STANDARDIZED PROCEDURE
EPISIOTOMY AND LACERATION REPAIR (Adult, Peds)

I. Introduction:

This protocol covers the task of episiotomy and laceration repair by a Certified Nurse Midwife (CNM). The purpose of this standardized procedure is to allow the CNM to safely perform an episiotomy and laceration repair when needed. An episiotomy and laceration repair may be needed in order to facilitate delivery of the fetus.

II. Background Information

A. Setting: The setting (inpatient vs outpatient) and population (adults vs pediatrics) for the Advanced Health Practitioner (AHP) is determined by the approval of the privileges requested on the AHP Privilege Request Form. If the procedure is being done on a Pediatric patient, make sure Child Life is involved and use age appropriate language and age appropriate developmental needs with care of children, as appropriate to the situation.

B. Supervision:

The necessity of the procedure will be determined by the Certified Nurse Midwife (CNM). The attending physician is the supervising physician for this procedure. Direct supervision will not be necessary once competency is determined, as provided for in the procedure. At that time, general or indirect supervision is acceptable.

The CNM will notify the physician immediately upon being involved in any emergency or resuscitative events or under the following circumstances:

1. Patient decompensation or intolerance to the procedure
2. Bleeding that is not resolved
3. Outcome of the procedure other than expected
4. Cervical lacerations
5. Third or fourth degree lacerations
6. Breakdown of repair or infection of site

C. Definitions:

1. Episiotomy – a surgical incision of the perineal body performed in order to facilitate delivery of the fetus
2. Laceration-A spontaneous tear to the vulva (perineum, vagina, labia) that occurs during the birth process
    a. First degree laceration – involving vaginal epithelium or skin
    b. Second degree laceration – extending into the muscles of the perineal body
    c. Third degree laceration- involving the rectal sphincter
    d. Fourth degree laceration – involving the rectal mucosa

    Note: CNM does not repair 3rd or 4th degree lacerations – these are referred to the attending obstetrician.

D. Indications:

1. Episiotomy (and subsequent repair) is performed when
   a. Shortening the time to delivery is assessed to be indicated (generally due to fetal intolerance of labor)
   b. Potentially extensive spontaneous lacerations are assessed to be imminent
2. Repair of episiotomy is indicated after performance of episiotomy
3. Lacerations are repaired
   a. First degree – if there is bleeding, or indicated by comfort or cosmetics
   b. Second degree – always
   c. Third and fourth degree lacerations are not repaired by CNM. These are referred to the attending obstetrician.

E. Precautions/contraindications:

None

III. Materials

The following materials may be used during episiotomy and laceration repair:

1. 1% Lidocaine as local anesthetic if indicated
2. Scapel
3. Suture material, most commonly 3-0, 4-0, and 2-0 vicryl or chromic
4. Needle holder

IV. Procedure

A. Pre-treatment evaluation:

1. Assess extent of lacerations and their suitability for CNM repair
2. Assess patient need for analgesia/anesthesia

B. Set up:

Gather all necessary materials.

C. Patient preparation

1. Explain procedure to patient.

D. Performing the procedure:

1. Wash hands and don personal protective equipment
2. Procedure is conducted using sterile technique
3. Perform episiotomy if needed
4. Repair is conducted using appropriate suture and in fasion appropriate to the location and depth of the laceration

E. Follow-up treatment

1. Assessment of vulva/perineum is made daily while patient is in the hospital and at 6 weeks postpartum by the CNM or his/her designee.
2. Written and verbal instructions regarding wound care is reviewed with the patient before discharge from the hospital.

V. Documentation

A. Documentation is in the electronic medical record

1. Documentation of the pretreatment evaluation and any abnormal physical findings.
2. Record the time out, indication for the procedure, procedure, EBL, the outcome, how the patient tolerated the procedure, medications (drug, dose, route, & time) given, complications, and the plan in the note, as well as any teaching, discharge, and follow-up instructions.
3. Follow-up documentation of post partum evaluation appears in the daily progress notes by CNM or his/her designee.

B. All abnormal or unexpected findings are reviewed with the supervising physician.

VI. Competency Assessment

A. Initial Competence

1. The CNM will be instructed on the efficacy and the indications of this therapy and demonstrate understanding of such.
2. The CNM will demonstrate knowledge of the following:
   a. Medical indication and contraindications of episiotomy and laceration repair
   b. Risks and benefits of the procedure
   c. Related anatomy and physiology
   d. Consent process (if applicable)
   e. Steps in performing the procedure
   f. Documentation of the procedure
   g. Ability to interpret results and implications in management.
3. The CNM will observe the supervising physician perform each procedure a minimum of **three** times in its entirety.

4. The CNM will perform an episiotomy or a laceration repair a minimum of **three** times under direct supervision of the supervising physician.
5. Supervising physician will document CNM's competency prior to performing procedure without supervision.
6. The CNM will ensure the completion of competency sign off documents and provide a copy for filing in their personnel file and a copy to the medical staff office for their credentialing file.

B. Continued proficiency

1. The CNM will demonstrate competence by successful completion of the initial competency.
2. Each CNM will be initially proctored and signed off by an attending physician. Demonstration of continued competence shall be monitored through the annual evaluation and documentation of successfully performing **three** procedures within the past year and review of the procedures and any complications associated with them. In cases where this minimum is not met, the attending, must again sign off the procedure for the CNM. The CNM will be signed off after demonstrating 100% accuracy in completing the procedure.
3. Demonstration of continued proficiency shall be monitored through the annual evaluation.
4. A clinical practice outcomes log is to be submitted with each renewal of credentials. It will include the number of procedures performed per year and any adverse outcomes. If an adverse outcome occurred, a copy of the procedure note will be submitted.

VII. RESPONSIBILITY

Questions about this procedure should be directed to the Chief Nursing and Patient Care Services Officer at 353-4380.

VIII. HISTORY OF PROCEDURE

Revised March 2012 by Subcommittee of the Committee for Interdisciplinary Practice
Reviewed March 2012 by the Committee on Interdisciplinary Practice
Prior revision Sept 2010
Approved March 2012 by the Executive Medical Board and the Governance Advisory Council.

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