VAGINAL EXAMINATIONS IN LABOUR GUIDELINE

1. OPTIMAL OUTCOMES
   • The appropriate and accurate vaginal assessment of women presenting to Birthing Services

2. PATIENT
   • Pregnant woman with an indication for vaginal examination (VE)

3. STAFF
   • Registered Midwives
   • Student Midwives
   • Medical staff

4. EQUIPMENT
   • Sterile Gloves
   • Obstetric cream or KY Jelly
   • Disposable under sheet
   • Linen to cover woman and provide privacy
   • Tissues

5. CLINICAL PRACTICE
   • Confirm and/or assess the progress of labour at least every 4 hours unless otherwise indicated
   • Offer and recommend a VE prior to analgesia/epidural block
   • Do not perform a VE if there is a known placenta praevia or vasa praevia or the woman declines
   • Exercise caution in the following situations:
     o Prematurity
     o Ruptured membranes not in established labour
     o A known history of sexual abuse
   • Obtain verbal consent.
   • Ensure woman has an empty bladder
   • Maintain privacy throughout
   • Perform abdominal palpation with particular reference to descent of presenting part
   • Ensure woman does not have a latex or lubricant allergy
   • Wash hands, don sterile gloves and lubricate middle and fore fingers
   • Time VE between contractions where possible
   • Observe vulva for any unusual signs – eg varicosities, lesions, previous scarring
   • Part labia and insert two fingers gently through introitus in a backward and downward motion
   • Direct thumb away from urethral orifice and clitoris
   • Identify presenting part: feel for sutures and fontanelles to determine position of the presenting part, and also for any signs of caput or moulding. Determine station in relation to ischial spines
   • Feel for any signs of membranes and application of presenting part to the cervix

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VAGINAL EXAMINATIONS IN LABOUR GUIDELINE  cont’d

- Ensure no sign of cord presentation (pulsation)
- Identify consistency, effacement, position and dilatation of cervix
- Remove fingers and observe for signs of unusual blood loss
- Dispose of gloves, wash hands and listen to fetal heart sounds
- Discuss findings with woman and document on partogram and in integrated notes.
- Inform midwife in charge of shift and medical staff if appropriate.

6. HAZARDS/SUB-OPTIMAL OUTCOMES
- Introduction of infection
- Pain and distress – especially if woman has a history of abuse
- Precipitation of antepartum haemorrhage
- Risk of cord prolapse if ARM performed with presenting part not well engaged
- Stimulation of preterm labour
- Adverse reaction if unknown latex or lubricant allergy

7. DOCUMENTATION
- Partogram
- Integrated notes

8. EDUCATIONAL NOTES
- The woman must give her verbal consent before a VE is performed
- The progress of labour may be assessed by external methods in the absence of an epidural: observation and palpation of a woman's contraction, behavioural changes, abdominal palpation to assess decent of presenting part, vaginal loss, vocalisation
- The benefit of regular VE’s in a normal labour is unproven (Enkin et al 2000) but it is generally accepted that once in established labour a VE be performed every 4 hours.
- It is not always necessary to perform a VE to confirm second stage.

9. RELATED POLICIES/ PROCEDURES/CLINICAL PRACTICE GUIDELINES
- Admission to Delivery Suite
- Induction of labour
- Care of a woman in uncomplicated labour
- Ruptured membranes not in established labour
- Care of the woman in 2nd stage of labour

10. REFERENCES
- Royal College of Midwives UK (2006) Evidence based guidelines for midwifery led care in labour available online @ www.rcm.org.uk