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Trust Guideline for the Management of: Swabs, Tampons and Sharps in the Maternity Services when used for Vaginal Birth and Perineal Repair

For use in:	Maternity Services
By:	Midwives, Obstetricians, Midwifery Care Assistants (MCAs)
For:	Safe management of swabs, tampons and sharps within the maternity services when used for vaginal birth and perineal repair.
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Assessed and approved by the:	Maternity Guidelines Committee (MGC) If approved by committee or Governance Lead Chair's Action; tick here ☑
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To be reviewed by:	Amanda Anderson Sue Holland
Reference and / or Trust Docs ID No:	IO40 - 9635
Version No:	5
Compliance links: *(is there any NICE related to guidance)*	National Institute for Health and Clinical Excellence CG190 (February 2017) Intrapartum Care for Heathy Women and Babies
If Yes - does the strategy/policy deviate from the recommendations of NICE? If so why?	No

Version and Document Control:

Version Number	Date of Update	Change Description	Author
4.1	12/04/2021	Obstetric Guidelines Committee changed to Maternity Guidelines Committee. Extension granted for 6 months	Katherine Stanley Sam Smalley
5	27/08/2021	Section added on use of **green** wristbands. Process for intentionally retained pack. SBAR sticker used by theatre.	Sue Holland Amanda Anderson

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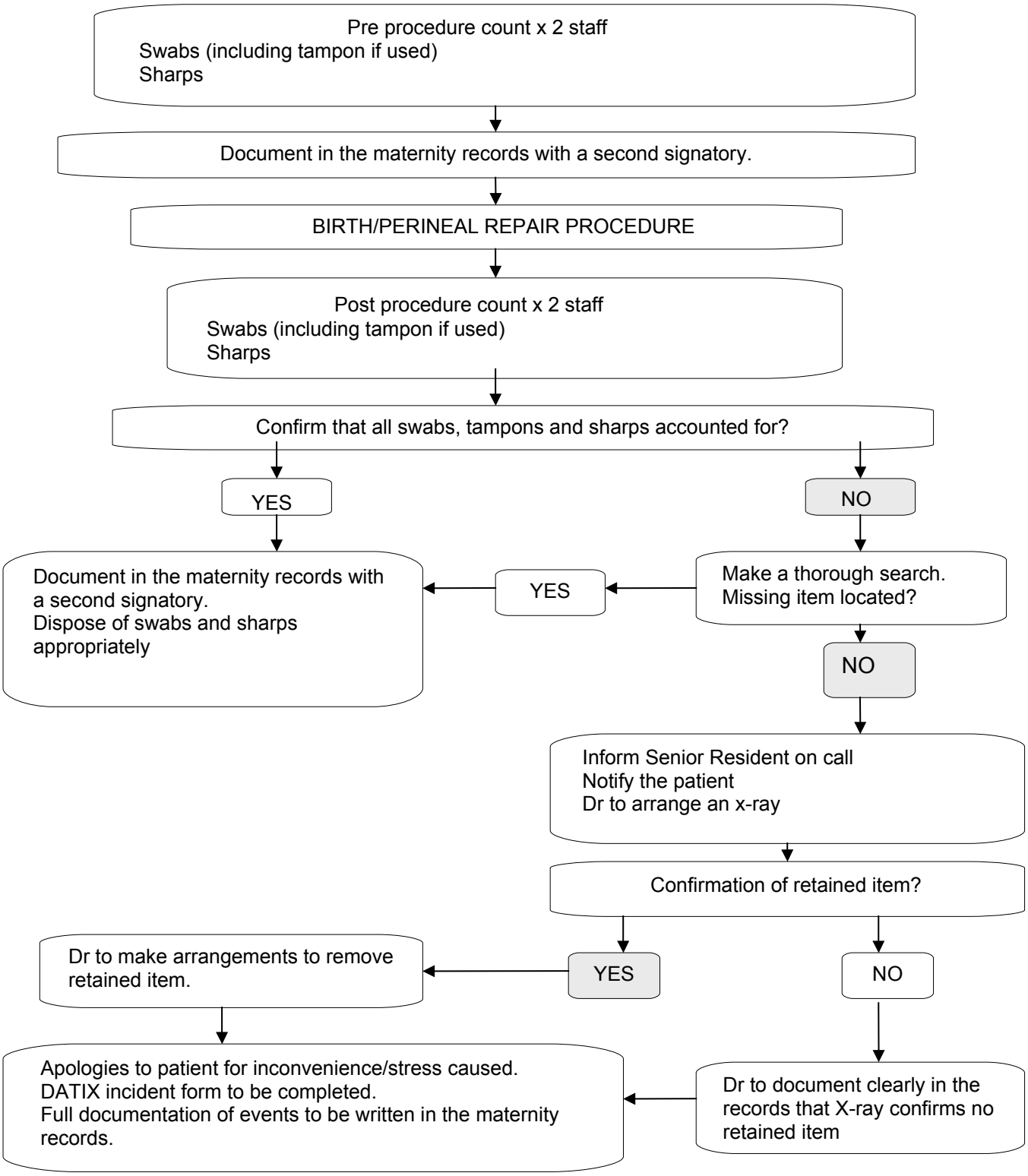
Trust Guideline for the Management of: Swabs, tampons and sharps in the maternity services when used for vaginal birth and perineal repair



Trust Guideline for the Management of: Swabs, tampons and sharps in the maternity services when used for vaginal birth and perineal repair

Quick reference guidelines

- The term “swab” refers to all items used in delivery and perineal repair: gauze, tampons etc.
- All swabs should be x ray detectable (all swabs supplied in pre packed sterile sets conform to this standard).
- Do not use cotton wool balls or small swabs.
- Any swabs, tampons, packs or rolls inserted into the vagina following the birth of the baby, must have the tape or part of the pack exposed outside the vagina and clipped to the drapes to allow recognition of a pack being insitu, this is in addition to it being part of the swab count.
- If a swab and/or instrument remains in situ for transfer to theatre the following actions must be taken.
    - **Green** alert bracelet x1 must be attached to the patient’s wrist alongside the ID bracelet.
    - The retained items must be included in the verbal handover given to the theatre team by the midwife and documented in the notes. The theatre team use a handover sticker See appendix 1 which they will bring to the room, which must be signed by the midwife.
    - When the item/s has been removed it must be placed in a clear bag and placed in full view of the scrub practitioner.
    - The **green** bracelet must be removed immediately following removal of the item/s and also placed in the clear bag which should then be sealed and remain in view.
    - The bag must remain in theatre until the procedure is complete, the final theatre item count has been completed and confirmed as correct at the WHO ‘Time Out’ (World Health Organisation 2009).
    - The bag must return to the delivery room with the patient in order that the item may be visualised as part of the final count of items originally opened and counted prior to transfer to theatre.
    - Removal of the item will be documented on the electronic peri-operative record (ORSOS) by the theatre team.
    - Additional guidance on the checking of items can be found in ‘Theatre Guideline for the Management of Checking and Counting of Swabs, Sharps and Instruments (including Medical Devices) - Trustdocs Id: 12619.
- The professional undertaking the procedure is responsible for the completion of the swab count pre and post birth/perineal repair, and signing for it. They are responsible for ensuring all swabs are accounted for and for obtaining a second signatory.

Intentionally retained pack

- When using a vaginal pack post delivery, the practitioner inserting the pack must determine a plan for removal and ensure that this is documented within the patient record and on the Orsos theatre system within the Theatre Care Plan.
- Ensure that the electronic theatre record is filed in the patient records and/or staff are able to access the electronic record.
- Additionally, a **green** wristband should be placed on the patient's wrist and ankle to clearly indicate a retained item and the patient informed/debriefed following surgery by the surgical team.

- Detail of the retained item and application of the **green** wristbands must be handed over to Recovery / the next location of care.
- Subsequent removal should be recorded in the patient notes and E3 by the surgeon/clinician removing the item and detail should include; date, time and designation of the person removing the item. **Green** wrist bands can then be removed and this also documented in the patient's notes and E3.

Objective

To ensure a safe and standardised management of swabs and sharps when used in the maternity services for vaginal birth and perineal repair. (excluding theatres).

Rationale

Retained swabs were classified as a "Never Event" by the National Patient Safety Agency (NPSA).

Such never events have previously occurred in the maternity services, with the risk management process and root cause analysis highlighting that checking procedures vary widely. There needs to be a standardised, universal procedure documented, and available to all staff involved in the management of swabs/sharps, (Johnson, 2012).Safe and standardised practice will improve patient safety.

The National Institute of Health and Clinical Excellence (NICE) guidance Intrapartum care (NICE2014) includes recommendations on the basic principles for perineal repair which include swab and sharp counts pre- and post-procedure.

Retained swabs reflect the failure of clinicians to comply with practice standards around a clinical procedure.

Broad recommendations

Please see quick reference guidelines.

Responsibilities for swab / sharp counts

- The professional undertaking the procedure is responsible for undertaking the count pre and post procedure and signing for it.
    - They are responsible for supervising that all swabs/sharps are accounted for and obtaining a second signatory.
- Midwives are responsible for counts when working with a student who is undertaking perineal repair.
- Responsibility can only be handed over to another professional with a formal handover of the swab count. This should be documented in the notes.

Recording of swab / sharp counts

- The professional undertaking the repair must have a second person with them to complete the count e.g. MCA, provided they are familiar with this guidance.
- The first count is to be undertaken once the trolley is set up and before the procedure is commenced.
- The confirmed number of swabs/sharps should be documented in the notes, prior to commencing the procedure. The co-signatory should sign the records for the pre count at the time.
- Additional swabs/sharps used must be counted by both parties and added to the board as soon as the count is completed.
- Swabs are available in packs of 5. If a pack is opened and found to contain more or less than this, it should be removed from the room and a new pack opened and counted.
- On completion of the procedure, swabs/sharps counts must be performed and all items accounted for. This is to be documented in the maternity records on the perineal repair pro forma. Best practice is for the co-signatory to remain the same. In the event of this not being possible, a handover must have been given to the person taking over including the swab/sharp count.
- Actual count numbers of swabs/sharps are to be documented in the records, not just count correct YES/NO.
- Trolleys and waste bags should not be removed from rooms until perineal repair is complete and all swabs/sharps are accounted for.
- Sharps should be disposed of as per Prevention and Management of Needle stick and Sharps Injuries (TrustDocs Id: 585)

Count discrepancy

- In the event of a discrepancy between the pre and post count, the person responsible for the repair must make a thorough search.
- If this search does not locate the missing item, the Senior Resident on call should be informed and the patient notified.

- The doctor must make arrangements for the patient to have an X ray to identify if a swab has been retained.
- If a swab is retained, appropriate arrangements will be made by the doctor to remove the item.
- All actions/findings must be clearly documented, including if the X ray confirms that there is no retained swab.
- Datix must be completed.
- Apologies must be offered to the patient for any inconvenience/stress caused. See Being Open Policy (TrustDocs Id: 977).

Auditing and Monitoring Compliance

The process for audit, multidisciplinary review of results and subsequent monitoring of action plans is detailed in the monitoring compliance table **Appendix 1.**

Summary of development and consultation process undertaken before registration and dissemination

The authors listed above drafted this guideline on behalf of the Maternity Guidelines Committee, who have agreed the final content. During its development it was has been circulated for comment to: Consultant Obstetricians, Divisional Director of Midwifery, Risk Manager for Obstetrics and Gynaecology, and Senior Midwives.

This version has been endorsed by the Maternity Guidelines Committee.

Distribution list / dissemination method

DivisionalDirector of Midwifery

Clinical Midwifery Matrons

Risk Manager

Trust Intranet

References / source documents

- Johnson, L. NHS Midlands and East. (2012) *Maternity Never Events Project- Review and thematic analysis of Maternity Never Events 2011/2012 2012/2013 (Q1)* -Final report August 2012.
- National Institute for Health and Clinical Excellence CG190 (February 2017) Intrapartum Care for Heathy Women and Babies London: NICE. Available at:www.nice.org.uk
- National Patient Safety Agency. (2015). *Never Events Framework 2015* London: NPSA. Available at www.nrls.npsa.nhs.uk
- National Patient Safety Agency (2010) *Rapid Response Report RRR012 Reducing the risk of retained swabs after vaginal birth and perineal suturing*. London: NPSA. Available at www.nrls.npsa.nhs.uk/alerts
- NHS Improvement –Never Events policy and framework revised January 2018
- *NHS Improvement –Never Events list 2018 Jan 2018 (updated Feb2021)*
- World Health Organisation (WHO) 2009 ***WHO Surgical Safety Checklist and Implementation Manual*** Available from: http://www.who.int/patientsafety/safesurgery/ss_checklist/en/ Accessed December 2018

Appendix 1
Obstetric Theatre Handover Sticker

Obstetric Theatres – Situation, Background, Assessment, Recommendation

S	Time Date Indication for Surgery Have the membranes ruptured?	ORSOS
B	Gestation BM Obstetric History Blood Loss	Epidural in situ Swab in situ (Green wristband on?)
A	MEOWS	Information
R	What is the plan	
	Theatre Staff Signature	

AFFIX PATIENT LABEL HERE

Receiver to complete and then repeat back key information to ensure understanding **Retain in patient notes with ORSOS care plan**
Version 2. 15/05/2021

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Appendix 1

Element to be monitored (For NHSLA documents this must include all Level 1 minimum requirements)	**Lead Responsible for monitoring** (Title needed and name of individual where appropriate)	**Monitoring Tool / Method of monitoring**	**Frequency of monitoring**	**Lead Responsible for developing action plan and acting on recommendations**	**Reporting arrangements** (Committee or group where monitoring results and action plan progress are reported to)	**Sharing and disseminating lessons learned and recommended changes in practice as a result of monitoring compliance with this document**
a) Standards for record-keeping in relation to all types of perineal trauma	Clinical audit lead	A formalised audit	yearly audit or when clinical risk identified regarding failure to follow guidance	Delivery Suite Matron	Departmental Clinical Governance Meeting	The Lead responsible for developing the action plans will disseminate lessons learned via the most appropriate committee e.g. Clinical Effectiveness; Clinical Governance, Patient Safety and where appropriate, the Compliance Assurance Group.
b) Pre procedure count, signed by 2 staff documented in maternity records	Clinical audit lead	A formalised audit	yearly audit or when clinical risk identified regarding failure to follow guidance	Delivery Suite Matron	Departmental Clinical Governance Meeting	
c) Post procedure count, signed by 2 staff documented in maternity records	Clinical audit lead	A formalised audit	yearly audit or when clinical risk identified regarding failure to follow guidance	Delivery Suite Matron	Departmental Clinical Governance Meeting	

This table should be incorporated into the policy / document in the Monitoring and review section or referenced in this section and attached to the document as an Appendix.