

Development of an Evidence-Based Protocol: Trauma-Informed Pelvic Exams in the Emergency
Department

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By Ashley Tuttle
BSN, University of Phoenix, 2012
ADN, Palomar College, 2010

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Chair, Cara Busenhardt, PhD, APRN-NM, CNM, FACNM

Co-Chair Krysta Ramirez Henry, DNP, APRN, CNM, FACNM, PMH-C

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The DNP Project committee for Ashley Tuttle certifies that this is the approved version of the following DNP Project:

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Chair, Cara Busenhardt, PhD, APRN-NM, CNM, FACNM

Co-Chair Krysta Ramirez Henry, DNP, APRN, CNM, FACNM, PMH-C

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Abstract

Problem: People that have experienced sexual trauma in the past require pelvic exams as part of health screenings, medical evaluations, and other indicated reasons; however, many people that have experienced sexual assault or other trauma are triggered by these exams. The American College of Obstetricians and Gynecologists recommends routine pelvic exams with cervical cancer screening every three to five years in adults, but often these exams often need to be completed for acute conditions or health concerns. The use of trauma-informed care (TIC) has been shown to reduce the likelihood of causing further traumatization or causing these patients to be triggered when pelvic exams are performed.

Aim: The aim of this Doctor of Nursing Practice (DNP) project was to develop an evidence-based, trauma-informed policy for patients receiving a pelvic exam in the emergency department in an urban, academic hospital that included preferred language or scripting and recommended exam procedure techniques. This practice guideline was designed to help providers perform trauma-informed pelvic exams on patients, improve provider confidence with trauma-informed exams, and increase patient satisfaction.

Method: After a thorough literature review, an evidence-based protocol was developed for an urban academic hospital in Kansas City, Kansas. This protocol was evaluated by an interprofessional team including physicians, advanced practice providers, forensic nurses, and registered nurses that care for patients in the emergency department using a validated and reliable tool for protocol evaluation. There was an opportunity for participants to offer comments and concerns, which were considered for inclusion in a revised protocol.

Results: After an evaluation of the guideline, it was determined that a revised guideline was not needed. The results of the evaluation were positive, and it is recommended the guideline be adopted by the emergency department if approved by an interdisciplinary team.

Keywords: emergency department, pelvic, pelvic exam, sexual trauma, trauma, trauma-informed care

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Introduction and Background

The knowledge and use of trauma-informed care (TIC) practices are used widely in the healthcare field. TIC can also be used when performing pelvic exams. TIC practices such as language surrounding exams and the tools used to perform the exam itself, are vital for all healthcare providers, especially those performing pelvic exams (Reproductive Health Access Project, 2019). Currently, there are no published evidence-based guidelines or protocols for TIC with pelvic exams. However, there are several experts in the field and institutions that are investigating what is best for the patient during pelvic exams, with the intention to provide guidance for practice based on the evidence they find. There are numerous healthcare settings in which pelvic exams are a vital part of assessments for patients, depending on the reason for the visit, such as pelvic pain, vaginal discharge, or vaginal bleeding. Patients may find that the pelvic exam can trigger previous trauma that they have experienced, such as from sexual assault or sexual abuse (Ades et al., 2019). On average, there are 433,648 victims (age 12 or older) of rape and sexual assault each year in the United States; one in six females have experienced a rape or attempted rape in their lifetime (Department of Justice, 2019).

Trauma-informed care recognizes the presence of trauma symptoms and acknowledges the role trauma may play in an individual's life (University of Buffalo, 2020). TIC does not take into consideration only those situations or patients with a history of sexual trauma but patients and situations with all kinds of past trauma, such as multiple hospitalizations and/or a history of abuse (Becker-Blease, 2017). This considerate type of care is becoming more prevalent in the United States health system and should be applied in all situations and with all patients requiring a pelvic exam, especially those with a history of sexual trauma. A standard should be set to use TIC for all patient encounters because there is no way to know each person's history without

screening each patient regarding traumas in their past. The use of TIC also reduces the likelihood of causing new trauma to the patient (Becker-Blease, 2017).

Problem Statement and Significance

Women that have experienced sexual trauma in the past will need to have pelvic exams as part of health promotion screenings, medical workups, and for other indicated reasons; however, these exams can be triggering to many women that have experienced sexual assault in the past (Cuevas et al., 2017). For routine care and asymptomatic patients, the American College of Obstetricians and Gynecologists (ACOG, 2016) recommends routine pelvic exams with cervical cancer screening every 3 to 5 years for women aged 21 to 65 years. In the United States, one in five women will experience sexual assault at some point in their lives (Smith et al., 2017), and the lifetime prevalence of post-traumatic stress disorder (PTSD) for women who have been sexually assaulted is nearly 50% (Scott et al., 2017). TIC may reduce the likelihood of causing further trauma during pelvic exams (Cuevas et al., 2017), which is a common procedure in health care.

Project Aim

The aim of this Doctor of Nursing Practice (DNP) project was to develop an evidence-based, trauma-informed policy for patients receiving a pelvic exam in the emergency department in an urban, academic hospital that includes preferred wording/scripting and exam techniques. This policy will help not only the providers perform trauma-informed pelvic exams on patients but may also improve provider confidence with trauma-informed exams and the patients would benefit from receiving more trauma-informed pelvic exams.

Project Details

Project Design

This DNP project was designed as a quality improvement project with a formal and systematic method to improve processes of a healthcare system using evidence-based practice. The project began with a literature review to determine what research has previously been completed on trauma-informed care and trauma-informed care surrounding pelvic exams. A thorough review of the literature, development of an evidence-based policy, and evaluation of the policy by an interprofessional team was completed.

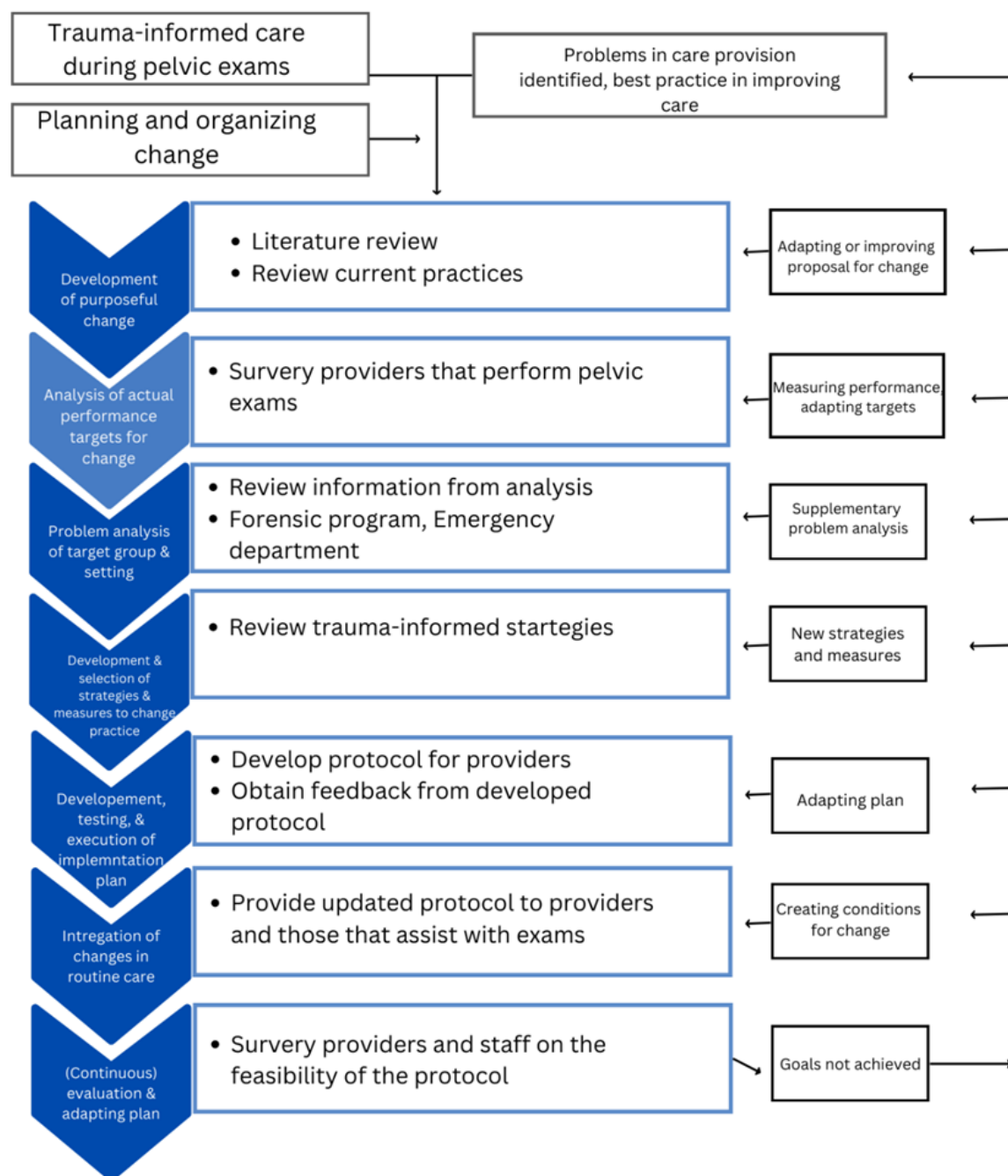
Theoretical Framework and Concept Map

The Grol and Wensing's Implementation of Change Model was used to develop an evidence-based protocol for TIC pelvic exams and then was evaluated on its feasibility in practice within an emergency department. This model is used to optimize patient care through safety and quality improvement; by putting the patient first and doing what is best for the patient. The focus of the model is the primary process in the care provided by physicians, nurses, and the teams they work in (Grol et al., 2013).

Figure 1 shows the process for using Grol and Wensing's Implementation of Change Model for creating an evidence-based protocol for TIC pelvic exams. Initially, there is a planning and organization of the change. Then it flows into the stages of implementation as outlined by Grol and Wensing. There is room for adjustment and shifting of the change as it is being implemented. Lastly, problems are identified and corrected, leading to improved care for the patient.

Figure 1

Implementation of Change Model: Trauma-Informed Care for Pelvic Exams in the Emergency Department



Note. Flow chart adapted from Grol, R., Wensing, M., Eccles, M., & Davis, D. (2013). Improving patient care: The implementation of change in health care. Wiley Blackwell.

Setting

The setting for this project was an emergency department in a large, urban, academic hospital in the Midwest region of the United States. This hospital's emergency department sees over 60,000 patients annually (K. Howe, personal communication, April 18, 2022). The providers within the department that perform pelvic exams include physicians, nurse practitioners, physician assistants, and forensic nurses. The department sees a wide variety of patients from diverse backgrounds, and pelvic exams are performed frequently.

Methodology

Quality Improvement Determination

This project was submitted to the KUMC Institutional Review Board for a determination as quality improvement. The project met the requirements of quality improvement as outlined by the KUMC Institutional Review Board due to the project being a systematic, data-guided activity designed to bring about immediate improvements in healthcare delivery in a particular setting. This project also aimed to identify improvements, implement small-scale changes, monitor results, and decide on additional changes and wider implementation. The project was guided by implementing good clinical care (University of Kansas Medical Center, 2019).

Review of the Literature

An initial search using PubMed, CINAHL, and Google Scholar was performed to guide the development of the evidence-based practice project. The search terms included "trauma-informed care," "sexual assault," "pelvic exams," "speculum exam," "trauma-informed care AND pelvic exams," "sexual assault AND posttraumatic stress disorder," "trauma-informed care AND sexual assault," "trauma-informed care AND women's health." Inclusion criteria for review included: (a) full-text resources, (b) English language, (c) publication within ten years,

and (d) research that focused on the effects on people receiving pelvic exams with a history of trauma. Exclusion criteria included any studies/articles that included children/pediatrics.

Development of Evidence-based Protocol

Using multiple published recommendations and examples from experts, an evidence-based protocol was developed on how to perform a trauma-informed exam and use trauma-informed care specifically in the emergency department that can be used by providers performing exams and others that may be in the room assisting with the exam (See Appendix A). The protocol will be formatted with an existing institutional policy and procedure template and will include all components of a thorough, up-to-date protocol, including appropriate references and links to resources.

Evaluation of Protocol

After the development of the protocol, a survey invitation was distributed to an interprofessional group of providers with a request for feedback on the appropriateness and feasibility of the protocol in the setting. The survey invitation, protocol, and evaluation tool were shared with the interprofessional group using a REDCap survey (REDCap Consortium, n.d.). The evaluation form, the AGREE II tool, included Likert-type statements of agreement. The data was then collected and managed securely using REDCap electronic data capture tools hosted at The University of Kansas Medical Center.

AGREE II Tool. The Appraisal for Guidelines for Research and Evaluation (AGREE) tool provided a framework to assess the quality of guidelines. It is a generic evaluation tool and can be applied to any guideline within healthcare and is intended to be used by healthcare providers that would like to assess a guideline before adopting it into practice. (AGREE Next Steps Consortium, 2013). The updated AGREE II version was used to this protocol (See

Appendix B). The AGREE II is comprised of 23 Likert-type statements organized into six quality domains: (1) scope and purpose, (2) stakeholder involvement, (3) rigor of development, (4) clarity of presentation, (5) applicability, and (6) editorial independence. It is recommended that at least two, but preferably, at least four appraisers review the clinical guidelines presented to increase the assessment's reliability. There are two scoring methods: (1) using individual appraisers' scores and (2) reaching consensus. The purpose of the scoring is to identify the limitations of the clinical guideline being considered and to select high-quality clinical guidelines to be implemented (AGREE Enterprises, n.d.).

Demographic Question. A project director-created demographic question was added at the end of the AGREE II survey. Respondents were asked to indicate their role in caring for emergency department patients. Results were reported in aggregate that demonstrated interprofessional evaluation of the protocol and toolkit (See Appendix C).

Data Analysis of Protocol

The Likert-type questions were reviewed to determine the participants' common feedback levels. The data was collected and analyzed using the REDCap system, with descriptive statistics, including percent agreement and frequencies for each item of the AGREE II tool and demographic question. The data was also utilized using the six domains of the AGREE II tool to determine if the protocol was appropriate for implementation or required revision. Items were evaluated for percent agreement with “agree” and “strongly agree.” Items that did not have an agreement will be suggested for improvements to the protocol.

Results

Review of the Literature

A review of the literature was performed to gain a better understanding of pelvic exams and how TIC may improve the experience of a pelvic exam for patients. After a review of the literature, several themes were identified related to TIC and pelvic exams. The themes were: (1) considering the patient's perspective of pelvic exams; (2) use of TIC to improve the experience of the patient and reduce further trauma; and (3) stirrup-less exams. These themes are presented below.

Pelvic Exam: Patient's View

When reviewing what women experienced during pelvic exams, two studies were reviewed. A study conducted within the Veteran's Affairs (VA) health system with females that presented for a routine health exam. Participants ($n = 67$) were provided with a self-administered questionnaire about their history of sexual violence; emotional distress surrounding manual pelvic examination, lying in stirrups, insertion of the speculum into the vagina; and perceived pain during the pelvic exam. The study found that those women that had experienced sexual violence had a high incidence of feeling distressed during the pelvic exam. Distress associated with pelvic examinations was highest for women with prior sexual violence and post-traumatic stress disorder (PTSD). Higher ratings of pain were also found among women with sexual violence when compared to those without. In this study, 77% of those women had experienced sexual violence. The women that had experienced prior sexual violence had a higher rating of distress than those that had not experienced sexual violence. Pain with speculum insertion was also a statistically significant finding for those who had experienced sexual violence versus those that had not. In a sentinel study, findings reveal the importance of treating women that have

experienced sexual assault using TIC because women that have experienced sexual trauma often experienced distress during pelvic exams (Bloomfield et al., 2014).

Bryand & Chor (2018) looked at cisgender females experiencing their first pelvic exam between the ages of 18 and 24; 30 patients within a health system were interviewed. The health system comprised an urban hospital and surrounding clinics in the acute and outpatient settings. The patients spoke of their experiences during the exam. Recommendations that emerged from the study included: (1) establish rapport and education before the examination; (2) establish practices to orient patients; (3) make no assumptions about identity; and (4) elicit continuous feedback. The study's findings called for practice guidelines to be provided to healthcare providers completing a patient's first pelvic exam.

Use of Trauma-Informed Care

In a case study completed by Ravi & Little (2017), a woman with a history of sexual violence had to undergo a pelvic exam, and the healthcare provider used TIC that helped improve the patient's experience. The provider used the core principles of TIC, the four R's, "Substance Abuse and Mental Health Services Administration's (SAMHSA) Concept of Trauma and Guidance for a Trauma-Informed Approach"(2014): (1) *realizing* the widespread impact of trauma; (2) *recognizing* signs and symptoms of trauma, including in patients and their families and in staff and clinical team members; (3) *responding* by fully integrating knowledge about trauma into policies, procedures, and practices; and (4) seeking to actively resist re-traumatization. The woman in the case study reported an improved experience during this visit when compared to previous.

A current framework that has been suggested surrounding the use of shared decision-making regarding pelvic exams for asymptomatic, nonpregnant patients; this framework involves

speaking with the patient about the recommendations of a pelvic exam for them and the risks and benefits of having an exam, versus not (Chor et al., 2019). In the population that this project was designed for, the population is typically symptomatic. However, this dynamic of shared-decision making can be used across all patient populations and is an example of using TIC by talking with the patient as to why it is recommended that an exam takes place but ultimately giving the patient the power during the exam and giving them the opportunity to continue with the exam or not and can be seen as a sign of trying to build trust.

Stirrup-less Exams

In the Seehusen et al. (2006) sentinel randomized controlled trial in the outpatient setting, 197 women were assigned to either have a pelvic exam using stirrups or without. The group that did not have the stirrups for their pelvic exam reported having an improved experience compared to those with the stirrups used. The women that underwent a pelvic examination without stirrups had a reduction in the mean sense of vulnerability from 23.6 to 13.1 ($p < 0.05$). However, there was no significant reduction in the sense of loss of control.

There are several ways to perform a pelvic exam without stirrups; it depends on what kind of table or bed is available for the patient. An exam table with an extension can be pulled out with the patient's feet resting on that piece. If on a cart or bed, use folded bath blankets or a commercially available wedge to put under the patient's hips. These are two examples of interventions that could be used to improve the patient's experience with pelvic exams.

Especially for those individuals that have experienced sexual trauma in the past

Chandramani et al. (2020) reviewed healthcare providers' experience performing pelvic exams. Emergency department healthcare providers ($n = 95$) that provided pelvic exams in an academic medical center were given a survey to rate their comfort level; providing pelvic exams

before and after education was provided by Sexual Assault Nurse Examiners (SANE). These nurses specialize in working with and collecting evidence from survivors of sexual assault. After the emergency department healthcare providers were provided education by SANE nurses on how to provide a trauma-informed exam, the healthcare providers indicated on their survey that they felt more comfortable administering pelvic exams (Chandramani et al., 2020).

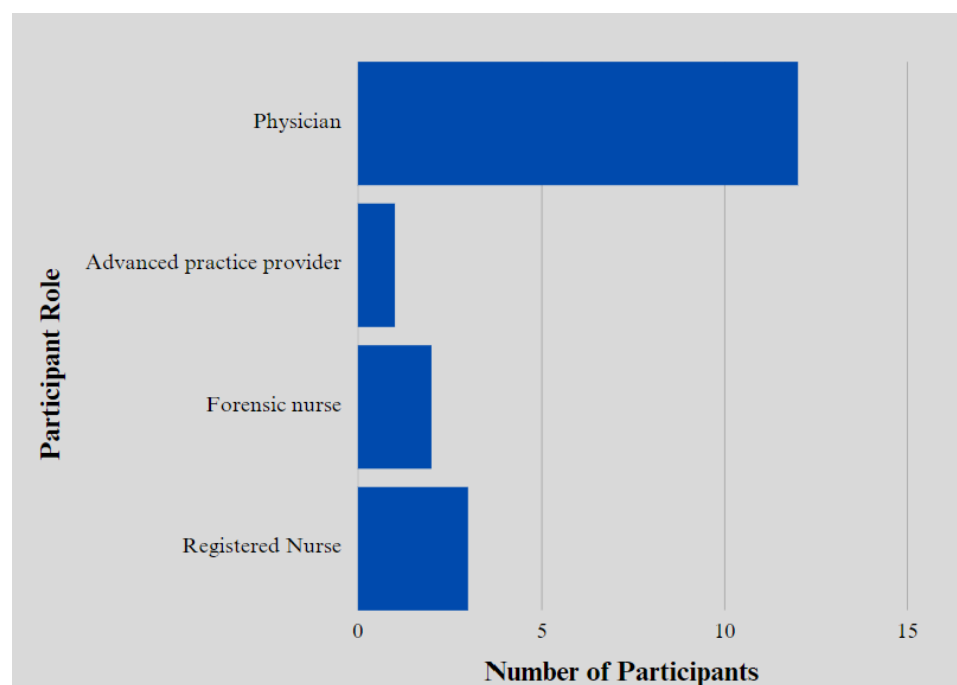
Conclusion of Literature Review

After reviewing the current evidence available, more studies with larger sample sizes need to be completed. However, there are interventions that are currently working to improve the experience of all women having pelvic exams, with emphasis on those that have previously had sexual trauma. Education to healthcare providers on how to provide a trauma-informed pelvic exam is needed, and there should be more research on what interventions can be implemented to improve the experience for women.

Survey Results

Demographic Question

An e-mail invitation was sent to 196 individuals working in the ED using a distribution list with one e-mail reminder to complete the survey. Individuals that were invited to participate in the survey included physicians, nurse practitioners, physician assistants, registered nurses, and forensic nurses, that work in the emergency department. Of those invited to complete the survey, six physicians, one advanced practice provider, three registered nurses, and two forensic (SANE) nurses responded ($n = 12$) (see Figure 2).

Figure 2*Breakdown of survey participants by role*

Note. Breakdown of interprofessional participants, by role, in the trauma-informed pelvic exam survey. Adapted from REDCap.

AGREE II Tool

The AGREE II tool is divided into six domains. The first domain looks at scope and purpose. All 12 respondents answered positively that the objectives of the guideline were specifically described, and the population of the guideline is specifically described. Most respondents, 91.6%, agreed with the health questions of the guidelines being specifically described (participants selected “agree” or “strongly agree” to the AGREE II survey item).

Stakeholder involvement is the second domain of the AGREE II tool that is reviewed by respondents. When respondents were asked if views and preferences of the target population were sought, 91.6% of respondents agreed. All respondents reported a positive rating to the

guideline development group, including individuals from all relevant professional groups, and the target users of the guideline were identified.

The third domain of the AGREE II tool is the largest section of the survey and looked at the rigors of development, including the methods, benefits, and updating of the guideline. When asked if systematic methods were used to search for evidence, 83.3% either agreed or strongly agreed while the additional respondents answered neutrally to the question. While the additional respondents answered neutrally to the question. When asked to rate the strengths and limitations of the body of evidence and the methods of the formulation being described, 75% of respondents answered either agree or strongly agree, and the additional 25% responded neutrally to both questions. Most respondents, 91.6%, agreed or strongly agreed that the health benefits, side effects, and risks were considered when formulating the guideline, while 8.4% answered neutrally. When asked if there was an explicit link between the recommendations and the supporting evidence in the guideline, 83.3% agreed or strongly agreed that there was an explicit link, while the other respondents stated they were neutral. Agree or strongly agree was selected by 75% of respondents that the guideline was reviewed by experts prior to its publication, while the remaining 25% selected neutral. 83.3% of the respondents agreed to strongly agree that there was a procedure for updating the guideline, and the other respondents were neutral.

Clarity of presentation is the fourth domain of the AGREE II tool. There were three questions presented to respondents and all respondents either agreed or strongly agreed with all three questions. They agreed that the recommendations were specific and unambiguous, that there were different options for the management of the health issue clearly presented; and key recommendations were easily identifiable.

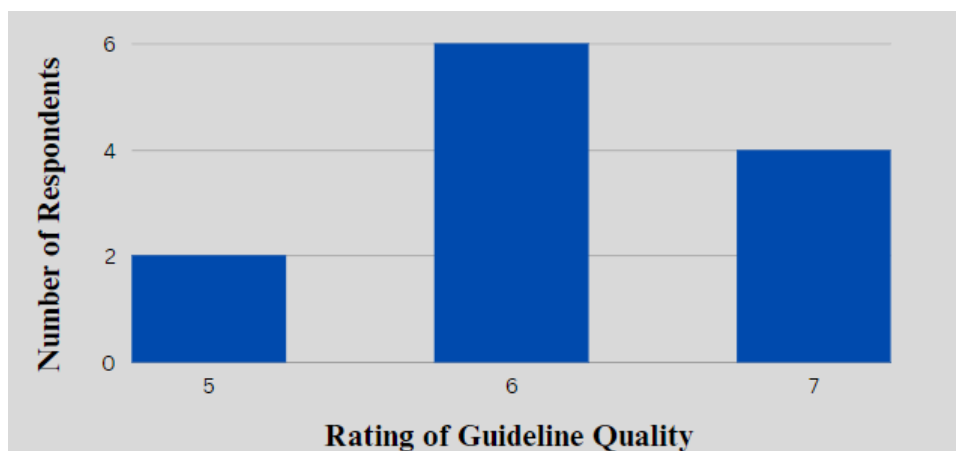
The fifth domain of the AGREE II tool is applicability. Many of respondents, 83.3%, either agreed or strongly agreed that the guidelines described facilitation and barriers to its application, while 8.35% responded with neutral, and an additional 8.35% slightly disagreed. Nearly all the respondents, 91.6%, agreed or strongly agreed that the guideline provides advice and/or tools on how the recommendations can be implemented, with 8.4% responding neutrally. All respondents either agreed or strongly agreed that the potential resource implications of applying the recommendation have been considered. Agreed or strongly agreed was selected by 83.3% of respondents that the guideline presents monitoring and/or auditing criteria, and 16.7% answered either disagree or partially disagree with the statement.

The sixth and final domain of the AGREE II tool is editorial independence. Many of the respondents, 75%, either agreed or strongly agreed with the statement that views of the funding body have not influenced the content of the guideline, and 25% reported it as neutral. Most, 83.3%, of the respondents stated that they agree or strongly agree that competing interests of the guideline development group members have been recorded and addressed, and the other 16.7% reported a neutral response.

Respondents were asked to rate the overall quality of the guideline with a scale ranging from one to seven, where “1” is the lowest quality and “7” is the highest quality, 16.7% selected a five. 50% selected a six, and 33.3% selected a seven (see Figure 3).

Figure 3

Participants Ranking of Overall Guideline Quality



Note. Participants ranking of overall quality of the trauma-informed pelvic exam guideline. Adapted from REDCap.

The last question in the AGREE II tool asked the survey participants if they believed the guideline should be used, and all respondents replied “yes.” No respondents selected “yes with modifications” or “no.”

Open-Ended Questions

All participants were allowed to provide written feedback in addition to the AGREE II survey questions. The open-ended prompts included the following: what changes to the guideline they would like to see, what about the guideline they liked, what the perceived barriers to the protocol were, and any general comments related to the guideline. Comments about improvements included a forensic nurse that was concerned about having an assistant, which is not typical in a forensic exam. Comments about what was liked about the guideline included “clearly defined. the importance of trauma-informed pelvic exams along with the ‘why’ and how to perform one,” and several comments reports that sample trauma-informed language was

included in the guideline was helpful. The participants were concerned that barriers to implementation would include time and changes to behavior and practice.

Discussion and Implications for Practice

Discussion of Results

The result of each Likert-style question within the six domains of the AGREE II tool as well as the open-ended questions were reviewed to see if a change to the guideline needed to be made based on the answers. All participants answered all of the Likert-style questions and many of them left feedback on the open-ended questions. The information received from the survey participants was robust.

There were a few concerns that were brought up in the open-ended question section of the survey. The main concerns with the guideline were taking too much time or requiring a second staff person in the room. Time can be a concern in the emergency department, especially based on the patient volume and acuity seen within this specific department. However, providers will likely find that once they start using the tools within the guideline and become more comfortable with the newer approach providers will find it doesn't take much more, if any more time than their previous approach to pelvic exams. Within the guideline, having the second staff person is optional, but meant to give the person receiving the exam the choice. The concern was brought up by a forensic nurse and it is typical that there are very few people in the room and only people that the person receiving the exam is comfortable with. In this case, it would be acceptable to not have a second staff member in the room.

Overall, all of the Likert-style and open-ended questions were positive in nature and participants reported that this would be a positive change for both providers and patients. Participants rated the guideline high in quality with all participants rating the guideline five or

higher on a scale of one to seven. All participants reported that the guideline would be useful in practice and did not recommend modification. After a thorough review of the survey results, it was determined that no changes would be made to the practice guidelines.

Dissemination of Project Findings

Moving forward, this project and practice guideline will be brought to nursing and physician leadership for review for adoption into the emergency department's policies and procedures. If the decision is made to move forward, an interdisciplinary team will review the guideline and provide any necessary changes and will move onto the physician leadership level for final approval. Additionally, this project will be publicly presented at the University of Kansas Medical Center on May 8, 2023.

Implications for Practice

With the addition of this guideline, care for patients that require pelvic exams would be improved through the use of trauma-informed care. The providers would have a guideline for how to provide trauma-informed care to all patients requiring a pelvic exam, including language, scripting, and exam set-up. Patients would then benefit from the use of trauma-informed care during their exam and have an improved experience when compared with traditional methods and reduce the risk of new trauma or re-traumatization. It is recommended that this guideline be used in practice after a collaborative team reviewed the data to ensure no changes are needed, and all supplies are available.

Conclusion

Many people with diverse backgrounds are seen and treated in the emergency department. It is at times important or necessary to perform a pelvic exam on a person, which can cause traumatization or re-traumatization depending on their background and how the exam is

performed. Therefore, it is important to use trauma-informed care on all patients and especially when performing pelvic exams. The trauma-informed pelvic exam protocol/guideline created is research-driven and evidence-based, which is highly regarded at the large, urban, academic hospital at which this guideline was reviewed. This guideline will assist providers in performing a more trauma-informed exam and thus should reduce the risk of potential harm to the patient.

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Appendix A

Trauma-Informed Pelvic Exam in the Emergency Department Practice Guideline

OBJECTIVE

To provide a guide for providers to use trauma-informed care when providing pelvic exams in the Emergency Department.

SCOPE

This guideline is applicable to all adolescent and adult patients requiring a pelvic exam in the Emergency Department. It is to be used by all providers performing pelvic exams in the department, such as physicians, nurse practitioners, physician assistants, and SANE RNs. This is primarily a guide for the emergency department but can be adapted to any department and/or providers throughout the hospital or health system.

DEFINITIONS

When used in this guideline, these terms have the following meaning:

Trauma-informed care: Trauma-informed care acknowledges the need to understand a patient's life experiences in order to deliver effective care and has the potential to improve patient engagement, treatment adherence, health outcomes, and provider and staff wellness (Menschner & Maul, 2016).

Pelvic exam: Examination of the external and internal reproductive organs

Speculum exam: Examination using a speculum to open the walls of the vagina to visualize the walls of the vagina and cervix.

Bimanual exam: The use of gloved, lubricated, fingers/hand inserted into the vagina while the external lower abdomen is palpated to assess for size, position, and/or tenderness of internal pelvic organs

Swab collection: use of cotton tipped applicators to collect specimens from the vagina or cervix. Can be done in conjunction with a speculum exam or without.

CLINICAL MANAGEMENT

In the care of all patients requiring a pelvic exam:

Before Pelvic Exam: before beginning the exam, provide the patient with education about the exam and obtain consent. Follow the steps below to provide patient empowerment and fully informed consent.

1. Provide power to the patient.
 - a. Ensure that the patient is in a private area, preferably in a room with a door that can be closed.
 - b. Knock before entering patient care area and request permission to enter the area.
 - c. After entering the room, sit down at or below eye level of the patient.
2. Ask
 - a. Ask if they would like to have a family member or friend present during the exam and allow that person to be present during any part of the exam.
 - b. Explain that you want a second staff member in the room and educate why they are needed. Allow them to decline the second staff member and chart the declination in the medical record

- c. Inquire if the patient has had a pelvic exam before.
 - d. If appropriate, ask how the experience was and if there are any special considerations for this exam.
- 3. Explain
 - a. Continue to provide the patient with power and remain seated at or below eye level of the patient.
 - i. Explain why you would like to perform the exam.
 - ii. Explain the steps of the exam that the provider wishes to perform, including what equipment will be used (e.g., speculum, swabs, lubricant, etc.).
 - iii. If applicable, include in the explanation whether the exam may require a bi-manual exam and the steps.
 - b. Allow the patient to ask questions and answer them as thoroughly as possible.
- 4. Obtain verbal consent.
 - a. Obtain verbal consent for all parts of the exam.
 - b. Allow the patient to decline parts of the exam if they choose to; they may be notated in the medical documentation.
 - c. Provide the patient with language to rescind consent during the exam (e.g., say “Stop,” and I will pause and we can resume when you are ready or say “Out,” and I will stop what I am doing and remove any equipment or tools quickly, but gently)
 - i. If the patient chooses to use the language provided, make sure to follow through immediately by stopping (pausing the exam until the patient is ready to resume) or removing equipment.

Performing Exam: During the exam, it is important to pay attention to how the room is set up, what language you use as a provider, and how you perform the exam.

- 1. Exam room setup
 - a. Have everything prepared for the exam before the patient assumes position of choice on the exam table/bed.
 - b. Consider performing exams without the use of stirrups (e.g., using bath blankets under pelvis or nothing under hips at all).
 - i. Consider that the use of an upside-down bedpan may feel unstable to the patient.
 - ii. Consider that the patient may feel uncomfortable putting fists under hips to provide tilt (this restricts their hands and may make them feel restrained).
 - c. Have a second staff member in the room with every exam.
 - i. The staff member can help watch for patient comfort and assist with exam as needed.
 - d. Choose most appropriate speculum for the exam.
 - i. Smallest appropriate speculum should be utilized.
 - ii. Consider using a NuSpec speculum, if available.
- 2. Language and scripting (see Supporting Documents section for tools)
 - a. Use trauma-informed language.
 - i. Remind the patient of the language provided to guide the exam (e.g., “Stop” and “Out”).

- ii. Give the patient the ability to rescind consent at any time during the exam.
 - iii. Avoid triggering language (e.g., relax, spread)
- 3. During exam
 - a. Explain what you are doing before you complete each step of the exam and ask permission.
 - b. Consider patient self-insertion of speculum
 - c. Do not push the patient's knees apart.
 - i. If the patient is having difficulty with positioning, offer the patient time to assume a more comfortable position.
 - ii. If the patient needs help with opening their pelvis, use your hands on the outside of their knees to show the patient how far apart you would like their knees to come to. For example, "let your knees fall apart until they are touching my hands".
 - d. Second staff member assess for continued patient comfort (e.g., non-verbal cues from patient such as wincing or withdrawing)
 - i. Can help to provide patient comfort, if needed.
 - e. Follow through with any request of the patient to pause or end the exam.

After Exam Completion: After the exam, be sure to debrief with the patient and provide follow-up education.

- 1. Debrief
 - a. Ask if there was anything that you could have done differently, if appropriate.
 - b. Review what occurred during the exam and any findings (samples collected, viewing of cervical os, bleeding, etc.).
- 2. Educate
 - a. Provide expected time frames for results on any testing completed.
 - b. Recommendations for any further testing that may be required.
 - c. Provide any further instructions that may be required.
 - d. Allow the patient to ask questions.

GUIDELINE OBJECTIVE(S):

Patient care guidelines are evidence-based and designed to assist clinicians and patients make decisions about appropriate health care for specific clinical circumstances. CMS requires that standards of practice and standards of care be entered into P&P and guidelines. These guidelines should not be considered inclusive of all appropriate methods of care or exclusive of other methods of care reasonably directed at obtaining the same results. The ultimate judgment regarding care of a particular patient must be made by the clinician in light of the individual circumstances presented by the patient and the needs and resources particular to the locality or institution.

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SUPPORTING DOCUMENTS

[Consent in Pelvic Care - Stephanie Tillman, CNM](#)

[Empowering Gynecologic Exams: Speculum Care Without Stirrups - Stephanie Tillman, CNM](#)

[Example scripting and language for pelvic exams - Chloë Lubell, CNM](#)

[Questioning the Routine Pelvic Exam: breaks down the elements of a routine pelvic exam, how to improve upon them, and which may not be necessary - Stephanie Tillman, CNM](#)

[Tips for providing pelvic exams on trans men - LGBT Family Health Team, Sherbourne Health Centre](#)

[Trauma Informed Care and Consent with Feminist Midwife Stephanie Tillman episode of Evidence Based Birth podcast.](#)

[WomanSafeHealth: Empowering WomanCare Strategies for Pelvic Exam Anxiety \(video\) - Dr. Elizabeth Shadigian](#)

Consent Process (Tillman, 2020)

Table 1. The Consent Process

Disclose the information that a reasonable provider would share and/or a reasonable patient would want to know in a similar situation,²⁹ including the following: - diagnosis or condition prompting the recommendation or treatment - benefits, and probability that the treatment will succeed - risks and complications - available alternatives, and their risks and benefits - possible consequences of forgoing treatment²⁶ Tailor information to the patient's literacy and numeracy levels³¹ Speak in the patient's preferred language, with a certified medical interpreter unless it is a shared native language with the health care provider³² Share information through the patient's preferred delivery system: verbal communication, decision aids, surveys, checklists, or interactive online models^{24,30} Ensure the decision can be made free from bias or coercion by the health care provider or the patient's family^{24,33} Document all processes of consent, including information shared and the patient's questions and answers, in the clinical record^{34,35}

Scripting and Language Guidance (Tillman, 2016)

Try not to make the exam about YOU as a provider: "You're going to feel 'MY' hand on your thigh and on the outside..." and rather say "You're going to feel goopy gel as I separate the labia and then pressure..."

"Relax your knees out to the side" may include the sexual assault trigger "Relax" for some people, and instead saying "Let your knees fall out to the sides" is likely less triggering.

Even when someone is in position for the exam, still check in on whether they are ready to begin the exam itself, and reiterate the safe words agreed upon.

Avoid "You're going to feel my touch." "Touch" is a very sexual term. Rather say, "You're going to feel my hand on your thigh, and here on the outside of the vagina."

Offer for anyone to suggest the language they prefer for their anatomy, trans and cis clients

Trauma Informed Pelvic Exams Infographic (Tuttle, 2022)

TRAUMA INFORMED PELVIC EXAMS

Trauma Informed Care, the standard of care for all sexual assault survivors, is now considered the standard for all health care and especially for intimate examinations (Tillman, 2020)



Tool created by:
Ashley Tuttle, BSN, RN, SANE-A

THE POWER SHIFT

Knock, ask for permission to enter, introduce self, sit down, and shift the power to the patient



ASK

Review chart for history of past trauma. Ask if they have had a pelvic exam before (how was the experience?). If appropriate, ask about past trauma. Not all feel comfortable disclosing. That's why it is important to use trauma informed practice with all patients

EXPLAIN AND CONSENT

Explain the exam/procedure, give the opportunity to ask questions, obtain consent, and give language to rescind consent



EXAM ROOM SETUP

Consider performing exams without the use of stirrups as well as general patient comfort in the room



LANGUAGE AND SCRIPTING

Use trauma informed language; avoid triggering language; explain what you are doing before you do it; give patient language to use such as "stop" and "out" to give them control of the exam and the ability to rescind consent

REMEMBER:
WHEN USING
"STOP" AND "OUT"
(OR SIMILAR)
FOLLOW THROUGH
IMMEDIATELY

"No"

IS A COMPLETE
SENTENCE

RESOURCES

www.nurseashley.com

www.samhsa.com

www.feministmidwife.com



@nurseashley.informed



<https://www.linkedin.com/in/nurseashleyinformed/>

DEBRIEF

After you have completed the exam, ask if there was anything you could have done differently.



Review with the patient the visit: what occurred during the visit, educate on any home instructions or referrals, and allow for questions.

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Tool created by:
Ashley Tuttle, BSN, RN, SANE-A



UPDATES AND REVIEWED BY

This guideline will be reviewed every three years (at a minimum) for currency of knowledge and evidence. If professional guidelines are released that change the procedure, this guideline will be updated appropriately.

CONFLICT OF INTEREST

The sponsor(s) of this guideline do not have any conflicts of interest to disclose; no funding has been provided to the sponsor(s) for this guideline.

Appendix B

AGREE II Score Sheet

Domain	Item	AGREE II Rating						
		1 <i>Strongly Disagree</i>	2	3	4	5	6	7 <i>Strongly Agree</i>
Scope and purpose	1. The overall objective(s) of the guideline is (are) specifically described.							
	2. The health question(s) covered by the guideline is (are) specifically described.							
	3. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.							
Stakeholder involvement	4. The guideline development group includes individuals from all the relevant professional groups.							
	5. The views and preferences of the target population (patients, public, etc.) have been sought.							
	6. The target users of the guideline are clearly defined.							
Rigor of development	7. Systematic methods were used to search for evidence.							
	8. The criteria for selecting the evidence are clearly described.							
	9. The strengths and limitations of the body of evidence are clearly described.							
	10. The methods for formulating the recommendations are clearly described.							
	11. The health benefits, side effects and risks have been considered in formulating the recommendations.							
	12. There is an explicit link between the recommendations and the supporting evidence.							
	13. The guideline has been externally reviewed by experts prior to its publication.							
	14. A procedure for updating the guideline is provided.							
Clarity of presentation	15. The recommendations are specific and unambiguous.							
	16. The different options for management of the condition or health issue are clearly presented.							
	17. Key recommendations are easily identifiable.							
Applicability	18. The guideline describes facilitators and barriers to its application.							
	19. The guideline provides advice and/or tools on how the recommendations can be put into practice.							
	20. The potential resource implications of applying the recommendations have been considered.							

	21. The guideline presents monitoring and/ or auditing criteria.							
Editorial independence	22. The views of the funding body have not influenced the content of the guideline.							
	23. Competing interests of guideline development group members have been recorded and addressed.							
Overall Guideline Assessment	1. Rate the overall quality of this guideline.	1 <i>Lowest possible quality</i>	2	3	4	5	6	7 <i>Highest possible quality</i>
Overall Guideline Assessment	2. I would recommend this guideline for use.	<i>Yes</i>	<i>Yes, with modifications</i>					<i>No</i>

(AGREE Next Steps Consortium, 2017)

Appendix C

Project Director-Created Demographic Question

1. What is our role working with patients in the emergency department?
 - a. Physician
 - b. Nurse Practitioner
 - c. Physician Assistant
 - d. Registered Nurse
 - i. Staff ED Nurse
 - ii. Forensic Nurse
 - iii. Nurse Educator
 - e. Other
 - i. Please state role