Chapter 5

DIGITAL VAGINAL EXAMINATION

Before the examination ask yourself: "*What decision has to be made at this time which requires information that can only be obtained from a vaginal examination*" (Walsh, 2000)

Indications

A Registered Nurse who has the knowledge and skill (vaginal examinations are an added nursing skill and require completion of a self-learning package and work with a preceptor), should perform vaginal examination(s) under the following circumstances as part of an initial assessment of labour and/or ongoing plan of care for labour

1. Within 30 minutes of a woman's admission to Triage to establish baseline
2. To evaluate / reassess progress of labour
3. Following a spontaneous rupture of the membranes or artificial rupture of membranes. If the FHR is decreased rule out cord prolapse
4. Before analgesia - to determine progress of labour
5. When there is evidence to suggest the onset of the second stage of labour, eg. Rectal pressure described by the patient, spontaneous urge to push
6. In the presence of atypical or abnormal fetal heart rate monitoring, i.e. bradycardia, complicated variable and/or late decelerations

Frequency of Examination

With epidural anaesthesia / analgesia this examination should occur:

- Minimally every (2) to (4) hours: more frequent examinations would be done with specific indications such as increased show and / or rectal pressure. These would be identified, documented and explained to the woman and her support person(s).

Without an epidural this examination should occur:

- Based on the woman's behavior which is indicative of progress in labour, eg. Presence of show, increased frequency and length of contractions
- Minimally every (2) – (4) hours in active labour to evaluate progress in labour.

Contraindication

Vaginal examination should **not** be performed under the following circumstances, until authorized by the attending physician:

1. Undiagnosed vaginal bleeding, history of bleeding of unknown origin
2. Known low lying, marginal or complete placenta previa
3. Active vaginal herpes
4. Premature rupture of membranes (less than 37 weeks)
5. Pregnancy less than 37 weeks

Minimize Number of Exams

1. PROM - to prevent ascending infection (speculum examination preferred)*
2. Active herpes -to prevent ascending infection

** An initial digital examination may be performed after the speculum examination for baseline data*

Assessment Criteria

1. Cervix – effacement (cervical length measurement, % taken up), dilatation (cm), consistency, position (anterior, mid position, posterior)
2. Presenting part (vertex, breech, compound presentation) position
3. Status of the membranes
4. Station (relation of presenting part to ischial spines)

A vaginal exam is used in conjunction with or preceded by abdominal palpation

The Bishops score (pre-induction cervical scoring) assesses dilatation, effacement, consistency, and position of the cervix, and the station of the presenting part. For a further discussion of this assessment refer to Chapter 20, Induction of Labour.

Method

1. Explain the procedure, indications for the exam, what the exam may feel like (sensations) and that it may cause discomfort. Encourage relaxation and breathing to promote comfort as required.
2. Ensure privacy for woman and ensure that if there are family/friends in the room that the woman wishes them to be present.
3. Wash hands and use a single sterile glove if ruptured membranes (clean gloves may be used if patient has intact membranes)
4. Position the woman with her thighs flexed and abducted. Instruct her to put the heels of her feet together (if able with pain management). Drape the woman to ensure privacy
5. Examine the perineum for lesions, edema or vesicles/blisters.
6. Assess for any bloody show, bleeding and/or amniotic fluid, noting colour, amount and consistency.
7. Use water based lubricant
8. Use only normal saline or sterile water if requested by physician/health care provider. Antiseptics, such as proviodine and hexachlorophene used on the perineum have not been shown to reduce infection and should not be used. They can cause irritation and are absorbed by mucous membranes (AAP, ACOG, 2007).
9. Using the nondominant hand spread the labia majora and continue to assess the genitalia.
10. Insert two fingers, one at a time, (index and middle) gently into the vaginal orifice. The fourth and fifth fingers should be flexed onto the palm and not touch the anus. Insert fingers into the vagina with any pressure directed posteriorly and if possible, wait for the vaginal wall to relax prior to extending fingers fully. Avoid urethral pressure, which can cause discomfort. The nondominant hand can gently rest on the fundus to help stabilize the presenting part.
11. If the woman verbalizes discomfort, acknowledge it and apologize. Pause for a moment and allow her to relax before progressing.

12. Assess the:
    i. Cervical dilatation, effacement and position (eg. Posterior, anterior)
    ii. Presenting part, position and station
    iii. Status of amniotic membranes, eg. Intact, bulging or ruptured
    iv. Characteristics of the amniotic fluid eg., colour, clarity and odour if membranes are ruptured
13. Assess the fetal heart rate (FHR) immediately after vaginal examination
14. Assist the woman in cleansing her perineum from front to back to remove lubricant or secretions or provide peri-care and assist into a comfortable position.
15. Inform woman of findings.
16. Document findings of vaginal exam, including woman's ability to cope and FHR on the graphic section of the OBCU Record of Care. The progress in labour needs to be clearly documented and communicated in labour (SOGC, 2000).
17. Notify the physician/resident if there has not been any progress in:
    i. Cervical dilation
    ii. Descent of presenting part

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