REGISTERED NURSE PAP TEST LEARNING MODULE REVISED 2012

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For More Information Contact:
Cancer Screening Programs
Health Promotion, Disease & Injury Prevention
Population & Public Health
Alberta Health Services
Holy Cross Centre, 2210 - 2nd Street
SW Calgary, Alberta, Canada T2S 3C3
Phone: 1-866-727-3926
Fax: 1-888-944-3388

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Thank-you to the 2008 reviewers of the revised Registered Nurse (RN) Pap Test Learning Module (2010):

- Connie Burkart, Manager, Colposcopy Clinic, Alberta Health Services (AHS) - Calgary
- Yvonne Burland, Former HIV/STI RN Specialist with Health Canada – First Nations Inuit Health
- Dr. Katy Campbell, Interim Dean, Faculty of Extension, University of Alberta
- Dr. Margaret Churcher, Family Physician, Calgary
- Dr. Jim Dickinson, Professor of Family Medicine, University of Calgary
- Melissa Hyman, Health Promotion Coordinator, AHS-CSP
- Dr. Laura McDougall, Medical Lead, Alberta Cervical Cancer Screening Program, AHS-CSP
- Dr. Jill Nation, Colposcopist, AHS – Cancer Care
- Alison Nelson, Manager, Health Promotion Unit, AHS-CSP
- Debbie Phillipchuck, Nursing Practice Consultant, College & Association of Registered Nurses of Alberta (CARNAC)
- Colleen Roy, Manager, STD Clinic and TB Clinic, AHS - Calgary
- Dr. Vivien Suttorp, Former Medical Consultant, AHS-CSP
- Evelyn Valge, Project Consultant, Valge Health Management Consulting

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- Eileen Bell, Manager, Program Development & Coordination, Screening Programs, Alberta Cancer Board
- Mary Bobey, Manager, Grace Women’s Health Resources, Calgary Health Region
- Yvonne Burland, HIV/STI RN Specialist, First Nations and Inuit Health Branch
- Dr. Katy Campbell, Director of Research and Policy, Academic Technologies for Learning, University of Alberta
- Bonnie Friesen, RN Educator, Faculty of Nursing, University of Calgary
- Patty Lenstra, Registered Midwife, Calgary
- Colleen Lucas, Evaluator, Screening Programs, Alberta Cancer Board
- Dr. Jaelene Mannerfeldt, Colposcopist/Gynecologist, Calgary
- Anne McKay, Manager, Public Health Nursing, Calgary Health Region
- Mary Nugent, Nurse Practitioner, Calgary
- Debbie Phillipchuck, Nursing Consultant – Practice, Alberta Association of Registered Nurses (AARN)
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SECTION 1: INTRODUCTION

Learning Objectives

Upon completion of this Section, the learner will be able to
1. Describe the Learning Module’s rationale and purpose.
2. Discuss the responsibilities of RNs, Employers, and preceptors related to RNs performing Pap tests.
3. Understand the concept of women-centred care.
4. List the learning objectives, types of learning resources, activities, and recommended schedule for completing the Learning Module.

Welcome to Alberta Health Services – Screening Programs’ (AHS-CSP) revised Registered Nurse (RN) Pap Test Learning Module (2010). The Learning Module is a continuing education resource for the Alberta Cervical Cancer Screening Program (ACCSP). ACCSP is coordinated by AHS-CSP in partnership with healthcare providers.

Learning Module Purpose and Rationale

The Learning Module’s purpose is to provide Registered Nurses (RNs) with knowledge and skill-based learning activities that may be used to develop and/or maintain competency in performing Pap tests.

- RNs are encouraged to use the Learning Module for their self-directed learning and as an ongoing resource to review as required.
- Employers are encouraged to utilize the Learning Module as a continuing education resource to support RNs in developing and maintaining competency in performing Pap tests.

The Learning Module was designed in 2004 in consultation with numerous Alberta healthcare providers and included an extensive review of national and international modules and related literature. The Learning Module was reviewed by cervical cancer screening and women’s health experts in 2008 and revised in 2009/2010.

The Learning Module was developed in response to the following issues

- In some areas of Alberta, access to Pap test services is inadequate. Access issues are related to a limited number of physicians or Nurse Practitioners (NPs) practicing in an area and/or the need for more women’s health services.
- In response to inadequate access to Pap testing and women’s health services, some areas and Primary Care Networks are expanding the role of RNs to provide Pap tests.

The icons to the left are used throughout the Learning Module to indicate important information, self-tests, learning activities, recommendations on policies, recommended readings, space to take notes, and the time required to complete specific sections.
Endorsement from College and Association of Registered Nurses of Alberta (Carna)

Carna recommends that all RNs practicing in Alberta whose position requires them to perform Pap tests AND who have not taken Pap test education in other programs complete the RN Pap Test Learning Module. RNs would need to discuss with their Employer whether the Learning Module is relevant to their practice setting and the Employer’s expectations.

Under the Health Professions Act (HPA) (2000; 2005), all RNs who engage in restricted activities must be competent to perform the particular restricted activity if that the activity is relevant to the practice setting, roles, and responsibilities of the RN. Those RNs who are performing Pap tests are expected to have the appropriate knowledge and skills.

The RN Pap Test Learning Module, developed by Alberta Health Services – Screening Programs, can be used by RNs and their Employers to support the attainment of competence in the performance of this restricted activity.

Liability Coverage/Protection

RNAs performing Pap tests raises issues related to physicians’ and RNs’ respective liability coverage especially within collaborative practice settings such as Primary Care Networks.

Each healthcare provider is responsible for ensuring they have appropriate liability insurance and each healthcare provider is responsible for his/her own competent practice. Carna provides RNs with liability insurance through the Canadian Nurses Protective Society.

For more detailed information regarding Endorsement from Carna and Liability Coverage/Protection for RNs performing Pap tests, see Appendix 1: Carna Letter.

Professional Responsibility and Accountability

RNAs, Employers, and preceptors have shared responsibilities related to RNs performing Pap tests.

The information and theory within the Learning Module including recommended readings and Pap test videos (see Appendix 2: Pap Test Videos) together with a clinical practice component with a preceptor support RNs in the development of the necessary knowledge and skill to perform Pap tests.

RNAs’ Responsibilities

In the province of Alberta, health professionals are regulated under the Health Professions Act (HPA) (2000; 2005) which was proclaimed for RNs in 2005. Under the HPA Registered Nurses Profession Regulation (2005), RNAs have a responsibility to be competent in performing restricted activities. Please note the specific sections of the Health Professions Act that relate to restricted activities including Pap tests.
• “CARN A regulated members are **authorized to insert or remove instruments, devices, fingers or hands... (v) beyond the labia majora**” (which included Pap tests) [Section 15(1)(a)].

• “CARN A regulated members **must restrict themselves in performing restricted activities to those activities that they are competent to perform and to those that are appropriate to the member's area of practice and the procedure being performed** in accordance with CARN A guidelines” [Section 16].

RNs in Alberta are expected to practice in a manner consistent with the following standards, regulations, and legislation within all their practice activities:

• **CARN A Nursing Practice Standards (2005)** which state
  “The registered nurse applies nursing knowledge and skill in providing safe, competent, ethical care. Regulated members perform restricted activities authorized under the HPA regulations that they are competent to perform if they are appropriate to the area of practice” (Indicator 2.8)

  “The registered nurse collaborates with the client/significant others and other members of the health-care team regarding activities of care planning, implementation and evaluation” (Indicator 4.1).

• **CARN A Health Professions Act: Standards for the Performance of Restricted Activities (2005)**

• **Canadian Nurses Association (CNA) Code of Ethics (2002)**
  See the CARN A website at [www.nurses.ab.ca](http://www.nurses.ab.ca) for more details.

**Employers’ Responsibilities**

The Employer is expected to be familiar with and practice according to the Alberta Health & Wellness Employers’ Handbook, which addresses the HPA for the Employer. Electronic copy and paper versions of this handbook is available from Alberta Health and Wellness. Contact your local Director of Human Resources or Alberta Health and Wellness for further support on the HPA.

Employers have a responsibility to hire individuals who are competent and authorized to provide the restricted activities that are required as part of their position. In order to support RNs in performing Pap tests, a shift in thinking may be required. It may be helpful to consider the workplace as a “continuous learning environment” where RNs and Employers work together to identify learning needs and negotiate learning time.

The Canadian Nurses Association (CAN) and Canadian Association of Schools of Nursing (CASN) **Joint Position Statement on Continuing Competency for Registered Nurses (2004)** outlines the specific responsibility of RNs and Employers related to skill development through continuous lifelong learning. See the Canadian Nurses Association website at [www.cna-aic.ca](http://www.cna-aic.ca) for details.

The Employers of RNs who are expected to provide Pap tests as part of their position are required to

• **Provide adequate time, resources, preceptorship opportunities, and facilities** to ensure that RNs are adequately educated (both initially and on an ongoing basis) to provide quality Pap tests.
• Ensure that there is an explicit relationship with the RN taking the Pap test and a physician, nurse practitioner, or registered midwife for follow-up of the Pap test result.

• Develop policies and procedures related to RN Pap testing for their institution, agency, or clinic (see Appendix 3: Recommended Relevant Policies).

• Participate in ongoing monitoring of Pap test adequacy rates (see Appendix 4: Assessment Tools).

• Maintain a record of RN Pap test education.

It is strongly recommended that the Learning Module become a segment within comprehensive Employer policies and approach to providing holistic women-centred services, for example: clinical breast exams, Sexually Transmitted Infections (STI) testing. If the population that the RN serves has a high incidence of STI, the Employer may consider RN continuing educating related to performing STI tests. STI continuing education should be considered in combination with Pap test continuing education.

Preceptors’ Responsibilities
Preceptors who provide Pap test theory and a practicum experience are required to

• Be a Registered Nurse, Nurse Practitioner, Registered Midwife, or Physician.

• Be a skilled experienced Pap test taker.

• Be able to demonstrate continuing competencies in Pap test provision (with particular reference to transformation zone sampling, technique, sample preparation, audit of results including adequacy rate).

• Demonstrate good communication and counselling skills.

• Practice a women-centred approach to care.


• Have time to provide Preceptor duties such as mentorship, supervision, and review of assessment materials.

Women-Centred Care
A women-centred approach to care is important to conducting high quality Pap tests that are accessible, appropriate, and acceptable to women.

Women’s health involves women’s emotional, social, cultural, spiritual and physical well-being, and it is determined by the social, political and economic context of women’s lives as well as by biology. This broad definition recognizes the validity of women’s life experiences and women’s own beliefs about and experiences of health. Every woman should be provided with the
opportunity to achieve, sustain and maintain health, as defined by the woman herself, to her full potential. (Phillips, 1995).

The cornerstones of women-centred care are
- a focus on women
- involvement and participation of women
- empowerment
- respect and safety

Research has demonstrated that women-centred care is comprised of the following elements

1. **Comprehensive services** that
   - reflect women’s patterns and preferences for care
   - acknowledge women’s ways of communicating
   - address the complexities of women’s lives
   - are inclusive of diversity
   - have integrated service delivery
   - respond to women’s forms of communication and interaction
   - provide information and education

2. **Gender –sensitive knowledge development** which includes
   - evaluation
   - research

3. **A woman-centred workplace** which includes
   - a collaborative work environment
   - a common shared woman-centred philosophy
   - service providers with expertise in women’s health who act as consultants
   - good communication and concern for staff mental health and safety
   - gender and inclusiveness training

(Barnett et al., 2002)

The Pap test is only a part of an overall periodic health assessment. The RN should make it clear to the client that the Pap test does NOT constitute a full periodic health assessment. The client needs to see her physician, nurse practitioner, or registered midwife for a complete periodic health assessment which may include physical exam, risk assessment and screening for other disease processes. Periodic health assessments should not be annual but at intervals according to risk (including age).

**Learning Module Objectives**

On completion of the Learning Module theory and practicum, the learner will be able to

1. Demonstrate an understanding of cervical cancer and the guidelines of cervical cancer screening in Alberta.
2. Demonstrate an understanding of counselling and teaching strategies before, during and after an external/internal exam (speculum and Pap test).
3. Demonstrate an understanding of the learning, counselling, and communication needs of clients with special considerations.
4. Demonstrate an understanding of normal and abnormal female pelvic anatomy and physiology.
5. Demonstrate an understanding of and competently perform a woman-centred health history and an external/internal exam (speculum and Pap test) with women across the lifespan.

6. Demonstrate an understanding of abnormal findings, such as STI, and referral for appropriate follow-up.

7. Demonstrate an understanding of the guidelines for management of women based on Pap test results (Bethesda System) and in some circumstances, human papillomavirus (HPV) reflex test results.

8. Demonstrate an understanding of key medico legal issues such as quality documentation, client confidentiality, informed consent, negligence and accountability.

Learning Resources

- **Learning Module Content** – Sections 1 to 11, Glossary, References, and Appendices.

- **Recommended Readings** - As listed under “R” icon in relevant sections. Note: Many of the recommended readings are links to other online documents. It is recommended that RNs open and read the information directly from the website links versus printing paper copies that may potential outdate.

- **Pap Test Videos** - Refer to Appendix 2: Pap Test Videos. Note: The resource videos may have some variations regarding Pap test techniques. It is recommended that RNs practice techniques consistent with the Guideline for Cervical Cancer Screening (TOP, 2011). See www.screeningforlife.ca/cervical for more details.

- **Assessment Tools** – See Appendix 4: Assessment Tools for the Pap Test Skills Checklist, Client Satisfaction Survey, Pap Test Audit Form, RN Pap Test Learning Module Completion Form

- **Preceptor** - As arranged by each Employer.

Learning Activities

RNPs are required to be partnered with a Preceptor (RN, Nurse Practitioner, Registered Midwife, or Physician experienced and competent in well-woman care and performing Pap tests), who will oversee the educational process and be willing to participate in the following learning activities

1. **Theory Component** – The RN completes a self-paced review of Learning Module content, reads the required readings, views the related learning resources, and consults with her/his Preceptor as needed.

2. **Theory Assessment** – The RN completes the written assessments (Pre-Test, Post-Test and Case Studies) from the Learning Module content and submits them to her/his Preceptor for review. Answer Keys to facilitate feedback and discussion are available in Appendix 5: Answer Key Post-Test and Appendix 6: Answer Key Case Studies.

3. **Practicum Component**: The practicum involves observing a Preceptor conducting women-centred care, specifically Pap tests. The RN then conducts Pap tests both supervised and unsupervised, until deemed competent.

4. **Practicum Assessment**: The RN, the Preceptor, and the women receiving care assess the RN's Pap test skills using the Assessment Tools found in Appendix 4: Assessment Tools.

5. **Evaluation**: The RN, the Preceptor, and the Employer are encouraged to complete and submit the Learning Module & Practicum Evaluation Forms in Appendix 7: Evaluation.
Learning Module Completion Schedule

Upon successful completion of both the theoretical and practicum components and assessments, the RN will have fulfilled the competency requirements recommended in the Learning Module.

A suggested time schedule for completing the Learning Module is outlined on page 15.

As well, see Learning Module Completion Form in Appendix 4: Assessment Tools. The original form should be kept by the RN, with copies given to the Employer and the Preceptor to indicate the completion of all Learning Activities.

It is important for RNs to have broad clinical experience in conducting Pap tests. The RN must see a variety of clients to be proficient in determining normal from abnormal cervical variations. An RN who only observes healthy young clients may not have the skills to properly assess a multiparous client who may have many cervical lacerations etc.

It is both the RN's and Employer's responsibility to review ongoing competency. It is recommended that a formal process be developed for such review on a regular basis.
### RN Pap Test Learning Module Schedule

**THEORY**

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<td>Complete Pre-Test</td>
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     | Read Learning Resources          |
| .5h   | Complete Post-test (85%)         |
| .5h   | Preceptor review                 |
| 2h    | Complete Case Studies (85%)      |
| 1h    | Preceptor review                 |
| 1h/1h | Discuss Test/Cases with Preceptor|
| prn   | Complete any additional learning needs |

**PRACTICUM**

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<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-3h</td>
<td>*Observe Preceptor conduct Pap tests</td>
</tr>
<tr>
<td>7-10h</td>
<td>*Conduct consecutive Preceptor supervised Pap tests</td>
</tr>
<tr>
<td>7-10h</td>
<td>*Conduct consecutive unsupervised Pap test visits with client satisfaction surveys</td>
</tr>
<tr>
<td>2-3h</td>
<td>Clinical assessment of competency by Preceptor</td>
</tr>
<tr>
<td>2-3h</td>
<td>Review client satisfaction surveys (with Employer and Preceptor)</td>
</tr>
<tr>
<td>1h</td>
<td>Review adequacy rates of Pap tests (with Employer and Preceptor)</td>
</tr>
<tr>
<td>1.5-2h</td>
<td>Discuss all components of Learning Module with Preceptor and complete any additional theoretical and/or practical learning</td>
</tr>
<tr>
<td>prn</td>
<td>Re-assessment of any activity if required</td>
</tr>
<tr>
<td>prn</td>
<td>Complete Practicum Evaluation Survey</td>
</tr>
</tbody>
</table>

**EVALUATION**

- Complete Learning Module Evaluation Survey
- Complete Practicum Evaluation Survey

**ONGOING**

- Track Pap test adequacy rates as required by Employer
- Update competency yearly or as required by Employer.

---

**TOTAL RN TIME Required**

= ~37.75 to 46.75 h

**TOTAL PRECEPTOR TIME Required**

= ~18 to 24.5 h

---

*NOTE: The suggested hours are approximate as everyone learns individually.*

*See Learning Module Completion Form in Appendix 4: Assessment Tools for guidelines on number of observed, unobserved Pap tests, etc.*
SECTION 1: SELF-TEST

1. What is the main purpose of the RN Pap Test Learning Module?

2. List 2 responsibilities each for the RN, Employer and Preceptor related to RNs performing Pap tests.

3. Describe 3 key elements of women-centred care.

4. Describe 2 ways that you will apply the learning module resources and activities to assist you to increase your competency and skills related to performing Pap tests as an RN.
Please complete the following Pre-Test prior to proceeding to Section 2: Cervical Cancer & Cervical Cancer Screening. Answers will be provided after the completion of the Post-Test (which occurs after working through all the Sections).

Instructions for Test Completion

For multiple choice questions, please indicate ALL correct answers as appropriate.

For open-ended questions, please provide at least as many responses as the question asks for.

1. RNs in Alberta are expected to practice in a manner consistent with:
   b. CARNA Nursing Practice Standards (2005).

2. The responsibilities of Employers of RNs who are expected to provide Pap tests as part of their position include:
   a. Providing adequate education time, resources, preceptorship opportunities, and facilities.
   b. Ensuring that there is an explicit relationship with the RN taking the Pap test and a physician, nurse practitioner, or registered midwife.
   c. Developing policies and procedures related to RN Pap testing.
   d. Participating in ongoing monitoring of Pap test adequacy rates.
   e. Maintaining a record of RN Pap test education.

3. The cornerstones of women-centred care include which of the following factors?
   a. A focus on women.
   b. Involvement and participation of women.
   c. Empowerment.
   d. Respect and safety.

4. Which of the following is not a risk factor for cervical cancer?
   a. Multiple male sex partners.
   b. Early onset of first intercourse.
   c. Genital infections such as herpes simplex II (HSV2) and Chlamydia.
   d. Family history.
   e. HPV infection.
   f. Smoking.

5. The Alberta Cervical Cancer Screening Program is needed because:
   a. Organized cervical cancer screening programs reduce the rates of cervical cancer.
   b. Having regular Pap tests may prevent a few cervical cancers.
   c. Supporting women to have regular Pap tests can prevent almost all cervical cancers.
   d. All clients who develop cervical cancer in Alberta have not had regular Pap tests.
   e. More than ½ of the clients who develop cervical cancer in Alberta have not had regular Pap tests.
6. All women between the ages of 21 to 69 who have ever been sexually active should have Pap tests regularly. (Except women who have had a hysterectomy for benign reasons with no history of biopsy confirmed high grade lesions or cervical cancer).
   a. True
   b. False

7. Name four high risk groups in particular whom RNs should encourage to have Pap tests regularly.
   a. 
   b. 
   c. 
   d. 

8. Women older than 69 who have never been screened for cervical cancer need 3 negative and satisfactory annual Pap tests before screening can be discontinued.
   a. True
   b. False

9. Women younger than 21 who have been sexually active for 3 years need to be screened for cervical cancer.
   a. True
   b. False

10. Which age group is least likely to benefit from increased access to and promotion of Pap testing?
    a. Women aged 50 to 69
    b. Women aged 36-49
    c. Women aged 21-35
    d. Women under 21

11. List eight reasons why an eligible woman may be reluctant to have a Pap test.
    a. 
    b. 
    c. 
    d. 
    e. 
    f. 
    g. 
    h. 

12. If a client appears apprehensive before the pelvic exam, it is best to:
    a. Reassure her and press forward.
    b. Tell her that there is nothing to worry about.
    c. Ask open-ended questions about her apprehension around the Pap test procedure.
13. List four key things that should be discussed with the client after the Pap test visit:
   a. 
   b. 
   c. 
   d. 

14. List five client groups that may have special learning, counselling, and educational needs related to cervical cancer screening.
   a. 
   b. 
   c. 
   d. 
   e. 

15. Which of the following findings related to STI might be discovered during an external genital examination?
   a. Pubic lice/crabs
   b. Genital warts
   c. Genital herpes
   d. Inflammation of the Bartholin’s glands

16. A client presents with the following symptoms:
   - raised painless lesions on the labia, the vestibule, and/or in the perianal region. flesh-colored cluster of soft growths.

   The client most likely has
   a. Molluscum contagiosum
   b. Nabothian follicles
   c. Genital herpes
   d. Genital warts
   e. Yeast infection

17. List six abnormal findings of the ectocervix:
   a. 
   b. 
   c. 
   d. 
   e. 
   f. 
18. Which of the following are abnormal findings on the cervix that should be referred to a physician, nurse practitioner, or registered midwife:
   a. Friable tissue (soft, eroded)
   b. Red patchy areas
   c. Abnormal bleeding and inflammation
   d. Granular areas, white patches
   e. Pink colour
   f. Lesions

19. Name the three sampling areas of the cervix:
   a. 
   b. 
   c. 

20. When conducting a health history and assessing clients for specific concerns, what are the PQRST principles to follow?
   P 
   Q 
   R 
   S 
   T 

21. Women due for cervical cancer screening who are pregnant or who have had a total or subtotal hysterectomy due to biopsy confirmed high grade lesions or cervical cancer should be referred to a physician, nurse practitioner, or registered midwife for a Pap test.
   a. True
   b. False

22. A smaller and narrower speculum should be used with:
   a. Clients who have not engaged in full vaginal penetration during sexual activity
   b. Nulliparous clients
   c. Circumcised clients
   d. Clients whose vaginal orifices have contracted postmenopausally

23. It is acceptable to lubricate the speculum with:
   a. A very small amount of water soluble lubricant
   b. Warm water
   c. Vaseline

24. An acceptable way to insert the speculum is:
   a. Blade tips against the upper (anterior) wall of the vagina
   b. At an oblique angle
   c. With the speculum closed
   d. With the speculum slightly opened
   e. With the speculum angled 45° downward toward the small of the client’s back
25. **The best way to reposition a speculum for a client with a cervix with posterior orientation is:**
   a. Reinsert less deeply and anteriorly, with the base of the lower blade actually compressing the anterior wall of the vagina.
   b. Insert the speculum more deeply and posteriorly through compression of the perineal tissue. The blade tips will slip under the cervix into the posterior fornix.
   c. Choose a plastic speculum of a larger size and reinsert as you did prior.

26. **What are the ideal client conditions for cervical screening?**
   a. Avoidance of vaginal douching for 24 hours before the test.
   b. Avoidance of use of contraceptive creams or jellies for 24 hours before the test.
   c. Avoidance of intercourse for 24 hours before the test.
   d. Mid-cycle (but do not defer due to abnormal bleeding).
   e. During menses.

27. **The correct way to obtain an ectocervix specimen with spatula is:**
   a. Rotate spatula in cervical os only 360° and end rotation so spatula is in 3 and 9 o’clock position.
   b. Rotate spatula in cervical os only 180° and end rotation so spatula is in 3 and 9 o’clock position.
   c. Rotate spatula in cervical os only 90° and end rotation so spatula is in 3 and 9 o’clock position.

28. **The correct way to obtain a specimen with a cytobrush is:**
   a. Insert the cytobrush gently all the way into the cervical os but no further than the end of the bristles and turn 90° to 180°.
   b. Insert the cytobrush gently all the way into the cervical os but no further than the end of the bristles and turn 180° and back again.
   c. Insert the cytobrush gently all the way into the cervical os but no further than the end of the bristles and turn 360°.

29. **Over rotation of the endocervical brush will cause cell damage and slight capillary bleeding.**
   a. True
   b. False

30. **Unsatisfactory Pap tests are mostly a result of the following:**
   a. Cervical sampling issues
   b. Specimen collection issues

31. **List six key descriptions that could be documented following a Pap test visit:**
   a. ________________________________________________________________
   b. ________________________________________________________________
   c. ________________________________________________________________
   d. ________________________________________________________________
   e. ________________________________________________________________
   f. ________________________________________________________________
32. **During a Pap test visit, when does the RN seek to obtain informed verbal consent from the client?**
   a. At the start of the consultation.
   b. After you have explained the external exam, speculum exam, and the Pap test procedure and before you begin.
   c. After completing the external exam, speculum exam, and the Pap test.

33. **Is the RN legally responsible to protect confidentiality of client health information?**
   a. Yes
   b. No

34. **An informal verbal agreement between an RN and a physician, nurse practitioner, or registered midwife should be used to outline the RN’s role in performing Pap tests.**
   a. True
   b. False
SECTION 2: CERVICAL CANCER & CERVICAL CANCER SCREENING

Learning Objectives

Upon completion of this Section, the learner will be able to

1. Describe the role of HPV in cervical cancer.
3. Know where to find out more information about HPV and HPV vaccine.
4. Identify high risk groups who are underscreened/underserved.
5. Distinguish between opportunistic screening and organized population cancer screening programs.
6. List the main activities of the Alberta Cervical Cancer Screening Program (ACCSP).


Parts of this Section (HPV and Cervical Cancer, Incidence and Mortality Rates, Natural History, Risk Factors) are adapted from the Guideline for Screening for Cervical Cancer (TOP, 2011, p. 1, 6-7). Used with permission.

HPV and Cervical Cancer

More than 45 types of human papillomavirus (HPV) are transmitted by intimate sexual contact (Bosch et al., 2008), and persistent infection with a carcinogenic type is necessary for cervical cancer to develop (Walbommers et al., 1999). HPV is transmitted so easily that the lifetime cumulative prevalence of high-risk infection approaches 80% (Bosch & Harper, 2006). Most of these infections resolve without symptoms and without treatment. A woman’s immune system generally clears the virus, in which case any cervical cell changes the HPV infection may have caused resolve on their own (Trottier & Franco, 2006). When the virus is not cleared, persistent carcinogenic HPV infection may cause precancerous tissue changes that can, over many years, progress to invasive cervical cancer (Schiffman et al., 2007). Early detection and treatment during this lengthy precancerous stage can prevent the vast majority of cervical cancer.

Incidence and Mortality Rates

Cancer of the cervix is the 13th most frequently diagnosed cancer among Canadian women. An estimated 1300 Canadian women will develop cervical cancer in 2011 and 350 will die from it (Canadian Cancer Society’s Steering Committee on Cancer Statistics, 2011). The lifetime probability of a woman in Canada developing cervical cancer is now about 1 in 153 (Canadian Cancer Society’s Steering Committee on Cancer on Cancer Statistics, 2011), whereas in the absence of screening, the lifetime probability is estimated to be 1 in 28 (Goldie et al., 2004).
Between 1969 and 2004 there was an overall reduction in age-standardized mortality from invasive cervical cancer in Canada from 7.4 to 2.0 per 100,000 women and a reduction in incidence during this time from 21.6 to 7.5 per 100,000 women. This decline is mostly attributable to screening. Well over 1,000 lives are saved each year because of cervical screening efforts in Canada and many thousands of cases of invasive cancer are prevented (Health Canada, 2002).

Although the effectiveness of regular screening for cervical cancer is undisputed, a substantial proportion of Alberta women remain underscreened. About 30% of eligible women have not been screened at least once in the past three years. Approximately 150 women are diagnosed with cervical cancer each year in Alberta and roughly 35 women die from this mostly preventable cancer (Cancer Surveillance: 2008 Report on Cancer Statistics in Alberta, 2010). Most of these women are unscreened or underscreened (Stuart et al., 1997).

Natural History

Squamous cell carcinoma accounts for 80-90% of cervical malignancies and the remainder are mainly adenocarcinoma. Persistent infection with one of the carcinogenic types of HPV is a necessary but not sufficient cause of both squamous and glandular malignancy (Walboomers et al., 1999). Both types arise from a four-step progression as follows

- HPV transmission
- HPV persistence
- Development of precancer in persistently infected cells
- Invasive cervical cancer

(Schiffman et al., 2007).

Close to 90% of carcinogenic HPV infections are cleared spontaneously through cell mediated immunity within two years of infection. Backward progression from persistent HPV infection and from precancer is also possible.

Premalignant squamous lesions are classified as either low-grade squamous intraepithelial lesion (LSIL) or high-grade SIL (HSIL). The majority of LSIL appears to clear spontaneously and infrequently progresses to invasive carcinoma (Ostör, 1993). In contrast, approximately 13% of untreated HSIL will progress over time to invasive carcinoma. Precancer typically takes 5 to 10 years to develop from the initial HPV transmission (Schiffman et al., 2007). In a minority of women with precancer, invasive cancer will develop over many years (Schiffman et al., 2007). By detecting women with precancer during this lengthy progression, treatment can be targeted and invasive carcinoma prevented.

Risk Factors

The key determinants of HPV infection among women are

- The number of sexual partners.
- The age at which sexual intercourse was initiated.
- The likelihood that her partner(s) were infected with HPV as measured by their sexual behaviour.

(Bosch & de Sanjosé, 2007)

Women whose partners use condoms consistently are at lower risk of acquiring HPV infection (Winer et al., 2006). However, compared with STI transmitted through genital secretions, condoms provide less protection against infections like HPV that are transmitted through contact with infected skin or mucosal surfaces. These areas are not always covered or protected by a condom.
Women who are immunosuppressed have a higher risk of HPV infection and HPV is more likely to persist. For instance, women who are HIV positive are up to 10 times more likely than at-risk HIV negative controls to be infected with HPV, with the risk increasing with declining CD4 counts (Palefsky et al., 1999). Even after controlling for the presence and persistence of HPV infection, women with HIV are also 4.5 times more likely to develop precancerous cervical lesions, with the risk increasing with increasing HIV-related immunodeficiency (Ellerbrook, 2000). Furthermore, from five years before the date of AIDS onset to five years after this date, women with HIV/AIDS are at least four times more likely to develop invasive cervical cancer compared with the general population of women (Frisch et al., 2000).

Women with other conditions associated with immunosuppression are also at increased risk of high-grade precancerous lesions. These conditions include systemic lupus erythematosus (Tam et al., 2004), inflammatory bowel disease (Kane et al., 2008), and transplantation (Malouf et al., 2004).

Diethylstilbestrol (DES) was given to some pregnant women between 1940 and 1971 to prevent miscarriage. Women whose mothers took DES when pregnant with them have a 1 in 1000 risk of developing clear-cell adenocarcinoma of the vagina or cervix.

Among women with persistent HPV infection
- The most important risk factor for cervical cancer is inadequate cervical screening.
- Smoking independently increases the risk of cervical cancer by at least two-fold as does high parity.
(Bosch & de Sanjosé, 2007).

Rapid Progression of Cervical Cancer
Occasionally cervical cancer disease appears to have progressed more rapidly in some women. This may be due to
- *Inadequate specimen collection and preparation, and/or
- Lab misinterpretation.
*Rationale for why it is important to learn proper Pap testing techniques

Having regular Pap tests can prevent almost all cervical cancer by finding cell changes early enough to be treated effectively.

Half of the women who develop cervical cancer in Alberta have not had regular Pap tests.

HPV and HPV Vaccine

Certain types of HPV cause genital warts and other types of HPV cause abnormal cervical changes.
Gardasil® and Cervarix™ HPV vaccines offer protection against 2 types of HPV (16 and 18) that cause about 70% of cervical cancer. The vaccine also protects against 2 types of HPV (6 and 11) that cause 90% of genital warts. Gardasil® HPV vaccine is available in Canada for women between the ages of 9 and 26.

According to the National Advisory Council on Immunization (NACI) (2012) guidelines:

- HPV vaccine should be offered to females before they become sexually active to ensure maximum benefit. The primary age group recommended is 9 to 13 years.
- Females 14 to 26 should also be offered HPV vaccine (Gardasil® or Cervarix™). Women may potentially benefit regardless of prior sexual activity, Pap test abnormalities, or a known HPV infection.
- HPV vaccine is NOT recommended for pregnant women or females under nine years.
- For females older than 26 years, there is good evidence to recommend Gardasil® and fair evidence to recommend the use of Cervarix™.

Women over 26 should consult their physician about their need for HPV vaccine. Even if women are vaccinated against HPV, they still need regular Pap tests.

Together, Pap test screening and HPV vaccination offer effective protection against cervical cancer. Alberta Health & Wellness offers the vaccine free of charge to all girls in Grade 5 (beginning in 2008/09).

For more information on HPV, see [www.screeningforlife.ca/cervical](http://www.screeningforlife.ca/cervical), *Human Papillomma Virus (HPV): What You Need to Know and Do*.

For more information on HPV vaccine, see [http://www.health.alberta.ca/health-info/imm-HPV.html](http://www.health.alberta.ca/health-info/imm-HPV.html)

High Risk Groups

There are groups of women who are less likely to be screened for cervical cancer. Therefore it is valuable to focus on increasing screening engagement and retention rates in these populations including:

- older women
- women living in poverty
- immigrant women
- Aboriginal women
- rural women
- women who have poor access to Pap test providers

Opportunistic Versus Organized Population-Based Cancer Screening

The delivery of cervical cancer screening may be opportunistic or organized:

- **Opportunistic screening** depends entirely on the initiatives of individual clients and/or physicians/healthcare providers and does not achieve optimal screening coverage of the eligible population.
- **Organized population-based screening programs** allow for a standardized approach to screening, follow-up, and treatment. A population-based screening program is an organized,
An integrated process where a test is offered systematically to all individuals in the defined target population, and all activities along the screening pathway are planned, coordinated, monitored and evaluated through a quality improvement framework (Australia Population Health Development Principal Committee, Screening Subcommittee, 2008).

An organized cervical cancer screening program requires a registration database of eligible women. The database of an organized screening program enhances recruitment by identifying those women who have never been screened and facilitate the recall of women overdue for routine screening and those who have not had appropriate follow-up of an abnormal test.

Alberta Cervical Cancer Screening Program Overview

The Alberta Cervical Cancer Screening Program (ACCSP) is a provincial organized population-based screening program coordinated by Alberta Health Services in partnership with healthcare providers. The goal of the ACCSP is to reduce the incidence and mortality of cervical cancer through early detection and treatment of precursor conditions. The purpose of the ACCSP is to enhance and strengthen the cervical screening services already available to Alberta women aged 21-69 years. ACCSP coordinates a number of activities including, but not limited to:

- sending letters to eligible women (letters can include invitations, results, and/or reminder letters about needed tests)
- having a follow-up reminder system in place for healthcare providers
- supporting increased access to cancer screening services
- offering information and educational resources to the public and healthcare providers
- helping to ensure the quality of the screening process

ACCSP result letters are sent to women across Alberta after their Pap tests. Follow-up reminders are sent to healthcare providers and women regarding overdue follow-up tests. To view a map outlining which areas of the province receive invitations and reminders for routine screening, visit www.screeningforlife.ca/cervical. Research from around the world shows that organized cervical cancer screening programs like the ACCSP reduce the rates of cervical cancer. See ACCSP Program FAQs at www.screeningforlife.ca/faqs for more information on the program.

"Remember, one of the early signs of cervical cancer is unexplained abnormal bleeding. If a client continually puts off her exam because of irregular bleeding, it may delay diagnosis of cervical cancer." (IWK, 2001)

Using regular Pap tests to find abnormal cell changes at an early stage before there are any symptoms can prevent almost all cancers of the cervix. Do not defer the Pap test due to abnormal bleeding.

The following recommended readings provide additional information on cervical cancer, HPV, other precursors and natural history of the disease:


SECTION 2: SELF-TEST

1. What causes cervical cancer?

2. Describe cervical cancer
   a. Incidence in Alberta
   b. Natural history
   c. Risk factors (at least 3)

3. Where could you find more information on HPV and HPV vaccine? (2 sources)

4. What are three important high risk groups for RNs to target for Pap testing?

5. What is the difference between opportunistic and organized cancer screening?

6. What are four activities of the ACCSP?
SECTION 3: CERVICAL SCREENING CYCLE

Learning Objectives

Upon completion of this Section, the learner will be able to

1. Describe when and why to initiate cervical cancer screening.
2. List the risks of overscreening.
3. Identify who should have Pap tests and how frequently.
4. Identify clients who should be excluded from Pap testing and those who should have increased surveillance.


Initiating Cervical Cancer Screening

The current Alberta Guideline for Screening for Cervical Cancer (TOP, 2011) recommends that cervical cancer screening begin three years after onset of sexual activity or at 21 years, whichever occurs later. Sexual activity is defined as any skin-to-skin contact in the genital area including touching, oral sex, or intercourse with a partner of either sex.

The Guideline for Screening for Cervical Cancer (TOP, 2003) previously recommended that screening begin at 18 years for women who had ever had sexual intercourse. Cervical cancer is rare in Alberta among females younger than 21 years (see Figure 1). Over the 20 year period between 1988 and 2007, only six cases occurred in this age group (0.6 per 100,000) (Alberta Cancer Registry, 2009). This low rate is expected given the condition's slow malignant progression. High screening coverage in Alberta likely does not account for this low rate – a comparably low rate is observed in this age group in Europe, where most countries do not target women for screening before age 25 (Bosch & Harper, 2006). Invasive cervical cancer is rare among younger women because progression from HPV infection to precancer typically takes 5 to 10 years, and development of invasive cancer takes years longer (Schiffman et al., 2007).

Approximately 50% of women will acquire an HPV infection within four years of sexual debut (Richardson et al., 2003). Screening females who have become sexually active only recently tends to detect transient manifestations of recently acquired HPV infection that are likely to regress spontaneously. Among 13 to 22 year old women with LSIL, 93% will regress spontaneously while only 3% will progress to HSIL within three years (Moscicki et al., 2004). Among women younger than age 25 with histologically confirmed CIN 2 or 3, more than half of the lesions will regress without treatment by age 25, while the estimated rate of progression to invasive cancer from CIN 3 is roughly 0.3% per year in this age group (Sasieni et al., 2009).
Delaying routine screening invitations to age 21 is unlikely to miss invasive disease resulting from dysplasia arising in the teenage years. In fact, a recent case-control study in the United Kingdom suggests that screening women aged 20 to 24 has little or no impact on the incidence of cervical cancer (Sasieni et al., 2009).

Figure 1: Age-specific incidence rates for cervical cancer in Alberta, 1988-2007

Risks of Overscreening

The adverse effects of screening include anxiety pertaining to abnormal test results, psychosexual morbidity associated with colposcopy, and risks associated with treatment including consequent obstetric impact (i.e., risk of premature delivery) (Arbyn et al., 2008; Rogstad, 2002). With age, the proportion of abnormal Pap test results decreases, but abnormalities among older women are much more likely to be related to progressive disease.

The revised guidelines are intended to minimize the potential harm of overscreening, particularly among younger females who benefit the least from Pap testing. While the burden of cervical cancer in this age group is low, the burden of abnormal Pap tests is disproportionately high. Among 18 to 20 year old women screened through the ACCSP, approximately 15% receive at least one abnormal result. While only 0.2% of cervical cancer cases occur among females younger than 21 years, 10% of all colposcopy referrals are among females in this age group (see Table 1). Delaying screening until women are 21 years of age and have been sexually active for approximately three years will allow most of these lesions to regress, with almost all of the rare few destined to progress still being screen-detectable at a pre-invasive stage.
Table 1: Colposcopy referrals by age group in the Alberta Cervical Cancer Screening Program (ACCSP) 2006-2008

<table>
<thead>
<tr>
<th>AGE GROUP (YEARS)</th>
<th>NUMBER SCREENED*</th>
<th>NUMBER REFERRED FOR COLPOSCOPY **</th>
<th>% REFERRED FOR COLPOSCOPY</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-20</td>
<td>12,732 (3.7%)</td>
<td>1,276 (9.8%)</td>
<td>10.0%</td>
</tr>
<tr>
<td>21-29</td>
<td>68,801 (19.8%)</td>
<td>5,745 (44.2%)</td>
<td>8.4%</td>
</tr>
<tr>
<td>30-39</td>
<td>85,156 (24.6%)</td>
<td>2,986 (22.0%)</td>
<td>3.5%</td>
</tr>
<tr>
<td>40-49</td>
<td>82,356 (23.7%)</td>
<td>1,848 (14.3%)</td>
<td>2.2%</td>
</tr>
<tr>
<td>50-59</td>
<td>61,657 (17.8%)</td>
<td>774 (6.0%)</td>
<td>1.3%</td>
</tr>
<tr>
<td>60-69</td>
<td>29,409 (8.5%)</td>
<td>254 (2.0%)</td>
<td>0.9%</td>
</tr>
<tr>
<td>≥ 70</td>
<td>6,758 (1.9%)</td>
<td>80 (0.6%)</td>
<td>1.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>346,869 (100%)</strong></td>
<td><strong>12,963 (100%)</strong></td>
<td><strong>3.7%</strong></td>
</tr>
</tbody>
</table>

* Number of women who had at least one Pap test within the 3 year period
** Number of women referred for colposcopy at least once within the 3 year period

Screening Interval

The current Guideline for Screening for Cervical Cancer (TOP, 2011) recommends that cervical cancer screening should begin at age 21 or approximately 3 years after first intimate sexual activity, whichever occurs later (Intimate sexual activity includes intercourse as well as digital or oral sexual activity involving the genital area with a partner of either sex).

The Guideline for Screening for Cervical Cancer (TOP, 2003) previously recommended annual screening. Evidence from observational studies and epidemiologic modeling shows that annual screening offers only minimal additional protection against cervical cancer compared with triennial screening (Sasieni et al., 2003; Sawaya et al., 2003). This is particularly true after women have had ≥ 3 consecutive negative Pap tests (Sawaya et al., 2003). These negligible additional gains come at huge costs in terms of multitudes of women being subjected to extra Pap tests and colposcopy, even though most low-grade lesions and many high-grade lesions regress spontaneously.

Extension of the screening interval away from annual and towards 3-yearly screening is ideally undertaken in the context of an organized recall program with built-in quality assurance. The Alberta Cervical Cancer Screening Program (ACCSP) provides recall functions to women in some parts of southern Alberta and will roll-out province-wide in the near future. Women all across the province benefit from the program’s quality assurance processes for cytology and colposcopy.

Increased Surveillance

While extension of the screening interval is safe for many women with negative screening histories, some women should continue to screen annually.

Women who need annual Pap tests include those who are immunosuppressed because these women have of an increased likelihood of HPV infection, precancerous lesions, and invasive cervical cancer as described in Section 2: Cervical Cancer and Cervical Cancer Screening.
Another group that should undergo annual screening indefinitely includes women who have ever had biopsy confirmed high-grade squamous intraepithelial lesions (HSIL), adenocarcinoma in situ (AIS), or invasive cervical cancer. Despite undergoing treatment, these women have more than twice the risk of invasive cervical cancer compared with the general female population for 25 years or more (Melnikow et al., 2009; Strander et al., 2007). If they have undergone hysterectomy, these women should have vault smears every year (Soutter et al., 2006).

Discontinuing Screening

High grade abnormalities and cervical cancer is exceedingly rare among older women with adequate screening histories (Sawaya et al., 2003). Cervical cancer among older women occurs almost entirely among those who are unscreened or underscreened. Screening these women can reduce morbidity and mortality. Obtaining satisfactory samples from older women can be challenging because of conditions such as atrophy and cervical stenosis (see Section 6: Physiology, Anatomy & Abnormal Findings; Section 8: External & Speculum Exam).

Although the exact age to discontinue screening is somewhat arbitrary, after the age of 69 the potential harms of on-going Pap testing in well-screened women who are not otherwise at high risk may well outweigh the benefits. Since cervical cancer is so unlikely in these women, the potential benefits are minimal.

Women with an intact cervix can generally cease screening after age 69 if they have had at least three consecutive satisfactory and negative Pap tests at the recommended screening interval in the last 10 years.

Women who are immunocompromised and those who have a history of biopsy confirmed high grade lesions or cervical cancer should continue with annual screening.

Who Should Have a Pap Test and How Frequently?

It is important to be familiar with the timing and frequency that a client should receive Pap tests. For full details, see the Cervical Cancer Screening CPG Summary Chart from www.screeningforlife.ca/cervical

<table>
<thead>
<tr>
<th>Who Should Have a Pap test?</th>
<th>How Frequently?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• All women aged 21 (OR 3 years after initiation of sexual activity whichever comes later) to age 69</td>
<td>Once a year until 3 normal screening results (within 5 years), then every 3 years</td>
</tr>
<tr>
<td>• Women &gt; 69 infrequently screened</td>
<td>Until 3 consecutive normal screening results within the last 10 years, then discontinue</td>
</tr>
<tr>
<td>• Women &gt; 69 never screened</td>
<td>Once a year until 3 normal screening results, then discontinue</td>
</tr>
<tr>
<td>• Women of any age who are immunocompromised OR have a history of biopsy confirmed high grade lesions or cervical cancer</td>
<td>Annually</td>
</tr>
<tr>
<td>• Some women who have had a hysterectomy</td>
<td>See flow chart below</td>
</tr>
</tbody>
</table>
In Alberta, cervical cancer screening is a Pap test followed by an HPV test if needed. (See Section 10: Pap Test Results for more information).

**Flow Chart for Screening a Woman Who Has Had a Hysterectomy**

Start

- **Is the cervix still there?** (Documentation of complete removal) → no → STOP
  - yes → **Does the woman have a history of biopsy confirmed high grade lesions or cervical cancer?** → no → STOP
  - yes OR unknown → **Continue Screening**

**Exclusions from Pap Testing**

The following women may be excluded from Pap testing:

- Women who have never had intimate sexual activity (not just sexual intercourse, but digital or oral sexual activity with a partner of either gender).
- Women who have had a total hysterectomy for benign disease, with complete removal of the cervix and no history of biopsy confirmed high grade lesions or cervical cancer.
- Women >69 with a cervix, provided there have been at least 3 consecutive negative results within the last 10 years, there is no history of cervical malignancy or high grade lesions and she is not immunosuppressed.
- Women < 21 years old. Cervical cancer and high-grade lesions likely to develop into cervical cancer are rare in women younger than 21 years. This is because it takes many years for cervical cell changes to develop into cancer, beginning with a persistent high-risk HPV infection. Many women will have an HPV infection soon after becoming sexually active, but most of these regress on their own in 6-24 months. By waiting until age 21 to begin Pap testing, or 3 years after becoming sexually active, whichever is later, almost all important cervical cell changes will be found before they progress to cancer (Adapted from “Everything about Pap testing in Alberta just changed”, 2011). Women under age 21 may still require frequent interaction with healthcare providers for STI screening, HPV education, and HPV vaccination.
- Women who initiated intimate sexual activity less than 3 years ago.

**Please Note:**

The *Guideline for Cervical Cancer Screening* (TOP, 2011) does not recommend routine screening for the “excluded” women noted above. However, screening of these “excluded” women may be undertaken based on professional judgement.

Other provinces and countries have different policies and may have different screening intervals or start screening at different ages. This may be confusing for women coming to Alberta and needs to be clarified with clients who are new to Alberta.
Table 2: Summary Chart Cervical Cancer Screening Clinical Practice Guideline (2011)

<table>
<thead>
<tr>
<th>Screening Initiation</th>
<th>Screening Interval</th>
<th>Increased Surveillance</th>
<th>Discontinuing Screening</th>
</tr>
</thead>
</table>
| Cervical cancer screening should begin at age 21 or approximately 3 years after first intimate sexual activity, whichever occurs later. Intimate sexual activity includes intercourse as well as digital or oral sexual activity involving the genital area with a partner of either gender. For women under 21, interactions with health care providers may still be necessary for STI screening and HPV vaccination. | Within 5 years, screen with three negative Pap tests at least 12 months apart and then extend the screening interval to every 3 years. | Some women require more vigilant surveillance because of increased risk or past cervical disease. **Continue to screen the following women annually:**
  - women who have ever had biopsy confirmed high-grade squamous intraepithelial lesions (HSIL), adenocarcinoma in situ (AIS), or invasive cervical cancer. (If the woman has had a hysterectomy for invasive cervical cancer, she should have a vault smear annually thereafter.)
  - women with immunosuppression who have ever been sexually active. This includes women with human immunodeficiency virus (HIV/AIDS), lymphoproliferative disorders, organ transplantation, and women taking long-term corticosteroids. | Women older than 69 years who have had at least three consecutive satisfactory and negative Pap tests at the recommended screening interval in the last 10 years can discontinue screening. For women older than 69 who have never been screened, screen with three annual Pap tests. If results are negative and satisfactory, discontinue screening. |

**Screening Women with Special Circumstances**

- **Women who have had a hysterectomy with the cervix removed for BENIGN DISEASE** may discontinue screening as long as there is adequate pathological documentation that the cervix has been removed completely and there is no history of high-grade lesions.
- **Women who have undergone subtotal hysterectomy and retained their cervix** should continue with screening according to the guidelines.
- **Pregnant women** should be screened according to the guidelines, however care should be taken not to over-screen. Only conduct Pap tests during pre-natal and post-partum visits if the woman is otherwise due for screening.
  - If ASC-US or LSIL is detected during pregnancy, do not repeat the Pap test until 6 months post-partum. All other findings, especially more advanced lesions, should be managed according to the guidelines.
- **Women currently being assessed by a colposcopy clinic** should not undergo additional Pap testing until discharged from colposcopy.
- **Women who have received the HPV vaccine should continue with screening**. The HPV vaccine should be recommended to eligible unimmunized women according to NACI guidelines: [http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/07vol33/ac02/index-eng.php](http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/07vol33/ac02/index-eng.php)

Resources available at [SCREENING FOR LIFE.CA](http://www.screeningforlife.ca)
SECTION 3: SELF-TEST

1. What are 3 reasons the recommended age of cervical screening initiation was increased?

2. List who should have a Pap test and how frequently?

3. What is the screening process for women who have had a hysterectomy?

4. Who should be excluded from Pap tests and what are some special circumstances to note?

5. Who should be on increased surveillance?
SECTION 4: COUNSELLING & EDUCATION

Learning Objectives

Upon completion of this Section, the learner will be able to

1. Describe reasons why an eligible client may not want to obtain a Pap test.
2. Describe counselling and education strategies that are important to consider before, during, and after a Pap test.

This Section is adapted from SIAST, 2000, p.2-4. Used with permission.

Women have different reactions to having a pelvic examination. Some are quite calm and relaxed, while others are extremely apprehensive, embarrassed, or fearful and find the examination very uncomfortable. A client’s past experiences with pelvic exams, her comfort with her own body, and her sexuality all interrelate to determine her level of anxiety during a pelvic exam.

Reasons Why Women May Avoid Pap Tests

There are many reasons why an eligible woman may not want to obtain a Pap test including

- Lack of information and understanding of Pap test
- Fear of the test
- Fear of cancer
- Fear of pain
- Embarrassment
- Modesty
- Religious and social factors
- Language barriers including written and verbal
- Difficulty in communicating with healthcare providers
- Lack of childcare facilities
- Accessibility issues (e.g., transportation, parking, transit, access to the building)
- Other peoples' attitudes regarding the Pap test (e.g., husband, family, religious leaders)

(National Health Services, 1998)

To make the pelvic examination a positive experience for each woman, it is important that the RN performing the pelvic examination talk to the client before, during, and after the pelvic exam.

The RN needs to have a non-judgemental, gentle, sensitive, and caring attitude and create an atmosphere of trust, privacy, and respect. Communication is the key and a good RN-client relationship will promote client relaxation, reduce anxiety, enhance learning, and decrease client discomfort.
Before the Exam

**Introduce yourself to the client before she undresses** for the exam. Meeting the client before the exam when she is dressed and sitting, as opposed to lying in the lithotomy position in a gown, helps the client feel less vulnerable and more in control of the situation. If this is not possible, ask the client to undress, change into the gown, and be sitting on the exam table for initial discussion before the exam.

**Use open ended questions to assess the client's learning needs.** For example, “What have your friends told you about pelvic exams and Pap tests?” “How did you feel during your previous pelvic exams?”

**Explore sexual and reproductive issues.** For example, “How do you protect yourself against pregnancy?”

**Listening is important.** Focus on the client’s feelings, fears, and concerns and dispel any myths. Never talk down to a client or take her concerns lightly.

**Explain in simple and concise lay terms the following**
- Purpose of exam.
- The role of HPV testing. Give her a copy of the handout “HPV Testing: Information for Women Having Pap Tests” that are provided in the trays of liquid-based supplies. (See Section 10: Pap Test Results for more information about HPV testing, and see [www.screeningforlife.ca](http://www.screeningforlife.ca) for a copy of the handout).
- Procedure (external, speculum exam, and Pap test).
- Female anatomy.
- Optional positions for the exam (e.g. m-shaped position, knee-chest position – see Section 8: External & Speculum Exam for a brief explanation of each position).
- Instruments used in exam.
- Length of procedure and sensations (pressure, mild cramps not pain) experienced during the pelvic exam.
- There may be some minor painless spotting a day or two following the Pap test.

**Tell the client that you will tell her what you are going to do before you do it** and that if she feels any pain or anxiety at anytime during the pelvic exam that you will stop what you are doing until she feels more comfortable.

**Use language that is consistent with the client’s developmental age and educational level,** e.g., use the word sex instead of intercourse when deemed appropriate for the adolescent client.

**Visual aids work well.** Show the client a speculum and how it will be inserted into her vagina to visualize the cervix and a spatula and cytobrush. Give the client written information on Pap tests. See ACCSP brochures at [www.screeningforlife.ca/cervical](http://www.screeningforlife.ca/cervical).

**Assess the client’s need or desire for a chaperone.** The presence of a chaperone or friend during these procedures may comfort the client and protect her and the RN from physical, emotional, or legal problems.

**Ensure privacy.** Make sure that the door to the exam room is closed and will not be opened from the outside.
During the Exam

Position the client so that you have eye contact with her. Talk to and provide her with reassurance throughout the exam.

Tell her what you are going to do before you do it, e.g. “I am going to touch the outside of your labia.”

Reinforce to the client that anytime she feels uncomfortable you will stop until she tells you that you can proceed. Encourage the client to relax her inner thighs and flop her knees out to the side. Tell her that if she can keep her inner thighs relaxed that she will feel less pressure from the speculum. Avoid comments that may have sexual overtones, such as “spread your legs, dear.” “I am going to stick it in now” and “I am coming out now.”

Offer the client a mirror so that she can visualize what you are doing and so she can learn about her anatomy. Emphasize her normal anatomical structures.

Offer the client a sheet/drape for her knees if she chooses. Some women choose to have everything separated and some women prefer to have no obstruction so they can see what is going on.

Normalize the client’s feelings and experience. Ask the client “How are you feeling about coming to have your Pap test today?” If the client indicates feeling embarrassed the RN can normalize her feelings and discuss the root of her concerns. If a client has, for example, poor hygiene, do not single her out, say, “Let me tell you what I tell all the women that I see—use a mild soap and wash regularly.”

After the Exam

This is a great opportunity to reinforce learning and to answer any questions that the client may have. Ask the client to sit up on the exam table and if time permits, inform her that you will leave the room while she gets dressed and that you will return in a few minutes to discuss follow-up. If time does not permit, proceed to summarize and discuss the exam findings with the client. Discuss any concerns or findings that may need to be followed up by a physician, nurse practitioner, or registered midwife.

All abnormal findings or suspected sexually transmitted infections should be reported immediately to a physician, nurse practitioner, or registered midwife for follow-up.

Indicate how the client will receive the Pap test results. Pap test results usually go to the primary healthcare provider (i.e. physician, clinical medical director, nurse practitioner, or registered midwife) for follow-up. The process for receiving Pap test results varies by clinic. Please review your clinic/agency policy.

Explain that she will receive a result letter in the mail from the ACCSP about 3-6 weeks after her test. Let her know she can call the program’s toll-free number (1-866-727-3926) if she’s not sure she wants to receive a result letter.

Elicit and respond to client questions and give the client written information and instructions as appropriate. Provide the client with relevant pamphlets to reinforce learning. See ACCSP brochures at www.screeningforlife.ca/cervical.

Refer to Appendix 2: Pap Test Videos for a list of recommended Pap Test Videos for further guidance on counselling and education strategies.
SECTION 4: SELF-TEST

1. What are 4 reasons that would influence an eligible client to not obtain a Pap test?

2. Discuss counselling and education strategies that are important to consider before (3 strategies), during (3 strategies) and after (3 strategies) conducting a Pap test?
SECTION 5: CLIENTS WITH SPECIAL CONSIDERATIONS

Learning Objectives

Upon completion of this Section, the learner will be able to

1. Identify the special learning, counselling, or communication needs of the following client groups
   - Younger women
   - Lesbians and other sexual minorities
   - Clients with a history of sexual abuse
   - Clients with disabilities
   - Clients from different cultures.
   - Clients who have undergone female genital mutilation
   - Clients with barriers to access

This Section is adapted from SIAST, 2000, p.4-8. Used with permission.

Younger Women

Screening for cervical cancer is not recommended to start until age 21 or 3 years after the initiation of sexual activity whichever comes later (TOP, 2011). Younger women are at low risk for cervical cancer and are at high risk for transient, HPV-related cervical abnormalities. See Section 3: Cervical Screening Cycle for more information.

Nevertheless, younger women are at higher risk for sexually transmitted infections (STI). The importance of referring younger clients for STI testing cannot be underestimated.

STI and Younger Women

Since 1997, the Chlamydia rate (rate=per 100,000 population) for Canadians of all ages has been steadily increasing from 113.9 in 1997 to 248.9 in 2008 [Public Health Agency of Canada (PHAC), 2010a]. In Alberta from 1998 to 2008, the Chlamydia rate for all ages increased from 184.1 to 344.7 [Alberta Health and Wellness (AHW), 2010]. In 2008, approximately 65% of cases were in individuals aged 15 to 24 (AHW, 2010). The gonorrhea rate for Canadians of all age groups rose from 14.9 in 1997 to 38.2 in 2008 (PHAC, 2010b). In Alberta between 1999 and 2008, the gonorrhea rate for all ages increased from 18.4 to 60.8 (AHW, 2010). In 2008, approximately 51% of cases were in individuals aged 15 to 24 (AHW, 2010). As well, the infectious syphilis rates, while still relatively low in comparison, are increasing steadily. The Canadian infectious syphilis rate for all ages increased from 0.4 in 1997 to 4.2 in 2008 (PHAC, 2010c). The Alberta infectious syphilis rate for all ages increased from 0.1 in 1999 to 7.0 in 2008. In 2008, approximately 23% of all infectious syphilis cases were in individuals 15-24 (AHW, 2010).

According to the Alberta STI Treatment Guidelines (Alberta Health & Wellness, 2008),

*Given the current rise in all STI in Alberta, it is appropriate to assess for risk of and screen for STI at routine medical appointments. This is particularly important in individuals at higher risk for*
STI or in individuals where the risk of consequences of STI are high (e.g. adolescents, pregnant women). For more information, see [www.health.alberta.ca/documents/STI-Treatment-Guidelines-2008.pdf](http://www.health.alberta.ca/documents/STI-Treatment-Guidelines-2008.pdf)

The relatively high STI rates for younger women coupled with the fact that 70% of females can be asymptomatic for Chlamydia infection and 50% can be asymptomatic for gonorrhea infection stress the importance of screening in this population; particularly for Chlamydia (Public Health Agency of Canada, 2008).

First Pap Tests

A younger woman's first Pap test needs to be a positive experience as it sets the stage for future healthcare encounters. A younger woman’s first pelvic exam is an excellent opportunity to educate the adolescent about her body and to reassure her that she is developing normally. Many younger women feel embarrassed about their body and may be uncomfortable and unfamiliar with their external and internal genitalia. Always allow the woman to decide whether she wants a support person or her partner present for the pelvic exam. Be aware of potential issues that may arise when a support person or partner are present (i.e. there may be differences in the client’s sharing of her health history when the partner is absent versus present).

Ensure Confidentiality

Some young women present on their own for Pap testing or may present with a concern about possible pregnancy or STI. Establish trust by reassuring the client that whatever she discloses will be held in confidence except for issues that must be reported by law to child protection and public health/communicable disease reporting.

Counselling and Education

A good way of introducing an issue regarding sexual or reproductive health to a young woman is to say, “There are a lot of younger women who come to this clinic and have concerns about ..... I would like to share with you what some of the women your age ask most often.” Some younger women may still think in concrete terms. When educating the younger client about sexual and reproductive issues use direct, simple, developmentally appropriate, and concrete language as needed. Use appropriate models and diagrams available at your clinic/agency to help illustrate the educational material discussed.

Before and During the Pelvic and Pap Test Exam

Young women have a need to feel successful and competent. Give the client as much control of the situation as possible. Direct any open-ended questions at the client and not at her support person or partner. At the end of the pelvic exam and Pap test comment on the client’s strengths, e.g. “You handled the pelvic and Pap exam so well. It is hard to do something like that for the first time. I am really impressed.” Young women want to be perceived as being “normal” and want to be the same as their peers. Throughout the exam provide the young woman with reassurance that her questions and feelings about the pelvic exam and her sexual and reproductive health concerns are normal and emphasize her normal anatomy.

Equipment

A smaller sized speculum may be more appropriate for examining a younger woman.
Lesbian and Other Sexual Minorities

Women of all ages, races, social classes, and ethnic barriers have sex with women and may or may not identify as lesbian or other sexual minorities (including bisexual, trans-identified, transsexual, two-spirited, and queer). Lesbians and women of other sexual minorities are often isolated in society because of homophobia. Many lesbians and women of other sexual minorities avoid healthcare interactions because of their fear of discrimination (Clark et al., 2003). To provide a positive healthcare experience for lesbian and women of other sexual minorities, it is important for the healthcare provider to be aware of the unique health care needs of these women.

Cervical Cancer and STI for Lesbians and Other Sexual Minorities

Lesbian women have fewer Pap tests than heterosexual women (Cochran et al., 2000). They also have a low incidence of sexually transmitted infections (STI), vaginal infections, and cervical cancer. Nevertheless, they are still at risk.

It is essential to know a client’s sexual history regardless of her reported lesbian sexual orientation as many lesbian women may have had previous heterosexual relationships, (e.g. 77% of lesbians have one or more male sexual partners in their lifetime) (Diamant et al., 1999). The risk of STI and cervical cancer in lesbians and women of other sexual minorities is proportional to their sexual contact with men, and their sexual contact with women who have had previous male partners. Screening for cervical cancer among lesbians and women of other sexual minorities should be according to standard clinical practice guidelines.

Trichomoniasis and bacterial vaginosis occur in women who have sex with women. Condyloma and genital herpes are transmissible between women. HIV can be transmitted through unprotected (not using dental dam) oral sex (Health Canada, 2003).

Counselling and Education

- During sexual history taking, assess the gender of the client’s partner and type of sexual activity. Consider asking, “When you have sex, is it with men, women or both?” This wording takes the pressure off the client and may make her feel that you are prepared for each answer.
- Confidentiality: Ensure the client that the information gathered regarding gender of partner and type of sexual activity is required for assessing their risk for STI transmission and that it will remain confidential.
- Use the word “partner” rather than “boyfriend” with all clients.

During the Pelvic and Pap Test Exam

Be sensitive to the client’s need to have her partner’s involvement in healthcare education, decision-making, and as a support person during the pelvic exam.

Equipment

A smaller and narrower speculum should be used with nulliparous clients.

Clients with a History of Sexual Abuse

A Canadian study demonstrated that a history of sexual abuse may be associated with subsequent cervical cancer risk factors such as smoking, sexual intercourse at a young age, etc. (Young & Katx, 1998). Approximately 30% of all women have experienced some form of sexual abuse in childhood or adolescence (Holz, 1994). Some women who are survivors of sexual abuse are very anxious about
having a pelvic exam and use defence mechanisms (e.g. dissociate, stare, look vacant and/or do not respond appropriately) to cope with a pelvic exam.

Counselling and Education

**During the Speculum and Pap Test Exam**
Some women don’t have recall or have suppressed knowledge of childhood sexual abuse. This may impact the client’s comfort level but she may not be able to articulate why. It is important to support her during this time and encourage her to articulate her feelings in a safe environment.

**Give the client control of the situation.** Ask the client what would be helpful to make the pelvic exam easier for her. Give the client choices about what position she wants to be in, who she wants with her, and reassure her that if she feels uncomfortable at anytime during the pelvic exam that you will stop and proceed only when she feels comfortable for you to do so.

**Talk the client through the exam** and ask her how she is feeling and what she is experiencing. Tell her what you are going to do before you do it and provide her with reassurance. The phrases “let your knees flop out to the side” or “let the muscles in your thighs go soft” are appropriate. You may have to further review how to relax the pelvic muscles such as breathing out. If this doesn’t work and the client is so tense that it is difficult to insert the speculum, it may be best to stop the exam and defer it for another time. On a subsequent visit, remind the client that although the exam may remind her of the abuse, it is not the abuse, and although the procedure may be difficult but if it proceeds at the clients’ pace, it should be tolerable (Daley & Cromwell, 2002).

**If the client experiences a flash back during the pelvic exam:**
- Reassure the client that you believe her. Have her describe her past experience and reassure her that she is safe.
- Reassure her that although she is re-experiencing the memories she is not re-experiencing the event.
- Touch her only with her permission.
- Ask her specific concrete questions to ground her.
- Never leave her alone.

(Holz, 1994)

**Clients with Disabilities**
Each disability affects each person differently. Therefore, it is important for RNs to educate themselves about relevant aspects of a client’s disability. An RN’s sensitivity in asking only pertinent questions about the disability will increase the client’s comfort and cooperation.

**Clients with Physical Disabilities**
Since it is not necessary for a client to remove all her clothes for the examination, she can wear an
easily removable skirt or pair of pants. By only partially undressing, a client can conserve time and energy. Removing or rearranging the furnishings in the examination room will provide the space needed for a client to negotiate her wheelchair or for an interpreter to be seen. If a urine sample is required, a disabled client with mobility impairments (e.g., spinal cord injury, polio, or cerebral palsy) should be given the option of bringing a urine sample with her.

The RN should consider
- access to the clinic,
- the height of the exam table, and
- the client's physical limitations.

(National Health Services, 1998)

Equipment such as obstetric stirrups, a high-low examination table, or a particularly wide examination table can be obtained to facilitate safer transfers and positioning (Seidel et al., 1987). Using the lateral knee-chest position may be easier for a client with limited mobility.

**Clients with Learning Disabilities**

**Counselling and Education**

“When speaking with a disabled client, the RN should remember to speak directly to the client. Often people will address a disabled person’s friend, attendant or interpreter instead of speaking directly to the person” (Seidel et al., 1987, p.616). Depending on the level of the client’s functioning, use visual strategies such as showing instruments and using 3D models. Consider
- how to obtain informed consent
- involving the caregiver in communicating effectively with the client
- accepting that non-cooperation or distress of the client must be recognized as refusal or withdrawal of consent

(National Health Services, 1998)

**Clients with Hearing-Impairments**

The communication system used by a hearing-impaired or speech-impaired client (e.g. a sign language interpreter, word board, or talk box) should be discussed at the onset of the visit.

**Counselling and Education**

Before the examination, a client may wish to examine the instruments that will be used during the examination. If three-dimensional genital models are available, they can be used to acquaint the client with her anatomy, as well as review the examination process. Some clients may wish to view the examination with a mirror while it is happening.

When working with an interpreter, the RN should speak directly to the client at a regular speed instead of to the interpreter. If a client wishes to lip read, the RN should be careful not to move her face out of sight of the client without first explaining what she is doing. The RN should always look directly at the client and enunciate her words clearly when the client prefers lip reading.

**During the Speculum and Pap Test Exam**

The client with a hearing impairment will most likely want to assume the foot-stirrup position. Her head may be elevated so that she can see the RN and/or interpreter. The drape that is used to cover the client's body below her waist should be eliminated or kept low between her legs.

The client should choose which form of communication she wishes to use during her examination: a sign language interpreter, lip reading, or writing. Although a client may use an interpreter throughout most
of the visit, she may decide not to use the interpreter during the actual examination. Many clients will feel more comfortable with a female interpreter. If an interpreter is used, the client and the RN should decide where the interpreter should stand. The interpreter may stand by the RN at the foot of the table or, for more privacy she may stand nearer the client at the head of the table.

(Seidel et al., 1987)

Clients with Visual Impairments

Some visually impaired clients will want to be oriented to their surrounding whereas others may not. Each client should be encouraged to specify the kind of orientation and mobility assistance she needs. The RN should verbally describe and assist the client with the following

- locating where she should put her clothes
- where the various furnishings are positioned
- where and how to take a urine sample if one is needed
- how she can approach the examination table
- how to position herself on the table and put her feet in the stirrups

Counselling and Education

Before the examination, the RN can ask the client if she would like to touch the speculum, swab, or other instruments that will be used during the examination. If three-dimensional genital models are available, they can be used to acquaint the client with her anatomy as well as the examination process.

During the Pelvic and Pap Test Exam

A client with a visual impairment will probably want to assume a foot-stirrup position for the pelvic examination. A client may feel more at ease if continuous tactile or verbal contact is maintained (e.g. a hand on her leg or RN narrating what is taking place during the examination). It is important for the RN to identify herself on entering or leaving the examination room.

(Seidel et al., 1987)

Clients with Diverse Cultural Considerations

Language, culture, socio-economic factors, and education level may deter some clients from seeking medical treatment (Hislop et al., 2003).

Counselling and Education

- be aware of customs and health beliefs of aboriginal clients and other local ethnic groups
- consider the needs of clients whose first language is not English
- ensure the client understands the purpose of cervical screening
- ensure the client knows of the availability of a female RN to take the test
- where possible, arrange access to a trained interpreter; do not use children as interpreters (National Health Services, 1998). In small communities be sensitive to the lack of confidentiality that may occur.

Working with Translators

- When communicating through an interpreter, remember to address your remarks to the client directly so that she will feel like a participant in the discussion rather than talked about.
- Do not have side discussions that you would not usually have in the presence of a client who is fluent in English. Remember that a client’s knowledge of a few English words and the ability to
translate body language may lead her to misunderstand or misinterpret messages not directed at her.

(SIAST, 2000)

Clients Who Have Undergone Female Genital Mutilation (FGM)

Numerous women who have immigrated to Canada from East and West Africa, Arabia, Yemen, Oman, Indonesia, Malaysia, and India have had their external female genitalia excised. Please refer to Section 6: Physiology, Anatomy & Abnormal Findings for a full description and illustrations of FGM.

Counselling and Education

Clients who have experienced FGM may be anxious about exposing their genitals, especially in front of a male healthcare provider. Encourage the client to bring a female relative or friend with her or provide a female chaperone. Arrange for a female RN to conduct the pelvic exam.

Do not assume that clients who have been circumcised are not sexually active. These clients should be counselled about STI and cervical cancer risks on an individual basis.

During the Pelvic and Pap Test Exam

For clients with genital mutilation, the ability to perform a Pap test will depend on the size of the introital opening. A pediatric or small speculum may be necessary. If the introital opening is too small, the nurse will not be able to insert a speculum. These cases may require referral to the physician and examination under anesthesia.

Remember to

- be sensitive and non-judgemental
- avoid inappropriate comments
- not ask colleagues in to observe the pelvic exam, or make facial expressions

The following recommended reading provides additional information on female genital mutilation

- Female Genital Mutilation: Information Pack. See the World Health Organization website at www.who.int

Clients with Barriers to Access

Social determinants of health such as income inequality (e.g., low income women), social exclusion (Health Canada, 2004) (e.g., Aboriginal clients, sex trade workers) have a direct impact on health behaviours and access to healthcare services. Although having a Pap test may not be a top priority for clients with barriers to access, the RN who is working with these clients to assist them with housing, employment, food, and/or childcare can also integrate well-women’s care into client counselling. RNs can help decrease barriers to accessing health services such as Pap test clinics by offering drop-in clinics, bus vouchers, child care options, etc.
SECTION 5: SELF-TEST

1. What are 2 special learning, counselling or communication needs of the following clients

   a. Younger women

   b. Lesbians and women of other sexual minorities

   c. Women with a history of sexual abuse

   d. Disabled clients

   e. Women from different cultures

   f. Women with barriers to access
SECTION 6: PHYSIOLOGY, ANATOMY & ABNORMAL FINDINGS

Learning Objectives

Upon completion of this Section, the learner will be able to

1. Describe the menstrual cycle.
2. Describe normal developmental changes associated with female genitalia.
3. Describe the external and internal anatomy and physiology of the female.
4. Identify abnormal findings and indications of STI, and when referral is necessary.
5. Recognize variations of female genital mutilation.

Parts of this Section (Menstrual Cycle, Developmental Changes) are adapted from Cervical Screening Initiatives Program of Newfoundland and Labrador, 2001 and Mosby’s Guide to Physical Examination (Seidel, Ball, Dains, & Benedict, 1987, p. 581) respectively. Used with permission.

Menstrual Cycle

The menstrual cycle is a complex process involving the reproductive and endocrine systems. The average menstrual cycle usually occurs over 28 days, although the normal cycle may range from 22 to 34 days. Fluctuating hormone levels that, in turn, are regulated by negative and positive feedback mechanisms, regulate the menstrual cycle. The phases are described below.

Menstrual (Preovulatory) Phase

The cycle starts with menstruation (cycle day 1), which usually lasts approximately 5 days. As the cycle begins, low estrogen and progesterone levels in the bloodstream stimulate the hypothalamus to secrete gonadotropin-releasing hormone (GnRh). In turn, this substance stimulates the anterior pituitary to secrete follicle-stimulating hormone (FSH) and luteinizing hormone (LH). When the FSH level rises, LH output increases.

Proliferative (Follicular) Phase and Ovulation

The proliferative phase lasts from cycle day 6 to 14. During this phase, LH and FSH act on the ovarian follicle (mature ovarian cyst containing the ovum), stimulating estrogen secretion. This causes the endometrium to thicken and become more vascular. Late in the proliferative phase, estrogen levels peak, FSH secretion declines, and LH secretion increases, surging at midcycle (around day 14), stimulating ovulation. Then, estrogen production decreases, the follicle matures, and ovulation occurs. Normally, one follicle matures during the ovulatory process and is released from the ovary during each cycle.

Luteal (Secretory) Phase

During the luteal phase, which lasts about 14 days, FSH and LH levels drop. Estrogen levels decline initially, and then increase along with progesterone levels as the corpus luteum (progesterone-producing yellow structure that develops on the surface of the ovary, after the follicle ruptures) begins functioning. During this phase, the endometrium responds to progesterone stimulation by becoming thick and secretory in preparation for implantation of a fertilized ovum.

About 10 to 12 days after ovulation, when the ovum has not been fertilized, the corpus luteum begins to diminish as do estrogen and progesterone levels, until the hormone levels are insufficient to sustain
the endometrium in a fully developed secretory state. Then the ovum disintegrates, and the endometrial lining is shed (menses). This product consists of old blood, mucus and endometrial tissue. Decreasing estrogen and progesterone levels stimulate the hypothalamus to produce GnRH, and the cycle begins again.

Developmental Changes in the External and Internal Genitalia

Over a woman’s lifetime, the size of the uterine corpus and cervix change. For example, of the space filled by the whole uterus in a premenarchial female, one third may be uterine corpus, and two thirds may be cervix. In the adult multiparous female, the uterine corpus may occupy two thirds of the space available, whereas the cervix may fill a third.

Younger Women

External genitalia during puberty
- external genitalia increase in size
- clitoris becomes more erectile
- labia minora becomes more vascular
- labia majora and mons pubis become more prominent and begin to develop hair, often occurring simultaneously with breast development
- if the hymen is intact, the vaginal opening is about 1 cm in size

Internal genitalia during puberty
- vagina lengthens, and epithelial layers thicken
- vaginal secretions become acidic
- uterus, ovaries, and fallopian tubes increase in size and weight
- uterine musculature and vascular supply increase
- endometrial lining thickens in preparation for the onset of menstruation (menarche), which usually occurs between the ages of 8 and 16 years
- vaginal secretions increase just before menarche
- functional maturation of the reproductive organs is reached during puberty

Pregnant Women

If a client indicates that she is pregnant or the RN suspects pregnancy during the history or physical exam, she should be referred to a physician, nurse practitioner, or registered midwife for ongoing pre- and postnatal care. Pregnant woman only need Pap tests if they are otherwise due for screening.

The high levels of estrogen and progesterone that are necessary to support pregnancy are responsible for uterine enlargement during the first trimester. After the third month, uterine enlargement is primarily the result of mechanical pressure of the growing fetus. As the uterus enlarges the muscular walls strengthen and become more elastic.

During pregnancy an increase in uterine blood flow and lymph causes pelvic congestion and edema

As a result
- the uterus, cervix, and uterine neck (isthmus) soften, and the cervix takes on a bluish colour
- softness and compressibility of the isthmus results in exaggerated uterine anteflexion during the first 3 months of pregnancy, causing the fundus to press on the urinary bladder
Also
- vagina changes to a violet color
- mucosa of the vaginal walls and the connective tissue thicken, and smooth muscle cells hypertrophy
- vaginal secretions increase and have an acidic pH due to an increase in lactic acid production by the vaginal epithelium

Older Women

Concurrent with endocrine changes
- ovarian function diminishes during a client’s 40’s
- ovulation usually ceases about 1 to 2 years before menopause
- menstrual periods begin to ease between 40 and 55 years of age although fertility may continue
- menopause is completed after 1 year of no menses

Changes in external genitalia
- estrogen levels decrease, causing the labia and clitoris to become smaller
- labia majora also become flatter as estrogen levels decrease and/or body fat is lost
- pubic hair turns gray and is usually sparser

Changes in internal genitalia
- vaginal introitus gradually constricts
- vagina narrows, shortens, and loses lubrication, and the mucosa becomes thin, pale, and dry, which may result in dyspareunia and/or vaginal atrophy
- vaginal walls may lose some of their elasticity
- cervix becomes smaller and paler
- uterus decreases in size, and the endometrium thins
- ovaries also decrease in size to approximately 1 to 2 cm
- ligaments and connective tissue of the pelvis sometimes lose their elasticity and tone, thus weakening the supportive sling for the pelvic contents

External Genitalia


Mons Pubis

The **mons pubis** is the cushion of adipose and connective tissue covered by skin and coarse, curly hair in a triangular pattern over the symphysis pubis.

© Alberta Health Services – Cancer Screening Programs, 2012
Abnormal Findings
- excessive hair associated with excessive hair elsewhere
- absence of hair in a client >16 may suggest abnormality, however it is not uncommon for young women to shave their pubic hair

Urethral Orifice
The urethral orifice is normally pink with no excretion.

Abnormal findings
- erythema abnormal
- exudates
- abnormal mass within or upon the orifices

Vaginal Orifice and Skene’s Glands
When the labia are spread, the vaginal orifice (introitus) and the urethral meatus are visible. Less easily visible (normally invisible) are the multiple orifices of Skene’s glands (paraurethral glands), mucus-producing glands located on both sides of the urethral opening.

Abnormal findings
- visible Skene’s gland orifice
- erythema
- abnormal exudates
- abnormal mass situated within or upon the orifice

Bartholin’s Gland Orifices
Openings of the two mucus-producing Bartholin’s glands are located laterally and posteriorly on either side of the inner vaginal wall. Orifices of the Bartholin’s glands are normally not visible.

Abnormal findings
- erythema
- abnormal exudates
- an abnormal mass

Clitoris
The clitoris is the sensitive organ of sexual stimulation formed by erectile tissue. It is covered by the prepuce, which along with the frenulum is formed by the merged, inner parts of the labia minora. The adult clitoris is normally no greater than 0.5 cm. in diameter.

Abnormal findings
- enlargement
- atrophy
- any abnormal mass

Frenulum
The frenulum is the protective tissue covering the clitoris.

Abnormal findings
- abnormal mass within or upon the frenulum

Labia Majora and Minora
The labia majora border the vulva laterally from the mons pubis to the perineum. The labia minora, two moist smaller mucosal folds of delicate darker pink to red tissue, lie within the labia majora. They are made up of dense connective and erectile tissue. The labia majora and minora are usually
symmetrical but vary in size per client. Before menarche, the labia majora are poorly defined, and with the menopause, they atrophy. In a client of reproductive age, they are prominent.

Abnormal findings of labia majora or minora
- asymmetry or unusual enlargement
- abnormal exudates
- asymmetry
- focal hyperpigmentation
- sebaceous cyst - blocked opening of sebaceous gland evident by a small firm round nodule on the labia. Often yellow in color with a dark center.
- depigmentation
- erythema
- excoriations
- ulcerations
- leukoplakia may signify precancerous growth

Abnormal findings of the labia majora only are
- atrophy before menopause
- lack of prominence in a client over 16 years old

Vestibule
The vestibule is the space between labia minora, clitoris and the fourchette. It contains the vaginal opening, Skene's glands, and the hymen.

Hymen
The hymen, a tissue membrane varying in size and thickness, may completely or partially cover the vaginal orifice. In a virgin, the hymen normally contains a small aperture. An imperforate hymen may cause the retention of menstrual blood in the vaginal canal.

Perineum
The perineum is the structure constituting the pelvic floor and is referred to as the distinct bridge of tissue that separates the vaginal and anal orifices. It narrows as a result of vaginal delivery. It is usually smooth and unbroken however you may note a scar from a previous episiotomy or tear.

Abnormal findings
- extreme narrowing of the perineum
- fistula
- bulging
- abnormal mass

Vaginal Orifice
Also called the introitus. No part of the vaginal walls is normally visible through the vaginal orifice, unless the orifice is gaping as the result of one or more vaginal deliveries.

Cystocele - prolapse of the urinary bladder through the anterior wall of the vagina, sometimes even exiting the introitus. The bulging can be seen and felt as the client bears down. More severe degrees of cystocele are accompanied by urinary stress incontinence.
Rectocele - prolapse of part of the rectum through the posterior wall of the vagina is called rectocele or proctocele. Bulging can be observed and felt as the client bears down.

Female Genital Mutilation (FGM)

Some cultures traditionally excise women’s genitalia as a puberty rite or means of preserving virginity until marriage. Women who have undergone this practice may have many related negative health consequences. The World Health Organization has different classifications based on the extent of FGM.

- **Type I**: Excision of the prepuce with or without excision of part or all of the clitoris (clitoridectomy).
- **Type II**: Excision of the prepuce and clitoris together with partial or total excision of the labia minora.
- **Type III**: Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).
- **Type IV**: Unclassified: includes pricking, piercing or incision of clitoris and/or labia; stretching of clitoris and/or labia; cauterization by burning of clitoris and surrounding tissues; scraping of the vaginal orifice or cutting of the vagina; introduction of corrosive substances into the vagina to cause bleeding or herbs into the vagina with the aim of tightening or narrowing the vagina; any other procedure which falls under the definition of FGM given above.

(World Health Organization, 1996)

**Clitoridectomy**: The prepuce and head of the clitoris is removed.
**Excision:** Removal of the entire head of the clitoris and labia minora


**Infibulation:** Removal of the entire external genitalia


The following recommended reading provides additional information on female genital mutilation

- Female Genital Mutilation: Information Pack. See the World Health Organization website at [www.who.int](http://www.who.int)

Internal Genitalia

Lateral View of Internal Genitalia
Vagina

The *vagina* is a hollow highly elastic muscular tube extending between the urethra and rectum upward and back. The vaginal epithelium is normally continuous and unbroken and covered with epithelium fluid or transudate that is clear, colourless, and odourless. Blood is normal if it is menstrual. Before menopause the mucosa is pink; after menopause, paler. During pregnancy, the epithelium may appear cyanotic because of underlying venous congestion. In a nulliparous client, the vaginal mucosa typically displays rogations (wrinkles) that become less prominent after a vaginal delivery.

Abnormal findings
- abnormal masses or exudates
- blood of unknown origin
- cyanosis in a nongravid client
- erythema
- genital warts
- fistula
- hemorrhagic lesions
- leukoplakia
- nodularity
- pallor in a premenopausal client
- ulceration
- atrophic vaginitis – in older females, atrophy of the vagina is caused by lack of estrogen. The vaginal mucosa is usually dry and pale, but it may become reddened and develop petechiae and superficial erosions. The accompanying vaginal discharge may be white, gray, yellow, green, or blood-tinged. It can be thick or watery.

Fornices

The recess anterior to the cervix is called the *anterior fornix*, the one posterior to the cervix is the *posterior fornix*, and the one on either side of the cervix is the *lateral fornix*.

Uterus

The uterus is a small, firm, pear-shaped, and fibromuscular organ. It is about 7.5 cm. long, rests between the bladder and the rectum and usually lies at almost a 90-degree angle to the vagina. The uterus is divided into the following three layers
- perimetrium: external layer made up of a serous membrane.
- myometrium: middle layer made up of a heavy muscular wall.
- endometrium: internal lining which responds to changing estrogen and progesterone levels during the menstrual cycle.

The uterus has two parts: i) the cervix, which projects into the vagina, and ii) the fundus, which is the larger, upper part. In pregnancy the elastic, upper uterine portion (the fundus) accommodates most of the growing fetus. The uterine neck (isthmus) joins the fundus to the cervix. The fundus and the isthmus make up the corpus, the main uterine body. The size of the uterus varies depending on the number of births (parity) and uterine abnormalities. The uterus is anteflexed or anteverted above or over the empty bladder in most women, but can also be midplane (its long axis parallel to the long axis of the body), retroverted, or retroflexed.

Abnormal findings
- asymmetry
- enlargement in a nongravid client
- lateral displacement
- limited mobility
- any abnormal mass

**Uterine prolapse** occurs when the supporting structures of the pelvic floor weaken. This often occurs concurrently with a cystocele or rectocele. The uterus becomes progressively retroverted and descends into the vaginal canal. In first-degree prolapse the cervix remains within the vagina; in second-degree prolapse the cervix is at the introitus; in third-degree prolapse the cervix drops outside the introitus. See illustrations below.

Normal uterus                 First-degree prolapse        Second-degree prolapse        Complete prolapse


**Uterine cancer** in most cases develops in the glandular tissue of the endometrium and is called adenocarcinoma (Canadian Cancer Society, 2004). Having the following signs and symptoms does not necessarily indicate uterine cancer, but may require more discussion in the health history and a possible referral to a physician or nurse practitioner.

**Early uterine cancer symptoms**
- bleeding between menstrual periods
- heavy bleeding during periods
- spotting or bleeding after menopause
- bleeding after intercourse
- a foul discharge
- yellow watery discharge
- cramping pain
- pressure in abdomen or pelvis, back or legs
- discomfort over the pubic area
Post menopausal bleeding is bleeding after the first complete year without a period is considered a high risk factor for endometrial cancer and the client should be referred to a physician and possibly referred for an endometrial biopsy and pelvic ultrasound. The client should be told to watch for this so if this does occur she should contact her physician or nurse practitioner.

Fallopian Tubes

From each side of the fundus extends a fallopian tube, the fringed, funnel-shaped end of which curves toward the ovary. Usually nonpalpable, these 8 -14 cm. long, narrow tubes of muscle fibers have finger-like projections, called fimbriae, on the ends that partially surround the ovaries. Fertilization of the ovum usually occurs in the outer third of the Fallopian tube (Seidel et al., 1987).

Ovaries

The ovaries are almond-shaped structures that vary considerably in size but average about 3 – 3.5 cm long, 2 cm wide and 1 – 1/5 cm thick from adulthood through menopause. They lie near the lateral pelvic walls, a little below the anterosuperior iliac spine. The two primary functions of the ovaries are to produce ova and secrete hormones, including estrogen, progesterone, and testosterone. About 300 ova are released during a woman’s childbearing years.

Ovarian cancer can develop for a long time without causing any signs or symptoms (Canadian Cancer Society, 2004). When symptoms do start, they are often vague and easily mistaken for more common illnesses. Most women with ovarian cancer have advanced disease at the time of their diagnosis. To date there is no effective way of detecting ovarian cancer early and no effective ovarian cancer screening methods. Although bimanual exam is not a part of this module, the RN should be aware of signs of ovarian cancer. Having the following symptoms does not necessarily indicate ovarian cancer, but may require more discussion in the health history and a possible referral to a physician, nurse practitioner or registered midwife.

<table>
<thead>
<tr>
<th>Early ovarian cancer symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>• mild abdominal discomfort or pain</td>
</tr>
<tr>
<td>• abdominal swelling</td>
</tr>
<tr>
<td>• change in bowel habits</td>
</tr>
<tr>
<td>• feeling full after a light meal</td>
</tr>
<tr>
<td>• indigestion &amp; gas</td>
</tr>
<tr>
<td>• upset stomach</td>
</tr>
<tr>
<td>• sense that bowel has not completely emptied</td>
</tr>
<tr>
<td>• nausea</td>
</tr>
<tr>
<td>• constant tiredness</td>
</tr>
<tr>
<td>• pain in lower back or leg</td>
</tr>
<tr>
<td>• abnormal menstrual or vaginal bleeding</td>
</tr>
<tr>
<td>• more frequent urination</td>
</tr>
<tr>
<td>• pain during intercourse</td>
</tr>
<tr>
<td>• persistent cough</td>
</tr>
</tbody>
</table>

Cervix

The cervix normally protrudes into the vaginal vault by 1 to 3 cm. In a nulliparous client, its diameter is 2 to 3 cm. and following vaginal delivery increases in size to 3 to 5 cm. It is usually round and symmetrical in shape. A round (in nulliparous clients) or slit like (in parous clients) depression is the external os of the cervix and marks the opening into the endocervical canal (passage way between the cervix and the uterus) and uterine cavity. The trauma of a delivery may tear the cervix, producing permanent transverse or stellate lacerations.
The **ectocervix** is the lower part of the cervix that protrudes into the vagina. The **transformation zone** where the Pap test sampling needs to focus varies for each woman and is somewhere between the ectocervix and the endocervical canal.

The upper vagina is divided by the protrusion of the cervix into the vagina into vault-like anterior (front) fornix and posterior (back) fornix. The position of the cervix in the vagina has implications for the placement of the speculum during a pelvic exam.

![Normal Nulliparous Cervix vs Normal Parous Cervix](image)

From Faculty of Primary Care Nurse Practitioner Program, Saskatchewan Institute of Applied Science and Technology (2000). Pap Testing and Bimanual Exam p 17-19. Adapted with permission.

**Anatomy of the Cervix as a Whole**

![Diagram of Cervical Anatomy](image)


**Common findings**

- **Nabothian follicles** - mucus retaining cysts caused by normal changes of surface columnar squamous epithelium. They are usually small (5mm diameter) but occasionally may enlarge to 1.5 cm. If several are present the cervix may have a knobby appearance.

- **Polyp** - bright red, soft growth emerging from os. It is a benign lesion, but must be determined by biopsy. There may be discharge or bleeding.

**Nabothian Follicles and Cervical Polyps**
Abnormal findings of the cervix as a whole
- asymmetrical shape
- enlargement not attributable to a vaginal delivery
- an abnormal mass
- protrusion into the vaginal vault by more than 3 cm.

Ectocervix
The ectocervix is covered with smooth squamous epithelium that is normally moist with a clear, colorless fluid. In some women, the epithelial color is uniformly pink, and in others, an erythema surrounds the cervical os. Usually, it appears
- flat
- pink
- uniform
- featureless

Endocervix
A columnar, mucus producing epithelium lines the cervical canal. The columnar epithelium extends proximally from the squamo columnar junction (SCJ) to the endocervical canal and internal os. It covers a variable amount of the ectocervix and lines the endocervical canal. The endocervix
- is irregular.
- seems dark red because of the underlying vessels.
- produces mucus that is more profuse, clear, and watery just before ovulation.
- produces mucus that is thicker, duller and more tenacious after ovulation or during pregnancy.

Cervical Epithelium

Columnar Epithelium
Squamo columnar junction (SCJ)
The SCJ of the cervix is the area of change or line along which the squamous epithelium of the ectocervix meets the columnar epithelium of the endocervix. The SCJ is often marked by a line of metaplasia (see transformation zone below) and its location is variable. Age and hormonal status are the most important factors influencing its location. For example, it may be located
- at or very close to the external os during perimenarche.
- on the ectocervix at variable distances from the os in reproductive-aged women.
- further away from the os as high estrogen levels during pregnancy and with oral contraceptive use promote further eversion of the SCJ.
- receding up the endocervical canal from the perimenopause on, or with prolonged exposure to strong progestational agents which cause atrophy.
- receding into the endocervical canal (inverted) and cannot be readily visualized during post menopause.

Transformation Zone
This is the area of transformation where squamous epithelium of the ectocervix has replaced columnar (glandular) epithelium of the endocervix through the process of squamous metaplasia. The SCJ discussed above is the visible border between the squamous and columnar epithelia of the cervix and represents the new squamocolumnar junction. Adjacent to the new SCJ the dynamic process of squamous metaplasia occurs throughout the reproductive years. This is a normal process during which columnar epithelium is replaced by squamous epithelium.

The transformation zone includes the area between the original squamocolumnar junction and the new squamocolumnar junction and has a variegated appearance. This zone
- is located 8mm to 13mm proximal to the ectocervix, but may extend as far as 20mm to 30mm into the cervical canal, and
- is higher within the cervix in older women and those who are pregnant

Variations in the Transformation Zone
A: narrow transformation zone

B: broader transformation zone—parous

C: broadly everted transformation zone—parous

D: post-menopausal (indrawn) or post-treatment type
Abnormal findings
- abnormal exudates or masses upon the ectocervix
- asymmetrical circumoral erythema with irregular borders
- blood of unknown origin
- cyanosis in a nongravid client
- diffuse erythema
- ulcerations
- nodularity or roughness is usually abnormal, but may be attributable to nabothian cysts which are common
- hemorrhagic lesions
- leukoplakia

Cervical Punctation (Carcinoma in situ) - Vertical, single-loop capillaries viewed end-on.

Mosaicism (Carcinoma in situ) - tile like pattern of vessels around blocks of white epithelium caused by neovascular changes. Coarser patterns and vessels indicative of higher grade lesions.

**Extensive erosion and severe dysplasia**

If there is a suspicion of malignancy e.g. inflammation of the cervix, abnormal bleeding from cervix, the RN should seek assistance before proceeding with the Pap test, except in certain circumstances*

*If there are no other healthcare providers to refer to on site, ensure clear clinical details are noted on the lab requisition and the client’s record. Mark the requisition for stat/urgent processing. The RN should proceed with doing the Pap test especially if the woman is unable/unlikely to return. If a Pap test is not taken, refer the client immediately for further investigation with her physician, nurse practitioner, or registered midwife. If there is an obvious lesion on the cervix, a Pap test may not be appropriate as results may return as negative (false negative) and this would be falsely reassuring. If the RN sees any lesion that s/he is unsure of, a Pap test should still be taken and the client should be referred to a physician, nurse practitioner, or registered midwife promptly.
## Summary Chart: Discharges, Infections, Ulcers, and Lesions

Any abnormalities or suspected infections of the vulva, vagina or cervix should be appropriately documented and the client should be reported immediately to a physician, nurse practitioner, or registered midwife for follow-up and further testing. Details about STI testing are not included in this module although it is considered a normal part of a well woman’s exam (depending on age and risk factors). If you are required, by your clinic/agency, to conduct STI testing please refer to your clinic/agency guidelines.


### Vaginal Discharges and Infections

<table>
<thead>
<tr>
<th>Name</th>
<th>Discharge</th>
<th>Erythema/Itching</th>
<th>Associated symptoms</th>
<th>Pictures (if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gonorrhea</strong></td>
<td>Often clients will be asymptomatic. Thick yellow/green discharge or discharge may be absent. May manifest with urethritis, cervicitis, and pelvic inflammatory disease (PID)</td>
<td>Cervix and vulva may be inflamed. May have cervical friability (bleeding when the first swab is taken) and/or erythema or edema.</td>
<td>Dysuria, frequency, abnormal vaginal bleeding, lower abdominal pain, deep dyspareunia, Bartholin gland inflammation, and discharge. If left untreated may result in infertility.</td>
<td><img src="image_url" alt="Gonorrhea Image" /></td>
</tr>
<tr>
<td><strong>Chlamydia</strong></td>
<td>Often asymptomatic. Color of discharge may vary greatly (e.g. may see yellow mucopurulent discharge from cervical os). May manifest with urethritis, cervicitis, and PID.</td>
<td>Hypertrophic, edematous, may have cervical friability and/or erythema or edema.</td>
<td>Intermenstrual spotting, spotting after intercourse, asymptomatic urethritis, deep dyspareunia, abnormal vaginal bleeding, lower abdominal pain. If untreated may result in infertility.</td>
<td><img src="image_url" alt="Chlamydia Image" /></td>
</tr>
<tr>
<td><strong>Gardnerella</strong></td>
<td>Scant or moderate discharge. May be grey with foul odor.</td>
<td>Usually no edema or erythema of vulva or vagina. Vaginal epithelium may be red, swollen, tender, and the client complains of burning and itching.</td>
<td>Strong fishy vaginal odor, particularly after intercourse.</td>
<td><img src="image_url" alt="Gardnerella Image" /></td>
</tr>
<tr>
<td>Name</td>
<td>Discharge</td>
<td>Erythema/Itching</td>
<td>Associated symptoms</td>
<td>Pictures (if available)</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------------------------------</td>
<td>---------------------------------------------------------</td>
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</tr>
<tr>
<td>Candidiasis</td>
<td>Scant to moderate discharge. May be thin but usually thick, white, curdy cheese like discharge which is adherent to vaginal wall/cervix.</td>
<td>Mild to severe itching and erythema of labia, thighs, perineum. Cervix may be red and edematous. Erythema and edema of vulva, vagina or introitus. Vagina may have white patches, some which may detach.</td>
<td>Dysuria, frequency, dyspareunia.</td>
<td></td>
</tr>
<tr>
<td>Trichomoniasis</td>
<td>Copious, frothy, grey, green, yellow white or yellow brown, strong foul odor.</td>
<td>Severe itching of vulva, with or without erythema. Petechiae of cervix and vagina (“strawberry spots”). The cervix may be inflamed and friable.</td>
<td>Dysuria and dyspareunia with severe infection.</td>
<td></td>
</tr>
<tr>
<td>Bacterial Vaginosis</td>
<td>Grey to white thin watery, discharge.</td>
<td>May have burning or irritation around vagina.</td>
<td>“Fishy” smelling odor.</td>
<td></td>
</tr>
</tbody>
</table>

### Genital Ulcer Disease

<table>
<thead>
<tr>
<th>Name</th>
<th>Discharge</th>
<th>Erythema/Itching</th>
<th>Associated symptoms</th>
<th>Pictures (if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syphilis</td>
<td>Secondary - Papules covered by gray exudate.</td>
<td>Syphilitic Chancre (Primary Syphilis) can appear as a single painless, indurated ulcer found on the genitals. Most chancres in women develop internally and often go undetected. Condyloma Latum (Secondary Syphilis) lesions appear 2 to 12 weeks after infection. They are flat, round, or oval.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genital Herpes (can be due to herpes simplex virus (HSV)-2 or HSV-1)</td>
<td>Clear watery discharge from early blister-like lesions.</td>
<td>Usually starts with painful papules followed by vesicles (blisters), ulceration, crusting, and healing. The lesions may itch and are usually painful.</td>
<td>Dysuria, swollen glands in groin, outbreaks vary and can return as often as every month or as rarely as once a year or longer. Initial infection is often extensive, whereas recurrent infection is usually confined to a small localized patch on the vulva, perineum, vagina, anus, or cervix.</td>
<td></td>
</tr>
</tbody>
</table>
## Papular Genital Lesions

<table>
<thead>
<tr>
<th>Name</th>
<th>Discharge</th>
<th>Erythema/Itching</th>
<th>Associated symptoms</th>
<th>Pictures (if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genital warts (caused by certain</td>
<td>nil</td>
<td>Warts may be round, flat or raised painless small, cauliflower-like bumps. They are generally flesh-colored, whitish pink to reddish brown, soft growths. Warts may be single or in clusters.</td>
<td>The client may present with a lump in vulva area before the wart actually appears. May spread to urethra, vagina, cervix, or anus area.</td>
<td>![Wart Image]</td>
</tr>
<tr>
<td>types of Human Papillomavirus (HPV). Other types of HPV cause abnormal cervical changes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Molluscum Contagiosum</td>
<td>nil</td>
<td>Painless genital lesions that have a smooth waxy appearance often with a white central umbilication.</td>
<td>This is usually a benign condition with few complications.</td>
<td>![Molluscum Image]</td>
</tr>
</tbody>
</table>

## Other STI

<table>
<thead>
<tr>
<th>Name</th>
<th>Discharge</th>
<th>Erythema/Itching</th>
<th>Associated symptoms</th>
<th>Pictures (if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pubic lice/crabs</td>
<td>nil</td>
<td>Evident by excoriations or itchy small red maculopapules in pubic hair and surrounding area. Look for nits or lice attached to base of pubic hair.</td>
<td></td>
<td>![Pubic Lice Image]</td>
</tr>
</tbody>
</table>

Note that signs and symptoms may overlap and may present differently in different clients. Some clients may have more than one infection at once which is difficult to diagnosis clinically, so testing is important!

### HPV

### STI Guidelines and Treatment
- Canadian STI Guidelines- see [www.phac-aspc.gc.ca](http://www.phac-aspc.gc.ca)
- Alberta Health & Wellness STI Guidelines – see [www.health.alberta.ca](http://www.health.alberta.ca)
SECTION 6: SELF-TEST

1. Describe the phases of the menstrual cycle

2. Describe normal developmental changes associated with the female genitalia particularly for adolescents and older adults

3. Describe 10 aspects of female external and internal anatomy and physiology

4. Identify 5 abnormal findings and indications of STI, and when referral is necessary

5. Describe 3 variations of FGM
SECTION 7: HEALTH HISTORY

Learning Objectives

Upon completion of this Section, the learner will be able to

1. Conduct a health history interview with women across the lifespan.
2. Tailor a health history interview to the client’s needs, preferences, and presentation.

Parts of this Section (Health History Review, Review of Related History) are adapted from Cervical Screening Initiatives Program of Newfoundland and Labrador (2001) and Mosby’s Guide to Physical Examination (Seidel et al., 1987, p. 585) respectively. Used with permission.

Health History Review

Cervical cancer screening is a sensitive issue for some women. Certain risk factors may give women feelings of guilt, embarrassment, and confusion. Using a positive manner to discuss risk factors can give women the opportunity to voice health concerns and to take responsibility for their overall wellbeing by taking part in the cervical and other screening programs.

Adequate and accurate data are keys to a successful health history. It is necessary to be sensitive to culture, language and age related concerns, which if recognized, helps the RN to understand the client’s responses and behaviour. Sometimes a phrase like “I realize how uncomfortable/embarrassing this is for you, but to help you, I need to know…” encourages the client to relax and assures her of the essential nature of such confidential information.

Terminology and language pose further barriers

- Be certain of what the client’s statements mean.
- Repeat statements for verification, when necessary, so that misunderstandings can be corrected. For example, the client might complain of “itching down there” – use pictures/drawings to identify location or ask client to point to the area.
- If language presents a problem, use an interpreter. Because of the confidential nature of the questions, a family member who is interpreting might be unsuitable.

During the reproductive health history interview

- Obtain health history data in a comfortable environment that protects the client’s privacy.
- Conduct the interview at an unhurried pace; otherwise the client may overlook important details.
- Ask questions preferably while the client is seated and dressed before the physical assessment. This ensures the client’s comfort and confidence.
- Use terms that the client understands. Explain technical language.
- Focus questions on the reproductive system, but maintain a holistic approach by inquiring about the status of other body systems and psychosocial concerns. Reproductive system problems may cause the client other problems related to such other areas as self-image, sexual functioning, and overall wellness.
- When choosing health history questions, consider their relevance and practicality for the client as well as the clinical setting. For example, asking a 69 year-old client the date of her last menstrual period is pointless. Conversely, asking her about menopause, irregular bleeding, and estrogen replacement therapy may be more appropriate. Do not collect information from a client that is not going to be used or addressed. As well, do not collect information that is beyond what the client wants to disclose/discuss.
In some settings, the RN will not complete a comprehensive health assessment as described in this Section. When choosing your health history questions consider the relevance to the client and focus on their areas of concern.*

*It may be necessary to conduct a short focused health history to determine whether to proceed with a Pap or refer to a physician. Only go into more depth if there are concerns relative to Pap testing (e.g., previous abnormal Pap tests, past gynecologic procedures such as cone biopsy or hysterectomy, intermenstrual spotting, previous problems with Pap tests such as pain, more specific questions about current genital infections, discharge). If a client does have a concern, symptoms, or a history that could indicate cervical pathology, STI, and/or other abnormal findings, she should be referred to a physician, nurse practitioner, and/or registered midwife for further investigation.

Review of Related History

The following health history components are recommended for a comprehensive well-woman Pap test visit focused on sexual and reproductive health. RNs need to use their clinical judgement within the context of their practice setting to determine the types of questions that are necessary for each woman and how to use more detailed questions with individual clients based on client need/request/disclosure.

Menstrual History

- Age at menarche.
- Date of last menstrual period: first day of last cycle
- Number of days in cycle and regularity of cycle
- Character of flow: amount (number of pads or tampons used in 24 hours), duration, presence and size of clots
- Dysmenorrhea: characteristics, duration, frequency (occurs with each cycle?), relief measures
- Intermenstrual bleeding or spotting: amount, duration, frequency, and timing in relation to phase of cycle
- Intermenstrual pain: severity, duration, timing, and association with ovulation
- Premenstrual symptoms (PMS): headaches, weight gain, edema, breast tenderness, irritability or mood changes, frequency (occurs with every cycle?), interference with activities of daily living, relief measures

Obstetric History

- Gravity (number of pregnancies)
- Parity (number of births); term, pre-term
- Number of abortions: spontaneous or induced
- Number of living children
- Complications of pregnancy, delivery, abortion, or with fetus/neonate

Douching History

- Douching within the last 24 hours
- Frequency: length of time since last douche; number of years douching
- Method and solution used
- Reason for douching
Contraceptive History
- Sexual intercourse, use of birth control creams/jellies, or lubricant within the last 24 hours
- Current method: length of time used, effectiveness, consistency of use, side effects, and satisfaction with method
- Previous methods: duration of use for each, side effects, and reasons for discontinuing each

Sexual History
- Difficulties, concerns, problems
- Dyspareunia: characteristics, duration and frequency
- Satisfaction with current practices, habits, and sexual relationship(s)
- Number of partners
- Sexual preference and orientation
- Type of sexual activity and condom use
- Date of last STI testing (*when appropriate to ask*)

Medical History
- HPV vaccination record (*when appropriate*)
- Medications: prescription, over-the-counter, illegal
- Date of last pelvic examination
- Date of last Pap test and results
- Past gynaecologic procedures or surgery (tubal ligation, hysterectomy, oophorectomy, laparoscopy, cryosurgery, laser therapy, LEEP, conization).
- Sexually transmitted infections
- Pelvic inflammatory disease
- Vaginal infections
- Tobacco use
- Diabetes
- Cancer of reproductive organs
- Screening mammograms every 2 years if over 50 (*40 with physician’s referral*).
- Colorectal cancer screening/Home stool test annually if over 50 (personal/family history may require earlier screening).

The following health history components may also need to be assessed *DEPENDING on client presentation, and clinic/agency policies, and the RN's professional judgment.*

Cleansing Routines
- Use of sprays, powders, perfume, antiseptic soap, deodorants, or ointments

Infertility
- Length of time attempting pregnancy, sexual activity pattern, knowledge of fertile period of menstrual cycle
- Abnormalities of vagina, cervix, uterus, Fallopian tubes, ovaries
- Contributing factors: stress, nutrition, medications (i.e. prescription, over-the counter, and illegal).
- Partner factors
Family History

- Cardiovascular disease
- Mother received DES while pregnant with client (increased risk of rare cervical and vaginal cancers as well as breast cancer due to prenatal exposure to this synthetic form of estrogen). See www.cancer.gov
- Multiple pregnancies
- Congenital anomalies

Older Adults

- Age at menopause or currently experiencing menopause
- Menopausal symptoms; menstrual changes, mood changes, tension, back pain, hot flashes
- Post menopausal bleeding
- Birth control measures during perimenopause
- General feelings about menopause: self-image, effect on intimate relationships
- Mother’s experience with menopause
- Symptoms related to physical changes: itching, urinary symptoms, dyspareunia
- Changes in sexual desire or behaviour: in self, in partner

For more information on other recommended screening tests within primary care settings, see Health Screen at www.topalbertadoctors.org

Assessing a Client For Specific Health Concerns - PQRST

PQRST stands for

- Provocative or Palliative
- Quality or Quantity
- Region or Radiation
- Severity Scale
- Timing

When assessing a client with a symptom or health concern, the RN uses symptom analysis to help the client describe the problem fully. A method for obtaining a systematic and thorough assessment, the symptom analysis is easy to remember with the mnemonic device, PQRST. The following questions serve as a guide to effective symptom analysis.
<table>
<thead>
<tr>
<th>P</th>
<th>Q</th>
<th>R</th>
<th>S</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provocative or Palliative</td>
<td>Qualify or Quantity</td>
<td>Region or Radiation</td>
<td>Severity Scale</td>
<td>Timing</td>
</tr>
<tr>
<td>What causes the symptom? What makes it better or worse?</td>
<td>How does the symptom feel, look or sound? How much of it are you experiencing now?</td>
<td>Where is the symptom located? Does it spread?</td>
<td>How does the symptom rate on a severity scale of 1 - 10, with 10 being the most extreme?</td>
<td>When did the symptom begin? How often does it occur? Is it sudden or gradual?</td>
</tr>
<tr>
<td>First occurrence: What were you doing when you experienced or noticed the symptom? What seems to trigger it? Stress? Position? Certain activities? Arguments? For a physical symptom, such as discharge: what seems to cause it or make it worse? For a psychological symptom: does the depression occur when you feel rejected?</td>
<td>Quality: How would you describe the symptom - how it feels, looks or sounds? Quantity: How much are you experiencing now? Is it so much that it prevents you from performing any activities? Is it more or less than you experienced at any other time?</td>
<td>Region: Where does the symptom occur? Radiation: In the case of pain, does it travel up/down your back, arms, neck, or legs?</td>
<td>Severity: How bad is the symptom at its worst? Does it force you to lie down? Course: Does the symptom seem to be getting better, getting worse, or staying about the same?</td>
<td>Onset: On what date did the symptom first occur? What time did it begin? Type of Onset: How did the symptom start, Suddenly? Gradually? Frequency: How often do you experience the symptom: Hourly? Daily? Weekly? Monthly? When do you usually experience it: During the day? At night? In the early morning? Does it wake you? Does it occur before, during or after meals? Does it occur seasonally? Duration: How long does an episode of the symptom last?</td>
</tr>
</tbody>
</table>

(Cervical Screening Initiatives Program of Newfoundland and Labrador, 2001).
SECTION 7: SELF-TEST

1. Describe the 9 key areas to review when conducting a health history?

2. What does the mnemonic device PQRST represent and what kinds of questions are asked in each of the 5 areas?
SECTION 8: EXTERNAL & SPECULUM EXAM

Learning Objectives

Upon completion of this Section, the learner will be able to

1. Describe how to perform a woman centred physical examination of the external genitalia.
2. Understand metal and disposable speculum functions.
3. Describe how to perform a woman centred speculum examination.
4. Identify which clients require referral to physician, nurse practitioner, and/or registered midwife for Pap testing and/or follow-up.

Part of this Section (Preparing the Client, External Exam, Clients with Special Considerations) are adapted from Faculty of Primary Care Nurse Practitioner Program, Saskatchewan Institute of Applied Science and Technology (2000) and Calgary Health Region (2001a).

Exam Equipment

Gather the following

- Vaginal speculum of appropriate size (for more information on choosing a speculum, see Review of Speculums later in the chapter)
- Portable light or a light source with a disposable speculum
- Gloves for a clean examination
- Mirror (optional)

Ensure a new plastic speculum or a properly cleaned and autoclaved metal speculum is used to prevent transmission of infection or cross infection (e.g. HPV) to the client.

Preparing the Client

1. Introduce yourself to the client before she changes into a hospital gown.
2. Obtain a relevant health history as explained in Section 7: Health History.
3. Explain the physical assessment plan and validate it with the client.
4. Explain the procedural steps to the client and the reason for performing an external genital, speculum, and Pap test examination.
5. Explain the role of HPV testing in cervical cancer screening. Provide her with a copy of the handout, “HPV Testing: Information for Women Having Pap Tests” that are provided in the trays of liquid-based supplies and are available at www.screeningforlife.ca.
6. Obtain verbal consent to proceed with the external examination, speculum exam and Pap test procedures.
7. Ask the client if she would like her support person to accompany her during the exam. Be sensitive to cultural diversity, e.g. Muslim women may not want their male partner present.
8. To minimize discomfort while inserting the speculum, have the client void prior to the procedure.


10. Drape lower half of client’s body. Since the gowns can be quite short, a drape placed over the client’s abdomen to knees can add to her sense of privacy. This is especially true if she has a friend or chaperone present.

11. Assist the client into lithotomy position so that her body is supine. Place arms by side or across the chest, knees apart, and buttocks near the end of the examining table. Alternate positions such as stirrups for lithotomy position, M-shaped, or knee chest positions may also be used as explained below.

**M-Shaped Position**

In the M-shaped position the woman
- lies on her back, knees bent and apart, and
- feet resting on the examination table close to her buttocks.

The speculum must be inserted with the handle up. If the woman feels her legs are not completely stable on the examination table, an assistant may support her feet or knees. The M-shaped position does not require the use of stirrups.” If the woman tips her pelvis forward, the speculum may be inserted with the handle down, making the cervix easier to slip between the blades of the speculum.

**Knee-Chest Position**

In the Knee-Chest position, the woman
- lies on her side with both knees bent, and
- with her top leg brought closer to her chest.

(A variation of this position would allow the woman to lie with her bottom leg straightened while the top leg is still bent close to her chest.)

The speculum can be inserted with the handle pointed in the direction of the woman’s abdomen or back. Because the woman is lying on her side, the RN should be sure to angle the speculum toward the small of the client’s back and not straight up toward her head. An assistant may provide support for the client while she is on the examination table or help the woman straighten her bottom leg if she prefers the variation of this position. If the client cannot spread her legs, the assistant may help her elevate one leg. The knee-chest position does not require the use of stirrups. It is particularly good for a woman who feels most comfortable and balanced lying on her side. This position is helpful for elderly clients or physically disabled clients who have less range of motion.

Note: Most clinic rooms have the bed against the wall so the RN should approach the client from the right side and the client would be lying on the left side. It is also helpful to have the woman lie with her trunk across the exam bed at an angle of at least 45 degrees so it is easier for the RN to see the cervix.

12. If the client wants to take an active part in the examination, elevate her head and shoulders to a semi-sitting position to maintain eye contact and provide the client with a mirror so that she can see what the RN is doing and has a full view of her genitalia.

13. Sit on a stool at the foot of the examining table.

14. Explain each step of the examination before it is done. Share your findings with the client throughout the examination. Be sure this is done in a supportive manner that the client won’t misinterpret. Comments on what you are seeing that may not be relevant or are comparative to others may be harmful. Wait until after the examination to discuss abnormal findings further as this may cause anxiety.

External Examination

The external examination is a part of the well-woman’s examination and the following steps may be selected according to client need, concerns, health history, and clinical setting. However, you may not be required to perform an external examination in certain clinical situations (e.g. a special Pap test clinic).

Check with your Employer’s policies to determine if external examination is required. The following information is an in depth description of the external exam and each step may not need to be performed depending on the RN’s assessment, the client’s needs, concerns, health history, and clinical setting.

Follow these steps

1. Glove.

2. Warn the client that you are going to touch her thigh then the labia. Touch the inner thigh with the back of the hand before touching the genitals.

3. Separate the labia with the fingers of one hand.

4. Observe and/or examine the following AS NEEDED based on symptoms, history and clinical setting

   a. **Inguinal and femoral lymph nodes** - Palpate as needed for enlarged nodes

   b. **Skin colour** - The skin should be smooth and clean
      
      i. Note as needed: Sores, rashes, or lesions

   c. **Pubic hair**
      
      i. Note as needed: Burrows of scabies, pubic lice nits

   d. **Labia majora** - May be gaping or closed, appear dry or moist, are usually symmetric, and may be atrophied or full. The tissue should feel soft and homogeneous.
      
      i. Note as needed:
         
         • Swelling, abrasion, rashes, or lesions, which suggest an infective or inflammatory process.
         
         • If any of these signs are present, ask the client if she has been scratching.
         
         • Observe for discolouration, varicosities, obvious scratching, or signs of trauma or scarring.
• Labial swelling, redness, or tenderness, particularly if unilateral, may be indicative of a Bartholin gland abscess.

e. Vaginal opening - Can be a thin vertical slit or a large orifice with irregular edges from hymenal remnants. The tissue should be moist.
   i. Note as needed: Swelling, discolouration, lesions, fistulas, discharge, or fissures

f. Perineum - Surface should be smooth; episiotomy scarring may be evident in clients who have borne children. The tissue will feel thick and smooth in the nulliparous clients. It will be thinner and rigid in multiparous clients.
   i. Note as needed: tenderness, inflammation, fistulas, lesions, or growths

g. Anus - Is more darkly pigmented, and the skin may appear coarse. **If you touch the anus or perianal skin, be sure to change your gloves so that you do not introduce bacteria into the vagina during the speculum examination.**
   i. Note as needed: scarring, lesions, inflammation, fissures lumps, skin tags, or excoriation

**View a Pap Test Video for an introduction to external, speculum, and Pap test examination procedures. See Appendix 2: Pap Test Videos. Please note that resource videos may have some variations regarding Pap test techniques. It is recommended that RNs follow practice techniques consistent with the Guideline for Screening for Cervical Cancer (TOP, 2011).**

**Speculum Exam Procedure**

Refer pregnant clients to a physician, nurse practitioner, or registered midwife if they are due for a Pap test and/or for prenatal care. Refer clients with a total or subtotal hysterectomy due to biopsy confirmed high grade lesions or cervical cancer to their physician or nurse practitioner for follow-up. Women who have had a total hysterectomy for benign reasons (e.g. endometriosis) do not need to continue with Pap tests.

It is essential to become thoroughly familiar with how the speculum operates before beginning the examination as to not hurt the client.

- Become familiar with the operation of the **metal speculum and the disposable plastic speculum.** The mechanical action of each is somewhat different.
- Plastic specula typically make a loud click when locked or released. It is therefore important to forewarn the client about this click and avoid surprise and unnecessary anxiety.
- It is also helpful to note that the blades of the speculum are of slightly different lengths to more easily allow the cervix to “pop” in between them when positioned correctly.
Metal Speculum

Disposable Speculum

Locate a metal and disposable plastic speculum at your clinic/agency. Handle and review the parts of the speculums as per the above diagrams to understand how they function.

After taking the client’s health history and examining her external genitalia, it is important to get an idea of the appropriate type and size of speculum needed. A smaller and narrower speculum may need to be used with clients who have not had vaginal penetration, nulliparous clients, clients who have undergone female genital mutilation, or clients whose vaginal introitus has contracted postmenopausally.
To begin the speculum exam

1. Select the proper sized speculum.

2. Check the setscrews on a metal speculum
   - Ensure the setscrew on the long handle (holding the two blades of the speculum together) is kept tightened.
   - Loosen the setscrew that holds the thumbscrew in place.

3. Lubricate the speculum with water. Water-soluble lubricant or jelly is NOT recommended due to a potential increase in unsatisfactory test results in both conventional and liquid-based cytology Pap tests.

   As a client ages, her vaginal walls atrophy and therefore are drier than a younger client. Special attention to client comfort and lubrication should be a priority.

4. Warm the metal speculum by rinsing it in warm (not hot) water, holding it in your gloved hand or under the lamp for a few moments, or by having speculums on a warm heating pad (test temperature against wrist before inserting). A cold speculum increases muscle tenseness.

5. Grasp the speculum with your dominant hand. The index and middle fingers should surround the blades and the thumb should rest against the back of the thumb rest to keep the tips of the blades closed.

6. Tell the client that she is going to feel you touching her. With the index and middle fingers of the other hand, open and push downward on the posterior fourchette. Ask the client to breathe slowly and try to consciously relax her muscles.

7. Place the blade tips against the lower (posterior) wall of the vagina to avoid contact with the urethra. Some RNs insert the speculum blades at an oblique angle: others prefer horizontal. In either case avoid touching the clitoris, catching pubic hair or pinching labial skin. Slowly insert the speculum maintaining gentle downward (toward posterior wall of vagina) pressure to avoid trauma to the urethra and vaginal walls.

8. Insert the closed speculum at the anatomic angle of the vagina (45 degree angle downward toward the small of the client’s back).
9. Insert the speculum further with gentle pressure downward. Continue to avoid pressure on the urethra and avoid catching pubic hair or pinching labial skin.

10. Insert the speculum up to the base of the cervix (the posterior fornix area) and then rotate it horizontally. Apply gentle pressure on the speculum against the perineum to help place the blade tips in the posterior fornix.

11. Remove the hand that has separated the labia.
12. Maintaining downward pressure of the speculum, open it by pressing on the thumbpiece. Open the speculum as little as possible to see the cervix. Greater vaginal distension is unnecessary, and painful.

13. Move the speculum blades slowly upward until the cervix comes into view. Adjust the light source. Note: if the speculum is directed posteriorly on insertion, it is easier to find the cervix and avoid a lot of unnecessary up and down movement of the speculum, which is uncomfortable for the client.

14. If this attempt is unsuccessful
   Close the blade tips and withdraw the speculum slightly, then reinsert more deeply and posteriorly, with the base of the lower blade actually compressing the perineum. Then slowly move the blades upward again.

15. Once the cervix is central and clearly in view, tighten the lever nut of the metal speculum to lock the blade tips in the open position.

In most clients, the cervix has a posterior orientation that slightly obscures the cervix due to the vaginal walls. The cervix can be further obscured through a retroverted uterus, marked posterior orientation of the cervix, or laxity of the vaginal walls.
Client with Retroverted Uterus

A cervix that is pointing anteriorly indicates a retroverted uterus. The speculum has to be much further forward and RN may have to invert speculum to see the cervix.

Client with Posterior Orientation of the Cervix

Insert the speculum more deeply and posteriorly through compression of the perineal tissue. The blade tips will slip under the cervix into the posterior fornix.

Marked Posterior Orientation of the Cervix


Client with Laxity of the Vaginal Walls

Inability to visualize the cervix due to laxity of vaginal walls may occur in some clients (e.g. obese clients). The blade base as well as the tips have to be opened when using a metal speculum. Unscrewing the handle nut in the metal speculum and pushing the Y-shaped piece upwards accomplish this. For the plastic speculum a larger size may be needed.

16. Inspect the cervix

Assessing the Cervix

Colour
Pink, with the colour evenly distributed. A bluish colour indicates increased vascularity that may be a sign of pregnancy. Refer pregnant clients to a physician, nurse practitioner, or registered midwife for Pap test and pre/postnatal follow-up. Symmetric circumscribed erythema around the os is a normal finding that indicates exposed columnar epithelium from the cervical canal.

Check for
• beginning practitioners should consider any reddened areas as an abnormal finding, especially if patchy or if the borders are irregular
• pale cervix may indicate anemia or menopause

Position
Correlates with the position of the uterus. A cervix that is pointing
• anteriorly indicates a retroverted uterus
• posteriorly indicates an anteverted uterus
• horizontally indicates a uterus in midposition
The cervix will be more posterior with the anteverted or anteflexed uterus and more anterior with the retroverted or retroflexed uterus. The cervix projects about 1 to 3 cm. into the vagina.
Note as needed:
- deviation to the right or left may indicate a pelvic mass, uterine adhesions, or pregnancy
- projection greater than 3 cm. may indicate a pelvic or uterine mass

**Size**
The diameter ranges from 2 to 3 cm however, clients who have had multiple pregnancies may have larger diameters.

Note as needed:
- enlarged cervix may indicate cervical infection

**Shape of Os**
Os of the nulliparous client is small, round, or oval. The os of a multiparous client is usually a horizontal slit or may be irregular and stellate. Trauma from induced abortion or difficult removal of an intrauterine device may change the shape of the os to a slit. Note if the os is small and round; or horizontal irregular slit; or unilateral transverse slit; or bilateral transverse slit; or stellate; or cervical eversion is present.

**Surface**
Should be smooth. Some squamocolumnar epithelium of the cervical canal may be visible as a symmetric reddened area around the os. Nabothian cysts may be observed as small, white or yellow, raised, round areas on the cervix and are considered to be a normal finding.

Note as needed:
- friable tissue (soft, eroded, may be bleeding), red patchy areas, abnormal bleeding, inflammation, granular areas, and white patches that could indicate infection, or carcinoma. Refer to physician, nurse practitioner, or registered midwife immediately.
- swollen Nabothian cyst - becomes swollen with mucous and distorts the shape of the cervix, giving it an irregular appearance.
- polyps

**Secretions**
Determine whether the discharge comes from the cervix itself, or whether it is vaginal in origin and has been deposited in the cervix. Normal discharge is odourless, may be creamy or white, may be thick, thin, or stringy, and is often heavier at midcycle or immediately before menstruation.

Note as needed:
- abnormal vaginal discharge (refer to Summary Chart - Discharges, Infections, Ulcers and Lesions in Section 6: Physiology, Anatomy & Abnormal Findings)

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If there is a suspicion of malignancy (e.g. inflammation of the cervix, abnormal bleeding from cervix) the RN must seek assistance before proceeding with the Pap test.

17. Perform Pap test (See Section 9: Papanicolaou Test)
18. Loosen the thumbscrew but continue to hold the speculum blades open.
19. Slowly withdraw the speculum, rotating it as you go to fully inspect the vaginal wall. The colour should be a similar pink colour as the cervix, or a little lighter. Clients with adequate estrogen levels have pink, moist, smooth or rugose and homogenous vaginal walls. Normal secretions that may be present are usually thin, clear or cloudy, and odourless.

Note as needed:
- inflammation
- lesions
- swelling
- cracks
- abnormal discharge
- abnormal colour
- presence or absence of rugae
- reddened patches, lesions, or pallor indicates a local or systemic pathologic condition
- secretions that are profuse; thick, curdy, or frothy; appear gray, green, or yellow; and may have a foul odor indicate infection

20. Close the blades when the end of the blades nears the vaginal opening, making sure that no vaginal mucosa, skin, or hair remains between the closed blades. Maintain downward pressure of the speculum to avoid trauma to the urethra. Note the odor of any vaginal discharge that has pooled.

21. Turn the blades obliquely at a 45° angle and remove slowly from vagina.

22. Place the used metal speculum in a bucket or dispose of disposable speculum.

23. Discard your gloves and wash hands.

24. Inform the client that the procedure is over and that she can move into a seated position to discuss treatment and/or healthy behavior goals. Alternatively, you could inform the client that you will leave for a minute while she gets dressed and that you will return to discuss treatment and/or healthy behaviour goals.

### Complete External & Speculum Examination of the Genitalia: Summary Table

<table>
<thead>
<tr>
<th>EXTERNAL EXAM</th>
<th>SPECULUM EXAM</th>
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</thead>
<tbody>
<tr>
<td>√ Skin Colour</td>
<td>Cervix</td>
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<tr>
<td>√ Public Hair</td>
<td>√ Colour</td>
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<tr>
<td>√ Labia Majora</td>
<td>√ Position</td>
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<td>√ Labia Minora</td>
<td>√ Size</td>
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<tr>
<td>√ Urethra</td>
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<td>√ Skene’s Glands</td>
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<td>√ Vaginal Wall</td>
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<td>√ Vaginal Opening</td>
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<td>√ Perineum</td>
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<td>√ Anus</td>
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### Consideration for Special Clients

#### Client with Hysterectomy

Getting an accurate history before the examination will assist you in knowing what to look for.
Refer clients with total or subtotal hysterectomy due to biopsy confirmed high grade lesions or cervical cancer to their physician or nurse practitioner for follow-up. Women who have had a hysterectomy for benign reasons (e.g. endometriosis) do not need to continue with Pap tests.

Older Adults

It is not appropriate to defer older clients from the external, speculum, and Pap test because of their age. See Discontinuing Screening in Section 3: Cervical Screening Cycle. The examination procedure for the older adult is the same as that for the adult of childbearing age, with a few modifications for comfort. The older client may require

- More time and assistance to assume the lithotomy position.
- Assistance from another individual to help hold her legs, since they may tire easily when the hip joints remain in abduction for an extended period.
- Head and chest elevated during examination if she has orthopnea.
- Use of a smaller speculum depending on the degree of introital constriction that occurs with aging.

Note that, in comparison to a younger adult, the older adult's

- labia appear flatter and smaller, corresponding with decreased levels of estrogen and/or degree of loss of subcutaneous fat elsewhere on the body,
- skin is drier and shinier,
- pubic hair is gray and may be sparse,
- clitoris is smaller,
- urinary meatus may appear as an irregular opening or slit. It may be located more posteriorly, very near, or within the vaginal introitus as a result of relaxed perineal musculature,
- vaginal introitus may be constricted and admit only one finger. In some multiparous older clients the introitus may gape with the vaginal walls rolling toward the opening,
- vagina is narrower and shorter, and you will see and feel the absence of rogation,
- cervix is smaller and paler, and the surrounding fornices may be smaller or absent. The cervix may seem less mobile if it protrudes less far into the vaginal canal. The os may be smaller, but, should still be palpable, (if the os is very small and/or closed over, it may be impossible to insert a cytobrush/spatula into the os. After 2 attempts, the RN will need to refer the client to a physician or nurse practitioner).
- pelvic musculature relaxes, so remember to look particularly for stress incontinence and prolapse of the vaginal walls or uterus.

As with younger clients, there may be signs of inflammation (older clients are particularly susceptible to atrophic vaginitis), infection, trauma, tenderness, growth, masses, nodules, enlargement, irregularity, and changes in consistency. Any concerns should be referred to a physician or nurse practitioner.
SECTION 8: SELF-TEST

1. Describe the parts and functioning of both the metal and plastic disposable speculums

2. Describe four areas to examine during the external genital exam

3. Which two groups of clients that RNs would refer to a physician, nurse practitioner, or registered midwife for Pap test and/or follow-up?

4. List the steps to follow to properly insert the speculum.

5. Describe four areas to examine for the internal genital exam.

6. What are two ways an older adult's normal external and internal genitalia may present in comparison to a younger adult?
SECTION 9: PAPANICOLAOU TEST

Learning Objectives

Upon completion of this Section, the learner will be able to

1. Understand the two methods of Pap testing (conventional cytology and liquid based cytology)
2. Identify ideal conditions for taking Pap tests.
3. Describe how to perform a woman-centred Pap test.
4. Understand how to accurately label & prepare Pap test slide OR cytology container and complete a cytopathology laboratory requisition form.
5. Identify abnormal findings and specific health conditions that require referring client to physician or nurse practitioner.

Refer pregnant clients to a physician, nurse practitioner, or registered midwife if they are due for a Pap test and/or for prenatal care. Refer clients with a total or subtotal hysterectomy due to biopsy confirmed high grade lesions or cervical cancer to their physician or nurse practitioner for follow-up. Women who have had a total hysterectomy for benign reasons (e.g. endometriosis) do not need to continue with Pap tests if they never had high grade, biopsy confirmed cervical lesions.

Remember that correct sampling technique increases the adequacy of the test sample and decreases the risk of a false negative result (SIAST, 2000).

“It is estimated that at least one third or more of false-negative cytology tests (negative results when a woman has a high-grade cervical lesion) are related to sampling issues.” (Salow et al., 2002).

Pap Test Methods

Liquid Based Cytology (LBC)

Liquid based cytology (LBC) is a relatively new method to obtain a cervical cell sample that is now used all across Alberta. LBC uses a brush and plastic spatula to obtain the cervical cell sample. Two different LBC products are available in Alberta. After the sample is collected, the brush/spatula are either swished (ThinPrep) or broken off and dropped into a small container (SurePath) of preservative liquid before being transported to the lab. The sample is spun at the lab to remove obscuring materials and a representative sample is spread on a slide for examination under a microscope.

The potential advantages of LBC include

1. Immediate preservation of collected cells.
2. More of the entire sample is recovered.
3. Preservative contains chemicals that lyse blood, mucus and inflammatory cells allowing for a clean specimen and easier identification of abnormal cells.
4. Multiple slides can be prepared.
5. Additional tests such as HPV testing may be performed on the same sample.
Ideal Conditions for Taking Pap Tests

- Avoidance of vaginal douching for 24 hours before the test.
- Avoidance of use of contraceptive creams or jellies for 24 hours before the test.
- Avoidance of intercourse for 24 hours before the test.
- Pap tests are not recommended during menstruation as it increases the chance of inadequate or unsatisfactory sample results. A mid-cycle test is optimum. Do not defer the Pap test due to abnormal bleeding.

Sampling Areas

The three sampling areas of the cervix are the ectocervix, the endocervix, and the transformation zone. The cervical lining is made up of two types of cells: rectangular columnar cells and flatter squamous cells. The area between these cell types is called the transformation zone (or squamo-columnar junction) because this is where columnar cells change into squamous cells. Due to the cell changes happening in the transformation zone, it is the most common area for abnormal squamous cells to develop.

The transformation zone is therefore the primary target for sampling of the cervix by the Pap test technique. Good Pap test sampling shows cells from each side of the squamo-columnar junction. This requires choosing the right instrument or parts of the instrument to ensure that it is firmly applied across the area. The spatula and brush are more important at different ages to gain good samples.

The location of the transformation zone varies from woman to woman and changes as women age. In young women, the transformation zone tends to be on the outer surface of the cervix (ectocervix) whereas it tends to be higher up in the cervical canal in older women.

See illustrations under “Transformation Zone” in Section 6: Physiology, Anatomy & Abnormal Findings and below under “Sampling The Ectocervix With The Spatula”.

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Consult LBC Manufacturer’s Instructions depending on type of LBC used in your clinic/agency.


Equipment for Pap Test

Ensure a new plastic speculum or a properly cleaned and autoclaved metal speculum is used to prevent transmission of infection or cross infection (e.g. HPV) to the client.

- Vaginal speculum of appropriate size
- Portable light or a light source with a disposable speculum
- Gloves, clean examination
- Cotton tipped swab (optional)
- Mirror (optional)
- Lab requisition & specimen label
- Pencil or pen
- Plastic spatula
- Brush
- LBC specimen container
- Information Sheet: HPV Testing Information for Women Having Pap Tests

Pap Test Procedure

This following information is adapted from Faculty of Primary Care Nurse Practitioner Program, Saskatchewan Institute of Applied Science and Technology (2000) and Calgary Health Region (2001) B.

1. Prepare the client as explained in the Speculum Exam Procedure, Section 8: External & Speculum Exam.

2. In an understanding and non-judgemental way, explain the purpose of the Pap test, the role of HPV reflex testing, the instruments to be used, the procedure, possible test results and follow up and the recommended frequency of Pap tests. Give each client written information on Pap tests as indicated and a copy of the handout, “HPV Testing Information for Women Having Pap Tests”, provided with each tray of LBC vials.

3. Assemble necessary equipment.
   Note: LBC requires a plastic spatula.

4. Label the Pap Test Container according to your clinic/agency lab requirements.

5. Open the Pap Test Container and place in a secure and accessible place near the examination bed

6. Consult LBC Manufacturer’s Instructions depending on type of LBC used in your clinic/agency.
8. Inspect the client’s external genitalia as explained in Section 8: Speculum Exam.

9. Warm and insert an appropriately sized speculum and inspect the cervix as explained in Section 8: Speculum Exam.

10. Gently wipe away excessive discharge/mucous on the cervix with an oversized cotton swab or 2 x 2” gauze on a long forcep (Kotaska & Matisic, 2003). This should be done as gently as possible to avoid removing the cervical cells to be sampled.

Sampling the Ectocervix with the Spatula

11. Assess position of transformation zone (T-zone) to ensure zone will be sampled.
   • To identify the T-Zone look for the colour change between the red columnar epithelium and the smooth pink mature squamous epithelium and be sure to sample this area.
   • The diagrams below show sampling of different cervixes with the spatula. The solid grey area is the squamous epithelium, the lined area is the transformation zone and the stippled area is the columnar epithelium.

   The spatula in the illustration is shaped slightly different from the spatulas more commonly used in Alberta. Spatulas that do not completely sample from the T-Zone necessitate the use of a cytobrush sample as well as the spatula sample.

   ![Diagrams showing different cervixes with the spatula]

   A: narrow transformation zone  
   B: broader transformation zone – parous  
   C: broadly everted transformation zone – parous  
   D: post menopausal (indrawn)

12. Using the spatula, insert the bifid end (i.e. the spatula end with two bumps on it) with the more extended bump going into the cervical os so that the spatula is horizontal at the 3 and 9 o’clock position.

13. Use firm pressure and rotate the spatula 360° ending back at your starting point in order to ensure that you have scraped along the entire T-zone. Care is required to follow the shape of the os especially if it is irregular or elongated.

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14. Withdraw the spatula carefully to avoid contamination with the vaginal walls.

15. Retain the sample on the front side of the spatula during transfer.

16. Consult LBC Manufacturer's Instructions depending on type of LBC used in your clinic/agency.

**Sampling the Endocervix With the Cytobrush**

Because bleeding may result from using a cytobrush, the endocervix sample is taken after the ectocervix sample (IWK Grace Health Centre 2001).

17. Consult LBC Manufacturer's Instructions depending on type of LBC used in your clinic/agency.

Over-rotating may damage some cervical cells, and often induces more capillary bleeding which may increase post Pap spotting and temporarily increase the risk of STI.

18. Remove the cytobrush carefully to avoid contamination by vaginal walls.

19. Slowly withdraw the speculum as explained in **Section 8: Speculum Exam**.

20. Place speculum in bucket.

21. Discard gloves and wash hands.

22. Inform the client that she may have bloody spotting following the procedure and offer the client a panti-liner.

23. Inform the client that the procedure is over and that she can move into a seated position as explained in the **Section 8: Speculum Exam**.

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24. Explain to the client how to find out her results and how she will be contacted and how follow-up will be arranged with her physician, nurse practitioner, or registered midwife if her Pap test is abnormal.

25. Ensure that the client understands her future appointment times and dates and understands the importance of follow up of abnormal Pap results with her physician, nurse practitioner, or registered midwife before she leaves the clinic. Indicate on written material when to schedule her next Pap Test.

26. Discuss and provide client with written information (see ACCSP brochures at www.screeningforlife.ca/cervical).

27. Offer her information about the ACCSP and explain that she will get a result letter from the ACCSP within 3-6 weeks after her test. Let her know she can call the program’s toll-free number (1-866-727-3926) if she’s not sure she wants to receive a result letter.

28. Complete requisition and prepare slide or container for transport to your regional Laboratory Services.

29. Make arrangements for the sample to be sent to the laboratory.

**Cytopathology Lab Requisition Form**

To ensure that all Pap test specimens receive an optimal evaluation, it is critical that accurate clinical information is communicated to the cytology laboratory. Please review the instructions for completing Pap test requisitions for your area

- Calgary Lab Services – see www.calgarylabservices.com/HealthcareProfessionals/SpecimenCollection/CompletingRequisition/

- DynaLIFEdx – see www.dynalifedx.com/web/HealthProfessionals/Requisitions/tabid/149/Default.aspx

Each lab may have variations to the laboratory form used. Become familiar with the form(s) used in your area.

HPV tests are not ordered with screening Pap tests per se. They are done on a reflex basis by the lab on residual liquid-based samples depending on a woman’s age and cytology result. (See Section 10: Pap Test Results).

Currently RNs are unable to obtain PRACIDS through Alberta Health Care Insurance Plan billing, therefore the Pap test may need to be submitted to the lab under the name of a physician or NP. Check with your regional lab for their preferences on the provider name listed on the Pap test requisition form. The Pap test requisition may need to be sent through a consulting physician, nurse practitioner, or registered midwife depending on the clinic/agency policy. If so, the results would be forwarded to the physician, nurse practitioner, or registered midwife and they would be responsible for follow-up of any abnormal results.
Sending the Pap Test

Ensure that packaging is in accordance with your lab’s specific packaging and transport requirements.

Locate the cytopathology laboratory requisition form used by your clinic/agency and become familiar with the specific clinical information that you are required to document. Also, review the lab’s preferences for practitioner name to be used on the form, and packaging and transport requirements.

- Calgary Lab Services – see www.calgarylabservices.com/files/LabTests/APCyto/ThinPrepGuide.pdf
- DynaLIFEDx – see www.dynalifedx.com/web/HealthProfessionals/SpecimenInformation/PackagingTransport/tabid/152/Default.aspx
SECTION 9: SELF-TEST

1. Name 4 ideal conditions for taking a Pap test

2. How do you sample the ectocervix with a spatula?

3. How do you sample the endocervix with a brush?

4. How do you prepare the Liquid Based Cytology specimen container?

5. Which clients do you refer to a physician, nurse practitioner, or registered midwife?
SECTION 10: PAP TEST RESULTS

Learning Objectives

Upon completion of this Section, the learner will be able to

1. Identify how Pap test results are interpreted and the reasons for normal and abnormal results.
2. Describe the appropriate follow-up for each Pap result using the TOP (2011) Management of Abnormal Cytology chart.
3. List groups with special circumstances for the follow-up and management of abnormal Pap tests.

This Section is adapted from the Guideline for Screening for Cervical Cancer (TOP, 2011, p. 3-5, 10-14). Used with permission.


An RN must have a specific working relationship outlined in writing with a physician, nurse practitioner, or registered midwife when performing Pap tests. It is the Employer's responsibility to make arrangements for an appropriate referral mechanism for follow-up of abnormal Pap test results.

Most RNs do not follow up with clients regarding their Pap test results unless the Employer policy specifically indicates that the RN can interpret Pap test results (often with supervision) and/or provide and/or arrange follow-up care. Pap test results usually go to the primary care provider (i.e. physician, nurse practitioner, or registered midwife) for follow-up.

The Bethesda System

The Bethesda system for reporting Pap tests (Solomon & Nayar, 2001) is the recommended standard for use in Canada and by the Alberta Cervical Cancer Screening Program. Reports include a statement of adequacy and the diagnosis. There are two categories of specimen adequacy, “Satisfactory for Evaluation” and “Unsatisfactory for Evaluation.”

 Unsatisfactory Pap Test Results

Unsatisfactory for evaluation indicates the test was rejected/not processed or that the specimen was processed and examined but was unsatisfactory for evaluation of epithelial abnormality. The reasons the test was considered unsatisfactory are given in the report (e.g., too few cells were collected).
Unsatisfactory Pap test results are mostly due to cervical sampling and specimen collection issues.

Possible reasons for unsatisfactory Pap tests include

- **Client Reasons:**
  - Intercourse within 24 hours of Pap test.
  - Douching or vaginal medication used 24 hours before Pap test.
  - Menses.
  - Body habitus (obesity may make the procedure more difficult).

- **Provider Reasons:**
  - Did not sample far enough into endocervical canal to obtain endocervical/metaplastic cells.
  - Did not follow manufacturer’s instructions for transferring the sample from the instrument to the liquid medium.
  - Lack of cellular exfoliation (instrument choice).
  - Lack of clinical information obtained.

(adapted from SIAST, 2000)

Abnormal Pap Test Results

The Bethesda (2001) diagnostic categories are as follows

**Negative for Intraepithelial Lesion (NIL) or Malignancy (NILM)**

- Pap tests interpreted as Negative for Intraepithelial Lesion or Malignancy indicate that the test was satisfactory and that the woman should continue with routine screening
- OR that the test was satisfactory with qualifiers and that it should be repeated in 12 months. The type of qualifier will be given in the report.

**Epithelial Cell Abnormality**

- Pap tests interpreted as Epithelial Cell Abnormality include both those that represent cervical carcinoma and those that have changes considered to indicate increased risk of cervical carcinoma.
- Changes indicative of increased risk for cervical carcinoma are reported as follows
  - Atypical Squamous Cells of Undetermined Significance (ASC-US)
  - Low-Grade Squamous Intrepithelial Lesion (LSIL)
  - Atypical Squamous Cells – cannot exclude HSIL (ASC-H)
  - High-Grade Squamous Intraepithelial Lesion (HSIL)
  - Atypical Glandular Cells (ACG)
  - Adenocarcinoma in Situ (AIS)

For more details on the Bethesda System, see
# Management of Abnormal Cytology

## Pap Test Result | Recommended Management
---|---
**Unsatisfactory** | Repeat Pap test in 3 months

### Atypical squamous cells of undetermined significance (ASC-US)
- **Women < 21 years** *(Although routine cervical screening is NOT recommended)*
  - Repeat Pap test every 12 months for 2 years (2 tests):
    - At 12 months: ONLY high-grade lesions should be referred for colposcopy
    - At 24 months: Negative → return to routine screening
      ASC-US or greater → refer for colposcopy

- **Women 21–29 years**
  - Repeat Pap test every 6 months for 1 year (2 tests). These tests must be at least 6 months apart.
    - If both repeat results are negative → return to routine screening
    - If either repeat result is ASC-US or greater → refer for colposcopy

- **Women ≥ 30 years** *(The lab will automatically perform reflex HPV testing)*
  - HPV Negative* → return to routine screening as if cytology was negative
  - HPV Positive → refer for colposcopy
  - HPV Indeterminate → manage as per women 21–29 years

### Low-grade squamous intraepithelial lesion (LSIL)
- **Women < 21 years** *(Although routine cervical screening is NOT recommended)*
  - Repeat Pap test every 12 months for 2 years (2 tests):
    - At 12 months: ONLY high-grade lesions should be referred for colposcopy
    - At 24 months: Negative → return to routine screening
      ASC-US or greater → refer for colposcopy

- **Women 21–49 years**
  - Repeat Pap test every 6 months for 1 year (2 tests). These tests must be at least 6 months apart.
    - If both repeat results are negative → return to routine screening
    - If any either repeat is ASC-US or greater → refer for colposcopy

- **Women ≥ 50 years** *(The lab will automatically perform reflex HPV testing)*
  - HPV Negative* → return to routine screening as if cytology was negative
  - HPV Positive → refer for colposcopy
  - HPV Indeterminate → manage as per women 21–49 years

### Atypical squamous cells – cannot exclude HSIL (ASC-H)
Refer for colposcopy

### High-grade squamous intraepithelial lesion (HSIL)
Refer for colposcopy

### Atypical glandular cells (AGC), Adenocarcinoma in situ (AIS)
Refer for colposcopy

### Squamous carcinoma, adenocarcinoma, other malignancy
Refer to specialist care

## Women > 40 years with cytologically benign endometrial cells should undergo endometrial sampling if:
- They have abnormal bleeding
- They are asymptomatic and post-menopausal
- *(Also consider endometrial sampling if the woman is asymptomatic, pre-menopausal and at increased risk for endometrial cancer due to chronic estrogen stimulation)*

*The risk of CIN2+ over 2 years is virtually the same for these women as for women with negative cytology in the absence of HPV testing.*

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Clients with ASC-US/LSIL and HPV Testing

Pap tests examine cells from the cervix for abnormalities that could develop into cervical cancer over time. For some low-grade lesions, the likelihood of progression isn’t clear. In the past, all women with low-grade lesions (ASC-US or LSIL) were recommended to repeat the Pap test at least 2 times at 6 month intervals. For a subset of these women, a reflex HPV test can determine right away whether the woman needs follow-up care.

In compliance with the 2011 TOP guideline, laboratories in Alberta perform HPV reflex testing on residual liquid-based samples for women based on their age and Pap test result. While informed consent for testing isn’t necessary, all women having a Pap test should be provided with the information sheet, “HPV Testing: Information for Women Having Pap Tests” that is included in trays of liquid based supplies and is also available at www.screeningforlife.ca.

HPV reflex testing is performed on samples from women 30 years and older with ASC-US and women 50 years and older with LSIL cytology results. (See Management of Abnormal Cytology chart on previous page.) For these women, high-risk HPV testing is as likely to detect high-grade precancerous lesions compared with repeat Pap testing, but with significantly fewer referrals for colposcopy. An added advantage is these abnormal results are resolved much faster and women aren’t lost to follow-up.

Women with negative HPV reflex test results should return to routine screening because their risk of significant pathology in the next two years is less than 2%, which is virtually indistinguishable from women with negative cytology for whom HPV results are unavailable. When reflex HPV results are positive, women are referred to a specialist for colposcopy.

For women 21-29 years with ASC-US and women 21-49 years with LSIL, HPV reflex testing is not helpful in deciding which women need follow-up care. For these women, repeat cytology is advised at 6 months and at 12 months. If either repeat finding is ASC-US or worse, the woman is referred for colposcopy. If both follow-up tests are negative, the woman is returned to routine screening.

Colposcopy

All women with high-grade lesions on Pap tests (ASC-H or higher), those who are HPV-positive on reflex testing (see above), and those with a repeat finding of ASC-US or LSIL are recommended for colposcopy or specialist care.

Colposcopy is used to closely examine abnormalities of the cervix. The cervix is magnified through a binocular scope with high intensity light. This allows for the identification of abnormalities based upon
- epithelial density (white epithelium) and
- vascular patterns (punctuation, etc.).
Using these parameters, an area of abnormality can be identified in order to direct a tissue biopsy by one of several available methods [punch biopsy, loop electrosurgical excision procedure (LEEP), etc.].

Women currently being assessed by a colposcopy clinic, including those who do not show up for their appointments, should not undergo additional Pap testing until discharged from colposcopy.
Special Circumstances

For women under 21 years with abnormal results

- Routine screening in this age group is not recommended. Dysplastic lesions in this age group are most likely to resolve spontaneously (Moscicki et al., 2004). If women younger than 21 years are screened, referrals for colposcopy should be minimized while carefully monitoring for progression. See modified follow-up guidelines for women younger than 21 years with Pap test findings of ASC-US or LSIL in the *Guideline for Screening for Cervical Cancer* (TOP, 2011).
- In women younger than 21 years with ASC-US or LSIL, HPV DNA testing is unacceptable. This is because HPV is so frequent in this age group that HPV testing would result in a high rate of colposcopy with a very low probability of cervical carcinoma or progressive disease. If inadvertently performed, the HPV test results should not influence management.

Pregnant women with abnormal results

- Pregnant women should be screened according to the guidelines by their physician, nurse practitioner, or registered midwife with care taken not to overscreen. There is no need to perform Pap tests during pre-natal and post-partum visits unless the woman is otherwise due for screening or is unlikely to return for screening at an appropriate time. In addition, cervical changes associated with pregnancy and birth make Pap tests more difficult to interpret.
- If ASC-US or LSIL is detected during pregnancy, it is not advised to repeat the Pap test until 6 months post-partum. All other findings, especially more advanced lesions, should be managed according to the guidelines.

Women who are estrogen depleted with abnormal results

- Women who are estrogen depleted may have atrophic cells on the Pap test. These atrophic cells may falsely mimic intraepithelial abnormalities and may be reported as a cytologic abnormality with atrophy.
- The lab will conduct routine HPV reflex testing for women 50 years and older with ASC-US or LSIL results. If the HPV result is negative, the woman can return to routine screening. If the result is positive, she should be referred for colposcopy.

Limitations of Screening

Like all screening tests, Pap tests are not perfectly sensitive. A single negative Pap test result does not rule out cervical precancer or cancer. Women need to be screened regularly according to the *Guideline for Screening for Cervical Cancer* (TOP, 2011).

A false negative screening test result occurs when the Pap test fails to detect an abnormality that is present on the cervix. False negative results arise because either

- the abnormal cells were not collected due to limitations of cervical sampling and specimen preparation
- OR because abnormal cells were not identified by the laboratory

The sensitivity of conventional cytology to detect high-grade lesions varies widely in published studies between 30% and 87% (Nanda et al., 2000) and liquid-based cytology (LBC) does not appear to increase sensitivity substantially, although it does reduce the rate of unsatisfactory samples (Ronco et al., 2007). Repeat screening at regular intervals increases the sensitivity of cervical screening and is necessary to provide adequate lifetime protection from cervical cancer.
The Pap test has been so successful at reducing cervical cancer incidence because its sensitivity increases in the context of repeated use.

- To help overcome the false sense of security that can arise from a false negative test result, it is important to advise women to report unusual vaginal bleeding or discharge including bleeding after intercourse, after menopause, or between menstrual periods.

- False positive screening test results are also of concern. Given the transient nature of many cervical changes, screening detects many abnormalities that are destined to resolve on their own. The 2011 TOP guideline is intended to minimize the anxiety and harms associated with screening while helping to assure that clinically significant cervical changes are identified.
SECTION 10: SELF-TEST

1. What are three Bethesda diagnostic categories used to categorize Pap test results?

2. List 2 places where you can find more information on the Guideline for Screening for Cervical Cancer (TOP, 2011)?

3. What are 3 reasons for unsatisfactory Pap tests?

4. Describe the recommended management steps for four different Pap test results.

5. What are 2 groups that may have special circumstances related to the management of abnormal Pap test results?

6. What are 2 reasons a false negative Pap test result occurs?

7. Why is it important for women to get regular Pap tests between the ages of 21 and 69?
SECTION 11: MEDICOLEGAL ISSUES

Learning Objectives

Upon completion of this Section, the learner will be able to

1. List general documentation elements.
2. Outline guidelines for documenting a Pap test visit.
3. Describe the importance of protecting client confidentiality.
4. Describe how to ethically obtain informed consent.
5. Define what negligence is and what defences are available.
6. Describe the RN’s accountability to the client, the Employer and the profession.

While RNs are familiar with medicolegal issues, it is important to review these concepts to reinforce the underlying philosophies.

Documentation

Clear documentation of the clinical Pap test visit is critical from a medicolegal perspective. Key general documentation elements involve

- Ensuring that the correct client name, health identification number, and contact information is recorded
- Using a systematic approach to document history taking, assessment findings, and counselling using Employer documentation policies
- Recording actions clearly and accurately
- Using only recognized abbreviations
- Accurately completing laboratory forms as required
- Storing client records in a confidential and secure manner as per Employer policies

Guidelines for documenting specifically a Pap test visit may include the following descriptions

- ease of examination
- specimens that were obtained
- abnormalities noted
- condition of labia, cervix, vagina, and any deviations from normal (describe)
- clients response to exam (e.g. any unusual responses that may indicate sexual abuse), and/or
- discharge teaching and follow-up

It is important that each Employer have specific documentation policies. It is important for RNs to be familiar with and follow what is expected by their specific Employer related to documentation.

Each area of Alberta Health Services or other Employers (such as a PCN or medical clinic) is expected to have specific documentation policies that need to be followed by the RN doing Pap tests.

Employers also need specific referral policies to ensure that RNs taking Pap tests have an explicit written agreement and/or employee/employer relationship with a physician, nurse practitioner, or registered midwife for follow up of Pap test results.
Other Medicolegal Issues
Medicolegal issues such as documentation, confidentiality of health information, informed consent, negligence, accountability, responsibility, and liability are clearly presented by the Canadian Nurses Protective Society (CNPS). Please review the CNPS articles listed below.

The following articles provide detailed information regarding medicolegal issues. All of the articles listed below are available at the Canadian Nurses Protective Society website at www.cnps.ca. You will require a password which you can obtain from the CARNa or CNPS via email or phone. See the CARNa website at www.nurses.ab.ca for contact information or phone 1-800-252-9392.

Accountability, Responsibility and Liability

Confidentiality

Documentation

Informed Consent

Negligence

Privacy

Vicarious Liability

Health Professionals Act, Liability, & Restricted Activities for RNs
See Section 1: Introduction for detailed information on the Health Professions Act (HPA) and restricted activities for RNs such as Pap tests. A letter from CARNa outlining the RN’s and Employer’s liability related to Pap tests is available in Appendix 1: CARNA Letter.
SECTION 11: SELF-TEST

1. What are 6 key elements that should be documented about a Pap test visit as per Employer policies?

2. What are 3 ways to protect client confidentiality?

3. What are 3 areas involved in ethically obtaining informed consent?

4. Define negligence and outline what defences are available to RNs?

5. Describe how you maintain your accountability as an RN to the client, your Employer, and to the profession.
POST-TEST

½ hour

Please complete the following Post-Test after completing Sections 1-11. The Answer Key is provided in Appendix 5: Answer Key Post-Test.

Instructions for Test Completion

Print the Post-Test.
For multiple choice questions, please indicate ALL correct answers as appropriate.
For open-ended questions, please provide at least as many responses as the question asks for.
Discuss your results with your Preceptor.

1. RNs in Alberta are expected to practice in a manner consistent with:
   b. CARNA Nursing Practice Standards (2005).

2. The responsibilities of Employers of RNs who are expected to provide Pap tests as part of their position include:
   a. Providing adequate education time, resources, preceptorship opportunities and facilities.
   b. Ensuring that there is an explicit relationship with the RN taking the Pap test and a physician, nurse practitioner, or registered midwife.
   c. Developing policies and procedures related to RN Pap testing.
   d. Participating in ongoing monitoring of Pap test adequacy rates.
   e. Maintaining a record of RN Pap test education.

3. The cornerstones of women-centred care include which of the following factors?
   a. A focus on women.
   b. Involvement and participation of women.
   c. Empowerment.
   d. Respect and safety.

4. Which of the following is not a risk factor for cervical cancer?
   a. Multiple male sex partners.
   b. Early onset of first intercourse.
   c. Genital infections such as herpes simplex II (HSV2) and Chlamydia.
   d. Family history.
   e. HPV infection.
   f. Smoking.

5. The Alberta Cervical Cancer Screening Program is needed because:
   a. Organized cervical cancer screening programs reduce the rates of cervical cancer.
   b. Having regular Pap tests may prevent a few cervical cancers.
   c. Supporting women to have regular Pap tests can prevent almost all cervical cancers.
   d. All clients who develop cervical cancer in Alberta have not had regular Pap tests.
   e. More than ½ of the clients who develop cervical cancer in Alberta have not had regular Pap tests.

© Alberta Health Services - Screening Programs, 2012
6. All clients between the ages of 21 to 69 who have ever been sexually active should have Pap tests regularly. (Except women who have had a hysterectomy for benign reasons with no history of biopsy confirmed high grade lesions or cervical cancer).
   a. True
   b. False

7. Name four high risk groups in particular whom RNs should encourage to have Pap tests regularly.
   a. 
   b. 
   c. 
   d. 

8. Women older than 69 who have never been screened for cervical cancer need 3 negative and satisfactory annual Pap tests before screening can be discontinued.
   a. True
   b. False

9. Women younger than 21 who have been sexually active for 3 years need to be screened for cervical cancer.
   a. True
   b. False

11. Which age group is least likely to benefit from increased access to and promotion of Pap testing?
   a. Women aged 50 to 69
   b. Women aged 36-49
   c. Women aged 21-35
   d. Women under 21

12. List eight reasons why an eligible woman may be reluctant to have a Pap test.
   a. 
   b. 
   c. 
   d. 
   e. 
   f. 
   g. 
   h. 

13. If a client appears apprehensive before the exam, it is best to:
   a. Reassure them and press forward.
   b. Tell them that there is nothing to worry about.
   c. Ask open-ended questions about their apprehension around the Pap test procedure.
14. List four key things that should be discussed with the client after the Pap test visit:
   a. 
   b. 
   c. 
   d. 

15. List five client populations that may have special learning, counselling and educational needs related to cervical cancer screening.
   a. 
   b. 
   c. 
   d. 
   e. 

16. Which of the following findings related to STI might be discovered during an external genital examination?
   a. Pubic lice/crabs
   b. Genital Warts
   c. Genital Herpes
   d. Inflammation of the Bartholin’s glands

17. A client presents with the following symptoms:
   - raised painless lesions on the labia, the vestibule, and/or in the perianal region. flesh-colored cluster of soft growths.

   The client most likely has:
   a. Molluscum Contagiosum
   b. Nabothian follicles
   c. Herpes
   d. Genital warts
   e. Yeast infection

18. List six abnormal findings of the ectocervix:
   a. 
   b. 
   c. 
   d. 
   e. 
   f. 
19. Which of the following are abnormal findings on the cervix that should be referred to a physician, nurse practitioner, or registered midwife:
   a. Friable tissue (soft, eroded)
   b. Red patchy areas
   c. Abnormal bleeding and inflammation
   d. Granular areas, white patches
   e. Pink colour
   f. Lesions

20. Name the three sampling areas of the cervix.
   a. 
   b. 
   c. 

21. When conducting a health history and assessing clients for specific concerns, what are the PQRST principles to follow?
   P
   Q
   R
   S
   T

22. Women due for cervical cancer screening who are pregnant or who have had a total or subtotal hysterectomy due to biopsy confirmed high grade lesions or cervical cancer should be referred to a physician, nurse practitioner, or registered midwife for a Pap test.
   a. True
   b. False

23. A smaller and narrower speculum should be used with:
   a. Clients who have not engaged in full vaginal penetration during sexual activity
   b. Nulliparous clients
   c. Circumcised clients
   d. Clients whose vaginal orifices have contracted postmenopausally

24. It is acceptable to lubricate the speculum with:
   a. A very small amount of water soluble lubricant
   b. Warm water
   c. Vaseline

25. An acceptable way to insert the speculum is:
   a. Blade tips against the upper (anterior) wall of the vagina.
   b. At an oblique angle.
   c. With the speculum closed.
   d. With the speculum slightly opened.
   e. With the speculum angled 45° downward toward the small of the client’s back.
26. **The best way to reposition a speculum for a client with a cervix with posterior orientation is:**
   a. Reinsert less deeply and anteriorly, with the base of the lower blade actually compressing the anterior wall of the vagina.
   b. Insert the speculum more deeply and posteriorly through compression of the perineal tissue. The blade tips will slip under the cervix into the posterior fornix.
   c. Choose a plastic speculum of a larger size and reinsert as you did prior.

27. **What are the ideal client conditions for cervical screening?**
   a. Avoidance of vaginal douching for 24 hours before the test
   b. Avoidance of use of contraceptive creams or jellies for 24 hours before the test
   c. Avoidance of intercourse for 24 hours before the test
   d. Mid-menstrual cycle
   e. During menses

28. **The correct way to obtain an ectocervix specimen with spatula is:**
   a. Rotate spatula in cervical os only 360° and end rotation so spatula is in 3 and 9 o’clock position.
   b. Rotate spatula in cervical os only 1800 and end rotation so spatula is in 3 and 9 o’clock position.
   c. Rotate spatula in cervical os only 900 and end rotation so spatula is in 3 and 9 o’clock position.

29. **The correct way to obtain a specimen with a cytobrush is:**
   a. Insert the cytobrush gently all the way into the cervical os but no further than the end of the bristles and turn 90° to 180°.
   b. Insert the cytobrush gently all the way into the cervical os but no further than the end of the bristles and turn 180° and back again.
   c. Insert the cytobrush gently all the way into the cervical os but no further than the end of the bristles and turn 360°.

30. **Over rotation of the endocervical brush will cause cell damage and slight capillary bleeding.**
   a. True
   b. False

31. **Unsatisfactory Pap tests are mostly a result of the following:**
   a. Cervical sampling issues
   b. Specimen collection issues

32. **List six key descriptions that could be documented following a Pap test visit:**
   a. ____________________________________________________________
   b. ____________________________________________________________
   c. ____________________________________________________________
   d. ____________________________________________________________
   e. ____________________________________________________________
   f. ____________________________________________________________
33. During a Pap test visit, when does the RN seek to obtain informed verbal consent from the client?
   a. At the start of the consultation.
   b. After you have explained the external exam, speculum exam and the Pap test procedure and before you begin.
   c. After completing the external exam, speculum exam and the Pap test.

34. Is the RN legally responsible to protect confidentiality of client health information?
   a. Yes
   b. No

35. An informal verbal agreement between an RN and a physician, nurse practitioner, or registered midwife should be used to outline the RN’s role in performing Pap tests.
   a. True
   b. False
CASE STUDIES

2 hours

Please complete the following Case Studies after completing Sections 1-11. The Answer Key is provided in Appendix 6: Answer Key Case Studies.

Instructions for Case Study Completion

Read the following Case Studies from the perspective of an RN providing Pap tests within a well-woman centred care setting within a clinic/health centre.

Write your answers in the space provided using additional paper if needed.

Case Study # 1

A 28 year old low income client presents to an active treatment centre in her community. She has had 3 pregnancies in 4 years, a history of 1 spontaneous abortion, 1 termination at 15 weeks and 1 live birth. She states that she doesn't want her male doctor to examine her and she thinks she may be pregnant. The doctor tells the RN that the client had an abnormal Pap test 3 years ago. There is no history on the file as the client has different doctors in the area. The client is adamant that she wants a female examiner, knows there is a trained RN on site and refuses to leave if she isn't examined. She has an extensive history of "no-show" appointments and may or may not have problems with abuse of alcohol and drugs.

1. What are the first priorities for this client?

2. What information do you need to proceed?

3. What might your legal/ethical, scope of practice issues be? How should you proceed?
Case Study #2
A 52 year old female client presents at a large urban health centre. During the health history, she states that she has some itchiness and watery vaginal discharge. On performing a speculum examination you note that the vagina is red and granular looking. There is a frothy yellowish foul-smelling vaginal discharge.

1. What may be causing the above symptoms?

2. Outline the plan of care you will discuss with this client.

3. Outline your educational and counselling strategies with this client.

Case Study #3
A 25 year old aboriginal client presents at a well baby clinic on a reserve community. She has her husband and a 4 month old baby with her and has a 2 and 3 year old at home. She is trying to get pregnant again. Discussion ensues as to her plan for a pregnancy so soon after this birth. She is slow to answer. The husband finally says that his wife has been told that she had an "abnormal cancer test" during her last pregnancy and that she was referred to the Women's Centre at her 6 week postpartum doctor's visit. She did not attend the post partum doctor's visit because she is afraid that she has cancer "down there". The client wants to have more babies before she has surgery. The client and her husband both think she will have her "womb taken out".

1. What is the first priority for this client?

2. Should the RN do cervical screening?
Case Study #4

A 38 year old female client presents in Well Women’s Clinic. On taking her health history you note that she has not menstruated for a couple of months but she indicates that her periods are often irregular and she doesn't think that she is pregnant. She has never had a Pap test and agrees to have one done today. On performing a speculum examination you note a bluish discolouration of the cervix. There is also a thin, creamy, gray-white, vaginal discharge. There is no inflammation on the vaginal wall or cervix.

1. What may be causing the discolouration of the cervix?

2. What may be causing the vaginal discharge?

3. How would you proceed?

4. Outline your educational and counselling strategies with this client.

Case Study #5

A 62 year old Aboriginal client presents for her Pap test. She has not been in for regular screening in the past. The client is very self-conscious about her body, as she believes that she is overweight. She has developed a good trusting relationship with her RN who has recently completed her RN Pap Test Learning Module and Practicum. The history is taken and there are no signs to indicate that this will be anything other than a routine screening. Upon examination the client becomes tense and somewhat upset. The RN has trouble finding the client’s cervix. The client continues to become more anxious and starts to cry, saying that the examination is painful.

1. What is the first priority for this client?

2. With a nervous client, what are some ideas to promote comfort?

1 Adapted from Calgary Health Region (2001)
3. When the client starts to cry, what should you do?

4. The cervix is pink and fleshy, but has some “bumps on it”. What might this be and what should you do?

Case Study #62

You work in a low socio-economic inner city practice with multiple immigrant women, many of who do not have English as a first language. A 65 year old client of East Indian background attends your office for the first time to get her blood pressure checked. She is a smoker. She has moved to stay with her son and help look after her grandchildren. She is mildly obese. She says that she has had no Pap tests since having children (the last child was born 45 years ago), that she has only rare sexual activity with her husband of many years and why would she need a Pap. She still has periods each month but they are getting heavier and closer together, i.e. q 3 weeks. When asked about previous Pap tests she said, I had a few when I was younger, in my 20’s and they said one was abnormal, so I had to have more frequent examinations at the Physician’s office.” She says that she really doesn’t want any more Pap tests.

1. What if this client had had a hysterectomy, how would you deal with the idea of doing a Pap test?

2. What else would you like to know about this client, particularly in regard to her risk for cervical cancer?

3. How would you discuss the risk of cervical cancer with her?

4. What if she agrees to have a basic assessment (e.g. blood pressure) but still refuses a Pap test—what would you do?

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2 Adapted from ACCSP Main Pro C Physician Course Working Group (2004)
GLOSSARY

A

Adenocarcinoma: A cancer that is derived from glandular tissue or in which the tumor cells form recognizable glandular structures. Most pancreatic cancer and prostate cancer, for example, are adenocarcinomas. About 15% of cervical cancers in Alberta are adenocarcinoma.

Adhesion: Scar tissue that unites surfaces which are normally separate. Adhesions can occur in the abdominal cavity, fallopian tubes, or inside the uterus. Adhesions can interfere with transport of the egg and implantation of the embryo in the uterus.

Amenorrhea: Absence of menstrual flow.

Anovulation: Absence of ovulation.

Anteflexed uterus: Normal position in which the body of the uterus tips forward toward the bladder.

Anteverted uterus: Normal position in which the body of the uterus tips forward toward the bladder.

ASC-H: Atypical Squamous Cells – cannot exclude High Grade Squamous Intraepithelial Lesion (HSIL).


B

Bartholin’s glands: Two small mucous glands located on each side of the vaginal orifice; their ducts open on the vulva.

Benign: Cell changes that have nothing to do with cancer.

Biopsy: The removal and examination of a small amount of tissue to establish a diagnosis.

Breakthrough bleeding: Vaginal spotting or bleeding that occurs between periods and is caused by the failure of progestin (usually taken in combination with estrogen as an oral contraceptive) to support the endometrium adequately.

C

Cancer: A general term for more than 100 diseases. It is the uncontrolled, abnormal growth of cells that can invade and destroy healthy tissue. Most cancers can also spread to other parts of the body.

Carcinoma: One of the five basic kinds of cancer and the most common. It begins in epithelial tissue (the lining or covering of an organ; makes up the majority of malignancies of the breast, uterus, intestinal tract, skin and tongue.

Carcinoma in situ: An early stage of cancer in which tumour cells are confined to the epithelial tissue or origin and have not yet invaded surrounding tissues.

Caruncles (of the urethra): Fleshy outgrowths of the mucous membrane of the female urethral mucosa.

Cervical carcinoma: A cancer of the uterine cervix (the neck of the uterus).
Cervical dysplasia: An abnormal tissue growth on the cervix that may progress to cancer if not treated in time; detected through a Pap test.

Cervical ectropion: Eversion of the epithelium onto the cervix.

Cervical eversion: When the tissue within the cervix "opens up" onto the outer part of the cervix.

Cervical stenosis: A partial or complete blockage of the cervical canal which can be a congenital defect or caused by surgical complications, infections, and/or radiation therapy.

Cervicitis: An inflammation of the cervix caused by one of a number of different organisms and generally classified as either acute or chronic.

Cervix: The neck or lower end of the uterus or womb that connects the uterus with the vagina.

Chemotherapy: The use of drugs to treat or control cancer.

Circumoral ertherma: Redness of the skin caused by dilatation and congestion of the capillaries, can be a sign of inflammation or infection.

Colposcopy: Examination of the cervix and vagina using a low-powered magnifying instrument known as a colposcope in order to assess the extent and severity of any problem and to determine appropriate treatment. Small biopsies may be taken during the test.

Competence: The integration and application of knowledge, attitudes, skills and judgement required for performance in a designated role and setting.

Cone biopsy: Also known as conization, refers to a surgical removal of a cone-shaped specimen of tissue from the distal end of the cervix for examination under a microscope; provides a more extensive sample for diagnosis than a simple biopsy.

Cystocele: Herniation of the bladder through the anterior vaginal wall (bulging of the bladder into the vagina).

DES: An abbreviation for diethylstilbestrol which was once used to treat menstrual disorders and to prevent miscarriage but is no longer prescribed for these cases because of the occurrence of reproductive abnormalities and cancers in the offspring of women so treated.

Diagnosis: Identification of a disease from signs, symptoms, patient history, laboratory tests, radiological results and physical findings.

Dysmenorrhea: Menstrual discomfort or pain.

Dyspareunia: Pain or discomfort in the vagina or pelvis during sexual intercourse.
**Dysplasia**: Abnormal tissue growth on the cervix that may progress to cancer if not treated in time; abnormal cell changes that are detected through a Pap test.

**Endocervical curettage (ECC)**: The removal of tissue from the inside of the cervix using an instrument called a curette.

**Erythema**: Redness

**Excoriation**: Damage to skin by e.g. scratching.

**Exudate**: Fluid or discharge usually as a result of inflammation.

**Fimbriae**: Any structure resembling a fringe or border.

**Fissure**: A narrow slit or cleft.

**Fistula (of the urethra)**: Abnormal passage between the urethra and another structure such as the vagina or rectum.

**Fornix/Fornices**: The anterior (front) and posterior (back) recesses into which the upper vagina is divided. These vault like recesses are formed by protrusion of the cervix into the vagina.

**Fourchette**: The place where the labia minora meet posteriorly.

**Friability**: Referring to tissue which is fragile and may bleed easily (e.g. When a swab is taken).

**FSH**: Follicle-stimulating hormone.

**Glandular premalignancy and malignancy**: A pathology result of atypical glandular cells, endocervical adenocarcinoma in situ, or adenocarcinoma.

**Gnrh**: Gonadotropin-releasing hormone.

**Gravida**: Number of pregnancies, regardless of their outcomes.

**Homogenous**: Same quality, composition and/or structure throughout.

**HPV**: Human Papillomavirus. HPV is the common name for a group of related viruses, some of which occur on the cervix and cause cervical cancer.

**HSIL**: High Grade Squamous Intraepithelial Lesion.

**HSV 1 or 2**: herpes simplex virus one and two. HSV 1 causes oral herpes and HSV 2 causes genital herpes. HSV-1 can also cause genital herpes through transmission during oral-genital sex.
**Hymenal remnants:** The tissue of the hymen that is still present.

**Hyperemia:** Congestion or increased blood flow to the area.

**Hysterectomy:** Surgical removal of the uterus. The ovaries may also be removed at the same time.

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**Induration:** Abnormally hard spot.

**Infertility:** The inability to conceive over a period of 1 year of unprotected regular intercourse. Contributing factors in women include abnormalities of the vagina, cervix, uterus, fallopian tubes, and ovaries. Factors influencing fertility in both women and men include stress, nutrition, chemical substance use, chromosomal abnormalities, certain disease processes, sexual and relationship problems, and immunologic response.

**Introitus:** Opening to the vagina located on the perineum.

**Invasive cervical cancer:** A stage of cervical cancer in which the cancer has spread from the surface of the cervix to healthy tissue deeper in the cervix or to other parts of the body.

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**Laparoscopy** - Examination of internal organs through use of a small telescope called a laprascope.

**Laser surgery:** Use of an intense, narrow beam of light (called a laser beam) to treat some forms of cancer or abnormal cells. Since a laser beam can be focused precisely on a tiny area, it is used to operate on delicate tissues. General anesthetic is unnecessary.

**LEEP:** Loop electrosurgical excision procedure. After freezing the cervical area, an electrical wire loop is inserted into the vagina and all the abnormal tissue that can be seen on the cervix is sliced off and removed.

**Leukoplakia** (of the cervix) - Raised white plaques on the cervix, may be due to different causes such as carcinoma or genital warts.

**LH** - Luteinizing hormone.

**Lithotomy position:** Client lies on back, legs flexed at the knees, thighs flexed and abducted. Stirrups may be used to support the feet.

**Localized cancer:** A cancerous growth that has not spread to other parts of the body.

**Liquid Based Cytology:** A technology that uses a plastic spatula and brush (depending on product used) to take a Pap test for cervical cancer screening. The sample is then either swirled or dropped into a liquid preservative in a specimen container. The sample is then spun in the lab to remove extraneous materials and a slide prepared for examination under a microscope.

**LSIL** - Low Grade Squamous Intraepithelial Lesion.
**M**

**Malignancy:** A tumour consisting of cancerous cells. Cells from a malignant growth can break away and start secondary tumours elsewhere in the body.

**Malignant:** Cancerous; tending to metastasize or spread.

**Menarche:** Onset of menstrual periods, usually occurring between age 9 and 17.

**Menopause:** Cessation of menstrual periods that occurs with the decline of cyclic hormonal production and function that accompanies aging. Premature menopause may occur as a result of, for example, illness or the surgical removal of both ovaries.

**Metastasis:** The spread of cancer cells from the original tumour to other parts of the body by way of the lymph system or bloodstream.

**Multigravida:** A woman who has been pregnant several times.

**Multiparity:** Condition of having two or more pregnancies that resulted in viable fetuses.

**N**

**Nulliparity:** Condition of never having delivered a viable infant.

**O**

**Oncology:** The study and treatment of cancerous tumours.

**Oncologist:** An oncologist is a physician who specializes in diagnosing and treating cancer.

**Oophorectomy:** Surgical removal of the ovaries.

**Orthopnea:** Ability to breathe easily only in the upright position.

**P**

**Pap test:** A test in which cells are removed from the cervix and examined under a microscope. Devised by Dr. George Papanicolaou, the Pap test is an effective way to detect abnormal cells (see cervical dysplasia) or cancer. Since the Pap test (like many medical tests) is not perfect, it is important to Pap test women on a regular basis to lessen the chance of missing any abnormal cell changes.

**Parity:** Condition of having delivered an infant or infants, alive or dead, during the viability period (fetus weighing 500 g or more or having a minimum estimated 20-week gestation); multiple birth is a single parity.

**Partial hysterectomy:** A hysterectomy in which the cervix is left in place.

**Pelvic exam:** Also called an internal examination; a gynecological examination of a woman's vagina, vulva, cervix, fallopian tubes, ovaries, and uterus.

**Pelvic Inflammatory Disease (PID):** PID is an inflammatory condition of the pelvic cavity that may involve the uterus, fallopian tubes, ovaries, pelvic peritoneum or pelvic vascular system; often caused by gonococcal and chlamydial infection, may be acute or chronic. Acute PID causes bilateral
tenderness in the adnexal areas and the client may guard the area. The symptoms of chronic PID are bilateral, tender, irregular, and fairly fixed adnexal areas; movement of cervix is painful.

**Polyp**: a growth of tissue or mass protruding from a mucous membrane; can occur wherever there is a mucous membrane including colon, bladder, uterus, cervix, vocal cords, or nasal passage; usually benign, they can lead to complications or eventually become malignant.

**Puberty**: Period when secondary sexual characteristics begin to appear and potential for sexual reproductive ability is obtained.

**Premenstrual syndrome (PMS)**: A cyclic cluster of signs and symptoms, such as breast tenderness, fluid retention, and mood swings, that occur cyclically usually after ovulation and before or during menses; characterized by at least 7 symptom-free days, usually in the first half of the menstrual cycle.

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**R**

**Rectocele**: Herniation of part of the rectum through the vaginal wall.

**Retroflexed uterus**: Normal position in which the uterine corpus flexes posteriorly toward the rectum at an acute angle.

**Retroverted uterus**: Normal position in which the uterine corpus flexes toward the rectum, but at a less acute angle than if retroflexed.

**Risk factor (in relation to cancer)**: Anything that increases a person's chances of developing cancer. For example, smoking is a risk factor for lung, head/neck and cervical cancer.

**Rugose**: Marked by ridges, wrinkled.

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**S**

**Salpingitis**: Inflammation or infection of the fallopian tube that is often associated with pelvic inflammatory disease (PID); causes lower quadrant pain with tenderness on bimanual examination.

**Sexually active**: Refers to both sexual intercourse and intimate genital contact including vaginal, anal, oral, and digital sexual activity.

**Skene's gland**: Glands lying just inside of and on the posterior area of the urethra in the female, one on each side of the floor of the urethra.

**Speculum**: A metal or plastic instrument used to spread the vagina open so that the cervix can be seen.

**Subtotal hysterectomy**: Removal of the uterus only, leaving the cervix in situ.

**Squamous premalignancy and malignancy**: A pathology report of ASC-US, ASC-H, LSIL, HSIL, or squamous cell carcinoma.

**Stage 1B tumors**: The cancerous area is larger than in stage 1A, but is still only in the tissues of the cervix and has not spread.
STI: Sexually transmitted infection, which includes Sexually Transmitted Diseases and other infections that may not manifest as disease.

Stellate cervical laceration: The trauma of a difficult delivery(ies) may tear the cervix, producing permanent lacerations. In a stellate laceration, the cervix has a number of slits in a star-like pattern.

Symptomatic: Showing indications of disease or illness.

Total hysterectomy: Removal of the uterus and cervix.

Transverse cervical laceration: The trauma of difficult deliveries may tear the cervix, producing permanent lacerations. In a transverse laceration, the cervix appears slit from side to side.

Tubal ligation: Surgical sterilization of a woman by constricting, severing, or crushing the fallopian tubes.

Tumor: A mass of abnormally growing cells that serve no useful bodily function. Tumors can be either benign or malignant.

Vaginal vault: Describes the vagina after a hysterectomy when no cervix remains.

Vaginal atrophy: Often a symptom of menopause; the drying and thinning of the tissues of the vagina and urethra. This can lead to dyspareunia (pain during sexual intercourse) as well as vaginitis, cystitis, and urinary tract infections.

Vaginitis: Inflammation of the vaginal mucosa marked by pain and/or purulent discharge.

Vesicle: Small elevation of the skin containing serous fluid (e.g. blister).

Virus: An infectious organism that invades and grows in cells and thereby alters their function; cause a variety of infectious diseases and may also induce some types of cancer.
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APPENDICES

1. CARN A Letter

2. Pap Test Videos

3. Recommended Policies

4. Assessment Tools:
   a. Performance Criteria Checklist for Preceptor
   b. Women’s Satisfaction Survey
   c. Pap Test Audit Form
   d. RN Pap Test Learning Module Completion Form

5. Pre-Post Test Answer Key

6. Case Studies

7. Evaluation of RN Pap Test Learning Module & Practicum
May 16, 2008

Alison Nelson
Health Promotion Manager
Screening Programs
Population Health and Information
Alberta Cancer Board
2202 2nd Street SW
Calgary, Alberta T2S 3C1

Dear Alison:

You have requested information on liability protection for registered nurses who perform PAP smears and are working for physicians in their offices. The College and Association of Registered Nurses of Alberta (CARNA) is the regulatory and professional body for registered nurses in the province of Alberta.

The Registered Nurses Profession Regulation under the Health Professions Act (HPA) (2000) authorizes registered nurses to "insert or remove instruments, devices, fingers or hands beyond the labia majora" which would involve interventions such as performing PAP smears. From a regulatory perspective, registered nurses working in a physician's office may perform many tasks such as injections, treatments, allergy shots, screening for certain conditions and illnesses, providing health information and doing PAP smears. Registered nurses are accountable and have a professional responsibility to be competent in the activities they perform. The RN PAP smear educational module developed by the cervical screening program is a means by which registered nurses can attain and maintain competence in the performance of PAP smears.

As to the liability of nurses performing PAP smears, it is important to recognize that in most instances, the nurse is an employee of the physician or clinic. The law holds the employer vicariously liable for the acts of any employee working within the scope of his or her employment, whoever they may be. This means that if a nurse employed by a physician is sued for something she did or did not do that arose out of her responsibilities as an employee (i.e. something the employer had directed her to do as part of her employment in that setting), the physician or clinic would be vicariously liable. I have enclosed an InfoLaw® bulletin from the Canadian Nurses Protective Society (CNPS) on vicarious liability for information. The key is that any health care employer, be it a hospital, clinic or physician, needs to carry sufficient liability protection to cover acts of employees.

In addition, registered nurses in Alberta also have liability protection through CNPS as the CARNA provides that protection through registration. Basic
liability protection is up to one million dollars per incident to an aggregate of three million per year. Registered nurses can also purchase CNPS Plus, which provides an additional 2-5 million dollars. If the nurse is a registered Nurse Practitioner, and is an independent contractor (not an employee), liability protection from CNPS is available up to $5 million per incident with a $5 million annual maximum. The additional $2-5 million in coverage from CNPS Plus is also available to this group, who carry greater responsibilities than RNs doing PAP smears, such as diagnosing, prescribing drugs and ordering tests and treatments.

While there may be concerns about RNs performing PAP smears from a liability perspective there are checks and balances in the system that aren’t there for other tasks a RN might perform. If the PAP smear shows inadequate cells the lab will request that another smear be taken within three months. The nurse and the employer can use this information to monitor the competent performance of PAP smears. It is the lab that will make the determination of the cytology result and communicate that to the practitioner. This is the same as it would be for a physician who is performing PAP smears.

I have discussed the issue with the Canadian Nurses Protective Society. They advised they have never had a case or incident reported where a nurse has been alleged or found negligent with respect to taking a PAP smear, and nurses have been doing this across Canada for many years. CNPS advised they consider taking PAP smears to be a very low risk activity from a liability perspective.

If you have further questions do not hesitate to contact me at 1-800-252-9392, extension 517.

Sincerely,

Debbie Philipchuk RN MN
Nursing Consultant - Policy and Practice

Enclosure
APPENDIX 2: Pap Test Videos

Videos that show how to perform a Pap test may have some variations regarding Pap test techniques. It is recommended that RNs practice techniques consistent with the Guideline to Cervical Cancer Screening (TOP, 2011). The resources listed below can be ordered by contacting the organizations directly via the links below. Screening Programs does not guarantee the accuracy or quality of the information in the videos or other resources.

1. **British Society for Clinical Cytology - How to Take a Cervical Smear**
   - Watch video online (NO COST)
   - Order CD with video clips and an accompanying booklet
   - [www.creationvideo.co.uk/videolibrary/medical/bscc/](http://www.creationvideo.co.uk/videolibrary/medical/bscc/)

2. **Brookside Press – 5 Minute Pap Smear, Internal Pelvic Anatomy, 5 Minute Pelvic Exam, Avoiding Pelvic Exam Errors, Pelvic Exam Variations**
   - Download videos online ($19.95US each)
   - [http://store.brooksidepress.org/5papsmvi.html](http://store.brooksidepress.org/5papsmvi.html)
   - [http://store.brooksidepress.org/5inpeanvi.html](http://store.brooksidepress.org/5inpeanvi.html)
   - [http://store.brooksidepress.org/5peeexvi.html](http://store.brooksidepress.org/5peeexvi.html)
   - [http://store.brooksidepress.org/4copeexer.html](http://store.brooksidepress.org/4copeexer.html)
   - [http://store.brooksidepress.org/peexva.html](http://store.brooksidepress.org/peexva.html)

3. **BC Cancer Agency Cervical Cancer Screening Program – A Women-Centred Approach to Cervical Cancer Screening Educational Video**
   - Watch video online (To request a username and password, call 604-877-6200 or e-mail: ccsp@bccancer.bc.ca and include your full name, profession and employer)
   - [https://phsa.mediasite.com/mediasite/LoginForm/](https://phsa.mediasite.com/mediasite/LoginForm/)

4. **BC Cancer Agency Cervical Cancer Screening Program – Speculum Exam and Pap Smear Video**
   - Order Form [www.bccancer.bc.ca/NR/rdonlyres/BB10EE87-95AB-43F5-994C-7D8DBD969424/29949/CCSPResourceOrderForm_June08.pdf](http://www.bccancer.bc.ca/NR/rdonlyres/BB10EE87-95AB-43F5-994C-7D8DBD969424/29949/CCSPResourceOrderForm_June08.pdf)
APPENDIX 3: Recommended Policies

The following is a summary, as noted throughout the module, of recommended areas for Employers to develop written policies and procedures. Some Employers may wish to develop more extensive policies. In addition to other relevant client care/services policy, specific policies relevant to RNs performing Pap tests are recommended in the following areas with regular reviews and update:

**Client Satisfaction**
Policy on obtaining feedback from clients regarding RN performance and a feedback process for collecting and responding to client feedback.

**Documentation**
Policy is needed for clinical areas that require particular documentation.

**Evaluation for Learning Module and Practicum Improvements**
Policy to require that RNs complete the evaluation of the RN Pap Test Learning Module and practicum Policy for the development of a feedback loop to help improve this learning module and the Employer to improve the practicum experience.

**Infection Control**
Policy to ensure clean decontaminated instruments is used to prevent transmission of infection or cross infection (e.g., HPV) to the client.

**Pap Test Adequacy**
Policy to require regular feedback from their Employer regarding adequacy rates and monitoring adequacy rates and ensuring that steps are taken to help the RN increase adequacy rates as required.

**Pap Testing Competency**
Policy on how often the RN must demonstrate competence in taking Pap tests. This will vary depending on the number of Pap tests taken by the RN on a yearly basis and other factors including adequacy rates. It is the RN’s responsibility to review ongoing competence and the Employer’s responsibility to establish standards within the clinical area. It is recommended that a formal process be developed for such review.

**Preceptor Relationship**
Policy on preceptorship and preceptor feedback process.

**Referrals to Primary Care Provider**
Policy that identifies the need for a RN to have an explicit written agreement and/or employer relationship with a physician, nurse practitioner, or registered midwife for the purposes of:
- Consultation during a Pap test if abnormal results are suspected
- Management and follow-up of Pap results OR Employer must secure an appropriate referral mechanism for follow-up of abnormal Pap results.

Policy for appropriate referral processes for clients with the following concerns:
- High risk and/or symptoms of STI
- Abnormal findings on external or internal examination
- Cervical abnormalities
- Total or subtotal hysterectomy due to biopsy confirmed high grade lesions or cervical cancer
- Pregnancy
RN Practice & the Health Profession Act
Policy on RN practice, continuing competency, and familiarity with the Health Professions Act (HPA).

RN Pap Test Learning Module Updates
Policy to require regular updating and maintaining of the RN Pap Test Learning Module. Updated versions can be obtained from www.screeningforlife.ca/cervical

Sexual Abuse
How to manage follow-up and referral of clients with a history of sexual abuse.
APPENDIX 4: Assessment Tools

A: Pap Test Skills Checklist

The preceptor is encouraged to offer regular feedback to the RN. It is recommended that a preceptor feedback process be set up in the employing clinic/agency. Once the RN has indicated readiness for final assessment the attached tool can be used to assess the RN’s performance during several Pap related client visits. The RN should attain 100% in all aspects of the Pap test Skills Checklist. Please note that #15 on the checklist may not be appropriate in some clinical settings in which case the preceptor would mark “NA” and exclude this from the performance criteria.

<table>
<thead>
<tr>
<th>CRITICAL ELEMENTS to Pap Testing Performance</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
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<tbody>
<tr>
<td>(Performs examination according to clinic/agency policies and procedure)</td>
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<tr>
<td>1. Proceeds if health history indicates. Refers client if there are concerns identified in the health history</td>
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<td>2. Explains procedure correctly and validates plan with client (informed verbal consent)</td>
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<td>3. Checks with client to determine if she needs to empty her bladder</td>
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<td>4. Discusses with client how she can take an active part in the examination</td>
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<td>5. Assembles necessary supplies</td>
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<td>6. Labels slide/container correctly</td>
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<td>7. Drapes client correctly</td>
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<td>8. Positions client correctly</td>
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<td>9. Sits on stool at foot of examining table</td>
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<td>10. Dons examination gloves</td>
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<td>11. Explains each step in the examination before it is done</td>
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<td>12. Touches inner thigh with back of hand before touching vulva</td>
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<td>13. Palpates inguinal and femoral area correctly</td>
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<td>14. Inspects the external genitalia correctly</td>
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<td>15. Examines the urethra, Skene’s glands, Bartholin’s glands correctly *May be N/A</td>
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<td>16. Selects the proper sized speculum</td>
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<td>17. Lubricates the speculum with only warm water</td>
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<tr>
<td>18. Inserts the speculum correctly so that the cervix is in full view</td>
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<td>19. Locks the speculum blades correctly</td>
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<tr>
<td>20. Inspects the cervix for colour, position, edema in zone of ectopy, size, shape of os, surface, and cervical secretions</td>
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<tr>
<td>21. Assesses position of transformation zone correctly</td>
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<tr>
<td>22. Obtains specimen with spatula correctly</td>
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<tr>
<td>✓ Rotates spatula in cervical os only 360°</td>
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<tr>
<td>✓ Ends rotation so spatula is in 3 and 9 o’clock position</td>
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<tr>
<td>✓ Transfers sample to slide correctly</td>
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<tr>
<td>✓ Applies to half of slide in a single uniform motion OR swirls plastic spatula in ThinPrep container vigorously OR drops plastic spatula in the SurePath container</td>
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<tr>
<td>23. Obtains specimen with a brush correctly</td>
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<tr>
<td>✓ Inserts brush gently all the way into the cervical os to end of bristles</td>
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<tr>
<td>✓ Turn 90° only</td>
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<tr>
<td>✓ Applies to half of slide in a rolling uniform motion</td>
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<tr>
<td>✓ Sprays slide with cytologic spray fixative immediately OR swirls plastic spatula in ThinPrep container vigorously OR drops plastic spatula in the SurePath container</td>
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<tr>
<td>24. Removes the speculum correctly</td>
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<td>25. Inspects vaginal wall while removing speculum</td>
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<tr>
<td>26. Prepares slide/container and completed requisition correctly for transport to laboratory</td>
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<td>27. Assists client out of lithotomy position</td>
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<td>28. Shares results of examination with client</td>
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<td>29. Provides health information and reading resources to client</td>
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<tr>
<td>30. Informs client of how results will be shared</td>
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<tr>
<td>31. Informs client of when next Pap test is due</td>
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<tr>
<td>32. Documents results of examination correctly on client’s Health Record</td>
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<tr>
<td>33. Identifies abnormal findings (STI, cervical abnormalities etc.) and promptly consults with or refers client to physician, nurse practitioner, or registered midwife</td>
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B: Client Satisfaction Survey

It is recommended that
- RNs obtain feedback from clients regarding their performance with Pap testing
- A feedback process is established in the employing clinic/agency for collecting and responding to client satisfaction surveys
- The following survey is given to all clients following their visit with the RN conducting unsupervised Pap related visits during her practicum (provide the client with the survey and an envelope, request that the client complete the survey in the waiting room, request the client put the completed survey in the envelope and give it to the receptionist)
- The collected surveys are used by the RN and preceptor to assist in feedback and review.

Please help us improve our services by answering the following questions about the Pap test service you received. The RN who provided this service is taking part in an evaluation to ensure a high quality of Pap test service for women.

You are asked to complete this survey, but this is voluntary. The survey will take about 10 minutes to complete. All results from surveys are combined so that your anonymity and confidentiality are protected. Do not write your name on this survey, unless you would like the Manager to contact you.

<table>
<thead>
<tr>
<th>DATE: __________________________</th>
<th>Please check (✓) one box for each question</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN Name: _____________________</td>
<td>Strongly Agree</td>
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<tr>
<td>The RN listened to health issues that were on my mind</td>
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<tr>
<td>The RN helped me to talk about my concerns</td>
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<tr>
<td>The RN respected my values, beliefs and culture</td>
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<tr>
<td>I could easily talk about personal matters with the RN</td>
<td></td>
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<tr>
<td>The RN took a detailed health history for my records (*the RN may not take a detailed health history in some settings)</td>
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<tr>
<td>The RN explained the Pap test to me in words I could understand</td>
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<tr>
<td>The RN asked if it was okay to go ahead with the Pap test</td>
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<tr>
<td>The RN assured me that the Pap test was confidential</td>
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<tr>
<td>The RN made sure I had privacy during the Pap test</td>
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<tr>
<td>I was offered a cover sheet to use for the Pap test</td>
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<tr>
<td>The RN checked with me during the Pap test to make sure I was comfortable</td>
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<tr>
<td>I had minimal discomfort during the Pap test</td>
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<tr>
<td>The RN gave me information about the Alberta Cervical Cancer Screening Program</td>
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<tr>
<td>The RN provided me with handouts to help me understand Pap tests</td>
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<tr>
<td>The RN told me when my Pap test result will be ready</td>
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<tr>
<td>The RN told me how I will get my Pap test results</td>
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<tr>
<td>I am satisfied with the services I received</td>
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What is one thing that the RN did very well?

What is one thing that the RN could do better?

If you would like the Manager to contact you, please write down your name and phone number (optional). Name: __________________________ Phone Number: __________________________

Thank you for your feedback.
Please put your completed survey in the envelope and return to the receptionist.
C: Pap Test Audit Form

It is recommended that RNs learning to perform Pap tests have regular feedback from their Employer regarding adequacy rates and those steps are taken to help the RN increase adequacy rates as required. It is recommended that Employers set up a process to regularly collect and review Pap test adequacy rates with the RN. The attached Pap Test Audit Form is provided to help the Employer monitor each RN’s Pap test adequacy.

<table>
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<tr>
<th>RN Name:</th>
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<table>
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<tr>
<th>DATE of PAP</th>
<th>AGE of CLIENT (in years)</th>
<th>RESULT (✓ Check appropriate boxes)</th>
<th>UNSATISFACTORY REASON (Noted on lab results form)</th>
<th>COMMENTS</th>
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## D: Learning Module Completion Form

**Date** ______________________
**RN Name** ______________________
**CARNA #** ______________________  **Employee #** ______________________
**Employer** ______________________
**Supervisor/Manager Name** ______________________
**Preceptor Name** ______________________
○ Copy for RN  ○ Copy for Employer  ○ Copy for Preceptor

<table>
<thead>
<tr>
<th>Component</th>
<th>Activity</th>
<th>Requirements/Tool</th>
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*The number of Pap tests that the RN completes during the practicum may range from 15-30 however it is recommended that emphasis be placed on high quality learning experiences rather than the total number of Pap tests completed. It is recommended that the RN observe and demonstrate until she/he feels comfortable and confident and is deemed competent by the Preceptor.

**Pap Test Adequacy Rate** is recommended to be less than 1% of tests are unsatisfactory and less than 10% of tests are without a transformation zone (Refer to Section 9: Papanicolaou Test).
APPENDIX 5: Answer Key Post-Test

Marking Instructions
- Each correct answer scores one mark (i.e. Question #1: 4/4 responses correct = 4 marks, 3/4 correct = 3 marks, etc.).
- The RN is required to get 85/100 marks to attain the module requirements for competency (85%).

1. RNs in Alberta are expected to practice in a manner consistent with:
   (ANSWER: SECTION 1 = a, b, c, d)
   b. CARNA Nursing Practice Standards (2005).

2. The responsibilities of Employers of RNs who are expected to provide Pap tests as part of their position include:
   (ANSWER: SECTION 1 = a, b, c, d, e)
   a. Providing adequate education time, resources, preceptorship opportunities, and facilities.
   b. Ensuring that there is an explicit relationship with the RN taking the Pap test and a physician, nurse practitioner, or registered midwife.
   c. Developing policies and procedures related to RN Pap testing.
   d. Participating in ongoing monitoring of Pap test adequacy rates.
   e. Maintaining a record of RN Pap test education.

3. The cornerstones of women-centred care include which of the following factors?
   (ANSWER: SECTION 1 = a, b, c, d)
   a. A focus on women.
   b. Involvement and participation of women.
   c. Empowerment.
   d. Respect and safety.

4. Which of the following is not a risk factor for cervical cancer?
   (ANSWER: SECTION 2 = d)
   a. Multiple male sex partners.
   b. Early onset of first intercourse.
   c. Genital infections such as herpes simplex II (HSV2) and Chlamydia.
   d. Family history.
   e. HPV infection.
   f. Smoking.

5. The Alberta Cervical Cancer Screening Program is needed because:
   (ANSWER: SECTION 2 = a, c, e)
   a. Organized cervical cancer screening programs reduce the rates of cervical cancer.
   b. Having regular Pap tests may prevent a few cervical cancers.
   c. Supporting women to have regular Pap tests and follow-up care can prevent almost all cervical cancers.
   d. All clients who develop cervical cancer in Alberta have not had regular Pap tests.
   e. More than ½ of the clients who develop cervical cancer in Alberta have not had regular Pap tests.
6. All women between the ages of 21-69 who have ever been sexually active should have Pap tests regularly. (Except women who have had a hysterectomy for benign reasons with no history of biopsy confirmed high grade lesions or cervical cancer).

(ANSWER: SECTION 2 = a)
   a. True
   b. False

7. Name four high risk groups in particular who RNs should encourage to have Pap tests regularly.

(ANSWER: SECTION 2 = see list below, need 4 correct)
   - Older women
   - Women living in poverty
   - Immigrant and refugee women
   - Un/underscreened ethnocultural or other communities
   - Aboriginal women

8. Women older than 69 who have never been screened for cervical cancer need 3 negative and satisfactory annual Pap tests before screening can be discontinued.

(ANSWER: SECTION 3 = a)
   a. True
   b. False

9. Women younger than 21 who have been sexually active for 3 years need to be screened for cervical cancer.

(ANSWER: SECTION 3 = b)
   a. True
   b. False

10. Which age group is least likely to benefit from increased access to and promotion of Pap testing

(ANSWER: SECTION 3 = d)
   a. Women aged 50 to 69.
   b. Women aged 36-49.
   c. Women aged 21-35.
   d. Women under 21.

11. List eight reasons why an eligible woman may be reluctant to have a Pap test.

(ANSWER: SECTION 4 = see list below, need 8 correct)
   - Lack of information and understanding of cervical cancer screening and Pap tests
   - Fear of test
   - Fear of cancer
   - Fear of pain
   - Embarrassment
   - Modesty
   - Religious and social factors
   - Inability to understand an invitation to participate in cervical screening because of language barriers
   - Difficulty in communicating with some health professionals
   - Lack of childcare facilities
   - Other peoples’ attitudes to the cervical cancer screening and Pap tests (i.e. husband, family, religious leaders)
   - Accessibility issues
12. If a client appears apprehensive before the pelvic exam, it is best to:
(ANSWER: SECTION 4 = c)
   a. Reassure her and press forward.
   b. Tell her that there is nothing to worry about.
   c. Ask open-ended questions about her apprehension around the Pap test procedure.

13. List four key things that should be discussed with the client after the Pap test visit:
(ANSWER: SECTION 4 = see list below, need 4 correct)
   - Exam findings
   - How client will receive her lab results
   - Client questions
   - Client education (i.e. written information; ACCSP brochures)

14. List five client groups that may have special learning, counselling and educational needs related to cervical cancer screening.
(ANSWER: SECTION 5: see list below, need 5 correct)
   - Younger women
   - Lesbians and other sexual minorities
   - Clients with a history of sexual abuse
   - Clients with disabilities
   - Clients from different cultures
   - Clients who have undergone female genital mutilation
   - Clients with barriers to access

15. Which of the following findings related to STI might be discovered during an external genital examination?
(ANSWER: SECTION 5 = a, b, c, d)
   a. Pubic lice/crabs
   b. Genital warts
   c. Genital herpes
   d. Inflammation of the Bartholin’s glands

16. A client presents with the following symptoms:
   - raised painless lesions on the labia, the vestibule, and/or in the perianal region.
   - flesh-colored cluster of soft growths.
(ANSWER: SECTION 6 = d)
   The client most likely has:
   a. Molluscum contagiosum
   b. Nabothian follicles
   c. Genital herpes
   d. Genital warts
   e. Yeast infection

17. List six abnormal findings of the ectocervix:
(ANSWER: SECTION 6= see list below, need 6 correct)
   - abnormal exudates or masses upon the ectocervix
   - asymmetrical circumoral erythema with irregular borders
   - blood of unknown origin
   - cyanosis in a nongravid client
   - diffuse erythema
   - excavations or ulcerations
• nodularity or roughness is usually abnormal, but may be attributable to nabothian cysts which are common
• hemorrhagic lesions
• leukoplakia

18. Which of the following are abnormal findings on the cervix that should be referred to a physician, nurse practitioner, or registered midwife:
(ANSWER: SECTION 6=a, b, c, d, f)
 a. Friable tissue (soft, eroded)
 b. Red patchy areas
 c. Abnormal bleeding and inflammation
 d. Granular areas, white patches
 e. Pink colour
 f. Lesions

19. Name the three sampling areas of the cervix.
(ANSWER: SECTION 6 = see list below, need 3 correct)
 • ectocervix,
 • endocervix
 • transformation zone

20. When conducting a health history and assessing clients for specific concerns, what are the PQRST principles to follow?
(ANSWER: SECTION 7 = see list below, need 5 correct)
 • P=Provocative or Palliative
 • Q=Quality or Quantity
 • R=Region or Radiation
 • S=Severity Scale
 • T=Timing

21. Women due for cervical cancer screening who are pregnant or who have had a total or subtotal hysterectomy due to biopsy confirmed high grade lesions or cervical cancer should be referred to a physician, nurse practitioner, or registered midwife for a Pap test.
(ANSWER: SECTION 8 = a)
 a. True
 b. False

22. A smaller and narrower speculum should be used with:
(ANSWER: SECTION 8 = a, b, c, d)
 a. Clients who have not engaged in full vaginal penetration during sexual activity.
 b. Nulliparous clients.
 c. Circumcised clients.
 d. Clients whose vaginal orifices have contracted postmenopausally.

23. It is acceptable to lubricate the speculum with:
(ANSWER: SECTION 8 = b)
 a. A very small amount of water soluble lubricant
 b. Warm water
 c. Vaseline

24. An acceptable way to insert the speculum is:
(ANSWER: SECTION 8 = b, c, e)
a. Blade tips against the upper (anterior) wall of the vagina.
b. At an oblique angle.
c. With the speculum closed.
d. With the speculum slightly opened.
e. With the speculum angled 45° downward toward the small of the client's back.

25. The best way to reposition a speculum for a client with a cervix with posterior orientation is:
(ANSWER: SECTION 8 = b)
   a. Reinsert less deeply and anteriorly, with the base of the lower blade actually compressing the anterior wall of the vagina.
   b. Insert the speculum more deeply and posteriorly through compression of the perineal tissue. The blade tips will slip under the cervix into the posterior fornix.
   c. Choose a plastic speculum of a larger size and reinsert as you did prior.

26. What are the ideal client conditions for cervical screening?
(ANSWER: SECTION 9 = a, b, c, d)
   a. Avoidance of vaginal douching for 24 hours before the test.
   b. Avoidance of use of contraceptive creams or jellies for 24 hours before the test.
   c. Avoidance of intercourse for 24 hours before the test.
   d. Mid-cycle (but do not defer due to abnormal bleeding).
   e. During menses.

27. The correct way to obtain an ectocervix specimen with spatula is:
(ANSWER: SECTION 9 = a)
   a. Rotate spatula in cervical os only 360° and end rotation so spatula is in 3 and 9 o'clock position.
   b. Rotate spatula in cervical os only 180° and end rotation so spatula is in 3 and 9 o'clock position.
   c. Rotate spatula in cervical os only 90° and end rotation so spatula is in 3 and 9 o'clock position.

28. The correct way to obtain a specimen with a cytobrush is:
(ANSWER: SECTION 9 = a)
   a. Insert the cytobrush gently all the way into the cervical os but no further than the end of the bristles and turn 90° to 180°.
   b. Insert the cytobrush gently all the way into the cervical os but no further than the end of the bristles and turn 180° and back again.
   c. Insert the cytobrush gently all the way into the cervical os but no further than the end of the bristles and turn 360°.

29. Over rotation of the endocervical brush will cause cell damage and slight capillary bleeding.
(ANSWER: SECTION 9 = a)
   a. True
   b. False

30. Unsatisfactory Pap tests are mostly a result of the following:
(ANSWER: SECTION 10 = a, b)
   a. Cervical sampling issues.
   b. Specimen collection issues.
31. List six key descriptions that could be documented following a Pap test visit:
   (ANSWER: SECTION 11 = see list below, need 6 correct)
   - ease of examination
   - specimens that were obtained
   - abnormalities noted
   - condition of labia, cervix, vagina, and any deviations to normal (describe)
   - clients response to exam (anything abnormal that made you think sexual abuse)
   - discharge teaching and follow-up

32. During a Pap test visit, when does the RN seek to obtain informed verbal consent from the client?
   (ANSWER: SECTION 8 & 11 = b)
   a. At the start of the consultation.
   b. After you have explained the external exam, speculum exam and the Pap test procedure and before you begin.
   c. After completing the external exam, speculum exam and the Pap test.

33. Is the RN legally responsible to protect confidentiality of client health information?
   (ANSWER: SECTION 11 = a)
   a. Yes
   b. No

34. The username and password needed to access recommended Canadian Nurses Protective Society InfoLaw documents related to RNs and Pap testing are:
   (ANSWER: SECTION 11 = need both username and password. Contact CARNA through www.nurses.ab.ca or phone 1-800-252-9392 to obtain the CNPS username and password.)
   a. ____________________
   b. ____________________

35. An informal verbal agreement between an RN and a physician, nurse practitioner, or registered midwife should be used to outline the RN’s role in performing Pap tests.
   (ANSWER: SECTION 1 & 11 = b)
   c. True
   d. False
APPENDIX 6: Answer Key Case Studies

Marking Instructions
- Each question answered by at least 1 appropriate point scores one mark (i.e. Question #1: 1 appropriate point for each of 4 questions = 4 marks, 2 appropriate points for each of 2 questions = 2 marks, etc.).
- The RN is required to get 17/20 marks to attain the module requirements for competency (85%).

Case Study #1
A 28 year old low income client presents to an active treatment centre in her community. She has had 3 pregnancies in 4 years, a history of 1 spontaneous abortion, 1 termination at 15 weeks and 1 live birth. She states that she doesn't want her male doctor to examine her and she thinks she may be pregnant. The doctor tells the RN that the client had an abnormal Pap test 3 years ago. There is no history on the file as the client has different doctors in the area. The client is adamant that she wants a female examiner, knows there is a trained RN on site and refuses to leave if she isn't examined. She has an extensive history of "no-show" appointments and may or may not have problems with abuse of alcohol and drugs.

1. What are your first priorities for this client?
   • Consent for treatment and sharing of information. Education, confidence and trust building are the most important priorities.
   • Pregnancy test.

2. What information do you need to proceed?
   • Results from previous tests.
   • Results from pregnancy test.
   • Confirm who the client’s previous doctors were.

3. What might your legal/ethical, scope of practice issues be? How should you proceed?
   • You may or may not be able to perform a Pap test or any STI testing depending on your clinic/agency policy on pregnant clients.
   • If client is under the influence of drugs informed consent may be an issue.
   • As she may leave, get a good history as well as all information for follow-up as she may be difficult to find.
   • If you are unable to perform Paps on pregnant clients, discuss if she would be more comfortable visiting a physician for Pap test, and prenatal (if required) follow-up if a female companion or RN was present.
   • If drugs or alcohol is a factor, but the situation is volatile, try to discuss her basic health needs, resources in the community etc. Encourage her to return and at subsequent visits encourage referral for substance abuse counselling.

Case Study #2
A 52 year old female client presents a large urban health centre. During the health history, she states that she has some itchiness and watery vaginal discharge. On performing a speculum examination you note that the vagina is red and granular looking. There is a frothy yellowish foul-smelling vaginal discharge.

1. What may be causing the above symptoms?
   • Possibly trichomonas
2. Outline the plan of care you will discuss with this client.
• Pap test deferred until inflammation has settled down.
• Possibility of a STI and the need to see physician or nurse practitioner for STI testing.
• Need to test and treat partner(s) if it is a STI.

3. Outline your educational and counselling strategies with this client.
• STI risk and prevention.
• Need for safer sex practices until STI testing and treatment is complete
• Reinforce use of male or female condoms with regular birth control methods (e.g. pill, patch, depoprovera).
• Help client create a plan for initiation and maintenance of STI prevention.
• Need for regular Pap tests.
• Answer questions.
• Provide literature on vaginitis, STI risks and prevention, and Pap test.

Case Study #3
25 year old aboriginal client presents at a well baby clinic on a reserve community. She has her husband and a 4 month old baby with her and has a 2 and 3 year old at home. She is trying to get pregnant again. Discussion ensues as to her plan for a pregnancy so soon after this birth. She is slow to answer. The husband finally says that his wife has been told that she had an "abnormal cancer test" during her last pregnancy and that she was referred to the Women's Centre at her 6 week postpartum doctor's visit. She did not attend the post partum doctor's visit because she is afraid that she has cancer "down there". The client wants to have more babies before she has surgery. The client and her husband both think she will have her "womb taken out".

1. What is the first priority for this client?
• Refer to a physician, nurse practitioner, or midwife.
• If required, get consents for examination and release and sharing of information.

2. Should the RN do cervical screening?
• No, if possible refer to a physician, nurse practitioner, or midwife, but stay involved as this couple will require good education and the team commitment to ensure appropriate care.
• Education and follow-up is important.

Case Study #4
4 A 38 year old female client presents in Well Women’s Clinic. On taking her health history you note that she has not menstruated for a couple of months but she indicates that her periods are often irregular and she doesn’t think that she is pregnant. She has never had a Pap test and agrees to have one done today. On performing a speculum examination you note a bluish discoloration of the cervix. There is also a thin, creamy, gray-white, vaginal discharge. There is no inflammation on the vaginal wall or cervix.

1. What may be causing the discolouration of the cervix?
• Possibly pregnancy

2. What may be causing the vaginal discharge?
• Likely bacterial vaginosis

3. How would you proceed?
• Perform a pregnancy test.
• If client is pregnant, refer to for follow-up care

4 Adapted from Calgary Health Region (2001) C

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4. Outline your educational and counselling strategies with this client.
   - **Information about bacterial vaginosis.**
   - Need for follow-up with physician, nurse practitioner, or registered midwife for treatment and follow-up of symptoms.
   - Discuss STI risk and prevention with client.
   - Reinforce use of male or female condoms with regular birth control methods (e.g. pill, patch, depoprovera).
   - Need for regular Pap tests.
   - Answer questions.

**Case study #5**
A 62 year old aboriginal client presents for her Pap test. She has not been in for regular screening in the past. The client is very self-conscious about her body as she believes that she is overweight. She has developed a good trusting relationship with her RN who has recently been certified to do cervical screening. The history is taken and there are no signs to indicate that this will be anything other than a routine screening. Upon examination the client becomes tense and somewhat upset. The RN has trouble finding the clients cervix. The client continues to become more anxious and starts to cry, saying that the examination is painful.

1. What is the first priority for this client?
   - Prior to starting, continue to build on the positive relationship.
   - Obtain detailed history.
   - Discuss any concerns before the exam. Overweight or very tense clients pose a challenge and may be more difficult to examine.

2. With a nervous client, what are some ideas to promote comfort?
   - Provide the client the opportunity to look at the equipment.
   - Facilitate the client to retain her modesty by allowing her to leave on as many clothes as possible, including her shoes if she desires.
   - Ensure a comfortable examination.
   - Try an exam position that is most comfortable for the client.
   - If she hasn't emptied her bladder, have her void or empty again as this can increase her anxiety.

3. When the client starts to cry, what should you do?
   - Stop the exam and discuss how she wants to proceed.
   - Change this size of the speculum if required.
   - Assess with if the speculum is too warm or cold? Check this with the client and after she is ready to proceed, proceed slowly.

4. The cervix is pink and fleshy, but has some "bumps on it. What might this be and what should you do?
   - May be nabothian follicles but assess appropriately to determine if they look like genital warts.

**Case study #6**
You work in a low socioeconomic inner city practice with multiple immigrant women, many of whom do not have English as a first language. A 65 year old client of East Indian background attends your office for the first time to get her blood pressure checked. She is a smoker. She has moved to stay with her son and help look after her grandchildren. She is mildly obese. She says that she
has had no Pap since having children (the last child was born 45 years ago), that she has only rare sexual activity with her husband of many years and why would she need a Pap.

She still has periods each month but they are getting heavier and closer together, i.e. q 3 weeks. When asked about previous Pap tests she said, I had a few when I was younger, in my 20's and they said one was abnormal, so I had to have more frequent examinations at the physician’s office”. She says that she really doesn't want any more Pap tests.

1. What if this client had had a hysterectomy, how would you deal with the idea of doing a Pap test?
   - Refer clients with total or subtotal hysterectomy due to biopsy confirmed high grade lesions or cervical cancer to their physician or nurse practitioner for follow-up. Women who have had a total hysterectomy for benign reasons (e.g. endometriosis) do not need to continue with their Pap tests.

2. What else would you like to know about this client, particularly in regard to her risk for cervical cancer?
   - Chief complaint at this time, past history.

3. How would you discuss the risk of cervical cancer with her?
   - Discuss relevant risk factors – e.g. current smoking, history of abnormal Pap tests, lack of regular Pap tests.

4. What if she agrees to have a basic assessment (e.g. blood pressure) but still refuses a Pap test—what would you do?
   - Gradually build up her trust in you and deal with the issues she has identified initially.
   - Discuss necessity of Pap test and ways to improve her comfort (e.g. having a companion/interpreter present during the exam).
   - May be helpful to explore language barriers and the meaning of the Pap test to her? Assess if there are any abuse issues that might pose doing a Pap test challenging for her and you?
# APPENDIX 7: Evaluation

## A: Learning Module Evaluation

Please complete the following evaluation of the Learning Module to help improve future revisions.

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<td>1. I achieved the learning module goals and objectives.</td>
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<tr>
<td>Explain</td>
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<tr>
<td>2. The learning module content increased my knowledge of cervical cancer, cervical cancer screening, and Pap testing techniques.</td>
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<tr>
<td>Explain</td>
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</tr>
<tr>
<td>3. The recommended readings increased my knowledge of cervical cancer, cervical cancer screening, and Pap testing techniques.</td>
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<tr>
<td>Explain</td>
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<tr>
<td>4. The Pap Test Videos enhanced my learning regarding how to perform a Pap Test.</td>
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<tr>
<td>Explain</td>
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<tr>
<td>5. The Pre/Post-Tests helped me to assess my knowledge and areas of improvement.</td>
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<tr>
<td>Explain</td>
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<tr>
<td>6. The Case Studies enhanced my learning regarding sensitive approaches to client examination and counselling.</td>
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<tr>
<td>Explain</td>
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<tr>
<td>7. The Assessment Tools were useful in assessing my skills and competencies.</td>
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<tr>
<td>Explain</td>
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</tr>
</tbody>
</table>

8. What did you find MOST useful about the learning module? [Answer]

9. What did you find NOT useful about the learning module? [Answer]

10. What further information would be helpful to include in this module? [Answer]

---

Do you consent to AHS-CSP Health Promotion Unit contacting you to speak to you directly about the learning module to help us evaluate the resource? Yes _____ No _____

If “Yes” please write down your contact information.

Name: ____________________________ Phone#: ____________________________

Email address: ____________________________

Thank you for completing Part A of this evaluation.

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B: Practicum Evaluation

Please complete the following evaluation of the Practicum to help improve future RN practicum experiences.

<table>
<thead>
<tr>
<th>See Note5</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My practicum objectives were met. Explain</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. I had the opportunity to participate in a variety of clinical situations. Explain</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I was given the opportunity to discuss any issues raised during my practicum. Explain</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I had the opportunity to develop adequate assessment skills. Explain</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I had the opportunity to develop adequate physical exam, speculum exam, and Pap test skills. Explain</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I had the opportunity to develop adequate counselling and education skills. Explain</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Overall, the Pap test practicum was valuable.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. What did you find MOST useful about the practicum?</td>
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<tr>
<td>9. What did you find NOT useful about the practicum?</td>
<td></td>
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</tr>
<tr>
<td>10. What further information would be helpful to prepare Preceptors?</td>
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</tr>
</tbody>
</table>

Thank you for completing Part B of this evaluation.

○ copy to your manager

---

5 Adapted with permission from Family Planning Queensland (November 2003). RN Pap Smear Provider Module: Clinical Handbook & Portfolio. Evaluation of Pap Smear Provider Clinical Attachment Form (Question #1,3,4,7, 9)
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