PULSUS
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J Nurs Res Pract, Volume 3 |
ISSN: 2632-251X

Annual Congress on

MIDWIFERY NURSING AND GYNAECOLOGY

December 04-05, 2019 | Dubai, UAE

# Quality improvement project: Reducing the swab retention during vaginal delivery

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In a universe of 8500 deliveries per year, between December of 2015 and March 2016, 4 incidents of swabs left in the vagina during the delivery were described on the safety reported system, with respective readmission of the patients for treatment. This repeated occurrence in a period of 4 months was an opportunity to reflect on clinical practices.

Swabs are used by obstetricians and midwives during vaginal delivery and perineal repair to clean and absorb blood. They can be difficult to identify once soaked in blood and are occasionally left inside the vagina by mistake. Retained vaginal swabs were more common than surgical swabs or any other category of foreign object. The impact of retained vaginal swabs can be severe. Women may experience serious physical and psychological complications including infection, secondary post-partum hemorrhage, sepsis, and depression, lack of bonding with their baby due to re-hospitalization and finally, loss of trust in the health organization with consequent discredit by the population. In addition, they represent a significant problem in that they are very difficult to be defended in clinical negligence litigation, as they reflex the failure of clinician to comply with practice standard. The repercussions can harm the professionals as a 'second victim'. Organizational consequences can be financial and reputational, as never events are considered to reflect quality and safety processes within an organization. Therefore, maternity service provider must put measures in place to manage this preventable clinical risk.

**Aim of the Project:** To implement a highly reliable and standardized count process during all vaginal births that was more in line with structured counts of the perioperative process. As consequence was expected to reduce the risk of retained swabs during vaginal delivery.

**Strategies for improvement:** The 4 incidents that happed in the maternity during December 2015 and March 2016, 3 were very similar situations. After delivery, the 3 patients needed to undergo perineum revision / repair under general anesthesia. The L/D team is a different team from OR and on these 3 cases, the handover does not contemplate that the patients were with vaginal swab to contain the blood lost.

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