

The Impact of Covid-19 Pandemic and Introduction of RCOG OASI Care Bundle on OASI Rate and Management

A quality improvement project at Cwm Taf Morgannwg University Health Board

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OBJECTIVES

1. Evaluate the Obstetric anal sphincter injury (OASI) rate
1. Impact of implementation of the RCOG Obstetric Anal Sphincter Injury (OASI) Care Bundle standards within the Health-Board
1. Management of OASI during Covid-19 pandemic
1. To recognise the trends in practice across the Health-Board

METHODS AND MATERIALS

- Retrospective audit covering all OASI injuries from
- **1st January, 2020- 31st December, 2020**
- Total of **98 case notes** were reviewed-
 - North- PCH + RGH - 46
 - South- POW – 52
- Relevant patient and birth factors and the elements of the **RCOG OASI Care Bundle** were analysed

AUDITABLE STANDARDS

Incidence of OASI is compared with reported incidence of less than 3.5% in the UK- National rates of 6% for Primigravida and 2% for Multigravida (RCOG/RCM 2020)

All women should be given a copy of **OASI Care Bundle information leaflet** and be informed antenatally (32-36 weeks) about OASI and what steps can be taken to minimise the risk

Prevention of OASI with

1. Manual perineal protection (MPP) at crowning
2. Episiotomy when necessary with documentation of the indications, the angle at which the episiotomy was performed, and the woman's consent for the same
3. Warm compression applied during the 2nd stage

OASI RATE (Total)	3%
Spontaneous vaginal	2.8%
Assisted Vaginal	5.2%

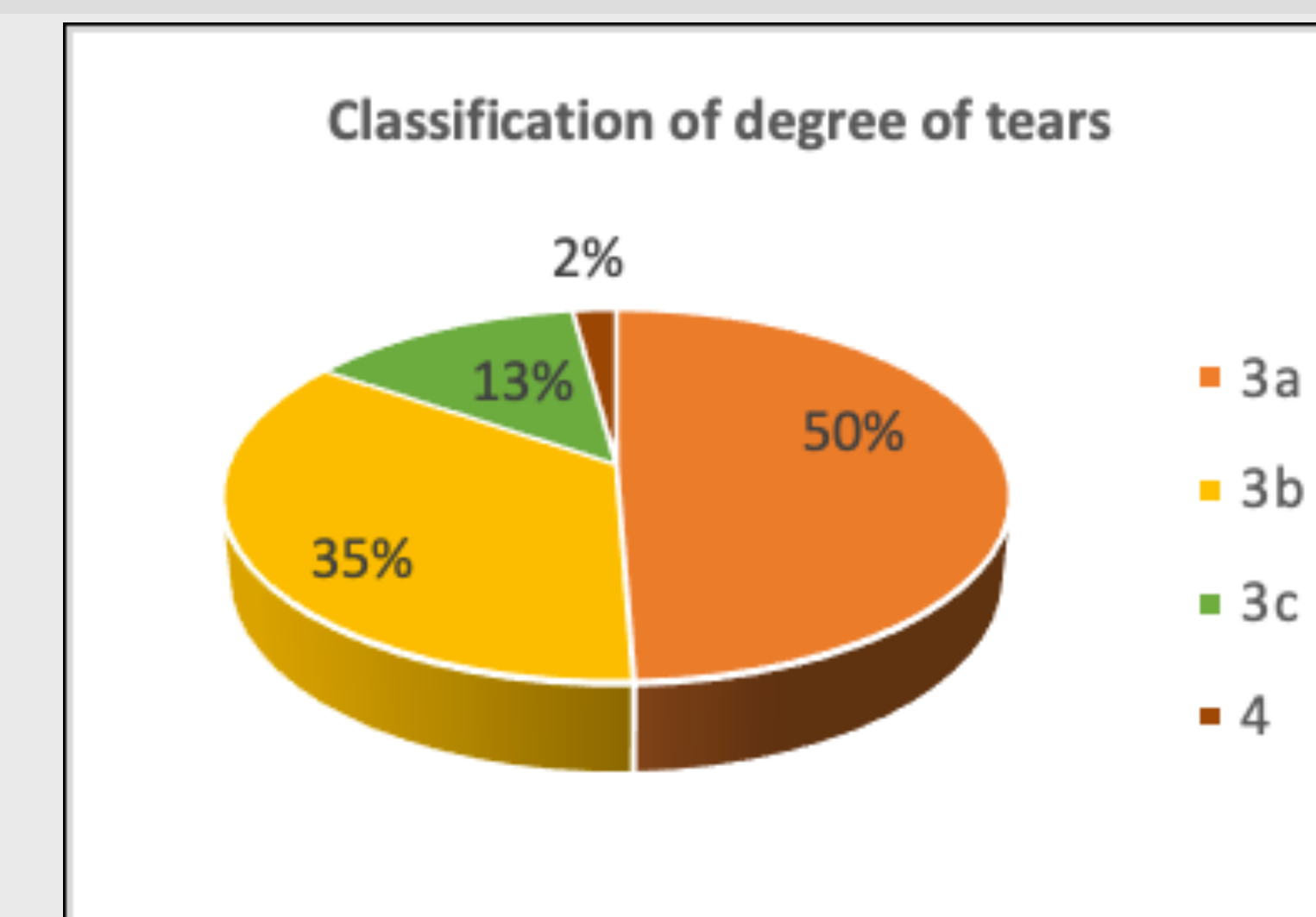
All repairs should be carried out by **trained clinicians** . All relevant healthcare professionals should attend hands-on training in perineal/genital assessment and repair and ensure that they maintain these skills.

Pain control: Regular oral analgesia, avoid opiates e.g. codeine or oral morphine
Oral course of **Broad-spectrum antibiotics**
Laxatives - Lactulose 10mls BD for 10 days (Avoid Fybogel)

Follow-up post OASI

All women with OASI must be referred for **Physiotherapy** at 6 weeks and and a follow-up in **OASI clinic** at 12 weeks postpartum

100% of women with OASI are **Datix** reported and investigated



RECOMMENDATIONS

- **Adapting our current standardised OASI care pathway to improve documentation and communication**
- **Reduce the inconsistency in some practices between health care professionals and across hospital sites**
- **To support mandatory formal training and update of all clinicians who perform repairs with a database**
- **Report all of these incidents and investigate them formally and ensure that these patients receive appropriate post- op care and follow up**

RESULTS

- 69.3% were Primigravida
- 3% of the total OASI had a previous OASI.
- Episiotomy was performed in 19.3% women.
- 3% of the OASI was complicated by shoulder dystocia and 4.1% by malposition.
- 12.2% of babies were over 4000g.
- 29.4% had an epidural in labour.
- Post-repair, all received antibiotics and analgesia. 57.1% had 'Fybogel' prescribed incorrectly.
- 79.5% and 63.2% were followed up in Physiotherapy and Perineal-Trauma clinic, respectively.

CONCLUSION

- Incidence of OASI compared with reported incidence of less than 3.5% in the UK. (NMPA)- 3%
- 100% evidence of adequate documentation of systematic examination of the vagina, perineum and rectum prior to suturing of an OASI- 96.8%
- 100% of OASI repaired with documented evidence of type of analgesia, suture material, method of repair and grade of the operator (proforma)- 82.3%
- 100% of repairs should be carried out by trained clinicians- Unable to establish training status and 100% of women with OASI are referred to a follow-up appointment - 79.7%
- 100% of women with OASI are Datix reported- 66.6%