



APPLY “SPONGE/GAUZE AND NEEDLE CHECKLIST” FOR PREVENTION OF A RETAINED SPONGE AFTER VAGINAL DELIVERY

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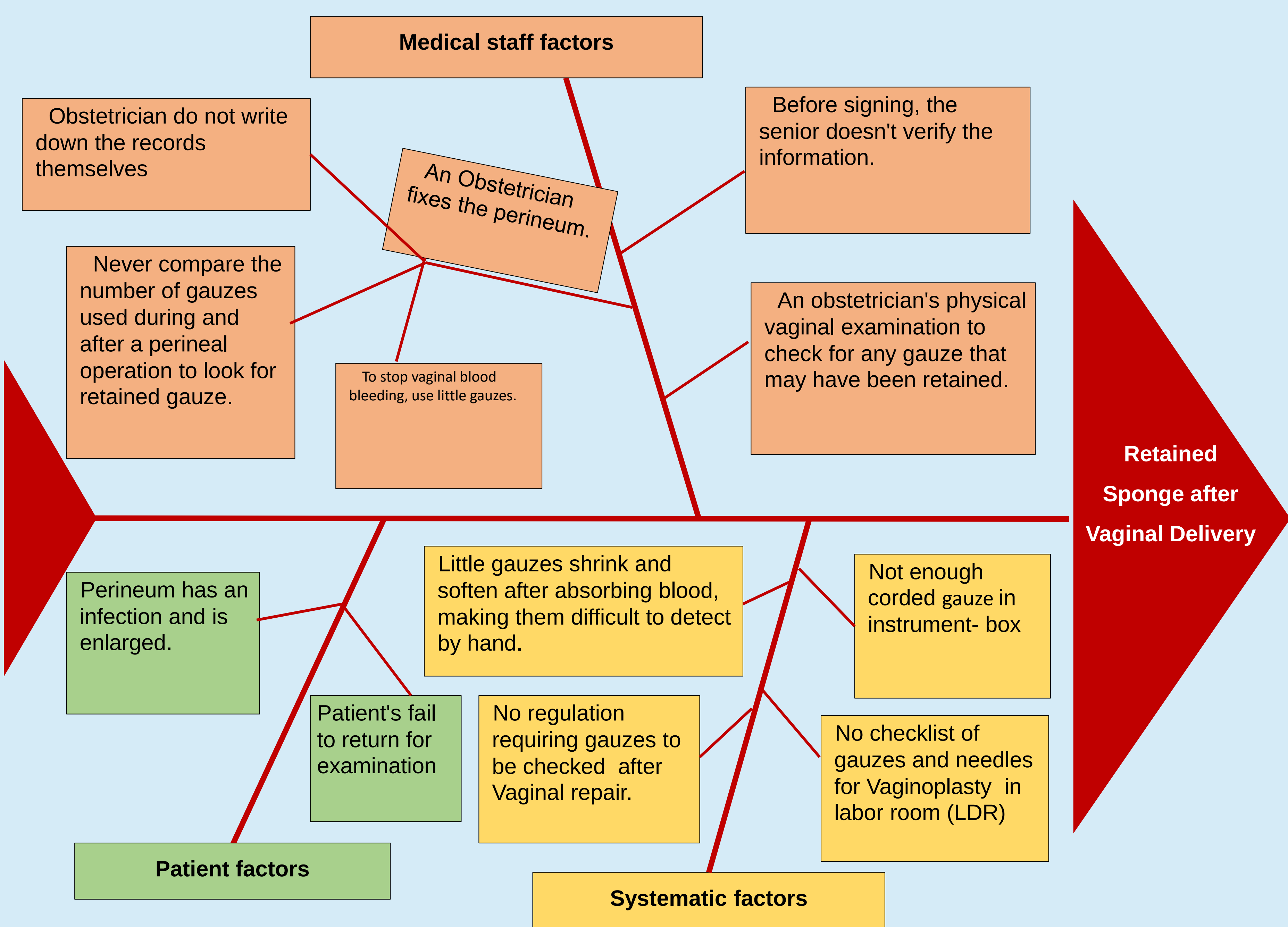
INTRODUCTION

There was a case of a retained vaginal sponge following an uncomplicated spontaneous vaginal delivery. Quality management department send link surveys to medical staff (N=54), Result in 74% of medical staff used to detect retained gauzes in vagina following vaginal delivery.

OBJECTIVES AND METHOD

To find factors related to retained sponge after delivery via conducting root cause analysis. Solutions applied to prevent retained sponge after vaginal delivery including: (i) Apply the “Sponge/Gauze and needle checklist” for 100% of cases using gauzes/sponge or/and needles during the operation (ii) Supply the checklist to HCW at every labor room; (iii) This checklist will be kept in medical record at the end of the procedure; (iv) An obstetrician performs the skills by writing down the records himself. Before signing the application, an obstetrician must review the information carefully; (v) Use corded gauze rather than loose little gauze to stop vaginal bleeding.

RESULTS

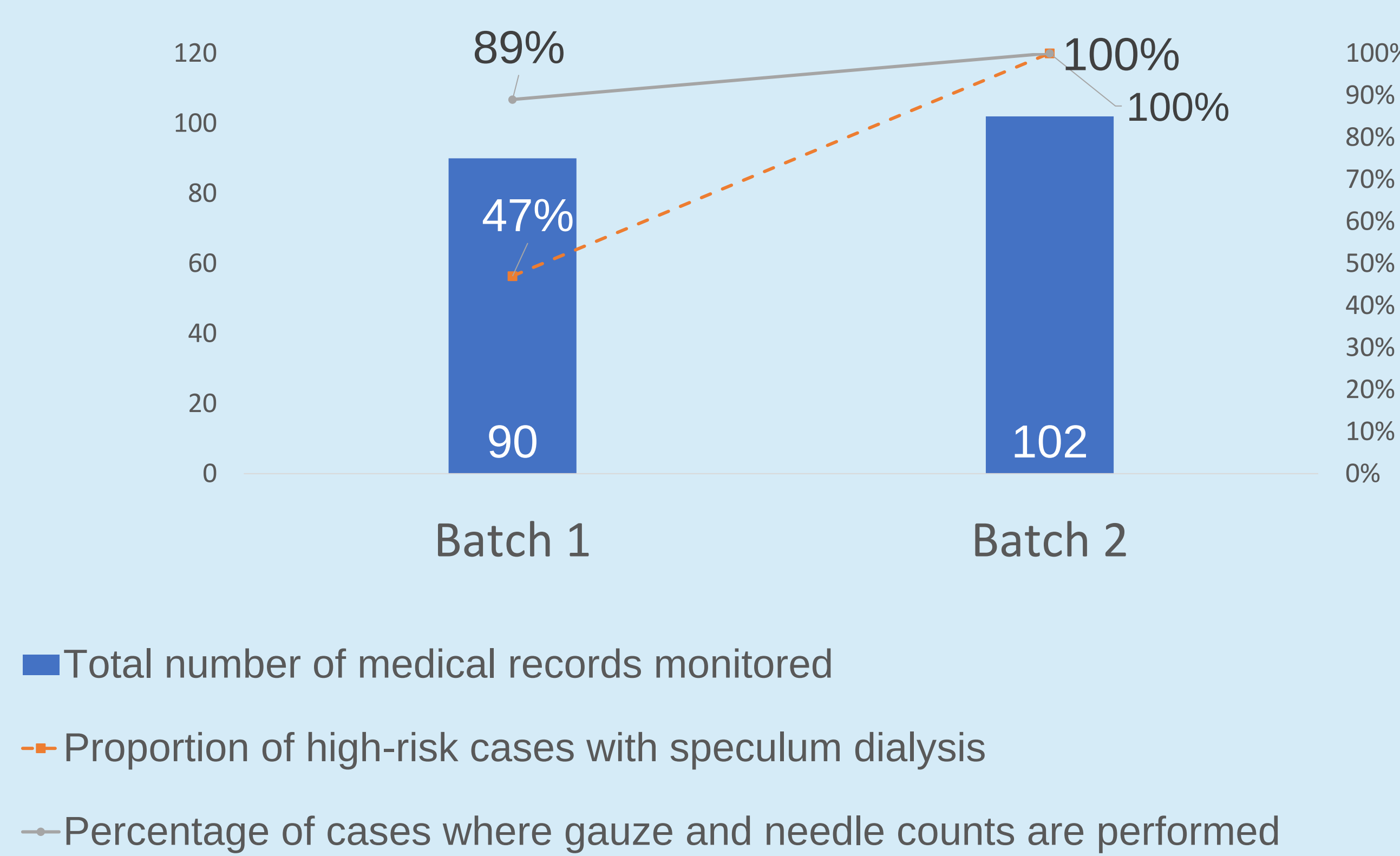


From 29/6/2022 to 17/10/2022, tools used in all cases requiring vaginal intervention at the Delivery Department (gauze, needles).

- All vaginal deliveries in the high-risk category should undergo a speculum examination before discharge.
- 100% of vaginal births who returned to exam without any evidence of missing gauze.

Gauzes/Sponge and needle checklist							
Dd mm yy							
Full name of patient							Finish
Year of birth							
Name of surgeon							
Time	Hrs min	Hrs min	Hrs min	Hrs min	Hrs min	Hrs min	Total before:
Number of tailed sponge							Total before:
Number of small gauzes							Total after:
Number of 30*10cm gauzes							Total before:
Number of needles							Total after:
Name who supply							Total before:
Leave sponge/ gauzes in vagina: ☐ Yes ☐ No							
Note:							
Last surgeon (sign and full name)				Last supplier (sign and full name)			

Graph comparing the results of 2 monitoring batches



CONCLUSIONS

This places a focus on using checklists to improve patient safety and prevent medical mistakes.

ACKNOWLEDGEMENT

We are grateful to the board of director, the incident reporting managers as well as doctors, midwives of Hung Vuong hospital who involved in developing and using this checklist.

REFERENCES

- Roadmap to preventing retained objects in vaginal deliveries, Minnesota Hospital Association.

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