Oxford University Hospitals NHS
NHS Foundation Trust

Oxford Academic Health Science Network

Quality Improvement Project

Reduce retained swab never events in maternity to zero by November 2018

Oxford Academic Health Science Network

Background

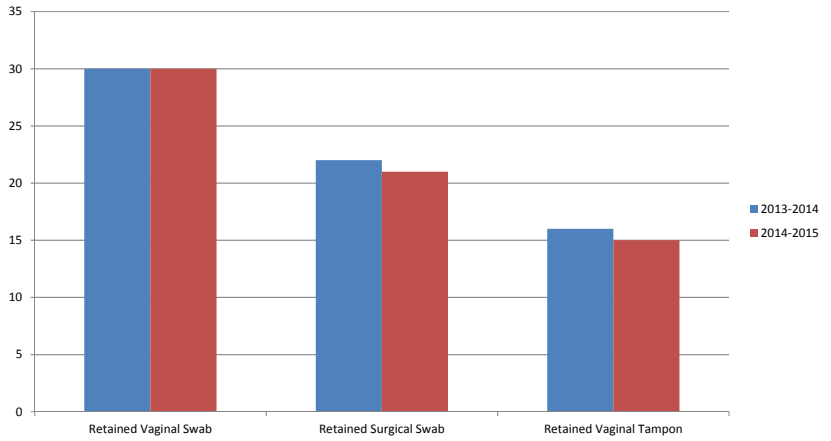
Maternity at the Oxford University Hospitals NHSFT wanted to reduce the incidence of retained swabs.

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Collated annually by NHS England

Oxford Academic Health Science Network

Never Events NHS England – retained foreign object post procedure



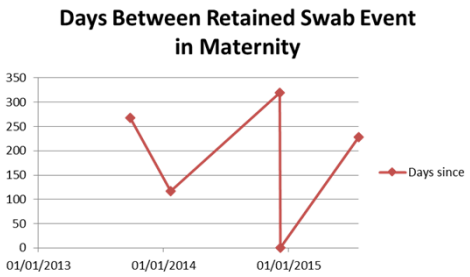
Oxford Academic Health Science Network

Start of Project

6 Events over 3 years
DATIX

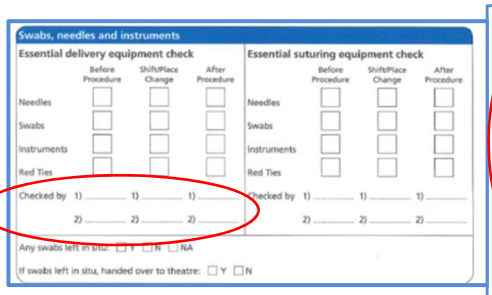
Days between incidents
1-319
4 occurred in the months January and December
No pattern evident
Currently - 356 days between incidents

In the last 7 months since the project started there have been 5 incidents of swabs left in situ and not handed over.
Theatre staff have noted these so they have not been classified as never events

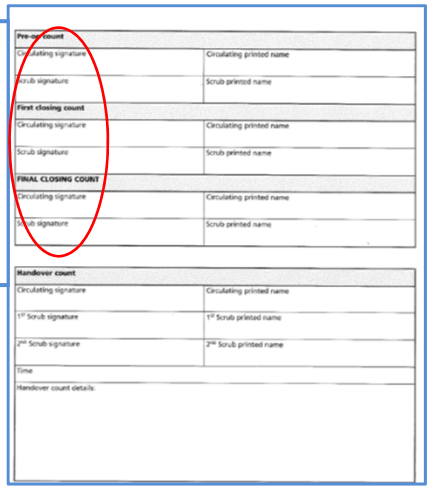


Oxford Academic Health Science Network

Review of the Current Practice?



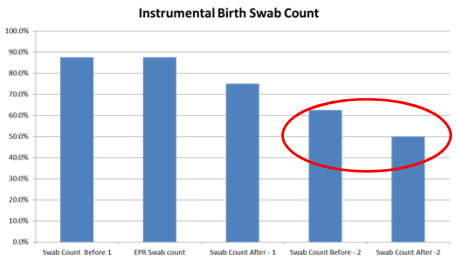
EPR



Oxford Academic Health Science Network

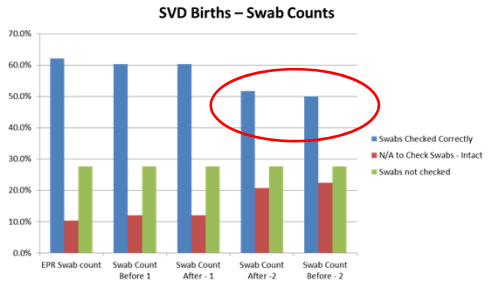
- Audited maternity notes to look at current practice
- January – July 2015
- 68 notes from JR including caesarean sections and vaginal births
- 35 notes from the Horton including caesarean sections and vaginal births
- Reviewed 5/6 incidents of retained swabs over the last 3 years

Pareto Charts Vaginal Births

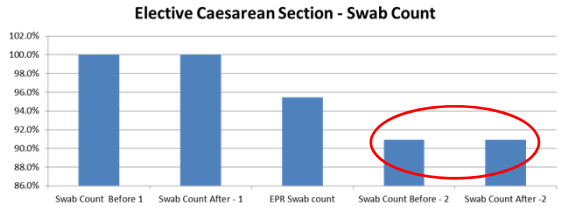


Almost 90% of 1st signature and EPR documentation of swab counts
Double checking of swabs 50-60%

Around 72% of swabs checks were done by one person and entered onto EPR.
Double checking of swabs with a 2nd person remains the area of concern

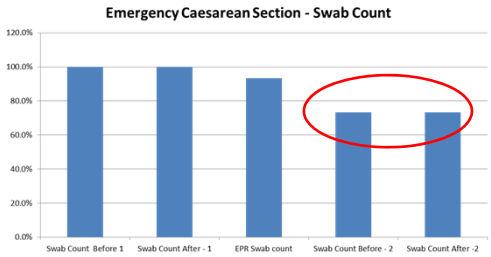


Pareto Charts Theatre Cases



For both elective and emergency caesarean section, the swab count of the first person checking was 100%

Between 75% - 91% of signatures to demonstrate double checking of swab counts were present



Oxford Academic Health Science Network

The Voice of the Woman

- I have been really worried about what was wrong with me and why I had so many infections
- I've lost vital bonding with my baby
- I'm concerned about the amount of antibiotics I was taking
- I've had numerous visits to the GP and examinations
- I've been in constant pain
- It's taken 5 months to sort this out – time lost with my baby

Oxford Academic Health Science Network

Feedback from Staff

So it is a busy night shift. We walk into Cat 1 section in theatre 1, and on the middle of the procedure they shout for another Cat 1 in theatre 2. On night shifts there are just 2 scrub nurses, so this meant no runner. Also there was no porter on the shift, which meant that scrub nurses have to also clean the theatre.

After the Cat 1, we had a bleeding manual removal of placenta coming to theatre 1. When we finished in theatre 2, there was another section to follow. We finished on both theatres about the same time, only to be followed with another case, another manual removal of placenta.

Its about 4am and with no breaks so everyone is really tired. We ask, "are there any swabs left in situ or any instruments". "No" from the member of staff who also has had a busy shift.

The epidural is topped up and we wait for it to take effect. When its time to lift the legs up, we notice that there are 2 x spencer wells clamps on the cord. Plus one swab in vagina and 2 swabs just laying on the sheets...

Oxford Academic Health Science Network

"If you always do what you have always done, you will always get what you have always got!"

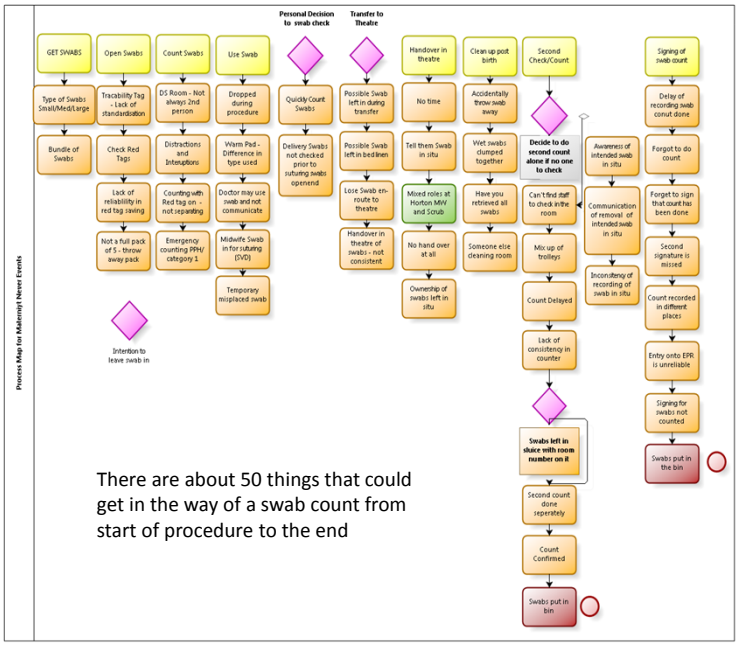
Don Berwick

Oxford Academic Health Science Network

Team Gathered

- Midwifery Support Worker
- Theatre Staff Nurse
- Junior Midwife
- Delivery Suite Co-ordinator
- Perinatal Risk Manager
- Delivery Suite Manger – HGH
- Practice Development Midwife

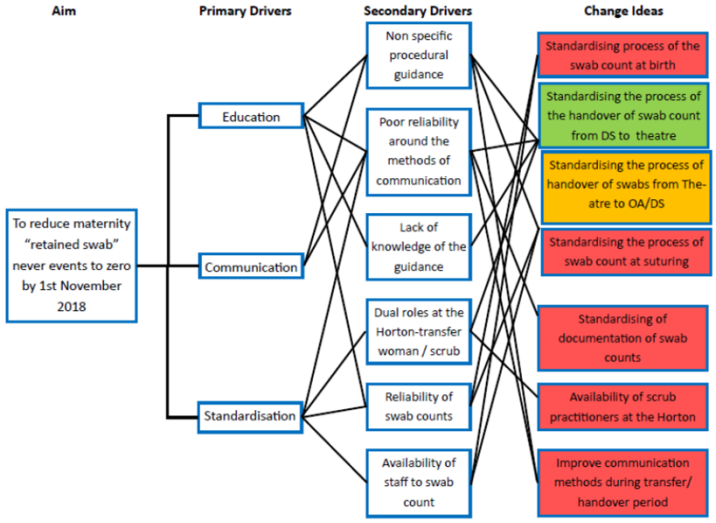
Process Map



There are about 50 things that could get in the way of a swab count from start of procedure to the end

Oxford Academic Health Science Network

Driver Diagram



Oxford Academic Health Science Network

Tasks before the test of change

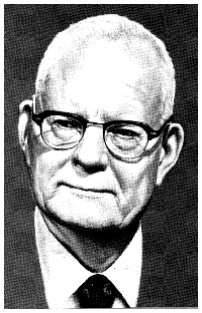
- Register project with trust clinical governance
- Agree what the procedure should be
- Amend current policy and ratify at WCGC
- Cost, agree and add paper bag to sterile delivery pack
- Design poster for the ward areas
- Plan roll out of first test of change/informing staff of changes
- Collect baseline data

Oxford Academic Health Science Network

Data

"Without data you're just another person with an opinion"

William Edwards Deming



Oxford Academic Health Science Network
www.oxfordahsn.org

Oxford University Hospitals NHS
NHS Foundation Trust

Maternity Theatre Data Collection Sheet

Please complete the boxes below, ticking only one reason why the woman was transferred to theatre (data only being collected for MROP/Suturing/EUA)
Circle **either** Y or N for the other boxes

MRN	Date	Time	MROP	Suturing	EUA	Verbal Handover Y/N	1st signature on handover	2nd Signature on handover	Swabs following patient	Swabs left in room	Was there a swab in situ that was not handed over
						Y/N	Y/N	Y/N	Y/N/NA	Y/N/NA	Y/N
						Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
						Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
						Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
						Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
						Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
						Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
						Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
						Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
						Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
						Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
						Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
						Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

Oxford Academic Health Science Network

New Policy

Transfer of Women to Theatre

When transfer to theatre is required after a pack has been opened (for example where a Manual Removal of Placenta (MROP) or suturing is required) a full count must take place before the woman is transferred to theatre. If it is clinically necessary to transfer the woman with an item from the original pack in-situ all members of the team must be made aware and the rest of the original pack of swabs must be placed in the yellow striped bag (available in the delivery pack JR/with delivery equipment HGH) along with the red string and transferred to theatre with the woman. If multiple packs have been opened, all swabs and red strings must be transferred.

Oxford Academic Health Science Network

The transferring midwife and theatre nurse will count the swabs together, mark the number and sign on the summary of labour and birth document to state they are handed over. NA will be written for the instrument count as they will stay in the room (the instruments remain the responsibility of the lead midwife and should be signed as correct post procedure – see below). If the woman is transferred to theatre with no swab in-situ, all swabs opened in the room and red strings will remain in the room. None should be transferred to theatre. The midwife and theatre nurse will sign the labour and birth summary document to note that there are no swabs in-situ.

Swabs, needles and instruments

Essential delivery equipment check

	Before Procedure	Shift/Place Change	After Procedure
Needles	NA	NA	NA
Swabs	5	5	NA
Instruments	5	NA	5
Red Ties	1	1	NA
Checked by	1) Midwife 1 2) Midwife 2	1) Midwife 1 2) Theatre 1	1) Midwife 1 2) Midwife 2

Essential suturing equipment check

	Before Procedure	Shift/Place Change	After Procedure
Needles			
Swabs			
Instruments			
Red Ties			
Checked by	1) ..... 2)	1) ..... 2)	1) ..... 2) .....

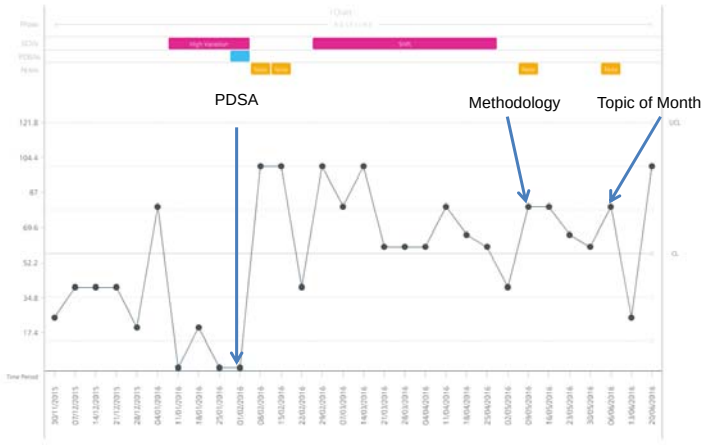
Any swabs left in situ: ☐ Y ☐ N ☐ NA ← Midwife and Theatre Practitioner **SIGN and tick here** if **NO** Swabs in situ to confirm handover happened!

If swabs left in situ, handed over to theatre: ☐ Y ☐ N

Oxford Academic Health Science Network

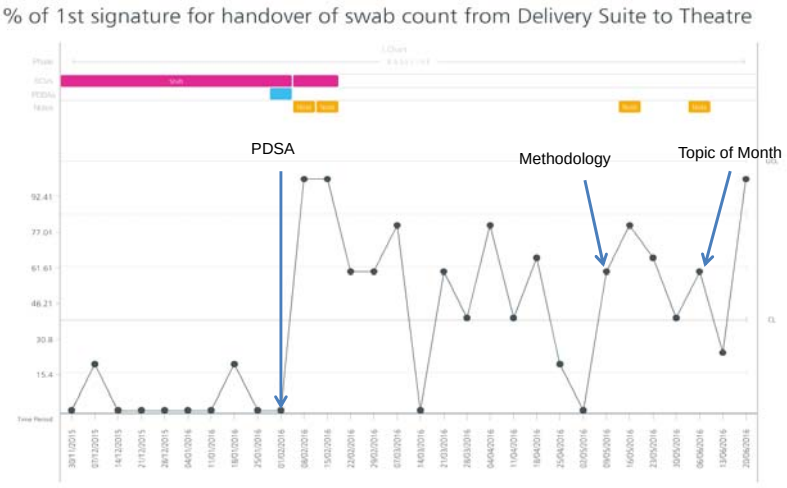
% of Verbal Handover

% of verbal handover of swab count from Delivery Suite to Theatre



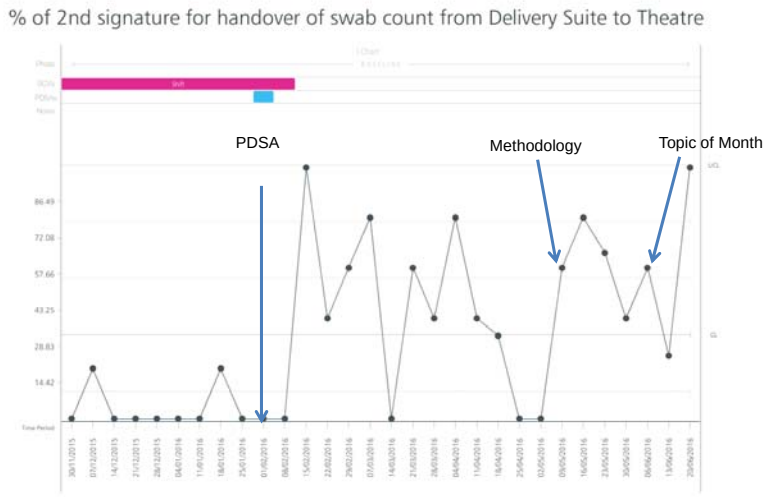
Oxford Academic Health Science Network

% First Signature on Handover



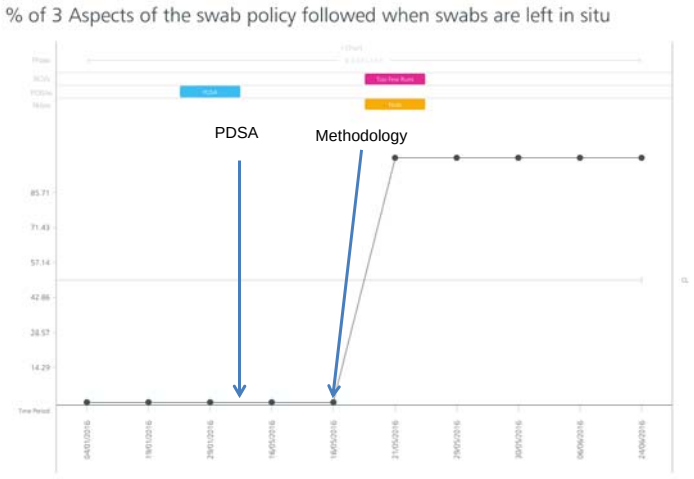
Oxford Academic Health Science Network

% Second Signature on Handover



Oxford Academic Health Science Network

% of 3 aspects of policy followed



Oxford Academic Health Science Network

Moving Forward

- Review how to sustain improvement
- Continue to spread the word of the updated guidance
- Design 2nd PDSA – handover of intentional packs
- Continue to collect data
- Move forward to improve other areas where swab counts are involved

Oxford Academic Health Science Network

Thanks

The maternity never event project team

- Jenny Brown – Theatre Staff Nurse
- Marina Thomson – Delivery Suite Co-ordinator
- Karen Beecroft – Practice Development
- Clare Pagett – Perinatal Risk Co-ordinator
- Rachel Chakravarti – Delivery Suite Manger HGH