**Better Births for Women**

Your toolkit for improvement work to reduce severe perineal trauma

OFFICIAL

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# Who is this toolkit for?

This resource is for maternity services that are planning improvement work to reduce the rate of third- and fourth-degree perineal tears for women giving birth.

# What is the toolkit?

This toolkit is based on quality improvement and improvement theory developed for the [Better Births for Women collaborative](https://www.safercare.vic.gov.au/improvement/projects/mbc/better-births).

The toolkit includes:

* background information on the Better Births for Women collaborative
* your step-by-step guide to getting started with reducing perineal trauma
* Better Births for Women collaborative driver diagram
* Better Births for Women change ideas, with links to resources to support your work.

# Background

## What is the Better Births for Women collaborative?

Women having their first birth vaginally in Victoria are four times more likely to experience a severe perineal laceration (third- or fourth-degree tear) compared to those having a subsequent vaginal birth (Victorian Perinatal Services Performance Indicators 2020–2021 report). This can have devastating long-term or lifelong impacts on physical and psychological wellbeing. Many of these tears are avoidable.

From 2019 until 2021, Safer Care Victoria (SCV) and the Institute for Healthcare Improvement (IHI) partnered with 14 health services to deliver the Victorian [Better Births for Women (BBW)](https://www.safercare.vic.gov.au/improvement/projects/mbc/better-births) collaborative which aimed to reduce the rate of third- or fourth- degree perineal tears through the introduction of an evidence-based clinical care bundle.

This clinical care bundle utilised the [WHA CEC Perineal Protection Bundle](https://women.wcha.asn.au/wp-content/uploads/sites/3/2022/04/wha_national_collaborative_how_to_guide_21.1.20.pdf) which was developed by the Women’s Healthcare Australasia (WHA) and the Clinical Excellence Commission, NSW (CEC). This work is referenced throughout this document as the Perineal Protection Bundle.

Partnering with consumers and encouraging participation and collaboration in care can help improve the safety and quality of care. The Better Births for Women Collaborative used the [‘Partnering in healthcare’ framework](https://www.safercare.vic.gov.au/sites/default/files/2019-02/Partnering%20in%20healthcare%20framework%202019_WEB.pdf) to elevate the consumer voice by engaging broadly with consumers in leadership roles within SCV and across the participating teams.

## What did the Better Births for Women collaborative set out to achieve?

The aim of the Better Births for Women collaborative was to reduce harm to Victorian women by reducing the rate of third- and fourth- degree perineal tears by 50 percent, by June 2021.

## What did we accomplish?

* Partnered with women during pregnancy, labour, birth, and immediately after birth, to support identification of risk factors and shared decision making
* Used improvement science as a framework for learning and change, including collecting data to understand our progress against a family of measures
* Worked towards consistent, reliable practice in key areas of clinical care:
  + warm perineal compresses
  + encourage a slow controlled birth
  + episiotomy when indicated, with correct technique
  + comprehensive assessment for perineal tears
  + accurate severity grading of perineal tears.

# Current improvement work

The Maternity and Newborn Learning Health Network (MNLHN) is looking to build on these efforts, working to facilitate sustainability and spread of the previous collaboratives. The MNLHN Improvement Program will support maternity services to reduce rates of severe perineal tears, utilising the tools and resources from the previous collaboratives.

# Using the Model for Improvement

## Your step-by-step guide

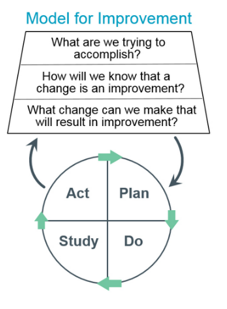
This guide brings together foundational quality improvement methods, the [Model for Improvement](https://www.safercare.vic.gov.au/improvement/step-by-step-guide-to-using-the-model-for-improvement) (see Figure 1) and information from the Better Births for Women collaborative. The Model for Improvement helps us deliver improved outcomes and support improvement in health care.

The Model for Improvement asks you to respond to three questions as you plan and undertake improvement work and it includes the Plan-Do-Study-Act (PDSA) cycle as the engine for developing, testing and implementing change in your system. Thoughtful, collaborative consideration of the three questions enables deep understanding of the problem or opportunity for improvement, identification of high-quality change ideas, and construction of an effective measurement strategy to capture learning and track progress.

The three questions are:

* What are we trying to accomplish?
* How will we know that a change is an improvement?
* What change can we make that will result in improvement?

Figure 1: Model for Improvement



1. Build your team

#### Improvement teams

Effective improvement in our complex healthcare system requires a team approach to share the work and to provide diverse knowledge and experience. Ideally, your team will include:

* a project lead who will be responsible for coordinating and driving the work
* at least one consumer with lived experience of your health service (two or three consumers is preferred)
* someone with quality improvement knowledge and experience with training in improvement science
* multidisciplinary representation with strong clinical leadership including medical (obstetricians, obstetric registrars, GPs) and midwifery staff
* an executive sponsor.

#### Executive sponsor

Support from your health service executive leadership is critical to enabling protected time to dedicate to the improvement work, access to resources, removal of barriers to progress and organisational commitment. Your executive sponsor is essential in championing your work within your health service and helping you sustain will and engagement throughout the work.

#### Partnering with consumers

We know better health outcomes are achieved when health professionals and services work in partnership with consumers, patients, carers, and communities. When consumer voices contribute to the design and development of strategies for improvement in care provision, local solutions to local problems are created based on the needs of the recipients of that care. If you are unsure where to start with consumer recruitment, reach out to the consumer liaison service in your hospital or the MNLHN via email [maternityandnewbornlhn@safercare.vic.gov.au](mailto:maternityandnewbornlhn@safercare.vic.gov.au) for support.

#### Applying an equity lens

When forming your team, consider how you will attract diverse perspectives and experiences. For example, the view of Aboriginal and Torres Strait Islander people, people who are culturally and linguistically diverse, women and LGBTQI+, and others who may be experiencing disadvantage. Including a diverse range of people can ensure solutions work across the population.

Helpful tools:

* [SCV Partnering in healthcare framework](https://www.safercare.vic.gov.au/support-training/partnering-with-consumers/pih)
* [Cultural responsiveness framework – Guidelines for Victorian health services](https://www.health.vic.gov.au/publications/cultural-responsiveness-framework-guidelines-for-victorian-health-services)
* [Designing for Diversity](https://www.health.vic.gov.au/populations/designing-for-diversity)
* [Institute for Healthcare Improvement (IHI) Achieving health equity](https://www.ihi.org/resources/white-papers/achieving-health-equity-guide-health-care-organizations)

1. Explore your opportunity for improvement

#### What does the data tell you?

At this stage of your work, data is key to understanding how many third- and fourth-degree perineal tears happen at your service, and the consistency and reliability of care in key areas of clinical practice connected to perineal outcomes.

Measures set out in the table below are used by participating services during the Better Births for Women collaborative Improvement Program to know whether the changes they were making and testing were leading to improvement. You may wish to use these to understand your service’s current performance and identify your area of opportunity for improvement. You can collect data across a range of measures to form a baseline before beginning to test changes. This will tell you about your system’s current performance. You could also undertake a ‘deep dive’, reviewing recent cases of third- and fourth-degree perineal tears at your service to explore whether there are gaps in the key areas of care.

Remember the equity lens: the segmentation of data by social groupings can help target improvement efforts to those who may be most disadvantaged.

### Improvement Program measures – adapted from Better Births for Women collaborative measures

#### Optional measures

|  |  |
| --- | --- |
| Outcome measures | * Percentage of total third- and fourth-degree perineal tears * Percentage of third- and fourth-degree perineal tears in non-instrumental vaginal births * Percentage of third- and fourth-degree perineal tears in instrumental assisted vaginal births |
| Process measures | **Bundle element 1: Use of warm compress during second stage labour**   * Percentage of women who have a warm perineal compress applied during the second stage of labour   **Bundle element 2: Encourage a slow controlled birth**   * Percentage of women who receive gentle verbal guidance and hands on technique, from commencement of perineal stretching to the birth   **Bundle element 3: Correct episiotomy technique used when indicated**   * Percentage of instrumental births in women having their first vaginal birth, who have an episiotomy performed * Percentage of episiotomies cut at 60degrees from the midline   **Bundle element 4: Comprehensive assessment for perineal tears**   * Percentage of women, who receive a comprehensive assessment for perineal tears following a vaginal birth   **Bundle element 5: Accurate severity grading of perineal tears**  Percentage of women whose perineal trauma is examined and graded by two experienced clinicians |
| Balance measures | * Percentage of women who have an episiotomy * Percentage of women who have caesarean sections |

#### Optional measures

|  |  |
| --- | --- |
| Outcome measures | Percentage of compliance with all five bundle elements |
| Process measures | * Percentage of women for whom there is evidence in their pregnancy care record of a conversation about details of the perineal protection bundle * Percentage of women who report a conversation with their treating health professional about details of the perineal protection bundle |

#### What do you know about the processes driving current practice?

Understanding your health service involves knowing the steps in the woman’s journey through pregnancy, labour and birth, and the factors affecting her experiences and outcomes. Detailed understanding of this will help you and the team identify where there are inconsistencies, gaps, duplications, or delays.

Helpful activities:

* Deep Dive Case Studies
* [Process mapping](https://www.ihi.org/sites/default/files/QIToolkit_Flowchart.pdf)
* [Affinity mapping](https://www.vic.gov.au/affinity-mapping)
* Cause and effect (fishbone/Ishikawa) analysis

* [IHI QI Essentials toolkit: Maternal health](https://www.ihi.org/resources/tools/better-maternal-outcomes-quality-improvement-workbooks)

#### What are the people telling you?

Change is an integral part of improvement work, but this is not always embraced by individuals or teams. It can be challenging to build and maintain momentum in the face of the resistance that change can provoke.

What do you know about the culture, communication, and teamwork in your context? Do you know who might be your champions for change?

Helpful tool:

* [IHI Psychology of change framework](https://www.ihi.org/resources/white-papers/ihi-psychology-change-framework)

1. What will you try to accomplish?

What are the specific, measurable, achievable, relevant, and timely (SMART) goals for your team? How much do you want to improve by? How can you set a goal that will energise and motivate, without seeming too far out of reach or too easy?

What is your timeframe? Is it a realistic match for how much you want to improve by and the complexity of your system? Is there a particular part of your service you want to focus on?

1. What will you focus on?

In improvement work, once we understand what problem or area of opportunity exists, the ideas and potential solutions we want to test in our system are referred to as change ideas. A change idea is an actionable, specific idea for changing a process. It can come from research, best practices, or from other organisations that have recognised a problem and have demonstrated improvement on a specific issue.

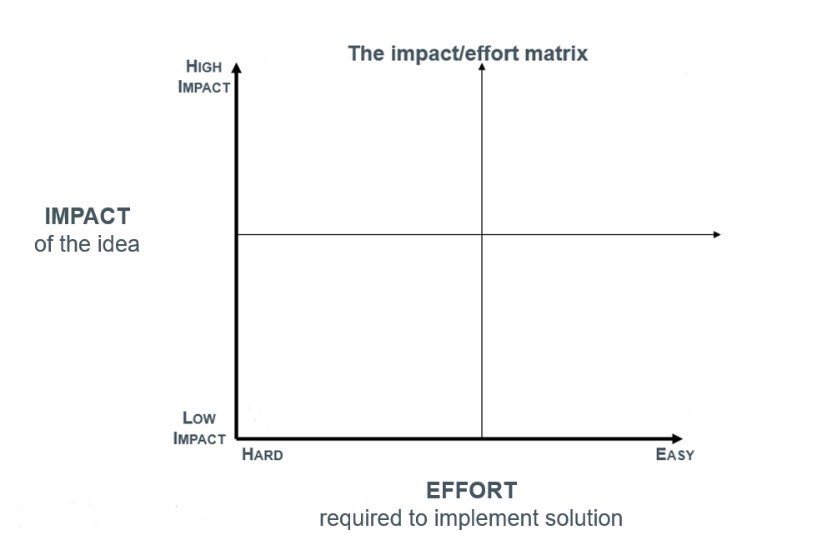
Change ideas can be tested to determine whether they will result in improvement and are often revised because of these tests. In the Better Birth for Women collaborative [driver diagram](#TargetPage) you will see change ideas down the right-hand side. The diagram is followed by a series of tables linking the ideas to resources teams have used and developed when testing and implementing these changes. Change ideas in the collaborative came from research work undertaken in other jurisdictions, and maternity services participating in the collaborative.

Consider the change ideas included in this toolkit as a menu of options from which you can choose the most relevant or highest priority area in your health service. Your data, understanding of current practice, clinicians and consumers voice and organisational priorities will guide how you prioritise ideas. Some teams may start with one driver. Others may choose to start by tackling one idea across all three drivers. Many teams find it helpful to start with the ‘low hanging fruit’, to build belief in the work.

Helpful tools:

* [Model for Improvement: Testing Changes](https://www.ihi.org/resources/how-to-improve/model-for-improvement-testing-changes)
* [Prioritising change ideas: impact/effort matrix](https://asq.org/quality-resources/impact-effort-matrix) (Figure 2).

Figure 2: Impact/effort matrix



1. How will you know that change is an improvement?

Measurement is essential to help learn about the impact you are having as you test changes in a wide range of conditions, whether changes are leading to improvement and what the next steps could be. You and your team will collect and learn from data in real time, using annotated charts to understand your impact, adjust your hypotheses along the way, and see progress towards your aim.

#### A family of measures

A small [family of measures](https://www.ihi.org/resources/how-to-improve/model-for-improvement-establishing-measures) will help track your progress:

* one or two outcome measures aligned to your aim
* up to five process measures aligned to activities or practices logically connected to your aim
* one or two balancing measures to monitor potential indirect impacts in your system.

You may wish to use measures from the collaborative or develop measures to suit your context.

#### Collecting data: when and how much?

The focus of data collection for improvement is specificity and frequency: is your data directly connected to your project and are you collecting it frequently enough to learn and respond quickly?

Frequency of data collection may look like:

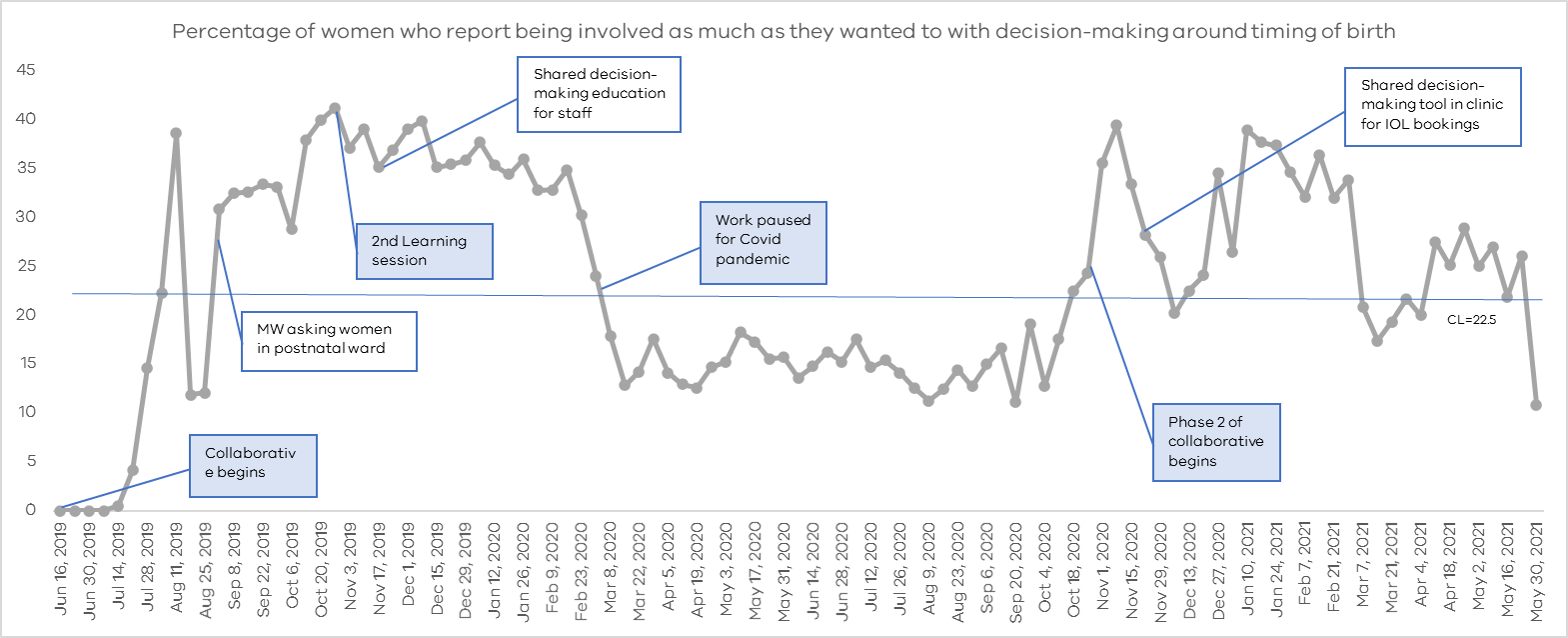
* outcome measures – monthly
* process measures – weekly
* balance measures – monthly.

You will need to collect just enough data to learn whether your changes are having an impact on your system. Too much and all your time will be taken up with data collection. Too little and you won’t learn effectively. A good place to start is to sample 20 patient records per week, noting that your data collection opportunities will vary depending on your service size.

#### Making sense of your data

Displaying your data on charts will help you understand the impact of your changes, assess progress, and communicate progress with stakeholders. A run chart is a line graph of data over time, demonstrating performance of a process and enabling you to determine between expected (common cause) and unexpected (special cause) variation. Annotating your run charts to show when tests of change happen will increase your understanding of how these changes are influencing practice.

Figure 3: Run chart example of a process measure



Helpful tools:

* [Run chart rules](https://www.ihi.org/education/IHIOpenSchool/Courses/Documents/11_RunChartRulesReferenceSheet.pdf)

#### Introducing changes into your system

Testing change using PDSA enables teams to learn what works and what does not in their efforts to improve processes. Initially, cycles are carried out on a small scale to see if they result in improvement, e.g. one patient on one day. Teams then expand tests and gradually incorporate larger and larger samples until they are confident that changes will result in sustained improvement.

It is important to complete each of the four stages of a PDSA cycle:

* **Plan** – be clear about what you are trying to learn with this PDSA cycle; note the questions you have and make predictions about what will happen, and document details of the test (who, what, when, where and how)

* **Do** – carry out the plan, observe and measure (that is, collect data) what happens. Take notes of what went well and what did not
* **Study** – analyse and compare data, check your observations against your predictions, summarise learnings
* **Act** – decide on what will happen next: will you adapt the change and test again, adopt the change, or abandon it and try something different with your next PDSA cycle?

1. Communication

Throughout your improvement initiative, communication is critical for:

* supporting effective teamwork
* working productively with your team’s executive sponsor
* building and sustaining momentum through consumer stories
* connecting with others on the same mission.

#### Supporting effective teamwork

Your team will need to connect frequently. What modes of communication do you already use which could support frequent contact? What modes of communication are accessible for consumers or other non-clinical members of your team? These might include:

* email
* Microsoft Teams chat or similar
* regular phone calls
* shared documents for asynchronous development
* a physical message board
* face-to-face or video-chat huddles
* regular face-to-face or virtual team meetings.

#### Working with your executive sponsor

To best support your work, remove barriers, and champion your cause, your team’s sponsor needs to be up to date with your improvement plans, successes and challenges. Keeping up to date can be achieved by:

* inviting your sponsor to team meetings regularly
* inviting your sponsor to all key project events
* sharing improvement stories and data that your sponsor can share more widely
* reaching out when you encounter barriers to your work progressing.

#### Building and sustaining engagement through stories

Narrative is highly effective at engaging the head and the heart. Great stories teach us not only how we ought to act but motivate us to act. Stories can be collected and shared from both a patient and staff/health service perspective. Consumer stories are powerful tools to help us learn, improve, and build engagement across health service teams.

Public narrative is composed of three elements: a story of self, a story of us, and a story of now. A story of self communicates *who I am* – my values, my experience, why I do what I do. A story of us communicates *who we are* – our shared values, our shared experience, and why we do what we do. And a story of now *transforms the present into a moment of challenge, hope and choice*.

We strongly recommend taking the time to capture consumer and staff stories as you go. This could be by:

* taking photos
* recording observations
* creating brief video interviews or audio recordings
* writing blog posts
* sharing social media posts
* presenting at conferences and forums.

#### Connecting with others who have the same goals

Having the opportunity to connect with other people undertaking improvement work, to learn from their successes and failures, and to share your own so others can benefit from your experience, is an important factor in sustaining motivation, gathering ideas and strengthening your improvement approach. This could be within your service, your community, across the state or even nationally. Consider:

* asking your manager what other improvement work is happening at your service
* reaching out to your professional college
* joining a community of practice
* starting a community of practice
* connecting with the team at SCV: [maternityandnewbornlhn@safercare.vic.gov.au](mailto:maternityandnewbornlhn@safercare.vic.gov.au).

# Driver diagram – Better Births for Women

This driver diagram was developed in partnership with the Collaborative Faculty, which included clinicians and consumers. It has been updated since the completion of the collaborative in line with stakeholder feedback.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| AIM |  | PRIMARY DRIVERS |  | SECONDARY DRIVERS |  | CHANGE IDEAS |
|  |  |  |  |  |  |  |
| By [insert date] we intend to reduce the rate of severe perineal trauma\* by x% in participating health services.  *\* Severe perineal trauma includes third and fourth degree perineal tears.* |  | Partnering with women |  | During pregnancy |  | Inclusion of information about the clinical bundle in childbirth education curriculum  Planning for risk assessment and shared decision-making during birth |
|  |  |  |  |  |
|  |  | During birth |  | Shared ongoing risk assessment and decision making |
|  |  |  |  |  |
|  |  | After birth |  | Offer all women the opportunity to discuss and ask questions about their perineal care, trauma and repair  Ask all women whether they were involved as much as they wanted to be in decision making about their care during birth |
|  |  |  |  |  |  |
|  | Application of evidence-based clinical care |  | Routine professional development |  | Incorporate education and simulation training on the five clinical interventions  Incorporate use of clinical models and/or pig sphincters for simulation training for grading trauma  Incorporate teach-back skills  Identify opportunities for in-the-moment teaching, reflection and clinical reasoning development, e.g. post tear huddles |
|  |  |  |  |  |
|  |  | Second stage of labour |  | **Intervention 1: Warm compresses**  Set up birthing environment to support use of warm compress  Provide necessary equipment for warm compress  Use ‘toe warmers’ or ‘hand warmers’ inside a peri-pad as warm compresses |
|  |  |  |  |
|  |  |  | **Intervention 2: Encourage a slow controlled birth using hands on technique**  Develop a video on hands-on technique, to share with all clinicians  Use clinical educators to provide education and simulation training  Establish standard process for documentation of intervention |
|  |  |  |  |
|  |  |  | **Intervention 3: Correct episiotomy technique used when indicated**  Episiotomy should be performed: at crowning of the fetal head, using a medio-lateral incision, at a minimum 60-degree angle from the posterior fourchette  Introduce post-repair episiotomy angle measurement  Use Episcissors for cutting episiotomies  Use cord-clamps to guide a 60-degree angle episiotomy when using mayo scissors |
|  |  |  |  |  |
|  |  | After birth |  | **Intervention 4: Comprehensive assessment for perineal tears**  For all women, genito-anal examination following birth needs to be offered, and where informed consent is given be performed by an experienced clinician and include a per-rectum examination for all women, including those with an intact perineum  Use a checklist for post-birth care that incorporates genito-anal examination |
|  |  |  |  |
|  |  |  | **Intervention 5: Accurate severity grading of perineal tears**  All perineal trauma should be graded according to the Royal College of Obstetricians and Gynaecologists (RCOG) grading guideline and reviewed respectfully by a second experienced clinician to confirm the diagnosis and grading  Develop local operational definitions for experienced clinicians  Provide staff rostering that supports availability of experienced clinicians |

## Primary driver 1: Partnering with women

Partnering with women and their support people is essential in achieving success. This part of the change package focuses on approaches to partnering and opportunities for sharing critical information at different stages: during pregnancy care, and during and after birth.

### Secondary driver: During pregnancy

| Change ideas | Explanation | Resources/References | Your team’s ideas |
| --- | --- | --- | --- |
| Inclusion of information about the clinical bundle in childbirth education curriculum | Provide education, and use teach back, to women in the antenatal period (34-36weeks gestation) that includes:   * Birth and birth risks * Interventions that might be used to help prevent perineal trauma * Perineal massage * Potential birth decisions that need to be made * Use of the lived experience videos   Health services should ensure that all women giving birth in their maternity unit are aware of the bundle elements, understand how this may influence their care and give informed consent to each part of the care bundle.  Early engagement with women about the clinical bundle allows for consideration of individual risk factors, providing women with the opportunity to make informed choices about their birth care. | [Talking about tears – a video for clinicians](https://www.youtube.com/watch?v=KY9ArcFz9qA)  [Torn at Birth](https://youtu.be/YSnU7wGOo6M) – patient experience video  [Teach-back](http://teachback.org/research/)  [Women’s experiences following severe perineal trauma: a metaethnographic synthesis](https://pubmed.ncbi.nlm.nih.gov/23057716/)  [Third and Fourth Degree Perineal Tears – Clinical Care Standard](https://www.safetyandquality.gov.au/sites/default/files/2021-04/perineal_tears_ccs_v3.pdf) – Australian Commission on Safety and Quality in Health Care (ACSQHC)  [Reducing third and fourth degree perineal tears – patient leaflet (multiple languages available)](https://women.wcha.asn.au/collaborate/breakthrough-collaboratives/perineal-tears/providing-information-and-engaging-women-in-decision-making) – Women’s Healthcare Australasia  [Intrapartum care: Care of healthy women and their babies during childbirth](https://www.nice.org.uk/guidance/ng235) – NICE Clinical Guideline |  |
| Planning for risk assessment and shared decision-making during birth | Shared decision-making is an important part of delivering person-centred care. It involves sharing of information, discussion and collaboration between a consumer and their healthcare provider and needs to be incorporated throughout the care continuum.  Information should be in a form that can be used and understood by patients and is appropriate to their health literacy, language and cultural needs.  Improved channels of communication will support enhanced risk assessment. | [The How to Guide: WHA CEC Perineal Protection Bundle](https://women.wcha.asn.au/wp-content/uploads/sites/3/2022/04/wha_national_collaborative_how_to_guide_21.1.20.pdf)  [Third and Fourth Degree Perineal Tears – Clinical Care Standard](https://www.safetyandquality.gov.au/sites/default/files/2021-04/perineal_tears_ccs_v3.pdf) – ACSQHC  [Shared decision making](https://www.safetyandquality.gov.au/our-work/partnering-consumers/shared-decision-making) – ACSQHC  [Using plain language in health information](https://pifonline.org.uk/resources/how-to-guides/using-plain-language-in-health-information/html-version/)  [Easy English](https://www.health.tas.gov.au/professionals/health-literacy/health-literacy-workplace-toolkit/written-communication/easy-english)  [The Power of Four Words: "What Matters to You?" | IHI - Institute for Healthcare Improvement](https://www.ihi.org/insights/putting-what-matters-you-practice-improve-patient-experience-and-equity)  [Engaging Patients and Families in Safety: Recommendations, Resources and Case Examples | IHI - Institute for Healthcare Improvement](https://www.ihi.org/insights/engaging-patients-and-families-safety-recommendations-resources-and-case-examples) |  |

### Secondary driver: During birth

| Change ideas | Explanation | Resources/References | Your team’s ideas |
| --- | --- | --- | --- |
| Shared ongoing risk assessment and decision making | Shared decision-making and ongoing risk assessment will support women to provide informed consent. | [The How to Guide: WHA CEC Perineal Protection Bundle](https://women.wcha.asn.au/wp-content/uploads/sites/3/2022/04/wha_national_collaborative_how_to_guide_21.1.20.pdf)  [Third and Fourth Degree Perineal Tears – Clinical Care Standard](https://www.safetyandquality.gov.au/sites/default/files/2021-04/perineal_tears_ccs_v3.pdf) – ACSQHC  [Shared decision making](https://www.safetyandquality.gov.au/our-work/partnering-consumers/shared-decision-making) –ACSQHC  [Using plain language in health information](https://pifonline.org.uk/resources/how-to-guides/using-plain-language-in-health-information/html-version/)  [Easy English](https://www.health.tas.gov.au/professionals/health-literacy/health-literacy-workplace-toolkit/written-communication/easy-english)  [The Power of Four Words: "What Matters to You?" | IHI - Institute for Healthcare Improvement](http://www.ihi.org/Topics/WhatMatters/Pages/default.aspx)  [Delivering Great Care: Engaging Patients and Families as Partners | IHI - Institute for Healthcare Improvement](http://www.ihi.org/resources/Pages/ImprovementStories/DeliveringGreatCareEngagingPatientsandFamiliesasPartners.aspx) |  |

### Secondary driver: After birth

| Change ideas | Explanation | Resources/References | Your team’s ideas |
| --- | --- | --- | --- |
| Offer all women the opportunity to discuss and ask questions about their perineal care, trauma, and repair | In particular, a timely debrief should be offered to all women who have experienced a severe perineal tear in line with open disclosure principles and the ACSQHC perineal tears Clinical Care Standard. | [Women’s experiences following severe perineal trauma: a metaethnographic synthesis](https://pubmed.ncbi.nlm.nih.gov/23057716/)  [Third and Fourth Degree Perineal Tears – Clinical Care Standard](https://www.safetyandquality.gov.au/sites/default/files/2021-04/perineal_tears_ccs_v3.pdf) – ACSQHC  [Talking about tears – a video for clinicians](https://www.youtube.com/watch?v=KY9ArcFz9qA) - ACSQHC  [Talking about tears - a video for women](https://www.youtube.com/watch?v=N6--tF6K91c) – ACSQHC  [Perineal Tear Debrief Guide](https://www.bettersafercare.vic.gov.au/sites/default/files/2022-05/perineal_tear_debrief_guide.docx) – SCV  [Perineal tears: How to get better (Easy English)](https://www.safetyandquality.gov.au/sites/default/files/2022-02/Perineal%20tears%20-%20How%20to%20get%20better.pdf) - ACSQHC |  |
| Ask all women whether they were involved as much as they wanted to be in decision making about their care during birth | Redesign transitions of care processes, to ensure the engagement of persons with a support role are fully utilised in the process. Ensuring partners, families and carers are engaged in discussions, including post-acute care planning and likely discharge location, and given opportunities to ask questions is part of this process. | [Engaging Patients and Families in Safety: Recommendations, Resources and Case Examples | IHI - Institute for Healthcare Improvement](https://www.ihi.org/insights/engaging-patients-and-families-safety-recommendations-resources-and-case-examples) [Action 5.14 | Australian Commission on Safety and Quality in Health Care](https://www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard/delivering-comprehensive-care/action-514)  [Third and Fourth Degree Perineal Tears – Clinical Care Standard](https://www.safetyandquality.gov.au/sites/default/files/2021-04/perineal_tears_ccs_v3.pdf) – ACSQHC |  |

### Primary driver 2: Application of the bundle components

Better Births for Women encourages the implementation of a clinically endorsed bundle of care that focuses on:

* warm compress during second stage of labour
* encouraging a slow controlled birth using hands-on technique
* episiotomy technique during third stage of labour when clinically indicated using correct technique
* comprehensive assessment for perineal tears
* accurate severity grading of perineal tears

### Secondary driver: During pregnancy

| Change ideas | Explanation | Resources/References | Your team’s ideas |
| --- | --- | --- | --- |
| Inclusion of information about the clinical bundle in childbirth education curriculum | Provide education, and use teach back, to women in the antenatal period (34-36weeks gestation) that includes:   * Birth and birth risks * Interventions that might be used to help prevent perineal trauma * Perineal massage * Potential birth decisions that need to be made * Use of the lived experience ‘Torn at Birth” video | [Talking about tears – a video for clinicians](https://www.youtube.com/watch?v=KY9ArcFz9qA)  [Torn at Birth](https://youtu.be/YSnU7wGOo6M) – patient experience video  [Always Use Teach Back! | IHI - Institute for Healthcare Improvement](http://www.ihi.org/resources/Pages/Tools/AlwaysUseTeachBack!.aspx)  [Teach-back](http://teachback.org/research/)  [Women’s experiences following severe perineal trauma: a metaethnographic synthesis](https://pubmed.ncbi.nlm.nih.gov/23057716/)  [Third and Fourth Degree Perineal Tears – Clinical Care Standard](https://www.safetyandquality.gov.au/sites/default/files/2021-04/perineal_tears_ccs_v3.pdf) – ACSQHC  [Reducing third and fourth degree perineal tears – patient leaflet (multiple languages available)](https://women.wcha.asn.au/collaborate/breakthrough-collaboratives/perineal-tears/providing-information-and-engaging-women-in-decision-making) – Women’s Healthcare Australasia  [Intrapartum care: Care of healthy women and their babies during childbirth](https://www.nice.org.uk/guidance/ng235) – NICE Clinical Guideline |  |
| Planning for risk assessment and shared decision-making during birth | Shared decision-making is an important part of delivering women-centred care. It involves sharing of information, discussion and collaboration between a consumer and their healthcare provider and needs to be incorporated throughout the care continuum.  Information should be in a form that can be used and understood by patients and is appropriate to their health literacy, language and cultural needs. | [The How to Guide: WHA CEC Perineal Protection Bundle](https://women.wcha.asn.au/wp-content/uploads/sites/3/2022/04/wha_national_collaborative_how_to_guide_21.1.20.pdf)  [Third and Fourth Degree Perineal Tears – Clinical Care Standard](https://www.safetyandquality.gov.au/sites/default/files/2021-04/perineal_tears_ccs_v3.pdf) – ACSQHC  [Shared decision making](https://www.safetyandquality.gov.au/our-work/partnering-consumers/shared-decision-making) – ACSQHC  [Using plain language in health information](https://pifonline.org.uk/resources/how-to-guides/using-plain-language-in-health-information/html-version/)  [Easy English](https://www.health.tas.gov.au/professionals/health-literacy/health-literacy-workplace-toolkit/written-communication/easy-english)  [The Power of Four Words: "What Matters to You?" | IHI - Institute for Healthcare Improvement](http://www.ihi.org/Topics/WhatMatters/Pages/default.aspx)  [Delivering Great Care: Engaging Patients and Families as Partners | IHI - Institute for Healthcare Improvement](http://www.ihi.org/resources/Pages/ImprovementStories/DeliveringGreatCareEngagingPatientsandFamiliesasPartners.aspx) |  |

### Secondary driver: Routine professional development

| Change ideas | Explanation | Resources/References | Your team’s ideas |
| --- | --- | --- | --- |
| Incorporate education and training on the five clinical interventions, shared-decision making and providing informed consent.  Incorporate use of clinical models and/or pig sphincters for simulation training for grading trauma | Local education on how to deliver each component of the bundle is essential to the success of the project and will enable staff to carry out all elements safely and effectively.  Ensuring informed consent is properly obtained is a legal, ethical and professional requirement on the part of all treating health professionals. It supports person-centred care and enables shared-decision making. | [Torn at Birth](https://youtu.be/YSnU7wGOo6M) – patient experience video  [The How to Guide: WHA CEC Perineal Protection Bundle](https://women.wcha.asn.au/wp-content/uploads/sites/3/2022/04/wha_national_collaborative_how_to_guide_21.1.20.pdf)  [Informed consent in health care](https://www.safetyandquality.gov.au/sites/default/files/2020-09/sq20-030_-_fact_sheet_-_informed_consent_-_nsqhs-8.9a.pdf) - ACSQHC  [Shared decision making](https://www.safetyandquality.gov.au/our-work/partnering-consumers/shared-decision-making) – ACSQHC  [Using plain language in health information](https://pifonline.org.uk/resources/how-to-guides/using-plain-language-in-health-information/html-version/)  [Easy English](https://www.health.tas.gov.au/professionals/health-literacy/health-literacy-workplace-toolkit/written-communication/easy-english)  [The Power of Four Words: "What Matters to You?" | IHI - Institute for Healthcare Improvement](http://www.ihi.org/Topics/WhatMatters/Pages/default.aspx)  [Delivering Great Care: Engaging Patients and Families as Partners | IHI - Institute for Healthcare Improvement](http://www.ihi.org/resources/Pages/ImprovementStories/DeliveringGreatCareEngagingPatientsandFamiliesasPartners.aspx)  [Clinical Conversation webinar: Women's Health Australasia Perineal protection bundle - the Five Bundle Elements](https://vimeo.com/884630842) presented by Jaimee Oxford, April Jardine and Leanne Murphy on 14 November 2023 |  |
| Educate clinical staff on teach-back technique and incorporate teach-back into clinical care processes | By using the ‘teach back’ technique throughout the care journey, clinicians will ensure that patients and carers understand the key messages which are necessary for the management of their care.  This method ensures they can ask questions as part of the process and their health literacy does not impede them. They, in turn, are to apply these to the management of their pregnancy. | [Always Use Teach Back! | IHI - Institute for Healthcare Improvement](http://www.ihi.org/resources/Pages/Tools/AlwaysUseTeachBack!.aspx)  [Teach-back](http://teachback.org/research/) |  |
| Identify opportunities for in-the-moment teaching, reflection, and clinical reasoning development |  |  |  |

### Secondary driver: Second stage of labour

| Change ideas | Explanation | Resources/References | Your team’s ideas |
| --- | --- | --- | --- |
| **Intervention 1: warm compresses**  Set up birthing environment to support use of warm compress  Provide necessary equipment for warm compress  Use ‘toe warmers’ or ‘hand warmers’ inside a peri-pad as warm compresses | Apply warm perineal compresses during the second stage of labour at the commencement of perineal stretching | [Perineal techniques during the second stage of labour for reducing perineal trauma](https://pubmed.ncbi.nlm.nih.gov/28608597/)  [Warm perineal compresses during the second stage of labour for reducing perineal trauma: A meta-analysis](https://pubmed.ncbi.nlm.nih.gov/31238205/)  [Perineal outcomes and maternal comfort related to the application of perineal warm packs in the second stage of labour: a randomized controlled trial.](https://pubmed.ncbi.nlm.nih.gov/18021143/)  [Perineal Tears: A literature review. A review undertaken for the Australian Commission on Safety and Quality in Health Care](https://www.safetyandquality.gov.au/sites/default/files/2021-05/perineal-tears-literature-review.pdf) |  |
| **Intervention 2**: Hands on technique  Develop a video on hands-on technique, to share with all clinicians  Use clinical educators to provide education and simulation training  Establish standard process for documentation of intervention | With a spontaneous vaginal delivery, using gentle verbal guidance, to encourage a slow controlled birth of the fetal head and shoulders:   * Support the perineum with the dominant hand holding the warm compress * Apply counter-pressure on the fetal head with the non-dominant hand * If the shoulders do not deliver spontaneously, apply gentle traction to release the anterior shoulder * Allow the posterior shoulder to be released following the curve of Carus | [Manual perineal support at the time of childbirth: a systematic review and meta-analysis](https://pubmed.ncbi.nlm.nih.gov/25976557/)  [Can the incidence of obstetric anal sphincter injury be reduced? The STOMP experience](https://pubmed.ncbi.nlm.nih.gov/27164486/)  [The Management of Third-and Fourth Degree Perineal Tears. RCOG - Green-top guideline No. 29](https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/third-and-fourth-degree-perineal-tears-management-green-top-guideline-no-29/)  [Perineal Tears: A literature review. A review undertaken for the Australian Commission on Safety and Quality in Health Care](https://www.safetyandquality.gov.au/sites/default/files/2021-05/perineal-tears-literature-review.pdf) |  |
| **Intervention 3**: Correct episiotomy technique used when indicated  Introduce post-repair episiotomy angle measurement  Use Episcissors for cutting episiotomies  Use cord-clamps to guide a 60-degree angle episiotomy when using mayo scissors | Episiotomy should be performed:   * at crowning of the fetal head * using a medio-lateral incision * at a minimum 60-degree angle from the posterior fourchette | [Selective versus routine use of episiotomy for vaginal birth](https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD000081.pub3/full#:~:text=Background,guarantees%20perineal%20trauma%20and%20sutures.) – Cochrane review  [Intrapartum care: Care of healthy women and their babies during childbirth](https://www.nice.org.uk/guidance/ng235) – NICE Clinical Guideline  [Evaluation of the incision angle of mediolateral episiotomy at 60 degrees](https://pubmed.ncbi.nlm.nih.gov/21247571/)  [The Management of Third-and Fourth Degree Perineal Tears. RCOG - Green-top guideline No. 29.](https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/third-and-fourth-degree-perineal-tears-management-green-top-guideline-no-29/)  [Obstetrical anal sphincter injuries (OASIS): prevention, recognition, and repair](https://www.jogc.com/article/S1701-2163(16)30081-0/fulltext)  [The use of Episcissors-60 to reduce the rate of obstetric anal sphincter Injuries: A systematic review](https://pubmed.ncbi.nlm.nih.gov/30999081/) |  |

### Secondary driver: After birth

| Change ideas | Explanation | Resources/References | Your team’s ideas |
| --- | --- | --- | --- |
| **Intervention 4: Comprehensive assessment for perineal tears**  For all women, genito-anal examination following birth needs to be offered, and where informed consent is given be performed by an experienced clinician and include a per-rectum examination for all women, including those with an intact perineum.  Use a checklist for post-birth care that incorporates genito-anal examination | A systematic examination ensures that anal sphincter injury and buttonhole tears are not missed.  Obstetric anal sphincter injuries and isolated rectal tears can be missed if a full examination is not performed. This can lead to serious consequences for women, including anal incontinence. Training is needed to ensure tears are correctly identified. | [Obstetrical anal sphincter injuries (OASIS): prevention, recognition, and repair](https://www.jogc.com/article/S1701-2163(16)30081-0/fulltext)  [Guideline for the systematic assessment of perineal trauma](https://www.researchgate.net/publication/272326540_Guideline_for_the_systematic_assessment_of_perineal_trauma) – British Journal of Midwifery  [Intrapartum care: Care of healthy women and their babies during childbirth](https://www.nice.org.uk/guidance/ng235) – NICE Clinical Guideline  [Diagnosis of perineal trauma: getting it right first time](https://www.britishjournalofmidwifery.com/content/clinical-practice/diagnosis-of-perineal-trauma-getting-it-right-first-time/)  [The Management of Third-and Fourth Degree Perineal Tears. RCOG - Green-top guideline No. 29](https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/third-and-fourth-degree-perineal-tears-management-green-top-guideline-no-29/)  [ACOG Practice Bulletin No. 198: Prevention and Management of Obstetric Lacerations at Vaginal Delivery](https://journals.lww.com/greenjournal/Abstract/2018/09000/ACOG_Practice_Bulletin_No__198__Prevention_and.66.aspx)  [Diagnosis of Perineal Trauma in Perineal and anal sphincter trauma](https://link.springer.com/chapter/10.1007/978-1-84628-503-5_2) - textbook. |  |
| **Intervention 5: Accurate severity grading of perineal tears**  All perineal trauma should be:   * graded according to the Royal College of Obstetricians and Gynaecologists (RCOG) grading guideline and * reviewed respectfully by a second experienced clinician to confirm the diagnosis and grading   Develop local operational definitions for experienced clinicians  Provide staff rostering that supports availability of experienced clinicians | All perineal trauma should be reviewed by a second experienced clinician using the RCOG grading scale. This practice ensures that tears are graded correctly and provides a training opportunity for more junior/inexperienced clinicians. | [The Management of Third-and Fourth Degree Perineal Tears. RCOG - Green-top guideline No. 29](https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/third-and-fourth-degree-perineal-tears-management-green-top-guideline-no-29/)  [Guideline for the systematic assessment of perineal trauma](https://www.researchgate.net/publication/272326540_Guideline_for_the_systematic_assessment_of_perineal_trauma) – British Journal of Midwifery  [Outcomes from medium term follow-up of patients with third and fourth degree perineal tears](https://pubmed.ncbi.nlm.nih.gov/20701512/)  [Occult anal sphincter injuries—myth or reality?](https://pubmed.ncbi.nlm.nih.gov/16411998/)  [Can we improve on the diagnosis of third degree tears?](https://pubmed.ncbi.nlm.nih.gov/11803094/#:~:text=Conclusions%3A%20With%20increased%20vigilance%2C%20it,diagnosis%20of%20third%20degree%20tears.)  [ACOG Practice Bulletin No. 198: Prevention and Management of Obstetric Lacerations at Vaginal Delivery](https://journals.lww.com/greenjournal/Abstract/2018/09000/ACOG_Practice_Bulletin_No__198__Prevention_and.66.aspx)  [Intrapartum care: Care of healthy women and their babies during childbirth](https://www.nice.org.uk/guidance/ng235) – NICE Clinical Guideline |  |

# Appendix: Driver diagram – accessible text format

## Better Births for Women

### Aim

By [insert date] we intend to reduce the rate of severe perineal trauma by *x*% in participating health services. (Severe perineal trauma includes third and fourth degree perineal tears.)

#### Primary driver: Partnering with women

Secondary drivers

During pregnancy

* Inclusion of information about the clinical bundle in childbirth education curriculum
* Planning for risk assessment and shared decision-making during birth

During birth

* Shared ongoing risk assessment and decision making

After birth

* Offer all women the opportunity to discuss and ask questions about their perineal care, trauma and repair
* Ask all women whether they were involved as much as they wanted to be in decision making about their care during birth

#### Primary driver: Application of evidence-based clinical care

Secondary drivers

Routine professional development

* Incorporate education and simulation training on the five clinical interventions
* Incorporate use of clinical models and/or pig sphincters for simulation training for grading trauma
* Incorporate teach-back skills
* Identify opportunities for in-the-moment teaching, reflection and clinical reasoning development, e.g. post tear huddles

Second stage of labour

* Intervention 1: Warm compresses
  + Set up birthing environment to support use of warm compress
  + Provide necessary equipment for warm compress
  + Use ‘toe warmers’ or ‘hand warmers’ inside a peri-pad as warm compresses
* Intervention 2: Encourage a slow controlled birth using hands on technique
  + Develop a video on hands-on technique, to share with all clinicians
  + Use clinical educators to provide education and simulation training
  + Establish standard process for documentation of intervention
* Intervention 3: Correct episiotomy technique used when indicated
  + Episiotomy should be performed: at crowning of the fetal head, using a medio-lateral incision, at a minimum 60-degree angle from the posterior fourchette
  + Introduce post-repair episiotomy angle measurement
  + Use Episcissors for cutting episiotomies
  + Use cord-clamps to guide a 60-degree angle episiotomy when using mayo scissors

After birth

* Intervention 4: Comprehensive assessment for perineal tears
  + For all women, genito-anal examination following birth needs to be offered, and where informed consent is given be performed by an experienced clinician and include a per-rectum examination for all women, including those with an intact perineum
  + Use a checklist for post-birth care that incorporates genito-anal examination
* Intervention 5: Accurate severity grading of perineal tears
  + All perineal trauma should be graded according to the Royal College of Obstetricians and Gynaecologists (RCOG) grading guideline and reviewed respectfully by a second experienced clinician to confirm the diagnosis and grading
  + Develop local operational definitions for experienced clinicians
  + Provide staff rostering that supports availability of experienced clinicians

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