• Explore the short and long-term implications of the course of action chosen by the client/couple
• Ensure the client/couple explore all the alternatives

9.3.1 Continuing with Pregnancy
• Discuss options for antenatal care and arrange an appropriate referral
• Explore financial and emotional needs and supports

9.3.2 Considering Adoption
• Encourage exploration of this option and arrange for appropriate referral

9.3.3 Considering Termination
• Enable appropriate referral to pregnancy clinic
• Promote the dissemination of accurate information relating to termination of pregnancy and other issues of fertility regulation, including rights and access to services
• Assist the client to explore the feelings and cultural issues regarding the unplanned pregnancy and provide strategies for decision making
• Appropriately outline the medical risks of termination of pregnancy versus ongoing pregnancy
• Discuss future preventative strategies with client/couple
• Refer appropriately in consultation with the client. The possible referral to a termination of pregnancy
Clinic will be made on the reasonable ground that it is necessary to preserve the client from a serious danger to her:
- Life
- Physical health
- Mental health (FPV 1996)

- Discuss post-termination feelings of grief, sadness, sense of loss and possible relief.
RESOURCE A

The National Policy for the Prevention of Cervical Cancer: Policy Overview

National Cervical Screening Program, Australian Government 1998

The national policy provides consensus guidelines on who should be screened and the frequency of screening. It states:

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

*All women who have ever been sexually active should commence having Pap smears between the ages of 18 to 20 years, or one or two years after first sexual intercourse, whichever is later. In some cases, it may be appropriate to start screening before 18 years of age.*

*Pap smears may cease at the age of 70 years for women who have had two normal Pap smears within the last five years. Women over 70 years who have never had a Pap smear, or who request a Pap smear, should be screened.*

*This policy applies only to women without symptoms, which could be due to cervical pathology. Women with a past history of high grade cervical lesions, or who are being followed up for a previous abnormal smear, should be managed in accordance with the NHMRC Guidelines for the Management of Asymptomatic Women with Screen-detected Abnormalities (2005).*

RESOURCE B

Guidelines for the Management of Asymptomatic Women with Screen Detected Abnormalities

National Health and Medical Research Council 2005

Click to view resource
RESOURCES

RESOURCE C
Sexual History-taking Proforma
Click to view resource

RESOURCE D

Procedure for Cervical Screening Recall System
Family Planning Victoria 2005

A systematic and standardised process of notification and recall of Pap test results is recommended.

Provision of Pap Test Results

- Notification of normal and abnormal Pap test results presents a number of issues for the health care setting and the women’s health nurse
- Refer to Figure 1 for notification guidelines for the client with normal Pap test result

NORMAL PAP TEST RESULT
Repeat Pap test in two years >
Repeat in one year as per VCS or health professional >

Mail accepted → Tear off slip (from Victorian Cytology Service results slip) mailed to client.

Phone but no mail → Client to contact (phone/in person) the health care setting. No further action by the health care setting.

No mail and no phone →

Fig. 1 Initial client notification for a normal Pap test result (The women’s health nurse should endeavour to notify the client of the result within seven to 14 days post-screening)
• Refer to Figure 2 for initial notification guidelines for an abnormal Pap test result requiring follow up in less than one year.

Special Consideration of Non-English Speaking Clients

The women’s health nurse should consider the following options when informing the non-English speaking client of her Pap test result:

• Pap test result given by the telephone to the client utilising a professional interpreter. If arranged prior (that is at the time of taking the Pap test) a nominated relative may be informed of the Pap test result. Details of this process of notification should be documented in the client’s medical records.

Client Recall and Review Procedures

A recall system provides systematic preventive care. A cervical screening recall system may include:

• Card-based or computer-based system showing due dates for Pap tests
• Reminder systems offered by other cytology agencies such as Victorian Cervical Cytology Registry and local pathology services.

The recall system should flag any result:

• With abnormal Pap test result:
  - Low grade, high grade, inconclusive, unsatisfactory requires recall policies within the health care setting. Please refer to figures two and three in Resource C
• Where there is no recommendation from Victorian Cytology Service and the reviewing practitioner has recommended a repeat Pap test in one year or less
• Where the reviewing practitioner’s recommendation differs to that of Victorian Cytology Service (unless the practitioner’s recommendation is repeat in two years)
• With a recommendation of repeat Pap test in one year or less where the client has requested ‘Not for Pap Registry’
• Where a colposcopy is recommended. All clients with a Pap test recommending referral for colposcopy or further investigation will be actively followed up until there is documented evidence of their attendance at the referral point for ongoing management.
**Client’s Contact Details**

- Check the client’s contact details at each Pap test to ensure current address and contact telephone number.

**Informing the Client at the Time of the Pap Test of the Pap Test Recall System**

- Advise the client to ring the health care setting after two weeks (depends on the specific health care setting policy) post Pap test, if they do not receive the results via post or other agreed method of contact.

**Establishment of Client Contact for Purposes of Result Notification**

- Clients should be contacted by mail, phone or in person as nominated by them at the time the Pap test was taken. Refer to figure two and three for different forms of contact. Figure three guides the women’s health nurse in the incidences when an abnormal Pap test requires immediate management.

- Some health care settings have ‘Contact authorisation forms’ to assist with the abovementioned process of notification.

- For some clients it may be advisable to send information in standard envelopes, which do not have the health care setting’s formal logo and contact details (except PO Box number) and utilise a normal postage stamp on the envelope.

- MAIL – contact with client is presumed to be established if mail is not returned.

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**Fig. 2 Methods of contact (modified to specific health care setting policies) for the notification of an abnormal Pap test result requiring follow-up**

<table>
<thead>
<tr>
<th>METHOD OF CONTACT</th>
<th>CONTACT ONE</th>
<th>CONTACT TWO</th>
<th>CONTACT THREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mail and phone allowed</td>
<td>One standard letter sent</td>
<td>Check with VCS, then attempt phone contacts</td>
<td>If successful and review is for a year, terminate contact attempts</td>
</tr>
<tr>
<td>Mail but no phone</td>
<td>One standard letter sent</td>
<td>Check with VCS, then send one standard letter</td>
<td>If review is needed less than one year or colposcopy repeat, then send a final registered letter</td>
</tr>
<tr>
<td>Phone but no mail</td>
<td>Attempt 3-6 phone contacts</td>
<td>Check with VCS, then attempt to phone 3-6 times</td>
<td></td>
</tr>
<tr>
<td>No mail and no phone</td>
<td>Emergency phone contact (phone 3-6 times)</td>
<td>Check with VCS, then use emergency contact phoning 3-6 times</td>
<td></td>
</tr>
</tbody>
</table>
• PHONE – contact with client is established when a women’s health nurse has spoken directly with the client.

If phone contact is unsuccessful, at least three attempts should be made to phone the client, with a maximum of six attempts. Phone calls will not mention the name of the health care setting to any person other than the client or authorised contact person.

Documentation
In the client’s medical records, it should clearly document:

• All action taken to notify if the Pap test is due or if further follow-up is required (noting when registered/ordinary mail has been sent and to which address)
• Each contact attempt (noting time, date and which phone number). Times of the phone calls are to be varied
• All action, advice and referrals with appropriate signature
• If they choose ‘Not for Pap Registry’ or to ‘opt off’ the Pap test registry. The Victorian Cervical Cytology Registry has a small alert sticker that can be placed inside the client’s medical record and on the Pap test request form. The client will be advised that they are required to take full responsibility for when their next Pap test is due.

Follow up on repeat Pap tests and colposcopies
• Ensure that the client database for follow up is maintained.

RESOURCE E

Client Letters for Notification of Results
Letter One: Normal Pap test result
Letter Two: Normal Pap test, other follow up required
Letter Three: Atrophic changes
Letter Four: Vagifem or Ovestin Instructions
Letter Five A: Low grade changes (Repeat Pap test in 12 months)
Letter Six: Recall

Click to view these resources
RESOURCE F

Procedure for a Pap Test
Victorian Cytology Service

1 Equipment
• Adequate, adjustable light source
• Disposable plastic speculum or a metal speculum (warmed under tap water)
• Sampling instruments
• Gloves
• Labelled slide(s) - full name, date of birth. The Victorian Cytology Service strongly recommends that the slide also contain the client’s medical record number. Refer to Resources I and J regarding the VCS protocol for labelling and fixing slides
• Spray fixative

2 Abdominal Examination
• Wash hands
• Ask client to empty bladder before the examination
• Inspect the abdomen (scars, lesions, skin conditions)
• Use a warm flat hand to palpate the woman’s lower abdomen (right and left suprapubic region) to ensure there are no obvious masses or tender area(s)
• This examination aims to provide the opportunity to make physical contact with the women in a less intrusive way than to do so by starting with introducing the speculum

3 Positioning
• Most people prefer to undertake the Pap test in the supine position with knees bent and feet placed together. The left lateral position can be used if Pap tests are difficult to obtain, such as in older women with lax anterior vaginal walls
• Placing a firm cushion under the pelvis will assist in visualising the cervix by altering the angle of the pelvis
• Ensure privacy with an appropriate cover sheet and screens.

4 External Genitalia Examination
• Wash hands and put on gloves
• Inspect the vulva with gloved hands. Look under clitoral hood and around the urinary meatus, the vaginal introitus, perineum and anal area to ensure normality
• Observe skin conditions and presence of abnormal discharge/bleeding.

5 Insert the Speculum
• Warm the speculum in water and test the temperature of the instrument with gloved hands and then against the client’s inner thigh. A small amount of lubricating gel placed along the sides of the blades can be used if necessary.
• Part the labia gently with one hand (usually the left) and slowly and steadily insert the speculum with the bills closed and horizontal and preferably the handle pointing downwards. If the speculum rests on the
fourchette this causes a reflex mechanism, which aids gentle insertion of the speculum

- When the majority of the speculum is inserted, gently open the bills to locate the cervix
- Adjust the speculum screw to maintain the position
- Observe the cervix and vaginal mucosa
- Insert the sampling instruments into the cervical canal
- Fix slide immediately with cytospray to avoid air drying. The ideal technique is to give two sprays from a distance of 20cms to avoid freezing artefact

6 Removal of Speculum

- While supporting the speculum, release the screw holding it open
- Remove the speculum by opening slightly and pulling back gently to allow the bills to clear the cervix
- Allow the pressure of the vaginal wall to close the bills as the speculum is removed
- Dispose of and process speculum according to infection control guidelines
- Assist woman to sit up, offer tissues or pad and allow to redress

7 Unable to Locate the Cervix

- Withdraw the speculum and palpate the position of the cervix with a gloved hand moistened with water to locate the cervix
- Reinsert the speculum once the position of the cervix has been identified.
- If the cervix remains ‘out of view’ then again, withdraw the speculum, instruct the woman to ‘bear down’ and then re-insert speculum.

8 Examination with lax vaginal walls

A wider or longer speculum can be used, but sometimes the vaginal wall may still obscure the cervix. A condom (tip removed) placed over the speculum may prevent intrusion of the lateral vaginal walls.
RESOURCE G

How to Take a Better Pap Smear
Richard Reid and Suzanne Hyne, Modern Medicine of Australia 1998, 14(5)

Click to view article

RESOURCE H

The Speculum Examination
Danielle Mazza, Australian Family Physician 1999 28(5):495–7

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Click to view article
RESOURCE I

Taking a Pap Smear
Victorian Cytology Service
Click to view resource

RESOURCE J

Procedure for Taking a Pap Smear Using the Cervex Sampler, or Spatula with/without Endocervical Brush
Victorian Cytology Service
Click to view resource
RESOURCE K

Procedure for Bi-manual Examination

Family Planning Victoria

- Wash hands and put on gloves
- Position the woman in the supine position, head resting on one pillow
- Apply lubricant to the gloved fingers that will palpate some structures in the pelvic cavity from inside the vagina
- Separate labia and insert one finger into the vagina using a downward pressure to relax the perineum, then insert the second finger
- Insert two lubricated fingers of the examination hand well into the introitus
- Follow the anterior vaginal mucosa deep into the anterior fornix and locate the cervix
- Note the description of the cervix:
  - Position
  - Size
  - Consistency of the cervix
  - Nulliparous (closed) or parous (slit) os
- Carefully manipulate the cervix in all directions to locate any abnormality
- Note and document the description of the uterus:
  - Position (anteverted or retroverted)
  - (anteverted, i.e. lying anterior to the axis of the vagina - the vaginal fingers elevate the cervix, press upwards gently towards the abdominal hand and palpate the uterus between the two hands (figure one)
  - (retroverted, i.e. lying behind the axis of the vagina - vaginal fingers behind the cervix with firm pressure from the abdominal hand displacing the pelvic contents of the uterus posteriorly and gently palpate the posterior fornix to feel in the retroverted position (figure two)
- Displace the cervix laterally by placing a finger on each side of the cervix and rocking gently. Note if any pain or tenderness
  - Size
  - Consistency
- To palpate the adnexae (ovaries and Fallopian tubes) the tips of the vaginal fingers are placed in each lateral fornix in turn and then pushed backward and upward as far as possible without causing pain. The abdominal fingers simultaneously press downward and backwards. The normal fallopian tube cannot be palpated, and the normal ovary may or may not be felt. Repeat this examination of the other side of the pelvic cavity by gently changing the angle of the internal hand
• Palpate the pouch of douglas for masses or tenderness.

Procedure for Pelvic Floor Muscle Tone Assessment
• If it is appropriate to assess the pelvic floor tone at the end of the bi-manual examination, then the women’s health nurse will ask the client to squeeze the examining vaginal fingers of the practitioner in order to assess the tone of the pelvic musculature
• The client should be instructed to hold onto this contraction for as long as possible (up to 10 seconds). The women’s health nurse will then assess the strength of the second contraction in comparison to the first
• Following the bi-manual examination, the client will be instructed to push down and the women’s health nurse with their eyes approximately at the level of the vagina, will look for a bulging of the vaginal walls that might suggest a cystocele or urethrocele anteriorly, or a rectocele posteriorly
• Remove fingers from the vagina and offer tissues
• Document and explain the findings to the client.

RESOURCE L

Procedure for Breast Examination
MDAV HARM Program and Women’s Health Grampians 2004
The breast examination should be preceded by discussion of the rationale for examination in relation to age, medical history and family history.

Inspection of Breasts – Sitting
• Wash hands
• Client to remove all upper clothing and to cover the region with gown or covering sheet
• With the client in a sitting position on the examination couch, observe their breasts whilst arms are relaxed by the side and then raised above the head. This visual inspection allows for the women’s health nurse to note:
  - Scars
  - Change of contour
  - Swelling
  - Asymmetry
  - Skin condition
  - Skin texture changes or nipple retraction/discharges
  - Skin puckering or dimpling discharges
  - Inflammation.
• Check the lateral side of the breast and chest wall for symmetry in breast and nipple elevation.
• Palpate supraclavicular, subclavian, and axillary regions for lymph nodes. Determine the absence or presence of enlarged nodes or other subcutaneous masses, e.g. boils.
• Check the chest wall for adhesions between the breast and the chest wall. Ask the client to place their hands on their hips and bring shoulders forward to tighten the chest wall muscles.

Palpation of Breast Tissue – Lying Down
• With the client in the left lateral position with her right arm under her head and using the flat part of fingers held together, begin the examination at the right axilla breast. (Depending on breast size, the positioning may be modified.) Move fingers in small circles using light pressure followed by a deeper pressure. Palpate areas abnormal to inspection and areas questioned by the client.
• Move examination hand gradually towards the bra line in a systematic manner and then move across about 2 cm and work up, in circles, to the collarbone, then move across 2 cm and work down.
• When the strip covering the nipple is reached, ask the client to straighten legs and lie flat so that inner half of breast is flattened against the rib cage and continue in strips until reaching the sternum
• Gently place pressure on the areolar areas to detect any discharge from the nipples. Ask the client if she has noted any discharges from the nipple. The nipple examination should note any:
  - Distortion
  - Erosion (Paget’s)
  - Discharge (serous, milky, yellow, bloody)
  - When examination of the right breast is completed, re-position the client and repeat the procedure on the left breast.

Documentation
• Note normal breast changes such as:
• Document (Clinical Breast Proforma – Resource M – may be useful) any findings such as:
  - Nodules
  - Tumours
  - Masses, and evaluate their size, tenderness, consistency, mobility, circumscription and fixation to skin and underlying structures.
• If masses or abnormalities are found, discuss immediate follow-up action with client and refer to a general practitioner.

Education – Breast Awareness
• Encourage women to be familiar with the normal look and feel of their breasts. They should see a general practitioner if they notice any unusual breast changes.
**RESOURCE M**

Clinical Breast Proforma
MDAV HARM Program and Women’s Health Grampians 2004

[Click to view resource](#)

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**RESOURCE N**

Women’s Health Nurse Protocol for Management of the Client Who Presents with Symptoms or a History That Indicates Possible Sexually Transmissible Infections

*Family Planning Victoria 1999*

<table>
<thead>
<tr>
<th>General practitioner on site and available</th>
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<tbody>
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<td></td>
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<table>
<thead>
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<th>Client asymptomatic but clinical signs of infections</th>
<th>Client asymptomatic and no clinical signs of infections but requiring a screen</th>
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<th>Consultation with general practitioner</th>
<th>Full STI screen</th>
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<td>v</td>
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</table>

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<tr>
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<th>Counselling and education</th>
<th>Women’s health nurse to follow up results and notify client</th>
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<tr>
<td>Client asymptomatic and no clinical signs of infections but requiring a check-up</td>
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<td>Documentation/authorisation by telephone or fax</td>
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<td>Follow up counselling and education</td>
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<tr>
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<td>Negative if signs or symptoms persist</td>
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<tr>
<td>Refer client to general practitioner</td>
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</tbody>
</table>
Women's Health Nurse Protocol for Management of the Client Who Presents with a Vaginal Discharge

Southern Health Care Women's Health 1999

History and/or examination with clinical signs of infection, e.g. vaginal discharge

- Client has signs of candida
  - General practitioner on site and available
  - Consult with general practitioner (during clinical examination if appropriate)
  - Women’s health nurse undertakes examination. Documentation and/or authorisation of pathology test(s) such as STI screen as per health care setting protocol. Provide health education and information on vaginal health
  - Women’s health nurse to follow up results and notify client of action if required

- Positive diagnosis of candidias confirmed
  - If treatment effective, no further follow up required
  - If symptoms persist, client to be referred to general practitioner

- Positive for any other infections or symptoms
  - Refer client to general practitioner as per individual health care setting protocol

- Negative but signs and/or symptoms persist
  - General practitioner not available on site
RESOURCE P

Hepatitis B Vaccination Authorisation Form
Based on Family Planning Victoria’s Hepatitis B Authorisation Form

Click to view resource

RESOURCE Q

Emergency Contraception Authorisation Form
Family Planning Victoria 1999

Click to view resource
**RESOURCE R**

Women’s Health Nurse Protocol for the Management of the Client Who Presents Requesting Emergency Contraception

Southern Health Care Women’s Health 1999
RESOURCE T

Procedure for Diaphragm Fitting

- During a diaphragm fitting a pelvic examination is performed to assess the distance from the posterior fornix to the posterior aspect of the symphysis pubis; the vaginal wall muscle tone; and the position of the uterus and the cervix.

- The diaphragm should be inserted downwards and backwards to ensure that it covers the cervix.

- The front rim of the diaphragm must be pushed up into position behind the pubic bone.

- The cervix is then palpated through the diaphragm to ensure that it is covered.

- A correctly fitted diaphragm does not allow the insertion of a finger between the rim and the pubic arch.

- Discuss, demonstrate and provide privacy for client to practise removal and insertion technique.

- Whilst using the ‘practice’ diaphragm, the client is advised to use another form of contraception.

- The client should be encouraged to return in approximately one week for discussion about this method of contraception and level of satisfaction, and confirmation diaphragm bi-manual examination.

- The client is advised to return for a diaphragm fitting if after pregnancy; there is any weight change of five kilograms; gynaecological surgery.
CONTACTS

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Australian Sexual Health Nurses Association Inc
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F 02 9716 5073

BreastScreen Victoria
BreastScreen Coordination Unit
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F 03 9662 3881

Continence Foundation of Australia
AMA House
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120 Spencer Street
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F 03 9637 4779

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P 03 9347 0244
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Swanston Street
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P 8344 7276 (Department of General Practice)
P 1800 801 662 (Freecall)
PapScreen Victoria
The Cancer Council Victoria
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CARLTON SOUTH VIC 3053
P 131120
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F 03 9348 2134

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Victorian Cytology Service
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Chairperson
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F 9689 5150
**LINKS**

*Drugs*

**Australian Drug Foundation**
An independent, non-profit foundation working to prevent and reduce alcohol and drug problems in the Australian community.
www.adf.org.au

**Turning Point Alcohol and Drug Centre**
This Melbourne-based centre provides treatment, research services, training and support initiatives - with the aim of reducing alcohol and drug related problems in our community.
www.turningpoint.org.au

*HIV, Hepatitis and STIs*

**Access Information Centre at The Alfred**
A statewide resource centre on HIV/AIDS, Hepatitis and Sexually Transmissible Infections for the Victorian community (Australia).
www.accessinfo.org.au

**AIDS/Hepatitis and Sexual Health Line Inc**
Formed in 1985 in response to the emerging HIV/AIDS epidemic. It is Victoria’s telephone counselling, information and referral service on HIV, AIDS and all other sexually transmitted infections.
www.aidshep.org.au

**Australia and New Zealand HPV Project**
The project aims:

- To provide up-to-date information and non-judgmental support to people with genital warts.
- To provide health and medical professionals with user-friendly educational material that will assist with the diagnosis, treatment and management of genital warts
- To educate the public about the prevalence, transmission and management of genital HPV thereby reducing the stigma and fear associated with this common infection.

www.hpv.org.nz

**Australian Hepatitis Council**
An information resource primarily for people with hepatitis C, their families and friends, and their carers.
www.hepatitisaustralia.com

**Australian Society of HIV Medicine**
A key partner in the Australian response to HIV, hepatitis and related diseases. It works closely with government, advisory bodies, community agencies and other professional organisations.
www.ashm.org.au

**Hepatitis C Council**
Provides education, current information, community support, referral services and advocacy to those infected and affected by hepatitis C in Victoria.
www.hepcvic.org.au
Melbourne Sexual Health Centre (MSHC)
Provides sexual health services to Victorians and promoting sexual health throughout the community. The centre provides direct client services and has strong research and education activities.
www.mshc.org.au

The Australian Research Centre in Sex, Health & Society
Established as the Centre for the Study of Sexually Transmissible Diseases in October 1992 within the Faculty of Health Sciences at La Trobe University.
www.latrobe.edu.au/arcshs

Victorian AIDS Council/Gay Men’s Health Centre
Includes a community health service for the gay and lesbian community – but open to all.
www.vicaids.asn.aup

Professional bodies

Australian College of Midwives
This site has lots of information from professional documents to educational programs, codes of practice and an on-line store.
www.acmi.org.au

Australian Council on Healthcare Standards (ACHS)
An independent, not-for-profit organisation, dedicated to improving the quality of health care in Australia through continual reviews of performance, assessment and accreditation.
http://www.achs.org.au

Australian Divisions of General Practice
The peak national body representing 120 Divisions of General Practice across Australia.
www.adgp.com.au

Australian Health Promotion Association (APHA)
An association that supports health promotion professionals at a national level with branches in each state.
www.healthpromotion.org.au

Australian Nursing and Midwifery Council
www.anmc.org.au

Nurses Board of Victoria
A statutory authority to regulate the nursing profession.
www.nbv.org.au

Royal College of Nursing, Australia
The professional voice for nurses by speaking out on health issues that affect nurses and the community. The college website provides a list of Pap smear/ women’s health accredited sexual and reproductive health nurse courses which include courses for practice nurses. Information can be easily downloaded about credentialing and re-credentailing.
www.rcna.org.au

The Australian Practice Nurses Association
A professional association run by practice nurses for practice nurses. It provides representation, support and networking for practice nurses at national, state and local levels.
www.apna.asn.au
The Australian Women’s Health Nurses Association Inc
An organisation that supports women’s health nurses throughout Australia.
www.womenshealthnurse.com

The Public Health Association of Australia (PHAA)
Provides a forum for the exchange of ideas, knowledge and information on public health. The association is also involved in advocacy for public health policy, development, research and training.
www.phaa.net.au

Victorian Centre Against Sexual Assault
The peak body of the 15 centres against sexual assault, and the Victorian sexual assault crisis line (after hours). They work to ensure that women, children and men who are victim /survivors of sexual assault have access to comprehensive and timely support and intervention to address their needs.
www.casa.org.au

Women’s Health Nurse Association of Victoria
A professional organisation offering support and information to nurses working in the field of women’s health.
www.whnav.org.au

Australasian Menopause Society
The aim of the society is advancement of knowledge about menopause.
www.menopause.org.au

FPA Health (formerly Family Planning NSW)
Assists with sexual and reproductive health needs. They hold seven clinics around NSW, conduct health promotion programs and train health professionals.
www.fpahealth.org.au

Family Planning Victoria (FPV)
Sexual health clinics at Box Hill and the Action Centre in Elizabeth Street, Melbourne. Some of the services include: counselling and support for people with disabilities, confidential telephone helplines - with a free call number for rural and homeless clients, fertility, infertility, planned and unplanned pregnancy counselling and options. FPV provides professional and community education throughout Victoria.
www.fpv.org.au

Jean Hailes Foundation
A not-for-profit organisation providing services for women from adolescence to mid-life and beyond.
www.jeanhailes.org.au

Melbourne Sexual Health Centre
Specialises in providing services to people who have, or think they may have, a sexually transmitted infection.
www.mshc.org.au

Health services

Action Centre
The Sexual Health Clinic at Level 1, 92–94 Elizabeth Street, Melbourne is sensitive to the needs of adolescents and marginalised youth.
www.fpv.org.au
Royal Women’s Hospital, Well Women’s Service
The Well Women’s information service provided by the Royal Women Hospital provides a range of services for women of all ages.
http://wellwomen.rwh.org.au

Breast health
Breast Cancer Network Australia
The national voice of Australians affected by breast cancer.
www.bcna.org.au

BreastScreen
Provides mammographic screening across the state.
www.breastscreen.org.au

National Breast Cancer Centre
Provides comprehensive and easy-to-read information to help women with breast or ovarian cancer.
www.nbcc.org.au

General health information
BetterHealth Channel
Quality-assured, regularly reviewed, health and wellbeing information and services. This site is sponsored by the State Government of Victoria, Australia.
www.betterhealth.vic.gov.au

Clinicians Health Channel
Aims to service the needs of clinicians – doctors, nurses and allied health professionals – in Victorian public hospitals.
www.health.vic.gov.au/clinicians

Health Translations Directory
Information on a variety of health topics in languages other than English.
www.healthtranslations.vic.gov.au

Cancer information
The Cancer Council Victoria
The Council’s core business is cancer control. They conduct and support research, as well as delivering statewide support and prevention programs and advocacy to reduce the physical and emotional burden of cancer.

The Cancer Council’s Helpline is staffed by enquiries officers, who answer all general enquiries, and cancer nurses, who are registered nurses with oncology qualifications and experience.

For the cost of a local call, the Cancer Helpline can be contacted Monday to Friday 8.30 am to 8 pm by calling 13 11 20. The Cancer Helpline is available in languages other than English through the Multilingual Cancer Information Line.
www.cancervic.org.au
Cervical screening information

PapScreen Victoria
The Victorian Cervical Screening program. It is a joint Commonwealth-State funded program coordinated by the Victorian Department of Human Services. The Cancer Council Victoria is responsible for PapScreen’s communications and recruitment program.
www.papscreen.org.au

National Cervical Screening Program
Aims to reduce the incidence and deaths from cervical cancer through an organised approach to cervical screening.
www.cervicalscreen.health.gov.au

Victorian Cervical Cytology Registry
www.vccr.org

Victorian Cytology Service
www.vcs.org.au

Government bodies and government funded bodies

New South Wales Health
www.health.nsw.gov.au

Department of Human Services (DHS)
DHS is committed to ensuring that all Victorians have access to quality services that protect and enhance the community’s physical, mental and social well-being.
www.health.vic.gov.au

Victorian Public Health Division
Protects and promotes the health and wellbeing of all Victorians by providing leadership, support and services, in partnership with key stakeholders and communities.

VicHealth
Promotes the benefits of not smoking and adopting a healthy lifestyle.
www.vichealth.vic.gov.au

Victorian Legal Aid
Legal information about sex, family and friends, school, health, lifestyle and work. Click on the ‘Youth’ button.
www.legalaid.vic.gov.au

Multicultural

Migrant Information Centre (Eastern Melbourne)
Provides a range of services for migrants and refugees living in Melbourne’s eastern suburbs.
www.miceastmelb.com.au

NSW Multicultural Health Communication Service
Information on a variety of health topics in languages other than English.
www.mhcs.health.nsw.gov.au

Multicultural Health Communication Service
Provides information and services to assist health professionals to communicate with non-English speaking communities
www.mhcs.health.nsw.gov.au
Research and training

The Key Centre for Women’s Health in Society, University of Melbourne.
www.kcwh.unimelb.edu.au

National Health & Medical Research Council (NHMRC)
A statutory body that aims to raise the standard of individual and public health throughout Australia, foster the development of consistent health standards between the States and Territories, post medical research and public health research, and foster consideration of ethical issues relating to health.
www.nhmrc.gov.au

The University of Melbourne
www.unimelb.edu.au

World Health Organization
WHO’s objective is the attainment by all peoples of the highest possible level of health. Health is defined in WHO’s Constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
www.who.int/en

Sexuality

Gay and Lesbian Health Victoria
A not-for-profit organisation that provides gay and lesbian health information. Provides a free online newsletter.
www.glhv.org.au

The Coalition for Positive Sexuality
A grassroots, not-for-profit, activist organisation that provides complete and honest sex education. It is a great site for senior school students needing information for school assignments.
www.positive.org/Home/index.html

Youth

Sexuality Information and Education Council of the United States (SIECUS)
The national voice for sexuality education, sexual health, and sexual rights for almost 40 years.
www.siecus.org

SSAFE Schools
A website for teachers and others working in schools providing information and resources that supports the creation of inclusive environments for same-sex attracted young people.
www.ssafeschools.org.au

Wesley Central Mission
An Australian Church whose services include ministry to youth. Search for ‘youth’ at the search screen.
www.wesleymission.org.au

Women’s health services

Barwon/South West Women’s Health
A women’s health site for the Barwon/South Western Region. Contains a local services directory for women, news and events.
www.wholewoman.org.au
Women’s Health East
A metropolitan women’s health service site which describes services offered, available resources and some articles from the organisation’s newsletter.
www.whe.org.au

Women’s Health in the North
A women’s health service of the northern metropolitan region of Melbourne. Provides details of services offered, projects, training and publications.
www.whin.org.au

Women’s Health West
A women’s health service of the western metropolitan region of Melbourne. Provides details of services offered, projects, training and publications.
www.whwest.org.au

Women’s Health In the South East (WHISE)
A community based women’s health organisation providing details of services and programs offered.
http://home.vicnet.net.au/~whise/

Working Women’s Health
A statewide immigrant women’s health organisation that conducts health promotion with working women. The website provides details of the services offered.
www.workingwomenshealth.asn.au

Gippsland Women’s Health Service
A regional health and information service run by women for women. The website contains service details, library catalogue and project and program details.
www.gwhealth.asn.au

Women’s Health Goulburn North East
A rural women’s health service whose site provides information on services offered, publications & projects.
www.whealth.com.au

Women’s Health Grampians
A rural women’s health service which provides information on services offered and links to Grampians region breast cancer services.
www.whg.org.au

Women’s Health Loddon Mallee
A rural women’s health service whose website provides information on its services, some health issues and referral details for the region.
www.lmwh.net

Women’s Health Victoria
A statewide women’s health information service providing an accessible, active, quality health information service for women and the health sector.
www.whv.org.au

Women’s Health Information Centre (WHIC)
The Royal Women’s Hospital developed this website which provides service details, publications, events, and features a new topic each month.

Women’s Information and Referral Exchange (WIRE)
Provides free information, support and referrals to women across Australia
www.wire.org.au
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