

CROYDON PERINEAL TRAUMA & MANAGEMENT OF 3RD/4TH DEGREE TEARS MATERNITY GUIDELINE

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1 INTRODUCTION

Obstetric perineal trauma is widespread in women who have had vaginal deliveries. It is estimated that 85% of women who deliver vaginally would sustain a tear with 69% of them

requiring suturing (Mccandlish et al 1998). Perineal trauma can occur either spontaneously or when a midwife or obstetrician facilitates delivery by making a surgical incision (episiotomy) to increase the diameter of the vulval outlet.

The short and long term sequale of perineal trauma include pain and discomfort, dyspareunia, bladder, bowel and sexual problems. This can lead not only to physical problems but psychological and social problems for the woman and her family.

Perineal damage can have a major adverse impact on women’s health. It can cause long-term morbidity associated with anatomically misalignment of wounds or unrecognised trauma to the anal sphincter, which can lead to major physical, psychological and social problems. With improved awareness and training there is an increased likelihood of a consistent, high standard of care and repair of perineal trauma and detection and repair of anal sphincter injury. This should contribute to reducing the extent of morbidity associated with perineal trauma and obstetric anal sphincter injury (OASI).

2 CLASSIFICATION:

The following classification described by sultan has been adopted globally including the International Consultation on Incontinence, NICE, ACOG and the RCOG:

First degree	Injury to the perineal skin and/or vaginal mucosa
Second degree	Injury to the perineum involving th perineal muscles but not involving the anal sphincter
Third degree	injury to the perineum involving the anal sphincter complex
3a	<50% thickness of external anal sphincter (EAS) thickness torn
3b	>50% thickness of external anal sphincter thickness torn
3c	Both externeal and internal anal sphincter (IAS) torn
Fourth degree	Injury to the perineum involving the anal sphincter complex and anorectal mucosa
Rectal button-hole tear	Tear involving the rectal mucosa with an intact anal sphincter complex

3 PROCESS/PROCEDURE /COURSE OF ACTION REQUIRED

3.1 Episiotomy

- Defined as a surgical incision of the perineum during childbirth to increase the vulval diameter.
- Episiotomies should only be performed if there is a clinical indication for the procedure (selective). These include instrumental delivery, fetal distress, a rigid inelastic perineum or to facilitate delivery e.g shoulder dystocia, breech delivery
- If an episiotomy is to be made, it should be a mediolateral incision. This involves an incision starting from the midline at the posterior fourchette at a 60° angle when the head is crowning. It is recommended that the Episcissors-60 is used to perform an episiotomy.

- The patient should be informed and verbal consent obtained. It must be done only when the presenting part is distending the perineal tissue to avoid bleeding and with the woman adequately anaesthetised,.
- For episiotomies the repair should usually be undertaken within an hour of the episiotomy incision (RCOG 2008). It is preferable that the same person who performed the episiotomy sutures the tear. If the person who performed the episiotomy is unable to undertake the repair, the reason should be documented in the patient's notes.
- Episiotomy is recommended in a subsequent pregnancy in all women who attained an OASIS in their index pregnancy.

3.2 Systematic Assessment of the Vagina & Perineum

- Examination of the perineum should be undertaken in line with the Trust Sharps Injury Prevention Policy
- Perineal/genital trauma identification, assessment and management should be performed by clinically competent, trained and updated clinicians, or by those who are undergoing supervised practice.
- All patients who deliver vaginally should be assessed for perineal trauma. Before assessing for genital trauma, healthcare professionals should explain to the woman what they plan to do and why.
- Good lighting is essential when an assessment is being carried out.
- Ensure adequate analgesia whilst assessing for perineal trauma and the woman should be offered inhalation analgesia.
- When assessing for perineal trauma, the lithotomy or recumbent position is the preferred position for the woman so that the genital structures can be seen clearly.
- The timing of this systematic assessment should not interfere with mother–infant bonding unless the woman has bleeding that requires urgent attention. The woman must be comfortable and if possible breastfeeding or skin to skin contact maintained. The initial examination should be performed gently and sensitively and should be done in the immediate period following birth. Vaginal examination should be performed to assess for presence and extent of tear, the structures involved, the apex of the injury and assessment of bleeding.
- A rectal examination must be performed to assess whether there has been any damage to the external or internal anal sphincter muscles. Clinicians are encouraged to ask another clinician for verification of grade of tear especially if there is any uncertainty. The clinician undertaking the assessment and classification of perineal trauma should be clinically competent to carry out the procedure. The woman should be referred to a more

experienced healthcare professional if uncertainty exists as to the nature or extent of trauma sustained.

- The perineal and genital tract assessment and its results should be fully documented, possibly pictorially in CERNER or the birth notes.

3.3 First Degree Tear and Labial Lacerations

- Women should be advised that in the case of first-degree trauma, the wound should be sutured in order to improve healing, unless the skin edges are well opposed. First-degree and labial lacerations should be sutured if there is excessive bleeding and poor anatomical alignment.
- Labial lacerations may be sutured if the trauma is bilateral or bleeding as fusion may occur.
- Following discussion of the risks and benefits, informed verbal consent for examination and repair should be obtained or if she declines repair it should be documented in the woman's CERNER/Birth notes.
- The clinicians should discuss with the woman and give information on how to care for the perineum post delivery. All actions and discussions should be documented in CERNER or the woman's Birth notes.

3.3.1 Repair of 1st and 2nd Degree Perineal Tears

- Perineal repair should be undertaken in line with the Trust Sharps Injury Prevention Policy
- Women should be advised that in the case of second-degree trauma, the muscle should be sutured in order to improve healing.
- Following discussion of the risks and benefits, informed verbal consent for examination and repair should be obtained or if she declines repair it should be documented in CERNER or the woman's Birth notes.
- Perineal trauma repair is an aseptic surgical procedure requiring skill and expertise of the clinician. Therefore standard infection control procedures should be observed by the clinician.
- The woman should be informed of the extent of the tear and the repair procedure the clinician is undertaking. Repair of the perineum should be undertaken as soon as possible to minimise the risk of infection and blood loss.
- Good lighting is essential whilst the repair is being carried out.

- Lithotomy is the preferred position whilst the repair is being carried out. If lithotomy supports are to be used, ensure that the woman's legs are lifted simultaneously by two clinicians to the lithotomy supports to avoid any physical damage to the woman.
Adequate analgesia should be administered prior to commencement of suturing and if needed during suturing. The epidural may be topped up if required. Allergy to local anaesthesia should be checked before its administration. It is recommended that 15 – 20 mls of Lidocaine 1% (maximum dose = 3mg/kg body weight) is infiltrated in the wound and this should last over a one hour period. To achieve anaesthesia insert the hypodermic needle into the wound edges from the fourchette along the skin edges to the anal verge, and from the fourchette to the posterior vaginal wall to the apex of the tear. Before the local anaesthesia is injected into the muscles the needle plunger should be withdrawn to ensure that it is not in a blood vessel. After administration of the local anaesthesia the clinicians should wait for 2 – 3 mins to allow for the analgesic effect of the local anaesthesia.
- Before commencement of suturing the clinician should ensure that the woman is adequately anaesthetised. If there is any discomfort or pain experienced by the woman, more analgesia may be needed. If the woman reports inadequate pain relief at any point this should immediately be addressed. **Do not proceed with the repair if the woman does not have adequate analgesia.**
- Before suturing, the apex and the rest of the tear should be clearly identified.
Furthermore, a visual assessment of tissue alignment and how anatomical restoration would be achieved should be undertaken. If this is not achieved ask for a more senior clinician to suture the tear.
- Multiple or difficult tears should be repaired by experienced practitioners
- All equipment, swabs, tampons, needles and instruments should be accounted for before and after the procedure, with a second person verifying the count inline with the Trust Swabs, Sharps and Instrument Guidelines
- Arrange sterile drapes and maintain the dignity of the woman.
- Perineal area should be cleaned with normal saline prior to commencement of suturing.
 Assess the need for tampon if visualisation of the tear is impeded by bleeding or clots. If a tampon is used attach the tape of the tampon to a blunt ended forceps and secure to the sterile drape on the woman's abdomen.
- Second degree tears and episiotomies are usually repaired using a three stage approach, vaginal wound, perineal muscles and perineal skin using a continuous nonlocking technique.
- Sharps should be safely handled and disposed of as per hospital procedure. It is the responsibility of the person undertaking the repair to ensure that the equipment and sharps are accounted for and disposed of appropriately.

3.3.2 Equipment & Suture Material

- Suture material - An absorbable synthetic suture material namely, polyglactin 910 product (Vicryl rapide 2.0) should be used
- Suture pack with large x-ray detected sterile swabs
- Sterile drapes
- Sterile gloves
- Lidocaine 1% (20 mls)
- Syringe (20 mls)
- Hypodermic 23G needles
- Diclofenac Sodium 100 mg rectally or non steroid rectal anti-inflammatory medication if the woman is not asthmatic/ no drug allergy/ MOH
- Sterile gown or plastic apron
- X-ray detectable tampons
- Tap water/Normal saline

3.3.3 Step 1 suturing the vagina

- Identify the apex of the vagina wound and insert an anchor or first stitch 0.5 cms above the apex. This secures any bleeding points that may not be seen.
- Tie the knot
- Close the vaginal trauma with a loose continuous non locking stitch ensuring that the stitches are not too wide as the vagina may be narrowed. Endeavour to eliminate dead space. Continue to suture until you match the hymenal remnants and the final suture of the vaginal layer is made into muscle at the fourchette.

3.3.4 Step 2 suturing the perineal muscle layer

- Close the perineal muscles (deep and superficial) with continuous non – locking stitches.
 - Dead space should be eliminated as much as possible to avoid wound breakdown and risk of infection.
- Ensure that muscles and skin edges are realigned so that the skin edges can be brought together without tension.
- Ensure that stitches are not inserted through anal canal.

3.3.5 Step 3 suturing the perineal skin

- Suturing of the skin should be undertaken using a continuous subcuticular technique At the inferior end of the wound (anal verge) bring the needle out under the skin surface, reversing the stitching direction.
- The stitches are placed below the skin surface in the subcutaneous tissue avoiding nerve endings on the skin.
- Take bites of subcutaneous tissue from the left side of the wound edge, then the right side of the wound edge and continue in that ascending pattern until the hymenal remnants are reached.
- Secure the finished repair with an Aberdeen knot placed in the vagina behind the hymenal remnants.
- The vulva should be cleaned gently

3.4 Management following Perineal Trauma Repair (1st & 2nd)

- Good anatomical alignment of the wound should be achieved with no excess bleeding and consideration given to the cosmetic results.
- If tampon was used it should be removed.
- At the completion of the repair a vaginal examination should be performed to ensure that the vaginal introitus admits at least two fingers.
- A rectal examination must be done to exclude any sutures in the anorectal mucosa. If sutures are identified (except in a 4th degree tear repair), the stitches should be removed, and the wound should be re-sutured with the midwife in charge/Registrar and the woman should be informed. PR Diclofenac Sodium 100mgs PR should be offered routinely trauma provided these drugs are not contraindicated.
- All equipment, swabs, tampons, needles and instruments MUST be accounted for before and after the procedure, with a second person verifying the count inline with the Trust Swabs, Sharps and Instrument Guidelines
- If there is any discrepancy in the equipment count, a thorough search MUST be carried out and if not found the midwife in charge and doctors should be informed.
- If a swabs, tampons, needles and instruments, a vaginal examination should be carried out and if any equipment is not found, the woman should have an xray performed and an incident report done. The midwife in charge and the doctors should be informed. The Woman must not be moved from Labour Ward unless agreed by a Midwifery manager and a consultant Obstetrician

- The woman should be fully informed at all times.
- All women after perineal tear repair should be advised on perineal hygiene, pelvic floor exercises, avoid smoking, healthy diet and signs of wound infection.
- Following completion of the repair, an accurate detailed account should be documented covering the extent of the trauma, the method of repair and the materials used.
Perineal suturing repair should be routinely audited against NICE standards and guidelines.
- Difficult trauma should be repaired by an experienced practitioner in theatre under regional or general anaesthesia. An indwelling catheter should be inserted for up to 24 hours to prevent urinary retention.

In the postnatal period, perineal wound should be routinely inspected by the relevant clinician. If perineal wound infection or any perineal problem is suspected, the woman must be referred to the perineal clinic.

3.5 Suturing of the third/ fourth degree tears.

- Perineal repair should be undertaken in line with the Trust Sharps Injury Prevention Policy
- All repairs must be conducted in the operating theatre. If there is any doubt about the diagnosis it is safer to examine the woman in theatre and perform a full assessment.
Written consent must be obtained and serious risks of the procedure explained and should include bleeding, infection, anal incontinence and fistula formation. Following discussion the risks and benefits and informed consent for repair should be documented on the consent form prior to the procedure.
- Effective epidural or spinal anaesthetic is necessary. This must be confirmed by the woman that effective analgesia is in place
- Emotional support of the mother is paramount; the woman must be supported whilst the repair is being carried out. The woman's birth partner may wish to accompany the

woman in theatre and this option should be offered.

- Repair should only be conducted by an SpR who has been trained and is competent to carry out the repair. If there is any doubt, the consultant should be informed.
- There should be good lighting, appropriate equipment and aseptic conditions. All repairs must be conducted in the **operating theatre** where there is access to repair pack which has been specially prepared for this purpose.
- Intravenous antibiotics should be given at induction or prior to top up as follows: In principle the IVs could be the same as the oral follow on; 1st line Co-amoxiclav 1.2g IV stat.

Alternative regime for True Penicillin allergy

Mild allergy - Cefuroxime 1.5g IV stat + Metronidazole 500mg IV stat.

Severe allergy) Clindamycin 900mg IV stat + Ciprofloxacin 400mg IV stat.

In case of MRSA positive patients

Teicoplanin IV 400mg + Gentamicin IV 160mg + Metronidazole IV 500mg commenced intra-operatively. Discuss oral switch with microbiology.

For further information, see also '**Guidelines for antibiotic prophylaxis in surgery**'.

- The Cerner prescribing set appears as below and can be found by entering the search terms 'OASIS' ; 'Tear'; '3rd/4th degree tear'; 'perineal trauma' (ensure search type is set to 'contains' rather than 'starts with').
- All repairs must be performed under **general or regional anaesthesia**. This is an important pre-requisite particularly for overlap repair as the inherent tone in the sphincter muscle can cause the torn muscle ends to retract within its sheath. Muscle relaxation is necessary to retrieve the ends and overlap without tension.
- The full extent of the injury should be evaluated by a careful vaginal and rectal examination in lithotomy and the tear should be classified as above.
- The torn **anal epithelium** must be repaired with a continuous Vicryl 3-0 sutures via the vagina with the knots tightly secured. Interrupted sutures can also be used but continuous sutures are preferable. Ensure that the apex of the tear has been identified and there are no additional mucosal tears.
- An **internal anal sphincter** tear must be identified and repaired separately by end to end approximation with interrupted 3-0 PDS sutures. These sutures are monofilament and therefore less likely to precipitate infection compared to a braided suture.
- If less than 50% of the **external anal sphincter** (EAS) thickness is torn (3a tear) an end-to end repair should always be performed with mattress sutures to approximate the muscle ends. When more than 50% of the EAS thickness is torn (3b) then you can chose to perform an overlap repair only if the EAS is completely torn and you are confident in performing an overlap repair. Otherwise you should still perform an end to

end repair with mattress sutures to approximate the muscle ends. A proper overlap repair is not possible unless the EAS is completely torn in length and thickness. The torn ends of the EAS must be identified and grasped with Allis tissue forceps. The muscle is then mobilised and pulled across to overlap in a “double-breast” fashion with 3-0 PDS sutures.

- Great care must be exercised in reconstructing the **perineal muscles** to provide support to the sphincter repair. Remember that the anal sphincter would be more likely to be traumatised during a subsequent vaginal delivery in the presence of a short deficient perineum. Also ensure that the knots and suture ends of PDS sutures are completely

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buried with overlying tissue to avoid suture migration.

- All equipment, swabs, tampons, needles and instruments **MUST** be accounted for before and after the procedure, with a second person verifying the count inline with the Trust Swabs, Sharps and Instrument Guidelines
- If there is any discrepancy in the equipment count, a thorough search **MUST** be carried out and if not found, the midwife in charge and doctors should be informed.
- If a swabs, tampons, needles and instruments, a vaginal examination should be carried out and if any equipment is not found, the woman should have an xray performed and an incident report done. The midwife in charge and the doctors should be informed. The Woman must not be moved from Labour Ward unless agreed by a Midwifery manager and a consultant Obstetrician

3.5.1 Post third/fourth degree tear procedure.

- Following repair the midwife must record the details in the Obstetric Theatre Register.
 - Severe perineal discomfort particularly following instrumental delivery is a known cause of urinary retention and following regional anaesthesia it can take up to 12 hours before bladder sensation returns. Therefore a Foley's catheter should be left in for up to 24 hours.
- The following post op medication should be given to these women
- The Cerner prescribing set appears as below and can be found by entering the search terms ‘OASIS’ ; ‘Tear’; ‘3rd/4th degree tear’; ‘perineal trauma’ (ensure search type is set to ‘contains’ rather than ‘starts with’).

Analgesia

- Paracetamol 1g QDS □ Ibuprofen 400mg TDS

Laxative

- Lactulose 15mls BD for 10 days- Dose to be titrated to keep stools soft.

Oral antibiotics

- *1st line* ○ Co-amoxiclav 625mg TDS for 3 days
- *Mild penicillin allergy (eg. mild rash)* ○ Cephalexin 500mg TDS + Metronidazole 400mg TDS for 3 days □ *Severe penicillin allergy (Anaphylaxis, Angioedema, etc)* ○ Ciprofloxacin 500mg BD + Clindamycin 300mg QDS for 3 days

For further information, see also '**Guidelines for antibiotic prophylaxis in surgery**'.

- A Datix is completed in line with the Maternity Services Risk Management Strategy for women readmitted to hospital

3.6 Suturing of Rectal Button hole tears

- The Obstetric Consultant should be informed of all rectal button hole tears
- Perineal repair should be undertaken in line with the Trust Sharps Injury Prevention Policy
- All repairs must be conducted in the operating theatre. If there is any doubt about the diagnosis it is safer to examine the woman in theatre and perform a full assessment.
- Written consent must be obtained and serious risks of the procedure explained and should include bleeding, infection, anal incontinence and fistula formation.
- Following discussion the risks and benefits and informed consent for repair should be documented on the consent form prior to the procedure.
- Effective epidural or spinal anaesthetic is necessary. This must be confirmed by the woman that effective analgesia is in place
- Emotional support of the mother is paramount; the woman must be supported whilst the repair is being carried out. The woman's birth partner may wish to accompany the woman in theatre and this option should be offered.
- Repair should only be conducted by a Consultant or SpR who has been trained and is competent to carry out the repair. The consultant should be present to supervise repair of all rectal button hole tears.
- The opinion of a colorectal surgeon may be sought if there is any doubt particularly if the the button hole tear is high (beyond 7 cm from the anal verge) or there is faecal soiling.
- There should be good lighting, appropriate equipment and aseptic conditions. All repairs must be conducted in the **operating theatre** where there is access to repair pack which has been specially prepared for this purpose.
- The full extent of the injury should be evaluated by a careful vaginal and rectal examination in lithotomy and the tear should be classified as above.
- The proximal and distal end of the button hole tear must be clearly visualised. The rectal mucosa should be sutured with continuous 3-0 vicryl. The rectovaginal fascia should then be closed in layers using 2-0 vicryl. Vaginal skin should then be closed with 2-0 vicryl.
- All equipment, swabs, tampons, needles and instruments **MUST** be accounted for before and after the procedure, with a second person verifying the count inline with the Trust Swabs, Sharps and Instrument Guidelines

- If there is any discrepancy in the equipment count, a thorough search MUST be carried out and if not found the midwife in charge and doctors should be informed.
- If a swabs, tampons, needles and instruments, a vaginal examination should be carried out and if any equipment is not found, the woman should have an xray performed and an incident report done. The midwife in charge and the doctors should be informed. The Woman must not be moved from Labour Ward unless agreed by a Midwifery manager and a consultant Obstetrician

□

3.7 Delivery Management after Previous 3rd/4th Degree Tear and Rectal Buttonhole tear

- All women with a history of a 3rd/4th degree tear should be referred to the perineal clinic for follow-up at three months.
- The risk of recurrence of a 3rd/4th degree tear is up to 10%
- All women will have anal ultrasound and manometry in the perineal clinic □ In general, continent women who have no evidence of significant anal sphincter compromise would be given the option to have a normal vaginal delivery by a senior midwife/doctor.
- Women with mild anal incontinence with evidence of anal sphincter compromise would be counseled and offered caesarean section (see www.perineum.net).
- Women with significant faecal incontinence need to be counseled in the perineal clinic about a secondary sphincter repair.
- There is evidence that prophylactic mediolateral episiotomy prevents a recurrence of sphincter rupture and therefore an episiotomy should only be discussed with the woman prior to delivery. This is particularly important if there are predisposing factors such as big baby, OP position, instrumental delivery, shoulder dystocia, fibrotic band or inelastic perineum.

3.8 Returns /readmissions with problems following perineal repair

- When a woman returns or is readmitted with problems following perineal repair the Midwife responsible for the woman's care should refer the woman to the Perineal Specialist Midwife Bleep 919 or the Urogynaecology team to review the woman or for advice and to inform them that the woman has returned with problem. □ The woman is to be reviewed by the perineal team and a management plan is documented. A follow up appointment is made at the Perineal Clinic if required which the midwife responsible for care will arrange.
- If there has been wound dehiscence, the patient will be offered resuturing of the perineum or allowing the wound to heal by secondary intention. Resuturing of the wound will be carried out by the urogynaecology team.
- The Perineal Specialist Midwife monitors the rate and reasons for return of women with problems relating to all types of perineal repair.

- A Datix is completed in line with the Maternity Services Risk Management Strategy for women readmitted to hospital

3.9 Postnatal review and appointment

- All women who have sustained perineal trauma, whether sutured or not should receive advice regarding wound healing – times, rates; analgesia; crushed ice/gel pads; extent of trauma, care of sutures; hygiene and healthy diet, in order to promote healing. Advice given to women following perineal repair is documented in CERNER or the birth notes
- Following perineal repair women should be given the 'Your baby & You' information booklet and directed to page 18 & 20 to access information about perineal care and infection. If they have sustained a 3rd/4th degree tear they should receive a 3rd/4th degree tear information leaflet and a pelvic floor information leaflet.
- This should be documented in the Postnatal notes or CERNER
- All women's perineum should be assessed as part of the postnatal check. Assessment of the healing process should be made by asking if there is pain, discomfort, stinging, offensive odor or dyspareunia or wound dehiscence when performing a postnatal check.
 If any of the above are reported then observation of perineum should occur. If there is infection, inadequate repair, wound breakdown or poor healing then the woman should be referred to Triage, her GP or Accident and Emergency for review if at home or an Obstetric Registrar if in hospital.
- All women should be advised about the importance of performing pelvic floor exercises as soon after birth as possible.
- Every woman must complete a bowel questionnaire before discharge and be given the 3rd/4th degree tear information booklet.
- An appointment should be made for the women who sustain 3rd/4th degree tears to attend the PERINEAL CLINIC run by the specialist Urogynaecologist/Consultant Obstetrician at 10 to 12 weeks postpartum. The Midwife responsible for the woman's discharge home must ensure that an appointment is made, communicated to the woman and documented in her postnatal notes If there are any problems or you need advice you can bleep the perineal trauma Specialist perineal midwife (Bleep 919).

3.10 Documentation

- The systematic assessment and its results should be fully documented, possibly pictorially
- Verbal consent for repair of labial lacerations; first and second degree repair should be documented in CERNER or the woman's Birth notes.

- Written consent for repair of third and fourth degree tear should be documented on a consent form prior to the procedure.
- Following completion of the repair, an accurate detailed account should be documented covering the extent of the trauma, the method of repair and the materials used by completing the genital tract trauma and repair section under “observations and assessments” in the maternity information system (CERNER) The documentation must include a pre and post repair swab and needle count. □ Information, advice and support given to women following perineal repair must be documented in the woman’s notes (CERNER)
- Handover of care to the midwife on the postnatal ward should include a summary of the repair and any specific management requirements.

4 IMPLICATIONS

Unrecognised perineal trauma or inadequate repair of a perineal or 3rd/4th degree tear can have a major adverse impact on a woman’s health. It can lead to anal incontinence, perineal pain and dyspareunia. It is therefore associated with significant long-term maternal morbidity with a negative impact on quality of life.

5 EXCEPTIONS

None applicable

6 TRAINING

- CHS Maternity Training Policy; Training Needs Analysis; Skills & Drills details staff training requirements for perineal trauma and management
- On-going education and training of staff must be seen as an integral part of their continuous professional development.
- Perineal/genital trauma identification, assessment and management should be performed by clinically competent, trained and updated clinicians, or by those who are undergoing supervised practice. Clinicians should ensure that they are adequately trained and routinely updated before they undertake perineal repair.
- Clinicians should ensure that they attend the Trust’s suturing workshops to keep themselves updated.
- The Perineal Specialist Midwife, Specialist Lead Consultant obstetrician and Practice development Lead reviews the training content and attendance annually to ensure compliance with Trust and national guidelines
- A DVD describing how to diagnose and repair 3rd/4th degree tears is available on the labour Ward
- Newly ratified guidelines are uploaded to the intranet; staff are informed of this via the departmental newsletter. All staff have the responsibility to ensure awareness of the contents of the guideline.
- Staff have the responsibility to inform their line manager of any training needs which may affect their ability to follow this guideline

6.1 Equality Impact Assessment

The Equality Impact Assessment for this policy is attached in Appendix A.

7 MONITORING COMPLIANCE

Describe how compliance with this policy will be monitored. Include monitoring arrangements such as audit or review, responsibilities for conducting the monitoring / audit, methodology to be used, frequency of monitoring / audit, and the process for reviewing results and ensuring improvements in performance occurs.

The following table may be useful for ensuring key requirements are monitored.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
Recording in the health records the time and volume of the first void	Miss Thakar	A single audit tool will be used to capture the key elements of this policy	An audit of the key elements to be monitored will be carried out and once compliance achieved will be repeated three yearly	The audit report will be submitted to the Maternity Quality Board meeting.	The lead for any necessary action planning will be identified and actions will be agreed at the Maternity Quality Board meeting. The action plan will specify the time frame and will be monitored at the Maternity Quality Board meeting.	Required changes in practice will be identified and implemented. Changes will be shared both internally and externally where appropriate
When indwelling urinary catheter is used						
Commencement of a input/output chart when a catheter is reinserted						
When to refer to an appropriate clinician for evaluation						
When to instigate a management plan						
Documentation of all of the above						

8 REFERENCES

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9 ASSOCIATED DOCUMENTATION

Maternity Guideline – Bladder Care
 Maternity Guideline – Operative Vaginal Delivery
 Guidelines for antibiotic prophylaxis in surgery.

10 VERSION HISTORY TABLE

Version	Date	Author	Ratified by	Comment/Reason for change
1.0	January 2013	Mr Sultan Miss Thakar Adeyemi Johnson Fidelia Boateng	Maternity Quality Board	Revised in line with CNST Maternity Standards 2012/2013 Retemplated new Trust format Guidelines for perineal repair merged
				Maternity Guideline for Perineal Trauma, Version 2.0 2009 Maternity Guideline for The Management of 3rd/4th Degree Tears, Version 3.0 2011
1.1	September 2015	Miss Thakar Dr Naidu	Maternity Quality Board	Amendment of prophylactic antibiotics

1.2	June 2016	Karen Rooke	Maternity Quality Board	<p>Retemplated</p> <p>SI recommendations added</p> <p>Perineal repair should be undertaken in line with the Trust Sharps Injury Prevention Policy</p> <p>Equipment, swabs, tampons, needles and instruments verification inline with the Trust Swabs, Sharps and Instrument Guidelines</p>
1.3	June 2019	<p>Aswini Balachandran</p> <p>Miss Thakar</p> <p>Mr Abdul Sultan</p>	Maternity Quality Board	<p>Amendment of definition of tears as per RCOG greentop guideline 2015</p> <p>Breakdown of perineal wounds can be offered resuturing by the Urogynaecology team</p> <p>Repair of Rectal buttonhole tears</p>

APPENDIX A – EQUALITY IMPACT ASSESSMENT

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy: Perineal Trauma 1.3	Date: 27/09/2019
Officer conducting this Analysis : Patricia Howard	

Protected Characteristic	Positive Impact	Negative Impact	None	Reasons for decision
Age			✓	
Disability			✓	
Faith			✓	
Gender			✓	
Race			✓	
Sexual Orientation			✓	

APPENDIX B – CONSULTATION TEMPLATE

1.	Procedural Document's Name:	Perineal Trauma & Management of 3 rd /4 th Degree Tears Maternity Guideline
2.	Procedural Document Author:	Miss Thakar
3.	Group/Committee Consulted	Date
	Consultant Obstetricians and Gynaecologist	22/07/2019
	Midwifery Managers	22/07/2019
4	Name and Title of Key Individuals Consulted	Date
	Ranee Thakar	16/06/2019

	Abdul H Sultan	16/06/2019
	Adeyemi Johnson	16/06/2019
	Maternity Band 7s	24/07/2019
5	<p>Comments received</p> <p>To include repair of butthole tears.</p> <p>It is recommended that the Episcissors-60 is used to perform an episiotomy.</p> <p>If there has been wound dehiscence, the patient will be offered resuturing of the perineum or allowing the wound to heal by secondary intention. Resuturing of the wound will be carried out by the urogynaecology team.</p>	