MNLHN Improvement Program

Information Pack

OFFICIAL

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# Background

The Maternity and Newborn Learning Health Network (MNLHN) was established in December 2022 with the aim of bringing together consumers, clinicians, and researchers to improve safety and quality, experiences and outcomes for women, babies and families receiving maternity care in Victoria. The MNLHN identified 6 key priorities areas for the 3-year tenure of the program; 2 of which are reducing third- and fourth-degree perineal tears and reducing stillbirths.

Between 2019 and 2021, SCV partnered with the Institute for Healthcare Improvement (IHI) to deliver two large scale maternity improvement projects focusing on reducing severe perineal tears (Better births for women collaborative) and stillbirths (Safer baby collaborative). These projects built on the success of previous work undertaken by Women’s Healthcare Australasia (WHA) in the development of the Perineal Protection Bundle and the Stillbirth Centre for Research Excellence (CRE). Both projects were successful in improving patient outcomes and enabled the maternity sector to build improvement science skills and connect with other services across the state.

The MNLHN is looking to build on these efforts, working to facilitate sustainability and spread of the two previous collaboratives. The Maternity and Newborn Improvement Program will support maternity services who share the priorities to reduce rates of preventable stillbirth or severe perineal tears, to use the tools and resources from the previous collaboratives.

For more information on reducing stillbirths, please refer to Appendix 1.

For more information on reducing perineal trauma, please refer to Appendix 2.

# What are we trying to accomplish?

**Vision**

By December 2025, SCV MNLHN will drive sustainable improvement outcomes for Victorian women, babies, and families.

**REDUCING STILLBIRTH  
To reduce the rate of avoidable stillbirths in the third trimester[[1]](#footnote-2) in participating maternity services.**

**PERINEAL TEARS**

**To reduce harm to Victorian women by preventing of third- and fourth-degree perineal tears in participating maternity services.**

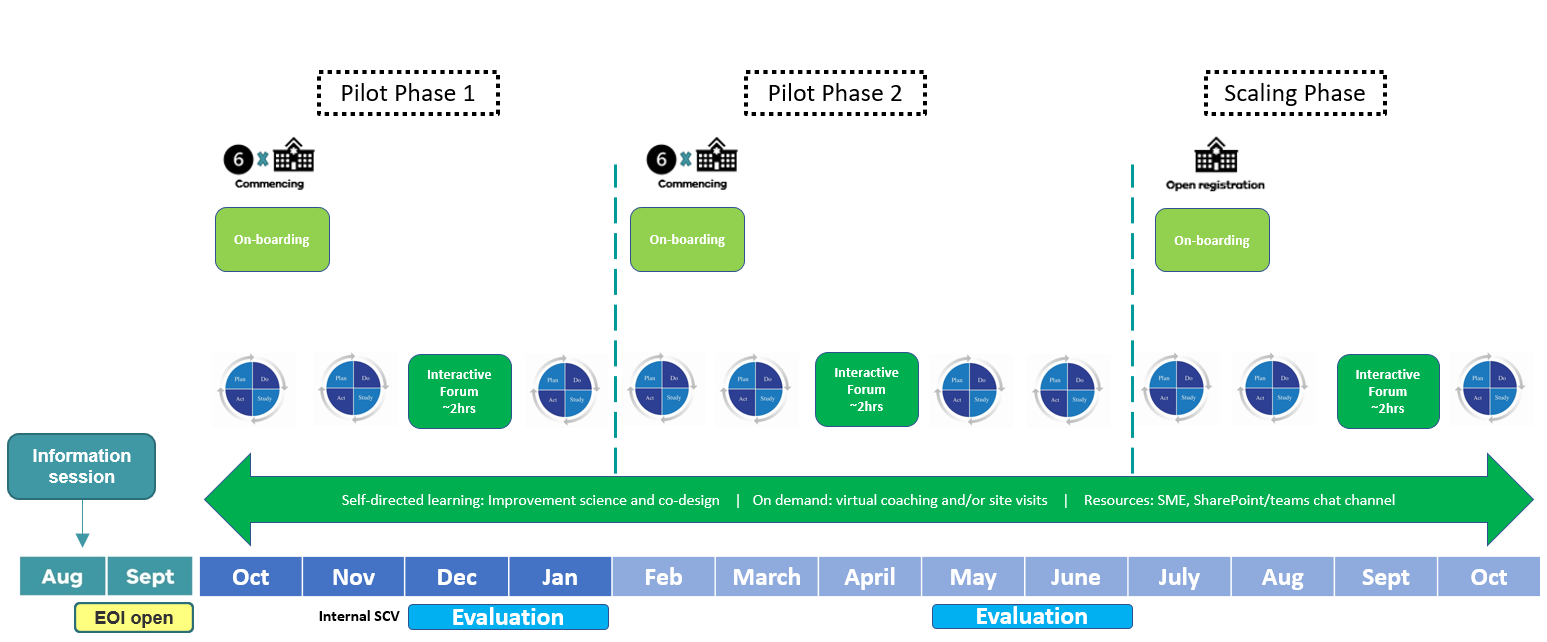
Note: the target reduction percentage for each health service for both initiatives will be determined in discussion with the health service, as well as previous outcomes of the collaborative utilising the same evidence-based clinical care bundle.

# How are we going to achieve this together?

SCV partners with health services and consumers to support the delivery of improvement initiatives and utilises the [Model for Improvement (MFI)](https://www.safercare.vic.gov.au/improvement/step-by-step-guide-to-using-the-model-for-improvement) (an evidenced-based improvement methodology) to do this. The Maternity and Newborn Improvement Program will use this same approach in the sustainability and spread of the stillbirth prevention and reducing perineal tears improvements.

The Maternity and Newborn Improvement Program (Figure 1) will support services to achieve sustained improvements in stillbirth prevention and reduction of perineal tears by providing a flexible and adaptive approach which enables services to commence improvements as outlined in Figure 1 below. A core principle of the MFI is starting small and testing changes before widespread implementation. We will be adopting a similar approach using a phased methodology and start by partnering with a small number of services. We will continue to test and refine this model before scaling up to invite all maternity services to participate in improvement work.

**Figure 1: Maternity and Newborn Improvement Program approach**



#### Definitions

**On-boarding**​ will offer an opportunity for participating health service teams to meet one-on-one with the SCV project team to discuss what the health service wants to achieve, decide on a measurement approach that is context specific, explore anticipated barriers or challenges to testing and implementing the work and discuss how SCV can support the health service’s improvement capability for the future.

**Interactive Foru**ms offer an opportunity to practice the “all teach, all learn” dynamic by sharing achievements, how services have overcome challenges, and what was learned about influencing system change. This series will be held virtually.

The above Figure describes the offerings for the participating pilot sites, however other public facing resources and events will also be available to the whole sector either on the SCV website or via direct communication. These include:

* + [Clinical Conversations](https://www.safercare.vic.gov.au/support-training/clinical-conversations) (Webinar format covering generalised topics to promote ‘active’ participation through sharing of activities and knowledge)
  + Toolkits (information, resources, and evaluations on previously run collaboratives)
  + Other Evidence Based Practice Resources
  + Improvement science resources
  + MNLHN updates

Following each pilot phase, SCV will internally undertake an evaluation to refine the Improvement Program and to further engage health services in our improvement initiatives.

# How will you know that change is an improvement?

Data is key to understanding how many incidents happen at your service, and the consistency and reliability of care in key areas of clinical practice connected to target outcomes.

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

During quality improvement activities, teams collect and use data over time 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.

Frequency of data collection may include:

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

The measurement strategy for the Improvement Program has been adapted from the outcomes used to track progress in the previous Safer baby and Better births collaboratives. The collection of data outcomes is designed for you to assess your system’s current performance, collecting data across all measures to form a baseline before beginning to test changes. You could also opt to complete additional optional measures, or undertake a ‘deep dive’ of recent cases of stillbirth and/or perineal tears to explore whether there are gaps in the key areas of care.

**How will you collect and report the data?**

We will request monthly data reporting from each team for each of the measures in the measurement strategy. The project team will provide each health service with two spreadsheets at the start of the project; one for collecting identifiable data at the health service level and one for reporting aggregated, de-identified data to SCV. As not all measures are suitable for all contexts, the SCV project team will work closely with each team to ensure that data collection and measurement plan for each service are suitable.

# How will Safer Care Victoria support you?

#### Safer Care Victoria will provide:

* A dedicated project team with expertise in improvement methodology to support health service teams in implementing the program
* Access to clinical experts
* An SCV-endorsed comprehensive change package which will include evidenced-based resources to enable sites to tailor their theory of change to their site-specific clinical context
* Ongoing improvement teaching and coaching (including site visits where feasible and indicated)
* Networking opportunities with other participating services, supporting knowledge sharing and learning opportunities via MS Teams and SharePoint applications
* Support for teams to generate, analyse, understand, and present data
* Access to IHI Open School, and
* Opportunities for developing your improvement capability.

# What will participation involve?

#### Participating organisations are expected to have a team allocated to driving and delivering this project. These teams are expected to dedicate a few hours a week to the project with the workload shared across all members. The team should include:

* A **project lead** who will:
* lead and drive the project
* ensure changes are tested and implemented and oversee data collection
* An **executive sponsor** who will:
* Connect the goals of the project to a strategic priority in their organisation
* Support the project team to attend project activities
* Enable protected time for the project team to dedicate to the improvement work
* Provide project teams with access to relevant resources
* Remove barriers to progress
* **Obstetric representative(s)** who may be an obstetrician or a senior obstetric registrar. This person may also act as the project lead.
* A **senior or lead midwife(s)** who may also act as the project lead.
* A **consumer representative** such as women and/or family members/carers. SCV is committed to partnering with consumers and it is strongly encouraged that participating health services involve consumers on their team from the beginning to bring a patient experience lens that will help drive safe, practical, and consumer centric quality improvement.
* A **quality improvement representative**, such as from the quality improvement team at a health service who can provide quality improvement support intrinsic to the health service
* You may identify other members of your team to assist in driving and delivering this project, such as allied health, professional leaders, other healthcare professionals and leadership personnel.

Health service teams are expected to:

* Attend an onboarding meeting with the SCV project team
* Collect and report data in line with the measurement strategy. This will include:
  + Baseline data
  + Ongoing monthly data
* Attend quality improvement activities and participate in coaching opportunities
* Connect and partner with consumers to elevate the consumer voice

If you or your Health Service are interested in doing improvement work but are unable to participate as described above, please contact us and we can discuss flexible options for joining the project and specific components that you and your site can choose to be involved in.

**MNLHN Improvement Program team contacts**

#### MNLHN Clinical and Consumer Leads

The MNLHN have clinical and consumer co-leads who are committed to partnering with patients, clinicians and researchers to driving safety and quality to improve Victorian maternity care for women, babies, and families.

**Bronwyn Hogan**  
Consumer Lead – MNLHN

Bronwyn has a Bachelor degree in Public Health, project management experience, partnership  
 engagement as well as consumer advocacy experience at the Royal Women’s Hospital. She is a proud mother to Harriet, twins Samantha and Patrick who are in heaven and Louis. Living in Swan Hill, Bronwyn provides a rural perspective to improve the safety and quality of maternity healthcare.

**Dr Penny Sheehan**  
Clinical Lead – MNLHN

Penny is the current Director of Obstetrics and Gynaecology at Eastern Health and holds positions of Head of the Preterm Labour Clinic at Royal Women’s Hospital, senior lecturer at Monash University and Honorary Lecturer at the University of Melbourne.

#### Improvement Program team

The Improvement Program team are responsible for the overall management of the MNLHN projects.

|  |  |
| --- | --- |
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|  |  |

# Terms of Use and Data Restriction Disclaimer

The MNLHN Improvement Program involves the collection of data from participating ‘health service entities’ (Data Contributors) into a database held by SCV, on the MNLHN SharePoint site. The data is not intended to include personal or health information of individuals and is collected for quality improvement and safety purposes in concordance with Privacy and Data Protection Act 2014 (Vic), Health Records Act 2001 (Vic) and Health Services Act 1988 (Vic). Data Contributors will be able to view information contributed only from their health service and will only be able to edit their own data. Data from other Data Contributors will be shared only with the written agreement of all parties and be at a whole-project level of de-identified and aggregated information.

Your access to the MNLHN SharePoint site is voluntary. Your consent to access the SharePoint site is obtained through the provision of your credentials by your employer. This consent is required to access the aggregated data needed for quality improvement data analysis.

In accessing the MNLHN SharePoint site, you acknowledge and agree that:

* You will adhere to the Privacy and Data Protection Act 2014 (Vic), Health Records Act 2001 (Vic) and Health Services Act 1988 (Vic) in relation to your participation in the MNLHN Improvement Program;
* You have been nominated as a member of the MNLHN SharePoint site by your participating Health Service or by SCV;
* You will not share your personal login details to any unauthorised personnel;
* You will comply with any terms of use, acceptable use of technology, privacy and information security policies set out by your Health Service when collecting, recording, storing and sharing personal information for the purposes of the MNLHN Improvement Program;
* You will not publish (or make publicly available) any data you obtain through the MNLHN SharePoint site;
* You will use the data obtained through the MNLHN SharePoint site only for the MNLHN Improvement Program work you are participating in;
* You will perform your data collection and sharing in accordance with this agreement within such reasonable time as may be stipulated by the Project Lead and/or otherwise in a timely manner;
* You will implement and administer a recordkeeping system that creates and maintains full and accurate hard copy and/or electronic records for the data collection spreadsheet in accordance with this agreement;
* Data Contributors are also to be considered as owners of personal identifiable data and so are responsible for the data, even when it is outside their immediate control. This is to prevent unauthorised access, use or misuse, change, damage or destruction by any unauthorised personnel. You will take steps to ensure that when data is shared, it is de-identified and done so securely with only authorised personnel;
* You will notify SCV of any suspected data breach within 24 hours of being made aware of the breach and will work with SCV to contain the breach and investigate its origin;
* In order for the MNLHN SharePoint site to be managed appropriately, you will notify SCV when:
  + you or another employee no longer requires access,
  + if you cease to work for the health service,
  + if a new employee joins your quality improvement team;
* Your access to the MNLHN SharePoint site will be terminated if:
  + your health service or SCV advises your assistance is no longer required,
  + you use the MNLHN SharePoint site in a manner inconsistent with the terms of use, or,
  + you are in breach of any of the acknowledgments set out above;
* Upon completion, expiry or termination of this agreement, the Data Collectors will transfer all records created and maintained for this project in a format and manner which is appropriate for the secure archival of confidential information and allows records to be quickly and easily retrieved and reviewed if requested by SCV.

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# Appendix 1: Reducing stillbirths

# Why are we doing this?

Reducing the rate of stillbirth is an Australian Government priority. We know that in many cases stillbirth is preventable, and research shows that 20-30% of late gestation stillbirths could be avoided with better care1. Most recent data from 2020 shows that Victoria’s stillbirth rate is 6.4 per 1,000 births after 20 weeks, with 178 stillbirths after 28 weeks2.

From 2019 until 2021, SCV partnered with the Institute for Healthcare Improvement (IHI) to deliver the [Safer Baby Collaborative (SBC)](https://www.safercare.vic.gov.au/improvement/projects/mbc/safer-baby) which aimed at reducing preventable stillbirths in participating services through the introduction of an evidence-based bundle of care.

This bundle of care aligns with work undertaken in the United Kingdom as part of the Saving Babies Lives Care Bundle and with the Safer Baby Bundle work as developed by the Stillbirth Centre of Research Excellence.

By implementing this bundle at participating services, SBC resulted in a total of 20 babies being saved with a 21% reduction in the aggregate stillbirth rate, from an average rate of 0.24 percent to 0.19 percent. The initiative saw an increase in the days between stillbirths by 131 per cent, from an average of 3.5 days to 8.1 days, including periods of 47 days and 32 days without a stillbirth occurring at any of the reporting sites. Additionally, smoking cessation rates of women during pregnancy increased by 200%, from an average of 11 per cent to 33 per cent.

As evidenced by the results of the SBC, there is a large area of opportunity for reducing preventable stillbirth. However, sustainable change and continuous improvement remains challenging. As recommended by CCOPMM, there is a need for strengthening quality improvement capability across maternity services2. As such, to continue building on existing improvements in stillbirth prevention and accelerating the implementation of best practice, the MNLHN will be delivering the Maternity and Newborn Improvement Program.

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**Table 1. Improvement Program Measures: Adapted from Safer Babies Collaborative**

|  |  |
| --- | --- |
| Required measures | |
| Outcome Measures | Percentage of stillbirths at 28 weeks or more gestation excluding congenital anomalies |
| Process Measures | **Bundle element 1: Supporting women to stop cigarette smoking in pregnancy**   * Percentage of women who continue to smoke during pregnancy * Percentage of women identified as smoking, who received ‘Ask, Advise, Help’ intervention   **Bundle element 2: Improving detection and management of fetal growth restriction**   * Percentage of women who have a symphyseal fundal height measurement taken and plotted on growth chart at each antenatal visit from 24 weeks gestation * Percentage of women who were screened for fetal growth restriction at first antenatal visit   **Bundle element 3: Raising awareness and improving care for women with decreased fetal movements**   * Percentage of women provided with decreased fetal movement (DFM) information and education from 24 to 28 weeks gestation * Percentage of women at 28 weeks’ gestation or more who have a cardiotocography (CTG) commenced within two hours of arrival at health service following a report of DFM   **Bundle element 4: Improving awareness of maternal safe sleeping position**   * Percentage of women who are provided with maternal sleep position education & brochure from 28 to 34 weeks gestation   **Bundle element 5: Improving decision-making around timing of birth for women with risk factors at term**   * Percentage of women who report being involved as much as they wanted to with decision-making around timing of birth |
| Balance Measures | * Percentage of women who birth, via induction or caesarean section before 39.0 weeks gestation * Percentage of babies with a birthweight >25th centile actively delivered for suspected FGR between 37.0-39.0 weeks gestation |

|  |  |
| --- | --- |
| Optional measures | |
| Outcome Measures | Percentage of compliance with all five elements of clinical care bundle |
| Process Measures | **Bundle element 2: Improving detection and management of fetal growth restriction**   * Percentage of women who were screened for fetal growth restriction at every antenatal appointment from 24 weeks gestation * Percentage of women (at any gestation) identified as at risk of FGR (level 2 or 3) whose care is escalated as per the FGR care pathway   **Bundle element 3: Raising awareness and improving care for women with decreased fetal movements**   * Percentage of women at 24 weeks’ gestation or more who present within 12 hours of reporting DFM   **Bundle element 5: Improving decision-making around timing of birth for women with risk factors at term**   * Percentage of women who report receiving information regarding stillbirth risk factors after 34 weeks gestation during timing of birth discussion |

# Driver diagram

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **AIM**  **What we want to achieve** |  | **PRIMARY DRIVERS**  **Parts of the system we will influence** |  | **SECONDARY DRIVERS**  **Where and when we will influence the system** |  | **CHANGE IDEAS**  **How we will influence the system** |
|  |  |  |  |  |  |  |
| By x we intend to reduce the stillbirth\* rate by x in participating health services.    *\*Stillbirth is defined as birth without signs of life at 28 weeks or more, excluding terminations and lethal congenital or chromosomal anomalies.* |  | Partnering with women |  | At booking |  | * Discuss expected length of pregnancy with all women * Include the consumer-designed poster and sticker, outlining 5 bundle elements, in all booking packs * Include information about stillbirth risk factors (smoking, fetal growth restriction (FGR), decreased fetal movements (DFM), maternal sleep position) |
|  |  |  |  |  |
|  |  | At pregnancy care appointments |  | * Discuss stillbirth risk factors (smoking, FGR, DFM, maternal sleep position) at every visit * Share links to the Stillbirth CRE Safer Baby Bundle consumer site   ***Bundle element 3: Management of decreased fetal movements***   * Share the ‘Movements matter’ resources with every woman   ***Bundle element 4: Promoting optimal maternal sleep position***   * Share the ‘Sleep on side’ video and resources with every woman * Ask every woman about sleep position, during pregnancy care appointments in the third trimester |
|  |  |  |  |  |
|  |  | When planning for timing of birth |  | ***Bundle element 5: Decision-making around timing of birth***   * Use shared decision-making tools to guide and document discussions * Share the ‘Every week counts’ resource with all women * Screen for stillbirth risk at term |
|  |  |  |
|  |  |  |
|  |  |  |  |  |  |
|  | Application of the bundle elements |  | Routine professional development |  | * Incorporate education and training on the five clinical interventions, shared-decision making and providing informed consent * Create training videos for the five clinical interventions * Introduce daily SBC huddles in antenatal clinic, to gather feedback and share information * Incorporate teach-back skills * Identify opportunities for in-the-moment teaching, reflection and clinical reasoning development |
|  |  |  |  |  |
|  |  | Every episode of care |  | ***Bundle element 1: Promoting smoking cessation***   * Screen for smoking behaviours using the Ask, Advise, Help brief advice intervention * Refer to Quit services * Include partners and other family members in screening and referral * Share information with GPs |
|  |  |  |  |
|  |  |  | ***Bundle element 2: Detection and management of fetal growth restriction (FGR)***   * Screen all women for their risk of FGR * Use a consistent technique for measuring symphyseal fundal height (SFH) * Plot SFH and estimated fetal weight (EFW) on growth charts |
|  |  |  |  |  |
|  |  | When reported |  | ***Bundle element 3: Management of decreased fetal movements***   * Assess all women who report DFM as soon as possible |
|  |  |  |
|  |  |  |
|  |  |  |

# Appendix 2: Reducing third- and fourth- degree perineal tears

# Why are we doing this?

Perineal tears are lacerations of the skin and tissue that separate the vagina from the anus3. Complications such as third- and fourth-degree perineal tears during vaginal birth are classified as severe trauma to the perineum and are associated with maternal morbidity such as perineal pain, incontinence, or painful sexual intercourse3. Furthermore, severe perineal trauma can lead to lifelong impact on a woman’s wellbeing, including both physical and psychological morbidities4.

In Victoria in 2017-18, the state-wide rate of third- and fourth-degree perineal tears in unassisted births was 3.2%, while the rate of third- and fourth- degree tears in assisted births was 4.7%. On both counts, the rate was higher in public hospitals than in private hospitals and there was significant variation between hospitals in rates of severe perineal tears, ranging from zero to 20% for unassisted vaginal births and zero to 11% for assisted vaginal births5.

From 2019 until 2021, SCV and IHI partnered to deliver the Victorian [Better births for women (BBW)](https://www.safercare.vic.gov.au/improvement/projects/mbc/better-births) Collaborative which aimed to reduce the rate of third- or fourth- degree perineal tears through the introduction of an evidence-based clinical care bundle.

The Victorian BBW Collaborative built on the success of the National Collaborative led by Women’s Healthcare Australasia (2017 to 2019) to reduce harm to women from perineal tears. This National Collaborative led to a 13.43% reduction in the rate of third- and fourth-degree perineal tears so the same clinical care bundle was adapted for Victorian Health Services to build on this success.

By implementing this bundle at participating services, BBW achieved a reduction of 45% in the aggregate severe perineal tear rate, preventing severe perineal harm in 155 women. As evidenced by the BBWC, the opportunity for improving the perineal tear rate in Victoria is significant. However, sustainable change and continuous improvement remains challenging. As recommended by CCOPMM, there is a need for strengthening quality improvement capability across maternity services2. As such, to continue building on existing improvements in the perineal tear rate reduction and accelerating the implementation of best practice, the MNLHN will be delivering the Maternity and Newborn Improvement Program

**Table 2. Improvement Program Measures: Adapted from Better births for women**

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

# Driver diagram

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

# References

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2. Stillbirth Centre of Research Excellence. The Safer Baby Bundle. <https://stillbirthcre.org.au/about-us/our-work/the-safer-baby-bundle/>
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4. Priddis H, Dahlen HG & Schmied V (2013). Women’s experiences following severe perineal trauma: a meta-ethnographic synthesis. Journal of Advanced Nursing 64:748–59.
5. Hunt RW, Davey M-A, Ryan-Atwood TE, Hudson R, Wallace E, Anil S on behalf of the Maternal and Newborn Clinical Network INSIGHT Committee 2018, Victorian perinatal services performance indicators 2017-18, Safer Care Victoria, Victorian Government, Melbourne

1. This initiative targets stillbirth at 28 weeks or more, a period of gestation in which more cases are deemed avoidable and excludes terminations and babies with lethal congenital or chromosomal anomalies. [↑](#footnote-ref-2)