To:	**Trust Board**
From:	**Chief Nurse**
Date:	**27th February 2014**
CQC regulation:	Outcome 16

Title:	**Never Event**

Author/Responsible Director: Director of Safety and Risk

Purpose of the Report:

This report is to advise the Board of a Never Event which was escalated on the 21st February 2014.

The Report is provided to the Board for:

Decision		Discussion	x
Assurance	x	Endorsement	

Summary / Key Points:

- A thirty year old lady underwent an instrumental delivery on the 25th December 2013 and was discharged home the following day. On the 14th February 2014 the lady was admitted to the Maternity Assessment Unit and a medium sized vaginal swab was removed. This incident constitutes a Never Event – "Unintended retention of a foreign object in a patient following vaginal birth".

Recommendations:

The Trust Board is requested to note this report and the immediate actions that have been put in place following this Never Event.

Previously considered at another corporate UHL Committee?

Strategic Risk Register:	**Performance KPIs year to date:** Red compliance – three Never Events reported in 2013/14.

Resource Implications (eg Financial, HR):
Patient episode payment will be withheld in line with the Never Events Framework Regulations.

Assurance Implications:
Immediate actions to avoid a repetition have been implemented.

Patient and Public Involvement (PPI) Implications:

Stakeholder Engagement Implications:

As above.

Equality Impact:
Information exempt from Disclosure: Patient identifiable details
Requirement for further review? Through Executive Quality Board and Quality Assurance Committee.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **27TH FEBRUARY 2014**

REPORT BY: **CHIEF NURSE**

SUBJECT: **NEVER EVENT**

---

1. INTRODUCTION

1.1 This report provides details of a Never Event which occurred within the Women's and Children's CMG and was escalated internally and to Commissioners on the 21st February 2014.

1.2 Never Events are incidents that have the potential to cause severe harm or death and are largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Never Events are governed by the "Never Events Policy Framework" document available at:-

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213046/never-events-policy-framework-update-to-policy.pdf

2. DETAILS OF INCIDENT

2.1 A thirty year old lady underwent an instrumental delivery at the Leicester General Hospital on the 25th December 2013. During the delivery an episiotomy was performed by the Specialist Registrar (SpR). Once the delivery was complete, the SpR prepared the patient for suturing and repair of the episiotomy.

The Registrar started the suturing but was then called to theatre to assist with an emergency Caesarean section. The Registrar asked the midwife to take over and continue with the repair.

The patient was transferred to the post natal ward and subsequently discharged in to the care of the community midwives the following day. The lady visited her GP five weeks post delivery and on the 14th February 2014 was admitted to the Maternity Assessment Unit (MAU) at the LRI. A medical review was undertaken and a speculum examination performed. During this procedure a medium sized swab was removed from the vagina. The patient was admitted to the ward and intravenous (IV) antibiotics were commenced. The patient was discharged home two days later with follow up planned.

3. IMMEDIATE ACTIONS TAKEN

3.1 The following actions have been taken as a result of this incident:-

- Patient was informed and apologies provided.

- A formal memo has been sent out to all Medical and Midwifery staff reminding them to have all swabs and needles checked prior to commencing a procedure and to document this count on the white boards which are provided in all delivery rooms. Once the procedure is completed, a second member of staff must attend to confirm the swab/needle count is correct. This must be documented in the patient's medical records.
- A full RCA report will be commenced.
- Statements from all staff requested.
- The Never Event has been escalated to the Commissioners.

4. RECOMMENDATIONS

4.1 The Trust Board is requested to note this report and the immediate actions that have been put in place following this Never Event.

Moira Durbridge
Director of Safety and Risk
February 2014