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Royal Cornwall Hospitals NHS Trust

Perineal or Genital Tract Injury Following Childbirth Identification and Management Clinical Guideline V3.0

December 2022

1. Aim/Purpose of this Guideline

1.1. This gives guidance to obstetricians, anaesthetists and midwives and allied health professionals on the identification and management of perineal or genital tract injury following childbirth and how to refer women sustaining perineal or pelvic health injury into the Perinatal Pelvic Health Service or Muskuloskeletal Pelvic Floor Dysfunction Service. (New 2022)

1.2. This version supersedes any previous versions of this document.

1.3. This guideline should be read in conjunction with the Royal Cornwall Hospital Trust (RCHT) guidance: Female Genital Mutilation/Cutting (FGM/C) Obstetric Clinical Guideline, Bladder Care for the Obstetric Patient Clinical Guideline, Postnatal Care Planning and Information Clinical Guideline. (New 2022)

1.4. This guideline makes recommendations for women and people who are pregnant or in the perinatal period. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman please ask them their preferred pronouns and then ensure this is clearly documented in their notes to inform all health care professionals.

Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. Definition and background

More than 85% of women who undergo a vaginal birth will sustain some degree of perineal injury [2] with 0.6–11% of all vaginal deliveries resulting in a third-degree or fourth-degree tear [1]. Data suggests the incidence of third and fourth degree obstetric anal sphincter injuries (OASI/OASIS) is rising but this may be due to improved education, awareness and identification of injury [2]. Incidence of perineal tears decreases with subsequent births [3] but birth injury can result in disabling immediate and long-term physical and psychological complications and accurate identification, management, documentation and postnatal care planning is crucial to mitigating long term sequalae [4]. (New 2022)

2.2. Female Genital Mutilation or Cutting [5]

See RCHT Female Genital Mutilation/Cutting (FGM/C) Obstetric Clinical Guideline. A Datix should be completed and a referral to the Perinatal Pelvic Health Service using the Health Professionals' referral form at Appendix 4 should be made for all birthing people with FGM/C at the time of identification. If FGM/C is identified antenatally a referral should also be made to the area consultant. (New 2022)

2.3. Definitions: (New 2022)

OASI/OASIS- Obstetric Anal Sphincter Injury/Injuries.

Pelvic health- Health of the structure and function of the pelvic muscles, organs and/or tissues.

Pelvic Floor Dysfunction- Deviation from the normal function of the pelvic muscles, organs and/or tissues.

Prolapse- a displacement of a part or organ of the body from its normal position, usually downwards or outwards, often resulting in it protruding from an orifice.

Urinary and fecal incontinence- involuntary leakage of urine, flatus or faeces

Dyspareunia- any pain or soreness that occurs during sexual intercourse.

Obstructed defecation- Difficulty emptying stool from the rectum during the phases of defecation.

Perineal/genital tract injury- Any form of tear, graze or injury to the vagina, perineum or genital tract.

2.4. Guideline for the management of perineal or genital injury following childbirth

Following vaginal birth an initial examination for perineal and genital injury should be offered as soon as possible. This examination should be carried out aseptically and clean sterile gloves should be used. This should be done once the general wellbeing of the mother and baby has been established, it should not however, interfere with the mother and baby skin to skin contact.

2.5. Initial assessment

- Explain to the woman what the assessment will entail and obtain verbal consent.
- Offer inhalation analgesia.
- Ensure good lighting.
- Ensure the woman is in a suitable position to visualize the genital structures.
- Visual assessment of the extent of perineal trauma injury to include the structures involved and the apex of the injury, and an assessment of any bleeding.
- If injury is identified explain that a rectal examination to assess whether there is any damage to the external or internal anal sphincter is indicated. Obtain verbal consent before continuing.

2.6. Identification of the type of trauma

- 1st degree involves injury to the skin only.
- 2nd degree involves injury to the perineal muscles but not the anal sphincter.
- 3rd degree involves injury to the perineum involving the anal sphincter-

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

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

  3c: both the external anal sphincter and the internal anal sphincter torn.
- 4th degree involves injury to the perineum involving sphincter complex (external and internal anal sphincter) and anal epithelium.

2.7. **Sutures and suturing technique**

Continuous suture techniques are associated with less pain for up to 10 days' postpartum, an overall reduction in analgesia use and a reduction in suture removal compared with interrupted sutures for perineal closure (all layers or perineal skin only).6 (New 2022)

2.8. **Management of 1st degree tears**

Suturing should be advised unless the skin edges are well apposed and there is no bleeding from the injury site. If suturing is undertaken it should be as per the management of a 2nd degree tear.

2.9. **Management of 2nd degree tears and episiotomy**

Suturing to the muscles should be advised to improve healing. Following suturing of the muscle, if the skin edges are well apposed and there is no bleeding from the trauma site, the woman can opt to not have the skin sutured.

- Verbal consent should be obtained from the women and documented on the suturing proforma.
- Examination of the vagina and rectum prior to suturing to ensure the correct grade of perineal tear.
- The repair should take place using an aseptic technique, wearing clean sterile gloves.
- Equipment should be checked and swabs and needles counted before and after the procedure and the findings documented.
- Ensure good lighting.
- A skilled midwife or obstetrician (or one undergoing instruction from a skilled midwife or obstetrician) should undertake the repair.
- Confirm with the woman that she has adequate pain relief in the form of either local anaesthetic of up to 20mls of 1% lidocaine or under regional anaesthesia, unless there is a contraindication.
- Vicryl rapide 2.0 should be the suture material of choice.
- Visualize and identify the apex of the wound.
- A continuous suturing technique should be used to oppose each layer.

- Aim for good approximation of tissue, with alignment of the forchette and skin with a continuous subcuticular suture. Aim for a good cosmetic result.

- Confirm haemostasis.

- Examination of the vagina and rectum post suturing to ensure that suture material has not accidentally penetrated the rectal mucosa.

- Offer rectal non- steroidal anti-inflammatory analgesia, Voltarol 100mg, unless there is a contraindication e.g. asthma.

- Advice should be given to the woman regarding the extent of the injury, pain relief, diet, hygiene and the importance of pelvic floor exercises

2.10. **Management of 3rd and 4th degree tears**

Following the initial examination, if injury to the anal sphincter is confirmed or suspected an experienced practitioner trained in the recognition and management of complex perineal tears should be asked to make a further assessment.

2.11. **Management of 3rd and 4th degree tears**

Following the initial examination, if injury to the anal sphincter is confirmed or suspected an experienced practitioner trained in the recognition and management of complex perineal tears should be asked to make a further assessment.

If a 3rd/4th degree tear is confirmed:

- Repair should take place by an experienced, appropriately trained obstetrician (at either middle grade or Consultant level).

- Repair should be conducted in an operating theatre under regional or general anaesthesia with appropriate instruments and an assistant.

- Written consent should be obtained from the woman.

- The ‘WHO’ obstetric check list must be completed in theatre.

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

- The sphincter may be repaired with either an end to end or an overlapping technique depending on the experience of the surgeon. There is some evidence however that the overlapping technique has some benefit to the end to end technique. The ends of the sphincter should be brought together without any tension.

- The external anal sphincter should be repaired separately from the internal anal sphincter.

- PDS (3.0 PDS) should be used to repair external and internal anal sphincter.

- Surgical knots should be buried beneath the superficial perineal muscles otherwise there is the risk of knot migration. Women should be advised of this particularly if PDS is used.

- Women should be given IV Ceftriaxone and Metronidazole at the time of repair in theatre and should be followed by oral Cephalexin 500mgs TDS and Metronidazole 400mgs TDS for 5 days, unless there is a contraindication.

- An indwelling catheter should be left insitu, for at least 12 hours, if a spinal or full epidural top up is given.

- Women should also be prescribed 10 days of Fybogel and Lactulose

- All women with a 3rd or 4th degree tear should be given advice regarding the extent of the injury, pain relief, diet, hygiene, pelvic floor exercises and planned follow up care. (New 2022)

- All women with a 3rd or 4th degree tear will be referred to the Perinatal Pelvic Health Service for wound management and the Pelvic Floor Dysfunction service for postnatal physiotherapy. (New 2022)

- All women with a 3rd or 4th degree tear will be offered an appointment in the area consultant clinic at 6-8 weeks postnatal for an obstetric review. This review should include the following with documentation in the notes:

    - Symptom assessment-Pain at the site of repair, abnormal discharge, faecal urgency, faecal soiling, faecal incontinence, flatus incontinence.

    - Examination: Of Perineum, site of repair, vaginal examination (to assess healing of repair).

    - Anorectal examination: To assess resting and squeeze anal tone.

    - Discussion of injury/debrief.

    - Discussion of future mode of delivery and documentation of this.

- If these women are symptomatic of faecal incontinence, then a referral is made to the one stop consultant led Perineal Clinic for review. This includes history, examination, endo-anal ultrasound and ano-rectal physiology. (New 2022)

NB: If the 3rd degree tear is superficial and there is adequate lighting and analgesia then it is appropriate, after discussion with the woman, for the repair to be undertaken in the room. In these circumstances it is appropriate to obtain verbal consent only. However, it must be ensured that the woman receives an initial dose of IV antibiotics, oral antibiotics, appropriate laxatives and a postnatal follow up.

2.12. **Documentation (New 2022)**

2.12.1. A Datix should be submitted by the midwife providing care for all birthing people sustaining a 3rd or 4th degree perineal tear.

2.12.2. The RCH suturing proforma must be completed, for all types of repairs, and filed chronologically in the woman's health records. (Appendix 3).

2.12.3. Details of any perineal or pelvic health injury sustained during birth should be accurately recorded on the patient's electronic record (E3) and in the handheld notes to ensure women are contacted by the Perinatal Pelvic Health Service.

2.12.4. The Perinatal Pelvic Health Service clinical team/administrator will run a bi- weekly electronic record (E3) and Datix report of all perineal/pelvic health injury sustained, readmissions for pelvic health reasons and any births meeting the current inclusion criteria for the Perinatal Pelvic Health Service. This data will be used to identify prospective PPHS service users. It will also be used for audit and reporting. All staff with responsibility for digital or written documentation have a duty to ensure this is recorded accurately and contemporaneously in line with the NMC Code and Chartered Society of Physiotherapy guidance. Incomplete or inaccurate documentation may result in birthing people being omitted from PPHS support.

2.13. **Women who return to hospital due to a problem with perineal or genital trauma injury suturing**.

2.13.1. Women who return to hospital due to a problem with perineal or genital trauma suturing should be reviewed by an obstetric registrar or consultant. (New 2022)

2.13.2. An electronic incident form (DATIX) should be completed for any woman who return to hospital, for a non-routine appointment, with problems related to perineal or genital tract injury. These woman's

notes will be reviewed to ensure correct procedures were followed at the of suturing and any deficiency identified and feedback to the person performing the repair.

2.13.3. There is evidence to suggest that early re-suturing of perineal wound dehiscence within 14 days of birth may lead to improved healing and reduced pain (following the exclusion or treatment of concurrent infection)7. To prevent delay in treatment, an urgent referral to DAU should be made by the health professional providing care if wound dehiscence or infection is identified or suspected. (New 2022)

2.13.4. Birthing people returning to hospital due to problem with perineal or genital injury or pelvic health will be contacted by the perinatal Pelvic Health Service.

2.14. Suturing competence

2.14.1. Midwives

2.14.1.1. Newly qualified midwives will have suturing competencies assessed as part of the structured preceptorship programme.

2.14.1.2. A midwife who has not previously undertaken any formal training in perineal and genital injury repair should attend mandatory in-house training on suturing. The midwife may then undertake suturing under the supervision of a midwife already experienced in perineal and genital injury suturing.

2.14.1.3. All midwives who are already experienced in suturing will attend a formal in-house training session at least every 2 years.

2.14.2. Doctors in training

Competencies will be assessed as part of the structured training programme and assessment. For doctors not on a training programme, supervision by a senior obstetrician will be required and competency forms completed. Once they have achieved the level of independent practice supervision will no longer be required. Doctors should attend the in-house PROTECT (Prevention and Repair of Perineal Trauma Episiotomy through Coordinated Training) course. (New 2022)

2.14.3. **Maternity Support Workers**

Maternity Support Workers play a significant role in the postnatal care of women so should have a good awareness of the types of intrapartum perineal/pelvic health injury, expected healing and know how to escalate any concerns. All Maternity Support Workers will be provided with in-house training to support their role as part of mandatory maternity update week.

2.15. **Postnatal Care**

2.15.1. Midwives providing postnatal care should enquire about perineal and pelvic health at each contact and provide guidance on perineal wound care and pelvic floor exercises.

2.15.2. Women sustaining any form of perineal or pelvic health injury during birth should be given Perinatal Pelvic Health Service information postcard A (Appendix 7) and given information and guidance regarding the extent of the injury. They should be advised that they may also be contacted by a member of PPHS Team. (New 2022)

2.15.3. Women meeting the referral criteria for the Perinatal Pelvic Health Service should be given personalised Perinatal Pelvic Health Service information postcard B (Appendix 8) with their name and details of the pelvic health risk factor(s) added. They should be advised that they may also be contacted by a member of PPHS Team. (New 2022)

2.15.4. All women sustaining any form of perineal injury should be offered at least one perineal examination prior to discharge from the ward AND at least one perineal examination by a midwife prior to discharge from community midwifery care.

2.15.5. Midwives should consider extending postnatal care past 10 days and up to 28 days where there are ongoing concerns regarding perineal or pelvic health to ensure consistent advice and continuity of care. A referral should be made to the Perinatal Pelvic Health Service using the health professionals' referral form at Appendix 4 when extended care is required. (New 2022)

2.15.6. If there are any concerns regarding perineal wound healing or pelvic health at the point of discharge from community midwifery care, a referral to the Perinatal Pelvic Health Service should be made by the midwife providing care using the referral form at Appendix 4. (New 2022)

2.15.7. Maternity Support Workers providing postnatal care should enquire about perineal and pelvic health at each contact and escalate any concerns to a midwife. (New 2022)

2.15.8. Women meeting the PPHS referral criteria should be informed how to self-refer using the PPHS Self-Referral form (Appendix 5) if required (see Perinatal Pelvic Health Service Standard Operating Procedure). (New 2022)

2.15.9. Women who do not meet the current PPHS referral criteria but do meet Muskuloskeletal Pelvic Floor Dysfunction physiotherapy or Muskuloskeletal physiotherapy criteria will be identified and referred into the MSK PFD service by their midwife. Referrals to MSK Pelvic Floor Dysfunction and MSK physiotherapy are made via Maxims (see Appendix 6) (New 2022)

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	• The audit will take into account record keeping by obstetric and anaesthetic staff and midwives. • The results will be inputted onto an excel spreadsheet • The audit will be registered with the Trust's audit department
Lead	• Perinatal Pelvic Health Midwife
Tool	**All suturing** • Was a suturing proforma completed and filed in the woman's notes • Is it documented that information regarding support following the tear, was given **All forms of perineal trauma** • Is it documented that at least one perineal examination prior to transfer to community AND at least one perineal examination prior to discharge from community midwifery care was performed **For 1st/2nd degree tears** • Was the repair of a 1st/2nd degree tear performed by an appropriately trained midwife/obstetrician • Was verbal consent obtained for the 1st/2nd degree tear repair **For 3rd/4th degree tears**: • Was the repair of a 3rd/4th degree tear performed by an experienced, appropriately trained obstetrician (middle grade or Consultant level) • Was written consent obtained for 3rd/4th degree tears

Information Category	Detail of process and methodology for monitoring compliance
	• Was the repair of the 3rd/4th degree tear undertaken in the operating theatre • Did the woman receive 1 dose of IV antibiotics and a 5 day course of oral antibiotics • Did the woman receive a follow up at 6 weeks post delivery • Did the woman receive an appropriate laxative Adherence will be monitored as part of the ongoing audit process within the department on a Word or Excel template specific to the topic.
Frequency	• This audit will be added to the rolling audit programme and will take place every three years • 1% of all women who have had repair of genital tract trauma
Reporting arrangements	• A formal report of the results will be received annually at the Maternity Forum and Maternity Clinical Audit Forum as per the audit plan • During the process of the audit if compliance is below 75% or other deficiencies identified, this will be highlighted at the next Patient Safety meeting and Audit Forum and an action plan agreed.
Acting on recommendations and Lead(s)	• Any deficiencies identified on the annual report will be discussed at the Maternity Forum and Maternity Clinical Audit Forum and an action plan developed • Action leads will be identified and a time frame for the actions to be completed • The action plan will be monitored by the Maternity Forum and Audit Forum until all actions complete
Change in practice and lessons to be shared	• Required changes to practice will be identified and actioned within an agreed time frame. • A lead member of the Maternity Forum will be identified to take each change forward where appropriate • The results of the audits will be distributed to all staff through the Patient Safety Newsletter and Audit forum as per the action plan

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion and Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Perineal or Genital Tract Trauma Following Childbirth Identification and Management Clinical Guideline V3.0
This document replaces (exact title of previous version):	Perineal or Genital Tract Trauma Following Childbirth Identification and Management Clinical Guideline V2.1
Date Issued/Approved:	August 2022
Date Valid From:	December 2022
Date Valid To:	December 2025
Directorate / Department responsible (author/owner):	Rachel Mullins, Pelvic Health Midwife
Contact details:	01872 250000
Brief summary of contents:	This gives guidance to obstetricians, anaesthetists and midwives and allied health professionals on the identification and management of perineal or genital tract trauma following childbirth and how to refer women sustaining perineal or pelvic health trauma into the Perinatal Pelvic Health Service or Muskuloskeletal Pelvic Floor Dysfunction Service
Suggested Keywords:	Perineal, repair, perineum, suturing, 3rd/4th, 1st/2nd, degree tears, perineal, 1st, 2nd, 3rd, 4th, Vicryl,
Target Audience:	RCHT: Yes CFT: No CIOS ICB: No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Maternity Guidelines Group

Information Category	Detailed Information
General Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming approval by specialty and care group management meetings:	Caroline Amuksana
Links to key external standards:	CNST 3.5
Related Documents:	1. Frohlich, J. and Kettle, C., 2015. Perineal care. BMJ Clin Evid. 2015. 2. Gurol-Urganci, I.,Cromwell, D., Edozien, L., Mahmood,T., Adams, E., Richmond, D.,Templeton, A. and van der Meulen, J., 2013. Third- and fourth-degree perineal tears among primiparous women in England between 2000 and 2012: time trends and risk factors. BJOG. 2013 Nov;120(12):1516-25. 3. Smith, L., Price, N., Simonite, V. and Burns, E. 2013. Incidence of and risk factors for perineal trauma: A prospective observational study. BMC Pregnancy Childbirth 2013;13:59. 4. Dudley, L., Kettle, C., Waterfield, J. and Ismail, K., 2014. Perineal resuturing versus expectant management following vaginal delivery complicated by a dehisced wound (PREVIEW): a nested qualitative study. BMJOpen [online] 2017(7). 5. Royal College of Obstetricians and Gynaecologists. 2015. Female Genital Mutilation and Its Management- Green Top Guideline No. 53. July 2015. 6. Kettle, C., Dowswell, T. and Ismail, K. 2012. Continuous and interrupted suturing techniques for repair of episiotomy or second-degree tears. Cochrane Database Syst Rev. 2012 Nov 14;11(11) 7. Okeahialam, N.,Thakar, R., Kleprlikova, H.,Taithongchai, A. and Sultan, A. 2020. Early re-suturing of dehisced obstetric perineal wounds: A

Information Category	Detailed Information
	13-year experience. Eur J Obstet Gynecol Reprod Biol. 2020 Nov, 254:69-73 8. Royal College of Obstetricians and Gynaecologists (March 2007) Management of third and fourth degree perineal tears. Green top Clinical guideline number 29 RCOG. London 9. National Institute for Health and Clinical Excellence (NICE 2007) Intrapartum care: Care of Healthy Women and their babies during childbirth. London: NICE
Training Need Identified?	Suturing competence A midwife who has not previously undertaken any formal training in perineal and genital trauma repair should attend a formal in-house training session on suturing. The midwife may then undertake suturing under the supervision of a midwife already experienced in perineal and genital trauma suturing. All midwives who are already experienced in suturing will attend a formal in- house training session at least every 2 years. Doctors in training. Competencies will be assessed as part of the structured training programme and assessment. Doctors not on a training programme, supervision by a senior obstetrician will be required and competency forms completed. Once they have achieved the level of independent practice supervision will no longer be required.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	e.g. Clinical/Midwifery and Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
Oct 2009	V1.0	Initial issue	Karen Watkins Consultant Obstetrician
May 2011	V1.1	Updated to include compliance monitoring	Karen Watkins Consultant Obstetrician
April 2012	V1.2	Updated into Trust format	Karen Watkins Consultant Obstetrician
September 2012	V1.3	Changes to compliance monitoring only	Karen Watkins Consultant Obstetrician
March 2014	V1.4	Update of IV antibiotics to IV Ceftriaxone and Metronidazole for 3rd/4th degree tears	Karen Watkins Consultant Obstetrician
December 2016	V1.5	2.5 and 2.6 updates	Farah Lone Consultant Obs & Gynae
July 2019	V2.0	Full review. Additions following Freedom of Information request	Farah Lone Consultant Obs & Gynae
March 2021	V2.1	Addition of 2.11-Postnatal care guidance	Rachel Mullins Practice Development Midwife
January 2022	V3.0	Complete version update including Perinatal Pelvic Health Service provision and referrals. All additions are labelled ‘New 2022’. Addition of new Trust template	Rachel Mullins Perinatal Pelvic Health Midwife

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Perineal or Genital Tract Injury Following Childbirth Identification and Management Clinical Guideline V3.0
Directorate and service area:	Obstetrics and Gynaecology
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Rachel Mullins, Perinatal Pelvic Health Midwife
Contact details:	01872 252729

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	This gives guidance to obstetricians, anaesthetists and midwives and allied health professionals on the identification and management of perineal or genital tract trauma following childbirth and how to refer women sustaining perineal or pelvic health trauma into the Perinatal Pelvic Health Service or Muskuloskeletal Pelvic Floor Dysfunction Service
2. Policy Objectives	To ensure appropriate recognition and management of perineal and genital tract trauma following childbirth.
3. Policy Intended Outcomes	Ensure appropriate repair of trauma following childbirth.
4. How will you measure each outcome?	Compliance Monitoring Tool

Information Category	Detailed Information
5. Who is intended to benefit from the policy?	All women following childbirth
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Maternity Guidelines Group
6c. What was the outcome of the consultation?	Agreed
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	

Protected Characteristic	(Yes or No)	Rationale
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Rachel Mullins

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Perineal Suturing Proforma

CHA4266: Perineal Suturing Proforma (cornwall.nhs.uk)

Appendix 4. Health Professionals' Perinatal Pelvic Health Service Referral Form

Perinatal Pelvic Health Service – Health Professionals' Single Point of Access Referral

Please complete this form and email to: rcht.pelvichealthclinic@nhs.net

Patient details (please print) Name:

Address:

Date of birth:

NHS/CR number:

Referral criteria	Please tick
Third degree tear	
Fourth degree tear	
Episiotomy performed	
Any form of Female Genital Mutilation (FGM)	
Any labial tears	
Instrumental deliveries (forceps or ventouse)	
Failed assisted deliveries (forceps or ventouse)	
Shoulder dystocia	
At least 2 of:	
Baby weighing 4kg or more	
Prolonged second stage/pushing for more than 1 hour	
Mulitparity ≥4 (4+ deliveries)	
Significant bladder injury	
Loss of bladder sensation	
Urinary incontinence	
Faecal/flatus incontinence	
Perineal wound complications	
GPs/Community Midwives/ AHPs: Please refer to RCHT Day Assessment Unit if suspected perineal wound dehiscence or infection for any grade of tear	

Any other relevant information (please print):

Name of referrer (please print): Designation:
Contact details of referrer:
Date of referral:

Appendix 5- Perinatal Pelvic Health Service Self- Referral Form

Perinatal Pelvic Health Service Self-Referral Form

<table>
<tr><td colspan="3">This form should be used only for persons who are antenatal or who are within one year of giving birth and wish to seek specialist treatment for the following:
• Bladder or bowel problems
• Symptoms of pelvic organ prolapse
• Perineal trauma/ wound concerns
• Dyspareunia (painful sex)
Please complete this form clearly and comprehensively. Incomplete forms can cause delay. Once received, the form will be reviewed, and an appointment will be arranged.</td></tr>
<tr><td>Full Name

Address

Postcode</td><td>Contact phone numbers

Home

Mobile

Work</td><td>Consent to message

Yes/No

Yes/No

Yes/No</td></tr>
<tr><td>GP Name:

GP practice name and address:

Telephone number:</td><td colspan="2">Midwife Name (if applicable):

Telephone number:

Health Visitor (if applicable):

Telephone number:</td></tr>
<tr><td>Have you had any contact with Perinatal Pelvic Health Service previously?</td><td colspan="2">Yes No (please circle)</td></tr>
<tr><td colspan="3">Maternity History</td></tr>
</table>

Currently pregnancy: Yes No Estimated due date: Number of pregnancies, inclusive of all pregnancies that didn't carry to full term: Please give details:	Recent birthing date: Mode of birth: Significant birth events: Number of previous births and dates: Mode of births: Significant birth events:

When did your symptoms start? (Was it related to pregnancy, childbirth or after surgery)

How long have you had your symptoms?

Have you previously had treatment for these symptoms? (if yes please give details)

Have you had any tests on your bladder/ bowel/ back? (e.g. scans, urodynamics, colonoscopy)

Since your symptoms started do any of the following apply to you? Please tick yes or no

	YES	NO
Unexpected bleeding or staining from the vagina?		
Persistent bloating that doesn't come and go?		
Unexplained weight loss?		
Persistent abdominal pain?		
Do you have any numbness/ tingling in the area between your legs?		

If you have answered yes to any of the above, please seek urgent advice from your GP

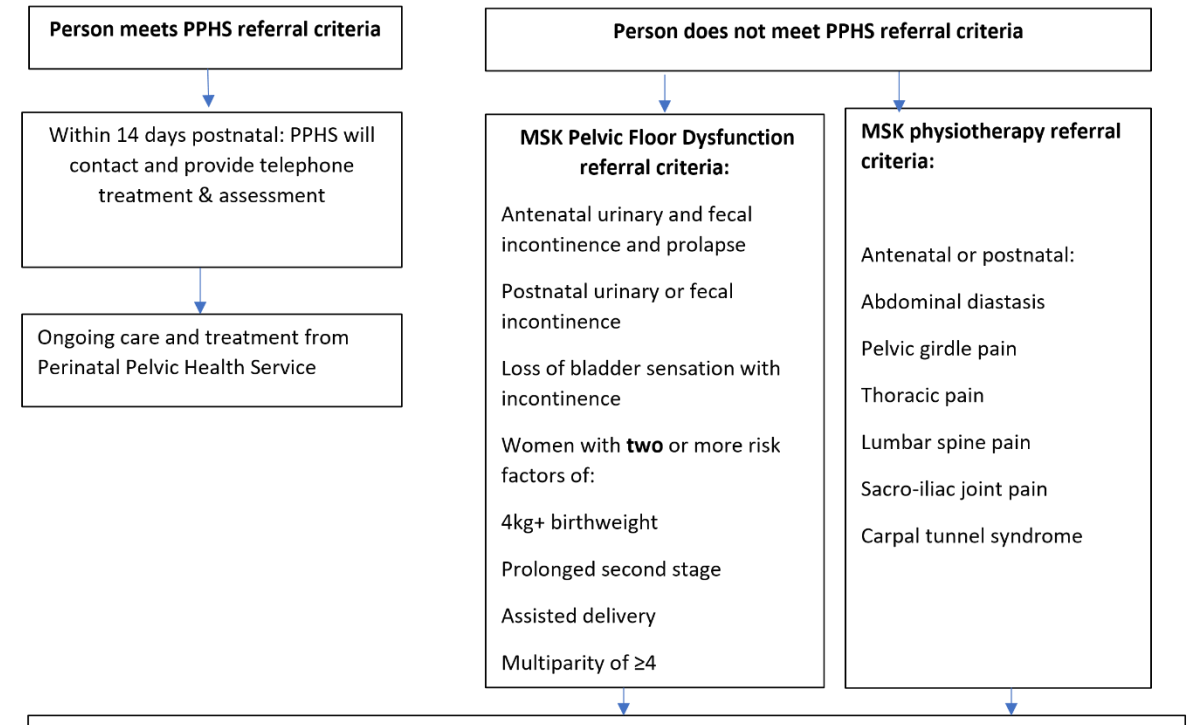
When was your last cervical smear?

Have you had any abnormal smear results? Please give details of any treatment received

General Health	**YES**	**NO**		**YES**	**NO**
Heart Problems			Neurological conditions e.g. MS		
High Blood Pressure			Rheumatoid Arthritis		
Low Blood Pressure			Osteoporosis		
Lung/ breathing problems			History of cancer		
Thyroid problems			Major surgery		
Diabetes			Mental health illness		
Epilepsy			Other		

If you have answered YES to any of the above, please provide details:
Please List ALL medications you are currently taking:
Is there anything else we should know?

Appendix 6. Alternative Physiotherapy Pathways and referrals for Perinatal Pelvic Health Service



How to make a Maxims referral for Muskuloskeletal Pelvic Floor Dysfunction Physiotherapy Service

1. Log in to **Maxims**
2. Type in patient **CR number**
3. Access correct **patient record**
4. On the Demographics blue bar at the top right of the screen- click on **'More'**
5. Click on **Patient Internal Referral/Add to WL**
6. **Type PHY into the Service box** and a list of options will appear
7. Select **Physiotherapy Pelvic Floor Outpatient Service**
8. Select urgency: **Urgent Yes or No**
9. Select whether **referral is for a new condition: Yes or No** (n.b. referrals will be rejected if the urgency and referral for new condition options are not completed)
10. Complete the **Service Specific Questions**
11. Complete the **Clinical Details**
12. **Press Save** to submit referral

How to make a Maxims referral for Muskuloskeletal Physiotherapy Service

1. Log in to **Maxims**
2. Type in patient **CR number**
3. Access correct **patient record**
4. On the Demographics blue bar at the top right of the screen- click on **'More'**
5. Click on **Patient Internal Referral/Add to WL**
6. **Type PHY into the Service box** and a list of options will appear
7. Select **Physiotherapy MSK Outpatient Service**
8. Select urgency: **Urgent Yes or No**
9. Select whether **referral is for a new condition: Yes or No** (n.b. referrals will be rejected if the urgency and referral for new condition options are not completed)
10. Complete the **Service Specific Questions**
11. Complete the **Clinical Details**
12. **Press Save** to submit referral

Appendix 7. PPHS Information Postcard A

Perinatal Pelvic Health Service

rcht.pelvichealthclinic@nhs.net

You have been given this card to support your pelvic health postnatally.
If you begin to experience **any** symptoms of pelvic floor muscle trauma you should speak to your midwife or GP as support is available.
Symptoms may include:
Urinary incontinence (leaking wee, needing to wee urgently or being unable to control when you wee)
Faecal incontinence (leaking poo, having staining in underwear or being unable to control when you poo or pass wind)
Pain during sex
A heavy sensation or a bulge inside your vagina or anus

If you need urgent care or advice
please contact the maternity advice line on
01872 252788

Cornwall Pelvic Health Team

Rachel Collett
Pelvic Health
Physiotherapist

Kirsty Sturgeon
Pelvic Health
Physiotherapist

Rachel Mullins
Pelvic Health
Midwife

You can also find out more about pelvic floor exercises and pelvic health conditions by visiting these websites:

Pelvic Obstetric and Gynaecological Physiotherapy

www.thepogp.co.uk/resources/booklets/

Royal College of Obstetricians & Gynaecologists

www. rcog.org.uk/en/patients/tears/

Appendix 8- PPHS information postcard B

Perinatal Pelvic Health Service

rcht.pelvichealthclinic@nhs.net

Dear

You have been given this card because you experienced

.....

.....

.....

during your birth

You may also be contacted by the Cornwall Perinatal Pelvic Health Service for support - turn over to meet the team

If you need urgent care or advice please contact the maternity advice line on 01872 252788

Cornwall Pelvic Health Team

Rachel Collett
Pelvic Health
Physiotherapist

Kirsty Sturgeon
Pelvic Health
Physiotherapist

Rachel Mullins
Pelvic Health
Midwife

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