TITLE	Perineum Wound Care Gudieline
Version:	1
Approved by: Date:	
Objective	To outline the guidelines and requirements for completing wound care for Perineal wounds in the North East and North Cumbria
Scope	This standard operating procedure details the process for how to ensure that correct guidelines are to be followed by all staff including apprentices and learners in the North East and North Cumbria.
Author/lead responsible for guideline:	Original Authors: South Tees Foundation Trust Shilpa Mahadasu: Consultant Obstetrician Ally Anderson: Practise Development Midwife Nadine Peart: Tissue Viability Team Edited For LMNS: Alaina Mcadam Midwife Rebecca Knowles Midwife
Date Issued:	April 2024
Next Formal Review Date:	April 2027
Target audience:	All staff including apprentices and learners.
Are these guidelines fully compliant with the national guidance	Yes

Wound Care for Perineal Wounds SOP

- Encourage the woman to have a shower once she feels up to it.

- Advise the woman about the importance of good ongoing perineal hygiene throughout the postnatal period, including daily showering of the perineum, frequent changing of sanitary pads, and hand washing before and after doing this.

- Educate women on signs of infection and future postnatal pelvic health, ensuring this is communicated in the appropriate way for the individual.

- At each postnatal contact, women should be asked whether they have any concerns about the healing process of any perineal wound; this might include experience of pain, discomfort or stinging, offensive odour/discharge, or dyspareunia.

- Perineal wounds should be inspected and ensured:
  - ✓ Wound is clean with no visible signs of infection.
  - ✓ No excessive pain or discomfort, or excessive swelling
  - ✓ No reports of discharge that has a strong or unpleasant smell
  - ✓ No incontinence of faeces or flatus.
  - ✓ No excessive pain when opening bowels.

- Signs and symptoms of infection, inadequate repair, wound breakdown, or nonhealing should be evaluated urgently and referred to the maternity triage/assessment unit.

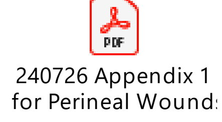
- Complete wound care assessment (appendix 1) if needed upon referral for above, to ensure appropriate ongoing assessments are carried out.

- Preparations such as Flaminal can be used for non-healing perineal wounds in the absence of infection.

- Ensure correct referrals are conducted and escalated to the Obstetric team/Tissue viability/Pelvic Health Team including Physiotherapy when required.

- Inform and educate women on pelvic floor muscle training and explain that it helps prevent symptoms of pelvic floor dysfunction. Including how to do them and when to seek help.

- Safety net women and ensure appropriate follow up for ongoing care is in place.



<table>
<tr><th colspan="6">Appendix 1: Wound Assessment and Treatment Plan</th></tr>
<tr><td colspan="6">Complete or attach patient label

Surname:……………………………………… Forename:…………………………………

DOB: ………………………………… Hospital no:………………………………

NHS Number:…………………………………………………………………</td></tr>
<tr><td colspan="2">Type of wound (please circle):</td><td colspan="2">Perineal wound</td><td colspan="2">Abdominal Wound</td></tr>
<tr><td>Pressure Ulcer</td><td>Moisture lesion</td><td colspan="2">Other (please state):</td><td colspan="2"></td></tr>
<tr><td colspan="6">History and duration of wound:</td></tr>
<tr><td colspan="4">Current treatment provided</td><td colspan="2">Allergies/sensitivities:</td></tr>
<tr><td colspan="6">Body Map (mark location of the wound under assessment):</td></tr>
<tr><td colspan="2">Pressure ulcer/moisture lesions</td><td colspan="2">Abdominal wound</td><td colspan="2">Perineal wound</td></tr>
<tr><td colspan="2"></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>Referrals made:</td><td>Date:</td><td colspan="2">Other (please state)</td><td colspan="2">Date:</td></tr>
<tr><td>Tissue viability</td><td></td><td colspan="2" rowspan="2"></td><td colspan="2" rowspan="2"></td></tr>
<tr><td>Plastics</td><td></td></tr>
<tr><td>Datix ref no:</td><td></td><td colspan="2">Date:</td><td colspan="2"></td></tr>
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Assessment of Wound						
	Date:					
Analgesia	Regular					
	PRN					
	Pain score 0-10					
Dimensions (mm)	Length					
	Width					
	Depth					
	Tracking (tick)					
Tissue: Type	Necrotic (Black) %					
	Slough (Yellow/Green) %					
	Granulating (Red) %					
	Epithelising (Pink) %					
	Haematoma					
Infection	Heat (tick)					
	NEW slough/necrosis (deteriorating wound bed)					
	□ Pain					
	□ Exudate					
	□ Odour					
	□ Size					
	Wound swab taken?					
Moisture: Exudate	Low					
	Moderate/Wet					
	High					
	Colour of exudate (Straw/Red/Green/Brown/Yellow)					
	Levels increasing/decreasing					
Edge	Macerated (White)					
	Oedematous					
	Cellulitic					
	Erythema (Red)					
	Excoriated (Red)					
	Healthy					
Blood Results	Hb					
	WBC					
	CRP					
Swab Results	Infection?					
	Antibiotic treatment?					
	Sign					

References

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- NICE (2020) *Surgical site infections: prevention and treatment*. Available at: https://www.nice.org.uk/guidance/ng125

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- Nice (2021) *Recommendations: Pelvic floor dysfunction: Prevention and non-surgical management: Guidance.* Available at: https://www.nice.org.uk/guidance/ng210/chapter/Recommendations#during-and-after-pregnancy

- NICE (2021) *Recommendations: Postnatal care: Guidance* (Available at: https://www.nice.org.uk/guidance/ng194/chapter/Recommendations#postnatal-care-of-the-woman