Quality Improvement: Appropriate episiotomies in a district hospital

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Keywords: quality, team, satisfaction, care, improvement

Abstract

Work satisfaction, enthusiasm and better patient care at times come from the simplest things. Quite a number of patients were coming with episiotomy dehiscence (gaping episiotomy) to the Taung Hospital. Most of them were primigravidae, on whom a routine episiotomy (according to the Hospital policy) had been performed.

A literature review showed that there routine episiotomy was not necessary, and that reducing the number of episiotomies had not increased the number of complications for the mothers or babies.

A multidisciplinary team did a quality improvement project to reduce the number of episiotomies. The results of the project were positive: the episiotomy rate decreased from 66,2% to 25,3% and the episiotomy dehiscence rate dropped from 2,28% to 0,7%. This had a positive impact also on patient satisfaction and staff morale. The experience is described as a quality improvement cycle and discussed in light of some principles of quality improvement in a rural hospital. *(SA Fam Pract 2003;45(6):17-19)*

INTRODUCTION

"Work is love made visible.

And if you cannot work with love but only with distaste, it is better that you should leave your work and sit at the gate of the temple and take alms of those who work with joy."[1]

What a beautiful sentence! By reading it one already feels good, or... - maybe - Frustrated. Other sentences may come to mind; sentences that we hear every day:

"We cannot go on like this...", "I do not enjoy my work anymore...", "It is too strenuous, I am always under pressure...".

Often there is little we can do to solve the serious problems we encounter in our work due to lack of funds, human resources, or infrastructure. At times we can be so discouraged and tired, that we do not even see the little things we can do to improve the quality of care we give.

THE PATIENT THAT TRIGGERED THE ACTION

On that particular afternoon the Gynaecology ward was overcrowded. M.N. was admitted with an episiotomy dehiscence. Usually these patients were admitted in the ward just for health education, Sitz baths (since at home they do not have proper facilities), surgical cleaning and secondary suturing if necessary.

Why was M.N. there? And how could we manage her effectively?

The practice in Taung hospital was to perform a routine episiotomy in all primigravida deliveries. The records showed that 15 out of the 17 patients admitted with episiotomy dehiscence in the previous six months were primigravidae with routine episiotomies. A literature review showed no evidence to support routine episiotomies:

A Cochrane review by Carroli et al concludes that restrictive use of episiotomy in vaginal deliveries is recommended and that the advantages of a routine episiotomy have never been scientifically proven.[2] Problems caused by routine episiotomies are well documented[3,4,5].

Reynolds and Yudkin in their analysis of 24,439 deliveries between 1980 and 1984 in a large British obstetric unit reported a decrease in the frequency of episiotomy from 73% to 45%. No change in the incidence of third-degree lacerations or complications for the new-borns was found.[6] Harrison and associates in their randomised trial came to the same conclusions, though they found a decrease in the episiotomy rate from 89% to 8% following the implementation of a non-episiotomy policy.[7]

QUALITY IMPROVEMENT

Quality in health is defined as the best outcomes with the available resources, in view of patient values and preferences.[8]

We called a meeting with all the

doctors, the staff from labour ward, the professional nurses from the district, the matrons of the hospital and the tutors from the Nursing College.

The purpose of the meeting was to reconsider the hospital policy on 'Indications for episiotomy'. The information from the literature review and the records review was presented. After an open discussion it was agreed to do a formal quality improvement project.

Topic

The topic was identified as "Indications for episiotomy".

The team

The team consisted of:

1. Tutors from the College who are responsible for Midwifery teaching.
2. Staff from labour ward.
3. The doctor in charge of the Maternity ward.
4. The doctor involved in training the Professional Nurses in primary health care.
5. The doctor in charge of the Gynaecology ward.

Standard

The standard in the literature was set at 'no routine episiotomies' and the rate of less than 30 % episiotomies per total deliveries.[6] There was clearly room for improvement. However, we did not set a specific standard for the hospital. There were some differences in opinion about a restrictive policy, though everybody agreed to keep in mind what had been discussed.

Present practice

Advanced midwives and professional nurses run the Labour ward. The doctor conducts only complicated deliveries. The policy and teaching by the professional nurses had been to perform a routine episiotomy on:

- All primigravidae.
- Patients with previous caesarean section who did not have a previous vaginal delivery.
- Gravida 2 patients where difficulty with the delivery is expected; and
- All patients with other indications for episiotomy, namely breech presentation, vacuum delivery, big baby, etc.

This resulted in 66,2% episiotomy rate (493 episiotomies performed over 745 deliveries) between the May and the November 1998.

Plan

The implementation plan was:

- To keep in mind all we discussed and learned at the meeting;
- To assess each primigravida delivery and see if a routine episiotomy could be avoided;
- To consider the other indications for episiotomy stated above still valid.

We decided to put it like this in order not to force change on this long established practice.

The atmosphere in the meeting was good. Everybody appreciated the purpose and the outcome of the meeting.

Measurement of implementation plan

From the 1st December 1998 till the 31st March 1999 there were 423 deliveries. According to the routine episiotomy policy 205 women would have had a routine episiotomy. Instead, only 107 episiotomies were performed on specific indications, e.g. big baby, vacuum extraction, breech presentation and tight perineum. There were no complications for the babies and some minor complications for the mothers ***(See Table I)***.

Evaluation of plan implementation

The episiotomy rate was reduced from 66,2% before the intervention to 25,3% after the intervention ***(see Figure 1)***. The episiotomy dehiscence rate was reduced from 2,28% to 0,7 %.

There had been a dramatic improvement in practice and outcomes. The team was of the opinion that this new practice was consolidated. From the records it appeared that the more experienced midwives were the first to have changed practice. Once all the other midwives had seen the positive results, they also had changed their practice.

Other gains were:

- Reduced workload for midwives to suture episiotomies;
- Saving on suturing and other material;
- Reduced admissions in the Gynaecology ward due to reduction of episiotomy dehiscence.

The Team was surprised that even though no strict standards had been set and no one had been forced to change, the results were good. A spirit of enthusiasm and achievement was evident amongst the team and the staff.

Patients were amazed for not getting an episiotomy and were very satisfied to go home after delivery without an episiotomy. This made them more comfortable and able to care for their babies.

Table I : Episiotomies performed on primigravidae

PRIMIGRAVIDAE DELIVERIES								
	WITH EPISIOTOMY			WITHOUT EPISIOTOMY				
Month	**Done**	**Gaping at 5 day post-natal clinic**	**Not done**	**Skin nicks**	**1st degree**	**2nd degree**	**3rd degree**	**Vaginal tears**
DEC	39	1	19	1	3	0	0	4
JAN	18	2	32	0	0	0	0	0
FEB	16	0	23	1	0	2	0	2
MAR	34	0	24	4	1	1	0	5
Total	**107**	**3**	**98**	**6**	**4**	**3**	**0**	**11**

Figure 1: Episiotomy rates before and after the intervention

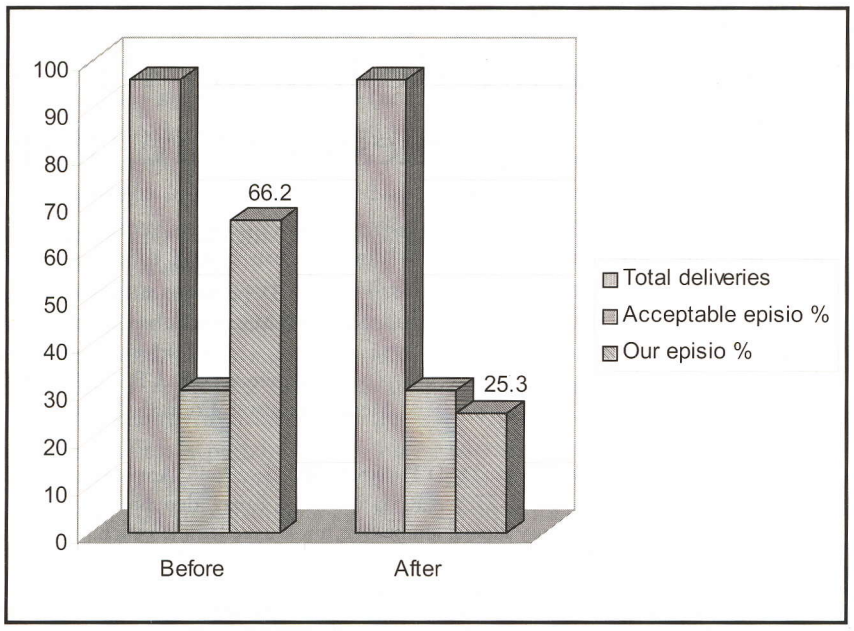

Table II: Principles of quality improvement
• Focus on the **Patient** Quality is improved by **Teamwork.**
• Understand and address **Processes Communication and relationships**.
• Use the best **Information Start Small Seek solutions Success.**

DISCUSSION

Reflecting on this project one can look at some principles of a quality improvement process ***(See Table II)***.

Focus on the patient

The wish to provide better care for a patient triggered the project. The process did not include patients as team members, which would have been better. Fortunately, the patients were very satisfied and the plan corresponded with their preference.

Quality is improved by Teamwork

The importance of teamwork is clearly demonstrated. Quality in primary care happens when a team is learning, changing and improving. A quality improvement project thrives on good teamwork and can enhance team functioning. The different roles in the team are not documented in this article. Aspects such as leadership, facilitation and management in teamwork are important and need attention.

Understand and address Processes

The process and history of a labour ward and the difficulty posed by a change was considered. That is why the strict standards and rules were avoided. An important aspect of the process was the fact that the most experienced team members took the lead. That inspired the rest of the team and led to positive changes.

Communication and relationships

The people in this team knew each other for a long time and this made it possible for the team members to participate in the process and trust each other. A specific focus in relationships makes quality improvement more effective and enjoyable.

Effective communication of the present practice, information from the literature and positive change in outcomes was communicated clearly and that encouraged the team.

Use the best Information

The team looked at the best available information in accessible Evidence Based Practice resources. They could act on this information, as it was both valid and relevant. The also used easily available and simple data to assess the present practice and monitor the change. This contributed to the understanding of the problem and encouraged change.

Start Small

This is a small and achievable project and its success made it possible for other quality improvement projects to be successful in the hospital and in the district.

Seek Solution

The initial discussion and the review of the literature provided a very simple solution. Not too much time was spent on analysing the problem. A lot of information could have been gathered about the type of organisms, the type of suturing material, the technique, the teaching, the feeding of mothers, the rising incidence of HIV and many other issues. Instead, the team found a solution and focused their efforts on that. Solution thinking is used in family therapy with the understanding that one cannot solve a problem with the same kind of thinking that created the problem[9]. It is helpful to consciously focus on the solution rather than the problem in quality improvement. It is creative and gives people hope.

Success

Success was a clear driver in the project. The initial success of the experienced midwives made a big difference. It is wise to work with things that can be successful and with people who can make it a success.

Improving quality is a journey. The family doctor plays a crucial role in making quality care possible. He/she has the responsibility to be an active agent for change and a structured quality improvement cycle is one way of achieving that.❐

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