Better births for women collaborative – Phase 2 Charter

## What will the Better Births for Women Collaborative accomplish?

### By June 2021 we intend to reduce harm to women by reducing the rate of 3rd and 4th degree perineal tears by 50 per cent

This will be accomplished by focusing on:

* Consistent, reliable use of the bundle of clinical care:
  + warm perineal compresses;
  + hands-on technique;
  + episiotomy when indicated, with correct technique;
  + genitoanal examination for all women after vaginal birth, and;
  + examination and grading of all perineal trauma by two experienced clinicians.
* Partnering with women during pregnancy, labour and birth, and immediately after birth, to support identification of risk factors and shared decision making.

## Background information

Prior to Phase 1 of the Better births for women collaborative, Victorian data demonstrated that women having their first vaginal birth were four times more likely to experience a severe perineal laceration (third- or fourth-degree tear) compared to those having a subsequent vaginal birth[[1]](#footnote-2). A third- or fourth-degree perineal tear is a significant birth-related complication. It is important these tears are prevented, and where they do happen, they are recognised so that appropriate treatment can be provided.

For the women sustaining these injuries, consequences can be long-term or lifelong, and impact on their physical and psychological wellbeing. The resulting trauma has been shown to have a detrimental psychosocial impact, with many women requiring ongoing intervention. It has also been shown that the trauma of sustaining a perineal tear and its complications can affect subsequent births choices where a vaginal birth is forsaken, increasing rates of elective caesarean section.

Utilising our partnership with the Institute for Healthcare Improvement (IHI), we began the Better births for women breakthrough series collaborative in August 2019, with the intent to further test and spread the success of an evidence-based clinical care bundle to reduce third- and fourth- degree perineal tear rates. Phase 1 was brought to an end in April 2020, due to the coronavirus (COVID-19) pandemic, and Phase 2 is commencing in November 2020.

### Phase 1 – what progress did we make?

#### Progress towards our aim

* Total third- and fourth-degree perineal tears **reduced by 25 per cent**.

#### Improvements in process measures

* Application of warm perineal compresses increased from 40 percent to 60 per cent.
* Use of hands-on technique and gentle verbal guidance increased from 50 per cent to 87 per cent.
* Episiotomy when indicated increased from 73 per cent to 90 per cent.
* Episiotomy cut at a 60-degree angle increased from 54 per cent to 73 per cent.
* Genitoanal examination for all women increased from 20 per cent to 73 per cent.
* Examination of all perineal trauma by two experienced clinicians increased from 27 per cent to 67 per cent.

## What does taking part in phase 2 of the collaborative mean?

### Phase 2 – Key dates for our six-month program

* 25 November 2020 – Kick off session
* 16 December 2020 – Virtual office (optional attendance for support and Q&A)
* 21 January 2021 – 1st virtual forum
* 10 February 2021 - Virtual office (optional attendance for support and Q&A)
* 25 March 2021 – 2nd virtual forum
* 27 May 2021 – Wrap up

Coaching calls with Improvement Advisors in training to be arranged.

#### Each participating service needs

* An executive sponsor who is supporting the work and ideally able to attend virtual forums with their team. We know from Phase 1 that active partnership between service leadership and the collaborative team is essential to achieve results. Teams succeed when a senior leader sponsors their work. The executive sponsor is responsible and accountable to the service for performance and results of improvement work. They may not be an active member of the collaborative team but support the team to achieve their aim by connecting with them regularly, removing barriers to their progress and championing their work to others in the service.
* A day-to-day team leader.
* A core team: This team may be comprised of an obstetrician, midwife, consumer and member with quality improvement experience. The team is responsible for identifying champions and driving change on the clinical floor.
* A wider team of six to 12 members (e.g. clinicians, managers), influencers in the organisation who can drive commitment and attention to the work and support frontline staff to test changes. This group includes a member responsible for data entry.
* Time dedicated to do the work (including online meetings and site visits): in our experience, optimal results are achieved when teams can devote at least 30 hours per week to the project (shared between members).
* Support for the core team to attend all virtual forums.
* A commitment to implement all elements of the bundle.

## How will we know that change is an improvement?

### Data collection

During quality improvement activities, teams collect and use data over time in order to assess change, adjust their hypotheses along the way and understand the impact of changes tested in a wide range of conditions. Data is used to understand if changes are leading to improvement and to determine teams’ next steps.

The following measures will be collected by the teams throughout Phase 2 of the collaborative.

#### Outcome measures

* Percentage of third- and fourth-degree perineal tears
* Percentage of third- and fourth-degree perineal tears in non-instrumental assisted vaginal births
* Percentage of third- and fourth-degree perineal tears in instrumental assisted vaginal births

#### Process measures

* Percentage of women who have a warm perineal compress applied during the second stage of labour
* Percentage of women who receive gentle verbal guidance and hands-on technique, from commencement of perineal stretching to birth
* Percentage of assisted births, in women having their first vaginal birth, where an episiotomy is performed
* Percentage of episiotomies cut at 60-degrees from the midline
* Percentage of women who receive a genitoanal examination following vaginal birth
* Percentage of women whose perineal trauma is examined and graded by two experienced clinicians
* Percentage of women for whom there is evidence in their pregnancy care record of a conversation about what to expect during birth and details of the perineal protection bundle (OPTIONAL)

**Balance measures**

* Percentage of women who have an episiotomy
* Rate of caesarean sections
* Percentage of women who were involved as much as they wanted to be in decisions about their care during labour and birth (OPTIONAL)

## What changes can we make that will lead to improvement?

Phase 2 Driver diagram

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **AIM** |  | **PRIMARY DRIVERS** |  | **SECONDARY DRIVERS** |  | **CHANGE IDEAS** |
|  |  |  |  |  |  |  |
| Reduce harm to Victorian women by reducing the rate of 3rd and 4th degree perineal tears by 50 per cent, by June 2021 |  | Partnering with women |  | During pregnancy |  | * Use the ‘Donut hesitate to ask’ tool with women during pregnancy care * Inclusion of information about the clinical bundle in childbirth education curriculum * Planning for risk assessment and decision-making during birth |
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|  |  | During birth |  | * Shared ongoing risk assessment and decision making |
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|  |  | 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 |
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|  | 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 |
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|  |  | Second stage of labour |  | ***Intervention 1: Warm compresses -*** *Apply warm perineal compresses during the second stage of labour at the commencement of perineal stretching*   * 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 |
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|  |  |  | ***Intervention 2: Hands on technique -*** *Encourage a slow controlled birth of the fetal head and shoulders for all vaginal births, using gentle verbal guidance, support the perineum with the dominant hand, apply counter-pressure on the fetal head with the non-dominant hand, if needed, apply gentle traction to release the anterior shoulder, allow posterior shoulder to be released following the curve of Carus*   * Develop a video on hands-on technique, to share with all clinicians |
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|  |  |  | ***Intervention 3: 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 |
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|  |  | After birth |  | ***Intervention 4: Genito-anal examination -*** *A per-rectum examination for all women, including those with an intact perineum* |
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|  |  |  | ***Intervention 5: Review of tear and grading – all perineal trauma to be reviewed by a second experienced clinician***   * Use the RCOG grading scale * Develop local operational definitions for ‘experienced clinicians’ |

1. The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2017, Victoria’s Mothers, Babies and Children, Safer Care Victoria, Victorian Government, Melbourne. [↑](#footnote-ref-2)