

<b>MANAGEMENT OF EPISIOTOMY</b>	<b>CLINICAL GUIDELINES</b> <b>Register No: 07045</b> <b>Status: Public</b>
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Contributes to CQC Regulation	9, 12

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<b>Policy to be followed by (target staff)</b>	<b>Midwives, Obstetricians, Paediatricians</b>
Distribution Method	Intranet & Website. Notified on Staff Focus
Related Trust Policies (to be read in conjunction with)	04071 Standard Infection Prevention 04072 Hand Hygiene 06036 Guideline for Maternity Record Keeping including Documentation in Handheld Records 07066 Assessment and Repair of Perineal Trauma 04260 Guideline for the Management of Operative Vaginal Delivery 09062 Mandatory training for Maternity Services (incorporating training needs analysis)

**Document History Review:**

Review No	Reviewed by	Active Date
1.0	Sarah Moon	March 2010
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## **INDEX**

- 1. Purpose**
- 2. Equality and Diversity**
- 3. Indications**
- 4. Technique**
- 5. Repair of Episiotomy**
- 6. Staff and Training**
- 7. Supervisor of Midwives**
- 8. Infection Prevention**
- 9. Audit and Monitoring**
- 10. Guideline Management**
- 11. Communication**
- 12. References**

## **1.0 Purpose**

- 1.1 This guideline is designed to aid maternity staff on when it is necessary to perform an episiotomy on a labouring patient and how to perform an episiotomy according to evidence-based research.

## **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 Indications**

- 3.1 There is little evidence to support routine episiotomy for labouring patients. At present, the research available state that routine episiotomy is of no advantage to a patient and therefore a clinical need should be identified before one is carried out.
- 3.2 An episiotomy should be considered/ performed if suspected maternal and/or fetal compromise and delivery needs to be expedited
- 3.3 An episiotomy should be performed if there is clinical indication, such as; suspected fetal compromise, shoulder dystocia to aid with performing internal manoeuvres or when there is anticipation of significant perineal and or rectal trauma.
- 3.4 The role of episiotomy for operative vaginal delivery should be evaluated on an individual basis pertaining to each case.  
(Refer to the 'Guideline for the management of operative vaginal delivery'. Register number 04260)
- 3.5 Episiotomy should not be offered routinely at a vaginal birth following previous third or fourth degree trauma.
- 3.6 Patients with infibulated genital mutilation should be informed of the risks of delay in the second stage and spontaneous laceration together with the need for an anterior episiotomy and the possible need for defibulation in labour.  
(Refer to the 'Guideline for the management of operative vaginal delivery'. Register number 04260)

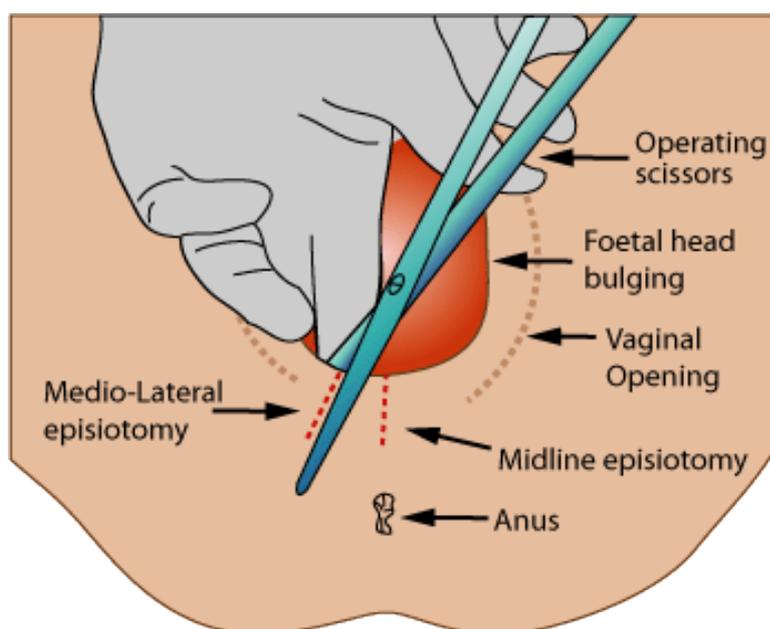
## **4.0 Technique**

- 4.1 The incision to be used is the mediolateral incision as it avoids the sphincter (therefore reducing the incidence of the episiotomy extending to a 3<sup>rd</sup> or 4<sup>th</sup> degree tear compared to the medial incision) and Bartholin's gland.
- 4.2 Before an episiotomy can be performed, the patient's informed consent needs to be obtained and documented in the health care records. The member of staff responsible for the patient should also ensure that the patient has no known allergy to lidocaine.
- 4.3 Infiltration of the perineum:
- If there is time and the patient can safely have lidocaine, then 10ml of 0.5% or 5ml of 1% lidocaine should be drawn up

- Two fingers enter the vagina along the proposed line for the episiotomy, to protect the presenting part prior infiltration
- Using a green needle insert the needle into the middle (downwards) of the fourchette. Slowly withdraw the plunger of the syringe to ensure that the needle has not entered a vein, if blood is aspirated, reposition the needle until no blood is withdrawn. Release one third of the lidocaine as the syringe is partially withdrawn from the fourchette
- Before the needle is completely removed from the fourchette tilt it so it is at the position where the incision will be made and again inject a third of the lidocaine. Finally, tilt the syringe to the other side of the proposed incision and give the final dose of lidocaine. This ensures that there is a semi-fanned anaesthetised area where the episiotomy is to be performed. Also, with only one site of entry for the needle, the risk of infection is reduced.
- Tested effective analgesia should be provided prior to carrying out an episiotomy, except in an emergency due to acute fetal compromise

#### 4.4 Incision of the perineum:

- Two fingers enter the vagina along the proposed line for the episiotomy, to protect the presenting part prior and during insertion of curved, blunt ended mayo scissors.



- A pair of mayo scissors (or a pair of blunt-ended scissors with sharp curved blade) should be used to ensure a clean cut
- The scissors should enter the vagina at the middle of the fourchette (as with the green needle) and then be directed at a 45 degrees, so it is halfway between the ischial tuberosity and the anus; and usually directed to the right side.
- The cut should be made when the presenting part is directly on the forchette, superficial muscles and skin of perineum (if not the episiotomy will fail to release the presenting part)

- Timing of the episiotomy is also important. If the procedure is undertaken too early, the presenting part will not be pressing on the perineum, and therefore complications associated with increased bleeding may occur
- The cut should also be done at the height of a contraction, when the tissues are stretched the most and with pressure of the presenting part bleeding is more likely to be less severe
- The cut should be four to five centimetres long and birth of the presenting part should follow immediately and therefore its advance needs to be controlled to avoid the episiotomy from extending

4.5 Document in either the Labour Care and Baby Delivery Record; or the Operative Delivery Care Record the indication for performing an episiotomy, the pain relief administered the technique and type of incision performed.

## **5.0 Repair of Episiotomy**

(Refer to the guideline for 'Assessment and repair of perineal trauma'. Register number 07066)

## **6.0 Staffing and Training**

6.1 An episiotomy should only be performed by a qualified member of staff who is competent (i.e. staff who have completed all their required competences) in carrying out an episiotomy. Staff wishing to gain their competences can perform episiotomies while under the supervision of an experienced member of staff.

6.2 All midwifery and obstetric staff are fully trained to perform episiotomy and it falls under their responsibility to adhere to Trust guidelines and best practice when performing an episiotomy. The practice development midwife regularly holds perineal repair workshops which include topics such as anatomy and physiology; and injuries to the perineum. All midwives and obstetricians should attend this workshop to ensure that their skills and knowledge are maintained.

(Refer to guideline for 'Mandatory training services (incorporating training needs analysis)'. Register number 09062.

6.3 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

## **7.0 Supervisor of Midwives**

7.1 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.

## **8.0 Infection Prevention**

8.1 All staff should follow Trust guidelines on infection prevention by ensuring that they

effectively 'decontaminate their hands' before and after each procedure.

- 8.2 All staff should ensure that they follow Trust guidelines on infection prevention. All invasive devices must be inserted and cared for using High Impact Intervention guidelines to reduce the risk of infection and deliver safe care. This care should be recorded in the Saving Lives High Impact Intervention Monitoring Tool Paperwork (Medical Devices).

## **9.0 Audit and Monitoring**

- 9.1 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.
- 9.2 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.
- 9.3 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.
- 9.4 Key findings and learning points from the audit will be submitted to the Clinical Governance Group within the integrated learning report.
- 9.5 Key findings and learning points will be disseminated to relevant staff.

## **10.0 Guideline Management**

- 10.1 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.
- 10.2 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.
- 10.3 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.
- 10.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for future training needs will be met using methods such as 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

## **11.0 Communication**

- 11.1 A quarterly 'maternity newsletter' is issued to all staff to highlight key changes in clinical practice to include a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly. Midwives that are on maternity leave or 'bank' staff have letters sent to their home address to update them on current clinical changes.
- 11.2 Approved guidelines are published monthly in the Trust's Staff Focus that is sent via email to all staff.
- 11.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.
- 11.4 Regular memos are posted on the guideline and audit 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.

## **12.0 References**

National Institute for Health and Clinical Excellence, Intrapartum care; care of healthy women and their babies during childbirth (2014) CG190 London. December.

Royal College of Midwives (2012) 'How to perform an episiotomy'. Midwives. Issue 5. RCM: London

National Collaborating Centre for Women's and Children's Health (2007) Intrapartum care: care of healthy women and their babies during childbirth. NICE: UK