VAGINAL EXAMINATIONS: PERFORMING

Keywords: chaperone, vaginal procedure, vaginal examination, VE, pelvic examination, intimate examination, assess labour progress

**PRE-PROCEDURE:**
1. Explain procedure & answer questions
2. Gain consent & offer a chaperone. Inform and gain consent for the presence of students & further consent if student is examining the patient for training / education.
3. Prepare: Empty bladder, provide privacy & attend hand hygiene
4. Abdominal palpation
5. Attend hand hygiene, apply gloves, and eye protection if risk of splash.

**PROCEDURE:**
6. If intrapartum, attend examination between contractions
7. Inspect external genitalia- labia, perineum, scars & note any discharge/liquor/blood
8. Gently insert lubricated fingers into vagina- avoid contact with clitoris
9. Assess:
   - Vagina: Muscle tone / dryness / excess heat
   - Cervix: Length/effacement, dilation, position, consistency, application (& if membranes intact / bulging / smooth)
   - Fetus: Presentation, position, station, caput, moulding, fontanelles, sutures
   - Any abnormal features (e.g. vasa praevia, pulsating umbilical cord)
   - Pelvis: Ischial spines (any undue prominence) & angle of suprapubic arch as withdraw fingers

**POST-PROCEDURE:**
10. Remove gloves & attend hand hygiene
11. Provide privacy for redressing, sanitary pad if required, remove soiled linen & make comfortable.
12. Auscultate fetal heart rate
13. Discuss findings with the woman
14. Document: Procedure, consent, persons attending examination (e.g. chaperone, family), justification for examination, findings & plan.

Note: This QRG represents minimum care & should be read in conjunction with the full guideline. Additional care should be individualised.

**AIMS**
- To guide vaginal examinations, ensuring dignity and privacy for all patients.
- To minimise the risk of professional actions being misinterpreted.
BACKGROUND

A vaginal examination (VE) can be used to assess gynaecological symptoms,¹ membrane sweep, assess cervical ripening before induction of labour, for performing labour induction methods, and during labour.² The use of routine preterm (<37 weeks) cervical screening has not been shown to reduce the risk of preterm birth and is not suggested.³

There is limited research determining the timing and effectiveness of routine intrapartum VE’s.⁴ Currently accepted reasons for an intrapartum VE include assessing progress, confirming full dilatation, presentation or engagement, artificial rupture of membranes or to determine if already ruptured, exclude cord prolapse after membrane rupture (particularly if fetal heart rate variation or ill-fitting presenting part) and for multiple birth assessment.⁵

KEY POINTS

1. A vaginal examination shall only be carried out if it will benefit the woman’s management and care.⁵

2. The woman shall be informed of the need for the examination and be offered an explanation as to the procedure that is involved in a way that she can understand and communicate.⁵⁻⁷

3. All vaginal examinations shall be preceded by an abdominal palpation.¹,⁵

4. Vaginal examinations shall not be carried out if:
   - Ruptured membranes in women who are not in labour (including if presence of active Herpes Simplex Virus (HSV) lesions in a woman with ruptured membranes, unless the woman is in labour).
   - Unknown placental localisation, or placenta praevia⁸
   - Frank bleeding⁸ (unless placenta is known to be in the upper uterine segment)⁵
   - The woman does not consent⁷,⁹

5. Consent: Verbal consent shall always be obtained from the woman before an examination.¹,⁵⁻⁷,⁹,¹⁰
   - If required, an interpreter should be used to ensure valid consent to examination.¹¹ Vaginal examinations should not be carried out on non-English speaking women without an interpreter / advocate, except in an emergency.
   - Any emergency situation and the circumstances that make the woman unable to consent should be documented in the medical record¹¹.

6. Chaperone:
   - The woman shall be given the opportunity to ask for and have a chaperone.⁶
   - The woman’s personal preference shall be documented in the clinical record.
   - Health care providers also have the right to request a chaperone.⁷
   - The person who is the chaperone shall be agreed to by the woman.⁷ No assumptions should be made as to who is the most appropriate chaperone. It
may not be acceptable to the woman for relatives to remain present during the examination. If the woman is not comfortable with a particular chaperone, another chaperone should be offered if the VE can be delayed. The woman should not feel pressure to proceed if a suitable chaperone is not available.  

- Document the chaperone’s name & designation in the medical notes. 

7. Refer to WNHS W040- Patient Interview and Examination Policy & NMHS COC13- Chaperone Policy as required.

8. During the examination:
   - Keep discussion relevant and avoid inappropriate verbal / non-verbal gestures
   - Avoid interruptions and unnecessary discussion with other staff members
   - At all times, treat the woman with privacy and dignity, minimising the amount of the woman’s body that is exposed and time spent undressed
   - Remain alert to verbal and non-verbal indications of distress from the woman
   - Any requests to discontinue the examination should be respected and documented in the medical record.

9. Hand hygiene shall be performed before and after the examination.

10. Where possible, intrapartum VE’s should ideally be attended by the same person to identify any changes.

PROCEDURE

PRIOR TO THE EXAMINATION

1. Check the woman understands the purpose of the examination and explain the procedure. Inform the woman that the examination should not be painful but may be uncomfortable.
   - If the woman does not want information about the examination, and prefers the treatment decision be left with the health professional, the health professional should encourage the woman to reconsider, however should not coerce her.
   - If the woman continues to decline receiving information, the health professional should determine the reason for the woman not wanting disclosure of information and if the woman expresses inability to manage receiving the information, the health professional should ensure the woman broadly understands what is involved.

2. Respond sensitively to any questions and concerns. Respect cultural and religious considerations. Ask if she has had a vaginal examination before, and discuss any concerns regarding her previous experience. The VE can be
particularly distressing to women who have survived sexual / physical abuse or FGM, or women who are very anxious.\(^5\)

3. Obtain consent\(^1,5-7,9,10\) for the procedure and for other people (including students) to be present during the examination, and record anyone attending the examination (e.g. family, chaperone, medical students).\(^7\)
   - The woman may decline the examination.\(^6\) If declined, explain procedure importance, offer a chaperone for support, and if still declined, defer to another time or another practitioner and document plan.\(^7\)
   - If the patient is unable to provide consent, refer to the Consent to Treatment Policy for the Western Australian Health System 2011. In some situations (e.g. child), providing a surrogate decision maker to consent to the examination and a familiar individual (such as a family member or carer) to accompany the patient, may be appropriate.\(^7\)
   - If initial consent is withdrawn during the procedure, cease the examination, discuss concerns, defer to another time / practitioner and document plan.\(^7\)

4. If relevant, see also Vaginal Examination in Children and Young Women

5. Chaperone: Irrespective of the gender of the examiner, offer a chaperone,\(^1,6\) and document their name and qualifications.\(^7\) See also NMHS Chaperone Policy.
   - A chaperone should be a qualified (e.g. nurse or appropriate training), impartial observer who is approved by the woman, maintains confidentiality and provides security for the woman and practitioner.\(^7\)
   - If the practitioner would like a chaperone but the woman does not consent, the practitioner does not have to perform the procedure, and may refer to another practitioner or defer to another time, where appropriate.\(^7\)

6. Students: The woman should be informed in advance if students will be in attendance and of the right to decline students. Additional consent is required if a student or junior doctor is to perform the examination for training / education.\(^1,7\)

7. The woman should empty her bladder.\(^1,9\) This increases her comfort and reduces any displacement of the fetal head by a full bladder.\(^5\)

8. The woman shall be given privacy to undress and dress.\(^1,6,7\) Provide a cover during the examination e.g. sheet.\(^1,6,7\) Do not assist the woman in removing clothes unless it has been clarified with them or their carer that assistance is required.\(^7\)

9. Position the woman comfortably.\(^9\) Perform an abdominal palpation before VE.\(^1,5,9\)

10. If using a speculum – see KEMH Clinical Guideline, O&G, Vaginal Procedures: Speculum Examination. Explain how the speculum is inserted, offer to demonstrate the speculum, and select an appropriate sized speculum and warm the speculum if required.

**PROCEDURE**

Vaginal Examination: Performing
Clinical Guidelines: Obstetric and Midwifery
1. Perform hand hygiene, put on gloves (both hands), and eye protection if risk of splash.

2. If intrapartum VE - wait to assess between contractions

3. Inspect the external genitalia and note any:
   - Amniotic fluid / Blood loss / Vaginal discharge - amount, colour, odour, ‘show’
   - Perineum: Lesions / scars (previous tears / episiotomy)
   - Labial: Oedema / varicosities / lesions
   - Scarring or evidence of Female Genital Mutilation (FGM). Record the type of FGM if present. See KEMH Clinical Guideline, O&M, Antepartum Care: Female Genital Mutilation

4. While separating the labia with the non-examining hand, gently insert lubricated fingers into the vagina. Avoid digital contact with the clitoris as this may be painful.

5. Assess vaginal muscle tone, dryness & excess heat. Dryness may indicate pyrexia

6. Locate the cervix and determine:
   - Length / effacement
   - Consistency
   - Position
   - Dilatation
   - Application (& feel for membranes- intact, bulging or smooth)
   - Presentation (& feel for fontanelles, sutures, moulding, caput & station)
   - Any abnormal features (e.g. vasa praevia, umbilical cord pulsation).

7. Assess the pelvis by palpating the ischial spines and assessing for undue prominence. Note angle of the suprapubic arch while withdrawing the fingers.

**POST-PROCEDURE**

8. Remove gloves and perform hand hygiene.

9. Give the woman a sanitary pad if necessary, change any soiled linen and assist her to become comfortable.

10. Auscultate the fetal heart.

11. Discuss the examination findings with the woman. For intrapartum VE, see also Clinical Guidelines, O&M, Intrapartum Care: Labour: First Stage: Care of the Woman; Partogram; & Management of Delay

12. Document the findings and justification for the VE in the medical notes and partogram (intrapartum).
REFERENCES / STANDARDS


Do not keep printed versions of guidelines as currency of information cannot be guaranteed. Access the current version from the WNHS website.