Worcestershire Acute Hospitals NHS Trust

OASI Care Bundle

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

Guideline for the management of birthing people opting in to the OASI (Obstetric Anal Sphincter Injury) Care Bundle to help prevent 3rd and 4th degree perineal tears during vaginal birth.

Please use this guideline alongside the Warm Compress SOP.

This guideline is for use by the following staff groups:

All maternity staff providing antenatal, intrapartum and postnatal care.

Lead Clinician(s)

Amanda Argyle — Specialist Midwife for Perinatal Pelvic Health Services

Approved by *Maternity Governance Meeting* on:	27th March 2026
Approved by Medicines Safety Committee on:	N/A
Review Date: This is the most current document and should be used until a revised version is in place	27th March 2029

Key amendments to this guideline

Date	Amendment	Approved by:
March 26	New Document	MGM

Inclusion statement
We recognise that although our policy uses words such as women/woman, not all birthing people or post-natal parents will identify as such. We encourage all staff to be welcoming of the diversity of our local population, be respectful of preferred language, pronouns, and adapt their communication appropriately. All staff should accommodate mothers and parents with individual needs or disabilities, whether they be physical or not visible, and adapt their care to support them with their pregnancy.

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Ockenden Maternity Guidelines Assessment

Is there National Guidance Available for this guideline?	Yes
National Guidance used to inform guideline *e.g. NICE/RCOG*	Recommendations | Intrapartum care | Guidance | NICE gtg-29.pdf
Does the guideline follow National Guidance if available? *If no, what rationale has been used.*	Yes
If no national guidance available or national guidance not followed, what evidence has been used to inform guideline.	N/A
Ratified at Maternity Guidelines Forum:	**27/03/2026**

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Introduction

It has been estimated that 85% of women having a vaginal birth will experience perineal trauma (Webb, 2014). Approximately 3% of women in the United Kingdom have an Obstetric Anal Sphincter Injury (OASI) (Thiagamoorthy et al., 2014).
An OASI is more likely if:

- Nulliparous: OASI rate is 6.1% in nulliparous women compared to 1.7% in multiparous women
- Asian ethnicity
- Birthweight >4kg
- Shoulder dystocia
- Occipito-Posterior position
- Prolonged 2nd stage of labour
- Instrumental birth
- Previous OASI: For women with a history of OASI, there is a 5-7% chance of experiencing repeat OASI in future vaginal births
- Maternal age over 35 years

Clinicians should be aware that risk factors do not allow the accurate prediction of obstetric anal sphincter injury. All women and birthing people are at risk of sustaining an OASI during vaginal birth (RCOG, 2015).

The reported rate of OASI (in singleton, term, cephalic, vaginal first births) in England has tripled from 1.8% to 5.9% from 2000 to 2012. The overall incidence in the UK is 2.9% (range 0–8%), with an incidence of 6.1% in primiparae compared with 1.7% in multiparae. With increased awareness and training, there appears to be an increase in the detection of anal sphincter injuries. A trend towards an increasing incidence of third- or fourth-degree perineal tears does not necessarily indicate poor quality care. It may indicate, at least in the short term, an improved quality of care through better detection and reporting.

Obstetricians who are appropriately trained are more likely to provide a consistent, high standard of anal sphincter repair and contribute to reducing the extent of morbidity and litigation associated with anal sphincter injury.
Women should be advised on how to reduce the risk of perineal trauma during the antenatal period.

The presence of two midwives during birth increases the ability to implement perineal protection strategies and has been shown to reduce OASI in women giving birth for the first time. Birthing in water is not associated with an increase in OASI rates (Sanders et al., 2024).

Reducing the risk of perineal trauma

RCOG and RCM collaborated to produce a “care bundle” which included a set of 4 evidence based interventions designed to significantly improve outcomes when used together. The OASI Care Bundle has been shown to reduce rates of OASI and should be discussed with women during the antenatal period. The OASI Care Bundle should be recommended to all women planning a vaginal birth and consent must be gained for each element.

Component 1 - Antenatal Discussion

Women should be given information on perineal trauma including OASI and episiotomy, their own personal risk factors for OASI and steps which can reduce their chance of experiencing OASI. This conversation is recommended between 32 – 36 weeks. Women and birthing people can be provided with written information available on the RCOG website via BadgerNotes and the RCOG Tears Hub Perineal tears and episiotomies in childbirth | RCOG.

Women should be advised that antenatal perineal massage is associated with a reduction in perineal trauma, OASI, episiotomy, length of second stage of labour and postnatal wound complications.

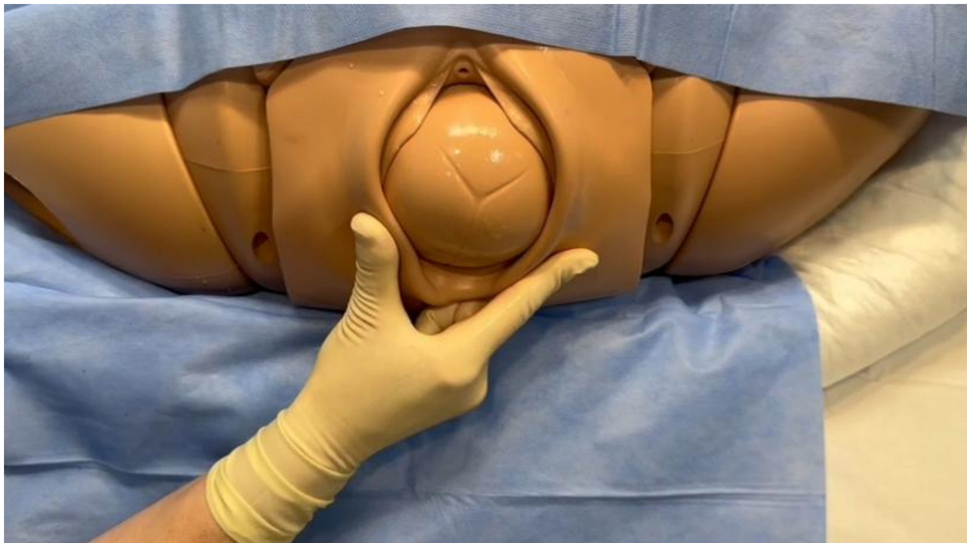
Documenting antenatal conversations

This conversation should be recorded on BadgerNet under the ‘Topics Discussed During Pregnancy’ tab, ‘OASI Care Bundle’.

When discussing birth preferences during pregnancy or labour, include the woman's preferences for techniques to reduce perineal trauma during birth and support her choices (NICE, 2023). This can be recorded in BadgerNet under “Labour and birth” tab, once “first stage established “ is recorded and “Discuss OASI and reducing risk with woman” appears as Yes/No.

Component 2 - Manual Perineal Protection

Perineal protection can be protective (RCOG 2015). The positive effects of perineal support suggest that this should be promoted, as opposed to ‘hands off’ or ‘poised’, in order to protect the perineum and reduce the incidence of OASI (RCOG 2015).



Manual perineal protection is advised for all vaginal births. Manual Perineal Protection includes:

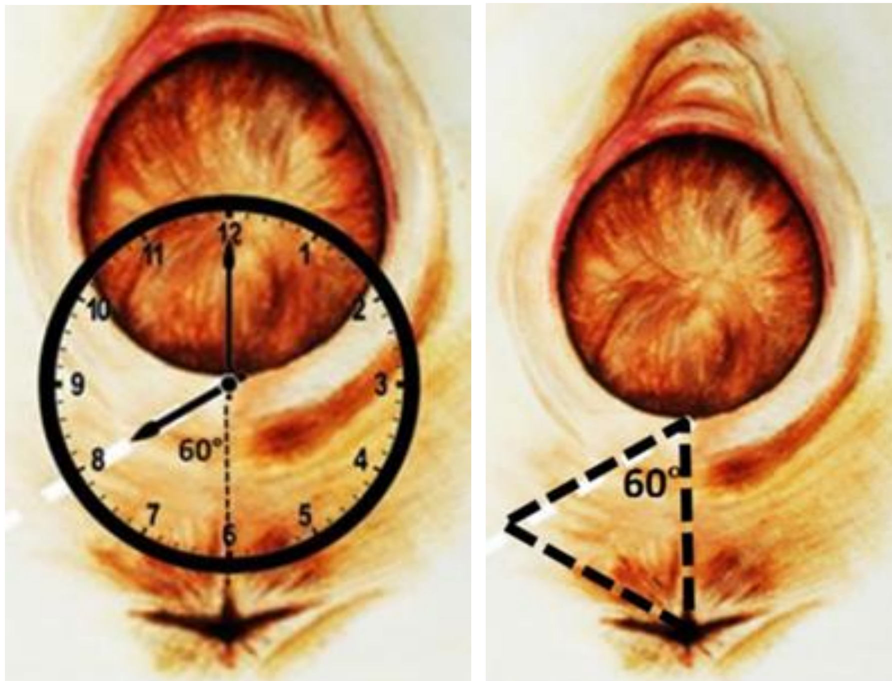
- One hand slowing down the birth of the fetal head
- The other hand protecting the perineum during the birth of the head and shoulders
- Coaching the birthing woman to use breathing techniques or gentle pushes during crowning to avoid tearing from uncontrolled expulsion
- Allowing shoulders to birth with maternal effort (without downward traction by clinician) whilst maintaining manual perineal protection. If traction is required, use gentle axial traction whilst another healthcare professional supports the perineum.

For those who birth in water, manual perineal protection is not advised.

Component 3 - Episiotomy

When indicated, episiotomy should be performed mediolaterally at 60-degree angle at crowning when the perineum is distended (RCOG 2015). This ensures a post delivery angle of 45 degrees.

Use local infiltration with Lidocaine.
Using your index and middle fingers to protect presenting part, infiltrate beneath the vaginal mucosa, beneath the skin of the perineum and deeply into the perineal muscle in a fan or featherlike way. Do not exceed maximum dose as per Midwives Exemption Policy
Aspirate to be sure that no vessel has been penetrated. If blood is returned in the syringe, remove the needle. Recheck the position carefully and try again. Never inject if blood is aspirated. The woman can suffer seizures and death if intravenous injection of Lidocaine occurs.
Midwives can administer Lidocaine according to the NMC exemptions, subcutaneous/intramuscular for perineal infiltration (NMC, 2010)



Indications for episiotomy:
- Suspected fetal compromise
- Prolonged second stage
- Instrumental birth
- To prevent severe perineal trauma
    - Feel digitally for remaining space/stretch
    - Observe the colour of the perineum and whether blood flow appears significantly reduced e.g. pallor of the stretched skin
    - Consider whether the perineum is unusually thick and rigid – possibly associated with prolonged second stage
    - Consider severe trauma caused by occiput-posterior presentation, manoeuvres required for shoulder dystocia and breech births

Clinicians should explain to women that the evidence for the protective effect of episiotomy is conflicting. There is no evidence that prophylactic episiotomy in women who have previously suffered an OASI prevents a recurrence of sphincter injury. However, if risk factors such as large baby, Occiput-posterior (OP) position, shoulder dystocia, fibrotic band or inelastic perineum occur an episiotomy should be strongly considered (RCOG, 2015).

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Component 4 - Systematic examination of the vaginal and ano-rectum after all vaginal births

All women who have a vaginal delivery are at risk of sustaining OASI or isolated rectal buttonhole tears. They should therefore be examined systematically, including a digital rectal examination, to assess the severity of damage, particularly prior to suturing.

Gently examine the vagina to find the apex of the tear.
Next, perform a per-rectal examination of the ano-rectum, initially looking for a buttonhole between rectum and vagina.
Then, move down to the entrance of the anus and use the pill-rolling technique to feel for the 'tone and bulk' of the sphincters over 180 degrees, (9 o'clock, to 3 o'clock). Note that the woman's ability to squeeze is affected by whether she has an epidural, and the muscles are often weak and/or numb following birth. If the bulk feels thinner anteriorly, it may be an OASI (thinner at '12 o clock' than at '9' and '3'). This should prompt a second review by a senior midwife or obstetrician (RCOG 2023).

Other considerations

Warm Compress (not part of RCOG bundle but is advised).

See Warm Compress SOP.

Where possible, avoidance of lithotomy for spontaneous vaginal births. Lateral positions and kneeling appear to be protective against OASI.

During second stage, if warm compress is declined by the woman or birthing person, offer gentle perineal massage as an alternative using a water-soluble lubricant (NICE, 2023).

The presence of two midwives during birth increases the ability to implement perineal protection strategies and has been shown to reduce OASI in women giving birth for the first time. Birthing in water is not associated with an increase in OASI rates (Sanders et al., 2024).

Documenting after birth

When completing documentation, record under "Episiotomy, tears, trauma" tab, record under "OASI care bundle-were all 4 components applied to birth?" Note: instrumental delivery should include the manual perineal protection component so this should not be a reason for not completing all 4 components.

Postnatal Referrals

All women who have sustained an OASI should have a referral made via BadgerNet to attend the Pelvic Floor After Pregnancy clinic (PFAP). This will automatically generate a physiotherapy referral for appropriate follow up care.

See Perineal Tears and Repairs.

Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	Hands on used	Audit	Monthly	Pelvic Health Specialist MW	Senior MWs/Labour Ward Forum	2 monthly
	Post Birth Documentation	Audit	Monthly	Pelvic Health Specialist Mw	Senior MWs/Labour Ward Forum	2 monthly

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Maternity Governance Meeting
Maternity Guidelines Committee

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Maternity Quality Governance Meeting

Appendices

Appendix 1

Antenatal information leaflet to be handed out at antenatal discussion between 32-36/40 (RCOG 2023)

Perineal Health in Pregnancy, Birth & Beyond

Antenatal discussion guide

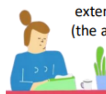
OASI TWO CARE BUNDLE

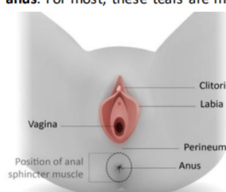
V5 AUGUST 2023

What types of perineal tears can occur during childbirth?

During vaginal birth, it is very common to experience a graze or tear of the labia or, more frequently, the **perineum**, which is the **area between your vagina and anus**. For most, these tears are minor and heal quickly.

- **1st and 2nd degree:** tears that involve muscle/skin that may require stitches
- **3rd and 4th degree:** severe tears which extend to the muscles that control the anus (the anal sphincter), requiring stitches. **These are also called 'Obstetric Anal Sphincter Injuries' (OASI).**





Am I at risk of a severe tear?

Severe tears (OASI) occur in **3-4 in 100 births.**
You are at significantly higher risk if:

- Forceps are used to help you give birth
- This is your first vaginal birth

The following may also increase your risk:

- You sustained a previous OASI
- Your baby is born in the back-to-back position
- Your baby is over 4kg (9 lbs)
- You are of South Asian ethnicity
- Your baby is born quickly
- You are over 35 years of age
- Your baby's shoulder gets stuck behind the pubic bone (shoulder dystocia)
- Ventouse is used to help you give birth
- The pushing phase of labour takes a long time

The alternative to a vaginal birth is a caesarean birth. Caesarean birth has different risks to yourself, your baby and your future pregnancies.

What about recovery?

Most women and birthing people who have a severe tear (OASI) repaired recover well, although it can take some time. Occasionally, long-term pain and a difficulty or inability to fully control the bladder, bowels or the passing of wind can occur. This could lead to:

- Feelings of depression, low mood, isolation
- Anxiety about leaving the house and not being able to quickly access a toilet
- Difficulty bonding with your baby
- Concerns about leakage while exercising
- Concerns about having sex or giving birth again

If you experience any of the above after birth, contact your doctor or midwife as soon as possible to access specialist care.

BRAIN can help you ask questions

The BRAIN acronym helps you have conversations that will support you to make a decision.

B = what are the benefits?
R = what are the risks?
A = what are the alternatives?
I = what does your intuition tell you?
N = what happens if we do nothing for now?

How can I reduce my risk of a severe tear?

Perineal massage with a natural oil (such as coconut or almond) from 35 weeks pregnant until birth, as illustrated here. Visit rcog.org.uk/tears for more information on how to do this.

A warm compress is a flannel heated with warm tap water and held against your perineum during the pushing phase of labour. Ask your midwife or doctor if they can provide this.

Spontaneous vaginal birth *(birth without forceps or ventouse)* can be encouraged by choosing the ideal place of birth (consider a homebirth or midwifery-led unit if you are low- risk), avoiding induction and epidural where possible, creating a relaxing environment (consider soothing lighting, sounds, smells) and remaining active throughout labour and birth. *For first-time mothers with an epidural*, lying on your side during the pushing phase of labour is recommended.

Choose a birth position that is most comfortable for you. Listen to your midwife and they will advise a slow and guided birth of the head. Positions at the moment of birth that may reduce risk of severe tears include:

The **OASI Care Bundle** is the following set of practices, most effective when applied together:

1. In the antenatal period, your midwife or doctor will **discuss severe tears (OASI) with you** and what can be done to reduce the risk of this occurring.
2. With your consent, your midwife or doctor will **use their hands to support** your perineum and the baby's head and shoulders during birth and encourage a slow and guided birth.
3. You may need an **episiotomy**—a cut through the vaginal wall and perineum to make more space for your baby to come out—your midwife or doctor will ask for your consent to do this.
4. After your baby has been born, your midwife or doctor will ask for your consent to **examine your vagina, perineum and anus** (just inside the back passage) to ensure any tears are identified and appropriately treated to avoid further consequences.

✓ **Developed by experts**
✓ **Supported by women**
✓ **Found effective in a 2017-18 study (OASI1)**

Please speak to your midwife or doctor if you have any questions.
For more information and support, visit: rcog.org.uk/tears **or** masic.org.uk

References

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