Genital examination in women

A resource for skills development and assessment
Acknowledgements

The RCN forums and individuals who collaborated in 2006 to produce *Vaginal and genital examination – guidance for nurses and midwives* (003 036), London: RCN

The RCN Public Health Forum and members who worked collaboratively in 2011 to produce *RCN Competences for nurses undertaking bimanual genital examinations* (004 134), London: RCN

Members of the Associate Members’ Working Group (AMWG) of the Faculty of Sexual and Reproductive Healthcare (FSRH) who produced the unpublished work *Genital Examination – a training guide*

Members of the working group who came together to amalgamate the three aforementioned documents:

- **Alison Craig**, Faculty of Sexual and Reproductive Healthcare (Scottish Sexual and Reproductive Health Lead Nurse Forum)
- **Colin Roberts**, British Association for Sexual Health and HIV
- **Debby Holloway**, RCN Women’s Health Forum Committee Chair
- **Jenny Greenfield**, Faculty of Sexual and Reproductive Healthcare, Associate Members’ Working Group Chair
- **Sarah Randall**, Consultant Community Gynaecologist/Chair of Faculty of Sexual and Reproductive Healthcare, Associate Members’ Working Group Chair
- **Wendy Moore**, Clinical Lead/RCN Reviewer/Vice Chair of Faculty of Sexual and Reproductive Healthcare, Associate Members’ Working Group Chair
- **Wendy Norton**, RCN Women’s Health Forum.

It is recognised that services are provided by nurses and midwives in a range of settings. For ease of reading, the generic terms ‘nurse’, ‘nursing’ and ‘nurses’ are used throughout this document to indicate the roles and contributions of nurses, midwives and specialist community public health nurses.

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Published by the Royal College of Nursing, 20 Cavendish Square, London, W1G 0RN

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About this document

The continuing development and extension of nursing roles benefits both nurses and their client groups. The ability to carry out genital and bimanual examinations is now a key requirement for many nurses working in primary, secondary and community care settings.

In order to enhance service delivery, more nurses are performing examinations, procedures, and observations involving female genitalia (often referred to as intimate internal vaginal or genital examinations). Genital examinations form part of many routine assessments of women and are used for diagnostic and treatment purposes related to gynaecological, obstetric and sexual health care. In 2004, the Royal College of Nursing (RCN) undertook a scoping exercise with relevant stakeholders and the results of this exercise have been built on and developed to create this guidance document.

This document is for:

- registered nurses and midwives working in NHS, independent and private practice arenas
- sexual and reproductive health nurses (including contraceptive advice)
- practice nurses
- nurses working in gynaecology, fertility services, custody suites, colposcopy, urology, community, and acute-based services and ultrasound
- health care professionals working in induced abortion services
- service providers and managers
- education providers
- clinical risk teams (for review of practice, risk assessment and review of individual practice)
- service and education commissioners
- health care assistants, with clarity around their roles.

The purpose of this document is to provide standards and sample assessment tools for training in genital examination in women for nurses working in sexual and reproductive health settings, and related health and social care settings. It assumes an extensive knowledge of relevant anatomy, physiology and pathology. It is envisaged that this document could be used by registered health care professionals who would require training in genital examination in order, for example, to undertake the following procedures:

- cervical sampling including liquid based cytology and colposcopy
- taking swabs as part of a sexual health examination
- inserting, checking or removing intra uterine devices (IUDs)
- vaginal ultrasound
- hysteroscopy
- and as part of any extended role in history taking and examination for the assessment of symptomatic women.

Training is intended to enable health care professionals to demonstrate competence at recognising the abnormal or symptomatic from the normal or asymptomatic pelvis, and not necessarily to make a diagnosis of genital pathology. If any abnormality is suspected then an experienced clinician should be consulted without delay to review the findings. Health care professionals should aim to make this examination as comfortable and non-threatening as possible, maintaining sensitivity and respect for the woman’s dignity.

This guidance will enable suitably qualified health care professionals to undertake genital examination in a competent and safe manner; to help trainers and assessors in the training process; and to ensure safe practice for women needing a genital examination. Genital examination should only be undertaken following appropriate history taking.

All health care professionals should ensure that they work within clearly defined boundaries of clinical competence in relation to assessment, diagnosis and treatment; making prompt and appropriate referral as indicated by the findings of the procedure. Nurses and midwives work to the Nursing and Midwifery Council
Who can undertake genital examinations?

Nurses and midwives are personally accountable for their practice and answerable for their actions and omissions. All nurses and midwives have a duty of care to women, who are entitled to receive safe and competent care. Competence is defined as ‘possessing the skills and abilities required for lawful, safe and effective practice without direct supervision’ (NMC, 2008). There is no single recognised training programme required in order to achieve competence to perform vaginal or genital examinations. Some extended roles do have recognised training, which would need to be completed prior to undertaking a procedure unsupervised, for example colposcopy as regulated by the British Society for Colposcopy and Cervical Pathology (BSCCP). Midwives are required to perform vaginal examination as part of routine care provision, and nurses fitting intrauterine contraceptive devices must be competent in genital bimanual examination. Sexual health competences (RCN, 2009) provide a framework for lawful, safe and effective professional practice without direct supervision.

The role of health care assistants and assistant practitioners should be clarified before engagement in examination procedures. Where clinical judgement is required, this is the role of the registered practitioner. It is expected that the health care assistant will contribute to nursing care, and their role here will be around preparation of the area and chaperoning.

Why are genital examinations performed?

A genital examination is performed in the three main areas of health care below.

- **Assessment or diagnosis** – for example, of adnexae, vagina, external genitalia, genital infections, colposcopy, cervical biopsy, pregnancy and labour, uterine and vaginal prolapse, incontinence, vaginal swabs, Bartholins cyst and abscess, transvaginal ultrasound, vaginal bleeding, amenorrhoea, searching for illegal substances, vaginal trauma, hysteroscopy, investigation of alleged sexual abuse or rape.

- **Screening** – for example, cervical cytology, transvaginal ultrasound, vaginal and cervical swabs.

- **Treatment** – for example, removal of polyps, cervical curettage, fitting of ring pessaries, insertion of prostaglandin pessaries, post surgical/radiotherapy follow-up, removal of a foreign body, vaginal dilatation, fitting of contraceptive devices, removal of placenta, evacuation of retained products, transvaginal chorionic villus sampling, endometrial ablation, and assisted reproduction techniques such as insemination or embryo transfer.

Valid consent

When any nursing or midwifery procedure takes place, valid consent must be obtained from the woman. Failure to do so may leave a nurse or midwife vulnerable to the charge of assault.

The Government and professional bodies (such as the RCN), as well as regulators (such as the NMC) provide a range of guidance documents on the issue of consent in a variety of situations, for example, young people, people with learning disabilities, in research, or people in prison. The information provided should also include an explanation of the status of the person performing the examination (for example, ‘learner’).
No one has the right to consent on behalf of another competent adult.

Key principles for obtaining consent from a woman undergoing the examination procedure should ensure that:

- she is a legally competent person
- consent is given voluntarily
- she is informed
- she is aware that she can withdraw her consent at any time.

Consent can be given in writing, spoken, or implied (by co-operation). Only in emergencies, where treatment is intended to preserve life may care be provided without consent. Usually the nurse or midwife performing the procedure is the person obtaining consent. The consent process should not be hurried. The woman should be given sufficient time to process information about the pros and cons of the procedure, and given time to ask questions before arriving at a decision to accept or refuse planned care.

Children and young people under 16 years of age are able to consent to treatment, provided they are deemed competent. Nurses or midwives working with children and young people should be aware of current law with regard to obtaining consent in each of the four countries of the UK. For example, the consenting age in Northern Ireland and Scotland is now 16 years of age (Sexual Offences (Northern Ireland) Order 2008) and Scotland has the Age of Legal Capacity Act (Parliament, 1991).

**Confidentiality**

Patient information is generally held under legal and ethical obligations of confidentiality. Information provided in confidence should not be used or disclosed in a manner that might identify a woman without her consent.

“You must treat information about patients and clients as confidential and use it only for the purposes for which it was given’ (NMC 2008).

Because of the sensitivity of the consultation and examination process, a woman must have trust in the nurse or midwife that she discloses her personal details to. Total confidentiality cannot be promised where information disclosed affects the welfare of others, especially in regard to child protection and criminal offences. In such circumstances, women should know that the information documented will be made available to other members of the team involved in the delivery of care.

**Chaperones**

All women should be offered a chaperone (the woman may wish this chaperone to be a family member or friend) to be present during an examination, procedure, treatment or any care, irrespective of organisational constraints or the settings in which this is carried out.

When the chaperone is a nurse or another member of the health care team, they can act as an advocate for the woman to:

- explain what will happen during the examination or procedure, and the reasons why
- assess the woman’s understanding of what she has been told
- provide a reassuring presence during the examination or procedure
- safeguard against any pain, humiliation, intimidation or unnecessary discomfort.

Although a woman should be offered a chaperone, she may find it difficult to have a third party in the room and request that she is on her own with the person doing the examination. Her request should be respected and documented, unless the health care professional feels that one is needed.

Nurses and midwives should always consider being accompanied by a chaperone when undertaking intimate examinations and procedures to avoid misunderstanding and, in rare cases, false accusations of abuse (RCN, 2002) and the name of the chaperone should be documented within the records.
Knowledge and skills

The examination environment

Genital examinations are carried out in many different environments, including hospital settings, sexual health clinics, GP surgeries, A&E departments, custodial settings, operating theatres, in radiology and in colposcopy or hysteroscopy suites. Local infection control procedures, manual handling and practice focused procedures need to be taken into account in all settings. It is imperative that genital examination is only carried out following appropriate history taking.

The following recommendations should be followed whenever possible and practical, and the dignity of the woman and her consent should be ensured at all times.

- The waiting area should be comfortable, displaying appropriate information.
- Toilet and hand washing facilities should be situated close by.
- Private, warm and comfortable changing facilities should be available.
- If possible, a woman should be given the choice to remain in her own clothes.
- It should be easy for clothing and/or underwear to be laid aside and for the disposal of any sanitary or continence products.
- If she needs to undress, or if there is a risk of damage to the woman’s own clothes, then there should be a clean gown available/offered.
- There should be no undue delay prior to examination.
- The examination should take place in a closed room that cannot be entered while the examination is in progress.
- The room should be stocked in advance with the necessary supplies to allow the examination to proceed as quickly as possible.
- A range of speculum sizes should be on hand to choose from, to make the examination as physically comfortable as possible.
- Latex-free products should be available.
- There should be a supply of sanitary products for after the examination.
- The provision of a mirror may help during the examination; if a woman is able to visualise her external genitalia during inspection, it may lessen her anxiety.
- If using an examination couch, the couch should be situated so that the woman faces away from the doorway during the examination and should be height adjustable, with fitments to enable lithotomy position, and the light source should be angle poised.

Prior to examination

Review the following considerations before commencing the procedure.

- What is the reason for performing the procedure?
- How will the information obtained be used to benefit the woman?
- Are you competent to perform the planned procedure?
- Has valid consent been obtained and documented?
- How will the information be recorded, stored or referred, if necessary?

Effective communication is a critical skill required throughout this procedure. Explain to the woman what is happening, before and during the examination.

Confirm consent:

- offer the woman the opportunity to decline the examination
- confirm that the woman is aware of her right to ask or indicate for the procedure to be stopped at any time
- confirm that the woman agrees to the procedure as described
record verbal consent and, if local policy requires, obtain written consent
consider the need for a chaperone and, if the woman declines, record this
if a learner is undertaking the examination, explicit consent for this must be obtained.

Check the woman understands the purpose of the consultation/examination:
ask if she has ever had a genital examination before
discuss any concerns regarding her previous experience (be alert to the possibility of sexual abuse)
explain the reason for the examination
assure the woman that privacy and dignity will be maintained throughout the procedure
discuss with the woman if she wishes to have a chaperone and/or someone of her choice in the room while she is being examined
take a history and exclude any materials that may cause an allergic reaction, eg latex or iodine
explain the procedure for the examination, using language that the woman will understand
ensure that the woman has emptied her bladder (in some cases this may not be appropriate, eg where swabs are required for urethral gonorrhoea or chlamydia, these will need to be taken before passing urine)
inform the woman that the examination should not be painful but may be uncomfortable
emphasise the importance of relaxation of the genital and/or abdominal muscles during the procedure
explain that she may stop the examination at any point with a request to do so, and agree how that request can be made, such as a key word, or raising of the hand
it may be appropriate to offer a woman the opportunity to take her own swabs (this is common practice in sexual health services)
explain that some women may experience some spotting after swabs and cervical sampling, if appropriate
ensure the woman has privacy if she needs to undress and show her where to place her clothing
the woman should be advised that it is usually only necessary to remove her lower garments
assistance to remove garments should only be given if required, and not in an attempt to hurry the woman
ensure the woman has enough tissue or a sheet to cover the genital area when undressed
ask if she would like you to talk through the procedure as it happens
ask the woman to let you know when she is ready.

If you are preparing the area, make sure the woman is aware of the possible sounds she might hear and what they represent:
position and check trolley, and the availability of required equipment
ensure there is good light and that any viewing light is switched on
light sources should be cold light and should not have hot exteriors which may cause discomfort to the woman
wash hands and wear gloves – consider possible latex allergy.

The examination

The following is broad guidance for vaginal and genital examination. The examinations performed will differ between fields of practice, depending on the purpose of the examination.

Assist the woman into the correct position for the examination, ensuring her comfort and taking into account any problems such as joint and back problems - it may be appropriate to offer a choice of position. Examinations may be undertaken in the prone or left lateral position, depending upon the procedure. Ensure that you inform the woman of the position she will be in and request that she remains in that position for the anticipated length of the examination or procedure.

Abdominal inspection and examination

Undertake a visual inspection of the skin and note hair pattern on the abdomen. Check inguinal lymph nodes for enlargement, pain or tenderness.
Perform an abdominal examination by palpating the woman’s abdomen working from the umbilicus towards pubic bone to identify the uterus, and note findings (size, position and tenderness of uterus). For the midwife, this examination will also focus on identifying the lie, position and gestation of a pregnancy.

- Palpate the abdomen in a systematic manner.
- Gloves are not required for this part of the examination.
- Light palpation – feeling the abdomen gently is especially helpful in identifying tenderness and muscular resistance. Keep your hand and forearm on a horizontal plane, with fingers together and flat on the abdominal surface, palpate the abdomen with a light, gentle dipping motion. Moving your hand from place to place, raise it off the skin. Moving smoothly, feel in all quadrants.
- Deep palpation – if there is no evidence of distress during light palpation, palpate the abdomen in the same systematic manner but deeper.
- It is often possible to palpate a full colon, especially in slender patients, but if you feel any other masses refer immediately to a doctor.
- Note any areas of tenderness or pain.
- Look at the woman’s face whilst performing the examination.
- Note any “guarding” – involuntary contraction of abdominal muscles.
- Rebound tenderness (usually only performed if the woman is extremely tender and there is concern about possible peritonitis/appendicitis) – press your fingers in firmly and slowly, and then quickly withdraw them. Watch and listen to the patient for signs of pain. Ask the patient to compare which hurts more, the pressing or the releasing. Pain induced or increased by quick withdrawal constitutes rebound tenderness. It results from rapid movement of an inflamed peritoneum.
- Patients with suspected peritonitis, appendicitis, ruptured ovarian cyst or ectopic pregnancy should be immediately referred to a doctor or the emergency department.

**External genital examination**

Inspect the external genitalia and note any of the following findings:

- lesions, colour, varicosities, scarring, infection, ulceration, discharge, cysts, trauma, tenderness, enlarged glands, Skene and Bartholins glands
- assess sexual maturity – hair development and distribution, and size of the vagina
- inspect mons pubis
- spread the labia – they should be the same colour and plump in adults (atrophied in post-menopausal women)
- on touch the labia should be mobile and soft
- in women who have not had a pregnancy the labia majora may meet midline and cover the labia minora; after childbirth they may be flaccid.

**Vaginal examination**

Depending on the reason for the examination, digital vaginal examination if necessary may occur before or after a speculum examination.

Part the labia and insert gloved and lubricated index and middle finger into the vagina. To assess the genital floor tone, ask the woman to ‘bear down’ and ‘squeeze’.

Advise the woman that you will be applying light pressure to the posterior fourchette and this will help the muscles to relax.

**Speculum examination**

The Cusco bivalve speculum is most commonly used for routine examination and inspection of the cervix. There are other specula, including the Sims, which are useful for complex examinations, continence assessment and during surgical procedures.

Follow the guidelines below to insert the speculum correctly.

- Ensure that the correct size and type of speculum is selected.
- Offer to demonstrate the speculum.
- Inform the woman about the sounds associated with the speculum use, if appropriate.
- Ensure the speculum is lubricated with water or water-based lubricant (be aware that lubricant can
obscure cervical cytology tests and swab results, so may not be used in some examinations) and warmed, if required.

- Ensure that the blades of the Cusco speculum are closed for insertion.
- Introduce, or instruct the woman to introduce, the speculum. The speculum should be inserted into the vagina in a slightly downward motion. If the labia are flaccid, gently opening them with your other hand limits any dragging or pulling. The insertion should be a slow and seamless procedure.
- Ensure that the speculum points down towards the posterior of the woman and insert into the vagina until flush with the perineum.
- Ensure no pubic hair is caught, and that there is no pressure on delicate structures such as the urethral meatus and clitoris.
- In the case of prolapsed vaginal walls, sheath the speculum with a condom or a non-latex glove finger with the end cut off, or use a wider or long-bladed speculum.
- Check the woman’s comfort – either with eye contact, verbally or using a chaperone.
- Open the speculum and look at the cervix (it is not necessary to fully open the speculum). To do this you may need to ask the woman to cough or change position.
- Fix or hold the Cusco speculum into the correct position.
- Note the colour, size, position, appearance, secretions and texture of the cervix.
- Note any polyps or contact bleeding, presence/absence of threads if intrauterine device is in situ.
- In a woman who has never had a pregnancy, the cervical os will be small and round, otherwise it will often look like a horizontal line and can be irregular.
- Note any nabothian cysts or follicles, which are a normal finding and have the appearance of small yellow nodules.
- Note that the cervix is usually midline, extending 2cm into the vagina. More than 3cm could indicate vaginal prolapse.
- Note that in pregnancy the cervix will look different and may have a bluish/purple tint, and normal vaginal discharge may also appear heavier.
- Note that the cervix and os also change position and appearance at different stages of the menstrual cycle and pre- and post-menopause.
- If collecting samples for sexual health screening or cytology, collect them according to local protocol using the pathology swabs in current use.
- It is important to remember that the cervical smear should be the first specimen collected regardless of any others to be collected.
- Remove the speculum carefully ensuring that you have not trapped the vaginal walls or cervix in the speculum as it closes. Remove with the speculum slightly open.
- Examine the vagina as the speculum is removed assessing the vaginal walls for infection, cysts or foreign bodies. Rugae are a normal finding in younger women.
- In older women you will need to be aware that the vaginal walls are thinner and drier and be careful not to cause damage with the speculum.

**Bimanual genital examination**

This examination is used by appropriately trained nurses and midwives, mainly for assessment and diagnostic purposes.

- Insert a gloved and lubricated index and middle finger into the vagina.
- Assess the vagina and note findings such as vaginal tone and vaginal wall support – degree of prolapse, varicosities, tenderness, protrusions, foreign bodies etc.
- Place the other hand on the abdomen and press towards the fingers inside the vagina.

**Examination of the cervix:**

- locate the cervix and lightly feel this between two fingers, then assess its size and movement; it should move freely (if there is an infection present this may not be appropriate as it would cause pain or discomfort)
- palpate the cervix – it should feel smooth and firm (hard and lateral displacement could indicate the presence of tumours/fibroids)
comment on findings such as mobility, discomfort, size, shape, consistency, depth/projection into vagina, angle, or any masses.

Palpation of the uterus:
- the abdominal hand should be midway between the umbilicus and the symphysis pubis
- the vaginal hand with palmer surface facing anteriorly should maintain contact with the cervix so that the nurse/midwife examining the woman can use the cervix as a ‘landmark’ for palpating the uterus
- lightly applying pressure to the posterior portion of the cervix with the vaginal hand will bring the uterus towards the abdomen
- once the uterus is raised, use the external hand to palpate, taking note of size, shape, position and consistency
- if the uterus is retroverted or retroflexed, it will not come up between the examining hands – differentiation between an anteverted and retroverted uterus is vital for certain procedures
- assess the uterus, taking note of size, shape, position, consistency, mobility and tenderness
- record findings from the uterine palpation.

Follow the guidelines below for palpation and examination of the adnexa:
- move abdominal hand to the lower abdominal quadrant on the same side as the internal hand
- move fingers in the vagina to either the right or left sides of the lateral fornix
- apply firm and steady pressure, beginning medial to the anterior iliac crest
- note any tenderness or masses
- palpate the position of the fallopian tubes on either side of the uterus; these are not normally palpable or tender
- when palpating the ovaries at the end of the fallopian tubes, advise the woman that some discomfort is likely
- the ovaries are approximately 2-4 cm in length, smooth, firm, mobile, sensitive to touch but not tender and, if palpable, should feel the size of an almond. In post-menopausal women they are smaller
- gentle moving of the cervix slightly from side to side will demonstrate ‘cervical excitation’. Should there be any adnexal masses or tenderness, advice should be sought
- if there is a potential diagnosis of ectopic pregnancy, this procedure should be performed by a skilled clinician, following pregnancy testing and ultrasound scanning.

Following the examination

Switch off the examination light and provide privacy for the woman to get dressed or rearrange her clothing. Ensure the woman has tissue available to wipe away any lubricant or discharge and that there is access to washing facilities and sanitary pads, if needed.

Ensure a full record is made of the examination performed, and that any tests taken and findings observed are recorded clearly and contemporaneously in the woman's notes. Document your findings using local policy. The following points should be included in your records:
- abdomen
- external genitalia
- vagina
- cervix
- uterus
- adnexae.

And may include reference to:
- size
- position
- consistency
- mobility
- mass
- tenderness.

Provide correct information about the findings and results of the examination. If swabs have been taken or screening performed this should include:
- how the results will be communicated
- when to expect results
• what to do if she does not get the expected results
• possible outcomes
• any further management.

Specific considerations
Special consideration should be given with vulnerable groups. The examination can be hindered or limited if a woman has had previous experiences that may make this examination traumatic, or if the experience itself requires particular care. Nurses need to be sensitive to the fact that some women presenting may have suffered some form of sexual abuse.

Women who experience difficulty with vaginal examination should be given the opportunity to discuss any underlying sexual, marital or trauma related issues. These discussions should take place when the woman is dressed. Some women may experience distress without any underlying history of sexual abuse or difficulties.

If the woman has not had a vaginal or genital examination previously, it may be appropriate to discuss the examination/procedure and rebook an appointment for a later date. It may be appropriate to see the woman more than once before she is comfortable enough to undertake the examination.

If the woman refuses or withdraws consent to the examination at any time, then it should be terminated, or if not already underway, it should not be carried out. You should not proceed with an examination if you feel that the woman is not physically or mentally able to cope with the procedure, for example if the woman:

- is unduly stressed or upset
- has had previous vasovagal reactions
- has an imperforate hymen
- has a full rectum
- has a clinical condition which prevents examination.

History of trauma
Some women will have a history of traumatic experiences with previous examinations or may have experienced sexual abuse, physical abuse or rape in the past. This may be evident within the history taking. The woman should be given an opportunity to discuss this, if she wishes. Referral for counselling may be appropriate.

In the case of an unreported rape the nurse or midwife should be aware of the referral pathway to the local rape assessment unit and the need to protect any potential ‘evidence’. For information on how to protect forensic evidence when sexual assault has been reported, a CD-ROM is available from www.careandevidence.org

If a woman discloses that she has been subject to domestic violence, it is important to ensure that information is available for her to contact a local or national helpline. It is also the responsibility of the nurse or midwife to record any disclosure and any physical signs of abuse. The woman may choose not to take further action but may wish to refer back to her medical records at a later date for evidence in a court case.

Vaginismus
Vaginismus can make vaginal and genital examination extremely difficult. This could be related to a previous vaginal examination, previous sexual abuse or reasons of unknown origin. Referral to a psycho-sexual counsellor may be necessary but the examination should not proceed if it will cause further distress to the woman.

Female genital mutilation (FGM)
Nurses and midwives should be aware that women from African countries, parts of the Middle East and South East Asia may have undergone FGM. It may be appropriate to ask if they have been circumcised or closed. For more information see the RCN publication Female genital mutilation (2006).

Police use of restraints
This is a contentious issue but should a woman be restrained eg in a custodial setting, then the nurse is still responsible for ensuring consent is given for the procedure to be carried out and that the woman’s dignity is maintained.

Requests for female only practitioners
Some women will request to only be examined by a female and this should be respected. If a female health
professional has been requested but is unavailable, alternative arrangements may have to be made. In emergency situations, where no female health professionals are available, sensible and practicable measures must be taken.

**Protecting the practitioner**
If the woman gains sexual satisfaction from the examination the need for a chaperone is paramount. This should be clearly documented.

**Antenatal contraindications**
If a pregnant woman has had an antepartum haemorrhage or is known to have placenta praevia then an examination should not be carried out.

**Language barriers**
Women with a limited command of or no English will require a recognised translator. Due to the intimacy of the examination and the sensitivity of the consultation, a family member or friend may not be appropriate to assist with the translation. If translated forms of written information are available they should be provided prior to the examination.

**Examination under anaesthetic**
A woman should give consent to "examination under anaesthesia" and be made aware of, as well as have the right to refuse any teaching or training of medical, nursing or midwifery learners whilst anaesthetised. Women can feel particularly vulnerable about being under anaesthetic and not having any control over the situation. It is therefore necessary that nothing additional is performed other than what is consented for. The nurse or midwife should act as the woman’s advocate.

Examination under anaesthetic by medical students/student nurses should have separate written consent.

**Capacity issues**
Where a woman has a temporary or permanent learning or physical disability, careful consideration should be given as to whether the proposed examination is screening or diagnostic in intent. Any resistance to the examination should be interpreted as refusal. If the examination is abandoned, alternative measures should be taken as necessary for the woman's health.

**Children**
This guidance does not include information on the examination of a child, which should only be carried out by specialist staff. The age of the child and the reason for the examination should be considered. It may be necessary to carry out the examination under anaesthetic, particularly in young children.

Where there is an indication that a child or young person may have been abused, practitioners should follow local child protection procedures and refer immediately.

In contraception, sexual health and termination of pregnancy services, appropriately trained nurses and midwives may examine young women under 16 but must do so under the requirements of the Fraser Guidelines (DH, 2001) and be fully aware of the laws regarding consent.

The Department for Education and Skills (DfES, 2005) has outlined a common core of skills and knowledge for working with children and young people in England. All practitioners who may come into contact with a child or young person under the age of 19 are advised to undertake a self-assessment against the requirements and to seek relevant additional training as required.
Learning outcomes framework

Purpose and scope of this learning and assessment framework

Having recognised learning outcomes ensures that women requiring a genital examination are cared for safely, and that training and assessment processes are congruent with local guidance.

This framework can be used to:

- help professionals to identify their individual training needs
- ensure nurses/midwives have the skills and knowledge to undertake bimanual genital examination competently and safely
- provide a basis for assessing individual competence to successfully and safely complete key skills
- inform the commissioning, development and delivery of education and training.

It is acknowledged that the practitioners coming to these assessments are well established registrants, and have an assumed level of basic knowledge and skills, including adhering to regulatory requirements (in particular, codes of practice).

Proceeding with these competences also assumes an extensive knowledge of relevant anatomy, physiology and pathology.

The following learning outcomes should be achieved to demonstrate that consistent and appropriate training has been successful. The assessment should be set against the content in the knowledge and skills section of this document, and an example is provided in the sample learning contract in Appendix 1.

The assessor needs to reassure themselves that the learner is already working at the higher level of practice; has an adequate understanding of relevant anatomy, physiology and pathology; demonstrates commitment to attaining a respectful and caring attitude, congruent with being a professional practitioner; and demonstrates a level of knowledge that would be acceptable in order to meet the standards outlined within this document.

Learning outcomes

1. Demonstrate an understanding of how to prepare the environment and equipment for undertaking vaginal, speculum and genital bimanual examination and specimen collection.

2. Demonstrate how to effectively prepare the woman physically and psychologically for vaginal, speculum or genital bimanual examination.

3. Demonstrate the knowledge and skills required to safely and effectively perform genital examination.

4. Demonstrate the knowledge and skills required to safely and effectively perform speculum examination with or without specimen collection appropriate to clinical indication/request.

5. Demonstrate the knowledge and skills required to safely and effectively perform genital bimanual examination.

6. Demonstrate the knowledge and skills required to interpret findings of examination to identify the woman's needs.

7. Demonstrate the knowledge and skills required to provide clear and accurate results to the woman.

8. Demonstrate the ability to provide holistic information advice and support to meet the woman's needs.

9. Maintain accurate records of interventions and outcomes.
**Introduction for trainers and assessors**

This section will focus on the expected skills of those health professionals who agree to train and assess the competence of nurses to perform genital examinations.

The learner must identify a trainer (ideally more than one) and an assessor, who should be a different person from the trainer.

A learning contract (Appendix 1) and logbook (Appendix 2) should be agreed between the learner and the assessor. The learner may find the use of a reflective diary useful.

Training and assessment can be obtained from any registered professional (doctor/nurse/midwife working in obstetrics, gynaecology, sexual health or contraception services) who holds a recognised teaching/mentoring qualification and who is competent in genital examination.

Some trainers may choose to develop a more formal checklist covering the topics to be assessed, and may use the knowledge and skills section as a guide. Consideration should be given to initial practical training on a genital model. It is envisaged that the majority of training will be on conscious women, but in some instances, genital examination of a woman undergoing a procedure under general anaesthesia may be undertaken with prior written consent.

Some learners may find that there is no suitably qualified person in their usual place of work to provide training and assessment. In this case the learner would need to find a local training service to help.

Assessment must be objective and be undertaken by a recognised assessor. It should cover knowledge, skills and attitudes. A sample assessment of learning outcomes and competence tool can be found in Appendix 3.

A learner may be working in a setting where they would not undertake bimanual examination. Therefore, the training is divided into two parts.

- **Part 1** must be completed by all learners and covers knowledge, attitude and skills in relation to the observation and speculum examination and excludes bimanual examination.
- **Part 2** covers bimanual examination for those who are required to learn this procedure.

The assessor must make it clear in the certificate of competence which elements of genital examination have been assessed, and the learner must agree to undergo further training should they need to undertake bimanual examination training in the future.

The learner should keep a logbook (Appendix 2) of any supervised practice they have undertaken in a clinical setting. The learner should ask the patient to complete a consultation feedback form (Appendix 4). The learner may also wish to explore electronic feedback mechanisms such as an online survey tool. The learner also should complete an evaluation of their training and return to the assessor for feedback on the process (Appendix 5).

The logbook may be used as preparatory training in conjunction with specialist training in female examination such as in intrauterine contraceptive device insertion where knowing the position of the uterus is critical.

Trainers may wish to set a timeframe over which training should be undertaken. The recommendation is that this training period should be no longer than six months.

There is a suggested template for a certificate of competence in Appendix 6.

**Standards for learning and competency**

A competent practitioner should be able to demonstrate a good level of knowledge, skills and attitude in all aspects of Part 1 and, if appropriate, Part 2.

For Part 1, it is recommended that practitioners observe five examinations and perform a minimum of ten examinations on asymptomatic women and a minimum of ten on women with symptoms or signs, in conscious women, and under supervision, before competence can be agreed by the assessor.
For Part 2, it is recommended that practitioners observe five examinations, and perform a minimum of ten bimanual examinations, in conscious women, and under supervision, before competence can be agreed by the assessor.

Assessment should be carried out using the previously described procedures.

The templates in Appendices 1-6 can be used and adapted to meet local requirements.

It is recommended that the learner maintains a record of assessed competence as evidence of continuing professional development and that a refresher of skills and knowledge should be carried out every three to five years, especially if the practitioner has not been using the skill in regular practice.
Appendix 1 Sample learning contract
(using learning outcome 1 as an example)

Identified need:
Demonstrates an understanding of how to prepare the environment and equipment for undertaking vaginal, speculum and genital bi-manual examination and specimen collection.

Strategy and resources:
Agree a plan of learning and assessment with trainer/assessor, including timeframes, appointments, reviews and feedback.
Comment on, for example:
○ access to training
○ training process: sufficient variety of cases
○ assessment process.

Action:
For example, the practitioner will:
○ prepare or supervise the preparation of the environment, taking into account any specific requirements
○ ensure environment enables the maintenance of privacy and dignity
○ prepare the equipment required, eg various sizes of speculum.
○ ensure all equipment for specimen collection or cytology is present
○ ensure provision of latex free products
○ ensure access for women with disabilities such as access to couches and specific positioning requirements.

Implementation:
Describe how the learning strategy is implemented.

Assessment:
Describe how achievement of the learning outcome will be demonstrated to the assessor.
## Appendix 2 Sample logbook

The learner should keep a logbook of all genital examinations and incidents associated with them, including positive and negative experiences for the learner or woman. This logbook will be used by the learner for learning, study and reflection and for the trainer as an assessment tool.

### Part 1

<table>
<thead>
<tr>
<th>Name of learner; place of work; contact details; training commencement date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case number; setting; date seen</td>
</tr>
<tr>
<td>Indication for genital examination; history taking; record keeping</td>
</tr>
<tr>
<td>Preparation of examination room and woman</td>
</tr>
<tr>
<td>Explanation and demonstration of procedure and any tests to be undertaken; how results will be managed</td>
</tr>
<tr>
<td>External genitalia examination and findings</td>
</tr>
<tr>
<td>Speculum examination and findings</td>
</tr>
<tr>
<td>Reflective practice on communication with the woman and other involved staff/individuals</td>
</tr>
<tr>
<td>Reflective practice on the woman’s view of the procedure</td>
</tr>
</tbody>
</table>

### Part 2 (learner must be undertaking or have completed Part 1)

<table>
<thead>
<tr>
<th>Name of learner; place of work; contact details; training commencement date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case number; setting; date seen</td>
</tr>
<tr>
<td>Indication for bimanual examination</td>
</tr>
<tr>
<td>Bimanual examination procedure and findings</td>
</tr>
<tr>
<td>Reflective practice as in Part 1</td>
</tr>
</tbody>
</table>
Appendix 3  Sample assessment of learning outcomes and competence tool

The assessor should only sign off the appropriate section once the learner is competent. A certificate of competence can be issued by the assessor.

<table>
<thead>
<tr>
<th>Action</th>
<th>Name and signature of assessor</th>
<th>Date</th>
<th>Name of clinic/hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part 1</strong></td>
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<tr>
<td>Has appropriate theoretical knowledge in anatomy, physiology and pathology</td>
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<tr>
<td>Understands the indication for examination, and takes an appropriate history</td>
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<tr>
<td>Understands and manages special situations regarding vulnerable groups including young women</td>
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<tr>
<td>Adequately demonstrates how to prepare the environment and equipment</td>
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<tr>
<td>Adequately demonstrates how to prepare the woman physically and psychologically</td>
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<tr>
<td>Gives appropriate information to the woman and understands the consent procedure</td>
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<tr>
<td>Demonstrates appropriate verbal and non-verbal communication with the woman</td>
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<tr>
<td>Recognises the abnormal and symptomatic and refers as appropriate</td>
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<tr>
<td>Demonstrates the knowledge, skills and attitude to safely perform the abdominal, external genitalia and vaginal inspection and examination</td>
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<tr>
<td>Demonstrates the knowledge, skills and attitude to safely perform the speculum examination</td>
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<td>Demonstrates the knowledge and skills to interpret findings and manage the case</td>
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<tr>
<td>Demonstrates the ability and attitude to provide appropriate support to meet the woman’s needs</td>
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<tr>
<td>Demonstrates excellent communication with colleagues</td>
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<tr>
<td>Demonstrates appropriate record keeping</td>
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<tr>
<td>Requests that the woman completes a feedback form</td>
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<tr>
<td><strong>Part 2</strong></td>
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</tr>
<tr>
<td>Demonstrates the knowledge, skills and attitude to safely perform the bimanual examination</td>
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<tr>
<td>Requests that the woman completes a feedback form</td>
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Comments
Appendix 4  Sample consultation feedback form

The health care professional you have seen today is undertaking a training course in genital examination. It would be very helpful if you could give some feedback about the consultation and examination you had today. Thank you for taking the time to complete this form.

Please mark one box on each line to show how you felt the health care professional treated you today.

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Not applicable</th>
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</thead>
<tbody>
<tr>
<td>The health care professional made me feel at ease</td>
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<td>The health care professional listened to me</td>
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<td>I understood what the health care professional was saying</td>
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<td>The health care professional responded satisfactorily to my questions</td>
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<tr>
<td>The health care professional involved me in discussing what course of action to take</td>
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<td>I feel confident about the health care professional’s knowledge</td>
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<td>I would be happy to see this person again</td>
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<td>Any other comments</td>
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### Appendix 5  Sample evaluation of learning and assessment form

<table>
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<th>Evaluate:</th>
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<tbody>
<tr>
<td>Factors that affected my ability to learn:</td>
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<table>
<thead>
<tr>
<th>Factors that have enabled me to learn:</th>
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<tr>
<th>Areas still to learn more about:</th>
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<th>Action plan going forward with time scales and who may be able to help:</th>
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<th>Useful resources:</th>
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Appendix 6  Sample certificate of competence

Certificate of competence

To be completed by the assessor

I certify that
(learner’s name)

Has been assessed at: (name and address of clinic/hospital)

as competent in the following areas:

1  Part 1
   Knowledge, attitude, skills: external genitalia examination, speculum examination  Yes / No

2  Part 2
   Bimanual examination  Yes / No

Delete as necessary. All learners must complete Part 1.

The learner is aware that s/he should only practice the skills that have been assessed and marked as ‘Yes’. If bimanual examination has not been assessed on this occasion, the learner is aware that further appropriate training will be required to complete Part 2.

Assessor:  Name (PRINT)

Qualifications

Contact details

Signature          Date

It is the responsibility of the learner to maintain competence in the assessed areas and adhere to their Codes of Practice at all times.
References


Royal College Of Obstetricians and Gynaecologists (2002a) Clinical standards: advice on planning the service in obstetrics and gynaecology. London: RCOG.


Useful websites

British Association for Sexual Health and HIV www.bashh.org

British Society for Colposcopy and Cervical Pathology (BSCCP) www.bsccp.org.uk

Department of Health www.dh.gov.uk

Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists www.fsrh.org

Family Planning Association (FPA) www.fpa.org.uk

Genito-Urinary Nurses Association (GUNA) www.guna.org.uk

Medical Foundation for Aids and Sexual Health www.medfash.org.uk

NHS Cervical screening service www.cancerscreening.nhs.uk/cervical

Royal College of Obstetricians and Gynaecologists www.rcog.org.uk

Further reading


Royal College of Nursing (2012) *RCN competences for nurses assessing and counselling women who request and/or receive long-acting reversible methods of contraception (LARC).* RCN: London.


Local policies on:

- chaperoning and confidentiality,
- manual handling policies,
- safeguarding.