Oxford University Hospitals NHS
NHS Foundation Trust

Oxford Academic Health Science Network
PATIENT SAFETY

Reducing Swab Retention Never Events in Maternity

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The problem

Retained vaginal swabs occurred on average 1:180 days 2012-2015. There were two never events in 2015 where swabs were left in situ of a woman post birth. This can lead to infection, depression, lack of bonding and multiple use of antibiotics. A quality improvement project to reduce retained swabs began in September 2015.

SWABS:

- SAVE IT
- SAY IT
- SIGN IT

Method

Test of Change 1: Improve handover of swabs from Delivery Suite to Theatres

- Updated swab policy to improve handover
- Sterile bag introduced into birth pack when transferring a woman with a swab in situ.

Test of Change 2: Improve handover of a known vaginal pack from Delivery Suite to Observation Area

- Vaginal pack sticker placed on woman's hand.

Sterile bag to transfer swabs in

Vaginal Pack sticker placed on woman's hand

Results

Outcome data:

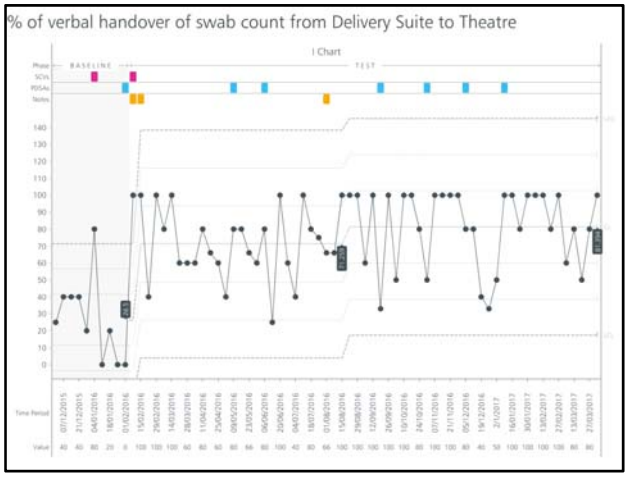
- More than 600 days incident free (as of April 2017 since the last never event).
- 102 days since the last near miss, previously one near miss every 5.5 days .

Process data:

Written and verbal handover of swabs from Delivery Suite to Theatres has improved dramatically.

- Verbal handover: 27% - 77%
- Written handover: 4% - 63%
- Following all 3 aspects of the swab policy at transfer when swab in situ: 0% – 95%
- Vaginal pack sticker is now used 89% of the time and women find it reassuring.

Example chart showing process data



Conclusions and Lessons Learnt

- Small, cost efficient changes have made significant improvement
- Collaborative working with senior management essential
- Proactive project team including front line staff ensures changes are at the forefront of working practice
- Involvement of a range of staff (all grades) to process map the situation
- Feedback from women essential about how the intervention effects them.
- Can we rely on handover alone or does technology have a part to play?

Visit our website for more information on this project:
http://www.patientsafetyoxford.org/clinical-safety-programmes/safety-in-maternity/