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

Document Control:

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V4.1	12/04/2021	Katherine Stanley Sam Smalley	Obstetric Guidelines committee changed to Maternity Guidelines Committee. Extension granted for 6 months.
V5.0	27/08/2021	Sue Holland Amanda Anderson	Section added on use of **green** wristbands. Process for intentionally retained pack. SBAR sticker used by theatre.
V6.0	23/06/23	Maternity Risk & Governance Facilitator	Removed the need to document in handheld notes; Green wristband procedure

Previous Titles for this Document:

Previous Title/Amalgamated Titles	Date Revised
None	Not applicable

Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

Consultation

The following were consulted during the development of this document:
Matron for Intrapartum Care
Lead consultant for Intrapartum Care
Chief of service for Obstetrics
Associate director of Quality & Safety

Monitoring and Review of Procedural Document

The document owner is responsible for monitoring and reviewing the effectiveness of this Procedural Document. This review is continuous however as a minimum will be achieved at the point this procedural document requires a review e.g., changes in legislation, findings from incidents or document expiry.

Relationship of this document to other procedural documents

This document is a clinical guideline applicable to Norfolk and Norwich University Hospital Trust. Please refer to local Trust's procedural documents for further guidance, as noted in Section 5.

Trust Guideline for the management of Swabs, Tampons and Sharps in the Maternity Services when used for vaginal birth and perineal repair

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1. Introduction

1.1. 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 for Healthy women and babies (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.

1.2. 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).

1.3. Scope

This guideline is intended for use by midwives and obstetric staff providing intrapartum care within the Norfolk and Norwich University Hospital Trust.

1.4. Glossary

The following terms and abbreviations have been used within this document:

Term	Definition
MCA	Maternity Care Assistant
MGC	Maternity Guideline Committee
NPSA	National Patient Safety Agency
NICE	National Institute for Health and Clinical Excellence
CGAP	Clinical Guidelines Assessment Panel
WHO	World Health Organisation
ORSOS	Operating Room Scheduling System
SWAB	Refers to all items used in delivery and perineal repair, gauze, tampons, packs, rolls
Sharps	Refers to all items used in delivery and perineal repair, instruments, needles
Red string	Refers to the string which is tied around the swabs in the packaging.
E3	Maternity electronic notes

2. Responsibilities

- Any maternity or obstetric health professional who is undertaking the procedure is responsible for the pre and post procedure count of swabs, tampons, sharps and red ties and should ensure a **green** alert bracelet has been labelled with swab count and is attached to the wrist alongside the ID bracelet.
- The health professional undertaking the procedure is responsible for recording the swab count pre and post procedure on E3 at the end of the procedure and when all swabs, tampons, sharps and red strings are accounted for.
- The midwife is responsible for pre and post procedure count of swabs, tampons, sharps and red strings 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 count. This should be documented on E3.

3. Processes to be followed

The following processes are to be followed 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).

3.1. Criteria for use of swabs and sharps when used for vaginal birth and perineal repair.

- All swabs should be x ray detectable (swabs supplied in prepacked sterile sets conform to this standard.)
- Cotton wool balls or small swabs should not be used.
- 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.
- If a swab and/or instrument remains in situ for transfer to theatre, refer to section 3.3

3.2. Process for the safe use of swabs, instruments, sharps and red string during vaginal birth or perineal repair.

- Two people are required to do a count of swabs/sharps/instruments and red string prior to the procedure, therefore the professional undertaking the procedure should have a second person with them to complete the count.
- The first count is to be undertaken once the trolley is set up and before the procedure is commenced.
- The whiteboard in the delivery room should be utilised to document and monitor the number of swabs, instruments, sharps and red string used.
- Additional swabs/instruments/sharps/red string should be counted by both parties and added to the board as soon as the count is completed.

- Any swabs, tampons, packs or rolls inserted into the vagina following the birth of the baby, must have the tape or part of the vaginal pack exposed outside the vagina and clipped to the drapes to allow recognition of a pack being in situ. This is in addition to being part of the swab count.
- If a swab is placed inside the vagina, a **green** alert bracelet should be attached alongside the ID bracelet on the patient's wrist. This is mandatory even if the patient does not leave the room.
- If swabs are placed inside the vagina, record the count of swabs in situ on the **green** alert bracelet.
- Do not dispose of any swabs, instruments, sharps or red string until the procedure is complete. Soiled swabs can be placed on the bottom of the trolley until the procedure is complete.
- The swabs, instruments, sharps and red string should be counted when the procedure is complete. It is gold standard for the same two people to do the post procedure count. 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/instruments/sharps/red string are to be documented in the patient record on E3, not just count correct YES/NO.
- The pre-procedure and post-procedure count should be recorded on the patient record on E3, alongside the name of all people involved in the count.
- The **green** wristband should only be removed when all swabs, instruments, sharps and red string has been accounted for unless intentionally retained see section3.3
- 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)

3.3. Process if a swab and/or instrument remains in situ for transfer to theatre.

- **Green** alert bracelet must be attached to the patient's wrist alongside the ID bracelet. The count of swabs in situ must be recorded on the green bracelet.
- The retained items must be included in the verbal handover given to the theatre team by the midwife and documented on the patient record on E3. The theatre team use an SBAR sticker for handover of care (see appendix 1) which they will bring to the room. This 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 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 be returned to the delivery room with the patient to ensure that the items are included in the final count of items originally opened and counted prior to transfer to theatre.
- Removal of the item will be recorded 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
- When possible, the post procedure count of swabs, instruments, sharps and red string should be undertaken by the same two people who did the pre-procedure count prior to transfer to theatre. If this is not possible a full handover should be given at handover.
- The count should be recorded on the patient record in E3.

3.4. Process for swabs to be retained in situ intentionally as vaginal 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 on E3 and on the ORSOS theatre system within the theatre care.
- Ensure that the electronic theatre record is filed in the patient records and/or staff have access to the electronic record.
- A **green** alert bracelet should be placed on the patient's ankle and wrist to clearly indicate an intentionally retained item, it should have the swab count recorded on the bracelet. The patient should be informed and 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 of the vaginal pack should be recorded in the patient record on E3 by the surgeon/clinician removing the item. Detail should include date, time and designation of the person removing the item. **Green** wrist bands can be removed only when the swab has been removed and the count is as recorded on the wrist band. Removal of the wrist bands should also be recorded on the patient record on E3.

3.4.1. Process for 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 arrange 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 on the patient record on E3 including If the Xray confirms that there is no retained swab.
- Datix must be completed.
- Apologies must be offered to the patient for any inconvenience/stress caused. Refer to the 'Being Open' policy (TrustDocs Id: 977.)

4. Training & Competencies

All parties involved in the count of swabs, instruments, sharps and red string should be familiar with the process.

5. Related Documents

Theatre Guideline for the Management of Checking and Counting of Swabs, Sharps and Instruments (including Medical Devices)	Trustdocs Id: 12619
Prevention and Management of Needle stick and Sharps Injuries	TrustDocs Id: 585
Being Open Policy	TrustDocs Id: 977.

6. References

1) 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.

2) 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

3) National Patient Safety Agency. (2015). *Never Events Framework 2015* London: NPSA. Available at www.nrls.npsa.nhs.uk

4) 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

5) NHS Improvement –Never Events policy and framework revised January 2018

6) *NHS Improvement –Never Events list 2018 Jan 2018 (updated Feb2021)*

7) 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

7. Audit of the process

Compliance with the process will be monitored through the following:

Key elements	Process for Monitoring	By Whom (Individual / group /committee)	Responsible Governance Committee /dept	Frequency of monitoring
Standards for record-keeping in relation to all types of perineal trauma. Documentation recorded in E3 by health professional responsible for procedure	Formalised audit	Clinical audit lead	Women and Children's governance team.	Annual audit or when clinical risk identified regarding failure to follow guidance.
Pre-procedure count of swabs, tampons, sharps and red string documented in E3	Formalised audit	Clinical audit lead	Women and Children's governance team.	Annual audit or when clinical risk identified regarding failure to follow guidance.
Post-procedure count of swabs, tampons, sharps and red string documented in E3	Formalised audit	Clinical audit lead	Women and Children's governance team.	Annual audit or when clinical risk identified regarding failure to follow guidance.

The audit results are to be discussed at the Women and Children's governance meeting to review the results and recommendations for further action. Then sent to the most appropriate committee e.g., Clinical Effectiveness, Clinical Governance, Patient Safety or where appropriate the Compliance Assurance Group, who will ensure that the actions and recommendations are suitable and sufficient.

8. Appendices

Obstetric Theatres – Situation, Background, Assessment, Recommendation

Receiver to complete and then repeat back key information to ensure understanding **Retain in patient notes with ORSOS care pla**

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

Version 2. 15/05/2021

8.1 Appendix 1. Obstetric Theatre SBAR sticker for handover of Care

9. Equality Impact Assessment (EIA)

Type of policy	Existing

Division	Women and Children's	**Department**	Maternity
Name of person completing form	Nikki Hill	**Date**	21/06/23

Equality Area	Potential Negative Impact	Impact Positive Impact	Which groups are affected	Full Impact Assessment Required YES/NO
Race	None	None	n/a	No
Pregnancy & Maternity	Failure of clinicians to comply with practice standards can potentially have negative psychological and physical impact.	Education and improved processes will have positive impact due to reduced incidents.	Postnatal women	No
Disability	None	None	n/a	No
Religion and beliefs	None	None	n/a	No
Sex	None	None	n/a	No
Gender reassignment	None	None	n/a	No
Sexual Orientation	None	None	n/a	No
Age	None	None	n/a	No
Marriage & Civil Partnership	None	None	n/a	No
EDS2 – How does this change impact the Equality and Diversity Strategic plan (contact HR or see EDS2 plan)?				

- **A full assessment will only be required if: The impact is potentially discriminatory under the general equality duty**
- **Any groups of patients/staff/visitors or communities could be potentially disadvantaged by the policy or function/service**
- **The policy or function/service is assessed to be of high significance**

IF IN DOUBT A FULL IMPACT ASSESSMENT FORM IS REQUIRED

The review of the existing policy re-affirms the rights of all groups and clarifies the individual, managerial and organisational responsibilities in line with statutory and best practice guidance.