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<th>ASSESSMENT AND REPAIR OF PERINEAL TRAUMA</th>
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<td>Anita Rao</td>
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<td>Jude Horscraft</td>
<td>Practice Development Midwife</td>
<td>28th August 2019</td>
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### Related Trust Policies

- 04071 Policy for Standard Infection Prevention Precautions
- 04072 Hand Hygiene Policy
- 06036 Maternity Record Keeping including Documentation in Handheld Records
- 09062 Mandatory training policy for maternity services (incorporating training needs analysis)
- 10008 Dissemination of Information to Patients in Maternity

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<td>1.0</td>
<td>Nina Smethurst and Julie Bishop</td>
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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 Impact Assessment

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. (Refer to Appendix C)

3.0 Recommendations For Initial Assessment of any Genital or Perineal Trauma

3.1 All lacerations and trauma to the genital tract need to be examined carefully, including a 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.

3.2 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, ideally in lithotomy 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.

3.3 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 (high vaginal wall), lateral vaginal walls, posterior vaginal walls, posterior vaginal 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.

3.4 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.

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

4.0 Classification of Perineal Tears

<table>
<thead>
<tr>
<th>Degree</th>
<th>Trauma</th>
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<tr>
<td>Intact</td>
<td>No trauma to the vaginal area or perineum noted. No suturing required</td>
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<tr>
<td>Grazes</td>
<td>Superficial splits of the vaginal walls/labia or perineal skin, these rarely requiring suturing.</td>
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<tr>
<td>Labial</td>
<td>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</td>
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<tr>
<td>First</td>
<td>Superficial lacerations to the vaginal and perineal skin only. Suturing to be considered and assessed on an individual basis.</td>
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<tr>
<td>Second</td>
<td>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</td>
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<tr>
<td>Third</td>
<td>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</td>
</tr>
<tr>
<td>Fourth</td>
<td>Complete disruption of the external and internal anal sphincter complex and the anal epithelium</td>
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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 Currently grazes and labial tears are assessed on an individual basis, if there is no bleeding and the skin edges are well opposed there is no need to suture.

6.2 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.

6.3 Bilateral labial tears will need to be sutured to avoid the skin healing together.

6.4 Seek advice from the Labour Ward Co-ordinator or registrar/consultant on call if in doubt.

6.5 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 complete the perineal repair section of the notes.

7.0 Assessment and Management of First Degree Tear

7.1 Suturing to be considered and assessed on an individual basis.

7.2 Complete the perineal assessment section for all women and document accordingly in the Labour Care and Baby Delivery Record.

8.0 Assessment and Repair of Episiotomy and Secondary Degree Tear

8.1 All second degree tears and episiotomies are to be sutured.

8.2 If suturing is declined, ensure a clear rational of the benefits of suturing has been given 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;
- Red needle (drawing up lidocaine)
- 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.

8.5 Complete perineal assessment section for all women as appropriate and document in the Labour Care and Baby Delivery Record.

9.0 Procedure

9.1 This is a sterile procedure (refer to the ‘Policy for standard infection prevention precautions’; register number 04071).

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

9.3 Entonox should always be offered and available prior to commencing the procedure.

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

9.5 Carefully visualise tear/episiotomy; identify landmarks (i.e. hymen ring) prior to commencement of suturing. This will facilitate correct tissue realignment.

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

9.7 Infiltrate perineal tear with 1% lidocaine 20 mls (as per PGD). 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 topped up prior to suturing.

9.9 If a patient reports inadequate pain relief at any point, stop suturing and address this immediately.

10.0 Technique

10.1 A continuous non-locking suturing technique used to oppose each layer but interrupted may be used if clinical judgement requires. Rational must be documented in healthcare record.

10.2 Tie off separately any bleeding points with a loop of suture. If haemostasis cannot be achieved call for a prompt 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.

10.8 A continuous non-locking suturing is associated with less short-term pain compared to the traditional interrupted method.

11.0 Completion

11.1 Check vagina- ensure it easily admits 2 fingers.

11.2 Perform a rectal examination to check for any sutures that may have penetrated the rectal mucosa. Inform the obstetric registrar if any concerns are identified.

11.3 Consider voltarol® 100mg per rectum for analgesia if there are no contraindications.

11.4 Clean the perineum and place a sterile pad in situ.

11.5 Legs should be carefully supported out of lithotomy with the aid of a second person.

11.6 Needles, swabs and instruments counts should be completed with a second person. IMS scan track identification stickers should be placed into the relevant section of the labour notes.

11.7 Complete perineal assessment section for all women as appropriate and document in the Labour Care and Baby Delivery Record.

11.8 The following information should be given and documented;

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

12.0 In the Community

12.1 Ensure adequate pain-relief and lighting.
12.2 Suture to the level of competency. 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
(Refer to Appendix B)

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. The data highlights approximately 30% of patients who suffer a third or fourth degree tear develop faecal incontinence at some point in later life.

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 Obstetric Anal Sphincter Injury (OASIs) – Third and Fourth 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 primigravida patients and after instrumental deliveries.

14.2 Consider an episiotomy if imminent severe tearing is suspected. Episcissors 60 should be used where possible. All episiotomies should be performed mediolaterally.

14.3 The risk factors for OASIs are:

- Macrosomia – greater than 4kg;
- Persistent occipitoposterior position;
- Primigravida;
- Induction of labour;
- Epidural analgaesia;
- Prolonged second stage (greater than 1 hour);
- 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.

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Assessment and Repair of Perineal Trauma/07066/7.0
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 the 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**

- 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.

15.9 **Post procedure**

- DATIX all 3rd and 4th degree tears at the time of the incident. Ensure the correct grade of trauma is highlighted in the DATIX;
- The woman’s details should be recorded in the OASis folder, kept in Recovery. This is to aid the Perineal Health Specialist Midwife in keeping an accurate record of all women who sustain trauma for follow-up;
- 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 should be given as per Trust Microguide 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 or poor bowel control 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.
- Women can also contact the Specialist Midwife for Perineal Health if they require further detailed support or advice in the postnatal period via email – perinealhealth@meht.nhs.uk
- When possible all women should be seen by the Women’s Health 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 given a pelvic floor exercise plan and given reassurance and advice on how to open their bowels.
- During the postnatal period, if there are any problems a direct referral to the specialist midwife for perineal health can be made or to the women’s health physiotherapist can be made by the Midwife by contacting the Specialist Midwife for Perineal Health via email perinealhealth@meht.nhs.uk.
- A 12 week postnatal appointment should be made in the Perineal Assessment Clinic for all women sustaining an OASi.
- Women who sustain a 3A tear will be seen in the Perineal Assessment Clinic by the specialist Midwife for Perineal Health. 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 in the Perineal Assessment Clinic by the Consultant Gynaecologist and Urogynaecologist. Women should be booked into clinic PKFPTB (Consultant initials; perineal trauma booking). The Consultant Perineal Assessment Clinic occurs on the 1st and 3rd Thursdays of every month.
- The postnatal discharge midwife should ensure the woman has received the Patient Information Leaflet, ‘Care of your perineum following 3rd and 4th degree tears’ and document this.

16.0 Management of Subsequent Pregnancy and Delivery

16.1 All women with previous history of an OASi (3rd/4th degree tear) should be referred to the Perineal Assessment Clinic between 28-34 weeks for individual assessment and discussion surrounding mode of delivery. Women should be booked into clinic PKFPTB. The Perineal Assessment 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 Assessment Clinic.

16.4 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. Women should be given the patient information leaflet entitled ‘Antenatal perineal massage’.

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

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

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

16.8 There is no evidence that prophylactic episiotomy prevents a recurrence of sphincter tear 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.

17.2 Following completion of the procedure, Lorenzo should be completed accordingly.

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.
- IMS scan track stickers

17.4 The postnatal/ discharge midwife should ensure the woman has received the Patient Information Leaflet, ‘Care of your perineum following 3rd and 4th degree tears’ and document this.
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 Development Midwife. (Refer to Appendix A)

18.2 Band 6 midwives and above are normally deemed competent to undertake perineal repair (excluding OASis). An electronic database recording competency status will be maintained by the Practice Development Midwife 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. Mandatory updates in the area of perineal health occur on an annual basis. Additional training and suturing updates are available throughout the year on a rolling programme.

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 Professional Midwifery Advocates

19.1 Professional Midwifery Advocates provide a mechanism of support and guidance to women and midwives. Professional Midwifery Advocates are experienced practising midwives who have undertaken further education in order to supervise midwifery services and 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 Specialist Midwife for Perineal Health 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.

25.0 References


Appendix A

Perineal Suturing Competencies Checklist

Name of Practitioner………………………………………………………………………………………………………

Qualified…………………………………………………………………………………………………………………………

<table>
<thead>
<tr>
<th>Date</th>
<th>Signature, Print and Designation</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Attended perineal repair workshop and obtained certificate

<table>
<thead>
<tr>
<th>Date</th>
<th>Signature, Print and Designation</th>
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</tbody>
</table>

Observed perineal repair

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

<table>
<thead>
<tr>
<th>Observed by</th>
<th>Date</th>
<th>Signature Name and Designation</th>
<th>Hospital number to use for auditing own repairs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
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<tr>
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<td></td>
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<tr>
<td>5</td>
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</tbody>
</table>
### Competence Checklist

<table>
<thead>
<tr>
<th>Demonstrate an increased knowledge base of perineal and anal muscles</th>
<th>Signature of Assessor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates rational for suturing and when to and when not to suture</td>
<td>Signature of Assessor</td>
</tr>
<tr>
<td>Assesses and classifies trauma appropriately</td>
<td>Signature of Assessor</td>
</tr>
<tr>
<td>Performs anal sphincter examination pre and post suturing</td>
<td>Signature of Assessor</td>
</tr>
<tr>
<td>Demonstrates aseptic technique</td>
<td>Signature of Assessor</td>
</tr>
<tr>
<td>Performs suturing in line with guideline technique</td>
<td>Signature of Assessor</td>
</tr>
<tr>
<td>Documents appropriately following repair</td>
<td>Signature of Assessor</td>
</tr>
</tbody>
</table>

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

If competence is 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

Management of Third and Fourth Degree Tear/ Severe Perineal Trauma

Severe perineal trauma (i.e. deep posterior vaginal wall trauma etc)

Hospital follow up at 3/12 in Perineal Trauma Clinic.

3rd/4th degree tear

Anorectal test, endosonography and manometry

Asymptomatic

Avoid traumatic delivery
Experienced person available for delivery

Mild symptoms

Conservative management
Dietary advice
Bulking agents
Constipating agents (Codeine Phosphate and Loperamide)
Physiotherapy and biofeedback

Severe symptoms
Large defect (greater than one quadrant)/low pressures
Secondary sphincter repair

Traumatic delivery anticipated
Macrosomic baby
OP position
Slow progress in labour

Offer caesarean section
# Appendix C: Preliminary Equality Analysis

This assessment relates to: Assessment and Repair of Perineal Trauma (07066)

<table>
<thead>
<tr>
<th>A change in a service to patients</th>
<th>A change to an existing policy</th>
<th>A change to the way staff work</th>
</tr>
</thead>
<tbody>
<tr>
<td>A new policy</td>
<td>Something else (please give details)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What are you proposing to change?</td>
<td>Full Review</td>
</tr>
<tr>
<td>2. Why are you making this change? (What will the change achieve?)</td>
<td>3 year review</td>
</tr>
<tr>
<td>3. Who benefits from this change and how?</td>
<td>Patients and clinicians</td>
</tr>
<tr>
<td>4. Is anyone likely to suffer any negative impact as a result of this change? If no, please record reasons here and sign and date this assessment. If yes, please complete a full EIA.</td>
<td>No</td>
</tr>
<tr>
<td>5. a) Will you be undertaking any consultation as part of this change? b) If so, with whom?</td>
<td>Refer to pages 1 and 2</td>
</tr>
</tbody>
</table>

Preliminary analysis completed by:

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annabel Petrus</td>
<td>Senior Midwife</td>
<td>June 2019</td>
</tr>
</tbody>
</table>