Mid Essex Hospital Services NHS
NHS Trust

ASSESSMENT AND REPAIR OF PERINEAL TRAUMA	CLINICAL GUIDELINES Register No: 07066 Status: Public

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5.1	Sarah Moon - Clarification to 3.0,15.9, Appendix B	May 2014
6.0	Sarah Moon	26 July 2016

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Appendix B - Documentation of the Health Care Records
Appendix C - Postpartum Care of the Perineum
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1.0 Purpose

1.1 This guideline provides guidance in the area of assessment and repair of perineal trauma to ensure that adequate assessment of the extent of the trauma is identified and furthermore, to provide a consistently high standard of perineal repair.

1.2 Practitioners including obstetricians and midwives who are appropriately trained gain further confidence and competence to enhance their optimum standard of care.

2.0 Equality and Diversity

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Recommendations For Initial Assessment of any Genital or Perineal Trauma

3.1 Before assessing for genital or perineal trauma, healthcare professionals should:

- Explain to the patient what they plan to do and why
- Offer Entonox inhalational analgesia
- Ensure good lighting
- Position the patient so that she is comfortable and so that the genital structures can be seen clearly
- The initial examination should be performed gently and with sensitivity and may be done in the immediate period following birth
- Following vaginal delivery a per anal (PA) and per rectal (PR) examination should be performed in the presence of **any degree of genital trauma including vaginal or perineal trauma**
- If genital or perineal trauma is identified following birth, further systematic assessment should be carried out

3.2 Systematic assessment of genital or perineal trauma should include:

- A further explanation of what the healthcare professional plans to do and why
- A confirmation by the patient that tested effective local or regional analgesia is in place
- A visual assessment of the extent of perineal trauma, Commence the examination anteriorly; examine the peri- urethral area and descent laterally to include the labia, vaginal vault, lateral vaginal walls, posterior vaginal walls, posterior virginal floor, the perineal body and the anal sphincter.
- The apex of the injury should be clearly identified and assessment of bleeding noted
- A per anal (PA) and per rectal (PR) examination to assess whether there has been any damage to the external or internal anal sphincter if there is **any degree of genital trauma including vaginal or perineal trauma.**

3.3 The timing of this systematic assessment should not interfere with skin to skin contact and mother–infant bonding unless the woman is unwell such as bleeding that requires urgent attention.

3.4 The patient should usually be in lithotomy to allow adequate visual assessment of the degree of the trauma and for the repair. This position should only be maintained for as long as is necessary for the systematic assessment and repair.

3.5 All lacerations and trauma to the genital tract need to be examined carefully (including rectal examination) with a good light source prior to suturing. Any doubt as to the extent of damage should be checked if necessary after consultation with a senior colleague.

3.6 The patient should be referred to a more experienced healthcare professional if uncertainty exists as to the nature or extent of trauma sustained.

3.7 The systematic assessment and its results should be fully documented, possibly pictorially in the health care records.

4.0 Classification of Perineal Tears

Degree	Trauma
Intact	No trauma to the vaginal area or perineum noted. No suturing required
Grazes	Superficial splits of the vaginal walls/labia or perineal skin, these rarely requiring suturing.
Labial	Superficial lacerations to the labia rarely require suturing in isolation. If bilateral labial lacerations are noted suturing should be commenced to prevent fusing of the skin
First	Superficial lacerations to the vaginal and perineal skin only. Suturing to be considered and assessed on an individual basis.
Second	Injury to the posterior vaginal wall, subcutaneous fat, perineal skin and superficial muscle (bulbo-cavernosus and superficial transverse perinei) and deep muscle. But not involving the anal sphincter; includes damage resulting from an Episiotomy
Third	Injury to the perineum involving the anal sphincter muscles 3a: less than 50% of external anal sphincter thickness torn 3b: more than 50% of external anal sphincter thickness torn 3c: Internal sphincter torn
Fourth	Complete disruption of the external and internal anal sphincter complex and the anal epithelium

5.0 Assessment and Management of an Intact Perineum

5.1 Complete the perineal assessment section for all women and appropriately document in the Labour Care and Baby Delivery Record and highlight that no suturing is required; this will then indicate that the perineal repair section is not applicable.

5.2 All intact perineums should still be given advice on bladder care, postnatal pain relief, extent of trauma i.e. grazes, diet including fibre, pelvic floor exercises and postnatal hygiene advice.

6.0 Assessment and Management of Grazes and Labial Tears

6.1 Complete the perineal assessment section for all women and document accordingly in the Labour Care and Baby Delivery Record. If suturing is required it should be clearly highlighted and then progress onto the perineal repair section of the notes.

6.2 Currently grazes and labial tears are assessed on an individual basis, is there is no bleeding and the skin edges are well opposed there is no need to suture.

6.3 Please note bilateral labial tears will need to be sutured to avoid the skin apposing to each other.

6.4 If there is a requirement to suture gain verbal consent and document technique in the Labour Care and Baby Delivery Record under the heading perineal repair.

7.0 Assessment and Management of First Degree Tear

7.1 Complete perineal assessment section for all woman and document accordingly in the Labour Care and Baby Delivery Record, Furthermore, highlight if suturing is required; if no suturing is indicated this should be clearly highlighted; this will then demonstrate that the perineal repair section is not applicable.

7.2 If there is a requirement to suture, gain verbal consent and document technique in the Labour Care and Baby Delivery Record under the heading 'perineal repair'

7.3 However, in the case of a first degree tear; defined as superficial lacerations to the perineal skin only. Suturing to be considered and assessed on an individual basis.

8.0 Assessment and Repair of Episiotomy and Secondary Degree Tear

8.1 Complete perineal assessment section for all woman as appropriate and document in the Labour Care and Baby Delivery Record and highlight if suturing is required.

8.2 Currently, all second degree tears and episiotomies are to be sutured. Discuss the need to suture with the patient and gain verbal consent and document technique in the Labour Care and Baby Delivery Record under the heading 'perineal repair'. If the woman declines ensure she has been given a clear rational of the benefits of suturing and document the conversation within the Labour Care and Baby Delivery Record.

8.3 Set up trolley with the following:

- Sterile suture/delivery pack
- Suture instrument set
- 20 ml syringe
- Green needle
- Obstetric Cream
- Clean Tap Water
- Lidocaine 1%, 20 mls
- Sterile gloves
- Vicryl rapide 0 or 2/0 (1-2 packets)

8.4 Position patient in lithotomy position, or support legs as best able if home confinement, to enable satisfactory visualisation of the perineum and provide support for the patient's legs.

9.0 Procedure

9.1 This is a sterile procedure and referral should be made to the 'Standard Infection Prevention' guideline'; register number 04071.

9.2 Count swabs and sutures prior to procedure with a second person.

9.3 Swab perineum with gauze soaked in clean tap water (one swipe only).

9.4 Carefully visualise tear/episiotomy to ensure extent of tear is recognised prior to commencement of suturing and to identify landmarks (i.e. hymen ring) that will facilitate correct tissue realignment.

9.5 Note that difficult repairs, cervical tears involving the urethra and third degree tear should be referred to the obstetrics registrar.

9.6 Infiltrate perineal tear with 1% lidocaine 20 mls (as per standing orders).

9.7 Infiltrate through the wound. Take care to infiltrate symmetrically to prevent distortion of the wound and subsequent repair.

9.8 Allow time for lidocaine to work. Alternatively, if patient has an epidural in ensure it is stopped up prior to suturing.

9.9 If a patient reports inadequate pain relief at any point this should immediately be addressed.

9.10 Always have entonox available.

10.0 Technique

10.1 A loose, continuous non-locking suturing technique used to appose each layer (vaginal tissue, perineal muscle and skin) is associated with less short-term pain compared to the traditional interrupted method.

10.2 Tie off separately any bleeding points with a loop of suture. If haemostasis cannot be achieved call for a review from the obstetric registrar/consultant.

10.3 Identify apex of the tear/episiotomy. Insert first suture above apex of tear and tie a knot. Avoid placing first stitch too deep remember close proximity to the rectum.

10.4 Close posterior vaginal wall using continuous non-locking sutures using **vicryl rapide 2/0**, on a tapecut needle (Reference suture number: **W9962**) 0.5cm from edge of wound, 1cm apart and 1cm deep.

10.5 Continue suturing until the introitus is reached using the hymenal remnants as a landmark. Bring the needle through the tissue underneath the hymenal ring into the muscle layer.

10.6 Define the depth of the wound close the perineal body (muscle layer) with continuous non-locking sutures.

10.7 Close the perineal skin using continuous subcuticular or interrupted transcutaneous

sutures. Continuous subcuticular are less painful.

10.8 For labial tears, suture if bleeding or if loose skin flaps present. Infiltrate skin edges with 1% lidocaine and join skin edges using Vicryl rapide 2/0. A continuous stitch is often most appropriate. Seek advice from the Labour Ward Co-ordinator or registrar/consultant on call if in doubt.

11.0 Completion

11.1 Check vagina. Ensure it easily admits 2 fingers and for any further high vaginal wall lacerations.

11.2 Perform a rectal examination to check for any sutures that have penetrated the rectal mucosa. Inform the obstetric registrar if any concerns are identified. Consider voltarol® 100mg per rectum for analgesia if there are no contraindications.

11.3 Swab the perineum and place a sterile pad in situ.

11.4 With a second person, count the needles, swabs and instruments, recording the findings on the clinical data collection system.
(Refer to Appendix B)

11.5 The woman should be given information on the following:

- Extent of the trauma
- Type of repair performed
- Postnatal pain relief
- Hygiene
- Diet (including fibre)
- Pelvic floor exercises

11.6 All postnatal advice following repair should be documented in the Labour Care and Baby Delivery Records and the Postnatal Record – Maternal.

12.0 In the Community

12.1 Ensure there is adequate lighting.

12.2 Suture to the level of competency according to labour guidelines regarding perineal repair. If unable to suture effectively, admit to Labour Ward for a second opinion i.e. 3rd or 4th degree tears.

13.0 Third and Fourth Degree Tears

13.1 Anal incontinence affects 11% of adults and occurs frequently in 2%.The commonest cause in healthy patients is unrecognised damage to the anal sphincter during childbirth. More than 30% of patients who suffer a third or fourth degree tear develop incontinence.

13.2 When a third and fourth degree tear occurs, 54-88% of patients have persistent structural sphincter defects and up to 57% remain symptomatic despite primary repair after delivery, including patients suffering from sexual dysfunction.

14.0 Prevention of Third Degree Tears

14.1 Third degree tears are not attributable to previous obstetric history and patients at risk are not easily identifiable in the antenatal period. Most severe tears occur in primigravid patients and after instrumental deliveries. Consider mediolateral episiotomy if imminent severe tearing is suspected.

14.2 The risk factors are highlighted below:

- Macrosomia - >4kg
- Persistent occipitoposterior position
- Primigravida
- Induction of labour
- Epidural analgaesia
- Prolonged second stage - >1hour
- Forceps delivery
- Midline episiotomy

15.0 Repair of Third and Fourth Degree Tears

15.1 Principles of repair - when the tear has been identified as involving the anal sphincter refer to an obstetric registrar/consultant.

15.2 Inform patient and her partner.

15.3 Inform anaesthetist who will need to perform anaesthetic assessment.

15.4 The procedure should only be undertaken by consultant obstetricians or specialist registrars / specialty doctor who have been assessed as competent to do so.

15.5 The obstetrician should discuss the need to suture with the patient and gain verbal consent and document in the operative delivery and theatre care record under the heading ‘repair of obstetric anal sphincter injury - Oasis’

15.6 All repairs must be performed in operating theatre where there is access to good lighting, appropriate equipment and aseptic conditions. Use the third degree repair pack which has been specially prepared for this purpose.

15.7 Ensure adequate anaesthesia either general or regional anaesthesia. These allow the anal sphincter to relax which is essential to retrieve the ends and overlap without tension.

15.8 **Procedure** as follows:

- Evaluate full extent of the injury by careful vaginal and rectal examination in lithotomy.

- Repair torn rectal mucosa with interrupted 2/0 vicryl sutures with the knots tied in the anal lumen.

- Identify and repair internal anal sphincter separately from external anal sphincter. Perform an end-to-end repair with interrupted or mattress 3/0 PDS sutures. These are

monofilament sutures and therefore less likely to precipitate infection compared to braided suture.

- Reconstitute external anal sphincter after careful identification using either end to end or overlap method with interrupted 3/0 PDS sutures.

- Complete repair of perineum as for episiotomy / 2nd degree tear. Ensure that the knots and suture ends of PDS sutures are completely buried with overlying tissue to avoid suture migration.

- Repair of third/fourth degree tears should be accurately documented in the health care records.
  (Refer to Appendix B)

15.9 **Post procedure** as follows:

- DATIX all 3rd and 4th degree tears at the time of the incident. Ensure the correct grade of trauma is highlighted in the DATIX.
  Input women's details into the 3rd and 4th degree tear folder which is kept on the postnatal ward to ensure the Perineal Health Specialist Midwife can keep an accurate record of all women who sustain trauma.

- Provide adequate post-operative analgesia as prescribed to include:
  i. Paracetamol 1g (up to four times a day)
  ii. Ibruprofen 400mg (up to three times a day)
  iii. Oramorph 10-20 mg (up to three times a day)

- Intravenous antibiotics (cefuroxime 1.5g and metronidazole 500mg) should be administered intra-operatively / post procedure and continued orally for 1 week.

- All women should be prescribed **stool softeners** (lactulose 15 mls twice a day or enough to keep stools soft) for 10 days as straining to pass a bolus of hard stool may disrupt the repair. This must be explained to the woman and the community midwife needs to ensure that normal bowel action has occurred within 3 days.

- All women should be provided with antibacterial soap or wash to reduce the risk of infection developing whilst the tear is healing. Women should be advised to wash the whole of the body at least once a day and if possible twice with the soap (It should be used first, before other hygiene products) Women should be advised to not use any products which are strongly scented or perfumed until the repair has had time to heal.

- Women should be advised about the importance of perineal hygiene including changing their sanitary towels regularly and how to note any signs of infection developing. If women feel they are concerned about infection they should be advised to contact their community midwife or GP promptly

- As the consequences of anal sphincter disruption can result in litigation, careful and detailed note keeping is essential. A diagram demonstrating the extent of the injury and technique of repair will serve to substantiate that a careful examination was performed.

- The woman must be given a detailed explanation of the extent of trauma and advised that if there is any concern about infection or poor bowel control they should contact their midwife or GP. Women can also contact the Perineal Health Specialist Midwife if they

require further detailed support or advice in the postnatal period via email (Susannah.Banks@meht.nhs.uk)

- When possible all women should be seen by the Women's Wealth Physiotherapist on the ward before discharge. The physiotherapist will attend the postnatal ward to perform a ward round. Women are offered advice on pain management, antenatal/postnatal bladder and bowel function/control and pelvic floor awareness. Women are provide a pelvic floor exercise plan and given reassurance and advice on how to open their bowels.

- If there are no concerns at this assessment woman will be advised that the women's health physiotherapist will contact them, via phone call, between 6-8 weeks postnatal. If at this phone call it is noted women need further physiotherapy support they will be offered a one to one appointment.

- If any concerns are noted at this initial assessment women will be referred to the physiotherapy department for a 6 week one to one postnatal appointment. Women will receive a letter asking them to phone the department to make a suitable appointment to see the Women's Wealth Physiotherapist (referrals can be made via extension 3155 to the Senior Physiotherapist Women's Health)

- A 12 week postnatal appointment should be made in the Specialised Perineal Trauma Clinic for all women sustaining a 3rd and 4th degree tear or with other severe perineal trauma at the discretion of the midwife/doctor.

- Women who sustain a **3A** tear will be seen in the Specialised Perineal Trauma Clinic by Perineal Health Specialist Midwife (Susannah Banks). Women should be booked into clinic **SSPTB** (which will run the 2nd and 4th Thursdays of each month)

- Women who sustain a **3B, 3C and 4th** degree tear will be seen by Consultant Gynaecologist and Urogynaecologist. Women should be booked into clinic **PKFPTB** (Consultant initials; perineal trauma booking). The Perineal Trauma Clinic occurs on the 1st and 3rd Thursdays of every month.

- The postnatal/ discharge midwife should document the discussion and giving of the Patient Information Leaflet in the 'Transfer from hospital to community midwife care' section; located in the 'Postnatal Care Record- Maternal'.
  (Refer to the guideline entitled' Dissemination of information to patients in maternity'; register number 10008)

16.0 Management of Subsequent Delivery

16.1 All woman with previous history of a 3rd/4th degree tear should be referred to the Perineal Trauma Clinic at between 28-34 weeks for follow-up and discussion of mode of delivery. Women should be booked into clinic **PKFPTB**. The Perineal Trauma Clinic occurs on the 1st and 3rd Thursdays of every month.

16.2 The risk of recurrence of a 3rd/4th degree tear is 7%. (the initial risk as a primigravida or first vaginal delivery is 5%)

16.3 All women will be assessed individually as to their clinical need for endo-anal ultrasound and manometry at the Perineal Trauma Clinic.

Women should be advised about the benefits on Perineal Massage from 34 weeks gestation to help prepare their perineum for a vaginal delivery and reduce the risks of perineal trauma at delivery. In addition, women should be given the patient information leaflet entitled 'Antenatal perineal massage'.

16.4 In general, continent women who have no evidence of significant anal sphincter Compromise will be suitable for a vaginal delivery by an experienced midwife.

16.5 Women with mild anal incontinence with evidence of anal sphincter compromise would be counselled and offered caesarean section.

16.6 Women with significant faecal incontinence need to be counselled about a secondary anal sphincter repair.

16.7 There is no evidence that prophylactic episiotomy prevents a recurrence of sphincter rupture and therefore an episiotomy should only be performed if there are predisposing factors such as macrocosmic/increased birth weight, OP position, shoulder dystocia, fibrotic band or inelastic perineum.

17.0 Record Keeping

17.1 Perineal repair should be accurately documented on the perineal repair section of the 'Labour Care Record' for perineal repair excluding 3rd/4th degree tears. For the documentation of 3rd/4th degree tears, the 'Operative Delivery and Theatre Care Record' should be utilised.
(Refer to Appendix B)

17.2 Following completion of the procedure, the Clinical Data Collection (CDC) system should be completed.

17.3 The following should be recorded in the either the 'Labour Care Record' booklet or the 'Operative Delivery and Theatre Care Record' booklet:

- Instrument set number
- Suture material
- Batch number

17.4 The clinical data collection (CDC) now requires the name of the person who checked your swabs, instruments and needles following suturing.

17.5 The postnatal/discharge midwife should discuss and provide information regarding perineal repair in the form of a patient information leaflet (PIL). The postnatal/ discharge midwife should document the discussion and giving of the PIL on the 'Transfer from hospital to community midwife care' section; located in the 'Postnatal Care Record-Maternal'.
(Refer to the guideline entitled' Dissemination of information to patients in maternity'; register number 10008)

18.0 Staff Competency and Training

18.1 Preceptorship midwives learning to suture or return to practice midwives must be supported and supervised by another professional (midwife/doctor) who has completed

perineal training and is competent in teaching this skill. Furthermore, preceptorship midwives should attend a perineal repair workshop and on completion of the course and having completed the number of supervised perineal repairs; a certificate is generated and a copy placed in the midwife's personal file for reference. A register of attendance is maintained by the Practice Educator.
(Refer to Appendix A)

18.2 Band 6 midwives and above are normally deemed competent to undertake perineal repair (excluding point 15.4). An electronic database recording competency status will be maintained by the Practice Educator on the Maternity hard drive.

18.3 Where there are concerns regarding the repair of the perineum, the responsible midwife should request a second opinion from the Labour Ward Co-ordinator and if indicated a review by the obstetric registrar/consultant.

18.4 Band 6 midwives and above should be trained in perineal repair in accordance with the 'Mandatory training policy for maternity services incorporating training needs analysis. (Register number 09062). Mandatory updates in the area of perineal repair occur on an annual basis.

18.5 A comprehensive list of those staff who have attended annual mandatory training will be held by the Practice Educator and staff will be expected to attend the update sessions to maintain competency.

18.6 Midwives are not competent to suture 3rd/4th degree tears and will refer these cases to the appropriate obstetric registrar or consultant.

18.7 Obstetric registrars/ consultants that are new to the trust require an appraisal where their current competences are established both on paper and clinically. Obstetric registrars are then appraised 6 months later to again assess their competences in terms of perineal repair. Evidence of the perineal repair workshop is a pre-requisite and the certificate should be filed in the individual's portfolio. Dependant on the individual obstetrician's appraisal and competences, this will denote who can perform 3rd/4th degree tears. Furthermore, the Lead Obstetric Consultant for Labour Ward retains a list at each change over of staff to determine who can perform 3rd/4th degree tears.

19.0 Supervisor of Midwives

19.1 The supervision of midwives is a statutory responsibility that provides a mechanism for support and guidance to every midwife practising in the UK. The purpose of supervision is to protect women and babies, while supporting midwives to be fit for practice'. This role is carried out on our behalf by local supervising authorities. Advice should be sought from the supervisors of midwives are experienced practising midwives who have undertaken further education in order to supervise midwifery services. A 24 hour on call rota operates to ensure that a Supervisor of Midwives is available to advise and support midwives and women in their care choices.

20.0 Infection Prevention

20.1 All staff should follow the Trust's guideline on infection prevention, using Aseptic Non-Touch Technique (ANTT) when performing this procedure

21.0 Re-admission due to Complications Following any Perineal Repair

21.1 Women re-admitted to the Postnatal Ward will be reviewed by the obstetric registrar/ consultant on call on admission. When possible the Perineal Health Specialist Midwife should be informed of the patient's readmission to enable them to provide the women with appropriate specialised support and advice. The midwife responsible should complete a risk event form via Datix Web. The incident report / investigation should consider the cause of the re-admission. The report generated by Datix Web will then be reviewed by the Maternity Risk Manager and action taken accordingly. Readmission rates and their causes should be reviewed at the Maternity Risk Management group meeting.
(Refer to point 19.2)

22.0 Audit and Monitoring

22.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

22.2 As a minimum the following specific requirements will be monitored:

- Who can perform the repair
- Documentation of consent for all types of perineal repair
- Management of third and fourth-degree tears
- Standards for record-keeping in relation to all types of perineal trauma
- Documentation of information given regarding support following the repair
- Maternity service's expectations for staff training, as identified in the training needs analysis
- Process for monitoring the rate and cause of returns of women with complications following perineal repair. General trends will be reported as a standing agenda item at risk management meetings

22.3 A review of a suitable sample of health records of patients to include the minimum requirements as highlighted in point 22.2 will be audited. A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken.

22.4 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

22.5 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

22.6 Key findings and learning points from the audit will be submitted to the Clinical Governance Group within the integrated learning report.

22.7 Key findings and learning points will be disseminated to relevant staff.

23.0 Guideline Management

23.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

23.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

23.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

23.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for further training; possibly involving 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

24.0 Communication

24.1 A bi-monthly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly.

24.2 Approved guidelines are published monthly in the Trust's Focus Magazine that is sent via email to all staff.

24.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

24.4 Regular memos are posted on the guideline notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

25.0 References

National Institute for Clinical Excellence (2014) Intrapartum Care. Care of healthy women and their babies during childbirth. NICE: CG190; December.

Royal College of Obstetricians and Gynaecologists (2004) Methods and Materials Used in Perineal Repair Green Top Guidelines: www.rcog.org.uk

Appendix A

Perineal Suturing Competencies Checklist

Name of Practitioner……

Qualified……

	Date	Signature , Print and Designation
Attended perineal repair workshop and obtained certificate		
Observed perineal repair		

Suturing to be observed by practitioner trained and competent in guideline technique

	Observed by	Date	Signature Name and Designation	Hospital number to use for auditing own repairs
1				
2				
3				
4				
5				

Competence Checklist

	Signature of Assessor
Demonstrates an increased knowledge base of perineal and anal muscles	
Demonstrates rational for suturing and when to and when not to suture	
Assesses and classifies trauma appropriately	
Performs anal sphincter examination pre and post suturing	
Demonstrates aseptic technique	
Performs suturing in line with guideline technique	
Documents appropriately following repair	

Assessed as competent by Registrar/ Midwife observing the 5th repair

If competence if not achieved at this point please refer to the Practice Development Midwife.

Referral for support needed: Yes/No

Name……

Signature……

Date……

When complete this form must be forwarded to the practice development midwife. It is then filed in the Midwife/Doctor's personal file.

Appendix B

Documentation

Labour Care Record

The following should be included within documentation:

- Date and time of procedure
- Consent
- Nature and extent of the tear/episiotomy
- Following vaginal delivery a per anal (PA) and per rectal (PR) examination should be performed in the presence of **any degree of genital trauma including vaginal or perineal trauma**
- Anaesthetic used
- Suture material used and batch number
- Perineal pack serial number
- Examinations per vaginam and rectum post repair
- Swab, needles and instruments check correct with a second person
- Legible signature and designation of suturing midwife or doctor

In addition, the midwife responsible should complete the Clinical Data Collection System

Postnatal Care Record

- Discussion and provision of information regarding perineal repair in the form of a patient information leaflet (PIL)

This list is not exhaustive – any other relevant information should also be reported.

Appendix C

Postpartum Care of the Perineum

To Achieve:

- Relief of perineal pain
- Aid healing
- Empower and educate patients

Management:

- Pelvic floor exercises
- Positioning
- Topical treatments
- Pharmacological treatments
- Alternative therapies
- Referral

Pelvic Floor Exercises:
Encourage venous return, lymphatic drainage and removal of traumatic exudates to promote healing. They also aid comfort by relieving stiffness and empowers the patient as it is a self-help method.

Positioning Postnatally:
Experimentation should be encouraged to find what is comfortable. Consider a valley cushion for those in severe discomfort. The traditional rubber ring is contraindicated. Experimentation with positions for breastfeeding is to be encouraged.

Topical Treatments:
These include the use of **intermittent** ice, cool packs and frequent bathing to keep the area clean and comfortable.

Pharmacological treatment in the form of analgesia is considered good practice. Consider the type and form taking into account allergies and existing medical conditions. Evidence suggests diclofenac 100mg per rectum gives best effect post suturing.

Alternative Therapies:
Alternative therapies for the treatment of postnatal perineal pain are available. They are many forms but care must be taken that patients consult a qualified practitioner prior to using. Midwives must take account of the NMC Midwives Rules and Code of Conduct with regard to recommending specific alternative therapies.
(Refer to the NMC Advice Sheet ‘Complimentary Alternative Therapies and Homeopathy’)

As autonomous practitioners we are able to make referrals, if we deem necessary. Referrals may be made to physiotherapists for treatment for severe postnatal perineal pain and also to obstetricians or other specialists.

Remember to document in the health care records when you have inspected the perineum, your findings and what recommendations you have made to the patient

Appendix D

Management of Third and Fourth Degree Tear/ Severe Perineal Trauma