



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Guideline on the Management of Perineal Repair
HSE Home Birth Service

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1. Guideline Statement

SECMs provide holistic intrapartum care to women, and perineal repair is integrated into such practice. All SECMs should be skilled and competent in perineal/genital assessment and repair. It is necessary for each SECM to ensure that he/she maintains and regularly updates these skills to provide comfortable and satisfactory repair with minimum delay.

2. Purpose

The purpose is to guide SECMs on appropriate and safe principles of perineal repair.

3. Scope

This guideline is provided as a guide to practice and applies to all SECMs undertaking the perineal repair of first- and second-degree tears (including episiotomy).

4. Legislation, Codes of Practice, Standards and Guidance

- 4.1 Health Acts, 1947 to 2015 and regulations made thereunder
- 4.2 Nurses and Midwives Act, 2011
- 4.3 Perineal Repair (Coombe Women and Infants University Hospital 2006)
- 4.4 Guidelines for Practitioners (Midwifery-Led Unit, HSE DNE Regional Service 2011)
- 4.5 The Scope of Nursing and Midwifery Practice Framework (NMBI 2015)
- 4.6 The Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (NMBI 2014)
- 4.7 Practice Standards for Midwives (NMBI 2015)
- 4.8 Recording Clinical Practice (NMBI 2015)
- 4.9 Guidance for Nurses and Midwives on Medication Management (ABA 2007)
- 4.10 NICE Clinical Guideline 190 – Intrapartum Care: care of healthy women and their babies during childbirth (NICE 2014)
- 4.11 Evidence Based Guidelines for Midwifery Care in Labour (RCM 2008)
- 4.12 The Irish Maternity Early Warning System (IMEWS) NCEC (DOH 2014)
- 4.13 Communication (Clinical Handover) in Maternity Services NCEC (DOH 2014)
- 4.14 Sepsis Management NCEC (DOH 2014)
- 4.15 HSE Policy and Procedure for Notification of Home Births to the National Ambulance Service (National Ambulance Service, HSE 2015)
- 4.16 Clinical Practice Guideline, Prevention and Management of Primary Postpartum Haemorrhage (HSE 2012).
- 4.17 Standards and Recommended Practices for Healthcare Records Management (HSE 2011)
- 4.18 National Consent Policy (HSE 2013)
- 4.19 Safety Incident Management Policy (HSE 2014)
- 4.20 National Maternity Strategy 2016-2026 (DOH 2016)

This list is not exhaustive and reference should be made at all times to the guideline for reference sources or the database of legislation, codes of practice, standards and guidance (Clinical Governance Group for the HSE Home Birth Service 2016).

5. Definition & Background

- 5.1 **Definition:** Perineal or genital trauma caused by either tearing or episiotomy should be defined as follows:

First degree: Injury to skin only.

Second degree: Injury to the perineal muscles but not the anal sphincter (includes episiotomy).

Third degree: Injury to the perineum involving the anal sphincter complex.

3a – less than 50% of external anal sphincter thickness torn

3b – more than 50% of external anal sphincter thickness torn

3c – internal anal sphincter torn

Fourth degree: Injury to the perineum involving the anal sphincter complex (external and internal anal sphincter) and anal epithelium (NICE 2007).

6. Roles and Responsibilities

6.1. The Director of Primary Care shall ensure:

- 6.1.1 The provision of appropriate systems and structures to support the SECM to provide perineal repair for women and their families availing of the HSE Home Birth Service.

6.2. The HSE Chief Officer shall:

- 6.2.1 Ensure the implementation of systems and structures for the SECM to provide perineal repair and care for women and their families availing of the HSE Home Birth Service.
- 6.2.2 Request that the SECM and DMO report any adverse incidents to the National Incident Management System (NIMS) as per HSE Safety Incident Management Policy 2014.

6.3. Designated Midwifery Officers (DMOs) shall ensure:

- 6.3.1 That the appropriate systems and structures are in place to implement this guideline.
- 6.3.2 That the SECMs have submitted evidence of competency in perineal repair.
- 6.3.3 That SECMs receive this guideline and monitor adherence to it.
- 6.3.4 That completed incident forms are received from the SECM and forwarded to the National Incident Management System (NIMS) as per HSE Safety Incident Management Policy 2014.

6.4. Self-employed Community Midwives (SECMs) shall:

- 6.4.1 Ensure competence in managing perineal repair and keep up to date in knowledge and skills-base as required.
- 6.4.2 Ensure that they have all the equipment required for perineal repair.
- 6.4.3 Ensure that the woman and her partner are prepared, during pregnancy, for the possibility of trauma to the perineum during birth and that the transfer of maternity care after the home birth may be required in certain circumstances.

- 6.4.4 Ensure that he/she has a second SECM in attendance at the birth for a second opinion and to check medications.
- 6.4.5 Liaise with Ambulance Control as per National Policy for Communication with National Ambulance Service (HSE 2015) and Transfer Policy, HSE Home Birth Service (HSE 2016)
- 6.4.6 Report any adverse incidents via the DMO to the National Incident Management System (NIMS) as per HSE Safety Incident Management Policy 2014.
- 6.4.7 It is the responsibility of the SECM to be aware of and sign that they have read, understood and comply with this practice guideline.

7. Procedure

7.1. General Principles

- 7.1.1. The following general principles should be observed when performing perineal repair:
- 7.1.2. Information is given to the woman and verbal consent gained.
- 7.1.3. Perineal trauma should be repaired using aseptic techniques in order to minimise risk of infection.
- 7.1.4. Correct hand hygiene technique is utilised.
- 7.1.5. Good lighting is essential to see and identify the structures involved.
- 7.1.6. Instruments should be checked for function, counted and recorded before and after the procedure, as should swabs and tampon(s).
- 7.1.7. Swabs should **never** be inserted into the vagina. If required, a tampon may be inserted and artery forceps should be attached to the tag of the tampon to remind the SECM to remove it after the suturing is complete.
- 7.1.8. Adequate analgesia is essential.
- 7.1.9. Privacy is maintained throughout the procedure.
- 7.1.10. Advice should be sought in cases of difficult or extensive trauma. Such cases need to be reviewed by an *experienced practitioner* and the woman may need to be transferred to a maternity hospital/unit.
- 7.1.11. Haemostasis and good anatomical alignment of the wound should be achieved, and consideration given to the cosmetic results.
- 7.1.12. Rectal examination should be carried out (a) prior to perineal repair to assess whether there has been any damage to the external or internal anal sphincter, **and** (b) after completing the repair to ensure that suture material has not been accidentally inserted through the rectal mucosa.
- 7.1.13. Gloves should be changed after rectal examination and prior to perineal repair.
- 7.1.14. Information should be given to the woman regarding the extent of the trauma, pain relief, diet, hygiene and the importance of pelvic-floor exercises.
- 7.1.15. 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 (NICE 2007).

- 7.1.16. Women should be advised that in the case of second-degree trauma, the muscle should be sutured in order to improve healing (RCOG, 2004) and it is recommended that the skin is also sutured (Kettle, 2002).
- 7.1.17. An absorbable synthetic suture material (such as Vicryl Rapide 2.0 or Serapid 2.0) should be used.
- 7.1.18. Ensure that the pack is sterile by checking that the 'Comply SteriGage Steam Chemical Integrator' has changed to the correct colour, confirming sterility of the contents of the perineal repair pack.
- 7.1.19. On completion of the perineal repair, the midwife must document the care provided in the woman's notes (see 7.6 for documentation).

7.2. Equipment

- 7.2.1. Gather all equipment and place on a prepared, clean, sterile area/table.
- 7.2.2. Equipment will include sterile packs as follows:
 - 7.2.2.1. Sterile perineal repair suture pack
 - 7.2.2.2. One packet of sterile gauze (disposable with radio opaque thread)
 - 7.2.2.3. Tampon (disposable with radio opaque thread)
- 7.2.3. On a separate prepared area, place:
 - 7.3.2.1. 20ml vial of 1% lignocaine
 - 7.3.2.2. 20ml & 10 ml syringe
 - 7.3.2.3. 21g (green needle) x2
 - 7.3.2.4. Antiseptic solution
 - 7.3.2.5. Suture material (Vicryl Rapide 2.0 or Serapid 2.0)
 - 7.3.2.6. Sterile gloves
 - 7.3.2.7. Plastic apron
 - 7.3.2.8. Goggles

7.3. Maternal Observations

- 7.3.1. Record vital signs
- 7.3.2. Palpate uterus and assess vaginal loss
- 7.3.3. Assess maternal emotional/psychological condition in response to labour and birth
- 7.3.4. Ask woman to void or if necessary insert urinary catheter to empty bladder
- 7.3.5. Assess need for analgesia
- 7.3.6. Ensure the woman is warm and comfortable
- 7.3.7. Encourage skin-to-skin contact and early breastfeeding

7.4. Assessment of Perineal Trauma

- 7.4.1. Before assessing for genital trauma, the SECM should include care as per 7.1 (General Principles).
- 7.4.2. Position the woman so that she is comfortable and so that the genital structures can be seen clearly. The woman may be placed in lithotomy to allow adequate visual assessment of the degree of the trauma, and for the repair. This position should only be maintained for as long as is necessary for the assessment and repair of the perineum.

- 7.4.3. The examination should be performed gently and with sensitivity, and should be performed in the immediate period following birth.
- 7.4.4. The assessment of the extent of perineal trauma should include the structures involved, the apex of the injury, and assessment of the bleeding.
- 7.4.5. A rectal examination should be performed to assess whether there has been any damage to the external or internal anal sphincter.
- 7.4.6. The woman should be referred to a more experienced healthcare professional in the maternity unit/hospital if uncertainty exists as to the nature or extent of trauma sustained.

7.5. Repair of Perineal Trauma

- 7.5.1. Repair of the perineum should be undertaken as soon as possible to minimise the risk of infection and blood loss, and prior to analgesia becoming ineffective.
- 7.5.2. Perineal repair should only be undertaken with tested effective analgesia.
- 7.5.3. For simple perineal repair, infiltrate with up to 20 ml of 1% lignocaine. Ensure that the lignocaine is effective prior to commencement of suturing (this may take between 5-10 minutes).
- 7.5.4. Entonox inhalational analgesia may also be considered both for infiltration and during the procedure in conjunction with the use of Lignocaine.
- 7.5.5. If the woman reports inadequate pain relief at any point, suturing should cease immediately and discussion should take place as transfer to a maternity unit/hospital may be advised.
- 7.5.6. A tampon may be inserted into the vagina to aid visibility of the wound; artery forceps should be applied to the tag of the tampon – swabs should never be inserted into the vagina.
- 7.5.7. It should be possible to insert two fingers into the vagina (to ensure correct suture technique).
- 7.5.8. Perineal repair should commence with the first suture inserted 5-10mm above the apex, using a continuous non-locked suturing technique for the vaginal wall and muscle layer (Chapman & Charles, 2009; NICE, 2014) and continuous sub-cuticular technique for perineal skin (Kettle, 2002).
- 7.5.9. Ensure the wound is anatomically correct and haemostasis achieved.
- 7.5.10. Remove tampon if inserted prior to suturing.
- 7.5.11. A rectal examination is performed to ensure that suture material has not been accidentally inserted through the rectal mucosa. Where there is evidence of the suture material within the rectal mucosa, it is important to immediately inform the senior obstetrician on duty.
- 7.5.12. Rectal non-steroidal anti-inflammatory drugs should be advised routinely (once prescribed by the doctor or registered nurse/midwife prescriber) following perineal repair of first and second-degree trauma provided these drugs are not contraindicated.

- 7.5.13. The perineum and genital area are cleaned, a sanitary pad is placed over the perineum and the woman is assisted back into a comfortable position.

7.6. Documentation

- 7.6.1. Classify extent and location of trauma.
- 7.6.2. Analgesia and/or anaesthetic type, amount used and method of administration.
- 7.6.3. Type and gauge of suture material used.
- 7.6.4. Technique for repair of posterior vaginal wall, muscle and skin.
- 7.6.5. A diagram explaining suturing performed should be drawn.
- 7.6.6. Vaginal and rectal examination findings.
- 7.6.7. Analgesia post-procedure if administered.
- 7.6.8. Needles, instruments, swabs and tampon must be counted and recorded pre- and post-procedure, checked and countersigned by the second midwife.
- 7.6.9. Advice given to the woman.

7.7. Non-suturing of Perineal Trauma

- 7.7.1. Perineal repair is undertaken to promote healing by primary intention, promote effective haemostasis and minimise the risks of infection.
- 7.7.2. There is limited evidence regarding the benefit or harm of leaving perineal trauma unsutured. A study undertaken by Fleming et al (2003) observed poor approximation in the healing of wounds in women who had not been sutured at six weeks post-partum.
- 7.7.3. Clinicians are advised to be cautious about leaving trauma where the skin edges do not oppose or muscle layers are involved unsutured, unless it is the woman's expressed desire. Her wishes and the subsequent discussion should be documented in her record (NCCWC 2007).

8. Monitoring and Audit

- 8.1. Monitoring of compliance with this guideline shall be undertaken by the DMO.
- 8.2. Audit of compliance with this guideline shall be undertaken by HSE professionals.

9. Training

The SECM shall ensure that she/he has sourced approved education and training to support the implementation of this guideline.

10. Implementation Plan

The Clinical Governance Group for the HSE Home Birth Service developed this document, which has been approved for implementation by the National Implementation Steering Group for the HSE Home Birth Service. This document will be piloted for a year from the approval date. It will be disseminated by the Designated Midwifery Officers to relevant healthcare personnel and to all Self-Employed Community Midwives who provide home birth services on behalf of the HSE.

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12. Appendix I: Technique

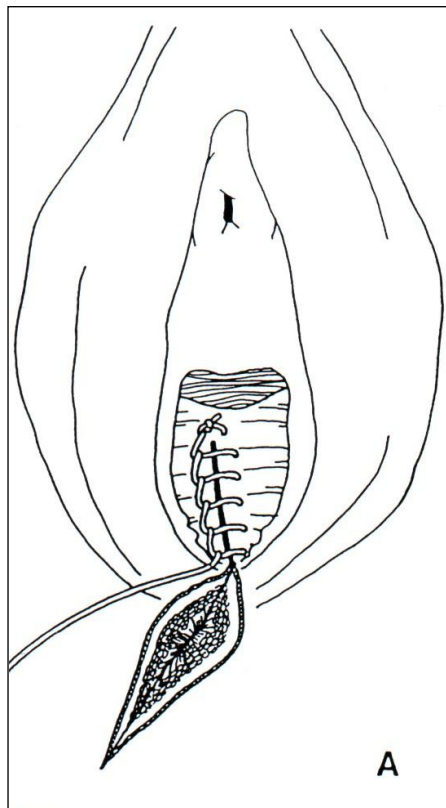
Trauma repaired in three stages

1. Repair of posterior vaginal wall
2. Repair of perineal muscles
3. Repair of skin

Posterior vaginal wall

- a) Identify apex of the wound
- b) Place an anchoring stitch 1cm above the apex to ligate any retracted blood vessels
- c) Tie a knot and cut off the short end
- d) Proceed with continuous interlocking or non-interlocking suture, placing each bite 0.5 to 1cm below previous. An illustration of the continuous interlocking suture is given below.
- e) Ensure that suture is not placed too deep or rectal mucosa may be penetrated
- f) Close posterior vaginal wall to the mucocutaneous junction and hymenal remnants
- g) Do not place sutures in hymenal remnants
- h) Bring needle through posterior vaginal wall out into muscle layer

Figure A: Interlocking suture to posterior vaginal wall



Muscle layer

- a) Repaired in one or two layers depending on depth
- b) Continuous or interrupted
- c) Appose muscle edges carefully
- d) Medial side of episiotomy wound tends to retract
- e) Place suture perpendicular to wound
- f) Ensure no dead space is left
- g) Muscle layer should approximate skin edges
- h) Check and confirm haemostasis

Skin

- a) Skin repaired with subcuticular suture
- b) Commence the repair at the anal end or under the fourchette by placing an anchoring stitch just under unjoined skin edges
- c) Take 0.5cm bit of tissue on either side
 - a. Not too deep or too large
 - b. Accurate approximation prevents puckering
- d) Suture tied off into posterior vaginal wall
- e) Check that haemostasis has been achieved

Continuous subcuticular suturing of perineal skin

- Insert suture in parallel lines at opposing points along wound margin just below skin



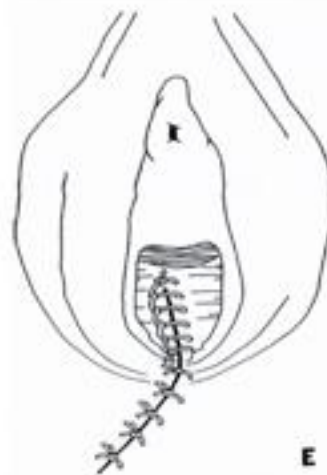
Continuous subcuticular suturing of perineal skin

- Draw edges together gently as repair continued toward introitus
- Ensure good approximation to avoid puckering
- Tie off final stitch in posterior vaginal wall



Interrupted sutures to skin

- Interrupted sutures can be used when a continuous subcuticular suture is unsuitable for closure of perineal skin



Reference: Guidelines for Practitioners (Midwifery-Led Unit HSE DNE Regional Service 2011)

13. Signature Page

I have read, understand and agree to adhere to the attached document:

[illegible]