AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards

Third and Fourth Degree Perineal Tears

Clinical Care Standard

April 2021

Published by the Australian Commission on Safety and Quality in Health Care

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ISBN: 978-1-925948-83-7

The Commission's preference is that you attribute this publication (and any material sourced from it) using the following citation:

Australian Commission on Safety and Quality in Health Care. Third and Fourth Degree Perineal Tears Clinical Care Standard. Sydney: ACSQHC; 2021.

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The Third and Fourth Degree Perineal Tears Clinical Care Standard has been endorsed by the following organisations:

Australian College of Midwives

Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

COPE
Centre of Perinatal Excellence

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Excellence in Women's Health

RURAL DOCTORS ASSOCIATION OF AUSTRALIA

WOMEN'S HEALTHCARE AUSTRALASIA

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Indicators

The following indicators will support health service organisations to monitor how well they are implementing the care recommended in this clinical care standard and are intended to support local quality improvement activities.

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The definitions required to collect and calculate indicator data are specified online at **meteor.aihw.gov.au/content/index.phtml/itemId/728215**. More information about indicators and other quality improvement measures is provided in **Appendix A**.

Clinical care standards

Clinical care standards help support the delivery of evidence-based clinical care and promote shared decision making between patients, carers and clinicians. They aim to reduce unwarranted variation and improve the appropriateness of care for a specific clinical condition or procedure, regardless of where people are treated in Australia.

A clinical care standard contains a small number of quality statements that describe the level of clinical care expected for a specific clinical condition or procedure. Indicators are included for some quality statements to assist health service organisations monitor how well they are implementing the care recommended in the clinical care standard.

A clinical care standard differs from a clinical practice guideline. Rather than describing all the components of care for a specific clinical condition or procedure, a clinical care standard focuses on key areas of care where the need for quality improvement is greatest.

Clinical care standards aim to support improved health care by considering the various perspectives of the community, clinicians and health service managers.

Clinical care standards are developed by the Australian Commission on Safety and Quality in Health Care (the Commission), an Australian Government agency that leads and coordinates national improvements in the safety and quality of health care, based on the best available evidence. By working in partnership with the Australian Government, states and territories, the private sector, clinical experts, and patients and carers, the Commission aims to ensure that the health system is better informed, supported and organised to deliver safe and high-quality care.

About the Third and Fourth Degree Perineal Tears Clinical Care Standard

Context

This clinical care standard was developed in response to a recommendation in the Second Australian Atlas of Healthcare Variation[1], that the Commission commence work on the development of a clinical care standard to improve national consistency in best practice care for the prevention, recognition and management of third and fourth perineal tears.

This clinical care standard describes the key components of care that women can expect when they are pregnant or experience a third or fourth degree perineal tear during birth. It supports the provision of high-quality, evidence-based care, taking into account the context in which care is provided, local variation and the quality improvement priorities of the individual health services.

Goal

This standard aims to reduce unwarranted clinical variation in rates of third or fourth degree perineal tears. It also aims to ensure that women who experience a third or fourth degree perineal tear receive appropriate care to optimise their physical and psychological recovery.

Scope

This clinical care standard applies to all pregnant women who are planning a vaginal birth, and to women who experience a third or fourth degree perineal tear. It applies to care provided during pregnancy, labour, birth and the postpartum period, as well as postoperative and longer-term follow-up care.

Pathway of care

This standard applies to care provided in the following care settings:

- Private obstetric (specialist) care
- Private midwifery care
- Care provided by general practitioners (GPs) and GP obstetricians
- Public hospital maternity and high-risk maternity care, including continuity of care models
- Remote area maternity care
- Community and home-based care
- Postnatal clinics specialising in the treatment of third and fourth degree perineal tears.

In this document, the term 'clinician' refers to all types of healthcare providers who deliver direct clinical care to women including:

- Aboriginal and Torres Strait Islander health workers
- Doctors (including obstetricians, gynaecologists, GPs, GP obstetricians, and colorectal surgeons)
- Midwives
- Nurses (including specialist continence nurses and women's health nurses)
- Physiotherapists
- Psychologists.

What is not covered

This standard does not cover:

- Surgical procedures for third and fourth degree perineal tears, or any complications that arise from this surgery
- Delayed complications associated with a previous third or fourth degree perineal tear
- Other obstetric injuries or complications.

Evidence that underpins this clinical care standard

Key sources that underpin the Third and Fourth Degree Perineal Tears Clinical Care Standard are current clinical guidelines from:

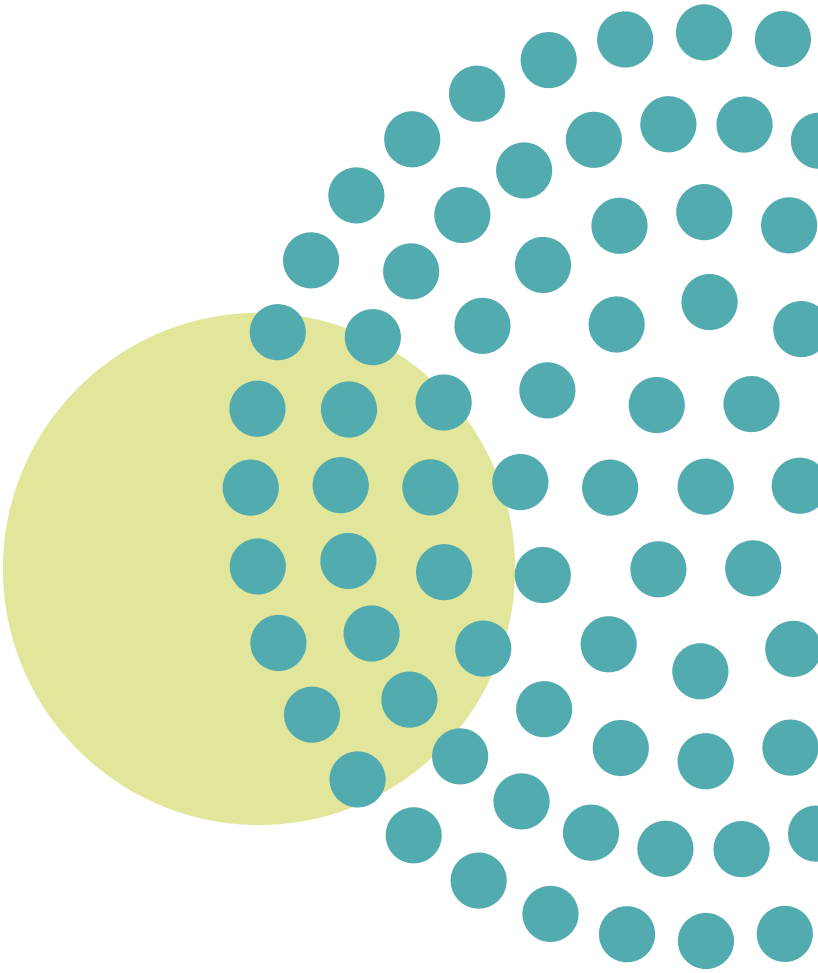
- American College of Obstetricians and Gynecologists, *Practice Bulletin No. 198: Prevention and Management of Obstetric Lacerations at Vaginal Delivery*[2]
- Society of Obstetricians and Gynecologists of Canada, No. 148: *Guidelines for Operative Vaginal Birth*[3]
- World Health Organization, *World Health Organization Recommendation on Techniques for Preventing Perineal Trauma During Labour*[4]
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists *Instrumental vaginal birth*[5]
- Royal College of Obstetricians and Gynaecologists, *The Management of Third- and Fourth-Degree Perineal Tears*[6]
- Society of Obstetricians and Gynecologists of Canada, *Obstetrical Anal Sphincter Injuries (OASI): Prevention, Recognition and Repair*[7]
- National Institute for Health and Care Excellence, Clinical Guideline 190: *Intrapartum Care for Healthy Women and Babies*[8]
- Royal College of Obstetricians and Gynaecologists, *Operative Vaginal Delivery*.[9]

A list of the evidence sources for this clinical care standard is available on the Commission's website at **www.safetyandquality.gov.au/perineal-tears**.

Supporting documents

The following resources for this clinical care standard are available on the Commission's website at **www.safetyandquality.gov.au/perineal-tears**:

- Third and Fourth Degree Perineal Tears Clinical Care Standard – Clinician fact sheet
- Third and Fourth Degree Perineal Tears Clinical Care Standard – Consumer fact sheet
- Third and Fourth Degree Perineal Tears Clinical Care Standard – Evidence sources
- Talking about tears – A video for clinicians
- Third and fourth degree perineal tears during labour and birth – A video for consumers
- Perineal tears: What you need to know during pregnancy – Information sheet
- Recovering from a third or fourth degree perineal tear – Information sheet



How to use this clinical care standard

The quality statements describe the expected standard for key components of patient care. By describing what each statement means, they support:

- **Patients** to know what care may be offered by their healthcare system, and to make informed treatment decisions in partnership with their clinician
- **Clinicians** to make decisions about appropriate care
- **Health service organisations** to understand the policies, procedures and organisational factors that can enable the delivery of high-quality care.

This clinical care standard should be implemented as part of an overall approach to safety and quality, incorporating the following principles and standards.

General principles of care

When applying the information contained in a clinical care standard, clinicians are advised to use their clinical judgement and to consider the individual patient's circumstances, in consultation with the patient, or their support people.

This clinical care standard aligns with key principles that are the foundation for achieving safe, high-quality care including:

- Person-centred care and shared decision making
- Informed consent
- Cultural safety for Aboriginal and Torres Strait Islander people.

This clinical care standard supports the values and principles in *Woman-centred care: Strategic directions for Australian maternity services*[10], which aims to ensure that Australian maternity services are equitable, safe, woman-centred, informed and evidence-based.

For more information and additional Commission resources, see **Appendix A**.

Measurement for quality improvement

Measurement is a key component of quality improvement processes. The Commission has developed a set of indicators to support clinicians and health services organisations to monitor how well they are implementing the care recommended in this clinical care standard. The indicators are intended to support local quality improvement activities. No benchmarks are set for these indicators.

The indicators are listed with the relevant quality statements. The definitions required to collect and calculate indicator data are available online at **meteor.aihw.gov.au/content/index.phtml/itemId/728215**. More information about indicators and other quality improvement measures is provided in **Appendix B**.

Information on other quality measures including patient-reported outcome measures and patient experience measures is provided in **Appendix C**.

Meeting the requirements of national standards and accreditation

Implementing this clinical care standard as part of a quality improvement activity can help health services meet the requirements of the NSQHS Standards.

More information about clinical care standards and the NSQHS Standards is included in **Appendix D**.

Background: Third and fourth degree perineal tears

What is a third or fourth degree perineal tear?

A perineal tear is an injury to the perineum, which is the area between the vagina and anus. Perineal tears are common during vaginal births, but most do not cause significant injury.

Third and fourth degree perineal tears are more serious tears – they extend from the perineum to the anus or rectum and include the muscle that controls the opening and closing of the anus (anal sphincter).[11,12]

First and second degree tears may need stitches, but women tend to recover within a few weeks or months.[12] Third and fourth degree perineal tears need surgical repair and may be associated with short- and long-term complications for women, affecting their physical, psychological and sexual wellbeing. Most women who sustain a third or fourth degree perineal tear recover well with appropriate treatment and support, although some will need specialised care to optimise their recovery.

While not all third and fourth degree perineal tears can be prevented, it is possible to reduce the risk of their occurrence.

Variations in care

About 3% of all Australian women who have a vaginal birth, and 5% of women having their first vaginal birth, will experience a third or fourth degree perineal tear.[13] This rate is above the reported average for similar countries in the Organisation for Economic Cooperation and Development.[1,14]

Within Australia, there is significant variation depending on where people live. In 2012–14, the average number of Australian women who had a third or fourth degree perineal tear ranged from 6 to 71 per 1,000 vaginal births, in different areas across Australia. There was up to a 12-fold variation between areas.[1]

Reasons for this variation in care may include:

- Differences in maternal and fetal risk factors (**Table 1**)
- Differences in the rate and type of instrument-assisted births (forceps or vacuum extraction). The risk is approximately doubled in an instrument-assisted birth (forceps or vacuum extraction)[15]
- Differences in the rate and type of episiotomy
- Changes to other practices during the second stage of labour, such as the woman's positions during birth, support of the perineum as the baby's head emerges and the speed of the birth of the baby's head
- Better recognition and reporting of third and fourth degree perineal tears
- Differences in health service policies and guidelines on perineal care and clinical practice, including the recognition and detection of perineal tears
- Differences in clinical experience.[1]

Call to action

This clinical care standard aims to reduce the risk of third and fourth degree perineal tears and improve the care for women who do experience them.

The morbidity associated with third and fourth degree tears can be considerable and may include complications such as:

- Perineal pain
- Faecal and flatus incontinence
- Painful sexual intercourse
- Reduced quality of life
- Depression.[6,16]

Accurate detection and appropriate repair of third and fourth degree perineal tears are important to minimise the risk of infection, blood loss, pain and incontinence.[6,8,17] If third and fourth degree perineal tears are not classified correctly and repaired promptly, they can have serious long-term consequences.

Surgical repair is effective in eliminating symptoms for 60–80% of affected women, but some women may be permanently affected despite appropriate treatment.[6,18] Women with third or fourth degree perineal tears should receive care to optimise their recovery including appropriate follow-up care to improve their physical and psychosocial wellbeing.

WHA CEC Perineal Protection Bundle

The WHA CEC Perineal Protection Bundle[19] is a quality improvement program aimed at reducing third and fourth degree perineal tears (see Box 1). This bundle is consistent with this clinical care standard.

Box 1: Quality improvement for perineal tears: The WHA CEC Experience

Women's Healthcare Australasia (WHA) implemented a quality improvement initiative that aims to improve outcomes for women by reducing avoidable third and fourth degree perineal tears.[19] The WHA National Collaborative was hosted by WHA in partnership with the NSW Clinical Excellence Commission and supported by Safer Care Victoria and the Clinical Excellence Division of Queensland Health.

The elements of care, which are further described in the WHA CEC Perineal Protection Bundle, include the following:

1. Apply a warm perineal compress during the second stage of labour at the commencement of perineal stretching.
2. With a spontaneous vaginal birth, 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, apply gentle traction to release the anterior shoulder; and allow the posterior shoulder to be released following the curve of Carus.
3. When episiotomy is indicated, it should be performed: at crowning of the fetal head, using a medio-lateral incision, at a minimum 60 degree angle from the fourchette. Note: Due to the increased risk of third or fourth degree perineal tears when a woman having her first vaginal birth requires the assistance of forceps or vacuum, an episiotomy should be offered.
4. For all women, genito-anal examination following birth needs to be offered and, where informed consent is given: be performed by an experienced clinician; include a rectal examination for all women, including those with an intact perineum.
5. All perineal trauma should be graded according to the Royal College of Obstetricians and Gynaecologists (RCOG) guideline and reviewed respectfully by a second, experienced clinician to confirm diagnosis and grading.

WHA recommends that services implementing the bundle adhere to all five components for each woman.

1

Quality statement 1

Information, shared decision making and informed consent

During the antenatal period, a woman is informed about the risk of a third or fourth degree perineal tear. Throughout pregnancy, labour and birth, she is supported to make decisions and provide informed consent for the care she receives.

Purpose

To ensure that women receive information during pregnancy about the potential of a third or fourth degree perineal tear, relevant risk factors and evidence-based care to reduce their risk. To support shared decision making and informed consent.

What the quality statement means

For women

Throughout pregnancy, you will receive information that will help you to make informed decisions about your care during pregnancy, labour and birth.

Birth is a natural process and many women give birth without medical intervention. However, your healthcare team should help you understand the possible risks and complications that sometimes occur, even if the risk is low.

Most women who give birth vaginally do not have severe damage to their perineum or anus. Around 3% have a third or fourth degree perineal tear.[13]

It is not possible to prevent all third and fourth degree perineal tears, but there are ways to reduce their likelihood. Discussing the potential benefits and harms of different options, and your own preferences, with your healthcare team can help you understand and make decisions about your care.

If you are planning a vaginal birth, you and a member of your healthcare team should discuss:

- Relevant individual risk factors and your birth history, including a previous third or fourth degree perineal tear
- The care you might be offered during labour and birth, including the use of induction of labour, epidural for pain relief, forceps or vacuum, or a caesarean section
- What you or your healthcare team can do to reduce your risk
- How a perineal tear is identified
- The treatment and likely outcomes if a third or fourth degree perineal tear is identified.

A record of this discussion will be kept in your healthcare record. During labour and birth you will be supported to make decisions and to provide informed consent for the care that is offered to you.

For clinicians

Throughout pregnancy, provide information and support women who are planning a vaginal birth to make decisions about the care they may receive during pregnancy, labour and birth.

By the third trimester, discuss the potential for a third or fourth degree perineal tear.

Discuss the following points together with the woman:

- The fact that perineal tears are common and most heal well without complications
- The fact that third or fourth degree tears are less common (around 3% of all women who give birth vaginally and 5% of first vaginal births)[13]
- Relevant risk factors for the individual woman, including her obstetric history (see **Table 1**), noting that it is not possible to predict who will have a third or fourth degree perineal tear
- What can be done to reduce risk according to current evidence
- The possible use of induction of labour, epidural analgesia, instruments, episiotomy and an unplanned caesarean section, and their risks and benefits
- The woman's preference for how she would like to give birth
- Assessment and examination to expect after the birth
- How a third or fourth degree perineal tear will be treated if it does occur, and what can be done to assist recovery and improve outcomes (noting that many woman do not have faecal incontinence).[20]

Midwives providing antenatal care for women with added risks (for example female genital mutilation or a previous third or fourth degree perineal tear) should arrange consultation with an obstetrician or GP obstetrician.

Decisions about the mode of birth for a woman with a history of a third or fourth degree perineal tear should include consideration of the risks and benefits of a vaginal birth compared with a caesarean section.[20] Discussion should consider current urgency or incontinence symptoms, the degree of previous trauma, the risk of recurrence, the success of the repair, any psychological effects, or the woman's request for a caesarean section.[8]

Provide information in a way that meets the woman's health literacy and cultural needs. Also offer support services, such as interpreter services, or support from an Aboriginal health worker, if needed.

Document the outcome of discussions, and any decisions or preferences, in the woman's healthcare record.[4,8,21]

Table 1: Risk factors associated with third or fourth degree perineal tears [2,3,6,16]

Risk factors
Individual risk factors (mother)
▪ Women having their first vaginal birth ▪ Women of south Asian ethnicity
Fetal risk factors
▪ Infants with a higher birth weight*
Risks arising during labour and birth
▪ Persistent occipito-posterior position ▪ Shoulder dystocia ▪ Prolonged second stage of labour ▪ Instrumental vaginal birth ▪ Epidural pain relief ** ▪ Midline episiotomy***

* > 3.5 or 4 kg in epidemiological studies
** Risk may be indirectly associated with prolonged second stage of labour or instrumental delivery
*** A midline episiotomy is associated with an increased risk compared to medio-lateral episiotomy.

For health service organisations

Ensure that policies, procedures and protocols are in place to support information provision, shared decision making and informed consent, consistent with the requirements of the NSQHS Standards.[22]

Ensure that information about third and fourth degree perineal tears and their management is consistent with current evidence and meets the woman's health literacy and cultural needs. Information should be easy to use and accessible.[23]

Ensure that healthcare professionals are appropriately trained and skilled to undertake clinical assessment of the risk of third and fourth degree tears and to communicate with women regarding risks, as part of shared decision making, and to obtain informed consent.

Ensure that systems are in place to record the key outcomes of discussions and assessments to enable appropriate clinical communication between clinicians. This is especially important when care is provided by a multidisciplinary team, a shared-care model is used, or women are referred to another clinician or transferred to a different care setting.[22]

2

Quality statement 2
Reducing risk during pregnancy, labour and birth

A woman choosing a vaginal birth is offered evidence-based care to reduce her risk of a third or fourth degree perineal tear.

Purpose

To ensure that women are appropriately assessed and provided evidence-based care during pregnancy, labour and birth to reduce the likelihood of a third or fourth degree perineal tear.

What the quality statement means

For women

There are ways to reduce the likelihood of a third or fourth degree perineal tear. You will have the opportunity to talk to your healthcare team about these options.

During pregnancy:

- Perineal self-massage (or with help from your partner) after 34 weeks of pregnancy can help protect your perineum and reduce the risk of third and fourth degree perineal tears.[16,24,25]
- Pelvic floor muscle training may help prepare you for labour and birth and reduce the possibility of a third or fourth degree perineal tear.[26]

During a vaginal birth:

- Applying warm compresses to the perineum during the second stage of labour can significantly reduce the risk of a third or fourth degree perineal tear[17]
- Slowing the rate at which the baby's head and shoulders emerge, with the help of your birth attendants, may help prevent perineal injuries[7,27]
- Perineal massage performed by your healthcare professional during the second stage of labour may reduce the risk of third and fourth degree perineal tears. However some women may not feel comfortable with this option and it is not recommended for everyone.[28,29]

If there is a clinical need, a member of your healthcare team may suggest an episiotomy where a cut is made in the vaginal opening to help make more space.[30] After the birth, the cut will be repaired with stitches. If you consent to an episiotomy, the cut should be made at the correct angle to reduce the risk of a perineal tear.[7,31]

Discussing these options with your healthcare team during pregnancy can prepare you to make informed decisions during labour and birth. You will always be asked for your preferences and consent for the care offered to you.

For clinicians

During pregnancy, advise the woman about evidence-based options that may reduce the risk of a third or fourth degree perineal tear, as follows:

During pregnancy:

- Perineal self-massage (or by her partner) after 34 weeks of pregnancy can reduce the risk of third and fourth degree perineal tears[16,24,25]
- Pelvic floor muscle training may help women prepare for labour and birth and reduce the risk of third and fourth degree perineal tears.[26] Ensure that the woman understands the correct technique to use and refer her to an appropriate clinician for training, if needed.

During a vaginal birth:

- Applying warm compresses on perineal distention can significantly reduce risk (moderate grade evidence)[4,16,17,28]
- Slowing the fetal head at crowning and the birth of the shoulders may reduce risk (low to moderate grade evidence)[7,16,27]
- Perineal massage during the second stage of labour may reduce risk, however, the acceptability of this practice to women has not been established (low to moderate grade evidence).[28,29]

Before birth, the possibility of an episiotomy, forceps, vacuum or an unplanned caesarean section should be explained so that the woman is aware of the risks and benefits, and has the opportunity to ask questions.

The selective use of episiotomy (see Box 2) may result in fewer women experiencing a third or fourth degree perineal tear (low to moderate grade evidence).[32,33] If an episiotomy is performed, a medio-lateral technique with the incision angle 60° from the midline is recommended.[7,16,31]

Medio-lateral episiotomy should be offered in instrumental vaginal birth, especially for nulliparous women.[16,2,6,31,34]

Box 2: Indications for consideration of episiotomy

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists note that episiotomy should be considered in the following circumstances:

- A high likelihood of a third or fourth degree perineal tear
- Shoulder dystocia
- A need for accelerated birth of a compromised fetus
- A history of female genital mutilation.[35]

Perineal tear outcome data should be collected and reviewed regularly at clinical review meetings.

For health service organisations

Ensure that policies, procedures and protocols detail evidence-based care to reduce the risk of third and fourth degree perineal tears. Ensure relevant clinicians act in accordance with policies and evidence-based guidelines.

Ensure that relevant clinicians are appropriately trained and skilled in assessment and classification of perineal tears.

Ensure that systems are in place to monitor variation in practice against expected health outcomes, and respond to risk, as per Action 1.28 in the NSQHS Standards (2nd ed.).[22]

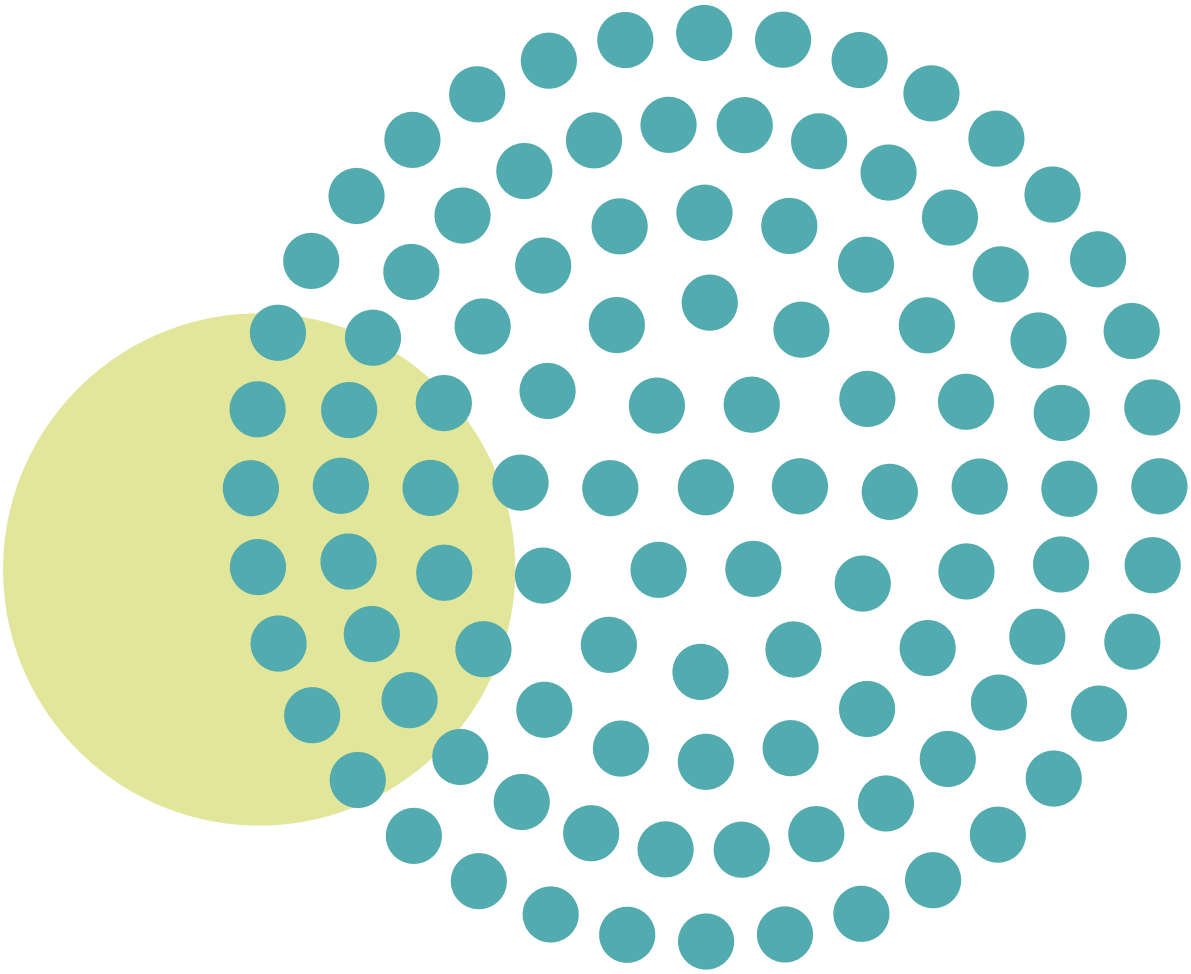
Provide timely feedback to clinicians on variation in practice and support them to review their clinical practice.

Indicator for local monitoring

Reducing risk during pregnancy, labour and birth

Indicator 2: Proportion of women who had a vaginal birth who received warm compresses in the second stage of labour
meteor.aihw.gov.au/content/index.phtml/itemId/728357

More information about these indicators and the definitions needed to collect and calculate them can be found online at METeOR.



3

Quality statement 3
Instrumental vaginal birth

When intervention is indicated in a vaginal birth, the choice of intervention is based on the clinical situation, the benefits and risks of each option and discussion with the woman.

Purpose

To ensure that decisions about an instrumental vaginal birth consider the individual clinical circumstances, and the benefits and risks of each option, including the risk of a third or fourth degree perineal tear, and the potential benefit of episiotomy.

What the quality statement means

For women

If your doctor or midwife is concerned about your health or the health of your baby during labour, they may suggest active assistance using either forceps or vacuum to help you have a vaginal birth.

Most instrumental births occur without complications, but there is a chance of serious risk to you or your baby. These risks need to be balanced against the risk of 'waiting' or using a different intervention.

Both forceps and vacuum increase the risk of a third or fourth degree perineal tear, especially for women having their first vaginal birth. The risk is higher with forceps than with vacuum. However, each woman's situation is different and a number of factors will be considered before an instrument is recommended for you. If forceps or vacuum are used, you may be offered an episiotomy to lower the chance of having a third or fourth degree perineal tear.

In very few situations, an alternative to using forceps or vacuum may be an unplanned caesarean section where you have an operation and the baby is born via a cut through the abdomen and uterus.[36]

A member of your healthcare team will discuss your situation with you, including the possible benefits and risks to you and your baby, for each available option. You may wish to discuss these options during pregnancy, in case you are offered forceps or vacuum during labour.

This care will be only be provided with consent from you, or your legal representative or guardian.

For clinicians

When an instrumental vaginal birth is indicated and more than one instrument may be appropriate, the choice of intervention should take into account evidence of the relative benefits and risks of the various instruments, the clinician's skill and the woman's preference.[37]

Instrumental vaginal birth may be indicated when there is:

- Fetal compromise
- A need to reduce the effects of the second stage of labour because of a medical condition
- Slow progress in the second stage of labour, associated with risks to the woman or fetus.[5,9]

Current guidance from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists[5] and the Royal College of Obstetricians and Gynaecologists (RCOG)[9] include recommendations regarding the conditions for a safe instrumental vaginal birth (see Box 3).

Box 3: Conditions required for safe instrumental vaginal birth

Safe instrumental vaginal birth requires a careful assessment of the clinical situation, clear communication with the woman, and should be performed by, or in the presence of, an operator with expertise in the chosen procedure and the management of any complications which may arise.

For further detail see **Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Instrumental vaginal birth. Melbourne: RANZCOG; 2016.**[5]

Clinicians should discuss with the woman the evidence regarding the risk profiles for both forceps and vacuum-assisted birth, as well as the benefits and risks of an unplanned caesarean section.

Forceps use is associated with increased risk of a third or fourth degree perineal tear and other vaginal trauma compared with vacuum-assisted birth. Both carry a small risk of any neonatal injury, but the nature of injuries differs between instruments[6,7,37] (see Table 2).

Table 2: Summary of risk associated with forceps and vacuum-assisted birth[37]

Forceps compared with vacuum	Risk estimate	Absolute rates (% of operative births)
More likely to cause		
▪ Third or fourth degree tears	RR; 1.89 (95% CI 1.51–2.37)	14% vs 7%
▪ Any type of vaginal trauma	RR; 2.48 (95% CI 1.59–3.87)	26% vs 12%
▪ Facial injury	RR; 5.10 (95% 1.12–23.25)	1.7% vs 0.2%
More likely to		
▪ Achieve a vaginal birth	RR; 0.65 (95% CI 0.45–0.94)	91% vs 86% successful vaginal birth
No significant difference between instruments		
▪ Any neonatal injury		
▪ Low Apgar score (<7) at 5 minutes		
▪ Low pH (<7.2) in umbilical artery at birth		

CI = confidence interval; RR = relative risk

During a first vaginal birth where instruments are used, medio-lateral episiotomy (with an incision angle of 60°) reduces the risk of a third or fourth degree tear.[2,6,16,31,34,38] Tools to help ensure the correct angle of incision include special episiotomy scissors, such as

Episcissors-60, which may assist midwives and obstetricians achieve a post-suturing angle of 40–60°.[39] The protective effect of episiotomy is highest when forceps are used, especially with a first time vaginal birth.[7]

Additional planning is recommended in case a vaginal birth is not achieved with the first approach, and the risks of subsequent options should be considered (for example, sequential use of instruments or caesarean section at full dilation).[5,6]

Early discussion during pregnancy about these possible interventions may help prepare the woman should she face this situation.[9,40] The discussion and her consent should be documented in her healthcare record.[5]

For health service organisations

Ensure that policies, procedures and protocols include the management of instrumental vaginal birth,[41] discussion with the woman about the possible benefits and risks associated with the available options and informed consent.

Ensure that conditions for a safe instrumental vaginal birth, as described in relevant clinical guidelines, are met within the facility, particularly with regard to availability of senior staff, facilities and back-up plans in case an instrumental birth is not successful.[5,9]

Ensure that clinicians are appropriately trained and experienced to provide safe, high-quality care during an instrumental vaginal birth in accordance with professional standards, and are working within their scope of clinical practice.[3] Ensure junior staff who do not have the requisite skills are supported by an experienced clinician.

Ensure that systems are in place to monitor variation in practice against expected health outcomes, as per **Action 1.28** in the NSQHS Standards (2nd ed.), including rates of instrumental births and perineal trauma.

Provide timely feedback to clinicians on variation in practice and support them to review their clinical practice.

Record risks and the planned mitigation strategies in the risk management system.[22]

Indicators for local monitoring

Instrumental vaginal birth

Indicator 3a: Proportion of women who had an instrumental vaginal birth using vacuum
meteor.aihw.gov.au/content/index.phtml/itemId/728359

Indicator 3b: Proportion of women who had an instrumental vaginal birth using forceps
meteor.aihw.gov.au/content/index.phtml/itemId/728363

Indicator 3c: Proportion of women who had a vacuum-assisted birth with episiotomy
meteor.aihw.gov.au/content/index.phtml/itemId/728502

Indicator 3d: Proportion of women who had a forceps-assisted birth with episiotomy
meteor.aihw.gov.au/content/index.phtml/itemId/728504

More information about these indicators and the definitions needed to collect and calculate them can be found online at METeOR.

4 Quality statement 4
Identifying third and fourth degree perineal tears

After a vaginal birth, a woman is offered examination by an appropriately trained clinician to exclude the possibility of a third or fourth degree perineal tear. A tear is classified using the Royal College of Obstetricians and Gynaecologists classification and is documented in the woman's healthcare record.

Purpose

To ensure that all women who give birth vaginally are offered an examination, in a respectful way, by a clinician trained to accurately identify and classify third and fourth degree perineal tears using the RCOG classification.[6]

What the quality statement means

For women

If a perineal tear occurs, it is important that it is assessed and treated promptly. Accurate identification of a third or fourth degree perineal tear will help ensure that you receive the correct treatment.

Soon after your baby is born, your doctor or midwife may recommend an examination to check for perineal tears. This examination will be offered and carried out in a respectful manner. You have the right to refuse, or to ask your doctor or midwife to stop at any time.

Some perineal injuries may be difficult to see, especially if there is swelling in the area.[42] Your doctor or midwife will offer to examine the area in and around your vagina and anus. If you consent, the doctor or midwife will place a finger inside your rectum and carefully feel for any damaged tissues. If a third or fourth degree perineal tear is thought to have occurred, a second member of your healthcare team may be present during examination to confirm the diagnosis. You will be offered (or you can request) pain relief for this examination.

Third and fourth degree perineal tears are repaired surgically. If you have this type of injury, you may need to be transferred to a hospital for repair.

Occasionally, a perineal tear may not be detected during examination, so, if you have symptoms that you are concerned about following birth, speak to your healthcare professional.

For clinicians

After a vaginal birth, offer to examine the woman for a perineal tear. Discuss why examination may be recommended, based on the woman's experience and evidence of perineal injury. Explain what is involved with examination and seek consent for any examination. Document the offer, and any examination conducted, in the medical record.

Offer appropriate pain management and conduct the examination with due respect for the woman's recent trauma.[8,43] If a tear is suspected or identified on examination of the perineum, further assessment is recommended, including a rectal examination to assess whether the internal or external anal sphincters have been damaged.[6-8,42]

Use the RCOG classification[6] described in Box 4 to grade the severity of the injury. Whenever possible, ask a second, experienced clinician to be present during the examination to assist with identifying and classifying the tear.[2,8] If in doubt about the degree of injury, classify the tear to a higher degree.[6] Incorrect classification can result in a suboptimal repair and may increase maternal morbidity in the longer term.[42]

Record the outcome of the examination in the woman's healthcare record.

Box 4: Classification of perineal tears[6]

The Royal College of Obstetricians and Gynaecologists (RCOG) classifies perineal tears as follows:

- First degree tear: injury to perineal skin and/or vaginal mucosa
- Second degree tear: injury to perineum involving perineal muscles but not involving the anal sphincter
- Third degree tear: injury to perineum involving the anal sphincter complex
  - Grade 3a tear – less than 50% of external anal sphincter (EAS) thickness torn
  - Grade 3b tear – more than 50% of EAS thickness torn
  - Grade 3c tear – both EAS and internal anal sphincter (IAS) torn
- Fourth degree tear: injury to perineum involving the anal sphincter complex (EAS and IAS) and anorectal mucosa.

Note: Rectal buttonhole injuries involve a tear of the rectal mucosa with an intact anal sphincter complex and, visually, there is no obvious damage to the perineum.[6] If not recognised and repaired, this type of tear may lead to a rectovaginal fistula. These types of injuries should be repaired.

Rectal buttonhole tears are not included in the RCOG classification and should be documented separately.

For health service organisations

Ensure that policies, procedures and protocols for classifying and reporting perineal tears are consistent with current evidence-based guidelines[21] such as the RCOG classification system,[6] and incorporate respectful communication regarding the examination and the request for verbal consent.

Ensure that clinicians are appropriately trained in perineal anatomy and skilled in assessment and use of the RCOG classification system.[6] Communication with the woman should be offered in a respectful manner and consent sought. Ensure junior staff who do not have the requisite skills are supported by an experienced clinician when a tear is being classified. If possible, a second, experienced clinician should be available during assessment to confirm the classification of the tear.

Indicators for local monitoring

Identifying third and fourth degree perineal tears

Indicator 4a: Proportion of women who sustained a perineal tear during birth who received a genito-anal examination to assess the grade of the perineal tear after birth
meteor.aihw.gov.au/content/index.phtml/itemId/728506

Indicator 4b: Proportion of women who had a vaginal birth who sustained a Grade 3a perineal tear
meteor.aihw.gov.au/content/index.phtml/itemId/728508

Indicator 4c: Proportion of women who had a vaginal birth who sustained a Grade 3b perineal tear
meteor.aihw.gov.au/content/index.phtml/itemId/728510

Indicator 4d: Proportion of women who had a vaginal birth who sustained a Grade 3c perineal tear
meteor.aihw.gov.au/content/index.phtml/itemId/728512

Indicator 4e: Proportion of women who had a vaginal birth who sustained a fourth degree perineal tear
meteor.aihw.gov.au/content/index.phtml/itemId/728514

More information about these indicators and the definitions needed to collect and calculate them can be found online at METeOR.

5

Quality statement 5

Repairing third and fourth degree perineal tears

When a woman has a third or fourth degree perineal tear, it is promptly repaired by an appropriately trained and experienced clinician, in a suitable environment.

Purpose

To ensure that third and fourth degree perineal tears are repaired by an appropriately trained clinician and in accordance with evidence-based guidelines.

What the quality statement means

For women

If you have a third or fourth degree perineal tear, your doctor will discuss with you the nature of your injury, the method of repair, any risks involved and the need for follow-up care.

Third and fourth degree perineal tears require surgical repair. The doctor carrying out the repair needs access to appropriate equipment, lighting and support staff, to achieve the best outcome for you. Usually, the repair will take place in an operating theatre.

Only doctors who are trained to do this type of surgery, such as an obstetrician, GP obstetrician or a colorectal surgeon, should carry out the repair.

You will need a local or general anaesthetic for the repair. A urinary catheter may be needed for a short time after surgery to remove urine while you are recovering, and is usually inserted before the repair. A rectal examination will be conducted with your consent at the end of surgery to check the repair.

If possible, the health service organisation will try to arrange for your baby and support person to stay with you during surgery, if that is your wish.

For clinicians

Accurate identification and prompt repair of severe perineal tears are important to minimise the risk of infection, blood loss, pain and incontinence, as well as long-term physical, emotional and sexual health consequences for women.[8, 42]

Discuss with the woman, the nature of her injury, the procedure for repair and any risks involved. Provide reassurance regarding her recovery and the expected outcome of the repair. Clinicians who respond in a respectful and dignified manner can improve the woman's experience of care.[43]

Surgical repair should be conducted as soon as possible to minimise the risk of infection and blood loss.[8]

The repair should be performed in a suitable environment with good lighting, sterile conditions and access to appropriate equipment and clinical support.[7,6,8,43] In most cases the repair should be conducted in an operating theatre. If the labour ward replicates the environmental conditions of an operating theatre, a risk assessment should be conducted to determine whether this is a suitable environment.

The repair should be conducted under adequate anaesthesia[6], using surgical techniques and materials that are consistent with evidence-based guidelines. A rectal examination should be performed after repair to ensure that sutures have not been inadvertently inserted through the anorectal mucosa.[8]

Only appropriately trained and experienced clinicians*[6-8,44] should repair a third or fourth degree perineal tear. Refer women to an appropriately qualified clinician if required.[8] Registrars should be supervised by a senior clinician[6], unless they have completed their Assessment of Procedural and Surgical Skills or the equivalent level of credentialing or training for the repair of third or fourth degree perineal tears.

Some women may decline surgical treatment because they do not want to be separated from their baby. Advise the woman whether it is possible for her baby and support person to be present during repair and support her to maintain uninterrupted skin-to-skin contact and breastfeed during the procedure, whenever possible.[8]

The decision to use prophylactic antibiotics should be made on a case-by-case basis, following recommendations in the current *Therapeutic Guidelines: Antibiotic*.[45,46] Although evidence is limited[16,47], prophylactic antibiotics for third and fourth degree perineal tears are recommended[3,4,6,7,48] or considered reasonable[2,44] in most clinical practice guidelines.

For health service organisations

Ensure that policies, procedures and protocols for the repair of third and fourth degree perineal tears are consistent with current evidence-based guidelines.[21]

Ensure that clinicians undertaking repairs are trained and credentialed in accordance with professional standards, and are working within their scope of clinical practice.

Ensure that operating theatre policies and protocols enable timely repair of third and fourth degree perineal tears or timely transfer to an appropriate facility and allow for the woman's baby and support person to be present during the repair whenever possible.[21,†]

* Appropriately credentialed under an obstetric or colorectal surgery specialist training program.
† Some women may decline surgical treatment because they do not want to be separated from their baby.[8]

6

Quality statement 6
Postoperative care

After repair of a third or fourth degree perineal tear, a woman receives postoperative care that includes the opportunity for debriefing, physiotherapy and psychosocial support.

Purpose

To ensure that a woman receives postoperative care during admission that optimises her recovery from a third or fourth degree perineal tear. To ensure that if it is not possible to provide this care before the woman leaves hospital, arrangements are made for her to obtain this care soon after discharge.

What the quality statement means

For women

After surgery, you may have medicines to help manage pain and constipation, and to prevent infection. A urinary catheter may be used for a short period to drain urine out of your body, because it will be hard for you to urinate normally.

While in hospital, you will have an opportunity to discuss your birth experience with a member of your healthcare team. They will discuss the repair, how to look after your injury at home, what to expect while recovering, how to manage breastfeeding if medicines are required, what symptoms to look out for, who to contact if you have any concerns and any follow-up care required.

You may also see a healthcare professional with experience in pelvic floor health, such as a physiotherapist, who will support your recovery.

If you feel unsettled or distressed, you may like to meet with a psychologist who can provide emotional support, or a social worker who may be able to arrange help with your daily activities at home.

If you leave hospital before having these appointments, arrangements will be made for you to obtain this care soon afterwards. Before leaving hospital, ask if any follow-up appointments have been scheduled for you.

For clinicians

While the woman is in hospital, give her an opportunity to discuss her recent experience with the clinician(s) present during the birth and to ask them questions.[8] Ensure that the woman is given information about her medicines, how to care for her injury at home, what to expect while recovering, symptoms to look out for and who to contact if she has any concerns. Provide information about follow-up care required in the short and long term.[6, 8]

Arrange an appointment with a healthcare professional with experience in pelvic floor health such as a physiotherapist, as well as with a psychologist, or social worker if she is likely to need support or assistance at home.

If this care cannot be provided before the woman leaves hospital, arrange an appointment so she can obtain care soon afterwards.

Ensure that the woman's discharge summary notes the care received and any follow-up required.[49]

For health service organisations

Ensure that policies, procedures and protocols support clinicians to provide appropriate postoperative care including access to services such as debriefing, physiotherapy, and psychosocial support services.

Ensure discharge policies support appropriate follow-up post-discharge.

7

Quality statement 7

Follow-up care post-discharge

A woman with a third or fourth degree perineal tear receives individualised continuity of care and appropriate follow-up and referral to optimise her ongoing physical, emotional, psychological and sexual health.

Purpose

To ensure that women who experience a third or fourth degree perineal tear receive appropriate follow-up care after leaving hospital, to optimise their physical, emotional, psychological and sexual health. To ensure that appropriate referral pathways are in place.

What the quality statement means

For women

After leaving hospital, you should receive follow-up care to promote your physical and emotional recovery and to provide advice for future pregnancies. Arrangements for this care should begin while you are in hospital.

In the weeks after your baby is born, you should be offered a follow-up appointment with an experienced member of your healthcare team who is familiar with your history. They will check that your injury is healing and discuss any other problems you are experiencing. They can help you if you have concerns about pain, incontinence, sexual activities, exercise, or relationship difficulties because of your injury. You may also feel sad or tearful for a period after this type of injury.

To support your recovery, a number of specialist services may be offered, such as:

- Clinics that specialise in treating women with third and fourth degree perineal tears
- Specialist doctors like obstetricians or colorectal surgeons
- Healthcare professionals with experience in pelvic floor health, such as a physiotherapist
- Psychological services.

Your GP or other primary care provider can provide follow-up care and refer you to other services if required. Information about your care and the recommended follow-up will be provided to them in a discharge summary from the hospital.

It is important to talk to your support person or partner, as they may also need help to understand how to support you while you recover and to look after their own health and wellbeing. You may choose for both of you to go to your appointments.

It is also recommended that you talk to a healthcare professional about your future plans for another pregnancy.[8]

For clinicians

Women who experience a third or fourth degree perineal tear need individualised, specialist follow-up care from clinicians with relevant expertise and experience. In the weeks after birth, ensure that the woman has a follow-up with a clinician who has relevant expertise and is familiar with her medical history, to assess and support the woman's physical, emotional and psychological recovery.[2]

Offer and arrange for post-discharge care in a multidisciplinary perineal clinic or other services appropriate to her clinical needs and injury, such as:

- Clinics that specialise in treating women with a third or fourth degree perineal tear
- Specialist medical practitioners, including obstetricians, gynaecologists or colorectal surgeons
- The GP who will provide ongoing care and referral, if needed
- Clinicians who specialise in pelvic floor function and postnatal rehabilitation for women with a third or fourth degree perineal tear, such as physiotherapists
- Healthcare professionals with specialist expertise providing care to women with third and fourth degree perineal tears, such as midwives
- Nurses with specialist expertise in continence management
- Psychologists with expertise or experience in postnatal mental health or birth trauma.

Any issues that may affect future births, and the woman's concerns about these should also be considered.[2,5-7] Acknowledge that, if the woman's support person or partner witnessed a traumatic birth, it may affect their health and wellbeing. Offer them an opportunity to debrief and refer them for support if required.

GPs and other primary care clinicians, will provide health care to the woman after discharge. Ensure that adequate information is recorded in discharge summaries about the birth and the woman's ongoing care needs including monitoring for late onset symptoms or signs of faecal incontinence, dyspareunia, postnatal anxiety or depression, or relationship difficulties, and provide appropriate referral options.[49]

Women with faecal incontinence will need support to effectively manage their condition. As such problems may emerge sometime after birth, inform women that support is available if needed and encourage them to report symptoms.

Advise women that a third or fourth degree tear does not exclude a subsequent vaginal birth.[2, 20] Advise them to discuss future birth planning with a maternity healthcare provider who has experience in caring for women with previous third or fourth degree tears, who can provide counselling about future pregnancies and discuss the woman's preferences.

For health service organisations

Ensure that policies, procedures, protocols and referral pathways promote comprehensive care, using a multidisciplinary team-based approach. This should include access to services appropriate for women with third and fourth degree perineal tears, including physiotherapy for pelvic floor rehabilitation, continence management, psychological support and surgical expertise, including in specialised multi disciplinary clinics. A discharge summary should be forwarded to the woman's general practitioner, which details the follow-up care and referrals needed.

Appendix A: General principles of care

This clinical care standard aligns with key principles that are the foundation for achieving safe, high-quality care. When implementing this clinical care standard, health services should ensure quality improvement activities support these principles.

Person-centred care

Person-centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers.[22, 50]

Clinical care standards support the key principles of person-centred care, namely:

- Treating patients with dignity and respect
- Encouraging patient participation in decision-making (see 'Shared decision making')
- Communicating with patients about their clinical condition and treatment options
- Providing patients with information in a format that they understand and encouraging them to participate in decision-making.

Woman-centred care

This clinical care standard supports the values and principles in *Woman-centred care: Strategic directions for Australian maternity services*[10], which aims to ensure that Australian maternity services are equitable, safe, woman-centred, informed and evidence-based. Women are the decision-makers in their care and maternity care should reflect their individual needs.[10]

This clinical care standard promotes the provision of individualised information and appropriate care based on current, high-quality evidence, including evidence on models of care. Models of care include midwifery continuity of care, obstetric-led care and shared care.

In the maternity setting, 'woman-centred care' recognises the woman's baby, partner, family, and community, and respects cultural and religious diversity as defined by the woman herself. It considers the woman's individual circumstances, and aims to meet the woman's physical, emotional, psychosocial, spiritual and cultural needs. This care is built on a reciprocal partnership through effective communication. It enables individual decision-making and self-determination for the woman to care for herself and her family. It respects the woman's ownership of her health information, rights and preferences while protecting her dignity and empowering her choices.[51]

Shared decision making

Shared decision making involves discussion and collaboration between a consumer and their clinician. It is about bringing together the consumer's values, goals and preferences with the best available evidence about benefits, risks and uncertainties of treatment, to reach the most appropriate healthcare decisions for that person.

Involving support people

The **Australian Charter of Healthcare Rights** (second edition)[52] describes the rights that consumers, or someone they care for, can expect when receiving health care.

Patients have the right to involve the people they want in planning and making decisions about their health care and treatment. This could be a family member, carer, friend or a consumer advocate such as a social worker. Many health services employ different types of liaison officers, such as Aboriginal and/or Torres Strait Islander liaison officers, who can provide patients with advocacy, information and support.

This clinical care standard does not specifically refer to carers and family members, but statements which refer to clinicians' discussions with patients about their care should be understood to include support people if this is what the patient wishes, or a substitute decision-maker if the person is unable to provide their consent.

Informed consent

Informed consent is a person's voluntary and informed decision about a health care treatment, procedure or intervention that is made with adequate knowledge and understanding of the benefits and risks to them, and the alternative options available. The Commission developed an informed consent fact sheet for consumers, available at **www.safetyandquality.gov.au/publications-and-resources/resource-library/informed-consent-fact-sheet-clinicians**.

Action 2.4 in the NSQHS Standards requires health service organisations to ensure that informed consent processes comply with legislation and best practice.[22]

Cultural safety and patient safety

Cultural safety is about overcoming the cultural power imbalances of places, people and policies to contribute to improvements in Aboriginal and Torres Strait Islander health.[53]

The **Cultural Respect Framework 2016–2026**[54] commits the Australian Government and all states and territories to embed cultural respect principles into their health systems. The framework should be used to develop, implement and evaluate cultural awareness and cultural competency strategies.

Health consumers are safest when clinicians have considered power relations, cultural differences and patients' rights. Part of this process requires clinicians to review their own beliefs and attitudes.[55]

The NSQHS Standards *User Guide for Aboriginal and Torres Strait Islander Health*[55] describes six specific actions that aim to help health services improve the quality of care and health outcomes for Aboriginal and Torres Strait Islander peoples.[22]

Appendix B: Indicators to support local monitoring

The Commission has developed a set of indicators to support clinicians and health services in monitoring how well they implement the care described in this clinical care standard. The indicators are a tool to support local quality improvement activities. No benchmarks are set for any indicator.

The process to develop the indicators specified in this document comprised:

- A review of existing Australian and international indicators
- Prioritisation, review and refinement of the indicators with the topic working group.

Most of the data underlying these indicators are collected from local sources, through prospective data collection or retrospective chart audits.

In this document, the indicator titles and hyperlinks to the specifications are included with the relevant quality statement under the heading 'Indicators for local monitoring'. Full specifications for the *Third and Fourth Degree Perineal Tears Clinical Care Standard* indicators can be found in the Metadata Online Registry (METeOR) at **meteor.aihw.gov.au/content/index.phtml/itemId/728215**.

METeOR is Australia's web-based repository for national metadata standards for the health, community services and housing assistance sectors. Hosted by the Australian Institute of Health and Welfare, METeOR provides users with online access to a wide range of nationally endorsed data and indicator definitions.

Other Commission-endorsed indicators to support local monitoring

Hospital-acquired complications

A hospital-acquired complication (HAC) refers to a complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.[21] The HACs list comprises 16 agreed, high-priority complications for which clinicians, managers and others can work together to address and improve patient care. Each of the HACs has a number of associated diagnoses and codes, which allow further exploration of the data. Data for HACs are derived from the admitted patient data collection.

Third and fourth degree perineal laceration during delivery is one of the nationally agreed HACs that is routinely collected in all hospitals in Australia. It can be used in parallel with the recommended clinical care standard indicators to monitor the quality of care women receive during childbirth.

The Commission has developed a number of resources for clinicians, managers and executives, governing bodies and others, to put in place strategies that reduce the occurrence of HACs. These are available at **www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications**.[52]

Appendix C: Measuring and monitoring patient experiences

Systematic, routine monitoring of patients' experiences of, and outcomes from, health care is an important way to ensure that the patient's perspective drives service improvements and patient-centred care. This is the case in all health services.

Patient experience measures

While this clinical care standard does not include indicators specific to measuring patient experiences, the Commission strongly encourages health services to use the Australian Hospital Patient Experience Question Set (AHPEQS). AHPEQS is a 12-question generic patient experience survey that has been validated in both day-only and admitted hospital patients across many clinical settings. The instrument is available for download to both private and public sector health services at **www.safetyandquality.gov.au/publications-and-resources/resource-library/australian-hospital-patient-experience-question-set-ahpeqs**.

Patient-reported outcome measures

In Australia, patient-reported outcome measures (PROMs) are an emerging method of assessing the quality of health care. The Commission is leading a national work program to support the consistent and routine use of PROMs to drive quality improvement.

PROMs are standardised, validated questionnaires that patients complete, without any input from healthcare providers. They are often administered at least twice to an individual patient – at baseline and again after an intervention, or at regular intervals during a chronic illness. The information contributed by patients filling out PROMs questionnaires can be used to support and monitor the movement of health systems towards person-centred, value-based health care.

PROMs are being used to evaluate healthcare effectiveness at different levels of the health system, from the individual level to service and system levels. There is growing interest across Australia and internationally in the routine interrogation of patient-reported outcome information for evaluation and decision-making activities at levels of the health system beyond the clinical consultation.

Appendix D: Integration with National Standards

National Safety and Quality Health Service Standards

Monitoring the implementation of this clinical care standard will help organisations to meet some of the requirements of the National Safety and Quality Health Service (NSQHS) Standards (second edition).[22]

The NSQHS Standards aim to protect the public from harm and improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.

Within the NSQHS Standards, the Clinical Governance Standard and the Partnering with Consumers Standard combine to form the clinical governance framework for all health service organisations that applies to all other standards.

- The Clinical Governance Standard aims to ensure that systems are in place within health service organisations to maintain and improve the reliability, safety and quality of health care.
- The Partnering with Consumers Standard aims to ensure that consumers are partners in the design, delivery and evaluation of healthcare systems and services, and that patients are given the opportunity to be partners in their own care, to the extent that they choose.

Action 1.27b and Action 1.28

Under the Clinical Governance Standard, health service organisations are expected to support clinicians to use the best available evidence, including clinical care standards (see Action 1.27b) and to monitor and respond to unwarranted clinical variation (Action 1.28).

Health service organisations are expected to implement the NSQHS Standards in a way that suits the clinical services provided and their associated risks.

Information about the NSQHS Standards is available at the **NSQHS Standards website**.

Glossary

Term	Definition
antenatal	The period between conception and the onset of established labour.[56]
assessment	A clinician's evaluation of a disease or condition, based on the patient's subjective report of the symptoms and course of the illness or condition and the clinician's objective findings. These findings include data obtained through laboratory tests, physical examination and medical history, and information reported by carers, family members and other members of the healthcare team.[22]
best practice guidelines	A set of recommended actions that are developed using the best available evidence. They provide clinicians with evidence-informed recommendations that support clinical practice, and guide clinician and patient decisions about appropriate health care in specific clinical practice settings and circumstances.[22]
buttonhole tear	See **rectal buttonhole tear**
caesarean section	An operation in which a baby is born through an incision (cut) made through the mother's abdomen and uterus.[36]
clinical care standards	Nationally relevant standards developed by the Australian Commission on Safety and Quality in Health Care, and agreed by health ministers, that identify and define the care people should expect to be offered or receive for specific conditions.
clinical practice guidelines	Clinical practice guidelines are statements that include recommendations intended to optimise patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.[57]
clinician	A trained health professional who provides direct clinical care to patients including registered and non-registered practitioners. Clinicians may provide care within a health service organisation as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They include nurses, midwives, medical practitioners, allied health professionals, and other clinicians who provide health care, and students who provide health care under supervision. See also **healthcare professional**
competence	The possession of required skills, knowledge, education and capacity.[51]
consultation	The seeking of professional advice from a qualified, competent source and making decisions about shared responsibilities for care provision. It depends on the existence of collaborative relationships, and open communication, with others in the multidisciplinary team.[51]
continuity of care	The practice of ensuring that a woman knows her maternity care provider(s) and receives care from the same provider, or small group of providers, throughout pregnancy, labour, birth and the postpartum period.[10]
credentialing	The formal process used by a health service organisation to verify the qualifications, experience, professional standing, competencies and other relevant professional attributes of clinicians, so that the organisation can form a view about the clinician's competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments.[22]

Term	Definition
episiotomy	A cut made by a clinician through the vaginal wall and perineum to make more space to deliver the baby.[30] See also **medio-lateral episiotomy, midline episiotomy and selective episiotomy**
female genital mutilation	The partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons.[58]
healthcare professional	Maternity healthcare professionals may include: ■ Aboriginal and Torres Strait Islander health workers ■ Doctors (including obstetrician/gynaecologists, GPs and GP obstetricians, and colorectal surgeons) ■ Midwives ■ Nurses (including specialist continence nurses and women's health nurses) ■ Physiotherapists ■ Psychologists. See also **clinician**
healthcare record	Includes a record of the patient's medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts for an episode of care.[22]
health literacy	The Australian Commission on Safety and Quality in Health Care separates health literacy into two components: individual health literacy and the health literacy environment. Individual health literacy is the skills, knowledge, motivation and capacity of a consumer to access, understand, appraise and apply information to make effective decisions about health and health care, and take appropriate action. The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the healthcare system, which affect the ways in which consumers access, understand, appraise and apply health-related information and services.[22]
health service organisation	A separately constituted health service that is responsible for implementing clinical governance, administration and financial management of a service unit or service units providing health care at the direction of the governing body. A service unit involves a group of clinicians and others working in a systematic way to deliver health care to patients. It can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, practices and clinicians' rooms.[22]
informed consent	A process of communication between a patient and clinician about options for treatment, care processes or potential outcomes. This communication results in the patient's authorisation or agreement to undergo a specific intervention or participate in planned care. The communication should ensure that the patient has an understanding of the care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.[59]
instrumental vaginal birth	A birth in which the operator uses forceps, a vacuum or other devices to extract the fetus from the vagina, with or without the assistance of maternal pushing. The decision to use an instrument to deliver the fetus balances the maternal, fetal and neonatal impact of the procedure against the alternative options of caesarean birth or expectant management.[60]

Term	Definition
maternity care	Care provided during pregnancy and in the 12 months after giving birth.[56]
medio-lateral episiotomy	A medio-lateral episiotomy starts within 3 mm of the midline in the posterior fourchette and is directed laterally at an angle of at least 60° from the midline towards the ischial tuberosity.[2]
midline episiotomy	A midline or median episiotomy starts within 3 mm of the midline in the posterior fourchette and extends downwards between 0° and 25° of the sagittal plane.[2]
multidisciplinary team	A team including clinicians from multiple disciplines who work together to deliver comprehensive care that deals with as many of the patient's health and other needs as possible. The team may operate under one organisational umbrella or may be from several organisations brought together as a unique team. As a patient's condition changes, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient. (A discipline is a branch of knowledge within the health system).[22]
nulliparous	a woman who has not given birth previously
obstetric anal sphincter injuries (oasis)	See **third and fourth degree perineal tear** and **rectal buttonhole tear**
occipito-posterior position	A malposition, where the back of baby's head is against the mother's back, often resulting in a long labour.
partnership	When patients and consumers are treated with dignity and respect, information is shared with them, and participation and collaboration in healthcare processes are encouraged and supported to the extent that patients and consumers choose. Partnerships can exist in different ways in a health service organisation, including at the level of individual interactions; at the level of a service, department or program; and at the level of the organisation. They can also exist with consumers and groups in the community. Generally, partnerships at all levels are necessary to ensure that the health service organisation is responsive to patient and consumer input and needs, although the nature of the activities for these different types of partnership will depend on the context of the health service organisation.[22]
perinatal period	The period covering pregnancy and the first year after pregnancy or birth.[61]
perineal tear	A tear of the skin and other tissues between the vagina and anus. The following classification is commonly used to describe the degree of the injury.[6] ■ First degree tear: injury to perineal skin and/or vaginal mucosa ■ Second degree tear: injury to perineum involving perineal muscles but not involving the anal sphincter ■ Third degree tear: injury to perineum involving the anal sphincter complex – Grade 3a tear: less than 50% of external anal sphincter (EAS) thickness torn – Grade 3b tear: more than 50% of EAS thickness torn – Grade 3c tear: both EAS and internal anal sphincter (IAS) torn ■ Fourth degree tear: injury to perineum involving the anal sphincter complex (EAS and IAS) and anorectal mucosa. Perineal tears may also be referred to as perineal lacerations. See also **third and fourth degree perineal tear**

Term	Definition
person-centred care	An approach to the planning, birth and evaluation of health care that is founded on mutually helpful partnerships among clinicians and consumers. Person-centred care is respectful of, and responsive to, the preferences, needs and values of consumers. Key dimensions of person-centred care include: ■ Respect ■ Emotional support ■ Physical comfort ■ Information and communication ■ Continuity and transition ■ Care coordination ■ Involvement of carers and family ■ Access to care. Also known as **patient-centred care** or **consumer-centred care**.[22]
psychosocial	Social factors that have the potential to affect a woman's emotional wellbeing.[61]
quality improvement	The combined efforts of the workforce and others – including consumers, patients and their families, researchers, planners and educators – to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development.[62] Quality improvement activities may be sequential, intermittent or continuous.[22]
rectal buttonhole tear	A tear that involves the rectal mucosa with an intact anal sphincter complex. This type of tear must be documented as a rectal buttonhole tear. It is not a fourth degree tear. If not recognised and repaired, a rectal buttonhole tear may lead to a rectovaginal fistula.[6]
risk assessment	Assessment, analysis and management of risks. It involves recognising which events may lead to harm in the future, and minimising their likelihood and consequence.[63]
risk factor	A characteristic, condition or behaviour that increases the possibility of disease, injury or loss of wellbeing.
scope of practice	The extent of an individual clinician's approved clinical practice within a particular organisation, based on the clinician's skills, knowledge, performance and professional suitability, and the needs and service capability of the organisation.[64]
selective episiotomy	A surgical cut of the vagina and perineum performed as required on women undergoing vaginal birth.
third and fourth degree perineal tear	A third degree perineal tear involves injury to the perineum involving the anal sphincter (muscle controlling the anus). A fourth degree perineal tear involves the anal sphincter and the anal mucosa (the lining of the anus or rectum).[6] See also **perineal tear**
shared decision making	A consultation process in which a clinician and a patient jointly take part in making a health decision, having discussed the options, and their benefits and harms, and having considered the patient's values, preferences and circumstances.[65]

Term	Definition
shoulder dystocia	When the baby's head has been born but one of the shoulders becomes stuck behind the mother's pubic bone, delaying the birth of the baby's body. If this happens, extra help is usually needed to release the baby's shoulder.[66]
system	The resources, policies, processes and procedures that are organised, integrated, regulated and administered to accomplish a stated goal. A system: ■ Brings together risk management, governance, and operational processes and procedures, including education, training and orientation ■ Deploys an active implementation plan; feedback mechanisms include agreed protocols and guidelines, decision-support tools and other resource materials ■ Uses several incentives and sanctions to influence behaviour and encourage compliance with policy, protocol, regulation and procedures. The workforce is both a resource in the system and involved in all elements of systems development, implementation, monitoring, improvement and evaluation.[22]
timely (communication)	Communication of information within a reasonable time frame. This will depend on how important or time critical the information is to a patient's ongoing care or wellbeing, the context in which the service is provided and the clinical acuity of the patient.[22]
training	The development of knowledge and skills.[22]
vaginal birth	Non-instrument-assisted birth.
woman-centred care	Care that recognises the woman's baby or babies, partner, family, and community, and respects cultural and religious diversity as defined by the woman herself. Woman-centred care considers the woman's individual circumstances, and aims to meet the woman's physical, emotional, psychosocial, spiritual and cultural needs. This care is built on a reciprocal partnership through effective communication. It enables individual decision-making and self-determination for the woman to care for herself and her family. Woman-centred care respects the woman's ownership of her health information, rights and preferences while protecting her dignity and empowering her choices. Woman-centred care is the focus of midwifery practice in all settings.[51] See also **person-centred care**

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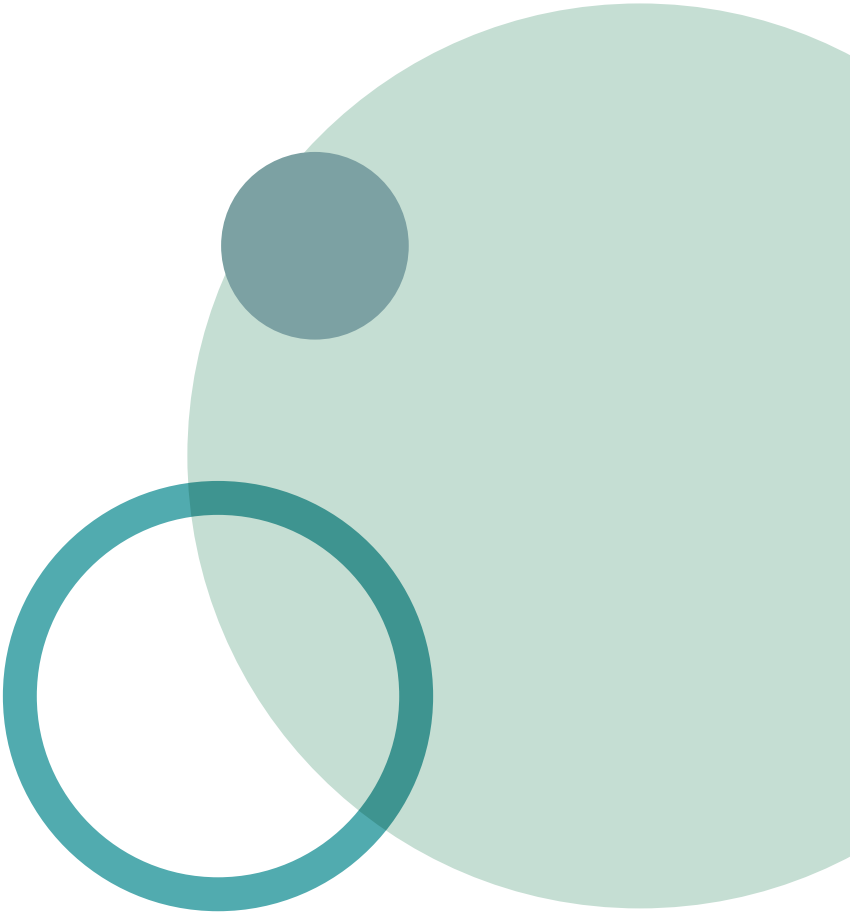


Acknowledgements

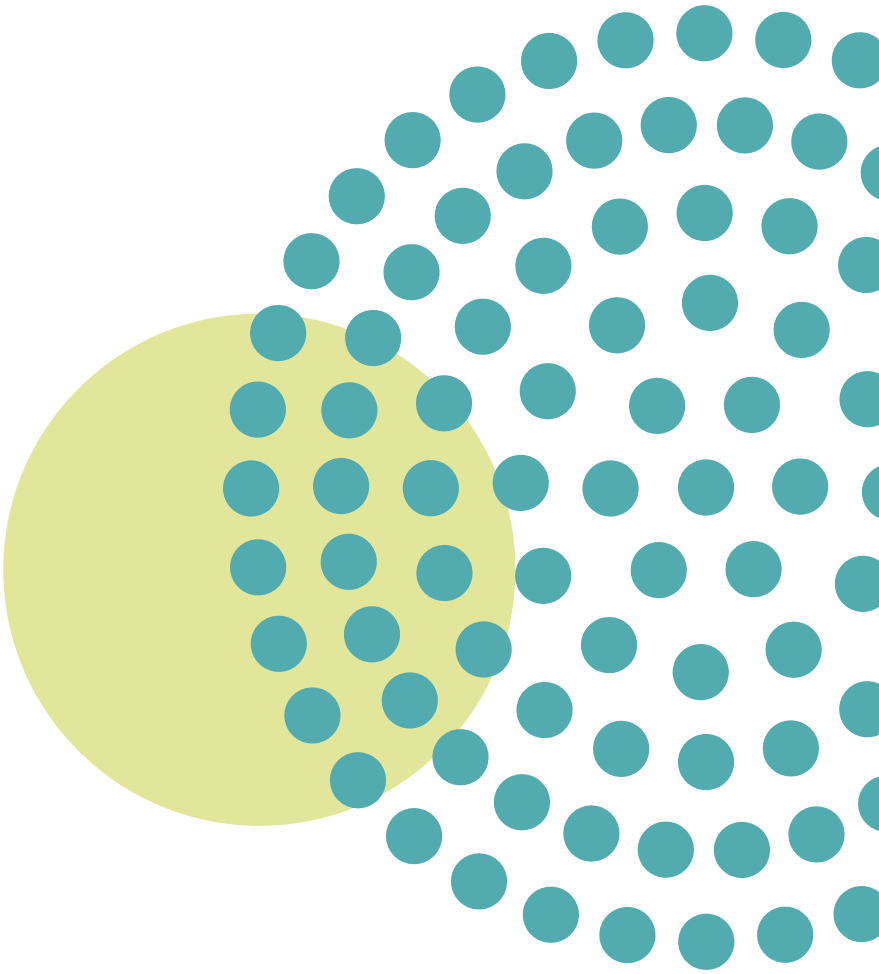
Many individuals and organisations have freely given their time and expertise in the development of this document. In particular, the Commission wishes to thank the Third and Fourth Degree Perineal Tears Clinical Care Standard Topic Working Group members, and other key experts who have given their time and advice. The involvement and willingness of all concerned to share their experience and expertise is greatly appreciated.

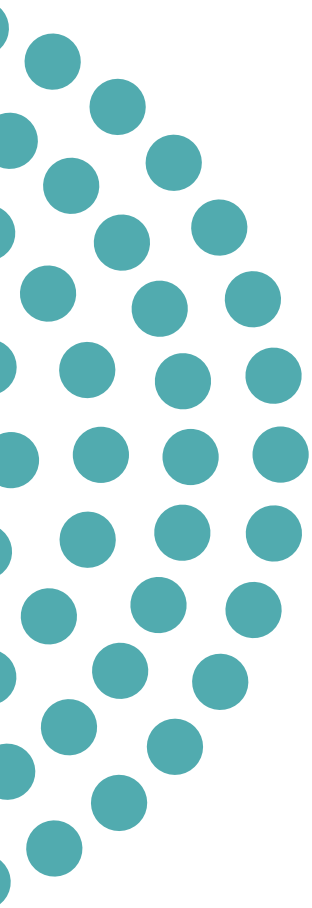
Members of the Topic Working Group included:

- Ms Leslie Arnott
- Professor Hannah Dahlen
- Professor Caroline Homer
- Associate Professor Emmanuel Karantanis
- Dr James Keck
- Associate Professor Boon Lim
- Ms Sue McBeath
- Ms Natalie McConochie
- Dr Nicola Yuen

A number of Commission staff were also involved in the writing and review of this publication, and the Commission wishes to acknowledge:

- Professor Anne Duggan
- Ms Alice Bhasale
- Ms Lisa Gray
- Ms Suzanna Henderson
- Ms Leslie Trainor
- Mr Suraj Rasakulasingam





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