WOMEN'S & NEWBORN HEALTH RPOGRAM
Policy/Protocol/Procedure

TITLE:	Vaginal Examination	**NUMBER:**	7172
Sponsor**:**	Director, Women's and Newborn Health Program	Page:	1 of 6
Approved by:	Medical Advisory Committee (MAC)	Approval Date: June 19th, 2018 Effective Date: February 14, 2019	
Applies To:	Registered Nurses (RNs) in the Women's & Newborn Health Program (BU, ELAU, ODU, PSCU)		

This is a Beyond Entry Level Competency (BELC) for Registered Nurses at the IWK and requires initial certification and ongoing recertification.

PREAMBLE

A vaginal examination is performed to evaluate the progress of labour by assessing the:

- cervical position,
- cervical consistency,
- cervical effacement and dilatation,
- status of the membranes,
- presentation, position of the fetus and station of the presenting part.

POLICY STATEMENTS

1. Vaginal examination is a beyond entry level competency (BELC) for registered nurses (RNs) which requires initial certification and ongoing recertification and may only be carried out by RNs who:
    - Have successfully completed the IWK Vaginal Examination Self Directed Learning Package (see Policy #324.2 – *Approval and Performance of Beyond Entry Level Competencies by Registered Nurses at the IWK Health Centre*), and
    - Have been supervised by an RN certified in vaginal examinations, a physician or a midwife, and have demonstrated competency.

2. A vaginal exam is only indicated if it will change the woman's plan of care and/or clinical decision making. To determine if a vaginal exam is warranted, the registered nurse will complete an assessment and consider the clinical situation, obstetrical history, labour progress, imminent delivery, anesthesia or any sedation.

GUIDING PRINCIPLES AND VALUES

Nurses should develop proficiency in performing vaginal examinations to assess labour progress to determine the need for nursing interventions such as position change and timing of medication.

Women undergoing a vaginal examination should be minimally exposed and should be advised of the necessity of the examination and the findings.

For women who are at no increased risk for complications, an evaluation of the quality of uterine contractions and vaginal examinations should be sufficient to detect abnormalities in the progress of labour (AWHONN, p.355). As labour progresses and the fetal presenting part descends, the cervix shortens and dilates changing from long, thick and closed to thin and 10 centimeters.

Nurses will collaborate with a patient/family by keeping them informed of labour progress. Options for supportive care and pain management will be discussed with the patient/family based on progress.

PROTOCOL

1. Vaginal exams should be considered:
    - Prior to an induction. See Policy # 20.51 – *Induction of Labour: Cervical Ripening Dinoprostone Controlled Release Pessary (Cervidil)*, Policy #20.52 – *Dinoprostone (Prostin) Gel for Cervical Ripening* and Policy #1315 – *Induction of Labour: Mechanical Methods of Cervical Ripening – Indwelling Catheter*.
    - When pre-term delivery is IMMINENTLY suspected (contractions, pelvic/rectal pressure).
    - To assess and/or confirm progress in labour/suspected dystocia of labour.
    - To assess and/or confirm full dilation.
    - To assess and/or confirm presenting part.
    - For application of fetal scalp electrode (FSE) or intrauterine pressure catheter (IUPC) insertion (see Policy #7050 – *Fetal Spiral Electrode – Application and Management* and Policy #7095 – *Intrauterine Pressure Catheter (IUPC)/Amnioinfusion*).
    - Following spontaneous rupture of membranes, unless the presenting part is known to be deeply engaged.
    - To identify cord prolapse – for example where there is fetal bradycardia or recurrent variable decelerations of the fetal heart rate.
    - Prior to analgesia to determine pain management and/or supportive care measures.
    - Prior to ambulation.

2. Assess for contraindications. Vaginal examinations are **not** to be performed for a woman in the following conditions:
    - Prematurity (unless delivery is imminently suspected)

- Placenta Previa
- Vasa Previa
- Suspected or known low lying placenta
- Unknown placenta location with bleeding
- Women with the following conditions are at higher risk of developing an infection. Vaginal examinations should be **extremely limited** and duplicate exams for learning purposes are not appropriate:
    i. Group B Strep positive with ruptured membranes
    ii. Prolonged rupture of membranes

PROCEDURE

1. Perform an abdominal assessment (Leopold's maneuvers) to determine fetal position, presentation and engagement, including contraction frequency, intensity and duration.

2. Based on clinical assessment proceed with the examination by discussing the indication and procedure with the woman and obtain verbal consent. Provide and maintain privacy for the exam.

3. Recommend that the patient empty her bladder prior to exam, if clinically appropriate.

4. The woman should be positioned on her back with her head slightly elevated. Position for comfort maximizing fetal perfusion.

5. Obtain sterile glove and sterile water soluble lubricant.

6. Don sterile exam glove for performance of exam. Perineal hygiene is important during periodic vaginal examinations. Attention to clean technique is critical, particularly if membranes are ruptured. Sterile water soluble lubricants may be used to decrease the discomfort during vaginal exams; however antiseptics such as povidone-iodine and chlorohexidine should be avoided.

7. The vaginal exam should be systematic beginning with the assessment of dilatation, and effacement then fetal presentation, station and position.

8. Findings of the vaginal examination will be documented in the patient's health record including the patient's response to the exam.

REFERENCES

Simpson, K.R. & Creehan, P.A. (2014). AWHONN Perinatal Nursing (4th Ed.). Chapter 14 Labor and Birth p.343-361. Lippincott, Williams & Wilkins.

RELATED DOCUMENTS

Policies

BC Women's Hospital (2014). Vaginal Examination. Policy #WW.03.09. Fetal Maternal Newborn and Family Health Policy & Procedure Manual. Retrieved on June 19th, 2017 from http://policyandorders.cw.bc.ca/resource-gallery/Documents/BC%20Women's%20Hospital%20-%20Fetal%20Maternal%20Newborn/Vaginal_Exam.03.09-7-APR-2014[4370][7425].pdf

Champlain Maternal Newborn Regional Program (2011). Vaginal Examination. Perinatal Nursing Procedure. Retrieved June 19th, 2017 from http://www.cmnrp.ca/site/cmnrp/index.php?page=737&l=en&s=0

IWK Health Centre Policy #324.2 Approval and Performance of Beyond Entry Level Competencies (BELC's) by Registered Nurses at the IWK Health Centre

IWK Health Centre Policy #7070 Intrapartum Fetal Health Surveillance

IWK Health Centre Policy # 7050 Fetal Scalp Electrode- Application and Management

IWK Health Centre Policy #7051.1 Care Directive- Application of Fetal Scalp Electrode

IWK Health Centre Policy #7095 Intrauterine Pressure Catheter (IUPC)/Amnioinfusion

IWK Health Centre Policy #30.11 Oxytocin Infusion

IWK Health Centre Policy #20.51 Induction of Labour: Cervical Ripening Dinoprostoone Controlled Release Pessary (Cervidil)

IWK Health Centre Policy #20.52 Dinoprostone) Prostin) Gel for Cervical Ripening

IWK Health Centre Policy #1315 Induction of Labour: Mechanical Methods of Cervical Ripening – Indwelling Catheter

Learning Packets

Vaginal Examination Self Directed Learning Package

Appendices

Appendix A – Definitions

APPENDIX A – DEFINITIONS

Beyond Entry Level Competency (BELC): a skill or task/function that may be performed by either registered nurses or physicians, but which are beyond entry level competence. In general, additional education and experience is required to attain and maintain competence relative to BELCs (requiring a certification process). Through the use of distinct language (e.g. specialized nursing competencies) agencies may acknowledge that BELCs are performed primarily by registered nurses. Note: in select practice settings, agencies may determine that certain BELCs are essential to competent practice and after a nurse's initial certification, may recognize frequency of performance as the criteria for demonstrating continued competence (e.g. establishing IVs). This request will be formally submitted to the Nursing Professional Practice Council (NPPC), in writing, as part of the approval process for BELCs.

Fetal lie: the relation of the fetal long axis to the long axis of the mother. It is either longitudinal, transverse, or oblique.

Fetal position: position refers to the relationship of the fetal presenting part to the anterior/posterior or right/left side of the birth canal. The fetal occiput, chin (mentum), and sacrum are the determining points in vertex, face, and breech presentations, respectively.

Fetal presentation: the presenting part is that portion of the body that is either foremost within the birth canal or in the closest proximity to it. It can be felt through the cervix on vaginal examination. The presenting part is ether the fetal head or breech, creating cephalic and breech presentation respectively.

Fetal station: the relationship of the leading edge of the presenting part of the fetus to the plane of the maternal ischial spines determines the station.

District Health Authority/IWK Policies Being Replaced

(Please List)

Version History

(To Be Completed by the Policy Office)

Major Revisions (e.g. Standard 4 year review)	Minor Revisions (e.g. spelling correction, wording changes, etc.)
2018	