

OASI Care Bundle:

Implementation guide for maternity sites in the roll-out phase



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Background

In England, the rate of obstetric anal sphincter injuries (OASIs) has tripled over the last decade from 1.8% to 5.9% among singleton, term, cephalic, vaginal first births. (1) The overall incidence of OASI in the UK is 2.9% (range 0—8%), with an incidence of 6.1% and 1.7% in primiparous and multiparous women respectively. (2)

The main risk factor for anal incontinence amongst childbearing women is OASI. A systematic review demonstrated a wide variation in the prevalence (2.2—36.7%) of anal incontinence in the short term, which can get worse over time. (3)

Short-term complications of OASI include pain, bleeding and infection, which can result in urinary retention and constipation. These complications can lead to multiple attendances in hospital or community services. Long-term complications of OASI include anal incontinence, chronic pain, dyspareunia and urinary incontinence (4) which have been shown to have a detrimental psychosocial impact requiring further counselling. In some circumstances, the trauma of sustaining an OASI and its complications affects subsequent births where a vaginal birth is forsaken for an elective caesarean, with associated additional costs. (5)

Medico-legally, the total value of negligence claims relating to OASIs, between 2000 and 2010 was estimated to be £31.2 million. (6) The specific negligent acts related to failure to consider a caesarean section, failure to perform or extend an episiotomy, failure to diagnose the true extent and grade of the injury, inadequacy of repair and failure to perform a repair.

Furthermore, the long-term healthcare costs can be significant, with ongoing imaging, outpatient, community and surgical follow-up required for further treatment.

Patient satisfaction is a key objective in maternity care. Failure to achieve this is perhaps indicated by rising complaints and litigation claims. (7) Any intervention to reduce OASI must therefore establish those very elements that have a direct impact on patient care, namely; evidence-based practice, standardized optimal care and comprehensive training for all clinicians.

About care bundles

The US Institute for Healthcare Improvement originally developed care bundles to describe a collection of interventions needed to effectively and safely care for patients. They define a care bundle as a small set of evidence-based interventions for a defined patient segment or population and care setting that, when implemented together, will result in significantly better outcomes than when implemented individually. (8)

Ideally, a care bundle should be concise and straightforward, comprising a set of three to five practices or precautionary steps. (8) Each of these components is an intervention or practice in its own right, ideally with a sound evidence base. The focus should be on how to deliver the best care. A care bundle should not introduce any practice or techniques that are not in standard practice in at least some settings.

The novelty of the approach is that it combines elements of good practice into one cohesive bundle that, when implemented, improves the reliability and quality of care as well as patient outcomes

It is crucial that a care bundle contains components that can be applied to an individual in one clinical episode, so that each application of the bundle is self-contained. In this way, compliance with the care bundle is easily monitored. **Each care bundle element is applied to every patient, every time.** This compliance should be recorded and monitored to help assess its impact in your maternity unit. As with any intervention, it is crucial to inform women about the use of the care bundle prior to birth. A care bundle can be viewed as a way of encouraging clinicians to act in accordance with accepted best practice. (9)

OASI care bundle development

A systematic review of the intrapartum interventions used to reduce the rate of OASI was conducted. This process involved the extraction of data from randomised controlled trials (RCTs) using comprehensive search strategies within EMBASE, Ovid MEDLINE, the Cochrane Library, the Maternity and Infant Care database and CINAHL. Following this, a review of the non-RCT literature was conducted identifying studies that considered the effect of various interventions on OASI rates. The results from these reviews were presented to the OASI Care Bundle Project Team of clinical experts for consideration in the final care bundle.

The final interventions selected for inclusion within the OASI Care Bundle were based on the expert consensus of obstetricians and midwives in the OASI Care Bundle Project Team. In addition to the quality of evidence, other factors such as feasibility and patient acceptability facilitated the selection process. The care bundle was piloted in two sites in 2016 over a 3 month period. The care bundle was found to be acceptable to clinicians. Engagement and support from senior staff, especially consultants and Band 7 midwives was found to be essential for successful implementation.

The OASI Care Bundle is composed of four evidence-based interventions that, when performed together and supported by an educational programme, may reduce the rate of third- and fourth-degree tears. (10, 11)

How to use this guide

The care bundle describes the evidence-based components that, when implemented together, improve the reliability and quality of care related to OASI prevention. This guidance is compatible with clinician discretion and **does not replace reasonable clinical judgement.** It is essential that this care bundle is used in conjunction with relevant guidance, such as those relating to consent, maternal position, operative vaginal births, episiotomy, perineal assessment, maternal coaching, and management of OASI. (12-14)

The care bundle is not to be used to the exclusion of other recommended interventions and practices. For

example, warm compresses have been shown to significantly reduce OASI (14), and may be used if feasible at the local unit. As with all aspects of maternal care, appropriate consent should be obtained prior to the use of any interventions.

This guide contains detailed descriptions of the four care bundle elements, recommendations for communicating effectively with the woman throughout the birth and suggested wording for documentation related to the care bundle. The content is informed by expert consensus and evidence-based practice. It provides a point of reference for use locally in an educational programme to support clinicians to implement the care bundle. At the end of the guide is a simple tool that will be provided to record compliance with the care bundle. It will be in the form of a sticker, which will be put on delivery packs or, when possible, added into the unit's Maternity Information System.

This guide is intended for use by all midwives and obstetricians using the care bundle during labour. The term 'clinician' is used throughout this guide and refers to both midwives and obstetricians. Local training on how to use the care bundle is essential to its success. Maternity units that have been selected to implement the OASI Care Bundle are encouraged, with the support of the Project Team, to develop their own educational programs to support the roll-out. Those championing change within each maternity unit are responsible for ensuring that staff who use the care bundle have had sufficient preparation to enable them to carry it out safely and effectively. To ensure standardisation of the techniques, a brief period of instruction may be necessary in the initial stages to ensure the correct performance for each care bundle component. A list of resources to support the development of a local educational programme is provided later in this guide.

Clinicians must be aware that risk factors for sustaining an OASI include being nulliparous, of South Asian ethnicity, baby's birthweight greater than 4 kg, shoulder dystocia, occipito-posterior position, prolonged second stage of labour, previous OASI and instrumental delivery. (1, 15) It should be remembered that even without these specific risk factors, a woman may sustain an OASI and therefore the care bundle should still be applied. There is limited evidence to suggest that a previous OASI alone increases the risk of recurrence in a subsequent pregnancy. (15)

The efficacy of the care bundle is dependent upon the conscientious application of all components. This guide provides information on how to perform all components and implement the care bundle. It is the effectiveness of the local change leaders, the quality of the educational programme, and the judicious compliance with the care bundle that will facilitate the achievement of optimal outcomes.



Elements of the OASI Care Bundle

There are **four** key elements:

1. **Inform the woman** about OASI and what steps can be taken to minimize her risk.
2. When indicated, **episiotomy** should be performed mediolaterally at a **60-degree angle at crowning**.
3. Documented use of **manual perineal protection (MPP)**:
 - For **spontaneous births**, manual perineal protection should be used unless the woman objects, or her chosen position for birth doesn't allow MPP.
 - For **assisted births**, manual perineal protection should be used.
4. Following birth, the **perineum should be examined** and any tears graded according to the RCOG guidance. The examination should include a **per rectum (PR)** check even when the perineum appears intact and this should be documented in the case notes.

As with all interventions, the care bundle should only be used with the woman's agreement. She should be aware that she can withdraw this agreement at any point during her baby's birth and that this will not affect her care. This facilitates a model of shared decision making.

1. Inform the woman about OASI and what steps can be taken to minimize her risk

Women should be given a copy of the **OASI Care Bundle information leaflet** at their antenatal appointment which takes place between **32-36 weeks**. Copies of this leaflet should also be readily available in appropriate places within the maternity unit where women will attend for services whilst they are pregnant, for instance: assessment units, ultrasound departments and consultant-led clinics. It may also be helpful to provide the RCOG patient information leaflets: *Third- or fourth-degree tear during childbirth* and *Understanding how risk is discussed in healthcare*. (16) If the woman has not received information about the OASI Care Bundle before the start of her labour, the clinician should explain the care bundle at this time and address any questions or concerns the woman may have.

Clinicians may be concerned that there are positions that will not allow them to use MPP. Women must be able to **mobilize freely during labour** and delivery, if they choose to do so. The only instance where it may not be possible to use MPP is when women are **labouring in water** or, on a **birthing stool**. All other positions should allow for the attending clinician to visualise the perineum and use their hands to support it at the time of birth.

Communication

If the clinician has particular concerns about a woman's individual risk for OASI (see risk factors listed above) they may wish to recommend that the woman adopts a position that allows for MPP to be applied during the birth. This discussion and the woman's decision for her birthing position should be documented in the maternity notes (see documentation examples below).

Documentation

We suggest that the following wording should be included in the woman's maternity notes with regard to the discussion of the care bundle:

"[Patient name] is aware of the OASI Care Bundle. She has no objection to it being used if she is in a position for birth that facilitates the use of the care bundle."

OR

"[Patient name] is aware of all the elements of the OASI Care Bundle and the rationale for its use. However, [patient name] declines its use because she objects to an element of the care bundle and/or prefers to adopt a position for birth that does not facilitate the use of the bundle" e.g. water birth, or birthing stool.

2. When indicated, episiotomy should be performed mediolaterally at a 60-degree angle at crowning

There is little evidence to support the routine use of episiotomy for an unassisted birth; however, there is some evidence that episiotomy reduces the risk of OASI during instrumental delivery. **Episiotomy should never be a 'routine' intervention to reduce the risk of OASI** and should only be carried out after clinical assessment of the fetal and maternal risks. The indication for an episiotomy should be recorded in the woman's notes.

In the context of this care bundle, episiotomy is indicated in cases of fetal distress, delayed second stage of labour, instrumental delivery, and in cases when a severe perineal tear is judged to be imminent - feel digitally for remaining space/stretch and observe whether blood flow to the perineum appears significantly reduced.

An episiotomy should be used for **all term forceps and ventouse/kiwi births in nulliparous women**. In **multiparous women, an episiotomy should also be used for all term forceps births, but may occasionally be omitted with a ventouse** birth after considering and discussing the woman's risk of sustaining an OASI.

If an episiotomy is indicated, it should be performed at a 60-degree angle on the woman's right as the baby's head is crowning. Evidence suggests that this will reduce the risk of OASI. All midwives and obstetricians should be competent in performing this intervention. Studies have demonstrated that a significant proportion of 'mediolateral' episiotomies are performed at an inappropriately acute angle, perhaps due to the distorted anatomy at the time of crowning. (17) Tools to facilitate achievement of the 60 degree angle, such as the use of scissors that indicate the correct episiotomy angle, have been shown to be effective and may be considered. (18)

Communication

It is important that the clinician communicates the indication(s) for which an episiotomy is being considered with the woman. For example, if the episiotomy is being performed when there are no immediate concerns about fetal wellbeing and the episiotomy is only being performed in an attempt to protect the perineum, the woman should be made aware of the equivocal nature of the evidence for this intervention.

As with any intervention, the woman should give her agreement before an episiotomy is performed.

When an episiotomy is used, clinicians should ensure that they document the indications for episiotomy, the angle at which the episiotomy was performed, and the woman's agreement for the episiotomy to be used.

3. Documented use of manual perineal protection (MPP)

- a. *For spontaneous births, manual perineal protection should be used unless the woman's chosen position for birth doesn't allow MPP, or she objects.*
- b. *For assisted births, manual perineal protection should be used*

The guiding principle for maternal position in the second stage of labour is maternal comfort and the encouragement of mobility as well as the widening of the pelvis outlet to assist birth. (19) There is no clear evidence that any particular position has a significantly protective effect on the perineum.

Manual perineal protection (MPP) is a bimanual technique that requires support of the posterior fourchette with one hand and cupping of the fetal head with the other to prevent the head coming out with great force as it progresses at crowning. The training provided by the OASI Care Bundle Project Team will focus specifically on using the 'Finnish Grip' technique of MPP. This manoeuvre must be used in combination with appropriate coaching of maternal breathing and reduced pushing as described below. It can be performed in most birthing positions that the woman feels comfortable in.

a. Spontaneous births

It is necessary for the clinician to **gauge the speed** at which the head is progressing to allow the use of appropriate pressure (enough to allow progress but prevent uncontrolled expulsion) at the correct time (at crowning, prior to birth).

- One hand is used to "cup" the fetal head and **control the speed and progress** of the presenting part.
- The other hand **supports the perineum** using the thumb and forefinger on the lower part of the labia, firm pressure is used while flexing (curling in) the remaining 3 fingers and pushing them against the perineum.
- As the face becomes visible use the middle finger of the perineal support hand to **assist with the birth of the chin** over the introitus.
- Encourage the mum to refrain from pushing and **breathe the baby out slowly**.
- Wait for restitution to occur, (still supporting the perineum) and encourage the mum to **push gently to birth the shoulders**.
- Continue MPP throughout the birth of the shoulders by **moving your non-dominant hand** to support the baby's body. Applying gentle axial traction until both shoulders are born.

Important principles are:

- **Coaching** the mum to avoid sudden expulsive pushing
- Maintaining **gradual progress** during the birth of the head
- **No undue downward traction** during delivery of the shoulders
- **Support the perineum** throughout the whole birth

Although access to the perineum is necessary for the achievement of MPP at crowning, it should never be a reason to restrict a woman's movement throughout the second stage. The clinician may have to adjust their own position in order to optimise their visualisation of the perineum to apply this technique. MPP is **not limited by the woman's position** and can be used in positions including: semi-recumbent, lateral and 'all fours' (hands and knees). Appendix 1 shows images of how MPP may be used in some of these positions.

b. Assisted Births

MPP should also be used during assisted births when using either forceps or vacuum. In these instances, the technique for MPP may have to be modified. Images for how to use MPP during instrumental births are also shown in Appendix 1. If two clinicians are available during an instrumental birth, the assistant will apply support from one hand on the perineum during the birth of the fetal head (including after the episiotomy has been cut) by the instrument of choice. On crowning, the clinician should control the speed of the birth of the head. If only one clinician is available it may be possible to use one hand to support the perineum and use the other to operate the instrument, provided this does not risk harming the woman or her baby.

Communication

It is recommended that women are encouraged to slow their breathing and control their pushes on crowning in anticipation of the birth of the fetal head. This allows the perineum to accommodate the gradual stretching caused by the head, thereby reducing the risk of tearing by uncontrolled expulsion. The fetal head should never 'pop out'; instead it should be guided in a controlled manner at crowning, with a combination of controlled slowed or shallow maternal breathing, reduced maternal pushing and MPP. If maternal effort is not proving effective, women should be given additional positive encouragement to try to facilitate the birth of the baby, but control must be maintained throughout.

During a spontaneous birth, the woman should have the opportunity to choose a birthing position which she finds most comfortable. If this position restricts visualisation of the perineum, and therefore the ability for the clinician to use MPP, then the clinician should communicate to the woman that they may not be able to visualize and protect their perineum, therefore, it may increase her risk of sustaining and OASI. If an instrumental birth is necessary, the woman will need to adopt the position required to successfully facilitate this.

If the clinician has particular concerns about a woman's individual risk for OASI (see risk factors listed above) they may wish to recommend that the woman adopts a position that allows for MPP to be applied during the birth. This discussion and the woman's decision for birthing position should be documented in the maternity notes (see documentation examples below).

Unless the baby's condition is critical, once the head is born, the clinician should wait for restitution of the head (external rotation) and internal rotation of the shoulders. Great care should be taken during the birth of the shoulders and MPP should be continued as the shoulders are delivered. The baby's body should be born following the direction of the curve of Carus, using gentle axial traction and maternal effort and avoiding undue

downward traction. MPP should continue, if possible, during the birth of the shoulders.

Documentation

We suggest that the following wording should be included in the patient notes with regard to the use of MPP:

“I [clinician name] applied manual perineal protection during the crowning of the baby’s head. [Patient name] agreed to this intervention and was in the [list that woman’s position for birth] position.”
Any difficulties with applying MPP should also be documented.

4. Perineal examination, including a per rectum examination, carried out following all vaginal births.

Following birth, a **thorough examination of the perineum should be carried out**. It is recommended that a competent clinician assess the perineum following every vaginal birth. This assessment must include a rectal examination as recommended by NICE (19) and should be carried out even when the perineum appears intact. Any tears should be classified according to the RCOG guidance (14) and documented in the case notes.

The technique of assessment is described in detail by Sultan and Kettle. (20) Appropriate and specific discussion with the woman is required in the event of an OASI in addition to routine postnatal debriefing.

Communication

The clinician should explain to the woman what they plan to do and the importance of doing this. Verbal consent must be obtained for the examination. The clinician should ensure that the woman is comfortable (with adequate analgesia) and in a position that allows optimal visualisation of the perineum for assessment. The woman’s dignity must be maintained throughout and the clinician must be willing to stop if asked to do so by the woman.

The woman’s agreement, the interventions and the post-partum discussions must all be clearly documented in the notes, together with examination findings and any follow-up plans.

Documentation

We suggest that the following wording should be included in the patient notes with regard to the post-natal perineal examination.

“I [clinician name] have performed a postnatal perineal per rectum examination and have found [list tears and degree]. I communicated this with [patient name].”

Ensuring continuous quality improvement

The Institute for Healthcare Improvement acknowledges that when using care bundles and all-or-none measurements, care is changed in important ways. (21) This includes:

1. challenging the assumption that evidence-based care is being delivered reliably
2. promoting awareness that the entire care team work together in a system designed for reliability
3. promoting the use of improvement methods to redesign care processes. (21)

We encourage the use of regular quality improvement methods to facilitate the implementation of the OASI care bundle in your maternity unit. Two examples are detailed below.

One option for ensuring continual quality improvement related to OASI prevention in your maternity unit is to use 'Plan Do Study Act' (PDSA) cycles to support the implementation of care bundle methodology. PDSA cycles test changes to assess their impact, ensuring that new ideas improve quality before implementation on a wider scale. (22) In the case of the OASI Care Bundle implementation, this means we are introducing the care bundle to a small cohort of women initially, then reviewing and modifying the approach before implementing it with a larger group of women, and so forth until the intervention is fit for purpose and implementation among all agreeing women. Incremental roll-out allows for the introduction of new systems without disrupting existing systems. (22)

Another method to promote continuous quality improvement is clinical audit. Clinical audit is described as a quality improvement cycle that involves measurement of the effectiveness of health care against agreed and proven standards for high quality and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes. (22) The care bundle compliance record lends itself to the audit of local compliance, with the care bundle as well as outcomes.

Resources for OASI care bundle training

Clinical training on the elements of the care bundle is vital to its success. We recommend that you use the time preceding the roll out period to ensure that your staff are trained on the care bundle. There are many existing resources that you can use to facilitate this training in your maternity unit. Specifically, we recommend the following:

- Maternity PEARLS—StratOG module
- Perineum.net
- Maternity PEARLS—RCM i-learn course
- Green Top guideline – Third and Fourth Degree tears

<https://stratog.rcog.org.uk/tutorial/perineal-surgery/introduction-to-perineal-surgery-599>

Women's involvement

It is imperative that women giving birth in your maternity unit are aware of the OASI Care Bundle and what it might mean for their care. We have developed an information leaflet for women planning to give birth in your maternity unit. (Appendix 2). It is recommended that you provide this leaflet at an antenatal visit from 32-36 weeks and discuss the care bundle with the woman. This conversation should address any

questions or concerns she may have about the care bundle in relation to her intrapartum care. The leaflet should be used as appropriate to reinforce verbal communication. To further support conversations with women, we have provided a communication timeline which may help you time and structure your conversations with women about the care bundle (Appendix 3).

Providing high quality care for women is our goal. It is therefore essential that we include their experience of the care bundle. The information leaflet indicates that women will be asked for 'their voice'. During the 3 month roll-out period in your unit, we will request that around 10 women are recruited over a week-long period to participate in a telephone interview about their birth experience. Detailed information about this will be provided during the roll-out phase.

Evaluation of the care bundle

The implementation period will run from January 2017 through Spring 2018. The care bundle will be evaluated to assess the effectiveness of the intervention. The primary outcome is OASI rates. At the end of the implementation period (Spring 2018), we will request an extract from your Maternity Information System (MIS) dating back to October 2016 and a before and after analysis of your unit's OASI rates will be performed. This data will not be patient identifiable. As well as data on OASI, we will also collect data on maternal characteristics (e.g. age, BMI, parity) and intrapartum care (induction of labour, mode of delivery, epidural use and shoulder dystocia) to adjust for case mix and risk factors for OASI. Rates of caesarean section will also be examined. This information will be fed back to you in a short report following the completion of these analyses.

Implementation outcomes will be evaluated through evidence of integration of the care bundle into routine practice (i.e. coverage and sustainability), as well as an assessment of acceptability and feasibility of the intervention.

In order to explore acceptability and feasibility of the OASI care bundle at each site, focus group discussions (FGDs) will be conducted. These will be an open forum for discussion about the care bundle. The discussion will be informed by a topic guide to ensure consistency across groups. One focus group will be conducted per maternity unit. Each focus group needs 6-8 participants, comprising midwives and obstetricians, and ideally should reflect a range of ages and levels. Focus groups will be facilitated by the OASI Project Team. They will last between one and two hours and will be scheduled at a time that is convenient for your unit. The results will be used to make any revisions to the care bundle.

Monitoring and feedback during roll-out

We will be monitoring the uptake of the care bundle during roll out and the period afterwards until the Spring of 2018 in two ways:

1. We will be requesting a **short extract from your MIS** on a weekly basis, covering data such as; number of births, 3rd and 4th degree tear rates and episiotomy rates, stratified by parity. This data will not be patient identifiable.
2. We will be asking all women's notes to include a **sticker** (provided by the project team, (see Appendix 4)) which will have a short list of 'tick' boxes which we will ask the attending clinician or an assisting/observing clinician to complete. For some units, it may be possible for these questions to be incorporated into their Maternity Information System and the data filled in as part of this process, instead of using the stickers. The decision of which process is most appropriate for a unit is for the Local Champions. We will ask that this data is also collected and fed back to us on a weekly basis by your local champions **throughout roll out** and **afterwards** until 2018.

Appendix 1: Images of manual perineal protection (MPP) in various birthing positions

Recumbent/semi-recumbent



1 MPP in the recumbent or semi-recumbent position / Image courtesy of Dr. Katariina Laine, University of Oslo, Norway.

Lateral



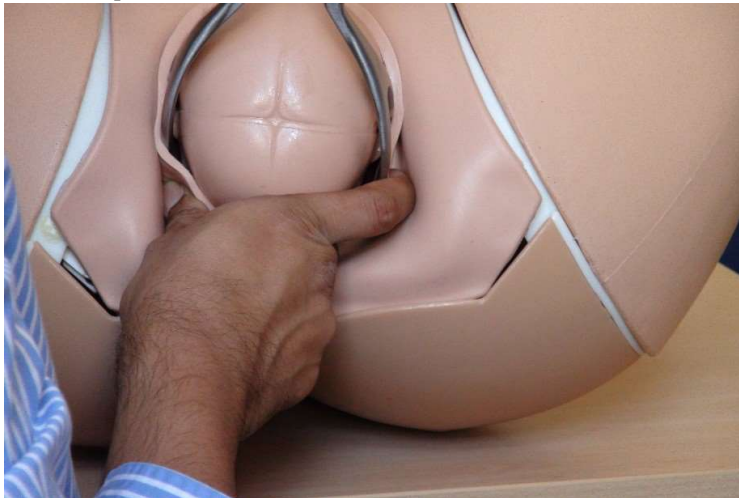
2 MPP in the lateral position / Image courtesy of Dr. Katariina Laine, University of Oslo, Norway.

‘All fours’ or hands and knees



3 MPP in all fours position / Image courtesy of Guy's and St Thomas' NHS Foundation Trust

Forceps



4 MPP while using forceps / Image courtesy of Croydon University Hospitals NHS Trust.

Ventouse



5 MPP while using a ventouse / Image courtesy of Dr. Katariina Laine, University of Oslo, Norway.



Appendix 2: OASI Care Bundle information leaflet for women



Obstetric Anal Sphincter Injury

Information for expectant mothers

Your maternity unit is taking part in a project which aims to reduce the rate of third and fourth degree perineal tears which can occur when you give birth

What type of tears can occur during childbirth?

It is common for the perineum to tear to some extent during childbirth. Up to 9 in every 10 women will experience some sort of tear or graze. For most, these tears are minor and heal quickly. Tears usually occur in the perineum, which is the area between the vaginal opening and the anus (back passage). Tears can also occur inside the vagina and in the labia.

First and second degree tears are the most common and are very unlikely to cause long term problems:

- **First degree:** small tears affecting only the skin which usually heal quickly and without treatment.
- **Second degree:** tears affecting the muscle of the perineum and the skin. These usually require stitches.

For some women the tear may be deeper. Third or fourth degree tears, also called obstetric anal sphincter injuries (OASI) occur in up to 6% of births for first time mothers and in 5% of subsequent births. These extend to the muscle that controls the anus (the anal sphincter) and will require stitches.

What causes third or fourth degree tears?

For many women there is no clear reason for experiencing a third or fourth degree tear and it is not possible to predict. However, it is more likely if:

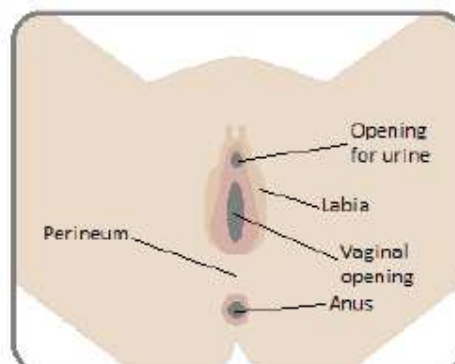
- This is your first vaginal birth
- Your baby is over 4kg (9 lbs)
- You have a long second stage of labour (the stage during which you push your baby out)
- Your baby's shoulder gets stuck behind the pubic bone (shoulder dystocia)
- You have an assisted birth (forceps or ventouse)

What is the difference between a tear and an episiotomy?

A tear happens spontaneously as the baby stretches the vagina during birth. An episiotomy is a cut made by the midwife or doctor into the perineum and vaginal wall to make more space for your baby to be born. Episiotomies are only done with your agreement. They are only done if your baby needs to be born quickly, often if you are having an assisted birth or if you are at risk of a serious perineal tear. Episiotomies are easily repaired after the birth and usually heal quickly.

How do I know what type of tear I have?

After the birth of your baby, your midwife or doctor will carefully examine your vagina, perineum and rectum to see if you have a tear, and if so, what type. They will then advise you if you need stitches. If you have a first or second degree tear, the stitching is usually done with a local anaesthetic in the room where your baby was born. If you have sustained a third or fourth degree tear, you will be transferred to the operating theatre where the stitches will be done following an epidural or spinal anaesthesia so that you have good pain relief.





What are the long term effects of third or fourth degree tears?

Most women who have a third or fourth degree tear heal completely. However, some women find they are not able to control their bowels or the passing of wind. Women who experience these symptoms will receive appropriate care, which may include physiotherapy or surgery. Some women who have a third or fourth degree tear may be concerned about having sex and may also be apprehensive about giving birth again. It is important to talk about any concerns to your midwife or doctor because support is available for you.

What can be done to reduce third and fourth degree perineal tears?

In your maternity unit, midwives and doctors will take a number of actions to try to prevent third or fourth degree tears during childbirth. This set of actions is incorporated into the OASI Care Bundle. The Care Bundle is based on the best and most up to date research evidence. It has been developed by an expert team of midwives and doctors. Your midwife or doctor will discuss the Care Bundle with you.

The Care Bundle will not affect the choices that you have made about your birth and you can still give birth in the position that you find most comfortable.

The 4 elements of the OASI Care Bundle:

- 1 You will be **informed** about OASI and what can be done to reduce the risk of it occurring.
- 2 Your midwife or doctor will use their hands to **support** both your perineum and the baby's head at the time of birth whilst communicating with you to ensure your baby is born in a slow and controlled way.
- 3 An **episiotomy** will be used, **only when essential**.
- 4 After the birth, an **examination of your vagina, perineum and rectum** (just inside the back passage) will be carried out to check for tears. Whilst this sounds uncomfortable (or unpleasant), it is quick and should not be painful. It is important that any perineal injury is identified and appropriately treated. Untreated perineal injury can have long-term consequences.

Is there any reason why the Care Bundle cannot be used?

The Care Bundle only applies to vaginal births and is not relevant if your baby is born by caesarean section (either planned [elective], or unplanned [emergency]). If you give birth in water, or on a birthing stool, it will not be possible for the midwife or doctor to use their hands to support your perineum and the baby's head. However, in these positions your midwife will work with you to achieve a controlled birth.

If you have any questions or concerns about the information contained in this leaflet, please speak to your doctor or midwife.

Project evaluation

We will evaluate the OASI Care Bundle to provide evidence on how effective it is. The rates of third and fourth degree tears in your maternity unit will be continually monitored. Midwives and doctors will be asked to provide their views on the Care Bundle.

YOUR VOICE

Providing high-quality care for expectant mothers is our ultimate goal. We would like to hear from you to understand your experience of giving birth whilst your maternity unit is using the Care Bundle. You may be invited to talk to the OASI Project Team about your birth. This is voluntary and your midwife or doctor will provide you with details about this at the time.

For more information about third and fourth degree tears please speak to your midwife or doctor, or visit:

<https://www.rcog.org.uk/patient-leaflet-tears-during-childbirth>

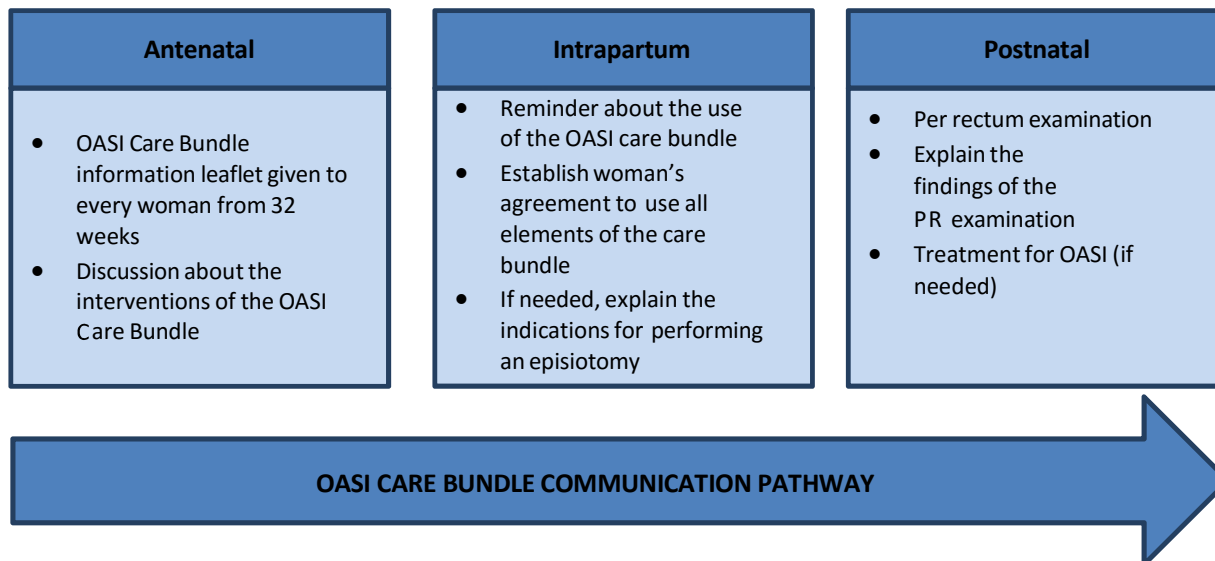
If you require additional details about the OASI Project, please visit:

<https://www.rcog.org.uk/OASICareBundle>


The OASI Project is led by Croydon Health Services NHS Trust in collaboration with the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of Midwives (RCM) and the London School of Hygiene and Tropical Medicine (LSHTM). It is supported by the Health Foundation.

Appendix 3: Communication pathway to support the OASI Care Bundle roll-out

Communication with the woman throughout her pregnancy pathway is critical to ensure shared decision making. Listed below are some of the key elements to guide your conversations with women and their birthing partners about the OASI Care Bundle at different stages of her care.



Appendix 4: Monitoring sticker



Please use a ✓ (yes) or ✗ (no) to answer the questions below about this birth:

A Was this a vaginal birth? *(If no, the remaining questions do not need to be answered)*

B Was this birth eligible for use of the care bundle? *(If no, the remaining questions do not need to be answered)*

C Was this birth compliant with **all four elements** of the care bundle?

D Who is filling out this form (please tick one)?

Attending clinician Assisting/observing clinician

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