WOMEN'S HEALTH AND PAEDIATRICS
MATERNITY UNIT

Perineal Trauma Management and Repair

Amendments			
Date	Page(s)	Comments	Approved by
Decr2005	P4, point 10	Bullet point added	Guidelines committee
Dec2008		Whole guideline review	Women's Health Guidelines Group
July 2010		Audit tool adjusted	Women's Health Guidelines Group
December 2011		Appendix added relating to swab counting following Never Event	Women's Health Clinical risk group
August 2012		Changes to antibiotics used for 3rd degree tears in line with ASPH guidance	Women's Health Guidelines Group
Feb 2013	2,3,4	Clarification of documentation Requirements	Women's Health Guidelines Group
Nov 2014	3	Clarification around Procedure	Women's Health Guidelines Group
Feb 2018	2	Reference to LOCCSIP Repair of vaginal or perineal trauma in the birth environment added	Head of Midwifery

Compiled by: Dr Sandra Newbold Consultant Obstetrician & Dianne Casey Clinical Specialist Labour Ward

In Consultation with: Wolf Gelman, James Thomas, Women's Health Guidelines Group, and Obstetric Consultants

Ratified by: Women's Health Guidelines Group

Date Ratified: August 2012

Date Issued: August 2012

Next Review Date: Feb 2021

Target Audience: Professionals who will be repairing perineal trauma

Impact Assessment Carried Out By: Women's Health Guidelines Group

Comments on this document to: Women's Health Guidelines Group

Perineal Trauma Management and Repair

See also:

- Training Needs Analysis (TNA)
- ASPH Trust Antibiotic Guideline
- Safety counting in maternity services
- LOCCSIP Repair of vaginal or perineal trauma in the birth environment.

Introduction and Purpose

This guideline sets out the expected management and follow up of post- delivery perineal trauma of all types by relevant staff working within maternity services.

Following delivery, all women should have a systematic assessment of the perineum, labia and lower vagina for an accurate evaluation of any trauma sustained. This should be documented in the maternal record.

All Midwives/Medical staff undertaking perineal suturing must have undertaken the appropriate level of training. The person planning to perform the repair (midwife or medical) must be satisfied that suturing of the wound is within her/his capabilities. Privacy should be maintained with the mother made as comfortable as possible throughout the procedure. Trauma should be repaired promptly following delivery. Asepsis should be maintained throughout the repair time. Repairs should be performed with Vicryl ^{TM}.

Classification of Perineal Tears

First degree: laceration of the vaginal epithelium or perineal skin only.
Second degree: involvement of the vaginal epithelium, perineal skin, perineal muscles and fascia but not the anal sphincter.
Third degree: disruption of the vaginal epithelium, perineal skin, perineal body and anal sphincter muscles. This should be further sub divided into:
3a: partial tear of the external sphincter involving less than 50% thickness
3b: more than 50% of the external sphincter is torn
3c: internal sphincter is torn as well.
Fourth degree: a third degree tear with disruption of the anal epithelium.
Rectal mucosal tear (buttonhole) without involvement of the anal sphincter is rare and not included in the above classification.

Repair of first degree tears, second degree tears and episiotomies:
NICE (2007) recommends that first degree tears should be sutured unless the skin edges are well opposed. However, it may be appropriate not to suture first a degree tear when it is not bleeding. This Unit recommends that all second degree tears are sutured (NICE 2007).

Prior to procedure:

- Repair should be conducted in accordance with LOCCSIP Repair of vaginal or perineal trauma in the birth environment.
- Reassure and inform woman of the need for the repair.
- Gain consent
  2nd degree tears - document verbal consent on page 67 of pregnancy and birth notes
  3/4th degree tears - complete written consent form and file in notes
- Ensure adequate analgesia, i.e. Epidural top-up or perineal infiltration. (Lidocaine 1% 10-20mls). Entonox may also be used while infiltration is taking place. If possible the baby should be visible to mother during the procedure.

Procedure: (as per NICE guidelines 2007)

- Count swabs, needles and instruments before starting procedure (signed by 2 persons on page 67 of Pregnancy and Birth notes).
- Clean perineal area with sterile water.
- Inspect perineum, labia, vagina, cervix and anal sphincter. This is to assess extent and position of trauma NICE (2007) recommends the inclusion of a rectal examination within this assessment
- Identify apex of wound and commence suturing from above apex, using a continuous non locking stitch for vaginal mucosa.
- Anatomical restoration of tissues and haemostasis must be ensured. Perineal muscles should be aligned using a continuous non-locking suture where practical. (NICE 2007)
- Skin edges are approximated, if well opposed skin sutures are not necessarily required. If skin is sutured continuous subcuticular repair is preferred, if practical.
- Always perform and document vaginal and rectal examination after completing the repair, this permits confirmation that the apex of the wound has been closed, that there is no perforation of the rectum with sutures and that no swab or pack has been left in situ. Please double glove to perform a PR, the practice of cutting a finger off a glove to do a PR is a risk to the patient as this could be left in situ and be unaccounted for
- Clean vulval area, apply sterile pad and make mother comfortable.
- Check swabs, instruments and needles and dispose of these appropriately. This must be documented and signed by 2 persons on page 68 of Pregnancy and Birth notes.
- Consider rectal Diclofenac and Paracetamol for analgesia, unless the woman has a medical contraindication to its use.
- Document extent of trauma, method of repair and materials in notes. This should include completion of diagram. Reassure the mother that the suture material will dissolve and inform her that postnatal perineal inspections will be carried out regularly by the midwife to assess healing. Advise mother on perineal hygiene. There is no evidence to support the use of salt or 'Savlon' over normal bath water.

Third and fourth degree perineal tears:

Anal sphincter disruption during vaginal delivery is recognised as a major aetiological factor in the development of faecal incontinence. However despite conventional primary sphincter repair of acute obstetric injury, anal incontinence is reported by 20% to 59% of women (Sultan 1997,Goffeng et al 1998).

Until the advent of anal ultrasound, the development of anal incontinence was attributed largely to pelvic neuropathy. However prospective studies before and after childbirth have shown that up to one third of women sustain anal sphincter damage that is not recognised at delivery (Donnelly et all1998, Sultan et al 1993). Although only one third of these women with defects are symptomatic in the short term, it remains to be established whether these women are at higher risk of incontinence in later life.

Operative instrumental delivery is associated with a greatest risk of 3rd and 4th degree tears. The overall risk of these tears in this unit is 2.7% of all vaginal deliveries, birthweight over 4kg, induction of labour and epidural anaesthesia are associated with an increased risk of 2%; persistent occipito posterior position and episiotomy increase the risk to 3%; nulliparity, shoulder dystocia and prolonged 2nd stage (over 1 hour) increase the risk to 4% whilst forceps delivery increases the risk further, up to 7% (Samuelsson et al 2000). Up to 50% of women with 3rd/4th degree tears have had an instrumental delivery (Sultan et al 1994). Vacuum extraction is associated with fewer 3rd/4th degree tears than forceps as shown by 2 large randomised studies (Johanson et al 1993, Sultan et al 1998).

Management of third and fourth degree tears:

All medical staff who undertake repair of 3rd & 4th degree tears must have received appropriate training this would not normally be completed by a doctor less than ST3 level midwives do not repair 3rd or 4th degree tears.

If you are in doubt ask the shift leader or the registrar to check the tear. All skin tears that extend to the anal margin are 3rd degree tears until proven otherwise by the registrar

- Count swabs, needles and instruments before starting procedure (signed by 2 persons) Document on page 69 of Pregnancy and Birth notes.
- The woman's perineum, vagina and rectum should be carefully examined in order to assess the extent of the injury.
- The Labour Ward/on-call Consultant should be informed if the registrar is not competent with repairing 3rd or 4th degree tears and is expected to attend to supervise the repair.
- Only staff specifically trained in the technique can perform the repair unsupervised. If Mr Gelman is in the hospital he would attempt to perform the repair and train staff.
- All repairs must be conducted in the operating theatre where there is access to good lighting, appropriate equipment and aseptic conditions.
- All repairs must be performed under general or regional anaesthesia, this is to aid adequate exposure of the sphincter muscles which may have retracted following the trauma. If the woman refuses a general or regional anaesthetic this must be documented in notes after appropriate explanation is given. Muscle relaxation is necessary to retrieve the ends and overlap without tension.
- The third degree repair pack should be used.
- The torn anal epithelium must be repaired with interrupted polyglactin (Vicryl™) 2/0 with the knots tied in the anal lumen.
- **Internal anal sphincter** tears must, if identifiable, be repaired separately by end to end approximation with interrupted Polydioxanone (PDS™) 3/0 sutures. These sutures are monofilamentous and therefore less likely to precipitate infection, long lasting and absorbable.
- The torn ends of the **external anal sphincter** must be identified and grasped with Allis tissue forceps. The muscle is then mobilised and pulled across in an overlap fashion or repaired "end to end" with 3/0 PDS™ sutures (RCOG guideline 2007).
- If the **external anal sphincter** is not torn completely (i.e 3a or 3b tears), do **NOT** cut healthy **external anal sphincter** fibres. In **these** cases, it is acceptable to repair the **external anal sphincter** using the end to end technique.
- Consider using No. 1 Vicryl for reconstructing the perineal muscles to provide support to the sphincter repair. Remember that the anal sphincter would be more likely to be traumatised during a subsequent vaginal delivery in the presence of a short deficient perineum.
- Skin should be closed with Vicryl Rapide™ 2/0 using a subcuticular stitch.
- A foley catheter should be placed in the bladder either at the start or at the end of the procedure, and should be left in situ for 24 hours (NICE 2007).
- At the end of the procedure both vaginal and rectal examination must be performed and rectal Diclofenac 100mg and paracetamol 1g inserted if not contraindicated.
- Count swabs, needles and instruments following the procedure (signed by 2 persons). Document on page 69 of Pregnancy and Birth notes.

After repair:

- Intravenous antibiotics should be commenced intra-operatively. Then oral antibiotics should be continued for 7 days. Please see ASPH Trust Antibiotic Guidelines
- On-going oral analgesia must be prescribed.
- Document repair on page 69 in Pregnancy and Birth notes. This should include a diagram.
- All women should be prescribed stool softeners (Lactulose™ 10mls twice daily.) and a bulking agent (Fybogel™ 1 sachet twice daily.) for 2 weeks as straining to pass a bolus of hard stool may disrupt the repair. This must be explained to the woman.
- Physiotherapists should be informed about the woman's 3rd/4th degree tear by the midwife so that the woman can start a course of intensive pelvic floor exercises. Physiotherapists will review the patients on the ward (and give an information leaflet) and within 6 weeks of delivery to start and intensive course of pelvic floor exercises. They will be followed up later in pelvic floor or Urogynaecology clinics.
- Hospital follow up in the pelvic floor clinic should be arranged before discharge by the midwifery/clerical staff of the Joan Booker ward, by contacting 6215/4544. The woman should be seen at about 3-6 months after delivery.

- All women who sustain at 3rd or 4th degree tear will be offered an appointment to meet with the Birth Reflections service.

Management of delivery after previous 3rd/4th degree tear:

It has been agreed by all consultants that any women with a history of 3rd/4th degree tear should be placed under the care of the Urogynae Consultants for follow up and management in subsequent pregnancies.

In general, continent women should be allowed to have a normal vaginal delivery
by an experienced midwife/doctor provided the woman is symptomatic, has a normal size baby and anorectal physiology tests and anal endosonography are normal. Women with mild anal incontinence need to be assessed and considered for Caesarean section. Women with significant faecal incontinence can have a normal delivery and secondary sphincter repair.
There is no evidence that prophylactic episiotomy prevents a recurrence of sphincter damage and therefore an episiotomy should only be performed if there are predisposing factors such as fibrotic scarring, inelastic perineum or shoulder dystocia.

Risk management:

- Complete Datix web
- There is a steady increase in litigation related to 3rd/4th degree tears. The majority are related to **failure to identify** the injury after delivery leading to subsequent anal incontinence. The rupture of anal sphincter *per se* is not, at present, considered substandard care, whereas failure to recognise it may be indefensible.
- Careful and detailed documentation is essential. A diagram demonstrating the extent of the injury and technique of repair will serve to substantiate that a careful examination was performed.
- The operating surgeon must perform a careful vaginal and rectal examination at the beginning and end of the procedure to check and document that there were no swabs/needles left behind in the vagina or rectum.
- The woman must be given an explanation of what had happened. She should be told that there is a small risk of impaired continence and that she will be offered an appointment with physiotherapist, Birth Reflections Services and in the Urogynaecology clinic.
- All women who return to maternity unit with perineal problems relating to a birth episode must have a clinical incident form generated. These events will be monitored by the Women's Health Risk Group.
- All swabs must be counted as per flowchart at appendix 2

Monitoring

Compliance with this guideline will be monitored by review of maternity records as detailed in the table below. Where deficiencies are identified action plans will be developed and changes implemented and disseminated as required.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangement	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
Management of all types of perineal trauma, which as a minimum must include: a. **who can perform the repair** b. systematic assessment of the perineum and lower vagina for an accurate evaluation of any trauma sustained c. when non-suturing may be applicable d. methods and materials used in perineal repair e. **documentation of consent for all types of perineal repair** f. **management of third and fourth-degree tears** g. process for offering a postnatal appointment with an appropriate clinician to all women who have had a third or fourth-degree tear h. **standards for record-keeping in relation to all types of perineal trauma** i. **documentation of information given regarding support following the repair** j. process for monitoring the rate and cause of returns of women with problems relating to all types of perineal repair	**Standard lead** Sandra Newbold- Consultant Obstetrician	1% of health records of all women delivered **plus** all women who have had a 3rd or 4th degree tear using audit tool Attached appendix 2	Annually	Reported to Labour Ward forum or Clinical Governance Group	**Criterion lead** Wolf Gelman- Consultant Obstetrician James Thomas Consultant Obsterician Urogynae team Labour ward manager Maternity Matron	• Communication bulletin • MDT Quality & safety half days • staff meetings • any other meeting as appropriate • Individual feedback as appropriate One or any number of the above

Appendices:
1. NPSA retained swab flowchart
2. Audit tool

References:
Donnelly V, Fynes M, Campbell D, Johnson H, O'Connell PR, O'Herlihy C. (1998) Obstetric events leading to anal sphincter damage. Obstet Gynecol **92** 955-61.

Goffeng AR, Andersch B, Andersson M, Berudtsson I, Hulten L, Oresland T. (1998) Objective methods cannot predict anal incontinence after primary repair of extensive anal tears. Acta Obstet Gynecol Scand **77 (4)** 439-43.

Johanson RB, Rice C, Doyle M, Arthur J et al. (1993) A randomised prospective study comparing the new vacuum extractor policy with forceps delivery. British Journal of Obstetrics and Gynaecology **100(6)** 524-30.

Kettle C, Hills R, Jones P, Darby L, Gray R, Johnson R. 2002 Continuopus versus interrupted repair with standard or rapidly absorbed sutures after spontaneous vaginal birth:arandomised controlled trial *The Lancet* **359** :2217 www.the lancet.com

NICE Intrapartum care 2007. The care of healthy women and their babies during childbirth. RCOG press.

Royal College of Obstetricians and Gynaecologists (2007) Management of third- and fourth-degree perineal tears following vaginal delivery. RCOG Press. Green top Guideline No. 29.

Samuelsson E, Ladfors L, Wennerholm UB, Gareberg B, Nyberg K, Hagberg H. (2000) Anal sphincter tears: prospective study of obstetric risk factors. British Journal of Obstetrics and Gynaecology **107** 926-31.

Sleep J, Grant A, Ashurst H, Spencer D. (1989) A randomised comparison of suture materials and suturing techniques for repair of perineal trauma. British Journal of Obstetrics and Gynaecology **96** 1272-1280.

Sultan AH, Kamm MA, Hudson CN, Thomas JM, Bartram CI. (1993) Anal-sphincter disruption during vaginal delivery. N Engl J Med **329** 1905-11.

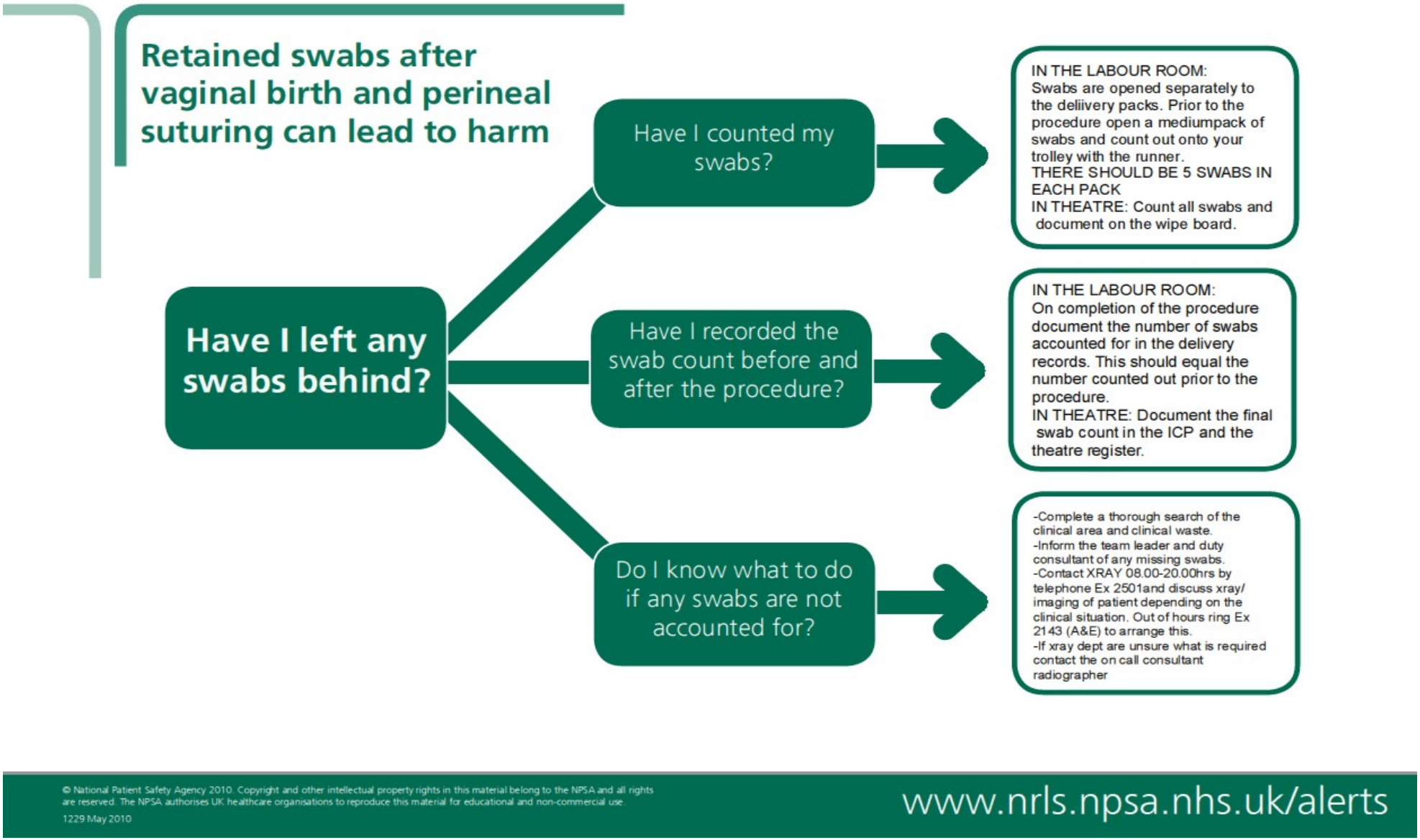
Sultan AH, Kamm MA, Hudson CN, Thomas JM, Bartram CI. (1994) Third degree obstetric and sphincter tears: risk factors and outcome of primary repair. BMJ **308** 887-91.

Sultan AH, Monge AK. (1997) Anal and urinary incontinence in women with obstetric anal sphincter rupture. British Journal of Obstetrics and Gynaecology **104 (6)** 754-5.

Sultan AH, Johanson RB, Carter JE. (1998) Occult anal sphincter trauma following randomised forceps and vacuum delivery. Int Journal Gynaecol Obstet **61(2)** 113-9.

Sultan AH, Thakar R (2002) Lower genital tract and anal sphincter trauma. Best Pract Res Clin Obstet Gynaecol **16**: 99-115

Williams A, Adams EJ, Tincell DG, Alfirevic Z, Walkinshaw SA & Richmond DH (2006) How to repair an anal sphincter injury after vaginal delivery: results of a RCT. BJOG; **113**:201-7


Retained swabs after vaginal birth and perineal suturing can lead to harm
Have I left any swabs behind?
Have I counted my swabs?
IN THE LABOUR ROOM:
Swabs are opened separately to the deliivery packs. Prior to the procedure open a mediumpack of swabs and count out onto your trolley with the runner.
THERE SHOULD BE 5 SWABS IN EACH PACK
IN THEATRE: Count all swabs and document on the wipe board.
Have I recorded the swab count before and after the procedure?
IN THE LABOUR ROOM:
On completion of the procedure document the number of swabs accounted for in the delivery records. This should equal the number counted out prior to the procedure.
IN THEATRE: Document the final swab count in the ICP and the theatre register.
Do I know what to do if any swabs are not accounted for?
-Complete a thorough search of the clinical area and clinical waste.
-Inform the team leader and duty consultant of any missing swabs.
-Contact XRAY 08.00-20.00hrs by telephone Ex 2501and discuss xray/ imaging of patient depending on the clinical situation. Out of hours ring Ex 2143 (A&E) to arrange this.
-If xray dept are unsure what is required contact the on call consultant radiographer
© National Patient Safety Agency 2010. Copyright and other intellectual property rights in this material belong to the NPSA and all rights are reserved. The NPSA authorises UK healthcare organisations to reproduce this material for educational and non-commercial use.
1229 May 2010
www.nrls.npsa.nhs.uk/alerts

Perineal Trauma – Audit Tool

Hospital number: | | | | | | | |

Date of delivery: | | | | | | |

Q1 Assessment of perineum and lower vagina has been documented? ☐ Yes ☐ No

Q2 The documentation includes evaluation of any trauma sustained? ☐ Yes ☐ No

Q3 Category of tear: ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th

☐ Labial ☐ Vaginal ☐ Cervical ☐ Episiotomy

Q4 Pr examination documented pre and post repair? ☐ Yes ☐ No

Q5 Repair requirements recorded? ☐ Yes ☐ No

Q6 If no repair, is this appropriate? ☐ Yes ☐ No

Q7 Name of person performing suturing: ☐

- Has named person received appropriate training? ☐ Yes ☐ No

Q8 Techniques used for repair documentation? ☐ Yes ☐ No

Q9 For 2nd tears only:

Method used ☐ Continuous ☐ Interrupted

Suture material used ☐ Vicryl rapide 2º ☐ Vicryl rapide 3º

Q10 Following materials used as per guideline:

- Interrupted polyglactin(Vicryl) for torn anal epithelium ☐ Yes ☐ No
- Interrupted 3/0 Polydioxanone (PDS) for internal anal sphincter ☐ Yes ☐ No
- 3/0 PDS for External anal sphincter ☐ Yes ☐ No
- No. 1 Vicryl for reconstruction of Perineal muscle ☐ Yes ☐ No
- Vicryl Rapide 2/0 for skin closure ☐ Yes ☐ No
- Rectal Diclofenac 100mg inserted at end of procedure ☐ Yes ☐ No

Q11 Post repair documentation includes:

- A diagram ☐ Yes ☐ No
- Method of suturing ☐ Yes ☐ No

- Swab and needle count ☐ Yes ☐ No
- Prescription of antibiotics ☐ Yes ☐ No
- Prescription of analgesia ☐ Yes ☐ No
- Prescription of Lactulose and Fybogel ☐ Yes ☐ No
- Advice given to women ☐ Yes ☐ No

For third and fourth degree tears only:

- Physiotherapy referral made ☐ Yes ☐ No
- Hospital follow up with Urogynaecology arranged ☐ Yes ☐ No

Q12 Has the women returned to ASPH for a Perineal trauma related episode? ☐ Yes ☐ No

Q13 Reason for return _____

Q14 If YES to Q12, has an Incident Form been completed ☐ Yes ☐ No

Q15 Was a referral made to the Birth Reflections Service ☐ Yes ☐ No

EQUALITY IMPACT ASSESSMENT TOOL

Name: **Perineal Trauma Management & Repair**

Policy/Service: **Women's Health**

Background • Description of the aims of the policy • Context in which the policy operates • Who was involved in the Equality Impact Assessment
• Women's Health Guidelines Committee involvement in the Equality Impact Assessment
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)
• There are no likely effects of this policy. • NICE 2007 Intrapartum guidelines Royal College of Obstetricians and Gynaecologists (2007) Management of third- and fourth-degree perineal tears following vaginal delivery. RCOG Press. Green top Guideline No. 29.
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
• No impact • No adverse effect
Conclusion • Provide a summary of the overall conclusions
A policy applicable to women who sustain perineal trauma and professionals who repair trauma and manage after care.
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified • Describe the plans for reviewing the assessment
• No changes required.

Guidance on Equalities Groups

Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)	**Religion or belief** (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)
Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)	**Sexual orientation including lesbian, gay and bisexual people** (consider whether the policy/service promotes a culture of openness and takes account of individual needs
Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)	**Age** (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)
Culture (consider dietary requirements, family relationships and individual care needs)	**Social class** (consider ability to access services and information, for example, is information provided in plain English?)

If further assessment is required please see the Integrated Single Equality Scheme.
For advice in respect of answering the above questions, please contact HR Manager, on extension 2552.

PROFORMA FOR RATIFICATION OF POLICIES AND GUIDELINES BY RATIFYING COMMITTEE

Policy/Guidelines Name:	Perineal Trauma Management & Repair.
Name of Person completing form:	Jacqui Rees
Date:	Aug 2012

Author(s) *(Principle contact)*	Mr James Thomas, Dr Sandra Newbold, Midwife Dianne Casey	
Name of author or sponsor to attend ratifying committee when policy/guideline is discussed	Women's Health Guidelines Group & Labour Ward Forum	
Date of final draft	August 2012	
Has this policy/guideline been thoroughly proof-read to check for errors in spelling, typing, grammar and consistency?		Yes
By whom:	Women's Health Guidelines Group	
Is this a new or revised policy/guideline?	revised	

Describe the development process used to generate this policy/guideline.
Women's Health Guidelines meetings, Labour Ward Forum, all Consultants, senior midwives
Who is the policy/guideline primarily for?
Professionals who will be repairing perineal trauma
Is this policy/guideline relevant across the Trust or in limited areas?
Limited to Women's Health, Maternity Unit
How will the information be disseminated and how will you ensure that relevant staff are aware of this policy/guideline?
ASPMat Newsletter, notice boards, Communication Bulletin
Describe the process by which adherence to this policy/guideline will be monitored.
Audit tool attached to policy
Is there a NICE or other national guideline relevant to this topic? If so, which one and how does it relate to this policy/guideline?
Yes – Intrapartum care and RCOG Green Top guidelines
What (other) information sources have been used to produce this policy/guideline?
See reference list
Has the policy/guideline been impact assessed with regard to disability, race, gender, age, religion, sexual orientation?
Yes – no adverse effects
Other than the authors, which other groups or individuals have been given a draft for comment?
Consultants, Labour Ward Forum
Which groups or individuals submitted written or verbal comments on earlier drafts?
Infection Control Consultant, Obstetric Physiotherapist & Obstetric Consultants
Who considered those comments and to what extent have they been incorporated into the final draft?
Guidance for antibiotic prescription given by infection control.
Have financial implications been considered? – no financial implications