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Never Event - RCA and learning

RCA – brief summary

- Low risk primip, term, spontaneous labour, transferred to DS but CTG reassuring
- Good progress but forceps delivery in room for failure to progress in second stage
- Maternal cardiac arrest emergency call during suturing – both MW and Registrar left room
- Registrar busy with eclampsia case
- MW completed suturing

RCA – never event

- 5 weeks later, patient visited practice nurse for coil fitting – found ping pong sized ball of retained swab.
- Swab discarded, no concerns raised
- Patient phoned community MW
- Never event instigated

Investigation

- Suture pack contents including swabs
- Photos of blood stained swabs taken to Practice nurse for identification
- Emergency call log
- Audit of perineal repair documentation

Audit of Perineal Repair Documentation

Table 4 – Process of repair (n=28)

	Yes	Not documented	Outcome
Documentation of consent	28 (100%)	0	3
Suture material: 2.0 Vicryl rapide	26 (92.85%)	2 (7.14%	2
PR post-repair	24 (85.71%)	4 (14.28%)	1
Pre-repair swab count	18 (64.28%)	10 (35.71%)	1
Post-repair swab count	26 (92.85%)	2 (7.14%)	2
Post-repair instruments and needles count	26 (92.85%)	2 (7.14%)	2
Was the repair performed within 1 hour of the delivery of the placenta	26 (92.85%)	2 (7.14%)	2

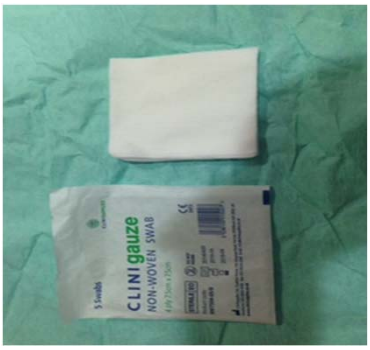
Suturing Guideline

- **Swabs:** must be 'counted out' in fives by the 'repairer' ***preferably*** to a witness, collected in a separate bucket during the procedure and 'counted in' to a witness after the repair is completed. A signature is required to confirm this has happened
- **1st recommendation** – Episiotomy and perineal guideline should be changed, "(***preferably***)" should be removed from the swabs section, to ensure the count is always witnessed."
- **2nd recommendation** – The perineal repair page is adjusted and has areas assigned for 2 signatures for pre and post procedure counts.
- **3rd recommendation** - All staff to be made aware that 2 signatures are required for counting swabs, needles and instruments following any suturing, with immediate effect

Action Plan (1)

(i) change in suture packs (ii) Change in suturing policy – all swabs to be counted , checked and signed by 2 trained personnel (iii) If another practitioner takes over during the procedure then a recount must take place. (iv) Change in policy to be disseminated to all staff	(i) All small, non X-ray detectable swabs to be removed (ii) Preprinted suture sheet to be amended to highlight need to record presuturing swab count and post suturing to be checked with 2 trained personnel (iii) Education and training to update all staff of above

Swabs used previously

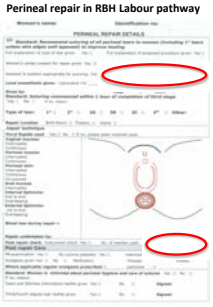


New Suture packs

Documentation of swab counts

"If another practitioner takes over during the procedure then a recount must take place."

Perineal repair in RBH Labour pathway



Perineal repair on K2

Action Plan (2)

Shared learning	• Report to be presented at local Clinical Governance and shared at • Academic Half Day. • In discussion with Oxford AHSN regarding regional presentation and sharing learning more widely • Share with CCG/local GP practice

Near -miss with Vaginal Pack

- Retained swabs - never event
- Vaginal packs also can be retained – forgotten after transferred to wards
- Pink wrist band

Never Events

"Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers

1100 cases in last 4 years (1 in every 38,000 procedures)

Never Say Never – from Roy Lilley's blog Feb 2016

- It seems to me there is something wrong with the notion of a 'never' event. We are kidding ourselves; they are not 'never', they are happening. Perhaps we need 'always' events.
- We '*always*' want strategies that improve the outcomes of care. *Always* want comprehensive and accessible data and records. We *always* use standardised and universal approaches to care. We *always* want great training and better communications, assertiveness, team working and time for debriefings. *Always* use succinct and clear check-lists and *always*, *always* speak up if we see something going wrong.
- I think we can say we will *always* strive to do better, *always* find out the gaps, the loops, the interfaces, the errors, mistakes, system failures and *always* dig-out why stuff goes badly wrong.