Aneurin Bevan University Health Board

Perineal Assessment and Repair Following childbirth: Guideline for Midwives

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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Approved by: Clinical Effectiveness Forum | Expiry date: 08/12/2019
Owner: Maternity Services | Policy Number: ABHB/F&T/0694

Contents:

Executive Summary

An estimated 85% of women who have a vaginal birth will sustain perineal trauma, from a spontaneous perineal tear or episiotomy or both (Albers, 2005).
Perineal trauma is defined as injury to the labia, vagina, urethra, clitoris, perineal muscles or anal sphincter. It can occur spontaneously during a vaginal birth, caused by trauma during an assisted delivery or by a surgical incision (episiotomy).

Perineal damage can have a major adverse impact on women's short and long term health. Incorrect repair, failure to recognise the extent of trauma and inadequate pain relief during repair can lead to major physical, psychological and social problems. The assessment and management of perineal trauma is a routine part of maternity care with the majority of first and second degree tears being performed by midwives (NHS QIS, 2008).

The severity of the trauma, skill of the operator, technique of repair and type of suture used for repair can all contribute to the levels of perineal pain that women experience (Kettle and O'Brien 2004). The most common complaint in relation to perineal suturing by women is about the delay in waiting to be sutured that causes anxiety as well as physical discomfort (RCM, 2012)

Current national evidence-based guidelines and Cochrane reviews recommend that second degree perineal tears and episiotomies are repaired using the continuous, non-locking suture technique and rapidly absorbing polyglactin suture material ie vicryle rapide (gauge 2-0 on 36mm tapercut needle (NICE, 2007; Kettle et al, 2007; 2010). Despite these guidelines, there continues to be a variation in the suturing techniques used by individual midwives.

There are also increasing legal implications and rising negligence claims associated with inadequate or incorrectly repaired perineal trauma (NHSLA, 2011). Failure to recognise the degree of injury and carry out a satisfactory repair, according to recommended guidelines, may now result in litigation.

Aims

To ensure midwives are using a consistent high standard of evidence based perineal care in order to minimise short and long term problems encountered by women following childbirth.

Scope

This document will apply to all midwives working in the health board within maternity services. This document cross matches to standard 7 – Safe and Clinically effective Care within the Standards for Health services in Wales (2010)

Roles and Responsibilities

It is the responsibility of every midwife to ensure competence in assessing and suturing perineal trauma. Personal limitations must be recognised and appropriate assistance sought when required. Once competence is gained, midwives have a duty to maintain their skills and keep up to date with new techniques and research evidence (NMC, 2015; RCOG, 2007) Midwives who feel they are not competent should inform their supervisor of midwives or line manager.

Systematic assessment of perineal trauma

Midwives are the lead professional for the majority of normal births and are responsible for the systematic assessment of the external genitalia, vagina and perineum (even if it looks intact) in order to identify the full extent of the trauma sustained. When assessing the perineum a rectal examination should also be carried out, following informed consent, to eliminate damage to the anal sphincter complex (internal and external anal sphincters) (NICE, 2007; RCOG, 2007).

Classification of trauma:

- **First degree** – injury to skin only
- **Second degree** – injury to perineal muscles but not the anal sphincter
- **Third degree** – injury to the perineum involving the anal sphincter complex:
  - **3A** – less than 50% of the external anal sphincter thickness torn
  - **3B** – more than 50% of external anal sphincter thickness torn
  - **3C** – internal anal sphincter also torn
- **Fourth degree** – injury to the perineum involving the anal sphincter complex (external and internal anal sphincter) and anal epithelium

  (Kettle and O'Brien 2004, RCOG Green-top Guideline)

Assessing for genital trauma following childbirth:

- Ensure privacy and maximise dignity through this procedure (MNC code 2015)
- Explain to the woman what you plan to do and why
- Offer inhalational analgesia
- Ensure good lighting
- Position the woman so that she is comfortable and so that the genital structures can be seen clearly (NICE, 2007)
- The timing of the systematic assessment should not interfere with mother-infant bonding unless the woman has bleeding that requires urgent attention (NICE, 2007)
- A rectal examination should be performed, with consent, to assess whether there has been damage to external and internal anal sphincter (NICE, 2007). The midwife inserts the index finger into the woman's rectum and asks her to squeeze. If the external anal sphincter is damaged the separated ends can be seen to retract backwards. As regional analgesia may affect muscle power in the perineum, the muscle bulk of the sphincter should also be palpated between finger and thumb (NHS QIS, 2008)
- Women should be advised that second degree perineal tears and episiotomies are sutured (NICE, 2007)
- If a woman does not wish to have a second degree tear sutured, following full discussion of the possible consequences, a second midwife should confirm the length and depth of the trauma and document the details in the woman's notes (Kettle, 2006)
- It should be established that the degree or trauma requiring repair is within the capabilities of the midwife performing the suturing
- Third and fourth degree tears and other difficult trauma should be repaired by an experienced operator in theatre under regional or general anaesthesia
- The systematic assessment and its results should be fully documented

Principles of perineal repair:

The main principles on which the practice of suturing is based are to control bleeding, minimise the risk of infection, assist the wound to heal by primary intention and achieve correct anatomical alignment. If the wound is left unsutured it will heal by secondary intention which involves the formation of granulation tissue which will

contract to form scar tissue. The RCM / RCOG PEARLS method of perineal suturing is to be followed.

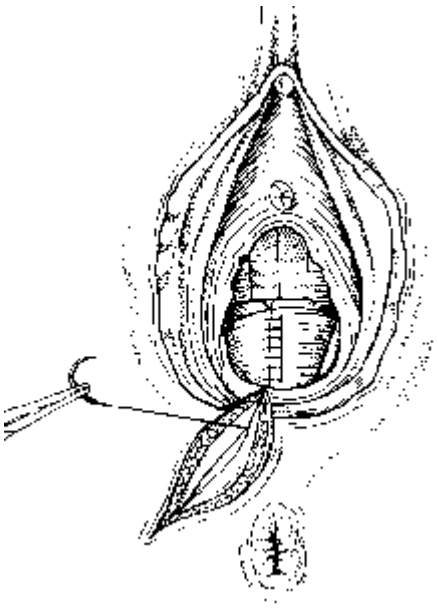
- Explain the procedure to the woman and gain her consent
- Ensure local analgesia is effective
- Suture as soon as possible after delivery as it is less painful and reduces the risk of infection.
- The baby can continue skin to skin contact throughout the procedure
- All swabs, tampons, needles, instruments used should be checked and counted before and after the repair. This check must be documented by date, time and attending staff must sign. Swabs should be X ray detectable
- Maternal observations should be checked before and after the procedure (RCM, 2013)
- The woman should be assisted into a comfortable position that allows good visualisation of the genital structures. It is not always necessary to place the woman in the lithotomy position (NHS QIS, 2008). This position should only be maintained for as long as is necessary for the systematic assessment and repair (NICE, 2007)
- Personal protective equipment should be used eg sterile gloves, sterile gown and visor
- The principles of asepsis should be adhered to throughout
- The vulva and perineal area should be cleansed with sterile water
- Sterile drapes should be placed over the perineal area to create a sterile field
- The wound should be adequately anaesthetised by either topping up a working epidural or by injecting the wound with 20 mls of local anaesthetic (Lidocaine 1%) using aseptic technique
- Suture material used should be vicryle rapide, gauge 2-0 on 36 mm tapercut needle (NICE, 2007). Use minimal suture material
- Perineal repair should be undertaken using a continuous non-locking suture technique for the vaginal epithelium, and muscle layers (NICE, 2007). This is associated with less short term pain compared with the traditional interrupted method

- Continuous subcuticular suture technique should be used for the skin (NICE, 2007)
- Handle tissue gently using non-toothed forceps
- Ensure good anatomical restoration and alignment to facilitate healing
- Close all dead space to ensure haemostasis and prevent infection
- 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, mobilisation, well balanced diet, adequate and regular analgesia and pelvic floor exercises

Repair of the perineal trauma:

Step 1 – Suturing the vaginal wall

- Identify the apex of the vaginal trauma
- Insert the first stitch (anchor) 5 – 10 mm above the apex to secure any bleeding points that may not be visible
- Using the surgeon's square knot secure that first stitch. Cut off the short end of the suture material, leaving about 1 - 2 cms.
- Suture should be placed 5 – 10 mm from the wound edges
- Each stitch should reach the trough of the wound to close any dead space
- Match each stitch on either side of the wound for depth as well as width
- Suture the posterior vaginal trauma using a loose continuous non-locking stitch (usually about 3 to 4 stitches) until the hymenal remnants are reached
- Insert one more stitch to close the hymenal ring.

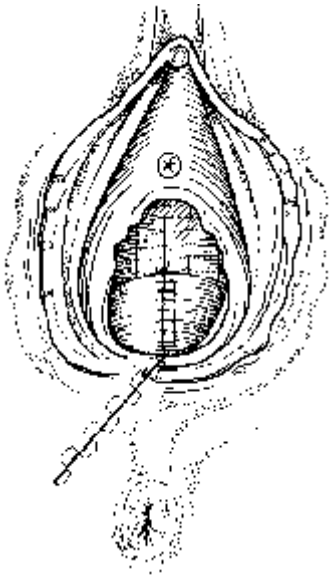


Step 2 – Suturing the perineal muscle layer

- Insert the needle at the level of the fourchette (near to the hymenal ring) to emerge deep in the centre of the muscle layer
- Check the depth of the trauma
- Using a continuous non-locking suture, place each stitch 5 – 10 mm below the wound skin edges and match each stitch for depth as well as width
- Close the perineal muscles in one layer, or if the trauma is very deep use two layers, ending with the needle at the inferior aspect of the trauma
- Ensure the muscle edges are apposed carefully leaving no dead space

Step 3 – Suturing the skin layer

- Reverse the stitching direction at the inferior aspect of the trauma
- Close the perineal skin by inserting fairly deep sutures in the subcutaneous layer
- Each stitch should be placed opposite each other, not pulled too tight and approximately 5 – 10 mm apart
- Complete the repair to the hymenal ring, swing the needle under the tissue into the vagina behind the hymenal remnants
- Complete the repair by using a loop or Aberdeen knot
- Check and count all equipment used and document



Immediate post operative care

- Inspect the repaired perineal trauma to ensure it has been anatomically aligned correctly and that haemostasis has been achieved
- A vaginal examination should be performed ensuring that two fingers can easily be inserted into the vagina
- A rectal examination should be carried out (with consent) to confirm that no sutures have penetrated the rectal mucosa
- Non- steroidal anti-inflammatory drugs (NSAIDs) eg diclofenac acid 100mgs may be administered per rectum if no contra-indications (Hedayati, 2003)
- The perineal area should be cleaned with sterile water and sanitary pad placed over the vulva
- Assist the woman into a comfortable position
- Check uterine contractibility and lochia
- Inform the woman of the exact extent of the trauma and the nature of the repair
- Midwives should discuss with women the importance of good personal hygiene necessary to avoid genital tract infection (CMACE 2011)
- Document the repair and the procedure in the woman's notes using a diagram to illustrate the extent of the trauma and location of sutures. Record any difficulty experienced in suturing eg excessive bleeding, friable tissue, bruising etc. Record also that the procedure was explained and consent obtained. All documentation should meet the requirements of NMC (2010)

- The woman should be given information on who to contact if there are any short or long term postnatal health problems (Bick et al, 2010)

Training

Midwives must be appropriately trained to ensure that they provide a consistently high standard of evidence based perineal care. It is therefore recommended that all relevant healthcare professionals should attend training in perineal/genital assessment and repair, and ensure that they maintain these skills (NICE, 2007). There is some evidence that surgical skills laboratory teaching when compared to traditional teaching alone can improve the knowledge and performance of episiotomy repair (Banks et al 2006). Periodic perineal assessment and suturing training is also available in ABUHB.

A '*Repair of Perineal Trauma by Midwives: Assessment of Competence Framework'* is used in ABUHB which aims to provide a structured approach to supporting midwives develop and achieve competence with repair of perineal trauma, based on up to date guidelines and standard of assessment. It is intended for newly qualified band 5 midwives, Return to Practice midwives and any other midwives who require assessment of competency with regards perineal suturing. Training needs should be identified with your Line Manager or Supervisor of Midwives.

Audit

This guideline will be monitored via the local risk management team in respect of postnatal readmissions or referrals for sepsis and wound dehiscence. Documentation of perineal suturing will be audited via the annual Supervisor of Midwives case notes audit

Appendix 1
Perineal Suturing Following Spontaneous/Instrumental Vaginal Delivery

Addressograph Here

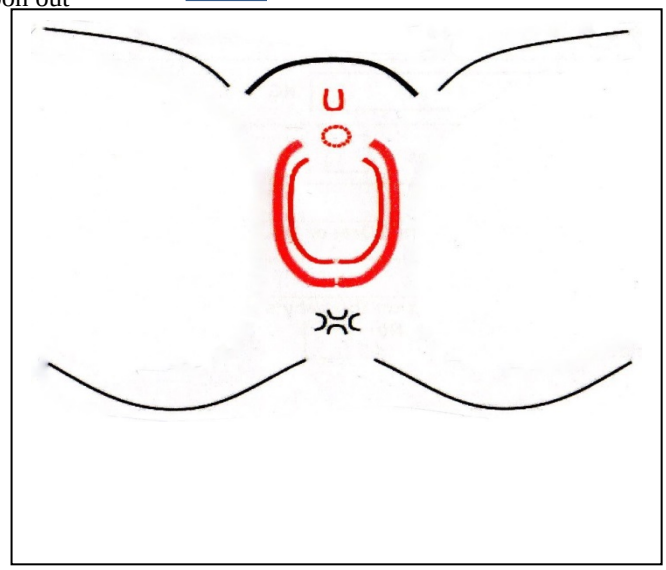
Anaesthetic G.A./ Spinal / Epidural / Pudendal Block / Local Infiltration

No. of swabs used: ☐ Number of swabs on completion: ☐ Checked By:

No. of needles used: ☐ No of needles on completion: ☐ …….

Vaginal Tampon used ☐ Vaginal Tampon out ☐

Suture material: ☐



Grade of Tear

1 ☐ 2 ☐ 3A ☐ 3B ☐ 3C ☐

4th ☐ Other ☐

Please mark all tears on diagram and Demonstrate location of sutures.

Vaginal Mucosa
Interrupted ☐
Continuous ☐

Vaginal Pack No / Yes

Perineal Muscle
Interrupted ☐
Continuous ☐

Urethral Catheter No / Yes
Vaginal Examination No / Yes
Rectal Examination No / Yes
Measured Blood Loss in mls ☐

Perineal Skin
Interrupted ☐
Continuous ☐
Un-sutured ☐

Signature…….
Print Name…….

References

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RCOG. (2007) The management of third and fourth degree perineal tears. Green-top guideline 29. RCOG: London.

APPENDIX 4

EQUALITY IMPACT ASSESSMENT GUIDANCE

Aneurin Bevan Health Board

Flowchart for the Completion of the EqIA Paperwork

1. Complete **FORM 1** 'Preparation and Assessment of Relevance & Priority'

↓

2. Complete **FORM 2** 'Evidence Gathering'

↓

3. Complete **FORM 3** 'Action Plan'

↓

4. Complete **FORM 4** 'Assessment of Relevance and Priority Scoring Chart' **To be scored following consideration of relevant action to be taken**

↓

5. Complete **FORM 5** 'Outcome Report'

FORM 1

Equality Impact Assessment (EqIA)

Form 1

Part A: Preparation and Assessment of Relevance and Priority

Step1: Preparation

1 What are you equality impact assessing?

PERINEAL ASSESSMENT AND REPAIR FOLLOWING CHILDBIRTH: GUIDELINE FOR MIDWIVES

2. Policy Aims and Brief Description

The aim of this guideline is to ensure midwives are using a consistent high standard of evidenced based perineal care in order to minimise short and long term problems encountered by women following childbirth.

3. Who Owns the Policy? - Who is responsible for the policy/work?

Authors –Gwyneth Ratcliffe Owned by Maternity Services

4. Who is involved in undertaking this EqIA? - Who are the key contributors to the EqIA and what are their roles in the process?

Gwyneth Ratcliffe senior midwifery manager J Beasley Senior midwifery manager

5. Other Policies- Describe where this policy/work fits in a wider context.

All Wales Normal Pathway for Normal Labour & Labour Ward guidelines

6. Stakeholders – Who is involved with or affected by this policy?

Women accessing maternity services within ABUHB **Midwifery staff working within ABUHB**

7. What factors may contribute to the outcomes of the policy? What factors may detract from the outcomes? These could be internal or external factors.

Distribution and availability, Availability of Perineal suturing training

Next Steps

For the next stage of the EqIA process please see form:
Part A, Step 2 - Evidence Gathering.

FORM 2

Aneurin Bevan Health Board

Equality Impact Assessment: Part A, Step 2 Evidence Gathering

Equality Strand	Evidence Gathered	Does the evidence apply to the following with regard to this policy/work? Tick as appropriate									
		Eliminating Discrimination and Eliminating Harassment		Promoting Equality of Opportunity		Promoting Good Relations and Positive Attitudes		Encouraging Participation in Public Life		Taking account of difference even if it involves treating some individuals more favourably	
Race	There is no evidence identified to demonstrate that a persons race will affect operation of this guideline		✓		✓		✓				
Disability	There is no evidence identified to demonstrate that a persons disability will affect operation of this guideline		✓		✓		✓				
Gender	There is no evidence identified to demonstrate that a persons gender will affect operation of this guideline, this guideline is designed for postnatal women		✓		✓		✓				
Sexual Orientation	There is no evidence identified to demonstrate that a persons sexual orientation will affect operation of this guideline		✓		✓		✓				
Age	There is no evidence identified to demonstrate that a persons age will affect operation of this guideline		✓		✓		✓				
Religion/ Belief	There is no evidence identified to demonstrate that a persons religion/belief will affect operation of this guideline		✓		✓		✓				
Welsh Language	There are facilities for translation if required.		✓		✓		✓				
Human Rights											

*This column relates only to disability due to the DDA 2005 specific duty

FORM 3

Aneurin Bevan Health Board
Equality Impact Assessment Action Plan

Name of Policy:

Recommendation	Expected Outcome	Divisional/Department Response	Responsible person	Progress to date
No additional actions required				

FORM 4

Aneurin Bevan Health Board: Equality Impact Assessment
Assessment of Relevance and Priority – Scoring Chart

Name of Policy:

Equality Strand	Evidence: Existing evidence to suggest some groups affected gathered from Part A Step 2.	Potential Impact: Nature, profile, scale, cost, numbers affected, significance.	Decision: Multiply 'Evidence' score by 'Potential Impact' score. ** please see bottom of the page for maths rule*
Race	1	3	3
Disability	1	3	3
Gender	1	3	3
Sexual Orientation	1	3	3
Age	1	3	3
Religion / Belief	1	3	3
Welsh Language	1	3	3
Human Rights	1	3	3

Evidence Available	
3	Existing data/research
2	Anecdotal/awareness data only
1	No evidence or suggestion

Potential Impact	
-3	High negative
-2	Medium negative
-1	Low negative
0	No impact
+1	Low positive
+2	Medium positive
+3	High positive

Impact Decision	
-6 to -9	High Impact (H)
-3 to -5	Medium Impact (M)
-1 to -2	Low Impact (L)
0	No Impact (N)
1 to 9	Positive Impact (P)

* Rule: Multiplication of a negative number by a positive number yields a negative result.
Multiplication of two positive numbers yields a positive result.
Multiplication of two negative numbers yields a positive result.

FORM 5

Aneurin Bevan Health Board

Equality Impact Assessment (EqIA) Outcome Report

Policy Title:	PERINEAL ASSESSMENT AND REPAIR FOLLOWING CHILDBIRTH: GUIDELINE FOR MIDWIVES
Organisation:	Aneurin Bevan Health Board
Name of policy Assessors:	Gwyneth Ratcliffe, J Beasley
Division/ Department:	Maternity Services
Proceed to Full EqIA:	The assessors are satisfied that as there are no negative impacts identified in this assessment a full EqIA is not required
Summary of the EqIA process and key points to be actioned:	This EqIA has been undertaken using the toolkit designed by the NHS Wales Centre for Equality & Human Rights. The toolkit gives due consideration to each statutory limb of the Equality Act (2010) and in keeping with an inclusive equality agenda, also includes consideration of the Welsh Language Act and the Human Rights Act. This report is not intended to provide a definitive account of the content and outcome of the EqIA screening process but offers a summary of the findings. In this instance, no negative differential is identified.
Responsibility for validation of the EqIA:	Maternity Service Clinical Effectiveness Forum
Date:	**08/12/2016**
Monitoring Arrangements:	This guideline will be monitored via the Maternity Services Clinical Effectiveness forum.
Policy expiry: date:	**08/12/2019**

This information is available on request in a range of accessible formats, Welsh and other community languages as required.

For more information please contact:
Aneurin Bevan Health Board Policy Process Manager on 01495 765460

APPENDIX 5

CHECKLIST FOR THE APPROVAL AND RATIFICATION PROCESS OF POLICIES AND OTHER WRITTEN CONTROL DOCUMENTS

CHECKLIST FOR THE APPROVAL AND RATIFICATION OF POLICIES AND OTHER WRITTEN CONTROL DOCUMENTS

Please note that no policies or other written control documents should be taken to the [enter sub committee name] for ratification unless they have been seen and approved by the [enter the name of the sub group or forum].

Name of Policy or written control document: PERINEAL ASSESSMENT AND REPAIR FOLLOWING CHILDBIRTH: GUIDELINE FOR MIDWIVES

Owner(s): …Maternity Clinical Effectiveness forum

Review Date: …08/07/2019……

1.	Please specify the date and name of person who carried out the policy or other written control document Equality Impact Assessment	Date: 08/12/2016 Gwyneth Ratcliffe/JBeasley			
2.	Have you taken into consideration the relevant legislation that may be applicable to this policy or other written control document? *Comments :*	Yes	✓	No	
3.	Has a patient information leaflet been developed to assist this policy or written control document?	Yes		No	
		Not Applicable	✓		
	If yes, is the information available in the variety of accessible formats and languages? *(including welsh and other community languages as appropriate)* *Comments :*				
4.	Where appropriate, have you consulted with the relevant services/personnel throughout	Yes	✓	No	

the Aneurin Bevan Health Board when completing the policy or other written control document?

(e.g. Voluntary, Legal, Pharmacy, IT, Finance, personnel, etc.)

Comments :

5. If applicable, please state what training has been identified as a result of this policy or other written control document, and what has been taken:

Prof C Kettle facilitates a full one day workshop for midwives, all midwives are encouraged to attend at least once. The Midwifery department are in the process of formulating a competency framework with a perineal suturing competence assessment included.

6. Have the necessary users been consulted in the development of this policy or written control document?
(e.g. Aneurin Bevan Health Board, Division/Locality wide, Third Sector, etc.)

Yes	✓	No		Not Applicable	

Please provide details: …… Sent out to all senior midwives for comments

7. Has the necessary Equality Impact Assessment documentation been completed?

Yes	✓	No	

If no, give reason(s):

8. Has the necessary Environment Impact Assessment been completed?

Yes		No		Not Applicable	✓

If no, give reason(s):

Ratification

The [enter name of committee, group or forum] has considered the information and agrees/ratifies on [08/12/2016].

Chair signature ……J Singh Obs Consultant……

Comments :