

Dr Jim Livingstone
Director of Safety, Quality and Standards



Department of
**Health, Social Services
and Public Safety**

www.dhsspsni.gov.uk

AN ROINN

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

MÁNNYSTRIE O

**Poustie, Resydënter Heisin
an Fowk Siccar**

Rapid Response Report

Subject:

Reducing the risk of retained swabs after vaginal birth and perineal suturing

For action by:

Chief Executive, HSC Board
Chief Executives, HSC Trusts for cascade to:
*Medical Directors
Directors of Nursing
Heads of Midwifery
CSCG leads*

Chief Executive RQIA for cascade to:
Independent hospitals and clinics

For Information to:

Chief Executive, Public Health Agency
Director of Public Health/Medical Director, Public Health Agency
Director of Nursing, Public Health Agency
Director of Performance Management & Service Improvement, HSCB
Director of Integrated Care
Assistant Director, Primary Care, HSCB
Professor David Woolfson, Head of School of Pharmacy, QUB
Professor Linda Johnston, Head of Nursing & Midwifery, QUB
Professor Hugh McKenna, Head of Life & Health Sciences, UU
Dr Owen Barr, Head of School of Nursing, UU
Professor Paul McCarron, Head of School of Pharmacy, UU
Post Graduate Dean, NIMDTA
Staff Tutor of Nursing, Open University
Director, Safety Forum
Lead, NI Medicines Governance Team
NI Medicines Information Service
NI Centre for Pharmacy Learning and Development

Summary of Contents:

The purpose of this circular is to aid the early detection of retained swabs after vaginal birth and perineal suturing

Enquiries:

Any enquiries about the content of this circular should be addressed to:

Safety & Quality Unit
DHSSPS
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BELFAST
BT4 3SQ

Tel: 028 9052 2239

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Circular Reference: HSC (SQSD)09/10

Date of Issue: 10 June 2010

Related documents

Safer Surgery Checklist
<http://www.dhsspsni.gov.uk/hss-md-18-2009.pdf>
<http://www.dhsspsni.gov.uk/hss-md-18-2009-attachment.pdf>

NICE Guidance: Intrapartum Care: care of healthy women and their babies during childbirth

http://www.dhsspsni.gov.uk/hsc_42
<http://www.nice.org.uk/nicemedia/live/11837/36275/36275.pdf>

Superseded documents

N/A

Status of Contents:

For completion of actions and assurance templates by 10 December 2010

Implementation:

Immediate

SQSD material can be accessed on:

<http://www.dhsspsni.gov.uk/index/phealth/sqs.htm>

Dear colleagues

Reducing the risk of retained swabs after vaginal birth and perineal suturing

The National Patient Safety Agency (NPSA) advise that swabs are used in maternity care for cleansing and to absorb blood and other fluids. They are usually pre-packed in delivery and suture packs. Swabs can be difficult to identify once soaked in blood and are sometimes mistakenly left inside the vagina. Retained swabs following a vaginal birth are a source of maternal morbidity, including pyrexia, infection, pain, secondary post-partum haemorrhage and psychological problems.

The content of the attached circular at Annex A has been reviewed by relevant professional colleagues in the Department and approved for regional dissemination.

I would ask you to bring this to the attention of relevant practitioners and key health and social care staff within your organisation. They should consider the best practice for their setting and take appropriate steps to minimise the risks to patients.

I would also draw your attention to the attached 'assurance template' which is a means of recording the response from the Trusts and Board in circumstances where SQS Circulars require action to be taken by a given date.

Yours sincerely



Dr J F Livingstone
Director, Safety, Quality & Standards

Reducing the risk of retained swabs after vaginal birth and perineal suturing

Issue

1. Swabs are used in maternity care for cleansing and to absorb blood and other fluids. They are usually pre-packed in delivery and suture packs. Swabs can be difficult to identify once soaked in blood and are sometimes mistakenly left inside the vagina. Retained swabs following a vaginal birth are a source of maternal morbidity, including pyrexia, infection, pain, secondary post-partum haemorrhage and psychological problems.

National Context

2. Between 1 April 2007 and 31 March 2009, the National Patient Safety Agency (NPSA) received 99 reported incidents of swabs being left in the vagina following birth. Only incidents of retained vaginal swabs identified in the postnatal period were included. In total 34 reports described signs of infection, such as offensive/foul smelling lochia (vaginal discharge) and/or the prescription of antibiotics.
3. NPSA/2010/RRR012: Reducing the risk of retained swabs after vaginal birth and perineal suturing is available on:
<http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=74113>

Local Context

4. All HSC organisations and independent sector organisations providing maternity services should ensure that they:
 - have written procedures in place for swab counts at all births (including perineal suturing);
 - audit swab count practices in their maternity services;
 - provide education and training about the counting procedure for all midwifery, obstetric and support staff;
 - ensure that all professionals (midwives and obstetricians) are aware of their responsibility for documenting the completed swab count in the woman's health record. The new NI Maternity Hand Held Record has a documentation sheet incorporated in which professionals must document their swab count following examination of /or suturing of the perineum;
 - in conjunction with their supplies department, risk assess sterile delivery and perineal suture packs and consider using x-ray detectable swabs;
 - ensure staff report incidents of swabs retained after vaginal births and perineal suturing as patient safety incidents;
 - cascade the clinical briefing sheet to relevant staff to raise awareness of the risks of swabs being unintentionally retained following vaginal births and perineal suturing.

Action Required

5. You will wish to bring the contents of this document to the attention of relevant staff, particularly those involved in governance and risk management within your organisation. Organisations need to be aware of this best practice circular in order to assist in complying with the Quality Standards for Health and Social Care –
 - i. Criteria 4.3(i) (the appropriate management of risk);
 - ii. Criterion 5.3.3(f) (implementation of evidence-based practice through guidance, for example, NPSA guidance). and
 - iii. Criteria 8.3(l) (effective communication and information)
6. HSC Trusts should take immediate action to implement this Rapid Response Report as outlined in paragraph 4 above by 10 December 2010. Trusts should provide assurance on this action to the HSC Board by completing Section 1 of the attached template.
7. The HSC Board should complete Section 2 of the attached assurance template and forward to the Department by 7 January 2011.

SQS CIRCULARS: ASSURANCE TEMPLATE FOR HSC BOARD AND TRUSTS

**Circular number: HSC (SQSD) 7/10
For Implementation by: 10 December 2010**

(Section 1 is to be completed by HSCT and forwarded to HSCB for consideration. Section 2 should then be completed by HSCB and forwarded to DHSSPS)

SECTION 1:

To: Chief Executive, HSC Board

I can confirm that the required actions set out in the above circular have been implemented in full by the due date.

I can confirm that the actions in the above correspondence have been partially implemented by the due date. The issues impacting on full implementation along with the timescales for resolving these issues are set out in the box below:

I can confirm that the organisation has been unable to implement any actions of the above circular for the reasons set out in the box below. (The actions being taken/required to resolve or clarify the issues preventing implementation and the timescales for this should be outlined):

I confirm that the HSC Trust's Chief Executive and designated senior manager have been advised of this response and are content that it should be submitted to the HSC Board.

Response submitted by: _____ (Name & contact details of person submitting response) on behalf of _____ HSC Trust. Date:

SECTION 2:

To: Director, Safety, Quality & Standards Directorate, DHSSPS

I note the response from the Trust and –

I can confirm that the HSC Board is content the action(s) taken, referred to in Section 1, complies with the requirements of the above circular.

I can confirm that further action, as outlined in the box below, is needed to ensure compliance with the requirements of the above circular

I confirm that the HSC Board's Chief Executive and designated senior manager have been advised of this response and are content that it should be submitted to the Department.

Response submitted by: _____ (Name & contact details of person submitting response) on behalf of HSC Board. Date: _____