

# Rapid Response Report

NPSA/2010/RRR012

From reporting to learning

26 May 2010

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

### Issue

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. Maternity services in England and Wales promote normal birth and it is recognised that there are a number of different birth environments, including the home. However, wherever swabs are used they should be accounted for every time.

### Evidence of harm

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. The degree of harm assigned to these incidents ranged from no harm to severe. A review of the NHS Litigation Authority (NHSLA) closed claims from 1 April 2007 to 31 March 2009 found 18 relevant cases relating to retained vaginal swabs in maternity services.

### Reducing the risk of harm

In 1997 the Association for Perioperative Practice in the UK (AfPP) published recommendations for inclusion in local policy to assist staff performing swab, instrument and needle counts in perioperative settings, which can be adapted for use in maternity services.

**For IMMEDIATE ACTION by all NHS organisations providing maternity services. The deadline date for ACTION COMPLETE is 26 November 2010.**

**Actions should be led by the director of nursing supported by the head of midwifery.**

NHS organisations should:

1. have written procedures in place for swab counts at all births (including perineal suturing);
2. audit swab count practices in their maternity services;
3. provide education and training about the counting procedure for all midwifery, obstetric and support staff;
4. ensure that lead professionals (midwives and obstetricians) are aware of their responsibility for documenting the completed swab count in the woman's health record;
5. in conjunction with their supplies department, risk assess sterile delivery and perineal suture packs and consider using x-ray detectable swabs;
6. ensure staff report incidents of swabs retained after vaginal births and perineal suturing as patient safety incidents;
7. 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.

**Further information** on this Rapid Response Report is available at [www.nrls.npsa.nhs.uk/alerts](http://www.nrls.npsa.nhs.uk/alerts)

The NPSA has informed NHS organisations, the independent sector, commissioners, regulators, industry and relevant professional bodies. Any queries should be directed to [rrr@npsa.nhs.uk](mailto:rrr@npsa.nhs.uk)

Gateway ref: 14333

© National Patient Safety Agency 2010. Copyright and other intellectual property rights in this material belong to the NPSA and all rights are reserved. The NPSA authorises UK healthcare organisations to reproduce this material for educational and non-commercial use.