Royal Devon University Healthcare NHS Foundation Trust

Workplace Support for Midwives

Reference Number: RDF1503-23
Date of Response: 09/05/23

Further to your Freedom of Information Act request, please find the Trust's response(s) below:

Please be aware that the Royal Devon University Healthcare NHS Foundation Trust (Royal Devon) has existed since 1st April 2022 following the integration of the Northern Devon Healthcare NHS Trust (known as Northern Services) and the Royal Devon and Exeter NHS Foundation Trust (known as Eastern Services).

1. Please could you outline the types of support that would be offered to midwives when they have been involved in a traumatic or difficult birth, or a birth involving the loss of a mother or baby.
   A variety of support is offered such as TRiM (Trauma Risk Management), Hot (at time of incident) and Cold debrief (includes a date to suit staff involved), PMA support and supervision. There is also employee support and counselling services available to all staff as well as one to one with line manager.

2. Please could you outline the specific types of support including any psychological support is offered to midwives when women have a severe perineal tear.
   No specific perineal tear psychological support, however all support mentioned above in answer to question 1 can be offered. Ad hoc suturing support is available if needed/requested.

3. Would an individual midwife be sent this information following this experience or is the support available and the midwife would need to choose which support to access?
   This would depend on the incident. Support is offered or made available on a case by case basis.

4. Please could you send me a copy of your Unit guideline that relates to perineal care during and following the birth of a baby.
   Please see attached.

5. Does your Unit follow the Obstetric Anal Sphincter Injury (OASI) care bundle?
   Not currently however plans in place to implement

Document Control

Title			
Care and Repair of Perineal Trauma after Childbirth Guidelines Guideline			
Author		**Author's job title** Maternity Services Clinical Risk Manager	
Directorate Clinical Support, Community & Specialist Services		**Department** Maternity Services	
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0.2	July 09	Draft	Approved at July MS Guideline Group
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1.0	Feb 10	Revision	Amended to include the recommendations made by the CNST Assessor
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3.0	Nov 2012	Final	Reviewed against new standards by Medical Team. Approved by Maternity Services Guideline Group on 10th October 2012. Table of contents updated.
3.1	Feb 2013	Revision	Title changes of Specialist Risk Midwife to Clinical Risk Manager for the Maternity Services in audit section.
3.2	Sep 2013	Revision	Clarification of training requirements.
3.3	Nov 2016	Re-approval	Approved by Maternity Services Guideline Group 07/11/16 for a period of 6 months to allow for the impact of changes in national guidance to be assessed.
3.4	Sept 2017	Re-approval	Approved by Maternity Services Guideline Group 04/09/17 for a period of 6 months to allow for the impact of changes in national guidance to be assessed and incorporated into local guidance.
4.0	April 2020	Final	Approved by Maternity Specialist Governance Group on 27.05.2020
4.1	May 2021	Revision	Lead Director updated. File name updated. Hyperlink updated. Approved by Maternity Specialist Governance Group on 26th May 2021

<table>
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<tr><td colspan="2">Lead Director
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Not Applicable</td></tr>
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• Obstetricians and Gynaecologists
• Women’s and children’s Directorate Management</td></tr>
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Antenatal clinic /Policies and Guidelines
Filename
Care & repair of perineal trauma after childbirth guideline v5.0 May 21</td></tr>
<tr><td colspan="2">Policy categories for Trust’s internal website (Bob)
Maternity Services</td><td>Tags for Trust’s internal website (Bob)</td></tr>
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CONTENTS

1 Purpose

1.2. The purpose of this document is to ensure adherence to evidence-based practice. This document has been prepared using evidence from the National Institute for Health and Clinical Excellence (NICE); the Royal College of Obstetricians & Gynaecologists (RCOG); the Royal College of Midwives (RCM) and the National Library for Health

1.3. The policy applies to all staff employed within Maternity Services.

1.4. Implementation of this policy will ensure that a consistent approach is taken to:

- Inspect the perineum, vagina, anus and rectum after childbirth.
- Effect perineal, vaginal, anal and rectal repair.
- Document the care and advice given.

2. Definitions

Definition of Perineal Trauma

Perineal trauma is defined as injury to the labia, vagina, urethra, clitoris, perineal muscles or anal sphincter[1]

First degree	Injury to perineal skin only.
Second degree	Injury to perineum involving perineal muscles but not involving anal sphincter
Third degree	Injury to perineum involving the anal sphincter complex: 3a. Less than 50% of EAS* thickness torn 3b. More than 50% of EAS* thickness torn 3c. Both EAS* and IAS* torn
Fourth degree	Injury to perineum involving the anal sphincter complex (EAS and IAS) and anal epithelium

*Internal/External Anal Sphincter

Definition of Episiotomy

An episiotomy is a surgical incision in the perineum to expedite vaginal delivery or to control perineal tearing.

3. The purpose of Care and Repair of the Perineal Trauma after Childbirth

Perineal trauma can have a significant adverse impact on a woman's short and long term health. Failure to correctly identify and repair perineal damage can lead to physical, psychological, sexual and social dysfunction.

Inadequate repair of the perineum may lead to increased bleeding; higher rates of infection; more pain; urinary and faecal incontinence.

Failure to identify perineal trauma or sub-optimal management may have a lasting effect on the woman and may expose the Trust to risk of litigation

Predisposing factors

Clinicians should be vigilant to factors that lead to a greater risk of perineal trauma3

- Birthweight over 4kg
- Persistent occipito-posterior position
- Nulliparity
- Induction of labour
- Epidural analgesia
- Shoulder dystocia
- Midline episiotomy
- Instrumental delivery

Assessment of Perineal Trauma

All women who have had a vaginal delivery should undergo perineal assessment with consent.

Before assessing the perineum for trauma, the healthcare professional will:

- Give a full explanation for the examination and its objectives
- Offer adequate analgesia
- Optimise maternal positioning and ensure good lighting

Perineal examination must be undertaken gently and in a sensitive manner, conducive to the woman's preferences. Practitioners must consider changing gloves prior to examination.

Assessment must be made in a systematic manner, visualising the external and internal structures. Practitioners must inspect the following, noting any trauma, its extent and the structures involved:

- Fourchette
- Labia majora
- Labia minora
- Clitoris
- Urethra
- Posterior vaginal wall
- Anterior vaginal wall
- Anus

If there is any suspicion that the perineal muscles are damaged, assessment of genital trauma should include a rectal (PR) examination to assess whether there has been any damage to the external or internal anal sphincter and look for button-hole tears in the vagina.

The timing of this systematic assessment should not interfere with mother–infant bonding unless the woman has bleeding that requires urgent attention.

The woman should usually be in lithotomy position 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.

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

The systematic assessment and its results should be fully documented, possibly pictorially on page 18 of the Perinatal Institute 'Birth Notes'.

Perineal Repair

Clinicians who undertake repair of the perineum must be able to demonstrate their competence. Repair of 3rd and 4th degree tears will be conducted by a senior doctor - SAS grade or above.

Consent for perineal repair must be obtained and documented on page 18 of the Perinatal Institute 'Birth Notes'.

Repair of the perineum should be undertaken as soon as possible to minimise the risk of infection and blood loss.

Perineal repair should only be undertaken with tested effective analgesia in place using infiltration with up to 20 ml of 1% lidocaine or equivalent, or topping up the epidural (spinal anaesthesia may be desirable, irrespective of the operator). If the woman reports inadequate pain relief at any point this should immediately be addressed.

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.

Women should be advised that in the case of second-degree trauma, the muscle should be sutured in order to improve healing. If the skin is apposed following suturing of the muscle in second-degree trauma, there is no need to suture it.

Where the skin requires suturing a continuous subcuticular technique is recommended. Interrupted sutures may be more suitable where infection is suspected; where there is poor haemostasis; or where there is suspected difficulty in opposing tissue.

Perineal repair should be undertaken with an absorbable synthetic suture material (Vicryl Rapide 2/0) using a continuous non-locked suturing technique for the vaginal wall and muscle layer.

Rectal non-steroidal anti-inflammatory drugs should be offered routinely following perineal repair of first- and second-degree trauma provided these drugs are not contraindicated.

The following must be observed when performing perineal repair:

Perineal trauma should be repaired using an aseptic technique.

Equipment should be checked and swabs and needles counted before and after the procedure.

Good lighting is essential to see and identify the structures involved.

Difficult trauma should be repaired by an experienced practitioner in theatre under regional or general anaesthesia. An indwelling catheter should be considered for 24 hours to prevent urinary retention.

Good anatomical alignment of the wound should be achieved, and consideration given to the cosmetic results.

Rectal examination should be carried out after completing the repair to ensure that suture material has not been accidentally inserted through the rectal mucosa.

Following completion of the repair, an accurate detailed account should be documented on page 18 of the Perinatal Institute 'Birth Notes', covering the extent of the trauma, the method of repair and the materials used including a swab count, needle count and tampon count.

Information should be given to the woman regarding the extent of the trauma, pain relief, diet, hygiene and the importance of pelvic-floor exercises. Some women may need further support and assurance following the repair from the appropriate health professional regarding extent of the trauma and recovery, these discussions and the giving of the information must be documented.

Principles of Perineal Repair

Check the extent of the trauma by thoroughly examining the vagina and perineum to establish the extent of the trauma, this is achieved using x-ray detectable swabs. Cotton wool balls must not be used.

A rectal examination should be performed as part of the assessment.

Suture as soon as possible after delivery - it is less painful and reduces the risk of infection. Following a water birth it is advisable to delay suturing for 1 hour following the birth.

Good lighting is essential to carry out the repair to visualise and identify the structures involved.

Handle tissue gently using non-toothed forceps.

Ensure good anatomical restoration and alignment to facilitate healing.

Close all dead space – ensure haemostasis and prevent infection.

Use minimal amount of suture material, and do not over tighten suture or knots. This may impede healing.

Following the repair a rectal examination should be performed to ensure no suture material has been inserted through the rectal mucosa.

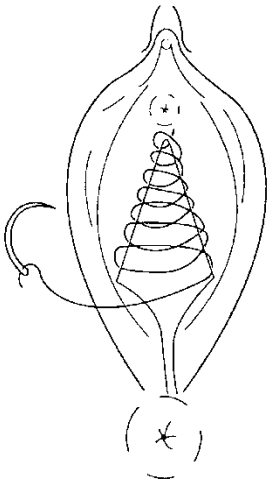
Advise women about perineal hygiene and pelvic floor exercises.

Method of Perineal Repair

A loose, continuous non-locking suturing technique used to appose each layer, is associated with less short-term pain compared with the traditional interrupted method.

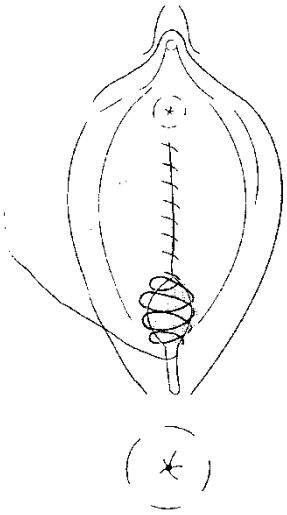
Step 1 Suturing the vaginal wall

Identify the apex.
Insert the anchoring suture 0.5 cm above the apex.
Repair the vaginal wall with a continuous non-locking stitch with approximately 0.5cm between each stitch.
Continue to suture until the hymenal remnants are reached, ensuring sutures are not placed in the hymenal remnants.
Place the needle behind the hymenal remnants and emerge in the centre of the perineal muscle.



Step 2 Suturing the perineal muscle

Check the depth of the trauma.
Repair the perineal muscles in one or two layers with the same continuous stitch.
Ensure the muscle edges are apposed carefully leaving no dead space.
Visualise the needle between sides to prevent stitches being inserted into the rectal mucousa.
On completion of the muscle layer, the skin edges should align so that they can be brought together without tension.



Step 3 Suturing the skin

Reposition the needle.
Commence sub-cuticular suturing of the skin from the end of the wound nearest to the anus.
Stitches are placed below the surface of the skin, the point of the needle should be repositioned between each side, so that it faces the skin edge being sutured.
Continue taking bites of tissue from each side until the superior wound edge is reached.

Hyperlink: Sub-cuticular repair

Sweep the needle behind the fourchette back into the vagina. Pick up a small amount of vaginal tissue to tie off the stitch and cut (the knot is formed inside the vagina to minimise discomfort).

Alternatively, the repair may be completed using the “Aberdeen” knot. The ‘Aberdeen knot’ is a method to secure that ensures that the knot is completely inverted in the mucosa with minimal knot bulk at the surface.

Link: Aberdeen knot

Immediate Post-operative Care

Inspect the repair to check that haemostasis has been achieved. NB – an excessive amount of suture material may well cause severe discomfort in the puerperium and beyond.

Only carry out the required amount of suturing to achieve haemostasis. Remove the vaginal tampon, if used, and account for all instruments, swabs and needles – discard sharps safely. Record same in the Perinatal Institute notes.

Perform a rectal examination following completion of the repair to detect any suture material which may have been accidentally inserted through the rectal mucosa.

Diclofenac Sodium 100mg may be given PR, if no contraindications exist. Remove woman's legs from lithotomy position. Make the woman comfortable.

Document repair in the Maternity Record and document the administration of local anaesthetic and Diclofenac Sodium on the Drug Administration chart.

Any difficulty experienced in suturing should be documented in the labour notes, e.g. excessive bleeding, friable tissue, or haematoma.

Explain the extent of trauma and advise the woman with regard to hygiene and pain relief associated with perineal trauma.

Additional notes

Where a woman is subsequently readmitted for secondary perineal repair and/or referred to a Gynaecologist with problems relating to all types of perineal repair a Datix incident report should be completed for review by the Maternity Risk Manager; processed and escalated in line with the risk management process and trigger the audit process.

Where there is a suspicion of Female Genital Mutilation (FGM) or trauma to the genitalia inconsistent with obstetric trauma, referral to a consultant obstetrician or gynaecologist should be made. FGM is a criminal offence in the UK. There is a mandatory duty to report FGM in children under the age of 18. Please seek the Advice of the Named Midwife for Safeguarding Children & Young People.

There is a mandatory requirement for health care professionals to submit their FGM data for both children and adults via the Health & Social Care Information Centre. Further details can be accessed on their website: http:// www.hscic.gov.uk/FGM.Submission became mandatory for acute trusts, GP practices and mental health trusts in 2015

Management and Care of Third and Fourth Degree Tears

The overall risk of obstetric anal sphincter injury is 1% of all vaginal deliveries. With increased awareness and training, there appears to be an increase in detection of anal sphincter injury.

Obstetricians who are appropriately trained are more likely to provide a consistent, high standard of anal sphincter repair and contribute to reducing the extent of morbidity and litigation associated with anal sphincter injury. Repair of third and fourth degree tears will be conducted by SAS grade doctors or above.

Obstetric anal sphincter repair should be performed by appropriately trained practitioners.

Formal training in anal sphincter repair techniques is recommended as an essential component of obstetric training.

For repair of the external anal sphincter, either an overlapping or end-to-end (approximation) method can be used, with equivalent outcome. Where the IAS can be identified, it is advisable to repair separately with interrupted sutures.

Repair of third and fourth degree tears should be conducted in an operating theatre, under regional or general anaesthesia.

When repair of the EAS muscle is being performed, either monofilament sutures such as polydiaxanone (PDS) or modern braided sutures such as polyglactin (Vicryl®) can be used with equivalent outcome.

When repair of the IAS muscle is being performed, fine suture size such as 3-0 PDS and 2-0 Vicryl may cause less irritation and discomfort.

When obstetric anal sphincter repairs are being performed, burying of surgical knots beneath the superficial perineal muscles is recommended to prevent knot migration to the skin.

Women should be warned of the possibility of knot migration to the perineal surface, with long-acting and non-absorbable suture materials.

Obstetric anal sphincter repair should be performed by appropriately trained practitioners.

Formal training in anal sphincter repair techniques is recommended as an essential component of obstetric training.

The use of broad-spectrum antibiotics is recommended following obstetric anal sphincter repair to reduce the incidence of postoperative infections and wound dehiscence.

The use of postoperative laxatives is recommended to reduce the incidence of postoperative wound dehiscence.

All women should be offered physiotherapy and pelvic-floor exercises for 6–12 weeks after obstetric anal sphincter repair.

If a woman is experiencing incontinence or pain at follow-up, referral to a specialist gynaecologist or colorectal surgeon for endoanal ultrasonography and anorectal manometry should be considered.

A small number of women may require referral to a colorectal surgeon for consideration of secondary sphincter repair.

Women should be advised that the prognosis following EAS repair is good, with 60–80% asymptomatic at 12 months. Most women who remain symptomatic describe incontinence of flatus or faecal urgency.

All women who sustained an obstetric anal sphincter injury in a previous pregnancy should be counselled about the risk of developing anal incontinence or worsening symptoms with subsequent vaginal delivery.

All women who sustained an obstetric anal sphincter injury in a previous pregnancy should be advised that there is no evidence to support the role of prophylactic episiotomy in subsequent pregnancies.

All women who have sustained an obstetric anal sphincter injury in a previous pregnancy and who are symptomatic or have abnormal endoanal ultrasonography and/or manometry should have the option of elective caesarean birth.

When third and fourth degree repairs are performed, it is essential to ensure that the anatomical structures involved, method of repair and suture materials used are clearly documented and that instruments, sharps and swabs are accounted for.

The woman should be fully informed about the nature of her injury and the benefits to her of follow-up. This should include written information where possible.

Women who have had obstetric anal sphincter repair should be offered a review between 6 & 12 weeks postpartum by a consultant obstetrician or gynaecologist or a designated professional with the necessary specialist skills. This appointment will be made via the consultant's secretary prior to discharge from hospital.

4. Education and Training

All relevant healthcare professionals will be able to demonstrate their competence in perineal /genital assessment and repair.

Perineal /genital assessment repair training sessions are offered in-house.

5. Consultation, Approval and Ratification Process

The author consulted with all relevant stakeholders. Final approval was given by the Maternity Specialty Governance Group.

All versions of these guidelines will be archived in electronic format by the author within the maternity team policy archive.

Any revisions to the final document will be recorded on the Document Control Report.

To obtain a copy of the archived guidelines, contact should be made with the maternity team.

6. Monitoring Compliance with and the Effectiveness of the Guideline

Monitoring of implementation, effectiveness and compliance with the Care and Repair of Perineal Trauma Guidelines is the responsibility of the senior clinical/management team.

7. References

- RCOG. Methods and materials used in perineal repair. London: RCOG; 2004. Green-top guideline No. 23.
- Sultan AH. Editorial: Obstetric perineal injury and anal incontinence. Clin Risk 1999;5:193–6.
- RCOG. The management of third and fourth degree perineal tears. London; RGOG; 2007. Green-top guideline No. 29
- Intrapartum care for healthy women and babies clinical guideline [CG190]Published date: December 2014 Last updated: February 2017; https://www.nice.org.uk/guidance/cg190/chapter/recommendations#care-of-the-woman-after-birth
- NHS Quality Improvement Scotland. Perineal repair after childbirth – A procedure and standards tool to support practice development. August 2008; http://www.nhshealthquality.org

8. Associated Documentation

https://www.northdevonhealth.nhs.uk/wp-content/uploads/2020/12/Female-Genital-Mutilation-FGM-Policy.pdf

Royal Devon and Exeter NHS
NHS Foundation Trust

Clinical Guideline for
Repair of Perineal Trauma

Summary

This guideline outlines the process for diagnosis, classification and management of perineal trauma after childbirth.

Key Points

The essential elements of this guideline are:

- How to classify perineal trauma
- Technique of perineal repair
- Specific advice for management of obstetric anal sphincter injury (3rd and 4th degree tears)
- Follow up arrangements for obstetric anal sphincter injury

CONTENTS

1.0 INTRODUCTION

1.1 Perineal trauma can have a major adverse impact on women's health and mismanagement of perineal trauma is a source of obstetric litigation. Long term morbidity associated with anatomically incorrect approximation of wounds or unrecognised trauma to the external anal sphincter can lead to major physical and social problems.

2.0 INTRAPARTUM INTERVENTIONS TO REDUCE PERINEAL TRAUMA

2.1 Warm compression during the second stage can be protective against significant vaginal tears.

2.2 Either the 'hands on' (guarding the perineum and flexing the baby's head) or the 'hands poised' (with hands off the perineum and baby's head but in readiness) technique can be used to facilitate spontaneous birth. Perineal protection at the time of crowning can be protective.

2.3 A routine episiotomy should not be carried out during spontaneous vaginal birth.

2.4 Where an episiotomy is performed, the recommended technique is a mediolateral episiotomy originating at the vaginal fourchette and usually directed to the right side.

2.5 The angle to the vertical axis should be 60 degrees at the time of the episiotomy.

2.6 An episiotomy should be performed if there is a clinical need such as instrumental birth or suspected fetal compromise.

2.7 Tested effective analgesia should be provided prior to carrying out an episiotomy, using 5mls lidocaine 1% except in an emergency due to acute fetal compromise.

2.8 Women with a history of severe perineal trauma should be informed that their risk of repeat severe perineal trauma is not increased in a subsequent birth, compared with women having their first baby.

2.9 Episiotomy should not be offered routinely at vaginal birth following previous third- or fourth-degree trauma.

2.10 Women with infibulated genital mutilation should be informed of the risks of difficulty with vaginal examination, catheterisation and application of fetal scalp electrodes.

2.11 They should also 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.

3.0 CLASSIFICATION OF PERINEAL TRAUMA.

- A first-degree tear involves vaginal skin only. This is the only tear that may not need to be sutured depending on the extent of the tear.
- A second-degree tear involves vaginal skin and perineal muscles.
- A third degree tear involves the anal sphincter. This is sub-divided into
  - 3a – less than 50% of external anal sphincter torn (EAS)
  - 3b – more than 50% of external anal sphincter torn.
  - 3c – internal anal sphincter torn. (IAS)
- A fourth degree tear involves the anal sphincter (EAS and IAS) and rectal mucosa.
- Rectal ‘button hole' tear – if a tear involves the rectal mucosa with intact internal and external anal sphincter complex, it is NOT a fourth degree tear. This should be documented as a rectal button hole tear.
- An episiotomy is a surgical incision of the perineal body to facilitate delivery.

4.0 EDUCATION

4.1 Episiotomies and perineal tears must be repaired by obstetricians or midwives who have been trained and supervised until fully competent.

4.2 Midwifery staff new to the Trust need to provide evidence of competency in suturing e.g. certificate and then be observed by LW Matron or Clinical Facilitators. For midwives who are not competent in suturing they must attend a suturing workshop and then be supervised by a midwife, LW Matron or Clinical Facilitator competent in suturing. Their suturing competency is then assessed by LW Matron, Clinical Facilitator, Registrar or Consultant and signed off. The form is then filed in their personnel file.

4.3 Any staff learning perineal repair must be under direct supervision at all times. It is the duty of the obstetric registrar or consultant on labour ward to supervise SHOs.

4.4 Only very small first degree tears do not need to be sutured.

4.5 Third and fourth degree tears should be performed by appropriately trained practitioners.

4.6 Women who refuse suturing after sustaining perineal trauma must be seen by the consultant or SpR on the labour ward to inform them of the risks of not being sutured. This discussion must be documented within the Electronic Patient Record (EPR) on MyCare.

5.0 NON SUTURING

5.1 The recommendation for leaving first, and particularly second-degree perineal tears is associated with poorer wound healing and non-significant differences in short term discomfort.

5.2 If a woman chooses not to be sutured, evidence of information and advice given must be documented within the EPR. To include:

- Reason for woman not following recommendation for suturing
- Diagram to illustrate the extent of trauma
- Size and depth of tear

- Bleeding
- Apposition of edges
- Maternal healing

5.3 Women on heparin/anticoagulants, low platelets or a bleeding diathesis such as haemophilia, should be advised to accept perineal suturing because of the increased risk of haematoma.

6.0 THE TECHNIQUE OF REPAIR – 1ST & 2ND DEGREE TEARS

6.1 Vicryl Rapide (2/0 gauge on a 35mm taper cut needle) is currently the suture material of choice, as it's tensile strength reduces between 10-14 days, and is completely absorbed by 35-42 days.

6.2 Repair should be undertaken as soon as possible, ideally within an hour of delivery. Document reason for any delay within the EPR. However, suturing of the perineum needs to be delayed by 1 hour if the woman has delivered in water, due to the effects of the tissues being immersed in water.

- Lithotomy position provides good visibility and access unless the woman has severe symphysis pubis dysfunction, when a lateral position is preferable.
- Clean to reduce the risk of infection.
- Carefully examine extent of tear, refer to senior colleague for further advice if unsure.
- Effective analgesia is essential; lidocaine 1% 20mls may be used. If Lidocaine 1% was used to perform the episiotomy then only 15 mls can be used for suturing as the total amount to be administered is 20 mls 1% Lidocaine. If an epidural is in use, it is recommended that it be continued.
- A digital rectal examination is recommended prior to commencing suturing to eliminate 3rd and 4th degree tears that may otherwise be missed.
- Muscle layer can be sutured with interrupted sutures, figure of eight sutures or continuous sutures, prior to commencing the posterior vaginal wall. This reduces the incidence of needle stick injury. The muscle layer may need several layers of sutures depending on the extent of the tear.
- Posterior vaginal wall should be sutured with continuous non-interlocking sutures once the apex has been visualised.
- Perineal skin should be sutured with a subcuticular suture. Subcuticular technique is proven to reduce postnatal perineal pain.
- Vaginal and Rectal examinations must be performed at the end of the procedure.
- **All swabs, instruments and needles must be counted** before and after performing the repair and documented within 'Perineal Trauma' section within the 'delivery summary' on the EPR. All sharps to be disposed of safely.
- All staff must accurately record the suturing by documenting in the suturing proforma.The woman should be given the patient information leaflet ' *Advice about your perineal stitches after giving birth'*

7.0 3RD AND 4TH DEGREE TEARS

7.1 Perineal tears should be correctly classified and this should be documented on the operation note within the EPR. Where there is doubt, it is advisable to classify it to a higher rather than lower grade.

7.2 Repair of 3rd and 4th degree tears should be conducted in an operating theatre without significant delay, ideally within four hours of delivery. Repairs should be performed under regional or general anaesthetic as the sphincter must be relaxed to allow repair without tension.
There are certain circumstances where repair can be performed in the delivery room (such as a situation where the woman has an epidural working well, good light and the theatre is busy) but this decision should only be made by a senior obstetrician.

7.3 The anal mucosa can be repaired with a continuous or interrupted technique using 3-0 polyglactin (vicryl).

The internal anal sphincter (IAS) should be repaired separately using 3-0 PDS (polydioxanone) with interrupted or mattress sutures without overlapping the ends of the IAS.

The external anal sphincter (EAS) should be sutured with 2/0 or 3/0 PDS (polydioxanone). 2-0 polyglactin (vicryl) can be used with equivalent outcomes.

For repair of full thickness external anal sphincter tears, either an overlapping or end to end technique should be usedusing several small sutures. Surgical knots should be buried to prevent knot migration to the skin.

For partial thickness (all 3a and some 3b) tears, an end to end technique should be used.

Then the 2nd and 1st degree parts of the repair should be sutured with Vicryl Rapide.

7.4 A rectal examination should be performed after repair and if sutures have inadvertently been inserted through the anorectal mucosa then these should be removed.

8.0 POST-OPERATIVE CARE FOR 3RD & 4TH DEGREE TEARS

ALL WOMEN SHOULD BE REVIEWED BY A DOCTOR PRIOR TO DISCHARGE FROM THE POSTNATAL WARD OR LABOUR WARD

- Full explanation of injury and repair
- Woman should be advised that prognosis following external anal sphincter injury is good with 60-80% of patients asymptomatic at 12 months.
- A course of laxatives, e.g. Laxido, to prevent constipation and wound dehiscence. Bulking agents should not be given.
- Broad Spectrum Antibiotics for a week
- Regular analgesia.
- The women should be given the patient information leaflet ‘ *Advice about your perineal stitches after giving birth’* and the fact documented on the suturing proforma.
- Review by Obstetric Physiotherapist for advice regarding pelvic floor exercises

9.0 FOLLOW-UP FOR ALL 3RD AND 4TH DEGREE TEARS

9.1 60-80% of women who have sustained a 3rd or 4th degree tear with appropriate repair are asymptomatic 12 months after delivery.

9.2 All women who sustained any 3rd or 4th degree tear should be offered an appointment to the designated perineal clinic which runs fortnightly in GOPD. This should be made for 3 months after delivery and ordered within the EPR prior to discharge if possible.

9.3 At the follow-up, the woman should be asked specifically about symptoms of pain, faecal and flatal incontinence and urgency. The woman should be offered examination.

9.4 All women who have sustained a 3b, 3c or 4th degree tear should be offered ano-rectal clinical measurements.

9.5 Referral to the colorectal team should be considered for any woman who has symptoms or abnormal clinical measurements.

9.6 In order for a woman who has had previous third- or fourth-degree trauma to make an informed choice, discussion with her about the future mode of birth should encompass:

- current urgency or incontinence symptoms
- the degree of previous trauma
- risk of recurrence
- the success of the repair undertaken
- the psychological effect of the previous trauma
- management of her labour
- findings from ano-rectal clinical measurements if previous 3b, 3c or 4th degree tear

9.7 There are no systematic reviews or randomised controlled trials to show the best mode of subsequent deliveries. If a woman is symptomatic or has abnormal clinical measurements then an elective Caesarean Section should be considered.

10.0 EPISIOTOMY

10.1 If an episiotomy is indicated for delivery, careful attention should be given to ensure that a 60 degree angle from the midline is made when the perineum is distended.

10.2 Evidence for the protective effects of episiotomy is conflicting but mediolateral episiotomy should be considered in instrumental deliveries.

10.3 Verbal consent must be obtained for the episiotomy and documented in the EPR.

11.0 DOCUMENTATION

11.1 Consent, suturing procedure and information/discussions should be documented within the EPR.

11.2 If the procedure is performed in theatre a theatre- perineal suturing proforma should be completed within the EPR

12.0 FUTURE MATERNAL MORBIDITY

12.1 All women requiring perineal refashioning within a year of delivery will be identified through surgical coding and from the ongoing third/fourth degree tear audit.

13.0 MONITORING COMPLIANCE WITH THIS GUIDELINE

13.1 Any concern or non-compliance with this guideline that is identified through the investigation of clinical incidents, claims or complaints will be reviewed as per the Trust Policies regarding Incidents, Claims and Complaints, and may result in an audit and/or amendment to the guideline.

13.2 Relevant Policies:

- Incident reporting policy and procedure
- Claims management policy and procedure
- Policy and Procedure for the Management of Complaints, Concerns, Comments and Compliments

14.0 REFERENCES

National Institute for Health and Clinical Excellence. *2007 NICE Intrapartum Guidelines: Care of healthy women and their babies during childbirth*. London.

Methods and materials used in perineal repair. RCOG Guideline No 23. Royal College of Obstetricians and Gynaecologists: 2000 London.

Management of third and fourth degree perineal tears following delivery. RCOG Guideline No 29. Royal College of Obstetricians and Gynaecologists: June 2015 London.

15.0 PUBLICATION DETAILS

Author of Clinical Guideline	Senior Maternity Matron – Hospital Services
Directorate/Department responsible for Clinical Guideline	Child and Women's Health Maternity Department
Contact details	
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Appendix 1

PERINEAL TRAUMA IN BIRTH SUMMARY

Appendix 2

Delivery Room - Perineal Suturing Proforma

Review the Delivery Report for details.

Classification of tears:

- 1st degree: injury to perineal skin only.
- 2nd degree: perineum involving perineal muscles, but not involving the anal sphincter.
- 3rd degree: injury involving the anal sphincter.
    - 3a – less than 50% of external anal sphincter torn (EAS)
    - 3b – more than 50% of external anal sphincter torn.
    - 3c – Internal anal sphincter torn (IAS)

4th degree: involvement of the anal sphincter (EAS and IAS) and rectal mucosa.

Episiotomy: Type of tear: Other tears:	Consent: {RH8 OB Consent:102440001}
Suture material:	Analgesia: {OB Analgesia:102440026}
Local: *** ml	Local type: {OB Local for Suture Repair:102440031}
PR prior to repair: {PR EXAMINATION:1024400025}	

Details of repair

Apex secured: {Yes/No:102440005}	Vaginal mucosa: {Repair:1024400020}
Perineal muscle: {Repair:1024400020}	Perineal skin: {Repair:1024400021}
Labial tear: {Repair:1024400021}	Status of repairer: {RH8 OB MIDWIFE OBS:31496}

Additional details:
***

External Vaginal / Perineal Examination

Haemostatsis: {Yes/No:102440005}	EBL: **Delivery Blood Loss** None
PR exam: {Yes/No:102440005}	PR Diclofenac: {In progress/ordered:14549}
Vaginal pack: {Yes/No:102440005}	If vaginal pack remove: ***

Comfortable throughout: {Yes/No:102440005}	Pain relief ordered: {Yes/No:102440005}
Antibiotics: {Yes/No:31488}	Laxatives:{Yes/No:102440005}

Advice given
Extent of trauma and type of repair: {Yes/No:102440005}
Hygiene: {Yes/No:102440005}
Diet, including fibre: {Yes/No:102440005}
Pain relief: {Yes/No:102440005}
Pelvic floor exercises: {Yes/No:102440005}

Counts

Swabs count before suturing:
Checked by:
Swab count after suturing:
Checked by:

Post-delivery plan

Level of care: {RH8 OB STANDARD HDU:31492}	VTE risk assessed: {Yes/No:102440005}
Uterotonics: {Uterotonics:102440029}	VTE prophylaxis: {VTE Prophylaxis:102440025}
Catheter: {Catheter:102440006}	Follow up required: {Perineal repair follow up:1024400026}
Remove Catheter: {Remove Catheter:31497}	Other: ***

Appendix 3

Theatre - Perineal Suturing Proforma

Date: **Location:**

Name: **DOB:** , **MRN:** **NHS:**

Diagnosis

Procedures

Surgeons

Procedure Summary
Anaesthesia: **ASA:** **Estimated Blood Loss:**
Total IV Fluids: *** mL
Drains:
Staff:

Classification of tears:

- 1st degree: injury to perineal skin only.
- 2nd degree: perineum involving perineal muscles, but not involving the anal sphincter.
- 3rd degree: injury involving the anal sphincter.
    - 3a – less than 50% of external anal sphincter torn (EAS)
    - 3b – more than 50% of external anal sphincter torn.
    - 3c – Internal anal sphincter torn (IAS)
- 4th degree: involvement of the anal sphincter (EAS and IAS) and rectal mucosa.

Episiotomy: Type of tear:	Consent: {RH8 OB Consent:102440001}
Other tears:	Analgesia: {OB Analgesia:102440026}
Suture material:	Local: *** ml
PR prior to repair: {PR EXAMINATION:1024400025}	Local type: {OB Local for Suture Repair:102440031}
Catheter: {Catheter:102440006}	

Counts before suturing

Details of repair

Apex secured: {Yes/No:102440005}	Vaginal mucosa: {Repair:1024400020}
Perineal muscle: {Repair:1024400020}	Perineal skin: {Repair:1024400021}
Labial tear: {Repair:1024400021}	External anal sphincter: {Repair:1024400023}
Internal anal sphincter:{Repair:1024400023} Suture material for sphincter repair: {OB suture material for sphincter repair:102440027}	Anal mucosa: {Repair:1024400023}

Additional details:
***

External Vaginal / Perineal Examination

Haemostatsis: {Yes/No:102440005}	EBL: 22/04/22 00:17 - 22/04/22 12:17 **Delivery Blood Loss** None
PR exam: {Yes/No:102440005}	PR Diclofenac: {In progress/ordered:14549}
Vaginal pack: {Yes/No:102440005}	If vaginal pack remove: ***
Comfortable throughout: {Yes/No:102440005}	Pain relief ordered: {Yes/No:102440005}
Antibiotics: {Yes/No:31488}	Laxatives:{Yes/No:102440005}

Advice given
Extent of trauma and type of repair: {Yes/No:102440005}
Hygiene: {Yes/No:102440005}
Diet, including fibre: {Yes/No:102440005}
Pain relief: {Yes/No:102440005}
Pelvic floor exercises: {Yes/No:102440005}

Counts after suturing

Post-delivery plan

Level of care: {RH8 OB STANDARD HDU:31492}	VTE risk assessed: {Yes/No:102440005}
Uterotonics: {Uterotonics:102440029}	VTE prophylaxis: {VTE Prophylaxis:102440025}
Remove catheter: {Remove Catheter:102440023}	Follow up required: {Perineal repair follow up:1024400026}
Other: ***	

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cc: Medical Record