COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE

safe health care for every woman

PATIENT SAFETY BUNDLE

Prevention of Retained Vaginal Sponges After Birth

READINESS

Every unit

- Educate all members of the health care team on the importance of preventing retained vaginal sponges.
- Educate all members of the health care team on proper counting and documentation techniques.
- Establish a process for preventing retained vaginal sponges in every birth setting that includes role assignments for all members of the health care team. Use sponge detection system (e.g. pelvic x-ray with radiopaque sponges or radio-frequency identification) when available.

RECOGNITION & PREVENTION

Every patient

- Perform opening count of all vaginal sponges and record the count in the birth record and in a location visible by all members of the health care team. *
- Place all used sponges into a separate receptacle or area of table for ease of retrieval during closing count.
- Perform closing count of all vaginal sponges and record the count in the birth record.
- Confirm absence of sponges in the vagina through validation of correct closing count and visual examination/inspection of the vagina and document in the birth record.

*In the event of a precipitous birth, the initial count should be performed immediately after birth before items on table are disturbed (except items immediately necessary for birth).

December 2017

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RESPONSE

To an incorrect closing count

- Conduct recount of used sponges, carefully search room (all drapes, kick buckets, and linens), and explore vagina, paying attention to vaginal fornicies to identify missing sponges.
  - If missing sponge is located, record correct closing count in birth record.
  - If missing sponge remains unaccounted for, utilize sponge detection system to rule out retained sponge.
    - If missing sponge is located, record correct closing count in birth record.
    - If missing sponge is not located, or in settings where sponge detection systems are unavailable, record the closing count as incorrect in the birth record and inform the patient of discrepancy in count.

REPORTING/SYSTEMS LEARNING

Every unit

- Establish a culture of safety and accountability in every birth setting.
- Develop a process for effectively documenting the sponge count for every birth and informing patient of discrepancies in count.
- Conduct multidisciplinary review of cases of retained vaginal sponge.
- Monitor outcome and process metrics.

This bundle is not intended for patients who are transferred to the operating room nor patients who have intentional, documented vaginal sponge/pack left in place. Organizations are encouraged to have institutional policies for monitoring, documenting, and accounting for these situations

Standardization of health care processes and reduced variation has been shown to improve outcomes and quality of care. The Council on Patient Safety in Women's Health Care disseminates patient safety bundles to help facilitate the standardization process. This bundle reflects emerging clinical, scientific, and patient safety advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Although the components of a particular bundle may be adapted to local resources, standardization within an institution is strongly encouraged.

The Council on Patient Safety in Women's Health Care is a broad consortium of organizations across the spectrum of women's health for the promotion of safe health care for every woman.

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