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NSW Sexually Transmissible Infections Programs Unit 2013
NSW Health Sexual Health Services
Standard Operating Procedures Manual 2013

NSW Sexually Transmissible Infections Programs Unit (STIPU)

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www.stipu.nsw.gov.au

May 2011
(Revised October 2013)
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INTRODUCTION

AIM

To provide a NSW Publicly Funded Sexual Health Services Standard Operating Procedures Manual (NSW SH SOP) that can be utilised or adapted at a local level.

BACKGROUND

The NSW Sexually Transmissible Infections Strategy 2016-2020 provides a state-wide framework for sexual health programs and focuses on preventing and managing sexually transmissible infection (STI). The Strategy outlines a number of objectives designed to achieve the overall goals. These include:

- promoting best practice standards within publicly funded sexual health clinics
- improved communication and development of referral pathways and protocols between publicly funded sexual health clinics and general practice
- increased support for sexual health service provision by general practice.

Many aspects of the Strategy require partnerships with agencies across the health and community sector, and across health service boundaries. Accordingly, the NSW Sexually Transmissible Infections Programs Unit (STIPU) was established by NSW Health to assist coordination and, where appropriate, to directly implement certain state-wide programs and initiatives.

Sexual health services in NSW provide a range of clinical, counselling and educational and health promotion activity. These services are provided in a range of settings with diverse models of service delivery and utilising various levels of human and financial resources. Services are delivered by medical and nursing staff, counsellors, Aboriginal sexual health workers, health promotion officers and administration staff. The sexual health workforce has varying levels of training, education and experience and a multidisciplinary approach to service provision is considered best practice.

Until development of this NSW Sexual Health Services Standard Operating Procedures Manual (NSW SH SOP) each of the NSW sexual health clinics had maintained separate clinical guideline manuals, in some cases with several different manuals in use within one former Local Health District (LHD).

The NSW SOP reflects priority areas as outlined in the STI Implementation Plan and NSW HIV strategy. PFSHS have a number of tasks is to enable easier and more frequent HIV and STI testing through innovative models of STI and HIV care. To provide leadership and support to general practice around HIV and STI care and management including contact tracing support. To create partnerships that builds the capacity of primary health care services to provide STI testing as part of routine care. These alternative services include mental health, drug health, youth health and antenatal services. It is important to note that young people are an important priority group identified in the STI Implementation Plan as they experience a variety of barriers to accessing sexual health services however PFSHS on their own do not have the capacity to provide sexual health services to all young people therefore partnerships and capacity building with general practice and alternate primary care providers is especially important.
Clinical guideline manuals are updated on a regular basis, usually by senior nurses (Clinical Nurse Consultants or Nurse Unit Managers) and form the basis of quality improvement (QI) activity and guidance for clinical practice. This document provides generic guidelines which may be adopted or amended to meet service requirements. Services may choose to adopt the manual in its entirety without amendment if it meets local areas service requirements and LHD clinical governance requirements.

Whilst the NSW SH SOP was instigated and developed by senior nurses from NSW Publicly Funded Sexual Health Services (PFSHS), the document has application for other disciplines and health providers involved in the prevention, STI and HIV. It is envisaged that through regular review, the document will evolve and expand to further represent a multidisciplinary, best practice approach across the continuum of care.

**DEVELOPMENT**

The NSW SH SOP was developed by the Senior Nurses Technical Group (SNTG) representing the nine former AHS with NSW STIPU providing secretariat support. A generic list of policies and procedures used across NSW was initially generated and the group divided tasks to review and revise the policies and procedures to reflect best practice standards and state wide practice against a standardised template.

**IMPLEMENTATION**

The NSW SH SOP can:

- enhance improved outcomes for clients by ensuring consistent approaches in client management, information provision and in service delivery
- enable benchmarking between services, promoting best practice approach including suitable outcomes
- reduce the time spent by individual senior nurses in each Local Health District (LHD) in developing and reviewing manuals
- ensure better use of resources and staff
- promote a standardisation of the sexual health workforce skills enabling enhanced staff sharing within and between LHD
- support innovation in models of service delivery within PFSHS
- ensure up-to-date clinical guidelines for use that are based on best practice and evidence based approaches in sexual health.

The input of psycho-social practitioners should be actively sought in the care of clients, where needed. While the inclusion of psycho-social practitioners in multidisciplinary teams should be considered best practice, it is recognised that resource poor settings are under staffed. In those settings, psycho-social support of clients should be sought from agencies external to the sexual health clinics or from counsellors employed in better resourced health settings within the State. Alternatively, in resource poor settings, nurses should be provided with extensive training in the delivery of first line psycho-social interventions and their practice supervised by senior practitioners.

The NSW SH SOP provides links to other sexual health guidelines, manuals and resources as referenced throughout the document, including the NSW Sexual Health Infolink (SHIL) – a NSW funded information and referral line staffed by experienced sexual health nurses. It operates Monday–Friday 9.00am–5.30pm, phone 1800 451 624
REVIEW PROCESS

A revision and review guide has been developed that will continue to draw on the expertise of the SNTG to ensure that best practice standards are maintained within the document.

As part of the review process:

- the SOP Manual will be fully reviewed every 3 years; upon completion of the 3 year review the manual will be tabled at the Publicly Funded Sexual Health Services Working Group and the Publicly Funded Sexual Health Services (PFSHS) Medical Directors Committee meeting in consultation with STIPU
- the SOP Manual will undergo yearly review for critical updates; any individual SOP requiring significant changes will be discussed at the PFSHS Medical Directors Committee meeting.
- see table below for review history.

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RESPONSIBILITIES

The NSW SH SOP provides generic guidelines for the operation of sexual health services; however, it is the responsibility of sexual health staff, management and services to ensure that they are operating within the policies, procedures and legal requirements of the individual LHD or organisation.
ENDORSEMENTS

The NSW SH SOP has been endorsed by the NSW STI Programs Unit Advisory and Working Groups and the NSW Sexual Health Medical Directors.

Reviewers 2013:

Dr Eva Jackson, Director Nepean Clinical Director, Staff Specialist, Sexual Health & HIV Services, Nepean Blue Mountains Local Health District

Clinical Associate Professor Katherine Brown, University of Sydney & University of Wollongong Clinical Service Director, Ambulatory and Primary Health Care Clinical Service Division Illawarra Sexual Health

Dr Natalie Edmiston, Staff Specialist, NCAHS (Auditable Outcomes)

Dr Rosalind Foster, Postgraduate Fellow Sexual Health, SSHC (Auditable Outcomes)
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SECTION 1

CLINICAL
SECTION 1: CLINICAL

C1 ANOSCOPY

1. Purpose and scope
To provide procedural guidelines related to the performance of anoscopy.

2. Outcomes
Anoscope is used appropriately to perform sexual health assessment.
Ensure client safety and comfort is maintained.

3. Procedure
Anoscopy should only be performed by a practitioner who has undertaken formal training in anoscopy.

Indications
Clients with abnormal anal cytology. Those who should be offered screening include:
- high risk clients such as MSM
- immunosuppressed clients
- women with a past history of CIN, VAIN or VIN
- patients with perianal condylomata with unusual appearance

Contraindications
Anoscopy should not be performed on an imperforate anus.
Caution should be exercised on patients with recent anal or rectal surgery.

Equipment
Where possible, single use equipment is recommended for all sexual health procedures to avoid cross contamination.1
Plastic disposable anosopes are recommended.
Prepare the following equipment:
- plastic disposable anoscope
- lubricating jelly
- gloves
- tissues
- light source.

Examination:
1. Explain the procedure and tell the client what they may feel (may cause the feeling of moving the bowels).
2. Ask client to move into left lateral position with the top leg flexed at the knee and hips.

3. Ask client to retract their right buttock to aid perianal inspection.

4. Inspect perianal skin looking for rashes, warts, ulceration, excoriation, haemorrhoids, fissures, bleeding and/or discharge.

5. Perform a digital rectal examination prior to anoscopy to check for pain, bleeding, or mass obstruction. Per rectum (PR) examination of prostate, lower rectum if indicated.

6. Generously lubricate the anoscope and anal verge with lubricating jelly.

7. Introduce the anoscope gently and advance it slowly with a slight side-to-side twisting motion while the patient bears down. If resistance due to contraction of the external anal sphincter is significant, constant pressure on the anoscope eventually fatigues the muscles and permits insertion.

8. Maintain pressure over the obturator with the thumb during insertion to keep the obturator from slipping out. To avoid pinching the anal mucosa, completely remove the anoscope and reinsert the device if the obturator slips or falls out during insertion.

9. Remove obturator.

10. As the anoscope is slowly withdrawn, the anal mucosa can be visualised over the entire circumference of the can.

11. Assess the physical appearance including:
   - colour and texture of rectal mucosa
   - presence of discharge
   - presence of ulceration
   - bleeding
   - lesions.

12. Collect appropriate swabs from rectal mucosa as indicated by the clinical history and examination.

13. Remove the anoscope. As the instrument is withdrawn at the anal verge, spasm of the external sphincter may lead to rapid expulsion. Firm counter pressure prevents expulsion. Reinsertion may be required for adequate visualisation of the anal verge.

For complicated cases in which the anatomy is distorted, the patient cannot tolerate the procedure, or the attempt at foreign body removal was unsuccessful, referral to a specialist for an examination under anaesthesia or admission to the hospital is indicated.

4. Documentation

Document clinical findings, tests attended, management, any adverse client events and follow-up plan in the medical record.
5. Definitions

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>CIN</td>
<td>Cervical Intraepithelial Neoplasia</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>PR</td>
<td>Per Rectum</td>
</tr>
<tr>
<td>VAIN</td>
<td>Vaginal Intraepithelial Neoplasia</td>
</tr>
<tr>
<td>VIN</td>
<td>Vulval Intraepithelial Neoplasia</td>
</tr>
</tbody>
</table>

6. References


C2 CERVICAL SCREENING AND ABNORMAL PAP TEST MANAGEMENT

1. Purpose and scope
To provide procedural guidelines in order to achieve the best health outcomes in the management of abnormal Pap test results.

2. Outcomes
Ensure best practice is demonstrated in managing abnormal Pap tests for clients who access sexual health services.

3. Procedure

Note Changes to National Cervical Screening Program likely in 2017:
In 2014 the Medical Services Advisory Committee (MSAC) recommended to the Australian Government, significant changes to the National Cervical Screening Program. It is anticipated that these changes will be accepted by government; however a change to the program is not expected until 2017. A summary of the recommendations include:

- an HPV test should be undertaken every 5 years;
- cervical screening should commence at 25 years of age;
- women should have an exit test between 70 and 74 years of age; and
- women with symptoms (including pain or bleeding) can have a cervical test at any age.

Until such time as an official change has been made, practitioners are advised to continue to implement the current program as described below.

Cancer Screening: Future changes to cervical screening

All women aged 20–69 should be informed of the recommendation to undertake 2 yearly cervical screening (Pap test). The Pap test may be performed at the sexual health service for those in priority populations or opportunistically otherwise refer woman to a General Practice or Women's Health service.

All women having Pap tests should be informed about the NSW Pap Test Register. The Register acts as a safety net to remind women and their health practitioner when a cervical test is overdue and the Cancer Institute NSW can ensure that women who return an abnormal test result receive the necessary follow-up care.

Women living with Human Immunodeficiency Virus (HIV) are recommended to have annual Pap tests. There is no provision for annual Pap Test Register reminders for women living with HIV. Services will need to consider local reminder systems.

Refer to:

National Health and Medical Research Council 2005, Screening to prevent cervical cancer: guidelines for the management of asymptomatic women with screen-detected abnormalities.

The guidelines address the current state of cervical cancer in Australia; the natural history of cervical neoplasia and terminology for cervical cytology; management of squamous abnormalities, glandular abnormalities and special clinical circumstances; and psychosocial, economic and implementation issues. A summary of the guidelines is provided below.
Management of low-grade squamous intraepithelial lesions (LSIL):

Women aged 29 years or less:

- a woman with a Pap test report of possible or definite low-grade squamous intraepithelial lesions (LSIL) should be recommended for a repeat Pap test in 12 months. If the women is HIV positive she should be referred for colposcopy
- a woman aged 30 years or more with a Pap test report of LSIL, without a history of negative smears in the preceding 2 to 3 years, should be offered either immediate colposcopy or a repeat Pap smear within 6 months.

Subsequent management of LSIL:

The results of the repeat cytology will determine subsequent management:

- if the 12-month repeat Pap test is reported as normal, the woman should have a further repeat Pap test in 12 months (i.e. 24 months after the index smear)
- if the 12-month repeat Pap test is suggestive of LSIL (possible or definite) the woman should be referred for colposcopic assessment
- if the 12-month repeat Pap test is suggestive of high-grade squamous intraepithelial lesions (HSIL) (definite or possible), the woman should be referred for colposcopic assessment
- referral for colposcopy should be considered for a woman if she has 2 LSIL / possible LSIL reports (at least 12 months apart) within a 3-year timeframe, regardless of intervening normal cytology reports.

Management of high-grade squamous intraepithelial lesions (HSIL):

- a woman with a Pap test report of definite or possible HSIL should be referred to a gynaecologist or other qualified colposcopist for colposcopic assessment and targeted biopsy where indicated.

Management of squamous cell carcinoma (SCC) of the cervix:

- a woman with a Pap test report of SCC should be referred to a gynaecologist or a gynaecological oncologist if available for urgent evaluation, ideally within 2 weeks.

Management of women previously treated for HSIL:

- a woman previously treated for HSIL requires cervical cytology followed by colposcopy at 4–6 months after treatment.
- cervical cytology and human papilloma virus (HPV) typing should then be carried out at 12 months after treatment and annually thereafter until the woman has tested negative by both tests on 2 consecutive occasions. The woman should then be screened according to the recommendation for the average population
- a women already undergoing annual cytologic review (Pap test) for follow-up for previously treated HSIL may be offered cervical cytology and HPV typing. Once she has tested negative by both tests on 2 consecutive occasions she should then be screened according to the recommendation for the average population.

Management of unsatisfactory Pap smears:

- a woman with an unsatisfactory Pap test report should have a repeat smear in 6–12 weeks, with correction, when possible, of the problem that caused the unsatisfactory smear (such as infection or pregnancy).

Follow-up of women who have undergone a hysterectomy:

- women who have had a hysterectomy for high-grade cervical abnormalities require continued screening because of their increased risk of vaginal neoplasia
• women with a history of normal Pap tests who have had a hysterectomy for benign disease (menstrual problems, prolapse, fibroids) do not require further Pap tests unless clinically indicated by symptom history. In women who have had a past history of invasive disease recommendations vary. Refer to Family Planning NSW 2011. Reproductive and Sexual Health: an Australian clinical practice handbook. 2nd edition.

Women who have clinical symptoms warranting further investigation should be assessed for gynaecological referral.

National Standards for Nurse Pap Test Providers relate to the legal and ethical responsibilities and may be used in assessing practice.

Refer to Appendix C2.1 for a flow chart of the pathway for the management of abnormal Pap smear results – high and low grade.

4. Documentation

Documentation of abnormal test result in medical record and action plan discussed with client.

Copies of referral letters sent are included in medical record.

5. Auditable Outcomes

100% of results are followed up according to the National Health and Medical Research Council 2006, Screening to prevent cervical cancer: guidelines for the management of asymptomatic women with screen-detected abnormalities, Australian Government, https://www.nhmrc.gov.au/guidelines-publications/wh39

6. Definitions

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HPV</td>
<td>Human Papilloma Virus</td>
</tr>
<tr>
<td>HSIL</td>
<td>High-grade Squamous Intraepithelial Lesions</td>
</tr>
<tr>
<td>LSIL</td>
<td>Low-grade Squamous Intraepithelial Lesions</td>
</tr>
<tr>
<td>Pap</td>
<td>Papanicolaou test used to detect premalignant and malignant processes in the cervix</td>
</tr>
<tr>
<td>SCC</td>
<td>Squamous Cell Carcinoma</td>
</tr>
</tbody>
</table>
7. References


8. Appendix

APPENDIX C2.1 – Pathway for the management of abnormal Pap smear results – low and high grade

PATHWAY FOR THE MANAGEMENT OF ABNORMAL PAP SMEAR RESULTS – LOW AND HIGH GRADE

If you are over 30 years of age and:
- have not had any Pap smears in the last two of three years; or
- you have had an abnormal result in that time
you should be offered a repeat Pap smear in six months or a colposcopy*

**PAP SMEAR**

- Low grade (definite or possible)
  - Repeat Pap smear at 12 months
  - Normal (most women will return to a normal result over time)
  - Repeat Pap smear at 12 months

- High grade (definite or possible)
  - Colposcopy
  - Treatment as required
  - Repeat Pap smear and colposcopy 4–6 month after treatment
  - Repeat Pap smear and HPV test in 12 months after treatment
  - When both HPV test and Pap smear are negative for two years in a row

**NORMAL**

- Repeat Pap smear at 12 months
- Normal

*You can discuss these options with your doctor, nurse or health worker and decide which option is best for you.

Ref Cancer Institute NSW 2013, Pathway for the management of abnormal Pap smear results – high and low grade, Cervical Screening NSW
C3 CONTACT TRACING

1. Purpose and scope
To provide information and support about contact tracing for health care providers involved in the diagnosis and management of sexually transmissible infections (STI) and blood borne viruses (BBV) including HIV.

2. Outcomes
Clients diagnosed with an STI, HIV or another BBV will be advised of the need for contact tracing and assisted where necessary, to notify their contacts in a timely and sensitive manner. Potential outcomes are the provision of information, testing and treatment to contacts and prevention of re-infection of the index.

3. Procedure
Refer to:
Australasian Contact Tracing Manual
The following principles should be followed when discussing contact tracing:

- contact tracing is part of good clinical care
- patients should be offered supportive non-judgemental assistance to contact as many sexual partners as possible.

Process
i. Identify the contacts
   a. Consider the time periods over which contacts require notification as these vary by STI (refer to STI Contact Tracing Tool for guidance on trace back periods).
   b. Attempt should be made to quantify and record the number of contacts that require notification.

ii. Decide on method
   a. In most cases contact tracing can be undertaken by the index case (patient referral) with support from the health care provider.
   b. In the following situations provider referral (health care provider contacts partners on behalf of the index patient) should be considered:
      • HIV, Syphilis and Gonorrhoea due to higher morbidity
      • casual or ex-partners as research shows they are less likely to be notified
      • repeat infections as a partner may not have been tested and treated
      • within Aboriginal communities due to stigma and issues around confidentiality
      • incarcerated or detained partners as they are more difficult to contact
      • if a patient requests provider referral or seems reluctant, lacking in confidence or worried about a partner’s reaction.
   c. When conducting provider referral, every attempt should be made to protect the confidentiality of the index person. This may sometimes mean requesting that another clinic initiate the contact tracing process, if the location of the clinic would de-identify the index case.
iii. Follow up

a. If the index case chooses to notify their own partners it is recommended to schedule a follow-up phone call or visit to determine if the patient was able to notify their partners. If contacts still require contacting, offer provider referral.

b. The number of contacts successfully notified should be recorded at follow-up.

Resources

The following resources are available to support index cases, their partner/s and health care providers.

Patient

a. www.letthemknow.org.au – this website has information on STIs and practical tips for patients on how to inform partners. Offers the option of notifying contacts via email, SMS or letter either personally or anonymously.

b. www.thedramadownunder.info – a website for men who have sex with men (MSM) with information about STIs experienced by gay men. It offers the option of notifying contacts via email or SMS either personally or anonymously.

c. www.bettertoknow.org.au – a website for young Aboriginal People with information about STIs, how and where to access STI testing and anonymous partner notification services via email or SMS.

Health Care Provider

a. NSW Contact Tracing Tool


f. NSW Sexual Health Infolink on 1800 451 626 Monday–Friday, 9:00am–5:30pm

4. Documentation

Documentation of the contact tracing process is important and must be kept for both clinical and medico-legal purposes. Information about a contact(s) is legally confidential information and accordingly must be kept securely.

The following should be included in client’s medical record:

- the contact tracing discussion
- the number of contacts to be notified
- the method chosen
- arrangements for follow-up
- at follow-up, the number of contacts successfully notified.
Provider referral

Health care workers undertaking the process of notifying a contact of their potential risk exposure does not give rise to a doctor / patient relationship. Therefore a separate medical record for a contact is not required as well according to NSW Health Policy the registration of contacts as clients of the service is not required (NSW Health Client Registration Policy PD 2007_094 http://www0.health.nsw.gov.au/policies/pd/2007/PD2007_094.html).

Information such as the contact tracing discussion, including any information provided by the contact regarding their infection status or further follow-up, are legally confidential information about the contact person. It would also be health information regarding the contact person for the purposes of the Health Records and Information Privacy Act 2002.

It is recommended that the contact tracing process be documented as a separate entry from progress notes and filed at the back of the medical record, facing backwards. This provides separation of the contact tracing entry within the patient’s health record. The entry should identify the information as a record of contact tracing, advise that details are not to be disclosed to the index patient and include an appropriate contact officer in the event an index patient requests access to their medical record through the Freedom of Information Act (an example of a Contact Tracing Proforma has been provided in (Appendix C3.1).

Requests for PFSHS to Undertake HIV/STI Contact Tracing on Behalf of External Health Care Provider

When the details of contacts are forwarded to a service in order for the service to undertake contact tracing, a similar process of documentation and storage should be established that ensures the records are confidential and secure. Information should be filed in a secure location.

Electronic and scanned medical records of contact tracing

For electronic or scanned records of contact tracing additional security measures may need to be considered by individual Local Health Districts.

5. Auditable Outcomes

100% of index cases with chlamydia, gonorrhoea, syphilis and HIV have contact tracing discussion and documentation of the discussion.

100% contact tracing outcome documented for index cases with HIV, gonorrhoea and syphilis.

Notification index = number of contacts notified / number of index cases. For index cases with Chlamydia, Gonorrhoea and Syphilis, a notification index of 0.7 minimum.

6. Definitions

<table>
<thead>
<tr>
<th>BBV</th>
<th>Blood Borne Virus</th>
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</thead>
<tbody>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmissible Infection</td>
</tr>
</tbody>
</table>

7. References


8. Appendices

APPENDIX C3.1 – example Provider Contact Tracing Form

EXAMPLE PROVIDER CONTACT TRACING FORM

<table>
<thead>
<tr>
<th>DATE:</th>
<th>Put index case number here only – in case of internal provider referral. For external provider referral put name and number of external referrer.</th>
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</thead>
<tbody>
<tr>
<td>CONDITION:</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>SHS: (if known)</td>
<td>LETTER SENT:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADDRESS:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHONE:</td>
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</table>

COMMENTS: (progress note can be attached if required)

________________________________________________________________________

________________________________________________________________________

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<tr>
<th>CONTACTS</th>
<th>CONTACTED</th>
<th>ATTENDED</th>
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<td>SHS: (if known)</td>
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<td></td>
</tr>
<tr>
<td>PHONE:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

COMMENTS: (progress note can be attached if required)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

NAME:

SIGNATURE:

1 Contact tracing records are to be kept confidential and secure
2 In the event a request is made for patient to access medical records please forward request to
C4 CRYOTHERAPY

1. Purpose and scope

To provide information and procedural guidelines on the safe application of cryotherapy for clinically diagnosed external genital warts and Molluscum Contagiosum virus (MCV).

2. Outcomes

Liquid nitrogen and/or compressed carbon dioxide used for cryotherapy will be applied, stored and handled safely.

3. Procedure

Refer to:

NSW Health Infection Control Policy (PD2007_036)


3.1 Safe Handling

Any person handling liquid nitrogen or compressed carbon dioxide must be aware of the potential occupational health hazards; risks involved in use; controls to minimise these risks; spill control; emergency response and incident reporting procedures. Refer to Liquid Nitrogen Safe Work Practice – see Appendix C4.1. Any person handling liquid nitrogen or a compressed carbon dioxide unit must be fully oriented to the safety techniques in order to safely and competently perform duties. Orientation and accreditation of clinical staff that will use these substances and devices is the responsibility of the appropriate line manager.

When transferring liquid nitrogen or compressed carbon dioxide, safety precautions are maintained at all times.

Personal protective equipment, including thick gloves and safety glasses should be used when handling.

Avoid confined areas and ensure adequate ventilation.

3.2 Application

Proceed as follows:

- cryotherapy destroys the wart tissue by freeze / thawing. It is suitable for external dry or moist warts and can be used in pregnancy
- identify lesion to be treated
- prepare equipment as per availability – may include:
  - canister of liquid nitrogen with cryotip
  - compressed carbon dioxide and acetone decanted into a single use metal pot with loosely wound cotton on wooden applicator
  - personal protective equipment
- position client for comfort and accessibility to areas being treated
- freeze full thickness of the wart / MCV lesion until there is whitening of the surrounding skin area for 2 mm. Use a freeze, thaw, freeze technique with lesions held frozen for 10–30 seconds
- allow to thaw and repeat up to 3 cycles depending on size and number of warts / MCV. Treatment of large warts or areas at 1 time can create wound care problems
- repeat treatment fortnightly until the warts / MCV have resolved
- reassess after 6 treatments or earlier if not responding
- use of topical anaesthesia cream / gel to reduce pain may facilitate cryotherapy.

### 3.3 Aftercare instructions for client

Advise as follows:

- advise that blisters may form on the treated area
- advise that pain and necrosis is common and bathing with salt water, preferably twice daily (2 handfuls of salt per bath or 2 tablespoons in a large bowl) may promote skin healing and reduce irritation
- keep skin clean and dry
- advise regarding adverse effects including possible balanoposthitis, irritation, local oedema, necrosis, ulceration and pain especially when area thaws. Both hyper and hypo pigmentation can occur and is usually temporary
- genital warts may recur
- avoid sexual contact or wear condoms after treatment until lesions have resolved
- condoms may reduce risk of transmission.

### 4. Documentation

All treatments given, immediate effects and verbal aftercare instructions are to be documented in the medical record.

### 5. Auditable outcomes

100% of patients / clients with genital warts and MCV offered STI screen at first presentation:
Target 100%

### 6. Definitions

| MCV       | Molluscum Contagiosum virus |

### 7. References


8. Appendix

**APPENDIX C4.1 – Example of Liquid Nitrogen Safe Work Practice**

<table>
<thead>
<tr>
<th>SWP#</th>
<th>Clinic Name</th>
<th>Facility</th>
<th>Risk Assessment No</th>
<th>Risk Level</th>
<th>Date Developed</th>
<th>Date Review Due</th>
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</thead>
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<tr>
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<td></td>
<td></td>
<td></td>
<td>High</td>
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</tbody>
</table>

**Risk of Injury:**

Severe burns (frostbite) to skin/eyes/lungs:

Eye

If liquid nitrogen is splashed into the eyes, immediately flush with large quantities of tepid water or eye irrigation solution. Attend Emergency Department and complete incident form.

Skin

Irrigate affected area with tepid water for 15-30 minutes. Apply sterile dry dressing. Attend ED and incident management reporting. Refer to Cryotherapy Standard of Practice.

Dizziness, unconsciousness, asphyxiation (liquid nitrogen can displace oxygen in air leading to danger of asphyxiation)

**Safety Rules:**

Move liquid nitrogen away from opening doors to prevent users being knocked while handling.

Ensure area is well ventilated when filling/opening cryospray. Report all spills/leaks immediately.

Alert other staff that filling process is underway

Ensure appropriate PPE is worn – full face shield, long sleeves, gloves and covered shoes

Avoid handling open cryospray units near door to lab

Do not invert canister after filling

**Job Steps:**

Place staff warning sign on outer lab door

Don PPE, ensure covered shoes are worn

Open empty cryospray units in preparation for filling

Fill each unit separately from storage canister to approximately ¼ full

Replace top of cryospray unit immediately after filling

Place cryospray units in holding receptacle on bench

When using cryospray ensure PPE is worn

**PPE Required:**

- Face shield must be worn
- Hand protection must be worn
- Foot protection must be worn
C5 EMERGENCY CONTRACEPTION

1. **Purpose and scope**

To provide guidelines on the assessment and management of women requiring hormonal emergency contraception.

2. **Outcomes**

Provide indications for use of hormonal emergency contraception.

Provide information on potential side effects

Provide access to information on contraceptive options.

3. **Procedure**

Emergency contraception (EC) is sometimes referred to as post coital contraception. It is a safe way to reduce the risk of pregnancy after unprotected sexual intercourse, sexual assault or potential contraceptive failure (e.g. missed combined oral contraceptive pills, early removal of diaphragm, condom break).

There are 2 methods of emergency contraception available. Hormonal EC and non-hormonal EC (copper IUD). This procedure refers only to hormonal Levonorgestrel Emergency Contraceptive Pill (LNG ECP).

The LNG ECP is available in 2 kinds of packages: 1 contains a single pill with a dosage of 1.5 mg, and the other contains 2 pills of 0.75 mg each.

LNG ECP is available over the counter at pharmacies without a prescription (S3), however cost and access to a pharmacy may be barriers to access for some women.

3.1 **Assessment**

All women attending the service should be asked about last unprotected sexual intercourse and current contraceptive method. Where a woman has had unprotected vaginal intercourse in the past 120 hours (5 days) and is not using other contraception, or has missed pills in an oral contraceptive pill cycle, or has had another contraceptive failure, provide information about LNG ECP. LNG ECP is most effective in the first 24 hours.

The only absolute contraindications to LNG ECP are an established pregnancy or allergy to the medication components.

A pregnancy test can be performed to rule out an established pregnancy prior to administration.

3.2 **LNG ECP Regimen**

Women should take LNG ECP as a single dose of 1.5 mg. If using a package that contains 2 pills of 0.75 mg LNG, a woman should take both pills at the same time. Note the labels on 2-pill ECP packages specify that the second pill should be taken 12 hours after the first. However, these labels do not reflect current scientific information.

Women should take the 1.5 mg LNG ECP dose as soon as possible after sex, but the treatment may be used up to 5 days after the coital act. Concomitant use of drugs that induce the CYP3A4 pathway such as some antiepileptic s, protease inhibitors, and herbal preparations may increase the metabolism of levonorgestrel. An increased dose of LNG ECP may be required.
Repeated use poses no known health risks, apart from side-effects such as menstrual irregularities although regular use of ECP as an ongoing contraceptive method is not recommended because other methods are more effective.

Additional information on indications, administration and side effects are provided in the Sexual Health and Family Planning Australia 2012, Contraception: an Australian clinical practice handbook, 3rd edition.

Note: Please refer to the following Sexual Health and Family Planning Australia statement regarding international reports on reduced efficacy of ECP in women weighing over 75kg. At time of writing there is insufficient evidence to conclude that the efficacy of the emergency contraceptive pill in women with higher BMIs is reduced to the extent that it should not be offered to these women.


3.3 Action of LNG ECP

Emergency contraceptive pills work before pregnancy by preventing/delaying the release of an egg (ovulation) or by stopping the egg and sperm from meeting. Extensive research on how LNG ECP work suggests that interference with ovulation is the primary and possibly the only mechanism of action. ECPs do not have any effects after fertilisation. ECPs cannot terminate or interrupt an established pregnancy and will not stop a fertilised egg from implanting in the uterus, nor can they harm a developing embryo. ECPs are ineffective once implantation has begun.

3.4 Follow up

Provide information on LNG ECP including side effects and discuss ongoing contraceptive needs. Information about all available methods is located in the Sexual Health and Family Planning Australia 2012, Contraception: an Australian clinical practice handbook, 3rd edition. It is recommended all sexual health services have copies of this resource available.

Advise a review in 3–4 weeks if:

- amenorrhea
- there is a high risk of pregnancy
- ongoing hormonal contraception is started immediately after LNG ECP
- LNG ECP used more than once in the cycle
- the next menstrual period is more than 7 days late
- the next menstrual period is unusual in some way (increased spotting before or after, unusually light, painful or prolonged)
- consider incubation periods when discussing STI screening.

4. Documentation

Document medication orders and administration on medication chart. For a list of medications which can be given under standing orders refer to section C9 MEDICATION – ADMINISTRATION OF MEDICATIONS ACCORDING TO STANDING ORDERS AND NURSE INITIATED MEDICATIONS

Findings from history and assessment must also be documented in the medical record, including assessment and ability to give informed consent for young people.
5. Auditable outcomes

100% of women reporting unprotected vaginal sexual intercourse within the previous 5 days, and no other contraceptive method or contraceptive failure, have documented evidence of being given information about emergency contraception.

6. Definitions

<table>
<thead>
<tr>
<th>EC</th>
<th>Emergency Contraception</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECP</td>
<td>Emergency Contraceptive Pill</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine Device</td>
</tr>
<tr>
<td>LNG ECP</td>
<td>Levonorgestrel Emergency Contraceptive Pill</td>
</tr>
</tbody>
</table>

7. References


C6 HIV MONITORING BY NURSES

1. Purpose and scope

To provide guidelines for nurses performing routine monitoring of clients with HIV infection, in the absence of a Medical Officer (MO). This is a guide only. Testing type and frequency should be directed by the needs of the individual, under medical supervision.

The purpose of monitoring is to assess the client’s general physical health, psychosocial wellbeing, as well as immune and virological status. More recently, as HIV is managed as a chronic condition, monitoring may also include screening for non-AIDS comorbidities such as cardiovascular, renal and bone disease in consultation with their primary care or shared care provider.

The purpose of serological monitoring is to:

- assess the need for prophylaxis for opportunistic infections
- assess the immunological response to treatment
- detect toxicities resulting from treatment.

2. Outcomes

Client monitoring is performed at appropriate intervals determined by their level of immune competence, or other individual needs, as identified by the MO.

Clients’ psychosocial needs, and lifestyle issues, which impact on health and wellbeing, are identified and addressed.

Clients with HIV understand the purpose of monitoring and are supported in their attendance for this via a system of scheduling and / or recall.

3. Procedure

(a) Obtain relevant history

<table>
<thead>
<tr>
<th>Table 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History</strong></td>
</tr>
<tr>
<td>Check patient identity and current contact details are correct.</td>
</tr>
<tr>
<td>Reason for attendance: routine review or other reason.</td>
</tr>
<tr>
<td>Symptom review: ask symptomatic and asymptomatic patients, as questioning may reveal overlooked or ignored problems.</td>
</tr>
<tr>
<td>Current medications, including combined antiretroviral treatment (cART), complementary therapies and over-the-counter medications.</td>
</tr>
<tr>
<td>Ask about adherence to cART (“It can be tricky remembering to take tablets every day. How many doses have you missed since your last visit?”).</td>
</tr>
<tr>
<td>Recreational drug use / cigarette smoking / use of alcohol.</td>
</tr>
</tbody>
</table>
### Table 1

<table>
<thead>
<tr>
<th>History</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full sexual history (2C12) regular / casual partners; condom use; last STI screen. For female patient, current contraception method.</td>
<td>STI screen as appropriate; provide safe sex advice; ensure patient is aware of preventing HIV transmission to others including NPEP and legal obligations re disclosure. Advise patient re facilitation of HIV transmission by concurrent STIs.</td>
</tr>
<tr>
<td>Mental health / depression (“How have things been going lately?”). Ask about work / relationships / domestic situation / finances.</td>
<td>Consider asking the following: For more than 2 WEEKS have you: 1. Felt sad, down or miserable most of the time? 2. Lost interest or pleasure in most of your usual activities? If yes to either, further anxiety and depression checklist here <a href="http://www.beyondblue.org.au/get-support/get-started-now">http://www.beyondblue.org.au/get-support/get-started-now</a> Refer to counsellor as appropriate; urgent action required if suicidal ideation or in crisis.</td>
</tr>
<tr>
<td>Healthy lifestyle</td>
<td>Check weekly diet intake and weekly exercise uptake; discuss healthy weight and BMI levels; weight circumference recommendations; discuss healthy eating and exercise guidelines.</td>
</tr>
<tr>
<td>Vaccination status</td>
<td>Check vaccination status and recent Hep BsAb result if available. Administer Fluvax annually and hep B vaccination, according to national and local guidelines and protocols. Pneumovax should be administered every 5 years.</td>
</tr>
<tr>
<td>Medical review</td>
<td>Ensure patient will return for review with S100 prescriber, sexual health physician or tertiary HIV consultant. Discuss need for shared care with General Practitioner (GP). Ensure accurate record of GP contact details for correspondence. <a href="https://www.nswhivsupport.org.au">NSW HIV Support Program</a> supports less experienced doctors to ensure patients have access to the 5 key support services 1. Appropriate clinical management, including treatment when clinically indicated 2. Psychosocial support 3. Counselling on HIV treatment and prevention of transmission to others 4. Assistance with contact tracing their partners who are at risk of infection 5. Linkage into relevant specialist and community services that assist in clinical management and maintaining safe behaviours</td>
</tr>
</tbody>
</table>
(b) Examination

Brief examination targeted to symptoms. Document findings and report to MO.

Genital examination if STI screen indicated and symptomatic; or self-collected swabs if asymptomatic.

For females, offer annual Pap smear.

Measure and record blood pressure, heart rate and temperature as required.

Measure and record weight, height, waist circumference, calculate BMI, perceived body shape changes.

NOTE: Abnormal findings in history and / or examination must be documented and reported to supervising MO as soon as possible.

(c) Venepuncture

Venepuncture is performed by an accredited Registered Nurse (RN), as guided by venepuncture procedure (2C14).

Specific blood tubes (e.g. clot activator, or anticoagulant types) required for each test will vary according to the laboratory used.

Ensure that:

- blood tubes are labelled according to local pathology handling requirements
- pathology forms state the specific tests required.

Table 2 (below) outlines the Laboratory tests to monitor HIV.

Two surrogate markers, the CD4 T-cell count and the plasma HIV RNA (viral load) are measured routinely to monitor the patient’s immune function and effects of their treatment. Note, recent changes now mean CD4 count is not used to determine when to start a patient on treatment.

The following clinical commentary provides clinical guidance on starting ARV therapy in people with HIV. Initiation of ART is determined by treating MO in consultation with the client.

Additional tests may be required, for example, for the detection of specific drug toxicities, antiretroviral resistance profiling, baseline or annual serological assessments. These should be performed in consultation with the treating MO.

Frequency of monitoring is client centred. It reflects the client’s stage in the journey of diagnosis and immune suppression, decision making regarding treatment, response to treatment and emergence of toxicities.

In general monitoring is performed 3 monthly; more frequently with decreasing CD4 count, at initial diagnosis, on commencing or changing treatment, or for the person who is experiencing significant side-effects or toxicities resulting from treatment.

### Table 2. Laboratory tests to monitor HIV

<table>
<thead>
<tr>
<th>Routine serological testing may include</th>
<th>Additional tests may include</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV viral load</td>
<td>Resistance testing at baseline, before initiating or changing treatment.</td>
</tr>
<tr>
<td>CD4 count (T cell subsets)</td>
<td></td>
</tr>
<tr>
<td>Full blood count</td>
<td>Serum amylase.</td>
</tr>
<tr>
<td>Liver function tests</td>
<td>Thyroid function test (annual).</td>
</tr>
<tr>
<td>Urea and electrolytes</td>
<td>Microbiological studies.</td>
</tr>
<tr>
<td>Fasting lipids (Cholesterol, HDL, LDL, triglycerides) at least annually</td>
<td>Cytomegalovirus serology at baseline.</td>
</tr>
<tr>
<td></td>
<td>Toxoplasmosis serology at baseline.</td>
</tr>
<tr>
<td>Fasting glucose or HbA1C</td>
<td>Hepatitis A serology at baseline and post vaccination.</td>
</tr>
<tr>
<td></td>
<td>Hepatitis B serology at baseline and as required referring to vaccination status.</td>
</tr>
<tr>
<td></td>
<td>Hepatitis C serology at baseline for all and annual for MSM.</td>
</tr>
<tr>
<td></td>
<td>HLA-B5701.</td>
</tr>
<tr>
<td></td>
<td>Vit D (250H) annual.</td>
</tr>
<tr>
<td></td>
<td>TB g IFN at baseline.</td>
</tr>
<tr>
<td></td>
<td>Calcium, phosphate, eGFR annual or more frequently if abnormal.</td>
</tr>
<tr>
<td>Syphilis serology (males)</td>
<td>Urine protein-creatinine ratio (uPCR) on random spot urine if urine dipstick screening ≥ + protein or eGFR &lt; 90.</td>
</tr>
</tbody>
</table>

### (d) Onsite clinical screening

Perform urinalysis (U/A) at least annually – check for protein, glucose and blood.

Consider performing rectal examination annually of HIV+ MSM due to increased risk of anal cancer.

Perform annual cardiovascular risk assessment for clients with HIV above 40 years of age. Although it is not validated to incorporate HIV as an independent risk factor, an example of a risk assessment tool is available at: [http://www.cvdcheck.org.au/](http://www.cvdcheck.org.au/)

Be aware that this tool may underestimate CVD risk in people living with HIV.

Client education is an important tool in assisting clients to understand the importance of routine laboratory testing and to make lifestyle changes to prevent chronic non-AIDS comorbidities.

A variety of resources are available from groups and community organisations such as ACON.


Clients should also be supplied with a schedule of follow-up appointments and supported through a recall system, if the clinic has facilities for this, to ensure that monitoring is performed in a timely manner.

### 4. Documentation

Complete consultation to be documented in medical record including:

- presenting issue
- psychosocial assessment; general and sexual health history
• presence / absence of any symptoms
• tests ordered and collected and sites screened
• findings of physical examination, vital signs, body measurements and urinalysis
• follow-up / management plan including referrals and advice given
• Contact tracing outcomes are documented per CT SOP

5. Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>cART</td>
<td>Combined Antiretroviral Treatment</td>
</tr>
<tr>
<td>CVD</td>
<td>Cardiovascular disease</td>
</tr>
<tr>
<td>eGFR</td>
<td>Estimated Glomerular Filtration Rate</td>
</tr>
<tr>
<td>ELISA</td>
<td>Enzyme-Linked Immunosorbent Assay</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>MO</td>
<td>Medical Officer</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmissible Infection</td>
</tr>
<tr>
<td>TB g IFN</td>
<td>Tuberculosis Gamma Interferon</td>
</tr>
<tr>
<td>U/A</td>
<td>Urinalysis</td>
</tr>
<tr>
<td>Western Blot</td>
<td>Confirmatory HIV test</td>
</tr>
</tbody>
</table>

6. References


C7 HIV TESTING

1. Purpose and scope

To provide procedural guidelines related to testing and diagnosis of HIV infection.

Refer to the following for additional information:
National HIV testing policy, Department of Health and Ageing, 2012
Disease Notification Infectious Diseases Ministry of Health NSW
Public Health Act 2010 No 127
Management of people with HIV infection who risk infecting others
Health Care Workers Infected with HIV, HBV or Hepatitis C
HIV Antibody Testing by Laboratories in NSW

2. Outcomes

HIV antibody testing is performed with the valid and informed consent of the individual.

3. Procedure

3.1 General Guidelines

The National HIV testing policy, Department of Health and Ageing 2012 guides the practice of Publicly Funded Sexual Health Services in NSW.

The general guidelines are as follows:

- performing HIV testing for immigration / insurance or workplace medicals is not the role of sexual health clinics. Clients should be referred to a General Practitioner
- a client with high risk of acquisition of HIV and without a previous HIV test or with relevant symptoms should have a physical examination, which includes their oral cavity and lymph nodes.

3.2 Explain the testing procedure

Anyone is eligible to receive their HIV result by phone should they elect this option after discussion with the health care worker (HCW) about the implications. (See also Use and Disclosure of Patients Information and Results Management section of this manual).

The client should be asked at each testing episode to elect how they would like to receive their results: ideally, in the case the client telephones the service or attends in person. Their election must be clearly documented in the patients’ medical record. In the case of unexpected and untreated positive results the client will be contacted asking them to attend the service.

A guide for health professionals around informed consent is available at http://testingportal.ashm.org.au/hiv
In addition, clinicians must provide the following information to clients as part of gaining informed consent:

- a client can elect how they receive their results
- if the clinician assesses the client as unsuitable for receiving phone results, this should be discussed
- if the client is contacted by the service asking them to attend in person, the clinician should not discuss the test result but discusses the need to attend for management.

### 3.3 Deferring an HIV Test

The gaining of informed consent process may lead to a decision not to test for HIV. Where the decision to defer testing is reached, follow-up appointments or counselling should be arranged as appropriate.

A person may not be able to cope with receiving a positive result if the client:

- is at high risk of self-harm
- is highly anxious
- has an unmanaged / undiagnosed psychiatric condition
- lacks social / emotional support structures and professional support structures are not readily available
- presentation is otherwise of concern to the clinician.

If a client who is not a resident of Australia (for example a traveller or visitor staying for less than 1 year) seeks an HIV test at the sexual health clinic, the clinician must consider the client’s:

- reasons for HIV testing away from their home country
- possible implications for the client upon their return
- knowledge of the availability of ongoing HIV medical care and treatment in their home country
- while it is not possible to fully understand the personal, legal, social and financial situation in relation to HIV in every country, extra care must be taken if considering HIV testing of clients who only remain in Australia for a short period of time. If the clinician is unsure if testing is appropriate, consult with a senior doctor or senior counsellor prior to proceeding. Deferring HIV testing until the client returns to their home country may be the best outcome.

### 4. Documentation

Consent to testing or the withholding of consent to testing should be clearly documented in the medical record.

Risk history should be documented along with any other issues raised during client consultation (e.g. presence / absence of symptoms, supports available, arrangements for result giving).

### 5. Auditable Outcomes

100% of clients provide informed consent for testing and this is documented in the medical record. 100% of appropriate clients are offered alternative results provision methods such as telephone, SMS, email.
6. Definitions

<table>
<thead>
<tr>
<th>HCW</th>
<th>Health Care Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
</tbody>
</table>

7. References

C8 LABORATORY PROCEDURES

1. Purpose and scope
To provide information and procedural guidelines on laboratory investigations performed in NSW Sexual Health Services.
Procedures for specimen collection are detailed in the relevant Standard Operating Procedures in this manual.
Refer to the following for additional information: NSW Health Policy Directive, Infection Control Policy.

2. Outcomes
Prompt diagnosis of STI and / or other genital infections is achieved in order to provide timely and effective management.

3. Procedure

3.1 Wet Film
The phase-contrast microscope is used for viewing wet films of vaginal discharge specimens and is especially useful in identifying trichomonas vaginalis.

Use of phase-contrast microscopy improves contrast differences between cells and the surrounding medium, by creating a dark image on a light background, making it possible to see cells without staining them.

The phase-contrast microscope is preferable to bright field microscopy when high magnifications are needed, or when the specimen is colourless or has fine details which do not show up colour well. Most living microscopic organisms are much more obvious in phase contrast.

The vaginal flora of healthy women consists primarily of lactobacilli that produce lactic acid and protect the vagina from microbial infections. In many women, small numbers of other bacteria such as anaerobes and gardnerella vaginalis are also present.

Infection of the vagina falls into 2 categories; vaginitis caused by trichomonas vaginalis and candida spp., and bacterial vaginosis which is associated with a mixed bacterial flora and a lack of lactobacilli, but is of uncertain aetiology. Microscopy is often the method chosen for diagnosing vaginitis and vaginosis because of its speed and specificity.

3.1.1 Equipment
Prepare the following equipment:
- glass slide
- cover slip
- pencil
- cotton tipped swab
- normal saline.

3.1.2 Procedure
Proceed as follows:
- label glass slide with client details as per local protocol, site and date
- insert a cotton tipped swab into the vagina and collect discharge from the posterior fornix
- gently tap the swab into a drop of saline on a glass slide
• place the cover slip over the sample
• register specimen according to laboratory requirements
• examine slide immediately after collection
• scan the slide on low power (x 10) to locate a representative area of the slide; change to high power objective (x 40)
• systematically scan the specimen beneath the entire cover slip, reading the slide in a minimum of 5 fields
• remove the slide from the microscope stage
• dispose of slide into sharps bin
• clean the microscope stage if needed
• document findings as per local laboratory and clinic requirements.

3.1.3 Documentation

Table 1. Documenting wet film findings

<table>
<thead>
<tr>
<th>Include presence or absence of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trichomonads</td>
</tr>
<tr>
<td>A protozoan, generally ovoid in shape and recognised by its jerky, swaying movement by means of flagellae.</td>
</tr>
<tr>
<td>Clue cells</td>
</tr>
<tr>
<td>Usually representing at least 20% of vaginal epithelial cells. Squamous vaginal epithelial cells that are covered with bacteria with the borders of the cells obscured owing to the presence of small rods or cocci.</td>
</tr>
<tr>
<td>Lactobacilli</td>
</tr>
<tr>
<td>The vaginal flora of healthy women consists primarily of lactobacilli which produce lactic acid and protect the vagina from microbial infections.</td>
</tr>
<tr>
<td>Hyphae +/- yeast spores</td>
</tr>
<tr>
<td>Suggests a diagnosis of candidal vaginitis.</td>
</tr>
<tr>
<td>Polymorphonuclear leukocytes</td>
</tr>
<tr>
<td>[PMNLs or polymorphs]. Quantify if present as per laboratory requirements, for example: 10 polymorphs per high powered field.</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>i.e. sperm, red blood cells.</td>
</tr>
</tbody>
</table>

3.2 Gram stain

The Gram stain allows the division of bacteria into 2 main groups; those that are Gram-positive (dark purple) and those that are Gram-negative (light red). The ability of Gram-positive bacteria to retain the purple colour reflects the thickness of their peptidoglycan-containing cell wall, which far exceeds that of Gram-negative bacteria.

Some bacteria cannot be classified using Gram stain, either because they lack cell walls (mycoplasma species), or because they are too small (Chlamydia species).

Gram staining consists of 4 components:
Primary stain (Crystal violet, methyl violet or gentian violet)
Mordant (Gram’s iodine)
Decolourizer (ethyl alcohol, acetone or 1:1 ethanol-acetone mixture)
Counterstain (Dilute carbol fuchsin, safranin or neutral red)

• the primary stain renders all the bacteria uniformly violet. The addition of Gram's Iodine results in formation of a dye-iodine complex in the cytoplasm. Gram +ve bacteria retain purple iodine-dye complexes after the treatment with the decolourising agent

The ability to obtain a good Gram stained smear depends on appropriate sample collection and producing an evenly spread specimen that is correctly fixed, stained and decolourised.

Sites for specimen collection for Gram staining may include male urethral, vaginal, endocervical, subpreputial and rectal.

3.2.1 Equipment
Prepare the following equipment:

- heat source
- glass slide
- crystal violet
- grams / Lugols Iodine
- Acetone or Ethanol
- carbolfuchsin / safranin counterstain
- blotting paper
- immersion oil for microscope
- lens tissue for microscope.

3.2.2 Procedure
Proceed as follows:

- don personal protective equipment; gown, gloves and goggles
- label slide prior to specimen collection
- sample from correct site, making a thin film on a clean glass slide, using a sterile loop or swab
- register specimen according to laboratory requirements
- air dry
- heat-fix the specimen on the glass slide by passing the uninoculated side of the slide over the heat source. The slide should not become too hot to touch
- flood slide with crystal violet and allow it to stand for at least 15 seconds. Rinse the slide under tap water
- flood slide with iodine and allow it to stand for at least 15 seconds. Rinse with water
- carefully decolourise with acetone or ethanol 95% until thinnest parts of the smear are colourless. Rinse the slide with tap water
- flood slide with carbolfuchsin / safranin and allow it to stand for at least 15 seconds. Rinse the slide with tap water
- carefully blot the slide dry with the blotting paper or dry with the heat source / bunsen burner.

3.2.3 Interpretation
Proceed as follows:

- determine where the stain material is located and place the slide (inoculated side up) on the microscope stage
• scan the slide on low power (x 10) to locate a representative area of the slide
• look for polymorphonuclear leukocytes [PMNLs or polymorphs]. At low power, these can usually be differentiated from epithelial cells, thus enabling the examiner to focus on the area containing a predominance of inflammatory cells. At low power, large fungal forms (all are gram positive) can also often be seen
• after selecting an area of interest, apply a drop of immersion oil to the slide and read the slide in a minimum of 5 fields on high power (x 100)
• remove the slide from the microscope stage and clean the oil from the lens
• dispose of slide into sharps bin or store for teaching / auditing purposes according to local clinic policy.

3.2.4 Documentation

<table>
<thead>
<tr>
<th>Table 2. Documenting gram stain findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include presence or absence of:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Polymorphonuclear leukocytes</th>
<th>[PMNLs or polymorphs] – quantify if present as per laboratory requirements, for example: 10 polymorphs over 5 high power fields.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonococci</td>
<td>Gram-negative diplococci seen in the cytoplasm of some of the polymorphs.</td>
</tr>
</tbody>
</table>

Depending on the site of specimen collection of the Gram stained slide, also report on:

<table>
<thead>
<tr>
<th>Clue cells</th>
<th>Usually representing at least 20% of vaginal epithelial cells. Squamous vaginal epithelial cells that are covered with bacteria with the borders of the cells obscured owing to the presence of small rods or cocci.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lactobacilli</td>
<td>The vaginal flora of healthy women consists primarily of lactobacilli that appear as gram positive bacilli which produce lactic acid and protect the vagina from microbial infections.</td>
</tr>
<tr>
<td>Hyphae +/- yeast spores</td>
<td>Suggests a diagnosis of candidal vaginitis or candida balanitis, depending on site.</td>
</tr>
<tr>
<td>Other</td>
<td>eg. sperm</td>
</tr>
</tbody>
</table>

3.3 Inoculation and streaking of culture plate

Agar plates are commonly used in routine diagnostic microbiology. Selective media is designed to allow the organism(s) of interest to grow, while reducing the growth of unwanted commensals.

Agar plates are inoculated with clinical material, and then ‘streaked’, a process that dilutes the original inoculum and results in the separation of organisms and the subsequent growth of discrete colonies. Single isolated colonies are the aim. This process allows individual colonies to be examined, subcultured if necessary, identified and tested for antimicrobial sensitivity.

3.3.1 Equipment

Prepare the following equipment:

• culture plate correctly labelled with client identification and specimen site
• inoculation loop
• heat source (optional)
• incubator.
3.3.2 Procedure

Proceed as follows:

- label plate with client identification as per clinic protocol and specimen site
- inoculate plate to size of 20 cent coin near the edge of agar plate without touching sides of plate
- heat the ‘loop’ to sterilise, if using metal, non-sterile loop
- allow to cool
- streak out the inoculum over the plate, taking care to:
  - streak evenly
  - not touch the sides of plate
  - not dig into agar
- heat the loop again to decontaminate / sterilise
- place the plate into appropriate 37°C incubator. The majority of sexual health specimens requiring incubation are incubated in CO₂
- incubate overnight or according to local policy.

4. Documentation

Document all laboratory and clinical findings in medical record.

Refer to Table 1. Documenting wet film findings and Table 2. Documenting gram stain findings.
5. Definitions

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>BV</td>
<td>Bacterial Vaginosis</td>
</tr>
<tr>
<td>PMNL</td>
<td>Polymorphonuclear leukocyte [polymorphs]</td>
</tr>
<tr>
<td></td>
<td>A type of white blood cell distinguished by its multi lobed nucleus. Neutrophils are by far the most abundant type of polymorph, and are among the first inflammatory cells to be recruited to the site of injury. Informally called a poly</td>
</tr>
<tr>
<td>SHC</td>
<td>Sexual Health Clinic</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmissible Infection</td>
</tr>
</tbody>
</table>

6. References


4. Laboratory Block, 2003, unpublished handout, Institute of Clinical Pathology and Medical Research (ICPMR).
C9 MEDICATION – ADMINISTRATION OF MEDICATIONS ACCORDING TO STANDING ORDERS AND NURSE INITIATED MEDICATIONS

1. Purpose and scope
To provide information and procedural guidelines on the administration of medications.
To provide information on the use of Nurse Initiated medications and Standing Orders in the sexual health clinical setting.
This procedure does not apply to sexual health Nurse Practitioners who have legislation supporting the ability to prescribe and dispense medications.

2. Outcomes
Medications are administered safely and comply with NSW Health, State and Commonwealth policies, procedures, regulations, institutional guidelines and laws.
Approved medication charts are to be used for prescribing medication and recording administration of medication. The National Inpatient Medication Chart or other speciality chart approved by the Drug and Therapeutics Committee may be used.
The ordering and administration of medications is documented as per the NSW Health Policy Directive 2013, Medication Handling in Public Hospitals using only the acceptable terms and abbreviations as per the NSW Health Information Bulletin Terminology, Abbreviations and Symbols Used in the Prescribing and Administration of Medicines.
Where Nurse Initiated and / or Standing Orders are used, the health care facility must have written policies and protocols in place for each medication that clearly outlines the procedure to be adopted including sufficient information for the nurse to make informed decisions as to when and when not to administer the medication. These must be endorsed by the health facility’s Drug and Therapeutics Committee and reviewed every 12 months, and reapproved as appropriate.

3. Procedure

3.1 Principles for Safe Medication Administration
Safe and accurate medication administration requires the 5 rights –
Right patient, and
Right drug, and
Right dose, and
Right time, and
Right route
Prior to administering medication on every occasion the clinician should:

- refer directly to the prescribers order on the medication chart – which must be clear, legible and not open to misinterpretation and should include: medication active ingredients and/or proprietary name, strength, form, route, dose, frequency and times for administration, maximum number of doses or maximum duration of treatment, date and time of the order, prescribers name and signature.
• if the order is unclear or ambiguous, or there is concern it is incorrect for the particular medical condition contact the prescriber for clarification

• check the identity of the patient – a strict process should be followed to verify the patient identity

• obtain an accurate and complete medication history including current and recent medicines (prescription and non-prescription)

• check previous medication adverse events and allergies before administration

• consider pregnancy and possible pregnancy and relevant precautions or contraindications

• ensure they have adequate knowledge of drug dosage, effects, contraindications, interactions, adverse effects and precautions, in addition to an overall knowledge of current therapeutics

• the same person should select, prepare, administer and record the administration which involves
  − reading the medication order
  − checking the dose, form, route and time

• check the expiry date and appearance of the medication. For medications requiring cold chain, i.e. vaccinations, ensure processes in place to maintain cold chain

• preparing the medication including checking medication name, strength, form, route, and expiry date against the medication order

• prepare medications directly from the container supplied by the Pharmacy service

• preparing doses only for one patient at a time immediately before intended use

• discard any unwanted portions of ampules and tables ay the time the dose is prepared

• rechecking at the point of administration – carefully reading the label, verifying the name, strength, form and route of medication against the medication order and any warning statements on the label.

• witnessing oral stat dose medications being consumed by the patient

• documenting the administration: signature of clinician, date and time of administration, site of injection (if applicable), d expiry date and batch number (for injectable medications), discussion of any adverse effects and consent to medication administration

• providing verbal and / or written information about the medication including ingredients, purpose and action, dose route and administration schedule, instruction about missed doses and special direction and precautions, common side effects and potential interactions to the patient eg. Consumer Medicine Information sheets.

Following the administration of any medication the following must be documented on the medical chart:

• signature of clinician who administered medication

• the date and time of administration

• site of injection (if applicable).

3.2 Double checking injectable medications

The NSW Health Policy Directive Medication Handling in NSW Public Health facilities recommends local policies should include the requirement for a second person to check the preparation and administration of injectable medication (wherever practical).

Within sexual health settings the following intramuscular injections are given: Hepatitis B vaccine, Hepatitis A vaccine, Seasonal influenza vaccine, Pneumovax, Ceftriaxone sodium, Benzathine Penicillin, Depo Medroxyprogesterone acetate. All nurses within publically funded sexual health
clinics complete a medication learning package to provide evidence of pharmacology knowledge for commonly used medications in the sexual health setting.

The aim of double checking is to detect and prevent potentially harmful medication errors. Current studies suggest there is limited evidence of effectiveness of double checking to improve safety and the process is associated with increased nursing workload. Additionally, single checking has the potential to improve medication safety as it encourages nurses to be more vigilant and update their pharmacology knowledge.

Based on current evidence, the lack of high alert medications and in use for sexual health, competency procedures for sexual health nurses and the autonomous role of sexual health nurses, the double checking of injectable medications is not practical or feasible within all sexual health setting. In services where the double checking of injectable medications is impractical, it is recommended that individual services create local documents to outline reasons for decision, local procedure for injectable medication and any quality assurance activities to minimise medication errors.

### 3.3 Standing Orders

Standing orders provide authorisation for nursing staff to administer Schedule 4, 4D and 8 medications in certain situations without a prior written order on a medication chart.

Standing orders may be applied generally to particular situations or developed specifically for persons under the care of a particular medical practitioner. They are only indicated for stat IM dose medications.

All standing orders must be approved by the Drug and Therapeutics Committee and be in the form of written instruction, signed and dated by the appropriate senior Medical Officer (MO). They must be reviewed at least every 12 months by the MO in consultation with the senior nurse, and forwarded to the Drug Committee for reauthorisation.

All medications administered under standing orders require an MO signature within 24 hours. It is the responsibility of the nurse who administered the medication to ensure this occurs.

Where sexual health clinics have no Accredited Immuniser Registered Nurse or no MO routinely present, the inclusion of Adrenaline for post vaccination anaphylaxis in standing orders is an option.

A sample of information for inclusion in Standing Order, or Nurse Initiated Medication submission to the health service Drug and Therapeutics Committee for the following medications is provided in Appendix C9.1: Azithromycin, Ceftriaxone, Levonorgestrel, Hepatitis B vaccine, Hepatitis A vaccine, Medroxyprogesterone acetate and Clotrimazole.

### 3.4 Nurse Initiated Medications

Nurse initiated medication is a Schedule 2 or Schedule 3 medication, that is approved by a health care facility to be administered without a medical practitioners authorisation. They are only appropriate for one off or occasional medications.

### 3.5 Telephone, Verbal, Email or Fax Medication Orders for medication

When a medical practitioner is unable to write directly into a medication chart the order may be given verbally or by telephone, facsimile, or email. The person receiving such an order must be a person approved to administer or prescribe medication at the particular patient care area.

The authorised prescriber must provide all of the following:

- The patients name and relevant identifiers
- The medication active ingredients, proprietary name (where applicable), strength (where different strengths are available), and form.
Dose
Route
Frequency and times for administration
The maximum number of doses or the maximum duration of the treatment with the medication

Due to risk of misinterpretation all orders received by telephone must be read back to the prescriber with the numbers as separate words e.g. Fifty milligrams, five zero milligrams for a 50mg dose. As a further check the prescriber should repeat the telephone or verbal order to a second person (except in community settings where no second person is available).

Verbally (face to face) or telephone
The authorised prescriber must confirm within 24 hours all doses administered either by countersigning the record of administration on the patients’ medical record and reviewing the patient as soon as appropriate or where this is not possible sending written confirmation of the order by fax or email and review the patients and soon as appropriate. Document verbal or telephone medication orders as per local protocols.

Fax or email
The authorised prescriber must review the patient as soon as appropriate and where possible, rewrite the current order for the medication on the medication chart and cancel the fax or email order or according to local protocol.

The authorised prescriber must document any reason for changing or ceasing medication orders in the health care record.

3.6 NSW Accredited Immuniser Nurses

NSW Accredited Immuniser Nurses are RNs who are currently accredited through the state vaccination program, under NSW Health Policy Directive Immunisation Services – Authority for Registered Nurses. Such nurses initiate and sign for vaccinations in the clinical setting without direct medical authorisation. To maintain authority to practice an annual cardio-pulmonary resuscitation (CPR) review and education update is required.

3.7 Sexual Health Service Pharmacy Imprest

Sexual health services may hold a limited range and quantity of commonly prescribed medication as determined by the Drug Committee. An example of medication for a sexual health service imprest is in Appendix C9.2.

3.8 Accreditation Requirements

Processes need to be in place to ensure adequate education and accreditation of designated RN to safely administer medication and utilise standing orders and nurse initiated medications.

A nursing accreditation learning package in Appendix C9.3 may be utilised as evidence for the accreditation process.

4. Documentation

All medications administered, including those under standing orders and nurse initiated medications are to be documented on the appropriate medication chart and stored in the medical record.

5. Auditable Outcomes

100% of medication orders are clearly documented on the medication chart including drug, dose, route, time and patient allergy status.
6. Definitions

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR</td>
<td>Cardio Pulmonary Resuscitation</td>
</tr>
<tr>
<td>IMI</td>
<td>Intramuscular Injection</td>
</tr>
<tr>
<td>LHD</td>
<td>Local Health District</td>
</tr>
<tr>
<td>MO</td>
<td>Medical Officer</td>
</tr>
<tr>
<td>NGU</td>
<td>Non-Gonococcal Urethritis</td>
</tr>
<tr>
<td>PO</td>
<td>Per Oral</td>
</tr>
<tr>
<td>PP</td>
<td>PrePack</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>SHC</td>
<td>Sexual Health Clinic</td>
</tr>
</tbody>
</table>

7. References


8. Appendices

APPENDIX C9 – Medication

APPENDIX C9.1 – Sample of information for inclusion in Standing Order, or Nurse Initiated Medication submission to the Health Service Drug Committee

APPENDIX C9.1.1 – Azithromycin as treatment for Chlamydia infection or contact of Chlamydia infection

<table>
<thead>
<tr>
<th>DEPARTMENT: Sexual Health Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following order may only be activated under the specific circumstances set out in the section “indications” and provided there are no contraindications present. This order must be checked and signed by a medical officer within 24 hours of activation of the standing order.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICATION STANDING ORDER DETAILS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>For the treatment of uncomplicated Chlamydia trachomatis infection of the anus, cervix, or male urethra and pharynx and the epidemiological treatment of possible anogenital or pharyngeal Chlamydia in recent sexual contacts of patients with anogenital Chlamydia infection.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXCLUSION CRITERIA:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Known hypersensitivity to ketolide and macrolide antibiotics including azithromycin, clarithromycin, erythromycin or roxithromycin. Under 14 years of age.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>POTENTIAL ADVERSE EFFECTS / INTERACTIONS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse effects: suprainfection; pseudomembranous colitis; GI upset; renal, hepatic effects including cholestatic jaundice, raised LFTs; vaginitis; haematological, cardiac, hearing disturbances; rash; hypersensitivity including angioedema, anaphylaxis (rare).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INTERACTIONS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>cyclosporin, digoxin; antacids; coumarins; Zidovudine.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azithromycin 1 gram oral statim.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROCEDURE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Chlamydia trachomatis detected on a urethral, vaginal, cervical, anal, pharyngeal swab or urine sample, or possible anogenital Chlamydia trachomatis in patients presenting as a recent sexual contact of anogenital Chlamydia infection.</td>
</tr>
<tr>
<td>2. Check for any contraindications.</td>
</tr>
<tr>
<td>3. Supply patient information leaflet for Azithromycin and for anogenital Chlamydia infection.</td>
</tr>
<tr>
<td>4. Review via phone or in person 1 week later to check medication compliance and contact tracing.</td>
</tr>
<tr>
<td>5. Advise patient to return in 3 months for follow-up testing.</td>
</tr>
</tbody>
</table>
### APPENDIX C9.1.2 – Azithromycin for male NGU

#### DEPARTMENT: Sexual Health Service

The following order may only be activated under the specific circumstances set out in the section “indications” and provided there are no contraindications present. This order must be checked and signed by a medical officer within 24 hours of activation of the standing order.

#### MEDICATION STANDING ORDER DETAILS:

For the treatment of uncomplicated Non Gonococcal Urethritis (NGU) in men.

#### EXCLUSION CRITERIA:

- Known hypersensitivity to ketolide and macrolide antibiotics including azithromycin, clarithromycin, erythromycin or roxithromycin.
- Under 14 years of age.

#### POTENTIAL ADVERSE EFFECTS / INTERACTIONS:

- Adverse effects: suprainfection; pseudomembranous colitis; GI upset; renal, hepatic effects including cholestatic jaundice, raised LFTs; vaginitis; haematological, cardiac, hearing disturbances; rash; hypersensitivity including angiodema, anaphylaxis (rare).

#### INTERACTIONS:

- cyclosporin, digoxin; antacids; coumarins; Zidovudine.

#### MEDICATION:

Azithromycin 1 gram oral statim.

#### PROCEDURE:

1. Assess the male patient by collecting a gram stain of urethral discharge and examining to ensure no testicular symptoms are present.

2. Uncomplicated NGU is diagnosed when five (5) or more Polymorphonuclear Leukocytes and an absence of intracellular gram negative diplococci in a minimum of 5 random X100 oil immersion microscopic fields detected on gram stain and no testicular symptoms.

3. Check for any contraindications.

4. Supply patient information leaflet for Azithromycin and NGU.

5. Review via phone or in person 1 week later to check medication compliance and resolution of any urethral symptoms.
APPENDIX C9.1.3 – Ceftriaxone and Azithromycin for Gonorrhoea or contact of Gonorrhoea

DEPARTMENT: Sexual Health Service

The following order may only be activated under the specific circumstances set out in the section “indications” and provided there are no contraindications present. This order must be checked and signed by a medical officer within 24 hours of activation of the standing order.

MEDICATION STANDING ORDER DETAILS:
For the treatment of uncomplicated Neisseria Gonorrhoeae infection of the anus, cervix, urethra or pharynx and the epidemiological treatment of possible anogenital and/or pharyngeal Gonorrhoea in recent sexual contacts of patients with Gonorrhoea infection.

EXCLUSION CRITERIA:
Known hypersensitivity to cephalosporin class of antibiotics, or lignocaine allergy.
Known hypersensitivity to ketolide and macrolide antibiotics including azithromycin, clarithromycin, erythromycin or roxithromycin.
Under 14 years of age.

PREGNANCY:
As with other patients, pregnant women infected with N. Gonorrhoeae should be treated with a recommended or alternate cephalosporin. Azithromycin 2 gm orally can be considered for women who cannot tolerate a cephalosporin.


PRECAUTIONS:
Major penicillin allergy requires discussion with medical officer prior to administration and observation in clinic for 30 minutes post-administration.

POTENTIAL ADVERSE EFFECTS / INTERACTIONS – CEFTRIAXONE:
Adverse effects: hypersensitivity; superinfection; headache, dizziness; blood dyscrasias; injection site reactions; GI upset; diaphoresis; flushing; fever; raised LFTs; rare: pseudomembranous colitis; prolonged PT, gallbladder concretions / precipitates, pancreatitis; others see full PI.

INTERACTIONS:
Chloramphenicol; coombs’, nonenzymatic urinary glucose tests; incompatible with amsacrine, vancomycin, fluconazole, aminoglycosides.

POTENTIAL ADVERSE EFFECTS / INTERACTIONS – AZITHROMYCIN:
Adverse effects: suprainfection; pseudomembranous colitis; GI upset; renal, hepatic effects including cholestatic jaundice, raised LFTs; vaginitis; haematological, cardiac, hearing disturbances; rash; hypersensitivity including angiodema, anaphylaxis (rare).

INTERACTIONS:
cyclosporin, digoxin; antacids; coumarins; Zidovudine.
MEDICATIONS:
Ceftriaxone sodium 500 mg intramuscular injection statim.
Dissolved Ceftriaxone sodium 1 g in 4 ml of lignocaine 1% solution.
Discard 2 ml of the reconstituted solution.
Administer the remaining 2 ml containing 500 mg of ceftriaxone by deep intragluteal injection.
Azithromycin 500 mg 2 tablets (1 gm) PO statim.

PROCEDURE:
1. Neisseria Gonorrhoeae is detected on a urethral, high vaginal, cervical, anal, pharyngeal swab or urine sample or possible anogenital and / or pharyngeal Neisseria Gonorrhoeae in patients presenting as a recent sexual contact of gonorrhoea infection:
   a. For patients diagnosed positive gonorrhoea PCR test, collect black charcoal swab or if this is not available Amies gel transport medium swab for Gonorrhoea culture from the infected site prior to treatment.
   b. For patients being treated as asymptomatic sexual contacts of Gonorrhoea, collect Gonorrhea sample as per STI screening guidelines for asymptomatic women, asymptomatic men who have sex with women and asymptomatic men who have sex with men. Refer to Section C14 – Screening Women for Sexually Transmitted Infections and Section C13 – Screening Men for Sexually Transmitted Infections.
2. Check for any contraindications.
3. Supply patient information leaflet for Ceftriaxone and for Gonorrhoea infection.
4. Follow Up: All patients treated for Gonorrhoea should be contacted in 1 week to discuss treatment compliance, resolution of symptoms and that contact tracing has been addressed.
5. TOC: A test of cure (using PCR) should be performed at 2 weeks for all patients with pharyngeal, rectal or cervical infections and any patient treated with an antibiotic other than ceftriaxone. If test of cure is positive then culture should be performed and a medical officer consulted. Test of cure is not required for urethral infection unless ongoing symptoms are present.

<table>
<thead>
<tr>
<th>Site</th>
<th>TOC</th>
<th>Test taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Throat*</td>
<td>2 weeks post treatment</td>
<td>Pharyngeal Gono PCR</td>
</tr>
<tr>
<td>Rectal</td>
<td>2 weeks post treatment</td>
<td>Anorectal Gono PCR</td>
</tr>
<tr>
<td>Cervical</td>
<td>2 weeks post treatment</td>
<td>ECS or Self collected Gono PCR</td>
</tr>
<tr>
<td>Urethral</td>
<td>Not recommended</td>
<td></td>
</tr>
</tbody>
</table>

6. Re-Testing: Advise patient to return in 3 months for follow-up testing.
**APPENDIX C9.1.4 – Levonorgestrel for Emergency contraception**

**DEPARTMENT:** Sexual Health Service

The following order should be followed for the treatment of patients under the care of all Medical Officers: Sexual Health Service.

**MEDICATION STANDING ORDER DETAILS:** Emergency Contraception

Procedure: If a female aged 14 years of age attends within 120 hours of unprotected intercourse and menstrual bleeding is not overdue and she has not had other previous unprotected intercourse since her last period, she may be given Postinor-2® (Levonorgestrel 1.5 mg as a stat dose 750 micrograms x 2).

**EXCLUSION CRITERIA:**
- Hypersensitivity to any ingredients of the preparation.
- Pregnancy.
- Known pregnancy (urine HCG to be performed prior to administration).

**MEDICATION:**
Levonorgestrel 1.5 mg po stat dose made of a single 1.5 mg tablet or 750 microgram x 2 tablets.

**COMMENTS:**
1. Instruct the patient to take either single dose of 1.5 mg or two (2) tablets of 750 mcg immediately by mouth.
2. Provide product information leaflet.
3. Advise the patient that they must return for a pregnancy test in 3–4 weeks if taken after 72 hours. There is a high assessed risk of pregnancy when emergency contraception was given, the next menstrual period is more than 7 days late, the next menstrual period is unusual in some way or if hormonal contraception is started immediately after taking emergency pill.
4. If the patient vomits within 2 hours of taking the tablet advice, to return for review as an additional tablet may be given.
### APPENDIX C9.1.5 – Hepatitis B vaccine

**DEPARTMENT:** Sexual Health Service

The following order should be followed for the treatment of patients under the care of all Medical Officers of the Sexual Health Service.

**MEDICATION STANDING ORDER DETAILS:** Hepatitis B vaccination – Adult

**INDICATIONS FOR VACCINATION:**

- If anti-HB core negative and at risk for Hepatitis B infection and has not completed a previous course of Hepatitis B vaccination.
- If partially vaccinated, continue vaccination with Hepatitis B vaccine according to standard Hepatitis B vaccination protocol (0, 1 and 6 months).
- HIV positive patients with no prior history of Hepatitis B infection should receive 2 injections of the normal adult dose i.e. twice the normal dose of Hepatitis B vaccine i.e. 1 dose of normal adult formulation in each arm on each occasion. Immunocompromised patients are likely to lose their protective antibodies over time, consequently anti-HB surface levels are checked annually for these patients and if ≤10 mIU / ml a booster dose of 2 injections of the normal adult dose should be administered.

**EXCLUSION CRITERIA:**

- Anaphylactic sensitivity to yeast or to any of the vaccine components.
- Previous anaphylactic reaction to Hepatitis B vaccine.
- Acute febrile illness ≥38.5° C.
- Allergic to yeast.
- Pregnancy (test urine HCG if uncertain).

Although pregnancy is not be considered to be a contraindication to the use of Hepatitis B vaccine for women in whom it would otherwise be indicated, there are few indications for vaccination during pregnancy and discussion with a doctor is required prior to administration during pregnancy.

**MEDICATION: HEPATITIS B VACCINE EITHER:**

- Adult Dose H-B Vax II Adult 10 microg / ml or Engerix-B Adult 20 microg / ml.
- Paediatric Dose H-B Vax II Paediatric 5 microg / 0.5 ml or Engerix-B Paediatric 10 microg / 0.5 ml.

**PROCEDURE:**

1. Assess patient meets the indications for vaccination.
2. Check patient has no contraindications.
3. Obtain verbal informed consent.
4. Administer adult Hepatitis B vaccine by intramuscular injection (IMI) into Deltoid muscle.
5. For adults over 20 years the full course of Hepatitis B adult vaccine consists of 3 doses, with an interval of 1 to 2 months between first and second doses with a third dose 2 to 5 months after the second dose.
6. For young adults less than 20 years of age, a total of 3 doses of 0.5 ml of paediatric formulation is recommended. The optimal interval is 1 month between the first and second dose and a third dose 2 to 5 months after the second dose.
7. Document the batch number, expiry date and site of injection in the medical record.
### DEPARTMENT: Sexual Health Service
The following order should be followed for the treatment of patients under the care of all Medical Officers of the Sexual Health Service.

### MEDICATION STANDING ORDER DETAILS: Hepatitis A vaccination

#### INDICATIONS FOR VACCINATION:
- Men who have sex with men who are Hepatitis A IgG antibody negative.
- People with chronic liver disease including Hepatitis B and Hepatitis C who are Hepatitis A IgG antibody negative.
- If partially vaccinated, continue vaccination with Hepatitis A vaccine.

#### EXCLUSION CRITERIA:
- Anaphylactic sensitivity to any of the vaccine components.
- Previous anaphylactic reaction to Hepatitis A vaccine.
- Acute febrile illness $\geq 38.5^\circ$ C.
- Less than 17 years of age for immunisation with VAQTA adult.
- Less than 15 years if immunisation with Havrix 1440.

#### MEDICATION:
- Inactivated Hepatitis A vaccine either: Havrix 1440 EIA U IMI stat or VAQTA Adult 50U IMI stat.

#### PROCEDURE:
1. Assess patient meets the indications for vaccination.
2. Check patient has no contraindications.
3. Obtain verbal informed consent.
4. Administer adult Hepatitis A vaccine by intramuscular injection (IMI) into Deltoid muscle.
5. The full course of Hepatitis A vaccine consists of 2 doses, with an interval of 6 to 12 months between first and second doses.
6. Document the batch number, expiry date and site of injection in the medical record.
## APPENDIX C9.1.7 – Medroxyprogesterone acetate for long acting injectable contraception

**DEPARTMENT:** Sexual Health Service  
The following order should be followed for the treatment of patients under the care of all Medical Officers: Sexual Health Service.

**MEDICATION STANDING ORDER DETAILS:**  
Long acting injectable contraception.

**PROCEDURE:**  
If a female aged more than 16 years has previously been prescribed depot medroxyprogesterone acetate by a medical practitioner the drug may be administered during the first 5 days of the menstrual cycle or early post partum period. For subsequent doses the interval since last injection should be no greater than 12–14 weeks between injections.  
Condoms should be used for the first cycle if the first dose is not given within the first 5 days of bleeding.  
Refer back to the medical practitioner if bleeding is unusual.

**EXCLUSION CRITERIA:**  
Hypersensitivity to any ingredients of the preparation.  
Breast cancer diagnosed in past 5 years.  
Pregnancy (test urine HCG before injection).

**MEDICATION:**  
Medroxyprogesterone acetate 150 mg / 1 ml depot IMI stat.

**COMMENTS:**  
1. Shake well before use.  
2. Administer by deep intramuscular injection into gluteal muscle.  
3. Provide production information sheet.  
4. Provide date next injection due.  
5. Instruct patient to return if pregnancy suspected or undiagnosed bleeding occurs.  
6. Discuss with Medical Officer if interval since last injection greater than 14 weeks.
APPENDIX C9.1.8 – Clotrimazole for topical treatment of vaginal candidiasis

**DEPARTMENT:** Sexual Health Service

The following order may only be activated under the specific circumstances set out in the section “indications” and provided there are no contraindications present. This order must be checked and signed by a medical officer within 24 hours of activation of the standing order.

**MEDICATION STANDING ORDER DETAILS:**

For the topical treatment of uncomplicated vaginal candidiasis in women.

**EXCLUSION CRITERIA:**

Known hypersensitivity to clotrimazole and / or to any of the excipients.

**RELATIVE CONTRAINDICATION:**

Recurrent proven Candida as single dose therapy is not adequate for this patient group.

**POTENTIAL ADVERSE EFFECTS / INTERACTIONS:**

Adverse effects: adverse effects are uncommon, but may include erythema, stinging, blistering, peeling, oedema, pruritus, urticaria and general irritation.

**INTERACTIONS:**

Interactions with latex.

Clotrimazole Vaginal Cream (Vaginal Pessaries) may reduce the effectiveness and safety of latex products, such as condoms and diaphragms. This effect is temporary and occurs only during treatment.

**MEDICATION:**

Clotrimazole 500 mg Pessary intravaginal stat.

**PROCEDURE:**

1. Assess the female patient by collecting a gram stain and / or wet prep of vaginal discharge and examining to ensure no genital lesions, cervical lesions or pelvic pain are present.

2. Uncomplicated vaginal candidiasis is diagnosed when the following are present: presence of spores or hyphae and absence of clue cells on a minimum of 5 random X100 oil immersion microscopic fields detected on gram stain; vaginal pH less than 4.5; patient complaint of vulvovaginal thick white discharge with itching, redness or swelling.

3. Check for any contraindications.

4. Supply patient information leaflet for Clotrimazole and candidiasis.

5. Review via phone or in person 1 week later to check medication compliance and resolution of symptoms.
APPENDIX C9.2 – Sexual Health Sample Pharmacy Imprest (example)

Injections
Benzypenicillin Sodium (BENPEN) 1.2 G injection
Benzypenicillin Sodium (BENPEN) 600 mg
Ceftriaxone (ROCEPHIN) 500 mg (Solv required)
Lignocaine (XYLOCAINE POLYAMP DUOFIT) 1% injection 50 x 5 mls
Lignocaine (XYLOCAINE POLYAMP DUOFIT) 2% injection 50 x 50 mls
Sodium chloride (PU) 0.9% injection 50 x 10 mls
Water for injection (AP POLYAMP) injection 50 x 10 mls
Water for Injection (AP POLYAMP) injection 50 x 5 mls
Adrenaline 1:1000 ml Protect from light

Refrigerated stock items
Penicillin Benzathine (PAN BENZATHINE BENZYLPENICILLIN) 900 mg 10 injections
Penicillin Procaine (CILICaine) 1.5 g injection x 5

Vaccines:
Engerix-B adult 20 microg / ml
Engerix-B Paediatric 10 microg / 0.5 ml
HB VAX II adult 10 microg / ml
HB VAX II paediatric 5 microg / 0.5 ml
HAVrix adult 1440 EIA U ml
HAVRIX junior 720 EIA U in 0.5 ml
VAQTA adult 50 IU / ml
VAQTA Paediatric 25U / 0.5 ml

Tablet and Capsule – Prepack
Azithromycin (ZITHROMAX ) 500 mg tablets x 2
Aciclovir prepack 200 mg pp30
Azithromycin prepack 500 mg tablets syd pp2
Ciprofloxacin prepack 100 mg syd pp1
Doxycycline Prepack 100 mg tablets syd pp21
Fluconazole (DIFLUCAN) 50 mg capsules stg pp3
Levonorgestrel 1.5 mg
Metronidazole (METRONIDE) 200 mg tablets 24
Paracetamol 500 mg tablets 120
Probencid 500 mg tablets 100
Tinidazole 500 mg tablets 4
Trimethoprim 300 mg tablets 7
Trimethoprim / Sulphamethoxazole 160 / 800 tablets
Valacyclovir 500 mg tablets

Topical Preparation: Prepacks
Acetone Prepack liquid sydpp 100 mls
Acetone BP (GALENICAL LIQUID) 100 mls
Podophylotoxin Prepack (WARTEC 0.15 % cream syd
Podophylotoxin Prepack (Condylidine) 5 mg / ml paint syd pp1

Topical Preparations
Eye stream eye irrigation 120ml (OH&S)
Hand lotion pump pack
Lubricating jelly
Lugols iodine (FA) 5% solution 100 ml
Permethrin (Lyclear) 5% cream 30 g
Permethrin (QUELLADA HEAD LICE TREATMENT 10 mg / ml topical solution 100 ml
Potassium Permanganate (STGM) 1 mg / 10 ml solution 100 ml
EMLA cream 5% / 5 g
Topical anti-fungal
Topical Steroid

Miscellaneous
Test Agent (MULTISTIX ) diagnostic agent 100 strips
Non Occupational Post Exposure Prophylaxis
Truvada
Kaletra or Combivir
stored and ordered as per local area protocol

APPENDIX C9.3 – Nursing accreditation learning package – medication administration and standing orders

Aim
• To develop a sound knowledge base in order to administer medications that are given in the sexual health context.

Objectives
• Utilise current resources to review medication information.
• Answer all questions correctly (ie.100%) to achieve accreditation.

Outcomes
At the completion of this package the RN will be able to:
• Name the medications given under standing order and nurse initiated medications.
• Demonstrate an understanding of indication for use, action, contraindication, dose, administration, adverse effects and drug interactions of standing order and nurse initiated medications and other common medications used in the sexual health context.
• Administer approved medications under standing orders.
• Administer approved nurse initiated medications.
• Order the correct medication for the individual client presentation.
• Accurately document actions related to medication administration.
• Demonstrate knowledge of medication error documentation process and IIMS reporting.
### Online Medication package – Multiple choice questions

| Medication administration | 1. How many drug schedules are listed under NSW poisons regulations? | a. Schedule 1 to 9  
b. Schedule 1 to 7  
c. Schedule 1 to 6  
d. Schedule 1 to 8 |
|---------------------------|---------------------------------------------------------------------|------------------------------------------------------------------|
|                           | 2. Referring to the categorisation system for prescribing medicines in pregnancy choose the correct answer: | a. Category X – Drugs which have caused, are suspected to have caused or may be expected to cause, an increased incidence of human fetal malformations or irreversible damage  
b. Category C – Drugs which have such a high risk of causing permanent damage to the fetus that they should not be used in pregnancy  
c. Category B1 – Drugs which have been taken by only a limited number of pregnant women and women of childbearing age, without an increase in the frequency of malformation or other direct or indirect harmful effects on the human fetus having been observed  
d. Category A – Available data from animal studies show no evidence of an increased occurrence of fetal damage. |
|                           | 3. Medication given under standing orders: | a. must be signed by a senior medical officer within 7 days of medication dispensed  
b. must be signed by senior medical officer within 24 hours of medication dispensed  
c. must be signed by a senior medical officer within 72 hours of medication dispensed  
d. do not require sign off as the nurse is considered competent to make the decision to dispense. |
|                           | 4. A nurse omits to have standing orders signed off. The next process is: | a. disciplinary action  
b. fake the MO signature as they would have signed it anyway  
c. discuss with manager and complete an IIMS report  
d. it’s not an issue as the RN is accredited to dispense standing order medication. |
|                           | 5. Nurses that have been accredited to administer medication under standing orders can: | a. write prescriptions for simple antibiotics  
b. dispense a course of treatment  
c. administer stat medication only  
d. must ring the doctor before administering any medication. |
|                           | 6. A telephone order can be obtained from a sexual health doctor for: | a. a course of PEP  
b. a course of Metronidazole when treating PID  
c. a single dose of any medication  
d. all of the above. |
|                           | 7. What must a clinician document when giving an injection? | a. medication and batch number  
b. batch number and expiry date  
c. medication, batch number, expiry date and anatomical site injection given  
d. medication, expiry date and anatomical site injection given. |
## Specific Medications

**Azithromycin**

8. The most common adverse effect with Azithromycin is?
   - a. Nausea and vomiting
   - b. Headache
   - c. Vaginitis
   - d. Skin rash.

9. The drugs that should not be given concomitantly with Azithromycin are:
   - a. Antacids and Efavirenz
   - b. Antacids and Ergot
   - c. Ergot and Sildenafil
   - d. Efavirenz and Sildenafil.

10. Azithromycin shows actions against which type of bacteria?
    - a. Gram negative aerobic bacteria
    - b. Gram positive aerobic bacteria
    - c. Both
    - d. Neither.

**Ceftriaxone**

11. The use of Ceftriaxone is contraindicated in patients with an allergy to:
    - a. Erythromycin
    - b. Sulphur
    - c. Penicillin
    - d. Acyclovir.

12. The correct route of administration for Ceftriaxone in the sexual health setting is:
    - a. Intravenous
    - b. Topical
    - c. Intramuscular
    - d. Oral.

13. What is the recommended diluent for Ceftriazone?
    - a. Water for injection
    - b. Normal saline
    - c. Lignocaine
    - d. Lignocaine with Adrenaline.

14. Ceftriaxone is classified in which use of medications in pregnancy category?
    - a. A
    - b. B1
    - c. B3
    - d. D.

15. Ceftriaxone is used for the treatment of which infection in the sexual health setting?
    - a. Neisseria Gonorrhoea
    - b. Chlamydia trachomatis
    - c. Ureaplasma urealiticum
    - d. Treponema pallidum.
### Metronidazole

16. Caution must be taken when using Metronidazole in pregnancy because it:

- a. Induces vomiting
- b. Crosses the placental barrier
- c. Is teratogenic
- d. Causes spontaneous abortion.

17. What is the drug Metronidazole primarily used for treating in the sexual health setting?

- a. Bacterial vaginosis and Trichomonas vaginalis
- b. Bacterial vaginosis and non gonococcal urethritis
- c. Trichomonas vaginalis and Gonorrhoea
- d. Chlamydia and bacterial vaginosis.

18. Metronidazole has many potential drug interactions. Which drug interaction is most likely to cause a psychotic reaction?

- a. Lithium
- b. Disulfiram
- c. Phenytoin
- d. Warfarin.

19. Advise the patient while taking Metronidazole and for 48 hours after to avoid:

- a. Sex
- b. Smoking
- c. Alcohol
- d. Fatty foods.

### Benzathine Penicillin

20. The standard treatment for secondary syphilis is:

- a. Benzathine penicillin 900 mg IMI stat
- b. Benzathine penicillin 1.8 grams IMI stat
- c. Benzathine penicillin 1.8 grams IMI 3 doses weekly
- d. Benzathine penicillin 1g IMI daily for 10 days.

21. Jarisch-Herxheimer reaction presents as a cluster of the following symptoms:

- a. Skin rash, urticaria, chills, fever
- b. Headache, arthralgia, malaise
- c. Malaise, skin rash, nausea, vomiting
- d. Chills, fever, arthralgia, headache.

### Clotrimazole

22. Clotrimazole treatment for vulvovaginal candidiasis is preferably applied:

- a. Mane
- b. bd
- c. tds
- d. Nocte.

23. The contraindications for use of Clotrimazole are:

- a. Imidazole hypersensitivity
- b. Danazol allergy
- c. Penicillin hypersensitivity
- d. Sulphur allergy.
### Clotrimazole

24. What is the effect on latex when in contact with Clotrimazole?
   - a. Minimal effect
   - b. Increases the effectiveness
   - c. Reduces the effectiveness
   - d. Acts as a lubricant.

25. Clotrimazole has the following action:
   - a. Anti-viral
   - b. Anti-parasitic
   - c. Anti-bacterial
   - d. Anti-fungal.

26. What schedule is vaginal clotrimazole?
   - a. Schedule 2
   - b. Schedule 3
   - c. Schedule 4
   - d. Schedule 8.

### Permethrin

27. Permethrin is commonly used to treat?
   - a. Scabies and lice
   - b. Lice and shingles
   - c. Scabies and shingles
   - d. Shingles and balanitis.

28. The schedule for Permethrin is?
   - a. S2
   - b. S4
   - c. S8
   - d. Unscheduled.

29. For optimal treatment apply Permethrin topically to:
   - a. Affected areas stat
   - b. Whole of body stat
   - c. Affected areas of body for 7/7
   - d. Whole of body for 7/7.

30. Which of the following is not a common adverse reaction to Permethrin?
   - a. Stinging
   - b. Tingling
   - c. Blistering
   - d. Burning.

### Emergency Contraceptive Pill

31. The emergency pill can be taken up to how many hours after unprotected sexual intercourse?
   - a. 12 hours
   - b. 36 hours
   - c. 120 hours
   - d. 172 hours.

32. How could a woman access the emergency pill?
   - a. Prescription from a doctor
   - b. Over the counter at a chemist
   - c. From a designated doctor or nurse at a sexual health clinic
   - d. All of the above.
### Emergency Contraceptive Pill

33. Which is not a common side effect of the emergency pill?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>a.</td>
<td>Vomiting</td>
</tr>
<tr>
<td>b.</td>
<td>Intermenstrual bleeding</td>
</tr>
<tr>
<td>c.</td>
<td>Late onset of next period</td>
</tr>
<tr>
<td>d.</td>
<td>Breast tenderness.</td>
</tr>
</tbody>
</table>

34. The emergency pill is most effective when:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>1.5 mg is taken as a stat dose</td>
</tr>
<tr>
<td>b.</td>
<td>Within 24 hours of unprotected sexual intercourse</td>
</tr>
<tr>
<td>c.</td>
<td>When a woman is not already pregnant</td>
</tr>
<tr>
<td>d.</td>
<td>All of the above.</td>
</tr>
</tbody>
</table>

### Genital Warts

35. What follow up instructions do you provide after a topical treatment of genital warts with LN2?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>a.</td>
<td>Bathing in salt water may promote skin healing</td>
</tr>
<tr>
<td>b.</td>
<td>Pick off the wart tissue in between LN2 treatments to promote faster healing</td>
</tr>
<tr>
<td>c.</td>
<td>Use topical anaesthesia post treatment</td>
</tr>
<tr>
<td>d.</td>
<td>None of the above.</td>
</tr>
</tbody>
</table>

36. Which of the following is not a common adverse effect of LN2?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Necrosis</td>
</tr>
<tr>
<td>b.</td>
<td>Odema</td>
</tr>
<tr>
<td>c.</td>
<td>Bleeding</td>
</tr>
<tr>
<td>d.</td>
<td>Ulceration.</td>
</tr>
</tbody>
</table>

37. LN2 should be applied to external genital warts until there is whitening on the surrounding skin of:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>1 mm</td>
</tr>
<tr>
<td>b.</td>
<td>2 mm</td>
</tr>
<tr>
<td>c.</td>
<td>3 mm</td>
</tr>
<tr>
<td>d.</td>
<td>4 mm.</td>
</tr>
</tbody>
</table>

38. LN2 works on genital warts by:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Burning the wart off the skin surface</td>
</tr>
<tr>
<td>b.</td>
<td>Freezing / thawing the wart resulting in wart destruction</td>
</tr>
<tr>
<td>c.</td>
<td>Chemical reaction resulting in wart destruction</td>
</tr>
<tr>
<td>d.</td>
<td>All of the above.</td>
</tr>
</tbody>
</table>

39. The instructions for self application of Podophyllotoxin solution and cream preparations are:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Apply bd for 3/7, then 4/7 break and repeat cycle over 4–6 weeks</td>
</tr>
<tr>
<td>b.</td>
<td>Apply daily for 4/7, then 3/7 break and repeat cycle over 4–6 weeks</td>
</tr>
<tr>
<td>c.</td>
<td>Apply bd for 7/7, no break and repeat cycle over 4–6 weeks</td>
</tr>
<tr>
<td>d.</td>
<td>Apply daily for 3/7, then 4/7 break repeat cycle over 4–6 weeks</td>
</tr>
<tr>
<td>e.</td>
<td>Liquid Nitrogen (LN2).</td>
</tr>
</tbody>
</table>

40. The over use of Podophyllotoxin results in:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Localised parasthesia</td>
</tr>
<tr>
<td>b.</td>
<td>Erythema, pain and ulceration</td>
</tr>
<tr>
<td>c.</td>
<td>Systemic pruritus</td>
</tr>
<tr>
<td>d.</td>
<td>Itchy and dry flaky skin.</td>
</tr>
</tbody>
</table>
### Genital Warts

41. Podophyllotoxin topical treatment for external genital warts:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>a.</td>
<td>Can be used in pregnancy, it is important to treat genital warts before a vaginal delivery</td>
</tr>
<tr>
<td>b.</td>
<td>Should not be used in women with inadequate contraception as effects on the fetus are not known</td>
</tr>
<tr>
<td>c.</td>
<td>Is safe to use in the first trimester of pregnancy</td>
</tr>
<tr>
<td>d.</td>
<td>Can be used on the vulva in pregnancy, but not intravaginally.</td>
</tr>
</tbody>
</table>

### Hepatitis A and Hepatitis B vaccination

42. The most common group of adverse effects to the Hepatitis A and Hepatitis B vaccines are:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>a.</td>
<td>Local site nodule formation, sweating, dysuria</td>
</tr>
<tr>
<td>b.</td>
<td>Local injection site pain, local injection site, erythema and malaise</td>
</tr>
<tr>
<td>c.</td>
<td>Local injection site pain, headache, dysuria.</td>
</tr>
</tbody>
</table>

43. The Hepatitis A and Hepatitis B vaccine must be stored and maintained at which temperature in order to maintain the cold chain?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>a.</td>
<td>0–5 degrees C</td>
</tr>
<tr>
<td>b.</td>
<td>5 degrees C</td>
</tr>
<tr>
<td>c.</td>
<td>2–8 degrees C</td>
</tr>
<tr>
<td>d.</td>
<td>2–12 degrees C.</td>
</tr>
</tbody>
</table>

44. The standard vaccination schedule for Hepatitis B is:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>0, 1, 6 months</td>
</tr>
<tr>
<td>b.</td>
<td>0, 1, 2 months</td>
</tr>
<tr>
<td>c.</td>
<td>0, 2, 6 months</td>
</tr>
<tr>
<td>d.</td>
<td>0, 6, 12 months.</td>
</tr>
</tbody>
</table>

45. Anaphylaxis hypersensitivity reaction to the Hepatitis A and Hepatitis B vaccinations is reported in which percentage of cases?

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>a.</td>
<td>43.2%</td>
</tr>
<tr>
<td>b.</td>
<td>11.6%</td>
</tr>
<tr>
<td>c.</td>
<td>&lt; 1%</td>
</tr>
<tr>
<td>d.</td>
<td>Nil reported.</td>
</tr>
</tbody>
</table>

46. The preferred site for IMI administration for Hepatitis A and Hepatitis B vaccination in adults is:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>a.</td>
<td>Anticubital fossa</td>
</tr>
<tr>
<td>b.</td>
<td>Deltoid</td>
</tr>
<tr>
<td>c.</td>
<td>Gluteal</td>
</tr>
<tr>
<td>d.</td>
<td>Anterior thigh.</td>
</tr>
</tbody>
</table>

### STI Case Studies

47. A male patient attends with dysuria for 3/7, no urethral discharge and no testicular pain. On examination you note a small amount of clear discharge and 10 polymorphs on gram stain. The other tests you perform are urine PCR for Chlamydia and culture for Gonorrhoea. In the area you are working Chlamydia is the most prevalent sexually transmitted infection. While awaiting the results your provisional diagnosis is non-specific urethritis (NSU). What treatment do you offer?

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>a.</td>
<td>Azithromycin 1 g po stat</td>
</tr>
<tr>
<td>b.</td>
<td>Ceftriaxone 500 mg IMI stat</td>
</tr>
<tr>
<td>c.</td>
<td>Azithromycin 1 g po and Ceftriaxone 500 mg IMI stat</td>
</tr>
<tr>
<td>d.</td>
<td>Await results of Chlamydia and Gonorrhoea tests.</td>
</tr>
</tbody>
</table>
STI Case Studies

48. A male patient who has sex with men presents with a thick yellow discharge for 1 week. You see gram negative intracellular diplococci on the gram stain and diagnose Neisseria Gonorrhoea. The standard treatment is Ceftriaxone 500 mg IMI with Azithromycin 1 g po stat. Which antibiotic has a cross allergy with cephalosporins?
   a. Aztreonam
   b. Clindamycin
   c. Penicillin
   d. Sulfonamide.

49. A female sex worker drops into the clinic complaining of a fishy smelling, watery discharge for 2/52. She uses 100% condoms at work and has not had any broken condoms. She has 1 regular male partner of 3 years who doesn’t use condoms with. You perform a speculum examination and take samples for Chlamydia, Gonorrhoea, Trichomonas and bacterial vaginosis testing. The vaginal discharge has a pH of 6 and on the gram stain you find clue cells. Your diagnosis is bacterial vaginosis and the recommended treatment is Metronidazole. When providing information about the medication the patient informs you that she will be going to a wine festival on the weekend and will be drinking alcohol. What recommendation will you give to this patient?
   a. Not go to the wine festival and take the medication
   b. Take the medication and go to the wine festival as planned
   c. Start the treatment after the wine festival
   d. Not treat the bacterial vaginosis.

50. A 23-year-old women comes to your clinic. She had a broken condom with a casual male partner last night. She is very worried about sexually transmitted infections and becoming pregnant. When taking her history you find out she is day 10 of a 28 day menstrual cycle. Where in the menstrual cycle can this patient take the emergency pill?
   a. Anytime
   b. Only in the first 7 days of the cycle
   c. Only when she is ovulating
   d. If the next period is overdue.

51. A male patient came to the clinic for an asymptomatic screen. 1 week later you get the results and call the patient informing him of a positive urethral Chlamydia infection. He attends your clinic for treatment. What is the simplest treatment for Chlamydia infection?
   a. Doxycycline orally 100 mg for 7/7
   b. Ceftriaxone IM 500 mg stat
   c. Penicillin orally 500 mg bd for 5/7
   d. Azithromycin 1 g oral stat.

Contraception Case Studies

52. A 30-year-old female comes to you for contraceptive advice and is keen to commence Depo Provera injections. She is not keen to go back on OCP. What advice do you give to this patient?
   a. Irregular bleeding pattern is common after first injection
   b. Long term use can decrease bone density therefore advise the patient to increase calcium intake and exercise
   c. Slow return to fertility after ceasing contraception – some women can remain amenorrhoeic for 12 months
   d. The injection should be administered every 12 weeks
   e. All of the above.

53. The patient returns for her 2nd Depo Provera injection 2 weeks late. She has been happy with this form of contraception and is keen to continue. What do you do?
   a. Tell the patient that she will have to wait for her period to recommence
   b. Administer the injection as it is unlikely the patient will fall pregnant
   c. Check when the patient was last sexually active and exclude pregnancy. Administer and advise the patient to use condoms for 7 days and return in 4 weeks for a pregnancy test
   d. Advise patient to abstain from sex for 6 weeks then return for a pregnancy test and the contraceptive injection.
References

You will need to access these references, in addition to those listed in Medication – Administration, Standing Order and Nurse Initiated, to complete the package


Incident Information Management System (IIMS)

Accessed through LHD Intranet

IIMS is a computerised system for collecting, classifying, managing, analysing and learning about all incidents that happen within health care – clinical (clients), complaints, staff / visitor / contactor (OH&S) and property / hazard / security.

Incident type: Medications / IV Fluids

This incident type is used to classify the details related to medication or intravenous fluid incidents. For example, medication prescribing errors.
C10 POST EXPOSURE PROPHYLAXIS AFTER NON-OCCUPATIONAL EXPOSURE TO HIV

1. Purpose and scope
To provide information on the management of individuals non-occupationally exposed to human immunodeficiency virus (HIV), through the timely delivery of post exposure prophylaxis as a prevention intervention, particularly where exposures have resulted from unprotected sexual activity and injecting drug use.

Risk assessment and commencement of non-occupational post-exposure prophylaxis (NPEP) may / can occur in different settings throughout NSW; designated sexual health clinics; Emergency Departments (ED) in NSW Public Hospitals and accredited GPs.

Local Health Districts need to develop specific guidelines in relationship to NPEP to suit their unique settings, and are encouraged to develop clear pathways to enhance access for those at risk, including identifying those presenting with additional risk factors and developing referral pathways to counselling services.

Documents informing policy and guideline development:
2013 National Guidelines for post-exposure prophylaxis after non-occupational exposure to HIV. ASHM
NSW Department of Health – Human Immunodeficiency Virus (HIV) Management of non-occupational exposure

2. Outcomes
Antiretroviral post-exposure prophylaxis (PEP) will be appropriately offered following potential non-occupational exposures to HIV. Appropriate management includes:

- timely access to treatment and specialist advice following presentation / exposure
- informed choice for the exposed person
- regard for the confidentiality of the exposed person, as well as the source person
- appropriate choice of number and type of medications for each potential exposure
- appropriate follow-up and evaluation.

3. Procedure
Assessments for non-occupational exposure and the ongoing management where warranted, will be in accordance with the following documents:

2013 National Guidelines for post-exposure prophylaxis after non-occupational exposure to HIV. ASHM
NSW Department of Health – Human Immunodeficiency Virus (HIV) Management of non-occupational exposure

NPEP medications can only be prescribed by accredited HIV s100 prescribers, accident and emergency departments and specialised services.

Services can call the 24 hour, 7 day PEP Line: Phone 1800 737 669 or 1800 PEP NOW, which is staffed by experienced clinicians who can provide comprehensive risk assessment.
4. Documentation

Documentation on NPEP post-exposure risk assessment, counselling, consent, treatment, management and education is entered in the medical record.

5. Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>Exposed person</td>
<td>A person who has been potentially exposed to HIV through either occupational or non-occupational exposure</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>LHD</td>
<td>Local Health District</td>
</tr>
<tr>
<td>NPEP</td>
<td>Non-occupational post-exposure prophylaxis</td>
</tr>
<tr>
<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
</tr>
<tr>
<td>Source person</td>
<td>A person who is the potential source of infection for the exposed person</td>
</tr>
</tbody>
</table>

6. References


C11 PREGNANCY TESTING

1. Purpose and scope
To provide guidelines related to assessment of women requiring pregnancy testing.

2. Outcomes
Pregnancy tests are performed accurately and patients are given appropriate information on pregnancy options.

3. Procedure

History
Obtain relevant history:
- date and nature of last menstrual period (LMP), preferably 7 days overdue, but may be performed earlier if clinically indicated
- signs and symptoms of pregnancy eg. breast changes, nausea and vomiting
- dates of unprotected sexual intercourse since last menstrual period
- explore concerns and feelings about the result
- ascertain whether consensual sexual intercourse
- current medications
- obstetric as appropriate

Equipment
Prepare the following equipment:
- pregnancy testing kit
- urine specimen
- gloves.

Instruct client to pass urine into specimen jar. Early morning specimen is ideal, but urine may be collected at any time.

Perform urine hCG testing
Follow the instructions on the pregnancy test kit on procedure and evaluation of test result.

3.1 Negative test result
If test is negative, and pregnancy is suspected, repeat in 1 week.

Indications for a repeat test:
- too soon to detect a pregnancy, within 7 days of missed period (particularly if not performed on first morning specimen)
- signs and symptoms of pregnancy
- if initial test was performed within the first 2 to 3 weeks of missed or late hormonal contraception
- discuss future contraceptive options.
3.2 Positive result
If the result is positive:
- discuss options
- provide immediate support
- provide appropriate referral and follow-up plan.

3.3 Serum hCG testing
Serum hCG offers little advantage over urine hCG except in the ability to provide quantitative results or when an abnormal or ectopic pregnancy is suspected. However, if pregnancy is clinically suspected and urine testing is repeatedly negative a serum hCG may be useful.

A serum hCG > 5 but < 25mIU / ml may indicate:
- early pregnancy
- miscarriage
- blighted ovum
- ectopic pregnancy
- pituitary hCG
- persistent trophoblastic disease
- nontrophoblastic tumour
- false positive hCG.

Repeat serum quantitative hCG in 2–3 days.

An abnormal rise or no change indicates an abnormal pregnancy or other health problem; consult with an MO.

4. Documentation
Record batch number and expiry date of pregnancy test kit.
Copy of referral letters to be kept in medical record.

5. Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>hCG</td>
<td>Human Chorionic Gonadotrophin</td>
</tr>
<tr>
<td>LMP</td>
<td>Last Menstrual Period</td>
</tr>
<tr>
<td>MO</td>
<td>Medical Officer</td>
</tr>
</tbody>
</table>

6. References
C12 REMOVAL OF FOREIGN BODY OR RETAINED OBJECT

1. Purpose and scope
To provide procedural guidelines related to the removal of foreign body or retained object.

2. Outcomes
Removal of foreign body is appropriately performed. Client safety and comfort is maintained.

3. Procedure

3.1 Removal of a foreign body from the rectum / urethra
Refer to nearest emergency department for assessment.

3.2 Removal of a foreign body from the vagina
Common objects that may become fixed in the vagina are:

- tampons – women sometimes forget they are there at the end of menstruation, or insert 1 whilst another is still in the vagina
- condoms or pieces of condom – retained during intercourse
- contraceptive device eg. sponge, cap
- sex toys
- some women will present with complaint of vaginal odour +/- discharge, others will be unaware of the retained product and it will be visible on speculum examination
- objects, in particular tampons that have been retained for some time, can have an offensive odour.

3.3 Procedure for removal
Ensure that when foreign object is identified, in particular retained tampon, preparation for removal is carried out.

Assemble:

- speculum and lubricant
- container with enough water to submerge object / tampon, sponge holding forceps, plastic bag for disposal
- insert speculum, visualise object, insert sponge holding forceps, grasp the object and remove, quickly submerge in container of water
- when able and appropriate remove object to plastic bag, secure and dispose of in clinical waste.

After removal of retained object / tampon, most clients require no further follow up, but should be advised to monitor discharge and if symptomatic – febrile, pain, vaginal odour, rash, swelling or discharge – need to see MO for review and possible treatment.

4. Documentation
Document presence of vaginal foreign body and type, noting any changes to vaginal environment eg. inflammation, discharge, colour, lesions, discomfort.
5. Definitions

| MO | Medical Officer |

6. References

C13 SCREENING MEN FOR SEXUALLY TRANSMISSIBLE INFECTIONS

1. Purpose and scope
To provide procedural guidelines on routine screening and testing for sexually transmissible infections in men.

2. Outcomes
Screening and testing for STI and BBV reflects current evidence and best practice. Men are appropriately screened and tested.

Screening for men who have sex with men (MSM) is appropriate and follows the current STIGMA guidelines.

3. Procedure
Procedure as follows:

- a sexual health history should be collected prior to screening. See Sexual History Taking – see Section C15
- if client declines clinical examination then urine and / or self collected anal swabs for Gonorrhoea and Chlamydia NAAT are appropriate
- ensure client privacy and consent throughout the procedure
- standard tests are outlined in the tables below however tests may vary based on individual assessment
- ideally, the client should not have passed urine for a minimum of 1 hour prior to collection of a first catch urine (FCU) specimen for Chlamydia and Gonorrhoea NAAT. However recent evidence shows 20 minutes is adequate1
- avoid passing urine for 1 hr prior to collecting a urethral swab6 however time since last urination should not prevent testing in a male with symptoms.
- testing contacts of non-gonococcal urethritis (NGU), Gonorrhoea and / or Chlamydia should include standard STI tests as outlined in Table 1.

3.1 History Taking
In conjunction with a full medical, social and sexual history, establish clinical and symptomatic history to determine what tests to perform.

Clinical history includes presence of:

- meatal or rectal discharge: colour, odour, consistency
- rectal burning, bleeding, discharge, feeling of fullness, change in bowel movements, pain, tenesmus
- external genital lesions: pain, tenderness, burning, itching, rashes, lumps, sores or ulcers
- dysuria
- testicular pain, lump or swelling
- body rashes
• major flu like symptoms, including lymphadenopathy
• tattoos, piercings, blood transfusions.

If presence of any symptoms ask type, duration, severity and any treatments used.

Table 1. Provides guidelines for sample collection and physical examination – Men Who Have Sex With Women

<table>
<thead>
<tr>
<th>Men Who Have Sex With Women (Heterosexual Male) *</th>
<th>Genital Examination</th>
<th>Urethral GC / Chlam / MG</th>
<th>Serology</th>
<th>Anal GC / Chlam</th>
<th>Pharyngeal GC</th>
</tr>
</thead>
<tbody>
<tr>
<td>HETEROSEXUAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asymptomatic heterosexual male including contact of Chlamydia*</td>
<td>No</td>
<td>Chlamydia urine NAAT*</td>
<td>HIV / STS +HBV / HCV (based on risk assessment)</td>
<td>No</td>
<td>No (may be required if history of oral sex)</td>
</tr>
<tr>
<td>Symptomatic heterosexual male</td>
<td>Yes</td>
<td>GC urethral gram stain &amp; culture and / or urine NAAT Chlamydia &amp; MG urine NAAT</td>
<td>Yes (as above)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Heterosexual Contact of Gonorrhoea</td>
<td>No</td>
<td>Chlamydia / GC urine NAAT</td>
<td>Yes (as above)</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

* If contact with someone from country other than Australia consider addition of Gonorrhoea based on epidemiological risk.

^ If urethral symptoms present. Evidence shows MG prevalence is second only to chlamydia and as testing is available through Public laboratories it is important to test due to emerging evidence about Macrolide resistant Mg.

Please note: if unable to obtain specimen, document this in medical record.

Other tests can be performed at the clinician’s discretion with clinical justification documented in the medical record.
Table 2. Provides guidelines on sample collection and physical examination – men who have sex with men (MSM)

<table>
<thead>
<tr>
<th>Men Who Have Sex with Men</th>
<th>Genital Examination</th>
<th>Urethral GC / Chlam / MG</th>
<th>Serology</th>
<th>Anal GC / Chlam</th>
<th>Pharyngeal GC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MSM</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asymptomatic MSM (including asymptomatic contacts of Chlamydia and NGU)</td>
<td>No</td>
<td>Chlamydia urine NAAT</td>
<td>Based on risk assessment &amp; STIGMA guidelines</td>
<td>GC / Chlamydia NAAT (Clinician or patient collected) ^^</td>
<td>GC NAAT / culture Chlam NAAT (Clinician or client collected)</td>
</tr>
<tr>
<td>MSM with urethral symptoms</td>
<td>Yes</td>
<td>GC urethral gram stain &amp; NAAT or culture Chlamydia urine NAAT^^ Consider MG urine NAAT</td>
<td>Yes (as above)</td>
<td>Yes (as above)</td>
<td>GC NAAT / culture Chlam NAAT</td>
</tr>
<tr>
<td>MSM with Rectal symptoms ^^^</td>
<td>Yes</td>
<td>Chlamydia urine NAAT</td>
<td>Yes (as above)</td>
<td>Clinician collected only Chlam NAAT / GC culture or NAAT Refer for LGV testing if chlamydia positive</td>
<td>GC NAAT / culture Chlam NAAT</td>
</tr>
<tr>
<td>Asymptomatic MSM Contact for Gonorrhoea</td>
<td>No</td>
<td>Chlamydia and Gonorrhoea urine NAAT</td>
<td>YES (as above)</td>
<td>GC / Chlamydia NAAT (Clinician or patient collected) ^^^</td>
<td>Culture and NAAT for GC contacts Chlam NAAT</td>
</tr>
</tbody>
</table>

## Can be performed on single first catch urine sample.

^### MSM with rectal symptoms / signs must be referred to MO.

Other tests can be performed at the clinician’s discretion with clinical justification documented in the medical record.
### Table 3. Screening Serology for MSM and Heterosexual Males

<table>
<thead>
<tr>
<th>Infection</th>
<th>Screening Tests may include: (check with local laboratory)</th>
<th>Indication / Action in sexual health context</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>HIV Antibody / Antigen</td>
<td>Based on risk assessment.</td>
</tr>
<tr>
<td>Syphilis</td>
<td>Syphilis EIA RPR / VDRL TPPA FTA Standard Tests for Syphilis (STS)</td>
<td>Note on laboratory form if previously treated syphilis or suspected early infection.</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>Hepatitis A Total Antibody</td>
<td>MSM screening, HIV positive, Chronic Hepatitis C, Chronic Hepatitis B. Recommend vaccination if not immune.</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Hepatitis B Core Antibody anti-HBc Hepatitis B surface Antigen HBsAg Hepatitis B Surface Antibody anti-HBs</td>
<td>Based on risk assessment. MSM screening Sex workers People from high endemicity countries Aboriginal and Torres Strait Islander people HIV positive Chronic Hepatitis C People Who Inject Drugs People who have been in custodial settings The universal vaccination program commenced in 2000 for all newborns. Hepatitis B vaccine was incorporated into the school based Adolescent Vaccination Program in 2004. Consider testing / vaccination for marginalised young people who may not have had school vaccinations. Recommend vaccination if not immune.</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>Hepatitis C Antibody Hep C Ab</td>
<td>Based on risk assessment. HIV positive Chronic Hepatitis B People Who Inject Drugs People who have been in custodial settings</td>
</tr>
</tbody>
</table>

* If contact with someone from country other than Australia consider addition of Gonorrhoea based on epidemiological risk.

# If unable to obtain specimen document this in medical record.

## Can be performed on single first catch urine sample.
3.2 Clinical Examination and Testing Procedure

Prepare equipment as required according to clinic protocol:

Genital examination
- palpate the inguinal nodes
- inspect pubic hair for lice and nits
- inspect the penile shaft, glans, meatus, retract foreskin if present and perianal area for lumps or lesions
- roll each testicle between thumb and fingers; the surface of the testicle should feel smooth
- palpate the epididymis, the cord-like structure running along the top and back of the testicle
- note lumps, pain or swelling.

Pharyngeal swab
- position the client for comfort
- palpate lymph nodes of the head and neck noting size, shape, mobility, consistency or tenderness; gently depress the tongue with a spatula
- view tonsillar crypts and posterior pharynx for signs of oedema, exudate, ulceration or tonsillar enlargement
- using the appropriate cotton tipped swab, swab the tonsillar crypts and posterior pharynx
- inoculate the culture medium or follow manufacturer’s instruction for NAAT or place in gel transport media.

Urethral swab
In asymptomatic males urethral meatal swabs are acceptable and effective at detecting NG and Chlamydia using NAAT
- retract the foreskin
- depress the urethra from the base of the penis to the glans or instruct the client to do the same.

If microscopy on site:
- with the meatus held open, gently insert the nunc loop or swab 5 mm into the distal urethra, collecting any secretions
- wipe the nunc or swab onto a glass slide
- inoculate the Gonorrhoea culture medium follow manufacturer’s instruction for NAAT or place in gel transport media.

If no microscopy on site:
- with the meatus held open, gently insert the transport swab 5 mm into the distal urethra, collecting any secretions
- inoculate the Gonorrhoea culture medium as per site. Follow manufacturer’s instruction for NAAT or place in gel transport media.

Urine collection
- instruct the client to void the first 10–30 mls of urine into a specimen container.
Rectal swab
- instruct the client into a lateral position with knees flexed
- ask the client to lift their upper buttock with their hand
- inspect perianal area for lesions, warts, rashes, skin tears or any other abnormalities
- lubricate the swabs with normal saline or sterile water
- insert each swab 3–4cm into the anal canal and rotate
- using the appropriate cotton tipped swab Innoculate culture medium or follow manufacturer’s instruction for NAAT or place in gel transport media.

3.3 Self collected rectal specimen collection
Self collected samples are acceptable and effective at detecting NG and Chlamydia using NAAT

Procedure:
- instruction should be given on hand washing before and after specimen collection
- specimens should be labelled prior to collection and biohazard bag / kidney dish provided for transport
- using the transport swab, moisten the swab tip with several drops of saline or sterile water to facilitate insertion
- instructional diagram can be provided to the client – see Appendix C13.1.

4. Documentation
Complete consultation to be documented in medical record including:
- presenting issue
- sexual health history
- presence of any symptoms
- tests collected and sites screened
- findings of physical examination
- diagrams to show location of clinical abnormalities are acceptable.

Document any reason for decline of physical examination if self collect swabs taken.

Documenting male physical exam includes:
- inguinal nodes: palpable, tender
- pubic, penile, perianal, rectal areas: spots, rashes, lumps, lesions, ulcers, redness, swelling
- meatus: discharge, erythema, lesions, ulcers
- testicles: lumps, tenderness or swelling
- throat and tongue: appearance, ulcers, lesions.
5. Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AntiHBc</td>
<td>Antibody to the Hepatitis B Virus core</td>
</tr>
<tr>
<td>Anti-HBs</td>
<td>Antibody to the Hepatitis B Virus surface</td>
</tr>
<tr>
<td>AntHCV</td>
<td>Antibody to Hepatitis C Virus</td>
</tr>
<tr>
<td>BBV</td>
<td>Blood Borne Virus</td>
</tr>
<tr>
<td>FCU</td>
<td>First Catch Urine</td>
</tr>
<tr>
<td>GC</td>
<td>Gonococcal</td>
</tr>
<tr>
<td>HBsAg</td>
<td>Hepatitis B Surface Antigen</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>LGV</td>
<td>Lymphogranuloma Venereum</td>
</tr>
<tr>
<td>MG</td>
<td>Mycoplasma Genitalium</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>NAAT</td>
<td>Nucleic Acid Amplification Tests</td>
</tr>
<tr>
<td>NGU</td>
<td>Non-Gonococcal Urethritis</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmissible Infection</td>
</tr>
<tr>
<td>STIGMA</td>
<td>Sexually Transmissible Infections in Gay Men Action Group</td>
</tr>
<tr>
<td>STS</td>
<td>Standard tests for Syphilis</td>
</tr>
</tbody>
</table>

6. References


7. Appendix

APPENDIX C13 – STI TESTING – MALE

Printable copies of the “Self Collected Specimens Chart” are available at: www.stipu.nsw.gov.au accessed September 26 2014

APPENDIX C13.1 – SELF COLLECTED ANAL SWAB DIAGRAM AND INSTRUCTIONS

![Anal Swab Diagram](image)

Design: Slade Smith http://members.iinet.net.au/~sladesmith

This card is for GPs and their patients and it aims to assist in self collection techniques for urine, vaginal and anal samples.

Why self collection?

Current PCR technology is very sensitive and has been validated for urine, vaginal and anal specimens. Self collection of specimens by patients is acceptable and can be helpful in situations where the patient is uncomfortable with the clinician collecting the sample directly or where consultation times are limited.

When is self collection of swab samples appropriate?

Self collected anal and vaginal swabs are only appropriate for asymptomatic patients. If patients have any symptoms a physical examination and clinician collected swab samples are recommended.
Preparing swabs for the client

1. Show the swab to the client.

2. Label the tubes with the patient’s details to avoid having to handle the tube after the patient returns the specimen.

3. Moisten the tip of the swab with saline or sterile water.

4. Remove the cap from the tube, put the swab inside and seal the tube.

5. Put all equipment in the specimen bag and hand it to the patient.

6. Review the collection process with the patient and remind them to put the swab inside the tube, seal the tube and put the sealed tube inside the specimen bag.
C14 SCREENING WOMEN FOR SEXUALLY TRANSMISSIBLE INFECTIONS

1. Purpose and scope
To provide procedural guidelines on routine screening and testing for sexually transmissible infections and Pap smears in women.

2. Outcomes
Screening and testing for STI and BBV reflects current evidence and best practice. Women are appropriately screened and tested.

3. Procedure
Preparation:
- a sexual health history should be collected prior to screening. Sexual History Taking – see Section C15
- a routine asymptomatic STI / BBV check at a sexual health service should include a physical genital examination and speculum examination or option for self collected swabs
- if a woman declines examination then self collected swabs may be offered and this should be documented in the client medical record (see Table 1 below)
- ensure client privacy and consent throughout the procedure
- standard tests are outlined in the tables below however tests may vary based on individual assessment
- testing for contacts of non-gonococcal urethritis (NGU), Gonorrhoea and / or Chlamydia should include standard tests as outlined in Table 1.

3.1 History Taking
In conjunction with a full medical, social and sexual history, establish clinical and symptomatic history to determine what tests to perform.

Clinical and symptomatic history includes presence of:
- vaginal or rectal discharge: colour, odour, consistency
- external genital lesions: burning, itching, rashes, lumps, sores or ulcers
- dyspareunia: deep or superficial
- irregular per vaginal (PV) bleeding: post coital bleeding (PCB), intermenstual or breakthrough bleeding (IMB / BTB)
- last menstrual period (LMP: if delayed establish pregnancy risk and symptoms)
- dysuria
- body rashes
- major flu illness including lymphadenophathy
- current contraception
- cervical screening history
- tattoos, piercing, blood transfusions
- if presence of any symptoms, ask type, duration, severity and any treatments used.
Table 1. Provides guidelines on sample collection and physical examination

<table>
<thead>
<tr>
<th>Female Sexual Health</th>
<th>Genital Examination</th>
<th>Gram stain</th>
<th>Wet film</th>
<th>Cx GC/Chlam</th>
<th>Anal GC/Chlam</th>
<th>Pharyngeal GC</th>
<th>Bi-manual</th>
<th>PAP smear</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asymptomatic (including asymptomatic NGU/ Chlamydia contacts)</td>
<td>NO unless requested by client</td>
<td>NO</td>
<td>NO</td>
<td>NO Self collected LVS NAAT for Chlamydia,## &amp; Gonorrhoea</td>
<td>YES if indicated @ Chlamydia &amp; Gonorrhoea NAAT</td>
<td>NO (may be required if history of oral sex) Gonorrhoea NAAT / Culture if sex worker screen ~</td>
<td>Not required</td>
<td>Opportunistic** Pap smear* only</td>
</tr>
<tr>
<td>Asymptomatic Gonorrhoea contacts</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>YES Self collected LVS NAAT for Chlamydia,## &amp; Gonorrhoea</td>
<td>YES if indicated @ Chlamydia &amp; Gonorrhoea NAAT</td>
<td>YES if indicated Gonorrhoea NAAT / Culture if sex worker screen ~</td>
<td>NO</td>
<td>Opportunistic** or if clinically indicated*</td>
</tr>
<tr>
<td>Symptomatic</td>
<td>YES</td>
<td>YES HVS &amp; cervical^</td>
<td>Wet film HVS</td>
<td>YES Endocervical swab for Chlamydia, NAAT, MG NAAT &amp; Gonorrhoea NAAT or culture***</td>
<td>YES if indicated @ Chlamydia and Gonorrhoea NAAT</td>
<td>YES if indicated Gonorrhoea NAAT / Culture if sex worker screen ~</td>
<td>YES</td>
<td>YES if clinically indicated*</td>
</tr>
</tbody>
</table>

## LVS NAAT Chlamydia / Gonorrhoea is preferred over urine as the small decrease in specificity could markedly decrease the positive predictive value in low prevalence populations. However, first catch urine for NAAT is still preferable to not screening the patient. If HVS or urine NAAT positive for N. Gonorrhoea, recall client to have culture to confirm where available, prior to treatment or at time of treatment if woman prefers immediate treatment.

^ Cervical gram stain only in those with mucopurulent cervicitis.

* Collection of Pap smears should be deferred if the woman is menstruating as the blood will interfere with specimen interpretation. However, other STI screening can be performed at this time.

** Pap smears can be offered to women in the SSHC priority groups who would not otherwise access a GP and in women with IMB or PCB.

*** Women who have signs of cervicitis should have endocervical Gonorrhoea culture taken if available and cervical MG NAAT added. Evidence shows MG prevalence is second only to chlamydia and as MG testing is available through Public laboratories it is important to test due to emerging evidence about Macrolide resistant MG. Females that present with vaginal symptoms only, a chlamydia/Gonorrhoea NAAT is the preferred test.

@ If a woman reports exclusive unprotected receptive anal intercourse ie. not having also had unprotected vaginal intercourse with the same person, has rectal symptoms, or is specifically requesting the test.

~ Australian STI Guidelines state in sex workers “If NAAT test result is positive, take swab at relevant site(s) for culture, before treatment. Cultures are the preferred test for samples from non-genital sites”

^^ Consider MG NAAT in women with persistent vaginal symptoms in patients who declined an exam.
Table 2. Provides guidelines on Serology Screening

<table>
<thead>
<tr>
<th>Infection</th>
<th>Screening Tests may include: (check with local laboratory)</th>
<th>Indication / Action in sexual health context</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>HIV Antibody Antigen</td>
<td>Based on risk assessment.</td>
</tr>
<tr>
<td>Syphilis</td>
<td>Syphilis EIA RPR / VDRL TPPA FTA Standard Tests for Syphilis (STS)</td>
<td>Note on laboratory form if previously treated syphilis or suspected early infection.</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Hepatitis B Core Antibody anti-HBc Hepatitis B surface Antigen HBsAg Hepatitis B Surface Antibody anti-HBs</td>
<td>Based on risk assessment. Sex workers; People from high endemicity countries; Aboriginal and Torres Strait Islander people; PLHIV; Chronic Hepatitis C; People who inject Drugs (PWID); People who have been in custodial settings. The universal vaccination program commenced in 2000 for all newborns. Hepatitis B vaccine was incorporated into the school based Adolescent Vaccination Program in 2004. Consider testing / vaccination for marginalised young people who may not have had school vaccinations recommend vaccination if not immune.</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>Hepatitis C Antibody</td>
<td>Based on risk assessment. HIV positive, Chronic Hepatitis B, PWID. People who have been in custodial settings.</td>
</tr>
</tbody>
</table>

3.2 Genital Exam and Testing Procedure

Offer the client the opportunity to empty her bladder prior to examination in order to optimise comfort (except in those women who have had a hysterectomy or have urethral symptoms).

Prepare equipment as required according to clinic protocol and availability, for example:

- Gonorrhoea culture medium or transport swab
- PCR collection kit
- cotton tipped wooden swab x 2
- large cotton mop x 1
- glass slide x 2
- saline
- cover slip
- speculum
- water based lubricant
- gloves.
Add for symptomatic:

- sabouraud culture plate / swab for MC&S
- pH strip
- cotton tipped wooden swab x 1.

Add for Pap smear:

- glass slide x 1
- cervex sampler
- cytobrush
- spray fixative
- pap slide holder.

External genital exam

Procedure:

- ask the client to recline in the supine position
- palpate the lower abdominal area and inguinal lymph nodes
- ask the client to open her legs into the lithotomy position
- inspect the pubic hair for lice and nits
- inspect the vulva, introitus, perineum and anus for lumps and other lesions.

Speculum examination

Procedure:

- a small amount of water or water-based lubricant can be used to aid insertion of the speculum
- advise the client about how to relax their pelvic muscles before inserting the speculum
- separate the labia, ensuring you avoid touching the clitoris
- gently insert the closed speculum following the posterior vaginal wall
- gently open the blades to locate and visualise the cervix
- inspect the vaginal walls and cervix for any sign of abnormality. If foreign body is noted refer to Section C12 – Removal of Foreign Body
- if difficulty is experienced locating the cervix, remove the speculum. Insert 1 finger into the vagina to feel for the position of the cervix. Re-insert the speculum in the direction of the located cervix
- to remove the speculum at completion of the exam, gently pull the speculum back to clear the blades from the cervix and then gently close the blades while removing the speculum.

Endocervical swab collection

The order of endocervical swab collection can vary. Collect the most relevant swab first, based on the clinical assessment of the client.

Procedure:

- insert a cotton tipped swab approximately 0.5–1.0 cms into the endocervical canal, avoiding contact with the vaginal walls
- rotate the swab to allow secretions to be absorbed
• if performing a gram stain roll / wipe the swab onto a glass slide prior to inoculating culture
• if not undertaking microscopy on site place the swab into gel transport media
• collect another swab and inoculate the Gonorrhoea culture medium or follow manufacturer’s instruction for NAAT. For a pinpoint os, a rayon tipped, aluminium stemmed swab is recommended
• repeat collection process with PCR collection kit
• depending on pathology services, some clinics may use same swab for both tests.

High vaginal swab collection
Procedure:

• sample the discharge present at the posterior fornix with a cotton tipped swab
• roll / wipe the swab onto a glass slide for a gram stain
• if performing wet film, gently tap the swab into a drop of saline on a separate glass slide
• place the cover slip over the drop of saline
• if the woman reports a discharge or odour, test pH on an indicator stick
• if indicated, inoculate a Sabauraud culture plate (for yeast culture)
• If not undertaking local microscopy and culture place swab in gel transport media.

Pap smear
Procedure:

• if necessary, remove secretions from the ectocervix with a cotton mop
• insert the Cervex Sampler into the cervical os and using a firm action, rotate 360o, repeat
• if squamocolumnar junction is not visible, add cytobrush inserting it gently into the os and rotate 360o once only
• transfer the specimens onto the glass slide by wiping in 1 direction, covering the surface area of the slide
• if a cytobrush is used roll the cytobrush across half the surface area of the slide
• transferring the specimens to the slide must be performed within 10 seconds or air-drying may occur
• spray the slide with spray fixative and then place in the plastic pap slide holder.

3.3 Other collected specimens

Vulval swab for candida culture
Using cotton tipped swab, sample the affected area. Wipe / roll onto a glass slide for gram stain and then inoculate the culture medium or use transport medium as per site.

Urethral swab for Neisseria Gonorrhoea
Procedure:

• locate the urethral meatus
• insert the nunc loop approximately 5 mm into the urethra
• gently rotate the loop
• roll / wipe the loop onto the glass slide and inoculate the culture medium or follow manufacturer’s instruction for NAAT
• alternatively use an aluminium stem nasal swab and place in gel transport media.
Pharyngeal Swab

- see diagram above
- position the client for comfort
- palpate lymph nodes of the head and neck noting size, shape, mobility, consistency or tenderness
- depress the midpoint of the arched tongue with spatula
- view tonsillar crypts and posterior pharynx for signs of oedema, exudate, ulceration or tonsillar enlargement

'Design: Slade Smith http://members.iinet.net.au/~sladesmith'
• depress the tongue with the spatula
• using the appropriate cotton tipped swab, swab the tonsillar crypts and posterior pharynx
• inoculate the culture medium or follow manufacturer’s instruction for NAAT or place in gel transport media.

Rectal swab

Procedure:
• ask the client to turn into the left lateral position with knees flexed
• ask the client to lift their upper buttock with their hand
• inspect perianal area for lesions, warts, rashes, skin tears or any other abnormalities
• lubricate the swabs with the normal saline
• insert each swab 3–4 cm into the anal canal and rotate
• using the appropriate cotton tipped swab inoculate the culture medium or follow manufacturer’s instruction for NAAT or place in gel transport media.

3.4 Self collected specimens

Instruction sheets for patients are available on the STIPU website

Instruction should be given on routine hand washing before and after specimen collection. All specimens should be labelled and a biohazard bag or kidney dish given to patients for transport to and from the toilets.

Self-collected vaginal swab

A self-collected vaginal swab is considered adequate for Chlamydia and Gonococcal PCR in asymptomatic women who decline a genital exam.

See Diagram in Appendix C14.1 – Self Collected Vaginal Swab
• show client the NAAT swab and explain how to open the swab kit
• instruct the client to insert the swab/s 3–5 cm into the lower vagina and rotate
• once swab removed from vagina ask client to follow manufacturer’s instruction for NAAT.

Self Collected Anal Swab

See Diagram in Appendix C13.1:
• show client the NAAT swab and explain how to open kit
• instruct the client to insert swab 3–4 cm into the rectal canal; swab may be moistened with saline or sterile water to facilitate insertion
• once swab removed from rectal canal ask client to follow manufacturer’s instruction for NAAT.

4. Documentation

Complete consultation to be documented in medical record including:
• presenting issue
• sexual health history
• presence of any symptoms
tests collected and sites screened
findings of physical examination
diagrams to show location of signs are acceptable
document any reason for decline of physical examination or if self collected swabs taken.

Documenting a female physical examination includes:

inguinal nodes: palpable, tender
public, vulval, perianal, rectal area: spots, rashes, lumps, lesions, cuts, redness swelling, presence of ectoparasites
vagina: colour, consistency of vaginal secretions, any inflammation of vaginal wall, lesions or lumps, odour, discomfort with speculum examination
cervix: appearance and size of os, colour and consistency of secretions from the cervix
bimanual examination: cervical motion tenderness (CMT), masses adenexal tenderness, uterine position
throat and tongue: appearance, ulcers, lesions

laboratory request form should include reason for tests being taken asymptomatic screen, contact of positive diagnosis, symptomatic (and describe symptoms and / or signs).

### 5. Definitions

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti HBVc</td>
<td>Core antibodies to Hepatitis B</td>
</tr>
<tr>
<td>BBV</td>
<td>Blood Borne Virus</td>
</tr>
<tr>
<td>BTB</td>
<td>Breakthrough Bleeding</td>
</tr>
<tr>
<td>CMT</td>
<td>Cervical Motion Tenderness</td>
</tr>
<tr>
<td>HCV</td>
<td>Hepatitis C Virus</td>
</tr>
<tr>
<td>IMB</td>
<td>Intermenstrual Bleeding</td>
</tr>
<tr>
<td>LMP</td>
<td>Last Menstrual Period</td>
</tr>
<tr>
<td>LVS</td>
<td>Low Vaginal Swab</td>
</tr>
<tr>
<td>MC&amp;S</td>
<td>Microscopy, culture and sensitivity</td>
</tr>
<tr>
<td>MG</td>
<td>Mycoplasma Genitalium</td>
</tr>
<tr>
<td>NAAT</td>
<td>Nucleic Acid Amplification Tests</td>
</tr>
<tr>
<td>NGU</td>
<td>Non Gonococcal Urethritis</td>
</tr>
<tr>
<td>PCB</td>
<td>Post Coital Bleeding</td>
</tr>
<tr>
<td>PCR</td>
<td>Polymerase Chain Reaction</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People living with HIV</td>
</tr>
<tr>
<td>PV</td>
<td>Per Vaginal</td>
</tr>
<tr>
<td>PWID</td>
<td>People who Inject Drugs</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmissible Infection</td>
</tr>
<tr>
<td>STS</td>
<td>Standard Tests for Syphilis</td>
</tr>
<tr>
<td>STIPU</td>
<td>STI Programs Unit</td>
</tr>
</tbody>
</table>
6. References


7. Appendix

APPENDIX C14 – STI testing – Female

Printable copies of the “Self Collected Specimens Chart” available at www.stipu.nsw.gov.au

APPENDIX C14.1 – Diagram self collected vaginal swab

Vaginal Swab

1. Wash your hands with soap.

2. Sit on the toilet or stand with one foot resting on the edge of the toilet. Separate the labia (folds).

3. Put the tip of the cotton swab stick about 2cm inside the vagina. Twist or rotate the swab once. Count to ten and remove the swab.

4. Follow instructions given by your doctor or nurse.

5. Wash your hands with soap.

Design: Slade Smith http://members.iinet.net.au/~sladesmith
C15 SEXUAL HEALTH HISTORY TAKING

1. Purpose and scope
To provide information about, and guide the practice of clinical staff in relation to sexual history taking in the sexual health clinical setting.

2. Outcomes
All clients attending sexual health services will have a sexual history undertaken as part of their consultation.
A concise sexual history will enable sexual health staff and clients to:

- identify specific risk behaviours
- assess symptoms to guide examination and testing
- identify anatomical sites for testing based on risk
- assess other related sexual health issues, including pregnancy risk and contraceptive needs
- inform the counselling process, health education required and contact tracing.
- identify opportunities for other health interventions eg. referral to drug and alcohol or mental health services, domestic violence, sexual assault and referrals to GPs for non-sexual health related issues.

3. Procedure

3.1 General principles

- confirm correct client identification
- introduce self and role
- clients are often anxious; creating a relaxed and friendly environment with respectful and a non-judgemental attitude should be part of the initial consultation
- good communication skills are required and may be particularly important in obtaining an accurate sexual history. Maintaining eye contact and having appropriate body language as well as the appropriate use of interpreters are important
- explain confidentiality and privacy issues and legal limitations of the same. Students and observers should be present only with the client’s consent, and the wishes of the client should be respected if consent is denied
- use language that is understandable to the client and normalises potentially uncomfortable topics. Avoid language which labels and makes judgements
- avoid making assumptions about client’s sexual orientation based on appearance
- ask general questions first, using open ended questions. Move on to the exploration of initial concerns and more closed ended questions as the sexual history taking proceeds
- provide a context for the questions to be asked and explain there are some ‘universal’ questions that are explicitly asked of all clients to assess risk
- sexual history taking provides an opportunity for client education around the issues of STI and safer sex practices.
3.2 Components of sexual history

**Reason for attendance:** the problem / issue, including symptoms.

**Symptom review:** ask symptomatic and asymptomatic clients, as questioning may reveal overlooked or ignored problems.

Direct questions about symptoms may include:

- duration and severity of symptoms
- urethral and vaginal discharge: amount, colour, odour, character
- abnormal vaginal or rectal bleeding
- genital rashes, lumps or sores
- itching and / or discomfort in the perineum, peri-anal and pubic region
- lower abdominal pain or dyspareunia
- difficulties / pain with micturition, defecation or during intercourse
- extra genital rashes
- acute seroconversion illness: night sweats, fever, oral ulceration, maculopapular skin rashes, myalgia.

**Sexual Behaviour Risk Assessment:** due to the sensitive nature of questioning, explain the context in which these are being asked.

Questions should assess:

- last sexual intercourse (LSI)
- last unprotected sexual intercourse
- history of unprotected intercourse
- gender of sexual contacts
- type of sexual activity practised (oral, anal, vaginal, toys)
- STI prevention used and whether consistently used and remained intact (condoms, dam)
- relationship with sexual contacts (regular, casual, known, unknown)
- are they able to contact partners if required
- have any recent sexual contacts had any symptoms or infections?
- number of opposite and / or same sex partners in the last 3 months and 12 months collectively.

At the first consultation take a sexual history and other history including:

- a full routine medical, allergy, social, alcohol and other drugs including injecting drug use, family
- gynaecological and reproductive, blood transfusion, tattooing, body piercing and past imprisonment
- history updated on each further visit as required.

**STI and BBV Risk Assessment:** additional questions to assess timing of tests and other risks to inform testing and management planning.

Questions should assess:

- date and results of previous STI and BBV testing
- history of syphilis infection including date and type of treatment
• past medical and surgical history (including any overseas medical treatment)
• alcohol, tobacco and other drug use
• current or past history of injecting drug use, sharing of needles, syringes or drug preparation equipment
• whether they have had sex overseas other than with the person they are travelling with. Record the nationality or country of birth of their sexual partners
• past confinement in gaol
• all men should be asked if they have ever had sex with another man
• sex industry worker or sexual contact with a sex worker
• previous blood transfusion history including country, date and reason for transfusion
• history of body piercing and / or tattoos including country, when done and whether sterile equipment used
• vaccination history including Hepatitis A, B and HPV.

Other relevant information: to identify issues that may be associated with or influence client management:
• current or recent medications
• recent course of antibiotics
• history of allergies especially adverse reaction to Penicillin
• contraceptive and reproductive health history, including contraceptive use and compliance and last menstrual period (LMP)
• cervical cytology history including date of last test and result, past abnormal cytology.

Clients under 16 years
Refer to Consent (Section G2) and Protecting Children and Young People (Section G6).

On completion of sexual history:
 • check that the client does not have any other concerns
 • explain the clinical examination and tests to follow
 • document if observer is present during consultation (eg. student, chaperone, interpreter)
 • how to obtain results: in person, by phone, booked or walk in appointment
 • when risk behaviour is identified referral to counsellor is recommended, if this is not possible or client is not agreeable, refer to SOP P3 – STI Prevention Counselling Guidelines to address risk taking behaviour.

4. Documentation

Sexual History will be documented using approved clinic visit forms.

Templates are provided for:
Sexual health service initial visit – see Appendix C15.1
Sexual health service further visit – see Appendix C15.2
Sexual Health Youth Outreach initial visit – see Appendix C15.3
Sexual Health Counselling Initial Visit – see Appendix C15.4
5. Definitions

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>BBV</td>
<td>Blood Borne Virus</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HPV</td>
<td>Human Papilloma Virus</td>
</tr>
<tr>
<td>LMP</td>
<td>Last Menstrual Period</td>
</tr>
<tr>
<td>LSI</td>
<td>Last Sexual Intercourse</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmissible Infection</td>
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</table>

6. References


7. Appendices

APPENDIX C15.1 – Sexual History Taking Allergy image to registration and further visit emailed separately

Registration

History/Physical Examination

Consult date

The patient presented for:

- Contact of STI:
- STI screening/testing
- HIV testing or monitoring
- HAV testing or vaccination
- HBV testing, monitoring or vacc.
- HCV testing or monitoring
- Pap smear
- ECP/Contraception (or advice)
- Sexual function / relationship
- Other advice / counselling
- Post-exposure prophylaxis
- PREP
- Review / management of a previously diagnosed condition
- Review / management from SSHC outreach screening
- Results
- Other

Ano/genital symptoms? □ No □ Yes
Other symptoms? □ No □ Yes
(You must complete this box)

Current or recent (2 mths) medications:

Drug allergy:

Other allergy:

CHECK ALLERGY STATUS
CHECK CLIENT MOBILE NUMBER

Microscopy results

<table>
<thead>
<tr>
<th>Site</th>
<th>TV</th>
<th>ONID</th>
<th>PMN</th>
<th>Lacto</th>
<th>Cells</th>
<th>Yeast</th>
<th>Other</th>
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<tr>
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<td></td>
<td></td>
<td>□</td>
<td>□</td>
<td></td>
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<td></td>
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<td>□</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urethra</td>
<td>□</td>
<td></td>
<td></td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wet prep</td>
<td>□</td>
<td>□</td>
<td></td>
<td>□</td>
<td>□</td>
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Slide read by: ________________________________

Sydney Sexual Health Centre - Registration pl – 27 November 2014
<table>
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<th>Past STI and G-U conditions</th>
<th>Ever tested for STIs?</th>
<th>No</th>
<th>Yes</th>
<th>Unsure</th>
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<td>no STI / nil known</td>
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<td>[ ]</td>
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<td></td>
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<td>proctitis / proctocolitis</td>
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<td></td>
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<td>bacterial vaginosis</td>
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<td>[ ]</td>
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<td>[ ]</td>
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</tr>
<tr>
<td>NGU</td>
<td>[ ]</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>other (specify)</td>
<td>[ ]</td>
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Please specify dates, methods of diagnosis, treatment etc.

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<tr>
<th>HAV status</th>
<th>not tested / unsure</th>
<th>acute HAV in past</th>
<th>subclinical ('immune')</th>
<th>HAV negative</th>
<th>HAV vaccine</th>
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</thead>
<tbody>
<tr>
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<table>
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<th>subclinical/immune</th>
<th>HBV carrier</th>
<th>HBV negative - no vaccination</th>
<th>HBV vaccination</th>
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<tbody>
<tr>
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<table>
<thead>
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<th>HCV status</th>
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<th>acute HCV in past</th>
<th>HCV negative</th>
<th>HCV positive</th>
<th>HCV a-viremic</th>
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</thead>
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<tr>
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<table>
<thead>
<tr>
<th>HPV vaccine status</th>
<th>No / unsure</th>
<th>Quadrivalent (Gardasil)</th>
<th>Bivalent (Cervarix)</th>
<th>Unknown vaccine:</th>
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<tbody>
<tr>
<td>If unknown, state country:</td>
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<table>
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<th>HPV status</th>
<th>not tested / unsure</th>
<th>tested negative</th>
<th>tested positive</th>
<th>test pending</th>
<th>Current ART therapy</th>
<th>nil</th>
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</table>

Approximate date of first positive or last negative or indeterminate test

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<tr>
<th>Tested where?</th>
<th>SSHC</th>
<th>Interstate</th>
<th>blood bank</th>
<th>other NSW</th>
<th>overseas</th>
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<th>asymptomatic</th>
<th>not AIDS</th>
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Most recent CD4 count

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<th>mm</th>
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Most recent viral load

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<th>Date</th>
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Cervical cytology and histology

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<th>Never had a Pap smear</th>
<th>Date of most recent smear</th>
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<td>normal</td>
<td>abnormal</td>
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Contraception

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<th>rhythm / natural</th>
<th>nil; inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>details</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Menstrual Hx

| | never pregnant | TOP | miscarriage n | live births n |
| | | | | |

Parity

| details | | | |
|----------| | | |

Sydney Sexual Health Centre - Registration no. 2 - 27 November 2014
Sexual History

Last contact - Who/When/Where?

 Practices

STI/HIV avoidance

Previous contact - Who/When/Where?

 Practices

STI/HIV avoidance

Other

Current

Duration / type

No. of MALE sex partners*
- last 3 months
- last 12 months

No. of FEMALE sex partners*
- last 3 months
- last 12 months

Details

No
Yes

Anal / vaginal sex with a condom in past 3 months with REGULAR partners (non-paying partners)

Details

No condoms
Some days
Usually
Always
Not applicable

Anal / vaginal sex with a condom in past 3 months with CASUAL partners (non-paying partners)

Details

No condoms
Some days
Usually
Always
Not applicable

Any partners, past or present, possibly at increased risk of STI/HIV?

Details

No
ho/bi
male
IDU
female
W in Aust
het.
partner with mut. partners
trans-
gender
partner from high prev.
country
other

Any sexual contacts outside Australia with a new partner in last 12/12

Details

No
Yes

If YES, which countries?

Details

Thailand
Philippines
Africa
North America
Central & South America
Europe (including UK)
Pacific (include PNG, not NZ)
New Zealand
Middle East

Was a condom used?

Details

No
Yes

Drug use
Cigarettes or equivalent per day

Details

day

No
Yes

Alcohol (one standard drink=10g)

Details

g/week

Injecting drug use?

Details

Never
Yes

If YES, most common drug

Details

Heroin
Amphetamines
Other (specify below)

Date last used

Details

If ever shared, date last shared

Date last used

Details

Needles/syringes

IDU pattern (when using)

Details

Rarely, <1 per month
1-3 per month
>3 per month
1-3 per day
>3 per day

IDU treatment programme?

Details

Never
In past
Currently

Other drug use issues

Details

Example only
Provisional Diagnosis – first SSHC visit with this condition; make later amendments in RED, initial and date

1. 
2. 
3. 
4. 
5. 

Micro / Histology:
- Genital Gr
- Pharynx Gr
- Anal Gr
- Urinary Gr
- Urinary Chem
- Genital Chem
- Sab
- HSV PCR
- MSU
- Pap
- Bs
- UHCG
- MG
- Sting PCR
- Other (specify)

Blood:
- STS
- RPR
- anti-HIV
- POCT
- anti-HIV
- anti-HBc
- anti-HBs
- anti-HBe
- anti-HCV
- anti-HCV
- anti-HSV
- HIV
- viral load
- T-cells
- FBC
- LFT's
- UOC
- Other

Immediate Management:
- No
- Podo
- Other contraception
- HPV vacc
- Other
- ARV
- Hep B vacc
- Cryo
- OCP/ECP
- Hep A vacc
- Topical
- Systemic antimicrobial

Drug / Dose / Frequency / Amount

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<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Frequency</th>
<th>Amount</th>
</tr>
</thead>
</table>

Prescribed (sign) | Date prescribed | Given/checked (initial) | Date/time given |

Details:

Partner Notification

Total # contactable

Total # contacted

Provider

Provider*

Follow up - where & when

Details:

Print surname, tick box & sign across label

Dr

RN

Q&A

RQA

Data entry

Consult

SSHC label

Sydney Sexual Health Centre – Registration pd – 27 November 2014
APPENDIX C15.2 – Sexual Health History Further Visit

Further Visit

## History/Physical Examination

- [ ] Next consultation when required

## Consult date

- The patient presented for:
- [ ] Contact of STI:
- [ ] STI screening/testing
- [ ] HIV testing or monitoring
- [ ] HAV testing or vaccination
- [ ] HBV testing, monitoring or vac.
- [ ] HCV testing or monitoring
- [ ] Pap smear
- [ ] ECP/Contraception (or advise)
- [ ] Sexual function/relationship
- [ ] Other advice/counseling
- [ ] Post-exposure prophylaxis
- [ ] Review/Rel of a condition diagnosed outside SSHC

## Results

- Other:

## Persistent ano/ genital symptoms?

- [ ] No
- [ ] Yes

## New ano/ genital symptoms?

- [ ] No
- [ ] Yes

## Current/recent meets

- [ ] Other

## Last contact

- [ ] Male
- [ ] Female
- [ ] Intercourse
- [ ] Oral sex
- [ ] Anal sex
- [ ] Masturbation

## Previous contact

- [ ] Male
- [ ] Female
- [ ] Intercourse
- [ ] Oral sex
- [ ] Anal sex
- [ ] Masturbation

## Any non-paying partners, since previous reporting, possibility of increased risk of STI/HIV?

- [ ] No
- [ ] Yes

## Anal/vaginal sex

- [ ] No
- [ ] Yes
- [ ] If yes, date last IDU

## Shared needles or syringes?

- [ ] No
- [ ] Yes

---

Sydney Sexual Health Centre - Further Visit - 27 August 2022

---

*example only*
**Provisional Diagnosis**
- First 5040 visit with this condition; make later amendments in RED, initial and date

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<thead>
<tr>
<th>Diagnosis</th>
<th>Code</th>
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<tbody>
<tr>
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</table>

**Persisting condition**
- Condition previously diagnosed above and still persisting; make later amendments in RED, initial and date

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<th>Diagnosis</th>
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</tbody>
</table>

**Wet Film**
- Yes, results

<table>
<thead>
<tr>
<th>Micro / Histo</th>
<th>Blood</th>
<th>Immediate Management</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**Gram Stain**
- Yes, results

<table>
<thead>
<tr>
<th>Micro / Histo</th>
<th>Blood</th>
<th>Immediate Management</th>
</tr>
</thead>
<tbody>
<tr>
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**CHECK ALLERGY STATUS**

**CHECK CLIENT MOBILE NUMBER**

<table>
<thead>
<tr>
<th>Drug / Date / Frequency / Amount</th>
<th>Initials ( sig)</th>
<th>Date prescribed</th>
<th>Overseen ( initials)</th>
<th>Date/time given</th>
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<tbody>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

**HIV+/CD4 count**

<table>
<thead>
<tr>
<th>HIV+/CD4 count</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Viral load**

<table>
<thead>
<tr>
<th>Viral load</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Partner Notification**

<table>
<thead>
<tr>
<th>Telephone</th>
<th>Add</th>
<th>SSHC Special clinic</th>
<th>Other Sydney Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Follow up - where and when**

- Telephone
- SSHC nurse
- Drop in
- SSHC counsellor
- SSHC doctor
- Private specialist

**Client Contact**

<table>
<thead>
<tr>
<th>Print surname, tick box &amp; sign across label</th>
<th>Dr</th>
<th>RN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SSHC label**

---

**Sydney Sexual Health Centre - Further visit 5040-21 August 2013**
APPENDIX C15.3 – Youth Outreach ‘AOD’ and ‘At Risk’ Assessment Data Collection

Registration AOD and ‘At Risk’ Assessment

Additional sexual history:

Age at first contact: _______ years
N/A

Comments:

Alcohol use: In the last 12 months how often would you have consumed Alcohol?

<table>
<thead>
<tr>
<th>How often (write number)</th>
<th>None (tick box)</th>
<th>Regularly 1-7 days/week</th>
<th>Sometimes 1-3 days/month</th>
<th>Rarely &lt; 12 days/year</th>
<th>Total quantity in grams (1 std drink = 10g)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How often would more than 4 standard drinks per session be consumed:

- [ ] not applicable
- [ ] none
- [ ] sometimes less than 50%
- [ ] usually more than 50%
- [ ] always

Comments:

Other Drug use (non IDU): In the last 12 months have you consumed any of the drugs below and how often?

<table>
<thead>
<tr>
<th>Drug</th>
<th>How often (write number)</th>
<th>None (tick box)</th>
<th>Regularly 1-7 days/week</th>
<th>Sometimes 1-3 days/month</th>
<th>Rarely &lt; 12 days/year</th>
</tr>
</thead>
<tbody>
<tr>
<td>marijuana</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>amphetamines</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecstasy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In the last 3 months what % of your sexual contact has been during or after drug/alcohol consumption?

- [ ] not applicable
- [ ] none
- [ ] sometimes less than 50%
- [ ] usually more than 50%
- [ ] always

Do you perceive your alcohol/drug intake is a problem?

- [ ] No
- [ ] Yes

Have you ever attended rehab/treatment program or been help for AOD?

- [ ] No
- [ ] Yes

Comments:

Education/Employment attendance Hx:

Current education status reached:

- [ ] completed studies
- [ ] still attending educational facility

Current employment status:

- [ ] Full Time
- [ ] Part Time

Experienced any problems at school/work that have resulted in:

- [ ] Poor attendance or dropping out
- [ ] Disciplinary action, suspension, expulsion or redundancy
- [ ] Repeating a class/grade or changing school/college
- [ ] Difficulty in entering workforce
- [ ] None of the above

Comments:
Accommodation:

- [ ] with both parents
- [ ] with one parent
- [ ] with other family
- [ ] independent (e.g., flat share)
- [ ] other
- [ ] foster care
- [ ] homeless
- [ ] other
- [ ] other

Family and Social environment –

If 15 yo are parents or legal guardian aware of sexual relationships?  
- [ ] No  
- [ ] Yes  
- [ ] N/A

In the last 12 months have you experienced or been involved in any of the following (if yes, comment below):

<table>
<thead>
<tr>
<th>Psychological abuse (e.g., verbal and/or cyber aggression, threats, bullying)</th>
<th>Physical violence</th>
<th>Feelings of isolation</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
</tbody>
</table>

Psychological History:

In the last 12 months have you experienced or had feelings of (if yes, comment below):

<table>
<thead>
<tr>
<th>Anxiety/depression</th>
<th>Self-harm or suicidal ideation</th>
<th>Eating disorders</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
</tbody>
</table>

Current or past Hx medically diagnosed psychological condition:
- [ ] No
- [ ] Yes (complete boxes below)

If Yes:
- [ ] Anxiety/depression
- [ ] Bipolar/schizophrenia
- [ ] OCD, ADD, ADHD
- [ ] Other

DOCS History:

Current or past DOCS involvement with client or other immediate family members:
- [ ] No
- [ ] Yes
- [ ] Unsure

DOCS notification this visit:
- [ ] No
- [ ] Yes

Consultation Time:____________________
PSP Codes:____________________
Sexual Health History

Date of last Sexual Health Screen: ____________________

HIV Status:
- HIV positive: [ ] Date diagnosed: ____________________
- HIV negative: [ ] Most recent test date: ____________________
- Not tested or unsure: [ ]

STI / BBV Diagnosis: [ ] Yes  [ ] No  [ ]
Details: ____________________

STI Vaccination history:
- Hepatitis A: [ ] Yes  [ ] No  [ ] Unsure
- Hepatitis B: [ ] Yes  [ ] No  [ ] Unsure

Do you have sex with: [ ] Men  [ ] Women  [ ] Both
Sexual Identity: ____________________

Risk category: [ ] W  [ ] IDU  [ ] overseas contact  [ ] ever  [ ] in last 12/12

Current relationship? [ ] Yes  [ ] No
Duration / Type ____________________

- No. of OPPOSITE sex partners: ____________________
- last 3 months
- last 12 months

- No. of SAME sex partners: ____________________
- last 3 months
- last 12 months

Last contact -- Who/when/where?

Practices

STI / HIV avoidance

Previous contact -- Who/when/where?

Practices

STI / HIV avoidance

Interpersonal Network Assessment

GENOGRAM

Description of Family Relationships:

Description of Intimate Relationship:

Description of Friendship Network:

Currently Employed? [ ] Yes  [ ] No

Description of relationships with colleagues:
C16 VENEPUNCTURE

1. Purpose and scope
To provide guidelines for the collection of serology specimens.
For additional information refer to:
- NSW Health Policy Directive: Infection Control Policy¹
- NSW Health Policy Directive: Sharps Injuries Prevention in the NSW Public Health System²
- SEALS Pathology Collection Procedure Manual, Venepuncture Protocol 2014 Prince of Wales Hospital, Randwick, NSW.³
- Australian Health Professional Training Solutions Training Manual HLT07 Health Training Package Volume 3 Pathology Specimen Collections, August 2012, Page 3-4. ⁴

2. Outcomes
Standard precautions and infection control principles are adhered to when collecting serology.
Any client complications arising from venepuncture are appropriately managed and documented, and relevant information should be written on the request form for the benefit of the laboratory technicians.

3. Procedure
Procedure as follows:
- standard precautions must be adhered to during any procedure where there is a potential for contact with blood and bodily fluids
- all required equipment to be placed in clean kidney dish and taken to the client’s side
- sharps containers must be secured on a trolley or on the wall and be located as close as possible to client for point of generation disposal
- collect blood sample
- discard needle and holder directly into sharps container at completion of procedure. Soiled equipment, eg. cotton balls, are placed in appropriate waste containers. Any waste that is visibly contaminated with blood should be placed into hazardous waste bin
- kidney dish is cleaned with alcohol wipe or neutral detergent after each client.

3.1 Anatomical description
Blood vessels consist of 3 types:
- arteries – carry oxygenated blood away from the heart and are not to be used for venepuncture. If by accident an artery is pierced, direct pressure is to be applied for 5–7 minutes. Stay with the client until bleeding ceases. Senior clinician to be informed and the client made aware to observe the site
- veins – are less muscular and elastic and have thinner walls than arteries. The common veins used for venepuncture in the cubital fossa are the:
  - Cephalic vein
  - Median cubital vein
  - Basilic vein
- capillaries – minute vessels which link into small veins are used for finger and heel pricks.
3.2 Sites to avoid

Limbs with any of the following:

- intravenous therapy
- portacath
- shunt
- on the side of a mastectomy
- graft site
- severe injuries
- infection
- poor circulation eg. vascular clients
- sclerosed or thrombosed veins
- veins that are to be saved for other treatment (eg. chemotherapy)
- haematoma.

3.3 Methods to assist vein dilation

Proceed as follows:

- attending to the client’s wellbeing; ensure they are comfortable, warm and relaxed
- gentle opening and closing of the hand to make a fist
- lowering the client’s limb
- ensure arm is straight and supported by bed or rolled towel
- gentle massage; do not hit or use excessive rubbing on veins
- warm towel over the limb
- immerse hand or foot in warm water.
3.4 Equipment

Prepare the following equipment:

- personal protective equipment
- gloves
- kidney dish
- cotton balls
- tourniquet
- alcohol swab
- bandaid
- multi-sample needle / winged infusion set / Luer adaptor
- needle holder
- appropriate vacuette blood tubes
- sharps container
- biohazard bag
- request form.

3.5 Technique

- Proceed as follows:
- ensure correct client and gain consent
- identify any previous issues with blood collection
- identify all tests to be done
- assemble all the required equipment and pathology request forms and explain the procedure to the client, reassuring them before commencing
- wash hands/perform hand hygiene
- transport equipment to the clients side in a kidney dish
- bring sharps container to clients side
- assess the anxiety level; reassure
- position client for safety and comfort
- support client’s arm
- remove any restrictive clothing
- apply the tourniquet; place a finger behind the tourniquet clip to prevent the skin or hairs being pinched. Place the tourniquet approximately 5–15 cm above the puncture site. It should be tight enough to prevent venous return. Don’t leave tourniquet on for more than 2 minutes as it can change blood components
- perform hand hygiene
- inspect and palpate the cubital fossa to determine an appropriate site. Palpate the vein to see if it feels elastic, well anchored and has rebound resilience. When you depress and release an engorged vein, it should spring back to a rounded, filled state. Avoid choosing a vein near an artery
• once vein is chosen, loosen tourniquet
• choose needle to suit vein; assemble equipment
• clean the skin and allow to air dry. Any alcohol left on the skin will be introduced into the skin causing discomfort
• choose equipment to suit vein. Assemble equipment.
• tighten the tourniquet
• don gloves and PPE preform hand hygiene then don gloves
• position the needle and holder in the direction of the vein, directly over the vein. Do not connect the tube before the needle has pierced the skin. With the free hand, secure the vein by stretching the vein and the skin
• inform the client that they may feel a sharp sting prior to piercing the skin. With the bevel of the needle uppermost, pierce the skin directly over the vein, entering at a 10–25° angle and with a smooth quick entry in and along the vein (securing the needle in the vein)
• with non-dominant hand, attach the collection tube to the needle connection. Tube will fill automatically
• if using a needle and holder system, it is important to secure holder and needle as any movement of the needle in the vein can cause rupture of vein wall causing a haematoma
• loosen the tourniquet if good flow – adjust as required
• assess client’s wellbeing and continue to assess throughout the procedure
• remove tube when filled with required amount and mix by inverting top to end 8 to 10 times gently.
• for further collections, attach tubes as before – tubes may be removed at any time during collection and reapplied after checking amount and mixing
• remove the final tube from the holder and loosen tourniquet
• withdraw needle from the vein in a quick movement. (Always remove the tube from the needle connection before withdrawing the needle from the vein – any remaining vacuum suction may collapse the vein and cause pain and discomfort)
• place a clean dry cotton ball over the puncture site and apply direct pressure to the site. Client may apply the pressure. Instruct the client to keep their arm straight
• discard the needle and holder at point of collection
• place tubes into the kidney dish, label tubes, check with client correct details on blood tube and then place in biohazard bag
• check bleeding by gently pressing vein above the puncture site and blotting with cotton ball – do not wipe as this will dislodge the clot and cause further bleeding
• check for allergy, then cover the puncture site with bandage, remove previously loosened tourniquet from client’s arm. Ask client to remove bandage after a couple of hours.
• clean the work area and kidney dish
• inspect tourniquet and discard if bloodstained
• remove gloves and wash hands
• transport specimen according to local requirements.
3.6 Equipment information

Safety winged infusion set (butterfly needle)
The safety needle can be used for collections on:

- multiple collections
- clients with ‘rolling veins’ and with little subcutaneous tissue and poor skin tone
- clients who have small or damaged veins i.e. PWID and HIV clients
- the safety shield is to be activated as the needle is withdrawn from the vein
- great care must be taken when using winged infusion set (butterfly needle). There have been more needle stick injuries reported through usage of winged infusion sets than with any other needle. The rubber tubing can recoil causing a bouncing effect of the needle. Stretching the tubing before use reduces the recoil movement
- winged infusion set to be directly discarded into sharps bin

Retractable needle devices
Retractable needle devices / safety syringes have a built-in safety mechanism which can be activated to retract after the blood collection is complete. These are available as a safety winged infusion set (butterfly needle), or needle and syringe device. These devices can minimise the risk of needle stick injury.

Blood Collection using Vacuette®
This is a closed, sterile vacuumed sealed system:

- tubes are named by additive for easy identification
- additives, draw capacity and expiry date are written on each tube
- stock must be rotated
- tubes will not draw when fill line reached
- liquid additives, citrate and ACD do dry out. Before use check levels
- invert tubes 5–6 times after use
- small tubes 1, 2 and 4 ml draw tubes are available for use when accessing small veins. In large volume tubes the vacuum is too strong and will collapse the vein(s).

3.7 Variance management

Unsuccessful attempts
After an unsuccessful attempt at venepuncture consider contacting a clinician with advanced skills in venepuncture for assistance.

Management of haematoma
Proceed as follows:

- release tourniquet
- remove needle straight away
- apply direct pressure to site, 3–4 minutes or until bleeding has ceased
- explain to client what has happened; treat symptoms and reassure
• elevate limb
• apply ice if extensive
• dab with clean cotton ball and inspect for spotting. Do not wipe, as clot covering venepuncture site may be dislodged
• apply crepe bandage or adhesive bandage
• if extensive seek medical attention.

Management of vaso vagal
• Recline chair or lay client down, lower head and elevate feet – if unable to get the client to a bed or reclining chair, lie client on floor.
• Do not leave client
• Call for assistance
• Maintain clear airway
• Check pulse and breathing. If absent commence procedure for Basic Life Support
• Place on their side or if on their back tilt head and support chin
• If pulse present and breathing:
  − gently pat cheek and call name
  − release restrictive clothing
  − if unconscious note the time and duration
  − follow incident and accident protocol
  − Early signs of Vaso Vagal
• blood may suddenly stop flowing
• client may become very quiet or restless
• client becomes hot and sweaty or cold
• pale face, white (blanching) around lips

Management of early signs of Vaso Vagal
• recline chair, lower head, lower than heart and elevate feet of lie on bed/floor. Do not lean client forward
• ask them to take long deep controlled breaths, hold, then release slowly to the count of ten – not frequent short breaths – this will cause client to hyperventilate
• release restrictive clothing
• wriggle their toes
• place cold towel on their forehead
• give them water to drink if not fasting
• reassure and inform them of what had happened, advise them to inform their Dr and mention to collection staff prior to having next blood test
4. Documentation

Document any adverse events, variance management undertaken and client outcome in the medical record.

All serology specimens must be labelled with client details and sent with a matching pathology request form when forwarded to the laboratory.

5. Definitions

<table>
<thead>
<tr>
<th>ACD</th>
<th>Acid Citrate Dextrose</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR</td>
<td>Cardio Pulmonary Resuscitation</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>PPE</td>
<td>Personal Protection Equipment</td>
</tr>
<tr>
<td>PWID</td>
<td>People Who Inject Drugs</td>
</tr>
</tbody>
</table>

6. References


3. SEALS Pathology Collection Procedure Manual, Venepuncture Protocol 2014 Prince of Wales Hospital, Randwick, NSW.


SECTION 2

POPULATION HEALTH
SECTION 2: POPULATION HEALTH

P1 NEEDLE AND SYRINGE PROGRAM

1. Purpose and scope

To provide information and guidelines related to the provision of the Needle Syringe Program (NSP) for staff working in NSW publicly funded sexual health services.

Refer to the following for additional information:

NSW Needle and Syringe Program Guideline 2013
NUAA NSW Needle and Syringe Program in 2020
NSW Hepatitis C Strategy 2014 – 2020
NSW HIV strategy 2015 - 2020

2. Outcomes

To minimise the transmission of blood borne viruses among people who inject drugs by:

- the distribution of sterile injecting equipment
- the provision of condoms and lubricant
- imparting relevant education and health promotion
- organising appropriate referral to health, treatment and welfare services
- maximising safe disposal of used injecting equipment.

3. Procedure

NSP primary and secondary outlets (where capacity permits) must stock a variety of injecting equipment, including a range of syringe sizes, needle gauges and disposal containers. NSP outlets may also provide other related equipment, such as water for injection, alcohol swabs or tourniquets.

All clients requiring injecting equipment must receive a reasonable supply of sterile needles and syringes. This is determined by the client and local supply constraints. All equipment must be distributed along with an appropriate disposal container. Instructions on where to dispose of needles and syringes also needs to be provided.

Services must not offer winged vein infusion sets (butterfly infusion sets) or syringes with a volume of 10 mls or greater unless specifically authorised to do so by the Director General, NSW Ministry of Health (Ref: NSW Ministry of Health Policy Directive 20062013, Needle and Syringe Program Policy and Guidelines for NSW, Department of Health NSW, accessed 19–21 December 2013).

NSP clients can attend the sexual health service for appropriate screening and vaccination.

Additional information given to client and available for staff should include:

- ADIS – 1800 422 599 (provides information on all NSP outlets and treatment services)
- NUAA – 02 8354 7343 (Metro) 1800 644 413 (Rural)
- NSW Needle Clean Up Hotline – 1800 633 353. Each facility must have established procedures for responding to Hotline calls.
4. Documentation

Local Health Districts collect and report NSP data on a quarterly basis. Data collection is normally coordinated by the primary NSP outlet, who should advise on what data needs to be collected. In areas where these do not operate, contact the Area HIV and Related Programs Manager. NSP services are required to evaluate the effectiveness of their programs against specific accountability measures and key performance indicators as set out by the NSW Ministry of health.

5. Definitions

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADIS</td>
<td>Alcohol and Drug Information Service</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>NSP</td>
<td>Needle and Syringe Program</td>
</tr>
<tr>
<td>NUAA</td>
<td>NSW Users and AIDS Association</td>
</tr>
</tbody>
</table>

6. References


7. Auditable Outcomes

All staff participating in NSP Services will complete NSP competency assessment within 3 months of commencement of their employment. See Section 4: Accreditation.
P2 STI PREVENTION COUNSELLING GUIDELINES

1. Purpose and scope

To provide resources and referral pathways for clinical staff to use with clients at risk of acquiring an STI/HIV.

2. Outcomes

Sexual health staff are able to identify and respond to clients at risk of acquiring an STI / HIV.

3. Procedure

STI / HIV Prevention Counselling

The goal of risk prevention counselling is to reduce the risk of people becoming infected with an STI or HIV or, if infected, prevent the infection being transmitted to others. Risk prevention counselling promotes and reinforces safe behaviour and aims to assist clients in building skills and abilities to implement behaviour change.

The current Sexually Transmitted Diseases Treatment Guidelines 2015 by the Centers for Disease Control and Prevention provides details and information on prevention counselling, prevention methods and counselling for specific infections, including HIV and Herpes.

The following is a summary of key STI / HIV prevention counselling information provided in the resource:

- prevention counselling is most effective when provided in a non judgemental and empathetic manner appropriate to the client’s culture, language, sex, sexual orientation, age and developmental level
- client centred counselling and motivational interviewing are approaches that move clients toward achievable risk reduction goals
- all providers should routinely obtain a sexual history
- educate clients about the specific actions that can reduce the risk of STI / HIV transmission
- direct the counselling approach to the client’s personal risks
- extensive training is not a prerequisite for effective risk reduction counselling, however the quality of the counselling is improved when providers have training in prevention counselling methods and skill building approaches.

Some clients may benefit from additional or more intensive STI / HIV risk prevention counselling. Examples of client presentations where referral to a sexual health counsellor should be considered are:

- new HIV diagnosis
- HIV PEP following a risk event
- repeat presentations for NPEP
- complex contact tracing
- risk taking behaviour
- low level of knowledge about prevention of STI and BBV transmission and high levels of anxiety about STI/ BBV risk.

If you have concerns that a person with HIV may be infecting others, refer to the NSW Health Policy Directive that provides a framework for the management of people with HIV infection who risk infecting others located at:

Refferrals

All clinical staff need to be familiar with local referral options and pathways.

In the first instance refer to a sexual health counsellor; if not available other referrals are suggested below.

First Line
- refer to sexual health counsellor.

Second Line
- refer to a skilled and knowledgeable local psychologist, counsellor or social worker
- consider GP assessment for a GP Mental Health Care Plan that enables Medicare funded referral of patients to psychiatrists, and for psychological therapy by clinical psychologists or focussed psychological strategies (FPS) services by qualified GPs or allied mental health professionals.

Third Line
- sexual health nurse with experience in STI risk prevention counselling who seeks appropriate support
- NSW Sexual Health Infolink 1800 451 624 can offer information and support to all health providers.

Crisis Referrals

Clients experiencing a crisis, eg. suicidal thoughts or behaviours, self harm, currently experiencing domestic violence and / or threatening to harm another person should be referred to crisis intervention services.

- **Mental Health Line**
  Ph: 1800 011 511
  24 hours, 7 days

- **Lifeline**
  Ph: 13 11 14
  24 hours, 7 days
  [www.lifeline.org.au](http://www.lifeline.org.au)

- **Kids helpline**
  1800 55 1800
  24 hours, 7 days

- **1800 RESPECT**
  (domestic and family violence and sexual assault)
  1800 737 732
  [www.1800respect.org.au](http://www.1800respect.org.au)

- **Domestic Violence Line**
  1800 656 463

4. Documentation

Document in the medical record the discussion and outcomes including plan of action following STI / HIV prevention counselling and referrals made.
5. Definitions

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>FPS</td>
<td>Focussed Psychological Strategies</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmissible Infection</td>
</tr>
</tbody>
</table>

6. References


P3 STI SCREENING BY WOMEN’S HEALTH NURSE – PROGRAM EXAMPLE

1. Purpose and scope

To increase awareness of and improve screening rates of Sexually Transmissible Infections (STI) in priority female populations attending services delivered by designated Women’s Health Nurses (WHN). The targeted infections are Chlamydia trachomatis, Neisseria Gonorrhoea and +/- Trichomoniasis vaginalis.

2. Outcomes

Increased screening for Chlamydia and Gonorrhoea +/- trichomoniasis in women who are from priority populations.

Service agreement established between local health district women’s health and sexual health services.

3. Procedure

WHN will identify women who require STI screening through request, on sexual health history or on genital examination. The STI screening tests used are genital swabs or urine for Chlamydia and Gonorrhoea +/- trichomoniasis. Programs should be set up based on local epidemiology and need for services. An example of criteria for a remote program may be that any sexually active woman can be offered STI screening for Chlamydia and Gonorrhoea +/- trichomoniasis, who meet the following criteria:

- aged less than 30 and Aboriginal or Torres Strait Islander, or
- have had a sexual partner change in the past 3 months.

Asymptomatic sexually active women aged over 30 requesting sexual health screening are referred to local GP / Medical Centre. Those from priority population groups may also be referred to a sexual health clinic.

Women with genital symptoms should be referred immediately for medical assessment:

- First line: Local sexual health service
- Second line: Local General Practitioner (GP).

Local area policies may need to be developed where access to sexual health services is limited.

Refer to the Flow Chart for STI testing by designated Women’s Health Nurses – see Appendix P4.5.

3.1 Screening

Collect a sexual history.

Tests are only to be collected where the woman has given her informed consent as per Ministry of Health Policy Directives:

- PD2005 406 Consent to Medical Treatment – Patient Information
- PD2013 007 Child Wellbeing and Protection Policies and Procedures for NSW

The person must be legally competent to give consent as outlined in NSW Health Policy Directive Child Wellbeing and Protection Policies and Procedures for NSW. Refer to Section G5.
What tests should be done?

The preferred screening tests for genital Chlamydia, Gonorrhoea and +/- trichomoniasis are Nucleic Acid Amplification Tests (NAAT), usually the Polymerase Chain Reaction (PCR). There are currently 3 ways to collect genital specimens to test for Chlamydia and Gonorrhoea in women. Each approach to specimen collection varies in sensitivity and is listed below from the most sensitive to least sensitive:

1. Clinician collected PCR cervical swab for Chlamydia and Gonorrhoea +/- trichomoniasis (if Pap smear being taken).

2. Client self collected vaginal PCR swab for Chlamydia and Gonorrhoea +/- trichomoniasis (high vaginal swab).

3. First catch urine specimen* PCR for Chlamydia and Gonorrhoea +/- trichomoniasis.

Note: A High Vaginal Swab for Candida albicans / bacterial vaginosis is no longer part of the WHN STI screening process. Please refer client if they are symptomatic.

* Ideally, urine samples should be taken at least 1 hour after last urine passed however the test should not be deferred if time is an issue. This is the least preferred screening modality however can be used if the client declines clinician collected or self collected swabs or if the environment is better suited to urine samples (eg. custodial settings).

How to do the tests

1. **Clinician collected cervical swab for Chlamydia and Gonorrhoea +/- trichomoniasis PCR**

   Proceed as follows:
   
   - name code (first 2 initials of the last name followed by first 2 initials of the first name) on specimen
   - date of birth
   - specimen type
   - time and date of collection
   - instruct the client to empty their bladder prior to examination in order to optimise comfort
   - instruct the client into the lithotomy position
   - visualise the cervix through speculum examination
   - remove external secretions from the ectocervix with a cotton mop if necessary
   - using appropriate swab, insert approximately 0.5 – 1.0 cm into the endocervical canal, avoiding contact with the vaginal walls
   - rotate swab
   - process swab as per manufacturer guide.

2. **Self administered PCR vaginal swab for Chlamydia and Gonorrhoea +/- trichomoniasis PCR**

   See Appendix C14.1 for a diagram of a self collected vaginal swab.

   Complete client identifying information details on the outer plastic casing of the PCR kit provided by the laboratory (sterile, swab with medium):
   
   - name code (first 2 initials of the last name followed by first 2 initials of the first name)
   - date of birth
   - specimen type (high vaginal swab)
   - time and date of collection
• provide swab to the client and request to self administer a swab of the vagina. Instructions should be: wash hands, part the labia, then insert the swab at least 2 cm into the vagina and rotate it in a circular motion.

Once completed, instruct client to insert the swab in the outer tube and seal with lid, wash hands:
• Process swab as per manufacturer guide.

3. First catch urine specimen for Chlamydia and Gonorrhoea +/- trichomoniasis PCR

Complete client identifying information on each 70 ml yellow top sterile specimen container (ensure that no preservative is added).

Client identifying information includes:
• name code (first 2 initials of the last name followed by first 2 initials of the first name)
• date of birth
• specimen type (urine)
• time and date of collection
• give specimen container to client and explain that approximately 25 mls or half the container of first catch urine (the first part of the urine stream) is required
• process specimen as per manufacturer guide.

3.2 Specimen request and transport

Complete pathology forms as per local policy.

The WHN ensures:
• specimen jars are tightly closed
• urine specimen and swab are placed in a small biohazard bag with pathology request form
• if same day transport to pathology is not possible, urine specimens are refrigerated to prevent deterioration at room temperature
• refrigeration is set at 2–8 degrees Celsius.

3.3 Management of results

Positive results
A referral pathway for referral of clients with positive results or genital symptoms will need to be implemented on a local level. An example of how women with positive results or genital signs can be referred is below:
• First Line: Local sexual health service (unless the client declines)
• Second Line: Local GP.

A standard referral letter (Appendix P4.1) or Doctor Treatment Letter (Appendix P4.2), along with a copy of the pathology result is sent to the preferred practitioner. Notation is entered in the medical record.

3.4 Contact tracing

If the client is referred to the sexual health service, the appropriate clinician will perform contact tracing as part of the client management.
The WHN will perform contact tracing for any client who declines referral to the sexual health service (and are therefore referred to the GP).

See Appendix P4.3 for Doctor’s letter Neisseria Gonorrhoea contact and Appendix P4.4 for Doctor’s letter Chlamydia contact.

Contacts should be directed to the local sexual health service or GP for management.

All contact tracing measures in NSW should conform with and be guided by the Australasian Contact Tracing Manual.

### 3.5 Data collection

Data collection is to be implemented on a local level.

### 3.6 Quality assurance

To ensure best practice standards are adhered to a quality improvement (QI) tool can be implemented. An example of a QI results form for management of negative/positive results is in Appendix P4.6.

### 4. Documentation

All tests taken must be documented in the health record.

### 5. Definitions

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>NAAT</td>
<td>Nucleic Acid Amplification Tests</td>
</tr>
<tr>
<td>PCR</td>
<td>Polymerase Chain Reaction</td>
</tr>
<tr>
<td>QI</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>SHN</td>
<td>Sexual Health Nurse</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmissible Infection</td>
</tr>
<tr>
<td>WHN</td>
<td>Women’s Health Nurse</td>
</tr>
</tbody>
</table>

### 6. References

7. Appendices

APPENDIX P4.1 – STI Testing by Designated Women’s Health Nurses

Womens Health Service

Address: 
Telephone: (+61-2) 
Facsimile: (+61-2)

WHN STANDARD REFERRAL LETTER TO DOCTOR

Dear Doctor,

Thank you for seeing ________________________ who attended the ______________ Women’s Health Centre to enquire about having screening for Sexually Transmissible Infections. She is asymptomatic.

We suggested she attend her local GP for this service. Below are the recommendations for a full routine sexual health screen on an asymptomatic heterosexual person. However, based on history and presentation it may be appropriate to add other testing.

Female: First catch urine or self collected vaginal swabs or clinician collected cervical or vaginal swabs for Chlamydia and Gonorrhoea +/- trichomoniasis (PCR)

Blood test for Syphilis (EIA)

Blood test for Hepatitis B virus (anti HBc)

Blood test for HIV antibody (HIVAb)

RACGP Guidelines for preventative activities in general practice 8th edition provides information on the importance of early detection of STIs and screening recommendations. Redbook.


Contact details of your local sexual health service are located at:

Patient fact sheets about any STI you may diagnose can be found at:
www.stipu.nsw.gov.au

Please call the NSW Sexual Health Infolink on 1800 451 624 for further information.

Yours sincerely,

RN Women’s Health Centre
Dear Doctor,

Thank you for seeing ___________________________ for treatment of genital Chlamydia / Gonorrhea. Please find enclosed a copy of the pathology result. This person was tested under a program which I supervise, where accredited Registered Nurses employed by NSW Health offer sexually transmissible infection (STI) testing to people who are at risk. This program offers opportunities for testing which might not otherwise occur.

The current treatment for uncomplicated:

Chlamydia is Azithromycin 1 gm p.o. stat

Gonorrhoea is Ceftriaxone 500 mg IMI in 2 ml of 1% lignocaine statim and Azithromycin 1 gm p.o. statim

The testing and treatment of the sexual contacts of infected individuals is essential for the community control of STI and your assistance in this matter is much appreciated.

Additional information is available in the National Management Guidelines for STIs 7th Edition (2008).

Contact details of your local sexual health service are located at:

Patient fact sheets about any STI you may diagnose can be found at:
www.stipu.nsw.gov.au

Please call the NSW Sexual Health Infolink on 1800 451 624 for further information.

Yours sincerely

Medical Director Sexual Health Centre

Date:
Dear Doctor,

The bearer of this letter is a contact of a patient who has been diagnosed with genital Neisseria Gonorrhoea.

Our patient has been treated with:

Ceftriaxone 500 mg IMI in 2 ml of 1% lignocaine statim and Azithromycin 1 gm p.o. statim

Other regime: _________________________________

People who are Neisseria Gonorrhoea contacts may present with no symptoms or abnormal physical findings. Nevertheless, these contacts are at risk of complications such as pelvic inflammatory disease, epididymitis and reactive arthritis.

For this reason we routinely treat people who have been in contact with a Neisseria Gonorrhoea associated condition. Abstinence from sexual intercourse is recommended until both partners have finished treatment or until 7 days after an injection of Ceftriaxone. Condoms should be recommended with all new partners.

May we request that you make an assessment for sexually transmissible infections and we suggest they attend their local GP for this service. Below are the recommendations for a full routine sexual health screen on an asymptomatic heterosexual person. However, based on history and presentation it may be appropriate to add other testing.

Female: First catch urine or clinician collected swabs for Chlamydia and Gonorrhoea +/- trichomoniasis (PCR)

Male: First catch urine for Chlamydia and Gonorrhoea (PCR)

Blood test for Syphilis (EIA)

Blood test for Hepatitis B virus (anti HBc)

Blood test for HIV antibody (HIV Ab)

Additional information is available at Australian STI Management Guidelines for use in Primary Care http://www.sti.guidelines.org.au/

Contact details of your local sexual health service are located at:

Patient fact sheets about any STI you may diagnose can be found at:
www.stipu.nsw.gov.au

Please call the NSW Sexual Health Infolink on 1800 451 624 for further information.

Thank you.

RN Women’s Health Centre
Dear Doctor,

The bearer of this letter is a contact of a patient who has been diagnosed with Chlamydia.

Our patient has been treated with:

- Azithromycin 1 g p.o. statim
- Doxycycline 100 mg b.d. for 10 days

Other regime:

The majority of people who are Chlamydia contacts have no symptoms or abnormal physical findings. Nevertheless, these contacts are at risk of complications such as pelvic inflammatory disease, epididymitis and reactive arthritis. Also, although current tests can usually exclude Chlamydia, they do not exclude other potential pathogens eg. Mycoplasma genitalium.

For this reason we routinely treat people who have been in contact with a Chlamydia-associated condition. Abstinence from sexual intercourse is recommended until both partners have finished treatment or until 7 days after a dose of Azithromycin. Condoms should be recommended with all new partners.

In the case of healthy pregnant female contacts, a single dose of Azithromycin is considered safe treatment or alternatively a 7–10 day course of Amoxicillin 500 mg qid for uncomplicated Chlamydia infection.

May we request that you make an assessment for sexually transmissible infections and we suggested they attend their local GP for this service. Below are the recommendations for a full routine sexual health screen on an asymptomatic heterosexual person. However, based on history and presentation it may be appropriate to add other testing.

- Female: First catch urine or clinician collected swabs for Chlamydia and Gonorrhoea +/- Trichomoniasis (PCR)
- Male: First catch urine for Chlamydia and Gonorrhoea (PCR)
- Blood test for Syphilis (EIA)
- Blood test for Hepatitis B virus (anti HBc)
- Blood test for HIV antibody (HIV Ab)

Additional information is available at Australian STI Management Guidelines for use in Primary Care http://www.sti.guidelines.org.au/

Contact details of your local sexual health service are located at:

Patient fact sheets about any STI you may diagnose can be found at:
www.stipu.nsw.gov.au

Please call the NSW Sexual Health Infolink on 1800 451 624 for further information.

Thank You

RN Women’s Health Centre
Testing for STI by Designated Women’s Health Nurses

**Female presents for routine PAP smear**

- Female sexually active under 30 years of age
  - AND
  - have had a recent partner change in past 3 months
  - OR
  - identify as Aboriginal or Torres Strait Islander

- Discuss and offer screen for Chlamydia – Gonorrhoea

- Results Positive

- Refer to SHN / SHP for 1st line treatment where available

- SHN to complete:
  - contact tracing
  - further testing as indicated

- Female over 30 years of age who requests screening

- Discuss Chlamydia and Gonorrhoea screening

- Refer to local Sexual Health Nurse or local GP. Provide NSW Sexual Health Infolink number **1800 451 624**

- Refer to GP 2nd line treatment

- WHN to complete contact tracing
### APPENDIX P4.6 – Sample QI Results Form for Management of Negative / Positive Results

<table>
<thead>
<tr>
<th>Patient Initials</th>
<th>Patient MRN</th>
<th>DOB</th>
<th>ATSI Y/N</th>
<th>Post Code</th>
<th>NEG Result</th>
<th>Positive Result CHL / GONO</th>
<th>Meets Criteria For Screening Y/N</th>
<th>Referred to SHN/GP</th>
<th>IF GP Referral Treatment Given (Describe)</th>
<th>IF GP Referral Treatment Date</th>
<th>IF GP Referral Contact Tracing Completed Y/N / NA</th>
<th>Actions</th>
</tr>
</thead>
</table>

Please ensure all screening is according to policy

Treatment of positive results should be referred to the SHN in the first instance

Each month completed form to be sent by fax / email to local Sexual Health Nurse
P4 STI SCREENING GUIDELINES FOR SEX INDUSTRY WORKERS

1. Purpose and scope
To assist primary health care providers in the prevention, diagnosis, management and treatment of sexually transmissible infections amongst sex industry workers.

2. Outcomes
Reduction in rates of STI and appropriate testing for asymptomatic STI among sex workers.

3. Procedure
Testing recommendations for asymptomatic current sex workers.
Clients with genital symptoms should have appropriate tests as per STI testing:

- Female (Section C14) and STI testing
- Male (Section C13) and STI testing.

These recommendations should apply regardless of whether condoms are used or not.

For full details refer to:

In summary it is recommended sex industry workers are tested:

3.1 Every 3–6 months
- Gonorrhoea (cervix / urine)
- Chlamydia (cervix / urine)
- Hepatitis B – immunise if negative (once a client is immunised against HAV / HBV further serology is unnecessary)
- Gonorrhoea (throat / anus).

Annually
- HIV (if HIV negative)
- Syphilis.

Consider, depending on sexual practice:
- Hepatitis A vaccination
- Chlamydia NAAT (anus).

3.2 More frequent screening
Frequency of testing will need to vary according to state legislative and regulatory requirements, as appropriate for the frequency and nature of work, and following any risk episodes (eg. condom breakage or mishap).
4. Documentation

All testing, treatment and results should be documented in the medical record. Documentation should include information about discussion with the client regarding planned follow-up as per the recommended guidelines. Below is an example of wording which can be used if a certificate of attendance is requested by the worker. Workers are not required to provide copies to employers but can request a copy if they wish.

Certificate of Attendance

<table>
<thead>
<tr>
<th>patient</th>
<th>(name of patient)</th>
</tr>
</thead>
<tbody>
<tr>
<td>attended</td>
<td>attended this Clinic)</td>
</tr>
<tr>
<td>on</td>
<td>(date)</td>
</tr>
</tbody>
</table>

This may have included testing for some sexually transmissible infections. Many infections may not be detectable for weeks or months after infection, if they become detectable at all. Therefore, screening cannot offer assurance that a person is not infected with a sexually transmissible infection if they have been at risk.

CONDOMS ARE ESSENTIAL FOR THE PROTECTION OF BOTH PARTNERS

Signature of Doctor or Nurse

Print Name

5. Definitions

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAV</td>
<td>Hepatitis A Virus</td>
</tr>
<tr>
<td>HBV</td>
<td>Hepatitis B Virus</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmissible Infection</td>
</tr>
</tbody>
</table>

6. References


P5 STI TESTING GUIDELINES FOR MEN WHO HAVE SEX WITH MEN

1. Purpose and scope
To provide a guideline for health care professionals in the appropriate types of tests and frequency of STI testing for MSM.

2. Outcomes
Reduction in the rates of STI in MSM and improved appropriate testing of MSM for STI by health care providers.

3. Procedure
For full details refer to:
MSM who do not have symptoms of STI are the focus of these guidelines but they also apply to testing at anatomical sites other than the location of any current symptoms. All MSM should be offered anal swabs even if they do not report receptive anal sex.
In summary it is recommended MSM are tested:

3.1 At least once a year
All men who have had any type of sex with another man in the previous year should be offered all of the following STI tests in the following ways:
- pharyngeal swab Chlamydia / Gonorrhoea NAAT
- anal swab Chlamydia / Gonorrhoea NAAT
- first void urine Chlamydia NAAT
- serology HIV if HIV negative
- serology Syphilis
- serology Hepatitis A, test if not vaccinated, if negative immunise
- serology Hepatitis B, test if not vaccinated, if negative immunise
- serology Hepatitis C (if HIV+ or history of injecting drug use).

3.2 More frequent testing
Up to 4 times per year is recommended for men who:
- have had any unprotected anal sex
- have had more than 10 partners in the previous 6 months
- participate in group sex
- use recreational drugs during sex
- are HIV positive.
3.3 HIV positive MSM
Consider Chlamydia and Gonorrhoea testing on each occasion of CD4 / viral load monitoring. Consider testing for Syphilis at least on each occasion of CD4 / viral load monitoring. All asymptomatic HIV positive MSM should have annual HCV testing.

3.4 Repeat testing
People diagnosed with Chlamydia or Gonorrhoea should be retested in 3 months to detect reinfection.

3.5 Other considerations from STIGMA Guidelines 2014
- Where possible collect Neisseria Gonorrhoea (NG) culture swab before treatment of NAAT-confirmed NG to assess antibiotic sensitivity of the NG isolate.
- Urethral Neisseria Gonorrhoea: Current evidence does not support a recommendation to screen asymptomatic Australian MSM for urethral N. Gonorrhoeae.
- Lymphogranuloma venereum (LGV): Routine LGV typing of asymptomatic Chlamydia infections among MSM is not currently justified.
- Herpes Simplex Virus (HSV) type-specific serology: Screening asymptomatic MSM is not currently recommended.
- Human Papillomavirus (HPV) infection: Cytological screening for anal cancer for asymptomatic MSM is not currently recommended.
- Hepatitis C Virus (HCV) testing: HCV testing is not recommended in HIV negative MSM who have never injected drugs. However, annual HCV testing is recommended for HIV positive MSM or men with traumatic sexual practices.
- Anogenital Mycoplasma genitalium (MG): Anogenital MG is uncommon in asymptomatic Australian MSM.

4. Documentation
All testing, treatment and results should be documented in the medical record. Documentation should include information about discussion with the client regarding planned follow-up as per the recommended guidelines.
5. Definitions

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCV</td>
<td>Hepatitis C Virus</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HPV</td>
<td>Human Papillomavirus Infection</td>
</tr>
<tr>
<td>HSV</td>
<td>Herpes Simplex Virus</td>
</tr>
<tr>
<td>LGV</td>
<td>Lymphogranuloma venereum</td>
</tr>
<tr>
<td>MG</td>
<td>Mycoplasma genitalium</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>NAAT</td>
<td>Nucleic Acid Amplification Test eg. PCR, LCR, SDA, TMA</td>
</tr>
<tr>
<td>NG</td>
<td>Neisseria Gonorrhoea</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmissible Infection</td>
</tr>
<tr>
<td>STIGMA</td>
<td>Sexually Transmissible Infections in Gay Men Action Group</td>
</tr>
</tbody>
</table>

6. References


P6 TRIAGE

1. Purpose and scope
Publicly Funded Sexual Health Services (PFSHS) specialise in the prevention and treatment of sexually transmissible infections. As NSW PFSHS have a limited capacity to see all patients who require services, the National and State Sexually Transmissible Infections (STI) strategies require the prioritisation of those most in need of services.

This document provides guidance on the use of triage for clinical and non-clinical staff within the community health and sexual health setting.

Triage ensures that:

- clients seen in PFSHS are appropriate for the service
- access to services is optimised for priority groups
- clients who are not a priority are referred to alternative services.

2. Outcomes
Clients attending PFSHS fit within the priority population groups outlined within the NSW HIV and STI strategy.

Non-priority clients are referred to primary health care services.

3. Procedure
3.1 Triage models

Some sexual health services have dedicated triage staff and some do not so it is a job shared between team members. There are a number of triage models that can be adapted for use in the differing services which include using the expert sexual health nurses of SHIL or the online ‘Am I at Risk’ tool [http://sshc.org.au/](http://sshc.org.au/) to triage clients for sexual health service. At the first point of contact to the service the person is asked questions to enable effective triage.

Appendix P7.1.2 would suit services housed within a general Community Health / Primary Health Centre who do not have dedicated and trained administration staff to provide all or part triage.

Appendix P7.1.3 would suit sexual health services that do have dedicated and trained non-clinical staff that are able to provide some triage capabilities.

Appendix P7.1.4 is an advanced assessment that would suit sexual health services with clinical and non-clinical staff trained and qualified in triage, with an environment that supports more detailed information being asked of clients.

3.2 Triage resources

SHIL also provides a direct call transfer service for PFSHS. This entails SHIL triaging callers and transferring the calls of clients assessed as belonging to the PFSHS priority groups, directly to the sexual health service. If the sexual health service answers the call the SHIL nurse will provide a verbal handover. Sexual health services can in this way make appointments or arrangements to see these clients as they have already been triaged. See Appendix P7.2.3.

The suggested wording and scripts are provided to assist staff to respond to clients in a consistent manner in Appendix P7.2.1. A suggested script for an after-hours telephone message is also included as Appendix P7.2.2.
To determine priority populations for triage in your local area, a Priority Population Calculator is provided in Appendix P7.3.1 and Appendix P7.3.2.

3.3 Training and accreditation

All staff going to perform triage should complete the online triage training located on the STIPU website:


The Flow Charts in Appendix P7.1.1 are a practical resource which provides guidance on assessing clients in line with the priorities and staffing of the individual service.

4. Documentation

Accreditation should be documented in the personnel file for the relevant clinical and non-clinical staff.

Procedures for data collection of clients triaged out should be established by individual clinics.

5. Definitions

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>BBV</td>
<td>Blood Borne Virus</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IMB</td>
<td>Intermenstrual Bleeding</td>
</tr>
<tr>
<td>MO</td>
<td>Medical Officer</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>NPEP</td>
<td>Non-occupational Post Exposure Prophylaxis</td>
</tr>
<tr>
<td>PCB</td>
<td>Post Coital Bleeding</td>
</tr>
<tr>
<td>PFSHS</td>
<td>Publicly Funded Sexual Health Services</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>SHIL</td>
<td>Sexual Health Information line</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmissible Infections</td>
</tr>
<tr>
<td>STIPU</td>
<td>Sexually Transmitted Infections Programs Unit</td>
</tr>
</tbody>
</table>

6. Auditable Outcomes

All PFSHS have a triage model in place as outlined above.

90% of PFSHS have an after-hours message on their main phone line.

7. References


7. Appendices

**APPENDIX P7 – TRIAGE**

**Appendix P7.1 Triage Flow Charts**

Appendix P7.1.1 Sexual Health Clinician Triage Tool – refer to delegation Chapter A2

<table>
<thead>
<tr>
<th>PRIORITY POPULATIONS</th>
<th>Should be advised to be seen today at SHC / Primary Health / ED</th>
<th>Offered next available appointment or offered walk in clinic if available</th>
<th>Who to triage to (triage to MO may be internal or to external services)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gay men and other men who have sex with men</td>
<td></td>
<td></td>
<td>RN or MO</td>
</tr>
<tr>
<td>People living with HIV</td>
<td></td>
<td></td>
<td>RN or MO</td>
</tr>
<tr>
<td>Sex workers</td>
<td></td>
<td></td>
<td>RN or MO</td>
</tr>
<tr>
<td>Transgender</td>
<td></td>
<td></td>
<td>RN or MO</td>
</tr>
<tr>
<td>Young people*</td>
<td></td>
<td></td>
<td>RN or MO</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander peoples</td>
<td></td>
<td></td>
<td>RN or MO</td>
</tr>
<tr>
<td>People who inject drugs</td>
<td></td>
<td></td>
<td>RN or MO</td>
</tr>
<tr>
<td>Sexual contact with person from high prevalence country</td>
<td></td>
<td></td>
<td>RN or MO</td>
</tr>
<tr>
<td>SYMPTOMS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rectal symptoms in patients having anal intercourse (eg. discharge, tenesmus, or bleeding)</td>
<td></td>
<td></td>
<td>MO</td>
</tr>
<tr>
<td>Genital ulceration / acute genital pain</td>
<td></td>
<td></td>
<td>MO</td>
</tr>
<tr>
<td>Rash / painless ulcer suggestive of syphilis (primarily in MSM)</td>
<td></td>
<td></td>
<td>MO</td>
</tr>
<tr>
<td>Pelvic or abdominal pain, dyspareunia, intermenstrual bleeding (IMB), post coital bleeding (PCB), testicular pain, swollen inguinal nodes</td>
<td></td>
<td></td>
<td>MO</td>
</tr>
<tr>
<td>Acute HIV / AIDS related symptoms / signs</td>
<td></td>
<td></td>
<td>MO</td>
</tr>
</tbody>
</table>
### Acute side effects of NPEP
- Male urethral discharge, dysuria, or urethral irritation
- Vaginal discharge
- Retained tampons or other foreign bodies
- Non acute IMB, PCB, pelvic pain, testicular pain, dyspareunia
- Genital rash (without ulceration, pain or dysuria)
- Other genital symptoms not mentioned in above category
- Non painful uncomplicated genital lumps

### OTHER PRIORITY PRESENTATIONS
- Non Occupational Post Exposure Prophylaxis (NPEP)
- STI / BBV contact
- Emergency contraceptive pill – priority group patients who report unprotected vaginal sexual intercourse in last 120 hours
- Acute distress or crisis

**Doctor’s referral:**
- any patient referred by another doctor for assessment or diagnosis of a condition (excludes screening or uncomplicated HPV management)
- for review (assess recency of letter to patient’s current signs / symptoms)

**Doctor’s referral:**
- for vaccination / wart treatment / asymptomatic screening

**Contact of person from priority group or from STI / BBV endemic areas**

**Sexual assault (not requiring forensic examination which should be done by a sexual assault team)**

**Travellers**
- only those belonging to any of the above priority groups

* Young people’s sexual health needs are met through general practice. Publicly funded sexual health services have limited capacity to meet the needs of young people and will continue to focus on those young people who are more marginalised (i.e. homeless, Aboriginal young people, gay or homosexually active or who are symptomatic or are a contact of an STI). Local decisions around the delivery of sexual health care for young people may also be influenced by the availability of general practitioners or/or other youth serving organisations within the community.
Appendix P7.1.2 – Flow Chart of Guideline for Sexual Health Triage at Community Health Centre

Triage at Community Health Centre Admin

Client phones or presents without an appointment

Clinician available

YES

Client triaged to clinician for assessment

NO

Client contact details taken for clinician to phone back

AND

NSW Sexual Health Infolink provided to talk to a clinician 1800 451 624 (SHIL will refer as appropriate)
APPENDIX P7.1.3 – Flow Chart for general triage by trained non-clinical staff including administration / reception at Sexual Health Service

Triage by Sexual Health Service Admin

Client phones or presents without an appointment

Admin asks: “Do you have any symptoms you are concerned about or do you have a referral letter from a Doctor?”

YES

Client triaged to 1st available clinician for assessment

NO

Admin asks: “Have you had any potential exposure to someone with an STI or HIV that you are concerned about?”

YES

Admin asks: “We are a specialised service. Before I can make you an appointment I need to ask you to speak to a Sexual Health Nurse. Is that ok?”

If YES:
Refer to 1st available clinician. If no clinician available then:
- a. call SHIL or get client to call SHIL. If priority SHIL will do a call transfer back to the SHC for you to make an appointment / fit client in or refer to a GP.
- OR
b. log onto the ‘Am I at Risk?’ website (www.sshc.org.au) and allow the client to complete the online triage, if they get given a 4 digit code they are a priority for the service

If NO provide SHIL number to talk to a Sexual Health Nurse

1800 451 624

NO

If no clinician available

Client contact details taken for clinician to phone back

AND

SHIL number provided to talk to a clinician

1800 451 624 (SHIL will triage and refer as appropriate)
We are a specialised service for people who cannot be managed by local doctors and as such cannot see everyone. I need to ask you some questions to make sure you are eligible to be seen here, is that OK with you? These questions are personal but we ask these questions of all new clients.

**Priority population assessment by trained sexual health administration / reception if no call to SHIL as in Appendix P1.1.**

Client phones or presents without an appointment

- “Do you have any symptoms you’re concerned about or have you got a referral letter from a Doctor?”
  - NO
  - “How old are you?”
    - IF < 25
      - IF YES
        - Client triaged to 1st available clinician
      - IF MSM
        - IF YES
          - If no clinician available
            - Client contact details taken for clinician to phone back or appointment made AND SHIL number provided to talk to a Sexual Health Nurse.
    - IF YES
      - “Do you identify as Aboriginal or Torres?”
        - IF YES
          - “Do you have sex with men or women or both?”
            - IF YES
              - “Have you had any potential exposure to someone with an STI or HIV that you’re concerned about?”
                - YES
                  - “Have you had any symptoms you’re concerned about or have you got a referral letter from a Doctor?”
                    - NO
                      - “How old are you?”
                        - IF < 25
                          - IF YES
                            - Client triaged to 1st available clinician
                          - IF MSM
                            - IF YES
                              - If no clinician available
                                - Client contact details taken for clinician to phone back or appointment made AND SHIL number provided to talk to a Sexual Health Nurse.
      - “Do you have sex with men or women or both?”
        - IF YES
          - “Have you injected any drugs in the last 12 months?”
            - IF YES
              - If no clinician available
                - Client contact details taken for clinician to phone back or appointment made AND SHIL number provided to talk to a Sexual Health Nurse.
    - IF NO to all questions
      - If no clinician available
        - Client contact details taken for clinician to phone back or appointment made AND SHIL number provided to talk to a Sexual Health Nurse.

*As I mentioned, we are a specialist service and your local doctor can provide you with what you need. Do you have a local doctor? Local doctors are also listed in the Yellow Pages under Doctors. You can also call the NSW SHIL on 1800 451 624 to speak to a Sexual Health Nurse.*
APPENDIX P7.2.1 – Sample triage script for sexual health administration / reception staff

Assessment by trained sexual health service administration / reception

If they say they don’t want to see their own GP remind them that the clinic is only funded to provide services to the specific target groups. Ask if they can see another GP? Provide some suggestions and alternatives, for example women’s health nurse (WHN) or Family Planning.

If they want a Pap smear or contraception refer them to WHN or Family Planning clinics if available and explain that Sexual Health does not offer these services anymore. Emergency contraception is also available over the counter at a chemist.

If the person is aggressive, persistent or rude, if possible, transfer them to speak with a clinician or call SHIL so they can speak with a sexual health nurse.

If client is a walk in, you can ask the same questions or have a small form with the information on it and ask the client to read this and say if they fit any of the groups.

MSM  Men who have sex with men
PLWH  People living with HIV
PWID  People Who Inject Drugs
SIW  Sex Industry Workers

APPENDIX P7.2.2 – Sample after-hours phone message script for closed sexual health services and community health services

This guideline is suggested to support improved access to information on sexual health services when consumers call after hours.

The guideline suggests that sexual health services provide as a minimum:

1. Name of the service and specifically state it is a sexual health service.
2. The service location / address.
3. The opening days and hours.
4. Contact details for after-hours emergency – National Health Direct on 1800 022 222.
5. The Sexual Health Infolink number and the NSW Health Sexual Health website.
6. If the caller can record a message or not.
7. For services wanting to use the ‘Am I at Risk’ tool, provide details of the web address (www.sshc.org.au) and advise them to call back if during business hours if they are given a reference number. Non-priority clients will be referred to primary care from this website.

An example of a message could be:

“You have reached the ………………… Sexual Health Service located at ………………… We are now closed.

The clinic hours are ………………… to ………………… on ………………… (days a week). For emergencies outside of these hours, please contact National Health Direct’s 24 hour information line on 1800 022 222. For expert sexual health information please call the Sexual Health Info Line on 1800 451 624 between 9.00am and 5.30pm, Monday to Friday or visit the NSW Health Sexual Health website at http://www.health.nsw.gov.au/sexualhealth/pages/default.aspx. This website contains up-to-date information and fact sheets.

This machine does not record messages. Thank you for calling.”
OR

“Please leave a message and contact details and we will call you back as soon as possible.

Thank you for calling.”

For services operating as outreach from community health centres the message should include as a minimum:

1. The name of the service and its location.
2. What days and times sexual health outreach is available.
3. The Sexual Health Information Link number and the NSW Health Sexual Health website.

An example of this message could be:

“You have reached the …………………. Community Health Centre located at …………………. We are now closed. Sexual health services are available on …….. (days a week) between …………..to …………..

For expert sexual health information please call the Sexual Health Info Line on 1800 451 624 between 9.00am and 5.30pm Monday to Friday, or visit the website http://www.shil.nsw.gov.au/ or the NSW Health Sexual Health website at http://www.shil.nsw.gov.au/.

**APPENDIX P7.2.3 – SHIL – NSW Sexual Health Infolink**

The NSW Sexual Health Infolink (SHIL) is a NSW Ministry of Health funded service which is staffed by experienced clinical sexual health nurses.

The aims of this service are to educate and promote the sexual health of the community and to facilitate efficient use of the publicly funded sexual health centres across NSW.

Currently the NSW Sexual Health Infolink serves many functions including providing HIV and STI clinical advice and support to general practitioners and other health care workers.

For members of the community the service also provides free and confidential HIV and STI triage, testing results, information, bookings and local referrals.

SHIL is also promoted in education programs and sexual health promotion campaigns across NSW.

The hours of operation are 9.00am to 5.30pm, Monday to Friday, phone 1800 451 624.

**APPENDIX P7.3.1**

NSW STIPU Priority Population Calculator Part 1
http://www.slideshare.net/stiprojects/priority-populations-calculator-part-1

**APPENDIX P7.3.2**

NSW STIPU Priority Population Calculator Part 2
http://www.slideshare.net/stiprojects/priority-populations-calculator-part-2
SECTION 3

GUIDELINES FOR PRACTICE
SECTION 3: GUIDELINES FOR PRACTICE

G1 CHAPERONES

1. Purpose and scope
To provide guidelines for the use of chaperones within the clinical setting. This is particularly relevant where physical and / or genital examination of clients is likely to occur.

2. Outcomes
Clients and clinicians feel safe and supported whilst participating in clinical consultations. Clients are witnessed to provide informed legal consent to procedures and the collection of information.

3. Procedure
All clinicians may ask clients undergoing examination whether they require a chaperone to be present. Circumstances where it may be preferable to have a chaperone include:

- clinician concerns about physical threat or sexual intimidation of female client being examined by male clinician, especially in the case where she has indicated a preference for a female clinician, but none is available
- first genital examination for client
- clients under 16 years of age
- distressed clients
- clients with a history of sexual assault
- clients with mental health +/- drug or alcohol related issues
- situations where the clinician has concerns about potential allegations or litigation.

The chaperone should be of a gender approved by the client.

Any client who requests a chaperone, and none is available, should be rebooked for examination at a time when a chaperone is available.

If the clinician has requested a chaperone, but the client has refused, the clinician does not have to perform the examination. The clinician may wish to defer the examination or refer the client to another service.

Clients who lack decision-making capacity (such as the developmentally delayed) require a surrogate decision-maker (family member, carer) to consent to the examination and the use of a chaperone in conjunction with client.

Informal chaperones who accompany the client as a support person are not appropriate to be involved in physical assessment, or necessarily to act as a witness in any future medico-legal allegation.

The chaperone should preferably be a clinical staff member. If staff resources do not allow this, medical or nursing students, who have performed or witnessed previous intimate examinations, and are aware of the responsibilities of a chaperone, may also act as chaperones.
Once the clinician and/or client identifies the need for a chaperone:

- clinician explains to client the purpose and likely content of the examination/procedure, and gains consent for the chaperone to be present
- the chaperone is invited into the consultation room and remains present for the entire physical examination and collection of any specimens
- the clinician should be careful not to reveal confidential information in front of the chaperone
- it is preferable that the chaperone position her/himself where they are able to clearly view, and therefore act as a witness for, the entire examination.

4. Documentation

Documentation should include:

- client consent or refusal to have chaperone present
- the name, designation and signature of the chaperone
- the presence of any support persons (informal chaperones) in the consultation room at the time of examination
- other documentation relevant to the examination, as per local guidelines.

5. Definitions

| Chaperone | A third person, preferably a clinical health care worker, who is present in the room during an examination or consultation |

6. References

G2 CONSENT

1. Purpose and scope
To provide guidelines for clinicians in NSW Publicly Funded Sexual Health Services (PFSHS) in obtaining valid client consent.

Refer to the following for additional information:

NSW Health Policy Directives:

2. Outcomes
It is a legal requirement that all clients attending PFSHS clinics give valid consent prior to any procedure or treatment.

3. Procedure

3.1 General principles to obtaining valid consent
To obtain valid consent sexual health clinicians should use their professional judgement to assess:

i) the client’s capacity to understand the procedures or treatments, and where appropriate use accredited interpreters to facilitate client comprehension of information

ii) ensure consent is freely given

iii) that it relates to the specific treatment or procedure and the following information is discussed:

- the nature of the infection/s or condition
- the proposed investigations and treatments, likely benefits and adverse effects
- likely scenario without the intervention or treatment
- other options, if any
- time and cost to client
- verbal information can be supported (but not substituted) by pre-prepared information handouts to assist in information exchange.

3.2 Age of consent to medical treatment
Pursuant to the current NSW Health Consent to Medical Treatment – Patient Information PD2005_406 a child aged 14 years and above seeking medical support and services may consent to their own medical care (in the absence of parental consent) provided they are deemed sufficiently mature and have the capacity to understand the nature and consequences of the procedures or treatments. The Policy Directive (PD) advises that parental or guardian consent is necessary for a child under the age of 14 years. For those who are over 16 years seeking medical services, their own consent is sufficient.

NOTE: the above is in accordance with the Minors (Property and Contracts) Act 1970 – section 49 which states that as long as valid consent is obtained from either:

i) a child aged 14 years and over or
ii) parental consent for children 16 years old and under, the sexual health clinician has a good defence against assault and battery claims. However, Section 49 makes no specific mention of young people under 14 years. This legislation is not the only law in NSW about minors’ consent to medical treatment. There is also common law which provides that a child can consent to their own treatment, provided they have sufficient maturity and understanding to do so. If a clinician can show that they considered whether the child was competent to consent, then this should assist in defending a claim (in the unlikely event that one eventuates).

3.3 Guardianship and HIV testing

If a person has been appointed a public guardian, consent for HIV testing needs to be obtained from the guardian. The following link provides an overview of the functions of a guardian around health care. http://www.publicguardian.justice.nsw.gov.au/Documents/now_youre_the_guardian_chapter_4.pdf

To contact the guardianship board:

4. Documentation

The law does not require that consent or the provision of information including warnings about material risks be documented in writing, however, documentation of the general points discussed will support clinicians in any subsequent legal proceedings. Please refer to Consent to Treatment – NSW Health page 6, “Does ‘written’ consent need to be obtained?”

5. Definitions

<table>
<thead>
<tr>
<th>PD</th>
<th>Policy Directive</th>
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<tbody>
<tr>
<td>PFSHS</td>
<td>(NSW) Publicly Funded Sexual Health Services</td>
</tr>
</tbody>
</table>

6. References

G3 INFECTION CONTROL

1. **Purpose and scope**
   To provide an outline of the broad principle of infection control applied to local settings.

2. **Outcomes**
   Ensure all staff working in Publicly Funded Sexual Health Services (PFSHS) clinics adhere to standard precautions and infection control principles to safeguard clients, staff and the general public from infection.

3. **Procedure**
   Refer to:
   
   NSW Health Policy Directive: Infection Control Policy (see below).
   
   Standard precautions and infection control principles must be adhered to during all client interactions contained in this Standard of Practice manual.

4. **Documentation**
   N/A

5. **Auditable Outcomes**
   100% of SHN will show completion of hand hygiene module yearly. [http://www.hha.org.au/LearningPackage/olp-home.aspx](http://www.hha.org.au/LearningPackage/olp-home.aspx)

5. **Definitions**

<table>
<thead>
<tr>
<th>PFSHS</th>
<th>(NSW) Publicly Funded Sexual Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHN</td>
<td>Sexual Health Nurse</td>
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</table>

6. **References**


G4 INTERPRETERS IN SEXUAL HEALTH SERVICES

1. Purpose and scope
To provide information on the use of health care interpreters (HCI) in the sexual health setting.
Refer to the following for additional information:

2. Outcomes
All people from culturally and linguistically diverse backgrounds (CALD) and people who are hearing impaired and deaf will be provided with equal access to sexual health services through the use of an interpreter.
Valid consent is obtained for any procedure, by using health care interpreters when needed to facilitate communication.

3. Procedure
When to use an interpreter
An accredited interpreter should be engaged when the information to be communicated is significant for health and/or health outcomes; the person requests an interpreter; or the person’s English skills are assessed to be inadequate for the situation.
Some specific health events where interpreters should be engaged include:
- interviews to establish clinical histories
- discussions seeking consent for investigations, treatment and research (see below)
- informing people of results of investigations and procedures
- providing information about medications
- consent to surgical intervention eg. diathermy warts under general anaesthesia.

3.1 Consent
Professional interpreters must be present to ensure client consent is valid and that the client has understood the information provided. It is the responsibility of sexual health service staff to be aware of requirements for obtaining valid consent. Refer to Consent Section G2.
Consent for treatment may not be valid if it is obtained through children, other family members, other clients, visitors, or non-accredited staff acting as interpreters.
Working with an accredited interpreter ensures that you communicate through a trained, bilingual person who is guided by a code of ethics and respects the confidentiality of the person, is impartial, accountable and strives for accuracy.
Working with an accredited interpreter should not only meet the needs of the person, but also the health care professional’s duty of care obligations to understand and be understood by people receiving a health service from you. Health services must consider the potential legal consequences of adverse outcomes when using unaccredited people to “interpret” if an accredited interpreter is available.
4. Procedure

Health Care Interpreter Services (HCIS) are available 24 hours a day, 7 days a week, either face-to-face, by telephone or by video conference and are free to public health clients. Interpreters should be booked as far in advance as possible.

Sexual health staff conducting a consultation with a client are responsible for arranging the HCI. Face-to-face interpreting service is the preferred option in provision of health care, although not always available in rural and remote areas. When using the telephone interpreter service it is preferable to use a speaker phone or a two handset phone.

4.1 Procedure for booking an interpreter

Contact details are available for each Local Health District (LHD) location.

Client details to be given to the HCIS when making a booking:

- client's first name and Medical Record Number (MRN)
- name of staff member booking the interpreter and their contact phone number
- date, time and length of time interpreter required
- sex of interpreter required
- language (dialect if necessary), or sign language.

4.2 Prior to the consultation

- allow extra time for the consultation
- discuss the nature and aim of the session with the interpreter
- identify if there is any relationship between the interpreter and the client
- provide ‘Information for Health Care Interpreters: sexual health services’ (Appendix G4.1) to the interpreter and allow the interpreter to ask questions, clarify terminology or express discomfort about any topics.

4.3 During the Consultation

- introduce yourself and the interpreter and explain that both you and the interpreter are bound by codes of ethics to maintain the confidentiality of the session
- address questions to the client, rather than to the interpreter
- speak a little more slowly, using short simple sentences in plain English, pausing after two or three sentences to allow the interpreter to relay the message
- seek the client’s permission if you need to obtain cultural information from the interpreter, however avoid lengthy conversations with the interpreter and have the interpreter explain the nature of any of these conversations to the client.

4.4 After the Consultation / Documentation

- offer a debrief for the interpreter if the consultation was emotionally taxing, and clarify any questions that may have arisen from the session
- document the presence of an interpreter in the medical file
- the interpreter is responsible for documenting and signing their visit and service provided in the medical record
- if Translating and Interpreting Service (TIS) is used, record the job number in the medical record.
4.5 Patient Refusal

The reasons why people may refuse the offer of an accredited interpreter are many and varied and may relate to the level of comfort or trust the client has with an interpreter. Sometimes refusal can be due to fear that the client and interpreter may know each other, particularly if they are members of a small community. Other reasons include the language used by the interpreter may be the wrong dialect, or the interpreter may be viewed as being of the ‘wrong’ gender or have different religious or political affiliations from the client.

If a client indicates a preference to manage without an interpreter, staff should:

• highlight the benefits of using an interpreter
• stress that the interpreter is bound to maintain confidentiality
• communicate that you have an obligation to ensure effective communication through the use of an interpreter when required eg. for consent
• document the client’s refusal in the medical record.

5. Definitions

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
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<tr>
<td>HCI</td>
<td>Health Care Interpreter</td>
</tr>
<tr>
<td>HCIS</td>
<td>Health Care Interpreter Service</td>
</tr>
<tr>
<td>LHD</td>
<td>Local Health District</td>
</tr>
<tr>
<td>MRN</td>
<td>Medical Record Number</td>
</tr>
<tr>
<td>TIS</td>
<td>Translating and Interpreting Service</td>
</tr>
</tbody>
</table>

6. References

APPENDIX G4.1 – Information for Health Care Interpreters: Sexual Health Services

Sexual health services are confidential, non-judgemental and health focussed. For you to best assist us with this approach we are providing you with this briefing.

While interpreting for us you will be exposed to our client’s sexual history in detail. It is important that our client is comfortable during this consultation and you feel able to interpret this information without showing discomfort. Below are listed some of the issues you may be required to interpret for us today. If you have any questions please address them before the interpreting session with the sexual health staff member you are working with.

Issues may include:

- sexual orientation
- men who have sex with men
- lesbians
- heterosexual men and women
- men and women who are sex workers
- transgender people
- people who inject drugs
- people who have multiple sex partners
- explicit descriptions of sexual acts
- explicit anatomical descriptions
- positive test results of sexually transmissible infections including HIV
- details of physical or sexual abuse
- psychological distress associated with discussion of any of the above.

If after any interpreting session you feel the need to debrief with someone, please ask the health care worker you are with and this can be arranged.

If you feel unable to provide a confidential, non-judgemental and health oriented service to any of the client groups above, you should inform us of your inability to do so, to enable us to book another interpreter.

Thank you.
G5 PROTECTING CHILDREN AND YOUNG PEOPLE

1. Purpose and scope

The aim of this document is to highlight the legal framework underpinning child protection in NSW and to provide guidance to clinicians working in NSW publicly funded sexual health services in understanding their role as mandatory reporters in the care and protection of young people.

This document must be used in conjunction with the following NSW Health Policy Directives and Interagency Guidelines:

- Child Wellbeing and Child Protection – NSW Interagency Guidelines
- Consent to Medical Treatment – Patient Information PD2005_406

2. Procedure

2.1 Legislation relevant to Child Protection

Sexual health clinicians working in NSW health publicly funded sexual health services should be informed of the legal framework underpinning their role in the care and protection of young people who attend their services. They include:

- **Definition of child and young person:** Under the NSW Legislation Children and Young Persons (Care and Protection) Act 19981 a child is defined as a person who is under the age of 16 years and a young person is a person who is aged 16 years or above but who is under the age of 18 years.

- **Mandatory reporting:** In accordance with the NSW Legislation Children and Young Persons (Care and Protection) Act 19982 Section 23 and Section 27 clinicians are mandated to report to Community Services (CS) children (ie. < 16 years of age) who are at risk of significant harm (ROSH) (refer to section 2.2 Recognising (ROSH)). Clinicians are not mandated but may voluntarily report young persons aged 16–17 years old who are in the ROSH threshold.

- **Clinicians are encouraged to be transparent with clients when making a ROSH report however client consent is not required (with the exception of homelessness)**

- **Age of consent to medical treatment:** Refer to Section G2 Consent Section 3.2 – Age of consent to medical treatment

- **Age of sexual consent:** Although age of sexual consent is legally 16 years old, (Crimes Act 1900 NSW – Age of sexual consent (section 66C)3 the Child Wellbeing and Child Protection Policies and Procedures for NSW Health PD2013_007 acknowledges that underage sexual activity occurs and allows clinicians to exercise their professional judgement and careful consideration to establish whether the child or young person presenting to their service has the capacity and sufficient maturity to engage in mutually consensual peer sexual activity (with a person/s within two chronological years of age) or whether there is any indication that the child or young person was or is currently being physically or psychologically coerced into sexual activity.

  - **NOTE:** acquisition / diagnosis of a sexually transmitted infection (STI) or pregnancy does not necessarily mean that (constitute) sexual abuse has taken place.
• **Information sharing:** under Chapter 16A4 and Section 2485 of the Children and Young Persons (Care and Protection) Act 1998, NSW clinicians and other health staff are able to share information about a child or young person if it relates to their safety, welfare and wellbeing.

• Refer to Section 6 of the Child Wellbeing and Child Protection Policies and Procedures for NSW Health PD2013_007 for guidance on information sharing.
  
  – Information can be exchanged verbally or by using the standardised forms which are linked in Child Wellbeing and Child Protection – NSW Interagency Guidelines. All information exchanged between health service providers must be recorded in the client’s medical record, either a transcript of the verbal or a copy of the standardised form placed in the medical records.

**2.2 Recognising Risk of Significant Harm (ROSH)**

In determining ROSH thresholds, sexual health clinicians will need to assess for indicators of sexual, physical or psychological abuse and neglect in children or young persons who attend their services. Refer to Appendix C15.3 – AOD and ‘At Risk’ Assessment Data Collection for a modified HEADS$S$6 interviewing instrument, used by SSHC youth clinic clinicians to assess for ROSH indicators.

**NOTE:** acquisition / diagnosis of a sexually transmitted infection (STI) or pregnancy does not necessarily mean that (constitute) sexual abuse has taken place.

Clinicians should consult the Mandatory Reporter Guide (MRG) to provide assistance in determining if a child or young person has been, or is currently at risk of being physically or psychologically coerced into unwanted sexual activities or any other indicators of abuse or neglect (by self or others) that has come to light from the ROSH assessment.

If there is an immediate danger to the child or young person contact the Police and / or the Helpline on 133 627.

If after consulting the MRG, clinicians remain unsure whether concerns meet the ROSH threshold they should consult the NSW Health Child Wellbeing Units (CWU) on 1300 480 420 (Monday to Friday, 8.30am–5.30pm) to:

• identify whether another agency has concerns or is working with a particular child, young person or family and whether this information impacts on the level of risk

• obtain advice and assistance in planning what referrals and services may be offered to assist the child, young person and their family.

Line Managers and Child Wellbeing Area Coordinators can also support clinicians with their responsibilities in relation to the safety, welfare or wellbeing of children and young persons.

**2.3 How to report a child or young person who is at significant risk of harm**

Mandatory reporters will be guided by the Mandatory Reporter Guide (MRG). A Decision Report can be generated with an explanation of the outcome based on your completion of the decision tree. This should be printed and filed in the medical records.

If it is established that there are sufficient concerns about suspected risk of significant harm, contact the Child Protection Helpline on 133 627 (24 hours a day, 7 days a week, state wide call centre).
3. Documentation

All information exchanged between health service providers must be recorded in the client’s medical record, either a transcript of the verbal or a copy of the standardised form placed in the medical records.

To meet legal and ethical requirements staff should print out and include a copy of the outcome of the online mandatory reporting guide.

4. Evaluation

Standard Operating Procedure (SOP) policies are reviewed 3 yearly. Adherence is monitored through ongoing medical record audit process.

5. Definitions

<table>
<thead>
<tr>
<th>CS</th>
<th>Community Services</th>
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<tbody>
<tr>
<td>CWU</td>
<td>Child Wellbeing Units</td>
</tr>
<tr>
<td>MRG</td>
<td>Mandatory Reporter Guide</td>
</tr>
<tr>
<td>ROSh</td>
<td>Risk of Significant Harm</td>
</tr>
<tr>
<td>SOP</td>
<td>Standard Operating Procedure</td>
</tr>
<tr>
<td>SHSC</td>
<td>Sexual Services Health Centre</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmissible Infections</td>
</tr>
</tbody>
</table>

6. References

8. Child Wellbeing and Child Protection – NSW Interagency Guidelines,  

   18 December 2009, Children’s Research Centre 608–831–1180,  
   services/structured-decision-making-system
G6 SEXUAL HEALTH OUTREACH

1. Purpose and scope

To provide procedural guidelines related to the provision of outreach sexual health services across NSW.

2. Outcomes

Outreach models of service provision are utilised where appropriate by publicly funded sexual health services.
Access by priority populations to publicly funded sexual health services is increased.
Increased STI and BBV screening to priority populations.
Increased health education and harm minimisation to priority populations.
Increased rates of immunisations to priority populations.
Safety of outreach staff is maintained.
Client safety and confidentiality is maintained.

3. Procedure

The primary purpose of outreach is to provide an alternate model of sexual health service provision to priority populations. Service provision may encompass provision of information, education and resources on sexual health and related issues and / or provision of STI / BBV screening and Hepatitis vaccination services. This is performed in order to improve screening and vaccination rates and to minimise the transmission of STI / BBV in priority populations.

Outreach sexual health services are services provided outside of the main publicly funded sexual health service. The issues that will be addressed and information that will be covered during a visit will vary according to the service types and needs of individual groups. Alternative frameworks may include providing services in another NSW Health facility (eg. Satellite clinic in mental health facility) or NGO (eg. screening clinic at SWOP) or other agency (eg. sexual health clinic in a private youth employment agency building).

Outreach activities should be recorded including type of service and location of the service (refer to Appendix G6.1). Any clinical consultations should be documented in the client’s medical record.

3.1 Safety and security


For safety reasons outreach must be conducted by no less than 2 staff at any time. This may be staff from the sexual health service, SWOP, another NGO or another sexual health centre. It is required that staff has their NSW Health Identification Cards on their person at all times whilst on duty.

Outreach workers must have a mobile phone with them whilst on outreach.

Outreach workers must keep a copy of their planned locations where it can be accessed by other service staff if needed.

Staff should not forcibly enter a premise if refused by management and should not aggravate any
situation by their presence. Pre-arrangement with organisations is preferred.

It is important that staff on duty use their discretion when conducting outreach, with the following in mind:

1. Staff safety.
2. Client safety.
3. Other person’s safety.
4. Staff personal property / hospital property.

If police are contacted by outreach staff, security and the director of the service must also be notified as soon as possible. Staff are required to be aware of exact addresses, crossroads and phone numbers of all brothels and establishments in case of an emergency and the NSW ambulance service needs to be called.

Debriefing and support should be available for outreach staff who experience disturbing or distressing incidents in the course of their work. This is available from the employee’s line manager or the local Employee Assistance Program.

3.2 Staff accreditation

Given the simplicity of self-collected swabs and urines, staff of sexual health services from non-medical professional backgrounds such as health promotion officers and counsellors, as well as doctors and nurses can advise clients how to collect a specimen after clinical competency has been demonstrated or as local clinic policy.

Specimen collection should be undertaken as outlined in Section C14 – Screening Women for STI and Section C13 – Screening Men for STI taking into account the local model of outreach care. Sexual health services may need to develop clinical competencies, training and accreditation process that cater to their model of care. Accreditation is discussed in Section 4 of this manual.

3.3 Specimen management

Sexual health service staff on outreach are responsible for the management of specimens at all times. Ensure specimens and pathology request form are labelled correctly, secured, placed in biohazard bag then placed in storage transport container or as local procedures in readiness for processing upon return to the sexual health service. Importance is placed on checking all specimens and paperwork to ensure correct identifiers are matched.

3.4 Management of results

All results should be managed as per local sexual health service policy for the management of results.

3.5 Vaccinations

Hepatitis vaccinations are able to be administered on sexual health outreach (eg. brothel / parlours, GLBTIQ) and should be managed according to local clinic policy.

Vaccinations can be administered by accredited and authorised registered immunisers as per Ministry of Health (MOH) policy PD2008_033


and must adhere to the Hepatitis B vaccination policy as per DOH PD2005_222


Hepatitis A (risk identified) and Hepatitis B vaccinations can be given on outreach service to clients who require it (eg. SIW, MSM) or other at risk priority populations.
An emergency kit containing adrenaline injection 1:1000 and a written protocol for the treatment of anaphylaxis, including adrenaline use available for each vaccination occasion of service. Administration of adrenaline is at all times undertaken in accordance with the procedures specified in the National Health and Medical Research Councils current edition of the Australian Immunisation Handbook.

The accredited nurses ensure that a medical practitioner is contactable for medical advice at all times during the vaccination period.

Transport vaccines in the insulated containers which must be performed as per NHMRC guidelines. Cold chain must be maintained within a temperature range of 2°Celsius to 8°Celsius and be taken and documented prior to leaving the clinic and on outreach to ensure cold chain has not been broken.

Oxygen cylinder is not essential for outreach.

4. Documentation

Document clinical findings, tests performed, management, vaccinations including any adverse events and follow-up management plan in the medical record.

5. Definitions

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AHNEM</td>
<td>After Hours Nurse Manager</td>
</tr>
<tr>
<td>BBV</td>
<td>Blood Borne Virus</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Government Organisation</td>
</tr>
<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
</tr>
<tr>
<td>SIW</td>
<td>Sex Industry Worker</td>
</tr>
<tr>
<td>SSHC</td>
<td>Sexual Services Health Service</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>SWOP</td>
<td>Sex Worker Outreach Project</td>
</tr>
</tbody>
</table>

6. References


7. NSW Health Infection Control Policy. PD2007_036

8. NSW Health Hand Hygiene Policy. PD2010_058

9. NSW Health Immunisation Services – Authority for Registered Nurses. PD2008_033


11. Hepatitis B vaccination Policy NSW Health. PD2005_222
### APPENDIX G6.1 – Health Promotion Outreach Form 2010

Multicultural Health Promotion Project Outreach Form Year 2010

<table>
<thead>
<tr>
<th>No #</th>
<th>Date (d/m)</th>
<th>Name</th>
<th>Establishment</th>
<th>Time</th>
<th>Referral</th>
<th>Written info (W)</th>
<th>Condom and Lube (C&amp;L)</th>
<th>Sex Health Education (SHE)</th>
<th>Other / Note</th>
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<tbody>
<tr>
<td></td>
<td>2010</td>
<td></td>
<td></td>
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<td></td>
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<table>
<thead>
<tr>
<th>W</th>
<th>M</th>
<th>R</th>
<th>O</th>
<th>C</th>
<th>L</th>
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### Appendix G6.2 – Example risk assessment for outreach

<table>
<thead>
<tr>
<th>SWP #:</th>
<th>Name of Task / Equipment:</th>
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<tr>
<td>10</td>
<td>Sex Industry Parlour Outreach</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Department Name:</th>
<th>Facility / Service:</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Assessment No:</th>
<th>Risk Level:</th>
<th>Date Developed:</th>
<th>Date Review Due:</th>
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</thead>
<tbody>
<tr>
<td>10</td>
<td>Medium</td>
<td>November 2011</td>
<td>November 2014</td>
</tr>
</tbody>
</table>

#### Risk of Injury:
1. Aggressive incident: Patient and/or parlour manager aggressor.
2. SSHC car breakdown/car accident.
3. Poor lighting around parlours at night.
4. Unfamiliar parlour/venue.

#### Safety Rules:
1. Outreach to always be conducted with a minimum of two staff members.
2. Staff to always stay together.
3. Always carry SSHC mobile phone, switched on and battery charged.
4. All staff should be trained in aggression minimisation and de-escalation techniques.
5. In the event of an incident or accident, staff should call the police if deemed necessary.
6. In the event of an incident or accident, SSHC management must also be notified, whether or not police are involved:
   - During clinic hours: Contact one of the following depending on availability (in order of priority) via reception on 9382 7678:
     - XXXX, Health Promotion Team Leader
     - XXXX, Clinical Nurse Consultant SSHC
     - SSHC manager on duty
   - After clinic hours: Contact the After Hours Nurse Manager (AHNM) to discuss the situation and decide necessary actions. AHNM can be contacted via switch 9382 7111, or directly on 9382 7100.

#### Job Steps:
- Staff should write destination area/s on Multicultural Health Promotion office whiteboard prior to leaving SSHC for outreach.
- Staff complete Community Safety Visit Checklist prior to leaving SSHC.
- Assess risk of parlour/venue environment prior to entering.
- Take note of entry/exit points upon entering parlour/venue.
- If a patient and/or manager become aggressive, try to remain calm and speak in a stable, neutral tone.
- In the event of an escalating situation, leave the parlour/venue.
- Call police as necessary without hesitation.
- Complete IIMS after incident or accident.
- In the event of an incident, staff member/s involved should participate in a debrief with line manager and/or SSHC management and also be offered counselling services. Staff should be informed of the Employee Assistance Program to access confidential employee counselling services.

#### PPE Required:
<table>
<thead>
<tr>
<th>Mobile phone</th>
<th>Car</th>
<th>ID tags</th>
<th>Torch</th>
</tr>
</thead>
</table>

Approved for use by Manager: Team Leader, Health Promotion
G7 USE AND DISCLOSURE OF CLIENT INFORMATION

1. Purpose and scope

The aim of this document is to provide policy and procedural guidelines for the use and disclosure of client information, including the management and follow up of results at publically funded sexual health services (PFSHS) and HIV units. These guidelines are generic and may be tailored for use by individual services. However, it is the responsibility of sexual health staff and management to ensure that they are operating within the policies, procedures and legal requirements of the Local Health District and the Ministry of Health.

Refer to the following for additional information.

NSW Health Policy Directives:
- Privacy Manual for Health Information 2015
- Health Records and Medical / Clinical Reports PD2006_050.pdf
- Contact Tracing Guidelines for Sexually Transmissible Diseases and Blood Borne Viruses
- Electronic Information Security Policy (PD2008_052)
- Consent to Medical Treatment – Client Information (PD2005_406)
- Health Care Records - Documentation and Management (PD2005_127)
- Process for Approval of New or Modified Data Collections (PD2005_155)
- Standard Procedures for Use of Health Care Interpreters (PD2006_053)
- Subpoenas (PD2005_405)
- General Disposal Authority (GDA 17) Public Health Services: Client / Client Records (GDA17)
- Notification of Infectious Diseases Under the Public Health Act 2010 (PD2013_010)
- Communication Strategy Guidelines - Department of Health (GL2005_074)
- Human Research Ethics Committees: Ethical Review for External Entities (PD2008_046)
- Health Records and Medical / Clinical Reports Charging Policy (PD2006_050)

2. Outcomes

Client’s personal information is managed in accordance with the Privacy Manual for Health Information. Clients of sexual health services who have had tests or presented with a symptomatic complaint and / or positive test result are followed up appropriately.

3. Procedure

Personal Health Information is any information collected from or about a client in order to provide them with a health service. It includes name, age, gender, contact information and all medical records. In this document, personal health information is also referred to as ‘client information’.

Use of Personal Health Information refers to the communication or handling of a client’s information within NSW Health service.
Disclosure of Personal Health Information refers to the communication or transfer of a client’s information to another organisation or individual.

3.1 Authorised use and disclosure

There are 3 categories of authorised use and disclosure:

1. Client information may be used or disclosed for the primary purpose for which it was collected. For example:
   - discussing test results with colleagues as a provision of care
   - providing a photocopy of test results to the client.

2. Client information may be used or disclosed for a secondary purpose or directly related purpose. For example:
   - sending a client an SMS appointment reminder
   - providing a summary letter to a referring GP.

3. Use, disclosure and sharing of information may be lawfully authorised for another purpose. For example:
   - infectious disease notifications
   - if the sharing of information relates to the safety, welfare and wellbeing of a child or young person it takes precedence over the protection of confidentiality or of an individual’s privacy. Consent is not required but should be sought (refer to Section 6, Information sharing of the Child Wellbeing and Child Protection Policies and Procedures for NSW Health PD2013_007).

The use or disclosure of personal health information outside of these categories requires the client’s consent. For example:
   - a friend of a client rings to confirm that a client is in the waiting room. The disclosure of this information is not authorised without client consent.

3.2 Privacy

Ministry of Health (MOH) employees are bound by law and ethical practice to be familiar with privacy policy and to safeguard client information from unauthorised use or disclosure. Discussions about clients, their information or their care are confidential and must take place in a private area.

Clients who express concern about privacy or confidentiality should be made aware of centre policy and privacy legislation.

3.3 Publications and case presentations

All details that could identify an individual client or community should be deleted in any public presentation of client-derived data. If in doubt, discuss with your unit manager. A Clinical Ethics Committee must approve any research that may involve publication or presentation of client-derived data however internal quality improvement activities are usually exempt from this process.

3.4 Mass media

The Directors of PFSHS and HIV units or their delegate are responsible for the management of all client information requests that arrive from the media. Requests from the media must be handled according to the NSW Health Media and Communication Protocols.
3.5 Medico legal and other legal issues

All medico legal and other legal issues relating to clients (including solicitor requests for medico legal reports) are to be referred to Medical Administration. The Directors of PFSHS and HIV units or their delegate must be informed of all client information requests that arrive in the form of subpoena. A medical legal officer is available for assistance and can be contacted through the medical records department.

3.6 Requests for personal health information

3.6.1 Requests from clients for copies of results
In general, clients are entitled to copies of results to take to their other health care providers and are provided free of charge. It is preferred that clients attend in person to obtain copies of their results.

3.6.2 Requests from other NSW Health Agencies
Information relevant to a client’s ongoing care can be provided to another organisation or person involved in the same client’s care within NSW Health without the need for the client to sign a release of information request. If there are concerns regarding the identity of the requesting individual, the health care worker can take the name of the individual and organisation and call them back to confirm. If any doubt remains the health care worker should check with a senior manager, local Health Information Service or local health district Privacy Contact Officer.

3.6.3 Requests for medical record summaries
All requests for summaries of medical records are directed to a senior clinician.

3.6.4 Requests for access to medical records
Clients are entitled to access their medical records by contacting Medical Record Administration at the facility. Any reference to the identity, behaviour, or diagnosis of a third party must be deleted from the medical record. Requests for a copy of a medical record must be submitted with the appropriate Authority for the Release of Health Records and Information form.

3.7 Contacting clients

Appropriate client follow up care requires a balance to be struck between respecting rights, preserving confidentiality, protecting public health, meeting legal obligations and providing quality care for the client and their contacts.

The method of recall depends on the documented arrangement made with the client at the time of the test. The client may or may not consent to be contacted with tests results and should specify which method of contact they prefer. The client’s preferred contact method and all attempts at recall are documented in the medical record.

3.7.1 Telephone
Client identity must be confirmed according to centre policy prior to the disclosure of personal health information. For this reason, it is best practice to not leave a phone message but to continue to call the client until they answer or send a short messaging service (SMS) requesting that the client calls back. In some circumstances it may be necessary to leave a discrete message with your name (but not your designation) and your telephone number (but not the name of the clinic).

3.7.2 Letter
Written communication should be marked ‘personal’ or ‘confidential’ on the outside of the envelope. Envelopes containing letters to clients should not indicate the source of the letter other than the return address. The contents should not give away any personal health information about the client. A discreet example is: “Could you please call and make an appointment with me?”
3.7.3 Email
As with other forms of communication, email exchanges between clinicians and clients are governed by ethical practice, privacy law and professional etiquette. There are risks and limitations inherent to online communication that should be communicated to clients at the consultation in which follow-up plans are made.

Email, like SMS, is not ideal for consultation, advice giving or dialogue but rather to supplement face-to-face and telephone encounters. Acceptable indications for emailing a client may include recall, general information giving or providing negative results to an asymptomatic client not requiring further follow up.

Authenticating client identity by email can be difficult and messages sent outside of the LHD network (i.e. to a client’s personal email address) are not necessarily secure. For these reasons, email is not ideal for discussions with clients about personal health information or topics that could cause harm or distress to the client if accessed by an unauthorised third party. Emails should, in general, be limited to essential information only and should use discrete subject headings (i.e. ‘your results’) and messages (i.e. “please call us about your results”).

Precaution should be taken to ensure that the correct email address is used and that unintended recipients are not inadvertently carbon copied. A hard copy of the correspondence should be filed in the client’s medical record. All emails to clients must include the sender’s full name, designation and contact information.

3.7.4 Email outside of NSW Healthnet
Email outside of NSW Healthnet is not secure and poses a higher risk of unauthorised access. The following procedures should be applied to external email:

- patient details should be included in an attachment, rather than in the email text
- all attachments should be password protected, and the recipient made aware of the password via telephone or separate email
- recipient should be advised to copy the attachment to a secure local drive before opening the file using the password
- the original email and attachment should be deleted from their inbox (and trash emptied) within a reasonable timeframe.

For example, to protect a Microsoft Word document:
Step 1. Select: ‘Options’ from the Tools menu
Step 2. Select: ‘Security’ tab
Step 3. Create a password in the filed ‘Password to open’, and check the field marked ‘read-only recommended’.

3.7.5 SMS
SMS technology, if available, is a practical way to provide discreet, succinct and generic information to clients. Indications for using SMS may include recall, results and following up on results and treatments.

3.8 Results, recall and follow up
The process of recall initiation and follow-up will vary by service. However, it is essential that systems are in place to ensure that appropriate follow up is initiated and followed through in a timely manner. Positive results vary by clinical significance and can be classified as urgent or non-urgent with others requiring no action. Table 1 (see Appendix G7.1), is a template flow chart for the management of test results that can be adapted for use at individual services.
3.8.1 Recall of clients for results
A delegate/s should be in place to initiate recall once the result is reviewed and it is assessed that the client needs to be contacted. In cases where there would be significant client or public benefit, it may be appropriate to attempt contact beyond what is routine. All attempts at client contact are documented in the medical record.

3.8.2 Management of clients who Do Not Attend
Systems should be implemented to identify when a client does not attend an appointment and has not rescheduled. This is especially important in clients attending the service for HIV care and management. Clinicians can assess the need for follow up according to centre policy and STI management guidelines and attempt client contact if required. In some cases, further reasonable attempts at contact may be appropriate where significant benefit to the client or public is to be gained. If untreated clients with a sexually transmissible infection or blood borne virus are not able to be contacted by standard recall process, the file may be reviewed with a senior clinician to determine if further attempts at contact are required. In certain situations, advice may be sought from the Public Health Unit. If a client cannot be contacted to inform of a new HIV diagnosis, review with a senior Medical Officer and / or the Centre Director.

4. Documentation
All client contacts and interactions must be accurately documented in the client’s medical record.

5. Definitions

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HSV</td>
<td>Herpes Simplex Virus</td>
</tr>
<tr>
<td>HSIL</td>
<td>High grade cervical squamous intraepithelial lesion</td>
</tr>
<tr>
<td>LGV</td>
<td>Lymphogranuloma venereum</td>
</tr>
<tr>
<td>LHD</td>
<td>Local Health District</td>
</tr>
<tr>
<td>LSIL</td>
<td>Low grade cervical squamous intraepithelial lesion</td>
</tr>
<tr>
<td>MG</td>
<td>Mycoplasma Genitalium</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSU</td>
<td>Mid Stream Urine</td>
</tr>
<tr>
<td>PCR</td>
<td>Polymerase Chain Reaction</td>
</tr>
<tr>
<td>PFSHS</td>
<td>Publically Funded Sexual Health Service</td>
</tr>
<tr>
<td>RPR</td>
<td>Rapid Plasma Reagin</td>
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<tr>
<td>SESLHD</td>
<td>South Eastern Sydney Local Health District</td>
</tr>
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<td>SMS</td>
<td>Short Messaging Service</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmissible Infection</td>
</tr>
<tr>
<td>TP EIA</td>
<td>Treponema Pallidium Enzyme Immunoassay</td>
</tr>
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</table>

6. References
1. Public Health Act 2010
2. NSW Health Policy Directive Notification of Infectious Diseases Under the NSW Public Health Act 2010 (IB2013_010)
7. Appendix

APPENDIX G7.1 – Flow Chart for the Management of Test Results*

<table>
<thead>
<tr>
<th>URGENT ACTION BY CLINICIAN</th>
<th>FOR REVIEW BY CLINICIAN</th>
<th>NO ACTION</th>
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<tbody>
<tr>
<td>• Syphilis serology reactive, RPR raised</td>
<td>• Syphilis TP EIA Positive RPR serology non reactive</td>
<td>• All negative routine STI tests</td>
</tr>
<tr>
<td>• Syphilis lesion PCR swabs positive</td>
<td>• HSV positive</td>
<td>• Syphilis PCR lesion swabs negative</td>
</tr>
<tr>
<td>• HIV positive, indeterminate or equivocal</td>
<td>• Hepatitis B Surface Antibody negative Antigen positive</td>
<td>• HSV PCR negative</td>
</tr>
<tr>
<td>• Chlamydia positive</td>
<td>• Hepatitis C core Antibody and surface Antigen positive</td>
<td>• MG negative</td>
</tr>
<tr>
<td>• Gonorrhoea positive</td>
<td>• HIV monitoring results (chemistry, immunology, haematology)</td>
<td>• Hepatitis A IgG positive or negative</td>
</tr>
<tr>
<td>• MG positive</td>
<td>• LSIL cervical pap smears</td>
<td>• Hepatitis B Core Antibody positive and Hepatitis B Surface Antigen negative</td>
</tr>
<tr>
<td>• MSU positive</td>
<td>• All non routine test results negative</td>
<td>• Hepatitis B core Antibody negative</td>
</tr>
<tr>
<td>• Hepatitis A IgM positive</td>
<td>• Any other positive, indeterminate or abnormal results not listed for Urgent Action</td>
<td>• Hepatitis C Antibody negative</td>
</tr>
<tr>
<td>• HSIL or higher grade lesion cervical pap smears</td>
<td>• Hyphae or spores</td>
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</tr>
<tr>
<td>• LGV positive</td>
<td>• Candida culture positive</td>
<td></td>
</tr>
<tr>
<td>• Trichomoniasis positive</td>
<td>• Clue cells</td>
<td></td>
</tr>
<tr>
<td>• Recall on receipt of result</td>
<td>• Cervical pap smears negative</td>
<td></td>
</tr>
<tr>
<td>• Up to 4 attempts in total</td>
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<td></td>
</tr>
<tr>
<td>• Coordinate subsequent follow up as per management guidelines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Consult with senior clinician if unable to contact patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Recall within 7 days of receipt of result</td>
<td>• No recall required</td>
</tr>
<tr>
<td></td>
<td>• Up to 2 attempts in total</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Coordinate subsequent follow up as per management guidelines</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No further contact required if unable to contact patient</td>
<td></td>
</tr>
</tbody>
</table>

*Not all positive results mean the person has an active infection but all are reviewed so that a management plan can be documented.

*Not all positive test results are specified. Where not specified, the clinician must use discretion and, if uncertain, discuss with a senior clinician.
SECTION 4: ACCREDITATION

A1 CLINICAL COMPETENCY ASSESSMENT AND ACCREDITATION FOR SEXUAL HEALTH NURSES

1. Purpose and scope Cherie D edit

To provide a framework for clinical nurses working in sexual health wishing to, or required to, undertake a process of clinical competency accreditation within their service, with the aim of providing a supportive learning environment whilst maintaining a high standard of client care.

The accreditation process provides a contract between a senior nurse accredited to assess clinical skills and the nurse new to the clinical setting.

It is recognised that competency develops over time and that the clinical learning will be ongoing both prior to and after clinical competency accreditation. The nurse will continue to practise under the ANMC and ASHHNA competency standards.

2. Outcomes

At the completion of the process, the nurse will be able to function as a member of the multidisciplinary team and manage client presentations within service policy and procedure guidelines.

3. Procedure

The Accreditation process is based on adult learning principles1 and experiential learning. Adults learn by:

- having a need to know why they should learn something and considering it important to acquire the new skill, knowledge or attitude
- having a need to be self directing and deciding for themselves what they want to learn
- having had a far greater volume and different quality of experiences than young people so that connecting the learning experiences to past experiences can make the learning experience more meaningful and assist the participant to acquire new knowledge
- becoming ready to learn when they experience a life situation where they need to know
- entering the learning process with a task centred orientation to learning
- motivated to learn by both extrinsic and intrinsic motivation.

The process of clinical competency accreditation has 3 distinct stages:

1. Orientation.
2. Clinical skills accreditation and formative review.
3. Summative review.

At each of these stages the clinical teacher and the nurse undertaking accreditation have objectives and outcomes that need to be met.
### Orientation

<table>
<thead>
<tr>
<th>Clinical Teacher</th>
<th>Nurse</th>
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<tbody>
<tr>
<td>• Establish recognition of prior experience</td>
<td>• Observe patient consultations</td>
</tr>
<tr>
<td>• Orient nurses to clinical areas; patient files; clinic forms and appointment system</td>
<td>• Commence supervised clinical skills</td>
</tr>
<tr>
<td>• Demonstrate clinical skills and clinical decision making with reference to clinic based guidelines and the standard operating procedure</td>
<td>• Engage in reflective practice during and after patient consultation</td>
</tr>
<tr>
<td>• Provide information on evidence based resources for use in the clinic setting and for self directed learning</td>
<td></td>
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</table>

### Clinical skills and formative review

<table>
<thead>
<tr>
<th>Clinical Teacher</th>
<th>Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Base skill review on clinical practice wherever possible</td>
<td>• Perform patient consultations with observation</td>
</tr>
<tr>
<td>• Observe patient consultations to ensure skills are performed in clinic context and continuity of care is maintained</td>
<td>• Provide rationale for any variations in patient consultation</td>
</tr>
<tr>
<td>• Provide specific, timely and constructive feedback based on observations</td>
<td>• Perform patient consultations independently once accredited for that skill</td>
</tr>
<tr>
<td>• Refer to clinic based guidelines and the standard operating procedure when teaching</td>
<td>• Continue to observe patient consultations and actively reflect on attitudes, knowledge and skills demonstrated</td>
</tr>
<tr>
<td>• Meet with nurse regularly to review file documentation and participate in reflective practice and planning for skill development</td>
<td>• Follow clinic based guidelines and the standard operating procedure</td>
</tr>
<tr>
<td>• Provide opportunities to role play skills and attributes</td>
<td>• Ensure a safe patient environment by working within own scope of practice</td>
</tr>
</tbody>
</table>

### Summative review

<table>
<thead>
<tr>
<th>Clinical Teacher</th>
<th>Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide feedback on clinical skills accreditation and clinical practice</td>
<td>• Undertake a clinical session with a senior clinician utilising feedback and reflection skills</td>
</tr>
<tr>
<td>• Develop action plan for skills not yet accredited</td>
<td>• Demonstrate ability to apply knowledge within the context of sexual health clinic practice</td>
</tr>
<tr>
<td>• 3 month review with line manager</td>
<td>• Demonstrate critical thinking and clinical decision making skills appropriate to the speciality and scope of practice</td>
</tr>
<tr>
<td></td>
<td>• Perform patient consultations independently for accredited skills</td>
</tr>
<tr>
<td></td>
<td>• Within multidisciplinary framework consult with senior colleagues as per delegation of clinical practice</td>
</tr>
<tr>
<td></td>
<td>• Commence medications package for standing order accreditation</td>
</tr>
<tr>
<td></td>
<td>• Ongoing skills accreditation, clinical supervision and as negotiated with line manager</td>
</tr>
</tbody>
</table>
Clinical teaching skills

Feedback

Feedback is a means of communicating thoughts and feelings about the performance and competence of another person. It is central to sharing ideas, information and skills, as well as being vital for establishing and building relationships.

Helpful feedback makes a conscious distinction between the person – who is always valued – and particular acts or specific work – which may be subject to critical comment. There are many characteristics of constructive feedback but the most important is the way it is given. The tone, the style and the content should be consistent and provide the message that the person is valued.

Skills for giving and receiving feedback are a learnt skill and an essential element of lifelong learning. Feedback provides information that the learner can use to make changes to their practice.

Guide to helpful feedback

- Be realistic – direct comments towards things that the person can act on
- Be specific – base your comments on concrete observable behaviour
- Be sensitive to the goals of the person – link your comments to their intentions
- Be timely – appropriate to timing of the event you are giving feedback on
- Be descriptive – describe your views, it is up to the person to accept or reject
- Be consciously non-judgemental – offer your personal view
- Don't compare – treat each person's work as their own
- Be direct – say what you mean
- Be positive – say what you appreciate
- Be aware – of your own emotional state and focus on the other person.

Reflective practice

Reflection is an intentional process of examining experience to help us understand the action and reasoning behind our thoughts and actions.

There are two main types of reflection: reflection in action (during the event) and reflection on action (after the event). The retrospective action of reflecting on a prior experience or action aims to promote one's thoughts and judgements, attitudes and actions in the context of a particular experience. The knowledge gained cannot impact on the actual event but it can be used in future events.

David Kolb articulates the experiential learning cycle that shows how the nurse plans, acts, observes and through understanding, plans for the next encounter.

Through reflection, it is possible for the learner and teacher to accumulate knowledge about and acquaint them with sexual health practice. The result is that the learning nurse not only changes their practice (learns from experience) but the teacher nurse can also impact in a co-participatory way on the learner's practice.

During the reflective process the clinical teacher will use listening techniques:

- recognise areas that need further reflection
- use questioning techniques to guide the learner's reflection
- share both experience and reflective insight
• support the learner’s reflective practice
• guide and supervise the learner’s journal writings.

Self directed learning
It is the responsibility of the clinician to maintain and update their professional knowledge relating to sexual health in order to provide a high quality service for clients and to develop case related experience. Time may be allocated within the roster for self directed learning.

Depending on the learner’s need you can also offer a learning package with focus questions (Appendix C9.3). This is not an assessable tool, rather an additional learning guide. There are also many online learning packages with topics on HIV, sexual health, history taking, women’s and men’s health.

The Clinical Competency Assessment Tools in Appendix A1.1 are based on the nursing duties outlined in the Delegation of Clinical Practice (Section A2).

Professional relationship issues
In the event that the nurse experiences difficulty in their relationship with the senior nurse, all measures should be attempted to ensure a professional, constructive and supportive relationship is maintained. If this is unable to be managed on an individual level, consultation with the line manager to develop a plan is recommended.

4. Documentation
To finalise the accreditation for each skill competency or practical procedure the competency accreditation record must be completed. This is often completed as reflection on action at a separate meeting time to the clinic.

Once complete all documentation is kept in the personnel file by the line manager.

For self directed learning or to guide the clinical teaching process a clinical action and reflection plan can be used by both the nurse and the clinical teacher – see Appendix A1.2. Learning activities can also be documented in the nurse’s professional portfolio. An example of a professional portfolio can be found at http://ashhna.org.au/wp-content/uploads/2014/12/ASHHNA_Competency-Standards-for-sexual-and-reproductive-health-and-HIV-nurses.pdf
5. Definitions

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANMC</td>
<td>Australian Nursing and Midwifery Council</td>
</tr>
<tr>
<td>ASHHNA</td>
<td>Australasian Sexual Health and HIV Nurses Association</td>
</tr>
<tr>
<td>BBV</td>
<td>Blood Borne Virus</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HPV</td>
<td>Human Papilloma Virus</td>
</tr>
<tr>
<td>MCV</td>
<td>Molluscum Contagiosum Virus</td>
</tr>
<tr>
<td>NPEP</td>
<td>Non-occupational Post Exposure Prophylaxis</td>
</tr>
<tr>
<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
</tr>
<tr>
<td>OH&amp;S</td>
<td>Occupational Health and Safety</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmissible Infection</td>
</tr>
</tbody>
</table>

6. References

7. Appendices

**APPENDIX A1 – Clinical Competency Accreditation**

**APPENDIX A1.1 – Example – Clinical Skills Accreditation Board and Competency Assessment Tools**

**Clinical Skills Accreditation Record**

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Clinical Skill</th>
<th>Mode of Assessment</th>
<th>Date Complete</th>
<th>Assessor’s Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CORE COMPETENCIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venepuncture</td>
<td>Competency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual health history taking</td>
<td>Competency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gaining Informed Consent and Pre and Post HIV / STI Test Discussion</td>
<td>Competency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asymptomatic Self...(Male/Female Competency</td>
<td>Competency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male – Clinician Collected STI Screen</td>
<td>Competency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female – Clinician Collected STI Screen</td>
<td>Competency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HPV and MCV detection and treatment:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Podophyllin</td>
<td>Competency and complete detection and treatment record</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cryotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• LN2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• CO2 slurry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Wallach freezer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imiquimod</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male consultation for uncomplicated Urethritis</td>
<td>Observation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female consultation for uncomplicated candida, BV and trichomoniasis</td>
<td>Observation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **PRACTICAL PROCEDURES** | | | |
| Preparation and interpretation of gram stain and wet film | Practical teaching session | | |
| Medication administration and Standing Orders | Read clinical guideline / business rule | | (Self Assessment) |
| Nurse initiated medications and standing orders | Education package | | |
| Treatment and follow-up uncomplicated Chlamydia | Observation | | |
| Treatment and follow-up uncomplicated Gonorrhoea | Observation |
| HIV monitoring | Observation |
| Assessment for NPEP | Competency |
| New sex worker screen and information | Observation |
| Needle and syringe program | Competency |
| Assessment and administration of emergency contraceptive pill | Case discussion or observation |
| Pregnancy testing and pregnancy options | Observation or role play |
| Results management | Observation |

APPENDIX A1.1.1 – Venepuncture

A) Statement of previous experience

________________________________________________________________________

B) Knowledge

Answer the following questions:

1. Name the 3 layers of the vein

________________________________________________________________________

2. How do the valves of the vein appear on the skin surface? Why should they be avoided?

________________________________________________________________________

3. List 2 characteristics of a good vein and 2 characteristics of a bad vein

________________________________________________________________________

4. What is the most frequently chosen site for venepuncture and why, and name the preferred vein from that site

________________________________________________________________________
5. How many attempts can you have before referring to a more experienced clinician?

6. Provide the rationales for lying patient down when taking blood

7. Name 2 clinical practices that reduce the risk of a haematoma

8. What action do you need to take if a haematoma develops?

9. What action do you take if the patient is experiencing a vasovagal episode? (you will need to access a nursing or medical dictionary to answer this question)

10. Circle the correct answer:

<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vacutainer is the preferred system to use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wear gloves when performing venepuncture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tourniquet can be left on for 10 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anchor skin above vein before inserting needle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insert needle bevel downwards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remove needle before loosening tourniquet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apply pressure to site once needle removed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Venepuncture

**CRITERION**

<table>
<thead>
<tr>
<th>1. Consent</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Obtains patient consent</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Prepares patient and equipment</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Collects correct tubes for tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Chooses correct needle size</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Places all equipment in kidney dish</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Labels blood tubes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Adheres to universal precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Positions sharps container for point of generation disposal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Uses adjustable examination chair for purposes of OH&amp;S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Asks patient to lay supine on the examination table</td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Asks patient to expose their antecubital fossa with the arm extended downward in a straight line</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Procedure</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Washes hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Puts on gloves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Identifies suitable vein – right median cubital vein (preferred)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Applies tourniquet 5–15 cm above the injection site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Cleans site with alcohol wipe with a single motion towards self</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Instruct patient to clench and relax fist several times</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Gently palpate vein</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Assembles equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Positions needle and holder in direction of vein bevel up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Applies skin tension and secures vein with free hand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Pierces skin directly over vein entering at 10–25 degree angle and with a smooth quick entry along the vein</td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Attaches vacuette tubes and changes as required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. Loosens tourniquet prior to removal of needle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. Removes vacuette tube prior to removal of needle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o. Places cotton wool at insertion site (no pressure)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>p. Withdrowls needle and replaces with cotton wool applying pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>q. Discards needle immediately into the sharps container</td>
<td></td>
<td></td>
</tr>
<tr>
<td>r. Instructs patient to apply pressure to site with cotton wool for 2–5 minutes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Venepuncture

### CRITERION

| s. | Ensures bleeding ceased |
| t. | Applies dressing / bandaid |
| u. | Disposes of used equipment appropriately |

#### 4. Safety

| a. | Ensures patient feels physically well following venepuncture |
| b. | Assesses patient for signs of vaso vagal or haematoma |
| c. | Appropriate use and disposal of sharps on the same side as nurse’s dominant hand, point of generation disposal |
| d. | Does not pass used needle from one hand to the other in order to discard |
| e. | Positions self comfortably |
| f. | Uses adjustable examination chair to avoid strain on posture |
| g. | Seeks assistance with difficult venepuncture – after 2 attempts |

#### 5. Utilises current infection control principles and procedures

| a. | Practices standard precautions |
| b. | Adheres to infection control policies |

#### 6. Documentation

| a. | Documents adverse events during or following venepuncture including number of attempts, failed attempts, haematoma, vasovagal |
| b. | Documents samples taken on patient visit form |
| c. | Documents tests ordered on pathology form |

#### 7. Knowledge of potential complications and management

| a. | Demonstrates knowledge of policy and procedure |
| b. | Demonstrates knowledge of possible complications and management |
| c. | Demonstrates knowledge of prevention of complications |
| d. | Ability to discuss rationale for choosing varying equipment (straight needle or butterfly) |

Competency achieved: ☐ Yes ☐ No

Date: 
Participant’s signature: 
Assessor’s signature: 
Comments:
APPENDIX A1.1.2 – Sexual History Taking

<table>
<thead>
<tr>
<th>CRITERION</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Verification of medical record</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Name, date of birth, identification number</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Review of medical record (if further visit)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Ascertains previous history details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Reviews medical record and checks previous relevant history eg. sexual and drug use / blood exposure history, mental health status, previous STI or BBV diagnoses, presence of chronic disease, recent medication, notes on past venepuncture experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3. Reviews previous test results</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. What was tested for and when – check incubation periods / window periods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Checks Hepatitis A and B, and HPV vaccination status</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4. History taking</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Communicates effectively</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Uses a pleasant, respectable manner and language that is appropriate to patients level of understanding; open body language</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Establishes rapport</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Explains service, reason for history taking and likely outcome eg. screen related to risk assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Creates a non-judgemental environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Does not use language that labels (eg. promiscuous)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Discusses confidentiality in relation to medical records and test results</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Follows a logical sequence of questioning using the designated history taking form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Obtains clear relevant facts including:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presence / absence of symptoms, genital or HIV seroconversion; past history of STI, BBV; past screening tests done and subsequent diagnoses and results; detailed sexual history, drug use and blood exposure risk history</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Information collected is sufficient to assess risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5. Facilitates patient participation in consult</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Creates an environment that facilitates patient participation e.g. active listening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Clarifies patient’s knowledge before providing information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Invites questions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Opportunity provided for patient to clarify / question</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>6. Provides information</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Reinforces essential information related to health issue and risk reduction e.g. transmission and prevention, safer sex, recommended screening guidelines, HPV information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Offers / provides written information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Explains any procedures appropriately</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 7. Documentation

<table>
<thead>
<tr>
<th>CRITERION</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Documentation clear and legible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Information recorded relevant to patient presentation and will facilitate continuity of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Documents any adverse events e.g. vaso vagal, medication reactions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Tests taken recorded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. All requested test/s clearly indicated in the medical record</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Plan for future care / follow-up documented</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Signs record correctly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Laboratory request form is labelled and test/s requested legibly</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Competency achieved: [ ] Yes [ ] No

Date:

Participant’s signature:

Assessor’s signature:

Comments:

---

**APPENDIX A1.1.3 – Gaining *Informed Consent and Pre and Post HIV / STI Test Discussion**

**Gaining *Informed Consent and Pre and Post HIV / STI Test Discussion**

<table>
<thead>
<tr>
<th>CRITERION</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Risk assessment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Ascertains patient’s perception of their level of risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Uses details from history to explain to patient what they have been at risk of acquiring, screening tests recommended and questions patient about their view of likelihood of a positive or negative result</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Corroborates or clarifies patient’s actual versus perceived risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Advises patient the likelihood of a positive or negative result</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Takes into account window / incubation periods when discussing testing timeframes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Informs the patient about test accuracy relevant to timing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Explains the rational for recommendations about screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Gaining informed consent</strong></td>
<td></td>
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<tr>
<td>a. Explains what is a HIV / STI tests</td>
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<tr>
<td>b. Explains what the tests are testing for</td>
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<tr>
<td>c. Advises the patient about the limitations of the HIV / STI testing (window period)</td>
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<tr>
<td>d. Advises the patient when the results are expected</td>
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</tbody>
</table>
e. Explains what a positive HIV / STI diagnosis means and what supports are available
f. Discusses what a negative HIV / STI test means
g. Discusses confidentiality and privacy issues regarding the results
h. Explains the implications of not being tested
i. Provides information about the process required to obtain the result
j. Obtains informed consent from the patient to perform testing
k. Provides health education, harm minimisation information or motivational interviewing as required to assist the patient in reducing risks in the future

3. Assess physical symptoms

- Takes appropriate action for any reported physical symptoms
- In the presence of abnormal findings refers to a senior clinician as per the delegation of clinical practice
- Incorporates findings into gaining informed consent in relation to potential positive results

4. Post-test discussion

- Demonstrates preparation undertaken before patient arrived
- Outlines plan of how consult will be approached, i.e. how and when results will be given and how patient’s potential responses will be managed; what counselling strategies might be used; and what information must be given to the patient and what can wait until a future consult
- Utilises effective communication skills to give the HIV result first then gives all other results
- Explains the meaning and implications of the results
- Reinforces window / incubation periods
- Reinforces transmission and prevention
- Offers / provides written information
- Offers immediate support such as counsellors where available
- Discusses contact tracing requirements and documents action plan
- Refers for medical assessment, if appropriate
- Informs patient how to access further information and support
- Offers Hepatitis A and B vaccine if relevant

*Informed consent for testing means that the person being tested agrees to be tested on the basis of understanding the testing procedures, the reasons for testing and is able to assess the personal implications of having or not having the test performed.

Competency achieved:  □ Yes  □ No

Date:
Participant’s signature:
Assessor’s signature:
Comments:
### APPENDIX A1.1.4 – Asymptomatic Self-Collected STI Screen (Male / Female)

#### Asymptomatic Self-Collected STI Screen (Male / Female)

<table>
<thead>
<tr>
<th>CRITERION</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>1. Prepares equipment</td>
<td></td>
<td></td>
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<tr>
<td>a. Prepares specimen equipment as applicable</td>
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<tr>
<td>b. Labels specimens appropriately and records site of specimen collection on patient label</td>
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<tr>
<td>2. Offers clinician collected throat swab (as applicable)</td>
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<tr>
<td>a. Observes oral cavity and notes any abnormalities i.e. lesions</td>
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<tr>
<td>b. Performs throat swab if indicated, swabbing the tonsillar crypts and posterior pharynx</td>
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<tr>
<td>3. Explanation of self collected swabs</td>
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<tr>
<td>a. Explains lower vaginal swab collection (insert swab approximately 2cm into vagina and rotate and place back into swab tube)</td>
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<tr>
<td>b. Explains first pass urine collection (first 30 mls of urine in jar and remainder in toilet and seal container)</td>
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<tr>
<td>c. Explains rectal swab collection (insert swab approximately 3–4cm into rectum and rotate and place back into swab tube)</td>
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<tr>
<td>d. Specimens given to patient in specimen bag / kidney dish</td>
<td></td>
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<tr>
<td>e. Directs patient to toilet</td>
<td></td>
<td></td>
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<tr>
<td>4. Utilises current infection control principles and procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Practices standard precautions throughout procedure</td>
<td></td>
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<tr>
<td>b. Adheres to infection control procedures when handling all specimens</td>
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</table>

Competency achieved: ☐ Yes  ☐ No

Date:

Participant’s signature:

Assessor’s signature:

Comments:

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## APPENDIX A1.1.5 – Male – Clinician Collected STI Screen

### Male - Clinician Collected STI Screen

<table>
<thead>
<tr>
<th>CRITERION</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>1. Prepares patient and equipment</td>
<td></td>
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</tr>
<tr>
<td>a. Prepares necessary equipment (eg. VCNT plates, PCR tubes, glass slides, cotton tipped swabs, nunc loop, normal saline, urine jar)</td>
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<tr>
<td>b. Adheres to principles of infection control</td>
<td></td>
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<tr>
<td>c. Ensures patient privacy (pulls curtains, allows patient to disrobe in private, uses modesty sheets)</td>
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<td></td>
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<tr>
<td>d. Positions patient in appropriate position: supine position for genital examination, left lateral for anal examination, sitting for throat examination</td>
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<td></td>
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<tr>
<td>2. Utilises current infection control principles and procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Practices standard precautions throughout procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Adheres to infection control policies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Physical examination and specimen collection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Demonstrates knowledge of anatomy and pathophysiology in clinical practice</td>
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<tr>
<td>b. Performs appropriate examination of the genitals: inguinal nodes, epididymis, vas deferens and testicles. Inspects pubic hair, skin and perianal area</td>
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<tr>
<td>c. Attends appropriate swab collection based on physical examination and risk assessment</td>
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<tr>
<td>d. Performs throat swab where indicated: swabs the tonsillar crypts and posterior pharynx and inoculates the appropriate tests (where indicated)</td>
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<tr>
<td>e. Performs anal swab where appropriate: positions the patient in the left lateral position, lubricates the swab/s using normal saline, inserts swab 2 cms into rectum and presses against lateral wall</td>
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<tr>
<td>f. Provides instructions for urine collection: first catch in sterile container with last urination over 20 minutes prior</td>
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<td></td>
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<tr>
<td>g. Performs testing for BBVs and Syphilis where indicated</td>
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<tr>
<td>h. Implements appropriate course of action in the presence of abnormal or changed findings</td>
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<tr>
<td>i. Appropriately labels and handles laboratory specimens</td>
<td></td>
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<tr>
<td>j. Inoculates specimens appropriately as per laboratory policy</td>
<td></td>
<td></td>
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<tr>
<td>k. Processes / stores / transports biological specimens appropriately</td>
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<tr>
<td>l. Disposes of equipment and waste in appropriate bins</td>
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<tr>
<td>m. Obtains patient signature on pathology form (if applicable) as necessary if Medicare billing is to be utilised for testing</td>
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<tr>
<td>4. Provides rationale for issues not addressed with patient during consultation</td>
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</tbody>
</table>

Competency achieved: □ Yes  □ No

Date:

Participant’s signature:

Assessor’s signature:

Comments:
### Female - Clinician Collected STI Screen

<table>
<thead>
<tr>
<th>CRITERION</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td><strong>1. Prepares patient and equipment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Gains patient consent for examination and tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Prepares necessary equipment (eg. VCNT / Sab plates, PCR tubes, glass slides, ph sticks, lubricant jelly, cotton tipped swabs, speculum)</td>
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<tr>
<td>c. Selects correct pathology tests for the individual patient</td>
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<tr>
<td>d. Adheres to principles of infection control</td>
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<td></td>
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<tr>
<td>e. Ensures patient privacy</td>
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<tr>
<td>Pulls curtains, allows patient to disrobe in private, uses modesty sheet</td>
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<tr>
<td>f. Positions patient in appropriate position (lithotomy position for vaginal examination, left lateral supine for anal examination, sitting for throat examination)</td>
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</table>

<table>
<thead>
<tr>
<th><strong>2. Utilises current infection control principles and procedures</strong></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Practices standard precautions throughout procedure</td>
<td></td>
<td></td>
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<tr>
<td>b. Adheres to principles of infection control</td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>3. Physical examination and sample collection</strong></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Demonstrates knowledge of anatomy and pathophysiology</td>
<td></td>
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<tr>
<td>b. Performs appropriate examination (external genitalia; inspects vulva, vaginal walls, cervix, perianal area, oropharynx)</td>
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<tr>
<td>c. Inserts speculum appropriately: lubricates speculum with water based jelly prior to insertion, separates labia holding them apart whilst inserting speculum avoiding the clitoris, inserts speculum horizontally</td>
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<tr>
<td>d. Collects appropriate swabs based on physical examination and risk assessment</td>
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<tr>
<td>Collects endocervical swabs for Chlamydia, Gonorrhoea and, if indicated, gram stain</td>
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<tr>
<td>Collects high vaginal swab from posterior fornix for gram stain, wet film and, if indicated, culture</td>
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<tr>
<td>Inoculates cultures appropriately</td>
<td></td>
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<tr>
<td>Attends pH tests (if indicated)</td>
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<tr>
<td>e. Provides correct swabs and instructions if self collected swabs are indicated</td>
<td></td>
<td></td>
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<tr>
<td>f. Provides instructions for urine specimen collection</td>
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<tr>
<td>First catch urine (Chlamydia, Gonorrhoea, pregnancy test) in a sterile container with last urination over 20 minutes prior</td>
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<tr>
<td>Midstream urine for urinalysis</td>
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</tbody>
</table>
g. Collectes Pap smear (where indicated)
   Chooses correct cervical sampler based on visual inspection of cervix and history (cervix sampler and/or cytobrush)
   Takes sample from the transformation zone
   Firmly rolls collected cells onto glass slide in one direction covering surface area of slide
   Does not allow slide to air dry by fixing specimen
   Vigorously swishes the cervix sampler and/or cytobrush into the liquid medium if additionally using Thin Prep

h. Removes speculum, keeps blades open until removed from cervix, inspects vaginal walls whilst slowly and gently removing speculum from vagina

i. Performs bimanual examination (when indicated), gains patient consent, palpates inguinal nodes, gently inserts 2 gloved and lubricated fingers into vagina, gently rocks cervix to assess for cervical motion tenderness, palpates Pouch of Douglass through posterior fornix, palpates uterus and left and right adnexa – assessing for pain or tenderness

j. Performs testing for BBVs and Syphilis where indicated

k. Performs throat swab where indicated
   Swabs the tonsillar crypts and posterior pharynx and inoculates the appropriate tests (where indicated)

l. Implements appropriate course of action in the presence of abnormal or changed findings

m. Appropriately labels and handles laboratory specimens

n. Inoculates specimens appropriately as per laboratory policy

o. Processes / stores / transports biological specimens appropriately

p. Disposes of equipment and waste in appropriate bins

q. Obtains patient signature on pathology form (if applicable). This is necessary if Medicare billing is to be utilised for testing

4. Provides rationale for issues not addressed with patient during consultation

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</thead>
</table>

   Competency achieved: ☐ Yes ☐ No

   Date:

   Participant’s signature:

   Assessor’s signature:

   Comments:
### Detection and Treatment of Genital Warts (HPV) and Molluscum Contagiosum

<table>
<thead>
<tr>
<th>CRITERION</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td><strong>1. Physical examination</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Demonstrates knowledge of anatomy and physiology in clinical practice</td>
<td></td>
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<tr>
<td>Correctly positions patient</td>
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<td>b. Correctly identifies genital wart(s)</td>
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<tr>
<td>c. Correctly identifies molluscum</td>
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<tr>
<td>d. Implements appropriate course of action</td>
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<tr>
<td><strong>2. Treatment</strong></td>
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<tr>
<td>a. Determines most suitable mode of treatment based on local policies and procedures and in collaboration with the patient</td>
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<tr>
<td>b. Selects appropriate form of treatment (cryotherapy, podophyllin or Imiquimod)</td>
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<tr>
<td>Obtains written order from doctor</td>
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<tr>
<td>Provides correct instructions for application</td>
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<tr>
<td>c. Cryotherapy: utilises nurse initiated treatment order and applies solution with care for 10–20 seconds in total. Ensures 1–2 mm diameter of surrounding skin is also treated. Repeats as needed</td>
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<tr>
<td><strong>3. Utilises current infection control principles and procedures</strong></td>
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<tr>
<td>a. Practices standard precautions</td>
<td></td>
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<tr>
<td>b. Adheres to infection control policies</td>
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<tr>
<td>c. Wears protective goggles for cryotherapy</td>
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<td><strong>4. Follow-up care</strong></td>
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<tr>
<td>a. Provides information pamphlets and verbal information about natural history, prevention and transmission</td>
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<tr>
<td>b. Skin care instructions provided</td>
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<tr>
<td>Treatment may cause irritation. Salt water washes may promote healing. Keep skin clean and dry</td>
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<tr>
<td>c. Advises to return in 7–10 days for cryotherapy follow up</td>
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<tr>
<td>d. Provide detailed instructions about application instructions as per medication orders</td>
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<tr>
<td>e. Provides information about smoking and HPV</td>
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<tr>
<td><strong>5. Provides rationale for issues not addressed with patient during consultation</strong></td>
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</table>

Competency achieved: ☐ Yes ☐ No

Date: ___________________________

Participant’s signature: ___________________________

Assessor’s signature: ___________________________

Comments: ___________________________
HPV AND MCV DETECTION AND TREATMENT RECORD

This is a tool used in assessing a Registered Nurse’s competence of consistently identifying HPV and / or MCV and rational for appropriate treatment chosen.

<table>
<thead>
<tr>
<th>No.</th>
<th>Date</th>
<th>MRN</th>
<th>SITE</th>
<th>Comments eg.</th>
<th>Patient or clinician detected</th>
<th>Appearance</th>
<th>Confidence in detection</th>
<th>Who you consulted with</th>
<th>Treatment chosen and rationale</th>
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<tbody>
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</table>

Competency achieved: ☐ Yes ☐ No

Date: ____________________________

Participant’s signature: ____________________________

Assessor’s signature: ____________________________

Comments: ____________________________

______________________________

______________________________

______________________________
### Assessment for PEP

#### CRITERION

1. **Demonstrates theoretical knowledge of non-occupational Post Exposure Prophylaxis (PEP)**
   - a. Able to discuss options for accessing PEP including out of hours access  
   - b. Assesses the risk of HIV transmission and BBV using the PEP recommendations tables located in the National guidelines for post-exposure prophylaxis after non-occupational and occupational exposure to HIV  
   - c. Able to discuss the drugs commonly prescribed in PEP regimens including indications, dosage, side effects and drug interactions  
   - d. Able to outline the rationale for the 72 hour cut off for commencement of PEP  
   - e. Able to discuss the efficacy and durability of PEP medication  
   - f. Outlines rationale for baseline tests prior to PEP commencement  
   - g. Accurately outlines PEP follow-up guideline  
   - h. Able to discuss the need for safe sex for the duration of PEP testing and follow-up

2. **Assessment of patient for PEP**
   - a. Takes an accurate drug and medical history and checks for potential drug interactions and contraindications  
   - b. Demonstrates ability to take accurate history of exposure  
   - c. Successfully identifies where PEP is indicated and explains this clearly to patient  
   - d. Discusses the process of referral to MO for review and where appropriate commencement of PEP  
   - e. Appropriately involves MO in decision where PEP initiation may not be clear or patient not suitable for PEP  
   - f. Demonstrates accurate ordering of baseline tests  
   - g. Demonstrates ability to explain PEP regime to patient, including adherence, drug interactions, side effect management and advises the timing of the first dose.

3. **Follow up post PEP**
   - a. Advises patient to contact sexual health clinic or present to emergency department if experiencing adverse effects or any other concerns  
   - b. Arranges follow-up according to PEP guideline, explaining rationale for testing intervals including delayed HIV seroconversion post PEP  
   - c. Advises the patient to practice safe sex for the duration of PEP testing and follow-up.

Competency achieved: □ Yes □ No

Date: ____________________________

Participant’s signature: ____________________________

Assessor’s signature: ____________________________

Comments: ____________________________

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NHS Brighton, Competency for assessing risk of HIV transmission for HIV PEP.  
# Needle and Syringe Program

<table>
<thead>
<tr>
<th>CRITERION</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td><strong>1. NSP policy guidelines and NSP</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Demonstrates knowledge of appropriate NSP service provision</td>
<td></td>
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<tr>
<td>b. Demonstrates awareness of NSP policies and procedures</td>
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<tr>
<td>c. Promotes appropriate health and social welfare services</td>
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<tr>
<td>d. Adheres to the state/territory department of health and service policies</td>
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<tr>
<td>e. Maintains patient confidentiality</td>
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<tr>
<td><strong>2. History taking and communication</strong></td>
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<tr>
<td>a. Communicates effectively; pleasant respectful manner, use of language appropriate to patient’s level of understanding, open body language</td>
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<tr>
<td>b. Establishes rapport</td>
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<tr>
<td>c. Creates a non-judgmental environment</td>
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<tr>
<td>d. Does not use language that labels</td>
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<tr>
<td>e. As appropriate, elicits a history specific to the needs of the patient</td>
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<tr>
<td>f. Obtains clear relevant facts for statistics</td>
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<tr>
<td>g. Maintains patient’s privacy, dignity and safety</td>
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<td><strong>3. NSP supply</strong></td>
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<td>a. Supplies needles, syringes and other equipment as per policy</td>
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<td>b. Supplies appropriate size disposal container</td>
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<td><strong>4. Utilises harm minimisation strategies</strong></td>
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<td>a. Demonstrates a philosophy of harm minimisation</td>
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<tr>
<td>b. As appropriate, promotes preventative health strategies</td>
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<tr>
<td>c. Demonstrates knowledge of health issues associated with injecting drug use (IDU)</td>
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<tr>
<td>d. Demonstrates knowledge of blood borne pathogens associated with injecting drug use (IDU)</td>
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<tr>
<td>e. Knowledge of alcohol and other drugs and their potential for harmful interactions</td>
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<tr>
<td>f. Provides appropriate information to patients</td>
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<td>g. As appropriate, provides information in regard to infection control within a public health context</td>
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<tr>
<td>h. As appropriate, provides information in reference to pharmacodynamics and pharmacokinetics of alcohol and other drugs</td>
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<tr>
<td>i. Offers safe sex supplies (condoms and lube)</td>
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<td><strong>5. Documentation</strong></td>
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<td>a. Documentation clear and legible</td>
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<td>b. Information recorded for statistics</td>
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Needle and Syringe Program

CRITERION

c. Plan documented

6. Termination of encounter

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<td>a. Written information given on health issues and / or referral services (as appropriate)</td>
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<td>b. Promotes safe disposal of sharps</td>
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Competency achieved: ☐ Yes ☐ No

Date:

Participant’s signature:

Assessor’s signature:

Comments:

APPENDIX A1.2 – Action and Reflection Plan

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A2 DELEGATION OF CLINICAL PRACTICE

1. Purpose and scope
To provide information and procedural guidelines related to the delegation of clinical practices from the Director / Medical Officer to a Registered Nurse.
This document outlines the scope of practice for nurses and is used as a training tool for new nurses.

2. Outcomes
Nurses working in NSW Sexual Health Services operate within delegation of clinical practice.
Client safety is maintained and appropriate assessment is performed.

3. Procedure
Delegation involves the Medical Director or a Medical Officer asking a nurse to provide care and treatment on their behalf. The care is delegated to a nurse deemed competent to carry out the procedure, assessment, management and follow-up required.
All Registered Nurses who have delegated authority will have demonstrated competence in nursing care through a clinical skills accreditation process. The nurse is deemed competent by the Director / Senior Medical Officer acting on the advice of the CNC or NUM or senior nurse.
The nurse assesses, plans, implements and evaluates nursing care in collaboration with the individual client and the multidisciplinary team and integrates organisation policies and guidelines with professional standards.
Table 1 (below) provides a template of delegation of clinical practice for adaptation to each service capacity and requirements.
Table 1. Delegation of Clinical Practice – Refer to Triage – Appendix P7.1.1

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<th>May be seen by RN</th>
<th>Consult with MO +/- refer as required</th>
<th>Refer to MO (may be internal or external MO)</th>
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<td>• STI screening and sexual health history taking in asymptomtic patients</td>
<td>Detected on examination – Cervicitis, cervical motion tenderness, testicular or scrotal signs, genital rash or lesion, extra-genital symptoms including: rashes, lesions, oral lesions</td>
<td>Any patient referred by another doctor for assessment or diagnosis of a condition (excludes screening or uncomplicated HPV management)</td>
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<tr>
<td>• Treatment and follow-up of uncomplicated: Chlamydia</td>
<td>Requiring a prescription of a non standing order or non nurse initiated medication</td>
<td>Women with pelvic symptoms or signs including: IMB, PCB, pelvic pain, pelvic mass, dyspareunia</td>
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<tr>
<td>• non gonococcal urethritis (NGU)</td>
<td>Assessment of urinary tract symptoms</td>
<td>Patients with rectal symptoms including: bleeding, fissures, discharge, pain</td>
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<tr>
<td>• Gonorrhoea</td>
<td>Management and follow-up of patients with positive HIV, Syphilis and Hepatitis serology</td>
<td>Men with testicular symptoms, scrotal symptoms or complicated arthritis (presence of more than urethral discharge, +/- dysuria or persistent symptoms for 3 weeks or more)</td>
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<tr>
<td>• contact of Chlamydia, Gonorrhoea or NGU</td>
<td>Patients requiring assessment and / or prescription for NPEP</td>
<td>Genital rash or lesion as presenting issue</td>
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<td>• genital warts</td>
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<td>Acute jaundice</td>
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<td>• molluscum contagiosum</td>
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<td>Acute HIV / AIDS related symptoms or signs</td>
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<td>• vulvovaginal candidiasis</td>
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<tr>
<td>• bacterial vaginosis</td>
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<td>• trichomoniasis</td>
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<tr>
<td>• Gaining Informed Consent and Pre and Post HIV / STI Test Discussion STI prevention counselling</td>
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<td>• Assessment for and administration of Hepatitis A, Hepatitis B and HPV vaccinations</td>
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<td>• Pregnancy testing and provision of information on pregnancy options</td>
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<td>• Asymptomatic post termination follow-up</td>
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<td>• Information about contraceptive options</td>
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<tr>
<td>• Assessment for use and administration of emergency contraception</td>
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<tr>
<td>• Assessment for use and administration of Depot Medroxy Progesterone Acetate (DMPA)</td>
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<td>• Assessment for use of the OCP</td>
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<td>• Pap smear test</td>
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<td>• Needle and syringe program services</td>
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<tr>
<td>• Health information and education</td>
<td></td>
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<tr>
<td>• Other procedures at the request of a Medical Officer e.g. Syphilis treatment</td>
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<tr>
<td>• Administration of medication under standing order</td>
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<tr>
<td>• Administration of nurse initiated medications</td>
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<tr>
<td>• Triage</td>
<td></td>
<td></td>
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<tr>
<td>• HIV monitoring</td>
<td></td>
<td></td>
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<tr>
<td>• Results management</td>
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</tbody>
</table>

4. Documentation

All information related to client care provided under this delegation must be documented in the medical record.

For all clients referred by a General Practitioner; unless the client objects, inform the referring
doctor via letter the results of the investigations, the treatment provided, and any other information necessary for continuity of care.

5. Definitions

<table>
<thead>
<tr>
<th>CNC</th>
<th>Clinical Nurse Consultant</th>
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<tbody>
<tr>
<td>DMPA</td>
<td>Depot Medroxy Progesterone Acetate</td>
</tr>
<tr>
<td>IMB</td>
<td>Intermenstrual Bleeding</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HPV</td>
<td>Human Papilloma Virus</td>
</tr>
<tr>
<td>MO</td>
<td>Medical Officer</td>
</tr>
<tr>
<td>NGU</td>
<td>Non Gonococcal Urethritis</td>
</tr>
<tr>
<td>NPEP</td>
<td>Non-occupational Post Exposure Prophylaxis</td>
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<td>NUM</td>
<td>Nurse Unit Manager</td>
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<td>OCP</td>
<td>Oral Contraceptive Pill</td>
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<td>PCB</td>
<td>Post Coital Bleeding</td>
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<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmissible Infections</td>
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</table>

6. References

N/A
A3 MEDICAL RECORDS QUALITY IMPROVEMENT PROGRAM

1. Purpose and scope
To provide a framework and set of tools for implementing and maintaining a medical record quality improvement (QI) program.

2. Outcomes
Ensure appropriate client management.

Ensure data collected and entered is appropriate and of the highest quality.

Provide a platform for staff support, ongoing education and professional development.

Ensure that the benchmark of less than or equal to 10% data error rate is maintained.

3. Procedure
There are 2 distinct systems of Medical Record QI systems:

- Continual Medical Record Quality Improvement (CMRQI) system
- Random Medical Record Quality Improvement (RMRQI) system.

Where staffing levels allow, all new staff can be placed in a CMRQI system until they have been accredited by the appropriate division delegate (eg. NC / NUM / MO / Counsellor) to audit their own files and become part of the RMRQI system.

Where staffing levels do not allow this, the new staff member can have a random number of their medical records reviewed each week by the appropriate division delegate.

The process of accreditation involves the appropriate division delegate reviewing all the new staff members’ medical records for a period of time to ensure at least 20 new visits and 20 follow-up visits can be reviewed. A Quality Improvement Audit Tool outlining the criteria and actions is in Appendix A3.1.

The appropriate division delegate completes the QI Audit Tool and provides feedback from the audit process.

The form is used for each staff member, one staff member per form. When the medical records have been reviewed, return the completed form to the individual staff member. Some medical record consultations may require discussion with the clinician concerned.

The auditee then completes any tasks required on the QI Audit Tool (if any) and returns the original form to the division delegate.

When the staff member has been accredited by the appropriate division delegate as satisfying the criteria for adequate medical record completion (10% error rate), they are removed from the CMRQI and enter the RMRQI.

A tool to summarise the assessment – Registration and Further Visit Continuous Medical Record Improvement Tool is provided in Appendix A3.2.

The RMRQI system requires a random sample (appropriate to clinic staffing levels, minimum 5 files or 10%) of the clinicians’ medical record consultations being pulled and reviewed. The medical record consultation is reviewed following the same process as CMRQI. The medical record should also be examined in light of providing positive feedback to staff members in cases for example, where normal expectations were exceeded.
4. **Documentation**

Feedback is provided on the Quality Improvement Audit Tool – Appendix A3.1.

5. **Auditble Outcomes**

Ensure that the benchmark of less than or equal to 10% data error rate is maintained on Random Medical Record Quality Improvement System.

6. **Definitions**

<table>
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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>CMRQI</td>
<td>Continual Medical Record Quality Improvement</td>
</tr>
<tr>
<td>MO</td>
<td>Medical Officer</td>
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<tr>
<td>NUM</td>
<td>Nurse Unit Manager</td>
</tr>
<tr>
<td>NC</td>
<td>Nurse Consultant</td>
</tr>
<tr>
<td>QI</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>RMRQI</td>
<td>Random Medical Record Quality Improvement</td>
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<tr>
<td>STI</td>
<td>Sexually Transmissible Infection</td>
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7. **References**

## 7. Appendices

### APPENDIX A3.1 – Medical Record Quality Improvement Program

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<td>3.2 Management complies to policies/procedures</td>
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<td>3.3 Verbal instructions to client are documented</td>
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<td>3.6 Delegation of responsibility adhered to</td>
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<td>4.6 Verbal instructions to client documented</td>
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<td>5.2 Advised how to collect results</td>
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<td>5.3 Letter written to referring doctor and copy in file</td>
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<td>5.4 Results documented and actioned</td>
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<td>5.5 Client recall documented and correspondence copied to file</td>
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**TOTAL ERRORS**

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<th>Action as a result of audit</th>
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<th>Y</th>
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<th>N/A</th>
<th>Y</th>
<th>N</th>
<th>N/A</th>
<th>Comments</th>
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<tbody>
<tr>
<td>File given back to clinician to review with comments</td>
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<td>Return to data entry for changes to be made</td>
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<td>Discussed with auditee to ensure understanding of process requiring review</td>
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<td>Complete hazard / incident (IIMS) form where appropriate</td>
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<td>Refer to relevant policies and procedures</td>
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### APPENDIX A3.2 – Registration and Further Visit Continuous Medical Record Improvement Tool

**Calculation used to ascertain % error rate**

\[
\text{Errors} = \frac{\text{No of records} \times \text{No of variable}}{100} 
\]

<table>
<thead>
<tr>
<th>Total # of MR reviewed:</th>
<th>Errors</th>
<th>100</th>
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<tbody>
<tr>
<td></td>
<td>Tally</td>
<td>Total</td>
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</tbody>
</table>

See MR variables below
- Allergy not adequately documented
- Reason for presentation not complete
- STI contact not complete
- Inadequate history
- HIV therapy not complete
- Past STD / GUM conditions – inadequate detail
- Hepatitis history – inadequate detail
- HIV testing history – inadequate detail
- Cervical cytology – inadequate detail
- Contraception – inadequate detail
- Sexual history – inadequate detail
- Partner(s) risk – inadequate detail
- Overseas contact – inadequate detail
- Sex worker box not complete
- Examination inadequately documented
- Tests ordered not complete
- Diagnosis inadequate
- Diagnostic code not complete or incorrect
- Treatment not complete
- Variation from protocol not explained
- Contact tracing inadequately documented

**Clinician’s name:**

**Date:**

---

**Summary:**

<table>
<thead>
<tr>
<th>Total registrations</th>
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<table>
<thead>
<tr>
<th>Total errors</th>
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<td>%</td>
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<table>
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<tr>
<th>Total further visits</th>
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<tr>
<th>Total errors</th>
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<td>%</td>
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A4 PROFESSIONAL STANDARDS

1. Purpose and scope
To provide links to professional standards of practice for the clinical and counselling staff working in Publicly Funded Sexual Health Services (PFSHS) centres.

2. Outcomes
All staff working in PFSHS has access to and knowledge of professional standards for their own practice and for the care of their clients.

3. Procedure
All staff act in accordance with professional standards governing their practice. Professional standards govern the following staff groups:
- Aboriginal and Torres Strait Islander HIV / sexual health workers
- Counsellors
- Medical Officers
- Nurses.

4. Documentation
N/A

5. Definitions

<table>
<thead>
<tr>
<th>HIV</th>
<th>Human Immunodeficiency Virus</th>
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</thead>
<tbody>
<tr>
<td>PFSHS</td>
<td>Publicly Funded Sexual Health Services</td>
</tr>
</tbody>
</table>

6. References

7. The Royal Australian College of General Practitioners 2011, The Curriculum Framework:
   The five domains of general practice, RACGP, accessed 19 September 2014
   http://curriculum.racgp.org.au/
A5 UNDERGRADUATE AND POSTGRADUATE STUDENT PLACEMENTS

1. Purpose and scope
To provide guidelines for staff who have undergraduate and postgraduate clinical student placements. To facilitate experiential learning in the sexual health setting.

2. Outcomes
Create a supportive clinical teaching environment, encouraging the development of attitude, knowledge and skills relevant to the sexual health context. Facilitate critical thinking and reflection. Facilitate the transition of theory to practice.
Provide opportunities for learners to set goals and give and receive feedback on clinical development. Ensure the mandatory requirements and procedures for all students undertaking clinical placements in NSW public health facilities are met.

3. Procedure
Undergraduate placement requests

Undergraduate / Postgraduate – All undergraduate and postgraduate placement applications need to submitted via ClinConnect. ClinConnect is a web-based application built to assist health services (Local Health Districts and Networks) and Education Providers to manage clinical placements for Nursing and Midwifery, Dental and Oral Health, Allied Health and Medical students. It is used for booking placements in Nursing and Midwifery, Allied Health and Dental & Oral Health and used to record placement and student details for Medicine. The clinical placement management system supports Education Providers and health facilities manage clinical training demand and capacity and reporting requirements to state and national level. ClinConnect is used for all placements undertaken in NSW Health facilities in the target professions. ClinConnect outlines the mandatory requirements for students and they are required to submit this paperwork to their institution prior to their placement. Students are then classified as either ‘Verified’ or ‘Non Verified’ and below outlines what documentation the placement facility needs to site depending on their status:

<table>
<thead>
<tr>
<th>Documentation Required</th>
<th>‘Verified’ Students</th>
<th>‘Non Verified’ Students</th>
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</table>
|                        | Student ID          | Only those students who have the NSW Health CRC OR National Police Certificate (and for Overseas Students – a Statutory Declaration or Police Certificate from their home country) outstanding may present for clinical placement providing they have this evidence with them on the first day.  
Students who require vaccination verification must be ‘verified’ prior to the commencement of clinical placement.  
In addition they must provide their:  
Student ID | }
Other placement requests

**Other placement requests** – Those wanting to complete a clinical placement that is not a requirement of a tertiary qualification will need to contact the placement facility directly to request this. Please see [Primary Health Care Nurse Clinical Placement Guidelines](#) that outlines the mandatory requirements to attend a clinic for a clinical placement. Please note although this document is specific to Primary Health Care Nurses the mandatory requirements are the same for anyone wanting to complete a clinical placement.

Clinical teaching and adult learning

You can use your knowledge of adult learning principles to facilitate student learning on placement.

The adult learning principles identified by Knowles are:

- adults are internally motivated and self-directed
- adults bring life experiences and knowledge to learning experiences
- adults are goal oriented
- adults are relevancy oriented
- adults are practical
- adult learners like to be respected.

**Discuss Learning Goals for the session:**

- guided by nurse / student – they are motivated to learn when they perceive a need to do so
- learning goals may also be articulated by their university / organisation
- undergraduate nurses may have articulated their learning goals for the week with their clinical teacher, but clarify individual session goals with each clinician
- be aware that the undergraduate students may never have seen genitalia in a clinical setting.

**Setting the tone**

- inform observer that you will be placing the client at the centre of the consult and will be attending to their needs
- discuss the nature of a sexual health consult and explore what it may mean for the observer and the client for example:
  - “What sort of fears and anxieties might a client experience coming to a clinic for the first time?”
  - “Clients may use some explicit language or talk openly about very personal issues, what are your thoughts about sitting in on a consult?”
- ensure uninterrupted non-verbal and verbal communication between you and the client
- articulate the boundaries of the observer not disrupting the consult, for example:
  - “If you have any questions we can discuss them at the end of the consult.”
  - “We ask our clients very sensitive in-depth questions about their sexual history; it is important to maintain a professional manner.”
- explain process for gaining consent from client to have an observer and if client says no you will continue the consult and they will do a learning activity
- explain the room set up including location of clinic items and infection control practices.
Gaining consent

- have the observation nurse wait outside of the room
- invite the client into the room and introduce yourself.

Inform the client you have a nurse observing you today and explain where that nurse is from / what course they are doing eg. “Hi, my name is xxx and I am one of the clinic nurses. Today with me I have (name) from (organisation) who is observing in the clinic today. Is it OK if he / she observes this consult?”

Allow time for the client to answer. If OK invite nurse / student into the room and introduce them to the client.

If the client says no – continue the consult without an observer.

Recheck consent before physical assessment.

Provide an opportunity for the client to consent to being observed ‘behind the curtain’.

“Thanks for agreeing for xxx to observe. Is it OK if he / she observes the physical examination?”

Attend to client cues: if you assess client to be uncomfortable inform them that the observer will not be coming in for the physical assessment.

After the consultation

Reflective practice and debrief

Facilitate reflection on aspects of the consultation through open questioning, eg.

- “What were one or two key aspects you learnt about during the consult?”
- “Did the client bring up anything in the consult that challenged your perceptions?”
- “Is there anything that you would like to follow-up from the consult (for example policy information, pamphlets)?”
- “What are some of the similarities / differences in the consultations you do in your setting?”

The observers may also have information in their learning package about:

- reflecting on a particular case
- reflecting on critical incident.

Giving feedback

- requested – ask if the person would like feedback
- be specific and descriptive
- focus on concrete / behavioural change
- clarify that the feedback you gave was what the student heard.

Supervision

Throughout the placement the observer will also discuss cases and issues with an allocated clinical teacher. Any professional conduct issues need to be discussed with the CNE / CNC / NUM. The observer may also have a supervisor allocated from their university / organisation. The supervisor can be utilised for support and needs to be aware of any professional conduct issues.

Example of skills that can be done under supervision:

- restocking
- clinic room set up
• throat swab
• IM injections
• sexual health history taking.

4. Documentation

If the student performs a clinical action under direct supervision it must be documented in the medical record.

The medical record must also be countersigned by the supervising RN.

5. Definitions

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<th>Clinical Nurse Consultant</th>
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<tbody>
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<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
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<tr>
<td>NUM</td>
<td>Nurse Unit Manager</td>
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<td>RN</td>
<td>Registered Nurse</td>
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</tbody>
</table>

6. References


