Royal College of Nursing

Genital Examination in Women

A resource for skills development and assessment

CLINICAL PROFESSIONAL RESOURCE

Endorsed by

FSRH The Faculty of Sexual & Reproductive Healthcare

Acknowledgements

This document was reviewed and updated in 2023 by the RCN Women's Health Forum, and endorsed by the Faculty of Sexual and Reproductive Health.

Notes:

It is recognised that services are provided by registered nurses and midwives, health care support workers, assistant practitioners, nursing associates and student nurses and midwives, and trainee nursing associates. For ease of reading, the generic terms 'nurse', 'nursing' and 'nurses' are used throughout this document. The RCN recognises and embraces our gender diverse society and encourages this guideline to be used by and/or applied to people who identify as non-binary, transgender or gender fluid. The RCN also recognises that not all those born female or male will identify with the same gender nouns, but for ease of reading use the term woman/man/men and where appropriate acknowledge non-binary terms.

This document has been designed in collaboration with our members to ensure it meets most accessibility standards. However, if this does not fit your requirements, please contact corporate.communications@rcn.org.uk

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1. Introduction

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 registered 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.

This document has been developed for:

- registered nurses, midwives and nursing associates working in NHS, independent and private practice arenas
- sexual and reproductive health nurses (including contraceptive advice)
- practice nurses
- nurses working in gynaecology, fertility services, early pregnancy assessment units, custody suites, colposcopy, urology, community, sexual assault referral centres, forensics, 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 and support workers, with clarity around their roles.

The RCN recognises we live in a gender diverse society and that this guidance includes genital examination carried out for assessment of people who do not identify as female, are non-binary or trans-gender.

The purpose of this document is to provide standards and sample assessment tools for training in genital examination in women for registered 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 intrauterine devices and IUS

- hysteroscopy
- nurses working within early pregnancy and acute gynaecology settings
- and as part of any extended role in history taking and examination for the assessment of symptomatic women.

Training is intended to enable registered 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.

Registered nurses, midwives and nursing associates work to the Nursing and Midwifery Council Code (NMC, 2018) which includes the need to be knowledgeable, as well as caring and respectful, and to observe confidentiality in all encounters with women as patients and as clients.

It is anticipated that registered nurses, midwives and nursing associates would access training, where a clear need to learn these skills is identified and where, as with other clinicians, a sufficient number of women are seen in order that competencies are maintained. They should be working with a relevant post-registration qualification. All midwives will develop skills as part of their pre-registration midwifery qualification, and therefore this document is intended as both a refresher and guide for enhancing practice.

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, removal of foreign body, ie, a tampon, uterine and vaginal prolapse, incontinence, vaginal swabs, Bartholin's cyst and abscess, 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.

Who can undertake genital examinations?

Registered nurses and midwives are personally accountable for their practice and answerable for their actions and omissions. All nursing staff 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, 2018). 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 and nurses undertaking hysteroscopy training from the The British Society for Gynaecological Endoscopy (BSGE) as part of routine care provision, including registered nurses fitting intrauterine contraceptive devices all must be competent in genital bimanual examination.

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/support worker, having relevant training, will contribute to nursing care, and their role here will be around preparation of the area and chaperoning.

Registered nursing associates training in cervical sample taking (England only)

In 2019, the NHS Screening programme announced that registered nursing associates would be eligible to perform cervical screening.

The following statement was issued by NHS Cervical Screening Programme, Health Education England and NHS England/NHS Improvement Primary Care Nursing team in September 2019:

"Enhancing the skill base of registered nursing associates (NAs), with the appropriate competency-based training in cervical screening, will:

- increase the number of sample takers across the country
- improve access to screening
- support screening's aim to reduce the incidence of cervical cancer and reduce the number of women who die from it."

Registered NAs working in primary care are eligible to train to undertake the role of cervical sample taker.

Governance arrangements: Screening providers need to ensure the following governance arrangements are in place:

Registered NAs must meet the core clinical competencies in the Skills for Health competency framework set out in the cervical screening sample taker guidance at: gov.uk/government/publications/cervical-screening-cervical-sample-taker-training.

To undertake cervical screening, NAs must have:

- completed a nursing associate qualification and be registered as a NA with the Nursing and Midwifery Council (NMC)
- undertaken initial theory and practical training as required by the NHS CSP, successfully completed the course and assessed as competent
- undertaken update training and maintained competency in line with national cervical sample taker training guidance.

Local governance: The registered NA role is not yet a named profession under the Treatment of Disease, Disorder or Injury (TDDI) legislation regulated by the Care Quality Commission (CQC). However, the CQC expects any provider to consider safety, quality, competency and TDDI legislation when deploying a NA. See: cqc.org.uk/sites/default/files/20190123_briefing_for_providers_nursing_associates_0.pdf CQC briefing for providers.

When a NA has registered with the NMC, a registered professional listed under the legislation (registered nurse or GP) will need to supervise the practice of that NA. The supervisor must be present at the GP practice when the NA is carrying out the procedure. The supervisor can undertake indirect supervision of the NA when carrying out this procedure. This is a delegated activity and the NA would be expected to work within the remits of their professional code.

NHS England/Improvement, Health Education England and PHE are working together to follow a test cohort of registered nursing associates to undertake cervical sample taker training. This evaluation will help make sure that the new profession of registered nursing associates can support primary care and health services to deliver this aspect of care. Any lessons learnt from the evaluation will be incorporated into the training guidance and communicated to providers by NHS England's primary care nursing team and PHE screening (Public Health England, 2019).

Professional issues

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 and understands 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.

> "As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately." (NMC 2018:8)

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. Absolute 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

A chaperone is present as a safeguard for everyone concerned (woman and practitioners) and is a witness to continuing consent of the procedure (FSRH, 2020). The General Medical Council (2013) and Care Quality Commission (2015) provide further information on the use of chaperones. All women should always be offered a chaperone* to be present during an examination, procedure, treatment or any care, irrespective of organisational constraints or the settings in which this is carried out. The offer and response should be documented in the woman's records.

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
- observe the woman to ensure she feels safe and is comfortable
- always be sensitive to cultural and religious issues, as well as the context of the woman's circumstances and specific needs.

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 and the name of the chaperone should be documented within the records (FSRH, 2020).

2. 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 procedures, manual handling and practice, prevention and control 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 and only where clinically indicated (FSRH, 2020).

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 if possible should be height adjustable, with fitments to enable lithotomy position, and the light source should be angle poised. This consideration should also take account of the need for positioning in relation to windows and the need to use a screen.

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. This will vary in colposcopy, hysteroscopy and IUD insertions
- 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
- caution should be exercised with language used; innocent language when used during vaginal/genital examination may be misconstrued, so it is best to avoid the use of any personal comments
- 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 or prior to ultrasound scanning)
- 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 is recommended that a woman should be advised how to take her own low-vaginal swab for chlamydia and gonorrhoe (this is common practice in sexual health services) BEFORE the rest of the examination
- 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. When 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 (variance in colour such as Lichen Planus/Sclerosis), varicosities, scarring, infection, ulceration, discharge, cysts, trauma, tenderness, enlarged glands, Skene and Bartholin's 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 postmenopausal 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
- any alteration to the genital area, including piercing, which may indicate female genital mutilation needs to be noted and discussed (see section on FGM, on page 20).

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 a waterbased 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 postmenopause.
- Inspection of the vaginal walls – note colour, odour and presentation of discharge eg, frothy, curdy or homogenous. Including inspection for internal warts.
- If collecting samples for sexual health screening or cytology, collect them according to local protocol.
- 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.
- Consider using vaginal lubricants with post-menopausal women prior to vaginal examination.
- 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.

Sims speculum use

- A Sim's speculum can be used to assess vaginal prolapse.
- Ask the woman to lie on her left side and bring her knees to her chest.
- Insert the blade of the speculum along the posterior wall of the vagina to hold it back.
- Ask the woman to cough or bear down whilst looking for uterine descent and cystocoele.
- Move the speculum to the anterior wall and ask the woman to cough or bear down observing for uterine decent and rectocele.

Speculum examination and STI screening in pregnant women

Where clinically indicated, the examination of a pregnant woman with a speculum is considered low risk and can be performed safely by a nurse who has received training on how to perform this examination. Swabs for sexually transmitted infections can be taken from pregnant women, without the need for a speculum examination, using a self-taken vulvovaginal swab (BASHH 2019). Routine cervical cytology is not recommended in pregnant women, as interpretation of the sample can be difficult, but should be deferred until 12 weeks postpartum (Public Health England, 2016). Pregnant women should be reassured that clinically indicated speculum examinations, and tests for sexually transmitted infections, can be safely carried out during pregnancy (Faculty of Sexual and Reproductive Health Clinical Standards Committee, 2019).

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/or middle finger into the vagina (depending on the vaginal canal may only be able to insert one digit).
- 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 and/or cervical motion tenderness is a sign of Pelvic Inflammatory Disease (PID) and would need further assessment by a doctor immediately
- 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 palmar 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 and requires immediate referral to a specialist if there is any suspicion of an ectopic pregnancy.

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. Wash hands and 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

Genital examination is a health test entirely removed from sexual activity. If a woman has not had penetrative sex, they are still entitled to be offered, and to accept, genital examination. Virginity is a social construct and should not be a barrier to examination, where clinically indicated and consented to.

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.

In certain situations, the woman can be referred for counselling, surgery or investigations. The vaginal and/or genital examination can be carried out at a later date when the situation has been rectified.

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 sexual assault referral centres (SARCs) 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

A woman's health and wellbeing exceeds the need for forensic evidence collection, for example if a woman needs physical examination due to bleeding following an assault this would take president over the forensic medical examination and should not be delayed because of it.

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 including the completion of a multi-agency referral form in line with local policy. 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.

It may be prudent to consider seeing the woman alone if they are accompanied by a partner. This should also include consideration of women who may have been subject to trafficking and/or modern slavery.

Post menopausal atrophic vaginitis

In women who are menopausal the vaginal tissues becomes thin and atrophic. This can lead to pain and trauma when undertaking vaginal and speculum examinations. If the examination can be rescheduled then women may be advised to use vaginal oestrogens for six weeks before the subsequent examinations.

Dysparenia

Asking whether a woman experiences painful sex/difficulty inserting tampons may be helpful. Referral to a pelvic health physiotherapist, if appropriate and available, may be indicated.

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, midwives and nursing associates 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: An RCN resource for nursing and midwifery practice (RCN, 2019).

FGM is illegal in the UK, and widely recognised as a form of abuse. The legislation relating to FGM has changed in 2015, and all health care practitioners should be aware of their role and responsibility with regard to reporting and recording, as well as how to best care for any girl or woman affected by FGM.

If a girl under 18 years of age has or is suspected of having had FGM carried out, then local safeguarding procedures should be implemented, including informing the police via the 101 nonemergency number (DH, 2015).

There is now a mandatory duty for all regulated health care professionals to report any concerns they may have about a female under 18 years and record when FGM is disclosed or identified as part of NHS health care.

If over 18 years of age recording of the case should be carried out in line with Department of Health requirement under the Enhanced Dataset requirement (HSCIC, 2018). Further information is availably from the Department of Health (DH, 2019). The priority for the woman should always be proving the best care possible to support any physical or psychological, or psycho sexual needs she may have (RCN, 2019).

Virginity testing and hymenoplasty

Virginity testing and hymenoplasty have been illegal in the UK since 2022 (**Sections 136-160 of the Health and Care Act** (on virginity testing and hymenoplasty 1 July 2022 (Gov.uk, 2022a)). This legislation was introduced following growing concern that some girls and young women are being forced/coerced to have a virginity test, and subsequently undergoing hymen repair surgery.

Nurses need to understand the implications of this change in legislation, which may impact on their practice.

The government published guidelines in July 2022, which can be found at: **www.gov.uk/government/publications/virginity-testing-and-hymenoplasty-multi-agency-guidance** (Gov.uk, 2022b).

Virginity testing, also referred to as hymen, 'two-finger' or vaginal examination, is an inspection of the female genitalia, intended to determine whether a woman or girl has had vaginal intercourse.

Hymenoplasty (also known as hymenorrhaphy, hymen reconstruction or hymen repair) is a surgical intervention that involves reconstructing the hymen. There are a number of different techniques to achieve this but generally it involves stitching the torn edges of the hymen together with dissolvable stitches. The aim of the procedure is to ensure that the woman bleeds when she next has sexual intercourse (DHSE, 2021).

Hymenoplasty is regarded as a form of cosmetic/plastic surgery and used in the same way as other forms of cosmetic surgery for aesthetic rather than medical reasons, hence part of the controversy about banning it rests with the issue of freedom to choose by adult women (and those who were born female, but may not identify as being female), in the same way that there is freedom to choose other forms of surgery for aesthetic reason.

Police use of restraints

This is a contentious issue but should a woman be restrained, for example, 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 The general advice is that family members should not be used for translation purposes. 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 or other learners 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 necessary (ie, screening or diagnosis may make the requirement more urgent). Any resistance to the examination should be interpreted as refusal. If the woman does not have capacity then further guidance should be sought before proceeding. 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 safeguarding procedures and refer immediately. Please also see above section on mandatory reporting of suspected abuse, including FGM.

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.

3. 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. Demonstrate understanding and knowledge of local referral pathways, for example, psychosexual, sexual reproductive health referrals, sexual assault referral centres, and/or termination of pregnancy services.
10. Maintain accurate records of interventions and outcomes.

4. Training and assessment process

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 practice supervisor and practice assessor, in line with with NMC guidance (NMC, 2006) (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 should also keep a reflective diary which can be used to good effect to demonstrate learning and development.

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 on page 33.

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 on page 28 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
Name of learner; place of work; contact details; training commencement date
Case number; setting; date seen
Indication for genital examination; history taking; record keeping
Preparation of examination room and woman
Explanation and demonstration of procedure and any tests to be undertaken; how results will be managed
External genitalia examination and findings
Speculum examination and findings
Reflective practice on communication with the woman and other involved staff/ individuals
Reflective practice on the woman's view of the procedure

Part 2 (learner must be undertaking or have completed Part 1)
Name of learner; place of work; contact details; training commencement date
Case number; setting; date seen
Indication for bimanual examination
Bimanual examination procedure and findings
Reflective practice as in Part 1

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.

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

	Strongly agree	Agree	Disagree	Strongly disagree	Not applicable
The health care professional made me feel at ease					
The health care professional listened to me					
I understood what the health care professional was saying					
The health care professional responded satisfactorily to my questions					
The health care professional involved me in discussing what course of action to take					
I feel confident about the health care professional's knowledge					
I would be happy to see this person again					
Any other comments					

Appendix 5 Sample evaluation of learning and assessment form

Evaluate:
Factors that affected my ability to learn :
Factors that have enabled me to learn :
Areas still to learn more about:
Action plan going forward with time scales and who may be able to help:
Useful resources:

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 they 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 and further reading

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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.gov.uk/government/organisations/department-of-health-and-social-care

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

Institute of Psychosexual Medicine
www.ipm.org.uk

NHS Cervical screening service
www.gov.uk/guidance/cervical-screeningprogramme-overview

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

Royal College of Nursing

Modern slavery information
www.rcn.org.uk/clinical-topics/modern-slavery
www.gov.uk/government/collections/modernslavery

Female genital mutilation information
www.rcn.org.uk/clinical-topics/female-genitalmutilation

Safeguarding clinical pages
www.rcn.org.uk/clinical-topics/safeguarding

Domestic abuse clinical pages
www.rcn.org.uk/clinical-topics/domesticviolence-and-abuse

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Local policies on:

- chaperoning and confidentiality
- manual handling policies
- safeguarding.

RCN quality assurance

Publication

This is an RCN practice guidance. Practice guidance are evidence-based consensus documents, used to guide decisions about appropriate care of an individual, family or population in a specific context.

Description

This latest edition provides standards and sample assessment tools for training in genital examination in women for registered nurses working in sexual and reproductive health settings, and related health and social care settings.

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The Nine Quality Standards

This publication has met the nine quality standards of the quality framework for RCN professional publications. For more information, or to request further details on how the nine quality standards have been met in relation to this particular professional publication, please contact **publications.feedback@rcn.org.uk**

Evaluation

The authors would value any feedback you have about this publication. Please contact **publications.feedback@rcn.org.uk** clearly stating which publication you are commenting on.

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