

Institutional Handbook of Operating Procedures Policy 09.13.28	
Section: Clinical Policies	Responsible Vice President: EVP & CEO Health System
Subject: Patient Risk, Treatment, and Safety	Responsible Entity: Perioperative Governance Committee (PGC)

I. Title
Surgical Counts

II. Policy
To provide guidance to perioperative personnel for preventing retained surgical items (RSIs) during operative or other invasive procedures. The expected outcome is that the patient is free from unintended retained foreign objects.

1. All perioperative team members will engage in safe practices that support prevention of RSIs.

The RN circulator will:

- a) Perform a room survey for open countable items from a previous procedure before conducting an initial count;
- b) Verify that the count board (eg, whiteboard) do not contain information from a previous procedure;
- c) View the surgical items being counted;
- d) Record the counts of soft goods, sharps, miscellaneous items, and items placed in the wound
 - on a standardized template;
 - in a location that is visible to the surgical team (e.g., the count board); and
 - in agreement with the scrub person;
- e) Record instrument counts on pre-printed count sheets;
- f) Participate in count reconciliation activities;
- g) Report any count discrepancy; and document count activities

The scrub person will:

- a) Maintain awareness of the location of soft goods (eg, radiopaque sponges, towels, textiles), sharps, and instruments on the sterile field and in the wound during the procedure;
- b) Count surgical items in a manner that allows the RN circulator to visualize the surgical items being counted;
- c) Speak up when a discrepancy exists; and
- d) Participate in count reconciliation activities.

The surgeon will:

- a) Use only radiopaque surgical items (eg, soft goods) in the wound;
- b) Maintain awareness of the location of items in the surgical wound during the course of the procedure;
- c) Communicate placement of surgical items in the wound to the perioperative team for notation in a visible location (eg, the count board);

2. Count soft goods, sharps and miscellaneous items and instruments:
 - a) Before the procedure to establish a baseline (i.e., initial count);
 - b) When new items are added to the field;
 - c) Before closure of a cavity within a cavity (eg, the uterus);
 - d) When wound closure begins;
 - e) When skin closure begins or at the end of the procedure when counted items are no longer in use (i.e., final count);
 - f) At the time of permanent relief of either the scrub person or the RN circulator, although direct visualization of all items may not be possible; and
 - g) Any time a discrepancy is suspected.
3. All perioperative team members will
 - a) Immediately inform the RN circulator and other members of the perioperative team if they observe an item dropped from the surgical field;
 - b) Promptly inform the RN circulator when a countable item was opened by another member of the surgical team.
 - c) Minimize distractions, noise, and interruptions during the surgical count;
 - d) Create a no-interruption zone that prohibits nonessential conversation and activities and prohibits rushing the count;
 - e) Not perform counts during critical phases of the procedure, including
 - Time-out periods,
 - Critical dissections,
 - Confirming and opening implants,
 - Care and handling of specimens.
4. A count may be requested by any member of the perioperative team involved in the counting process.
5. The initial count will be conducted before the patient enters the operating room or procedure room when possible. The initial count shall be completed before the incision.
6. Counts of sponges, sharps, instruments, and other miscellaneous items will be performed in order from large to small item size, proximal to distal from the wound. (i.e., from Sterile field to mayo stand to back table and lastly to items passed of the sterile field)
7. Items will be separated and pointed out while being audibly counted.
8. Packaged items will be counted according to the number that the item is packaged in.
 - a) Packages containing an incorrect number of items or items with a manufacturing defect will be
 - Excluded from the count,
 - Removed from the field,
 - Isolated from the rest of the countable items in the OR, and
 - Labeled.
 - b) These may be removed from the room before the patient's entry.

9. If the count is interrupted, the count for the type of item being counted during the interruption (eg, laparotomy sponge) will be restarted.
10. For multiple procedures or sterile fields, all items will be counted together at the final count while sterile technique is maintained.
11. All counted items will remain within the OR or procedure room until the counts are completed and reconciled.
 - a) Linen and waste containers will not be removed from the OR or procedure room until the counts are completed and reconciled and the patient has been transferred out of the room.
12. The final count will not be considered complete until all items (eg, sponges, malleable retractors, needle holders, scissors) used in closing the wound are removed from the wound and returned to the scrub person.
13. Used or open counted items will be removed from the OR or procedure room at the end of the procedure after the patient has left the room.
14. A complete count will be performed when there is a permanent relief of the RN circulator or scrub person.
 - a) All items will be accounted for, although direct visualization of all items may not be possible.
 - b) The relief count will be documented as a separate designated Relief count in the intraop record
15. Instrument counts may be waived for surgical invasive procedures in which accurate instrument counts may not be achievable or practical, including:
 - a) Complex procedures involving large numbers of instruments (eg, anterior-posterior spinal procedures),
 - b) Trauma procedures,
 - c) Procedures that require complex instruments with numerous small parts, and
 - d) Procedures for which the width and depth of the incision is too small to retain an instrument.
16. When instrument counts are waived, unless the patient's safety is at risk, intraoperative imaging will be performed before the patient is transferred from the OR.
17. A patient Event Report will be completed for any incorrect count or adverse event.

III. Procedures Interventions

Surgical Soft Goods

1. Use only soft goods that are radiopaque and easily differentiated from non-radiopaque soft goods (eg, sponges, towels) in the surgical wound.
 - a) Isolate non-radiopaque gauze sponges used for skin antisepsis that have a similar appearance to counted radiopaque sponges before the procedure begins to avoid possible confusion with the counted radiopaque sponges.
 - b) If gauze sponges are used for vaginal antisepsis, use radiopaque, counted sponges.
 - c) Do not use radiopaque sponges as postoperative dressings.
 - d) Do not use non-radiopaque sponges in the surgical wound. If use of towels in the surgical wound is necessary, use towels with radiopaque markers.
 - e) Withhold non-radiopaque dressing materials from the field until the surgical wound is closed.

- f) Keep dressing sponges included in custom packs sealed and isolated on the field until the surgical wound is closed.
2. Do not consider the final count complete until all surgical soft goods used in closing the wound have been removed from the wound and returned to the scrub person.
3. When counting radiopaque surgical soft goods,
 - a. remove the band surrounding surgical sponges and discard it;
 - b. Separate each item
 - c. Count audibly
 - d. count packaged radiopaque sponges to the number that the item is packaged in (eg, five, 10);
 - e. if an incorrect number of radiopaque sponges or a manufacturing defect (eg, marker, tag, or chip) is discovered in a package during the initial count,
 - exclude them from the count;
 - remove the items from the sterile field;
 - isolate these items from the rest of the countable items in the OR; and
 - label them.
 - f. Remove these items from the room before the patient's entry.
4. Leave radiopaque surgical soft goods in their original configuration and do not cut or alter them in any way.
5. Audibly communicate and record in a visible location (eg, count board) all radiopaque surgical soft goods placed in the surgical wound or other cavities (eg, throat, vagina) on placement and removal.
6. Before closing the wound, the surgeon should perform a methodical wound exploration (eg, top to bottom, quadrant to quadrant) for radiopaque surgical soft goods before closing the wound
 - a) For minimally invasive surgery, the surgeon should perform a methodical wound exploration before camera removal.

When using a Pocketed sponge bag system

1. Place used sponges in a standard location (eg, kick bucket) until transferred to a pocketed bag system.
2. Place only one sponge in each pocket of the pocketed sponge bag system.
3. Place the radiopaque marker of the sponge facing forward so that it is readily visible in the pocketed bag system.
4. Fill the pocketed bag system from the bottom to the top.

Therapeutic packing

1. When radiopaque surgical soft goods are intentionally used as therapeutic packing and the patient leaves the OR with this packing in place,
 - a) Document the number and types of items placed in the surgical wound in the medical record

- As reconciled and confirmed by the surgeon when this information is known with certainty, or
 - As incorrect if the number and the type of sponges used for the therapeutic packing is not known with certainty.
- b) Communicate the number and types of radiopaque surgical soft goods used for therapeutic packing as part of the transfer of patient care information and document in the patient's intraoperative record.
2. When the patient is returned to the OR for a subsequent procedure or to remove therapeutic packing,
- a) Determine from the intraoperative record of the surgery during which the packing was placed the number and type of radiopaque soft goods to be removed,
 - b) Document in the medical record the number and type of radiopaque soft goods removed,
 - c) Isolate the radiopaque sponges removed and do not include them in the counts for the removal procedure,
 - d) The surgeon should perform a methodical wound examination and order an intraoperative radiograph, and
 - e) Document the count for the removal procedure as reconciled if all radiopaque soft goods have been accounted for

Sharps and Miscellaneous Items

- a) Account for the following miscellaneous items
 - Catheter sheaths,
 - Electrosurgery scratch pads,
 - Endo-mechanical reload cartridges,
 - Guidewires,
 - Cervical cups,
 - Specimen bags,
 - Stapler anvils,
 - Bulb syringes,
 - Trocar sealing caps,
 - Umbilical and hernia tapes,
 - Vascular inserts,
 - Vessel clips, and
 - Vessel loops
 - Suture boots
 - Anti-fog solution
 - Marking Pens

- b) Do not consider the final count complete until all sharps used in closing the wound have been removed from the wound and returned to the scrub person.
- c) The scrub person should account for and confine all sharps on the sterile field until the final count is reconciled.
- d) Confine and contain sharps in specified areas of the sterile field or within a sharps containment device.
- e) Use a new container when a sharps container on the sterile field is full.
 - Include the full container in the count and do not remove from the OR until the final count reconciliation is completed and the patient has been taken from the room.
 - Account for sharps and miscellaneous items in their entirety immediately on removal from the surgical site.
 - If a broken or separated item is returned from the surgical site, the scrub person should immediately notify the perioperative team
 - In the event that a needle or miscellaneous item is lost during a minimally invasive procedure, the surgeon should weigh the risks and benefits of retrieving the item.
 - Depending on the clinical situation, make an attempt to locate and retrieve the item. (addressing this issue in the policy will help the staff make decisions)
 - Handle sharp items with an instrument and place in a sharps/needle counting device that is separate from the sterile field.

Instruments

- a) Count instruments for all procedures in which a body cavity (eg, thorax, abdomen, pelvis) is entered.
- b) Do not consider the final instrument count complete until all the instruments used in closing the wound (eg, malleable retractors, needle holders, scissors) are removed from the wound and returned to the scrub person.
- c) Account for individual pieces of assembled instruments (eg, suction tips, wing nuts, blades, sheaths) separately and document on the count sheet.
- d) Use preprinted count sheets to record instruments as the count is conducted.
- e) Record only the number of instruments opened for the procedure

Count Discrepancy

- a) All perioperative team members should take immediate action to resolve a count discrepancy.

RN circulator

- Inform the perioperative team and receive verbal acknowledgement from the surgeon of the type and number of items missing as soon as a discrepancy in a surgical count is identified.
- Call for assistance, search the room, including the area near the sterile field, floor, kick buckets, and linen and trash receptacles, and recount with the scrub person.

Scrub person

- Organize the sterile field, search the sterile field, including the drapes and tables, and recount with the RN circulator.

Surgeon

- Suspend closure of the wound if the patient's condition permits.
 - Perform a methodical wound examination while actively looking for the missing item.
 - Participate in the attainment of intraoperative radiographs or other imaging modalities as indicated to find the missing item.
 - Remain in the OR until the item is found or it is determined not to be in the patient.
- b) Recount the item type (eg, laparotomy sponges, suture needles) when the missing item is found.
 - c) If the missing item is not recovered, perform intraoperative imaging to rule out a retained item before final closure of the wound if the patient's condition permits.
 - If the patient's condition is unstable, take the radiograph as soon as possible in the next phase of care.
 - d) When accurate accounting of surgical items is not possible, perform intraoperative imaging before the patient is transferred from the OR.
 - e) Perform intraoperative imaging that provides full coverage of the surgical site and include any views deemed necessary by the surgeon and radiologist to maximize the opportunity to identify a missing surgical item, which may include
 - Using portable or fixed radiographic equipment,
 - Taking portable anterior and posterior oblique views,
 - Taking multiple images for full coverage of the surgical site or body cavity as confirmed by the surgeon,
 - Using fluoroscopy,
 - f) The radiologist and surgeon should review and interpret intraoperative imaging for RSIs.
 - When the radiologist is not immediately available, the surgeon should conduct a preliminary interpretation of the image.
 - g) Do not use radiographs for needles less than 10mm or sutures 5-0 and smaller
 - h) Document unresolved count discrepancies in the patient's record

Notify environmental services personnel and the next perioperative team in the room about items reported missing in an unresolved count discrepancy.

IV. Documentation

The RN circulator will document soft good, sharp, miscellaneous item, and instrument counts, and measures taken to prevent RSIs on the patient's intraoperative record, including

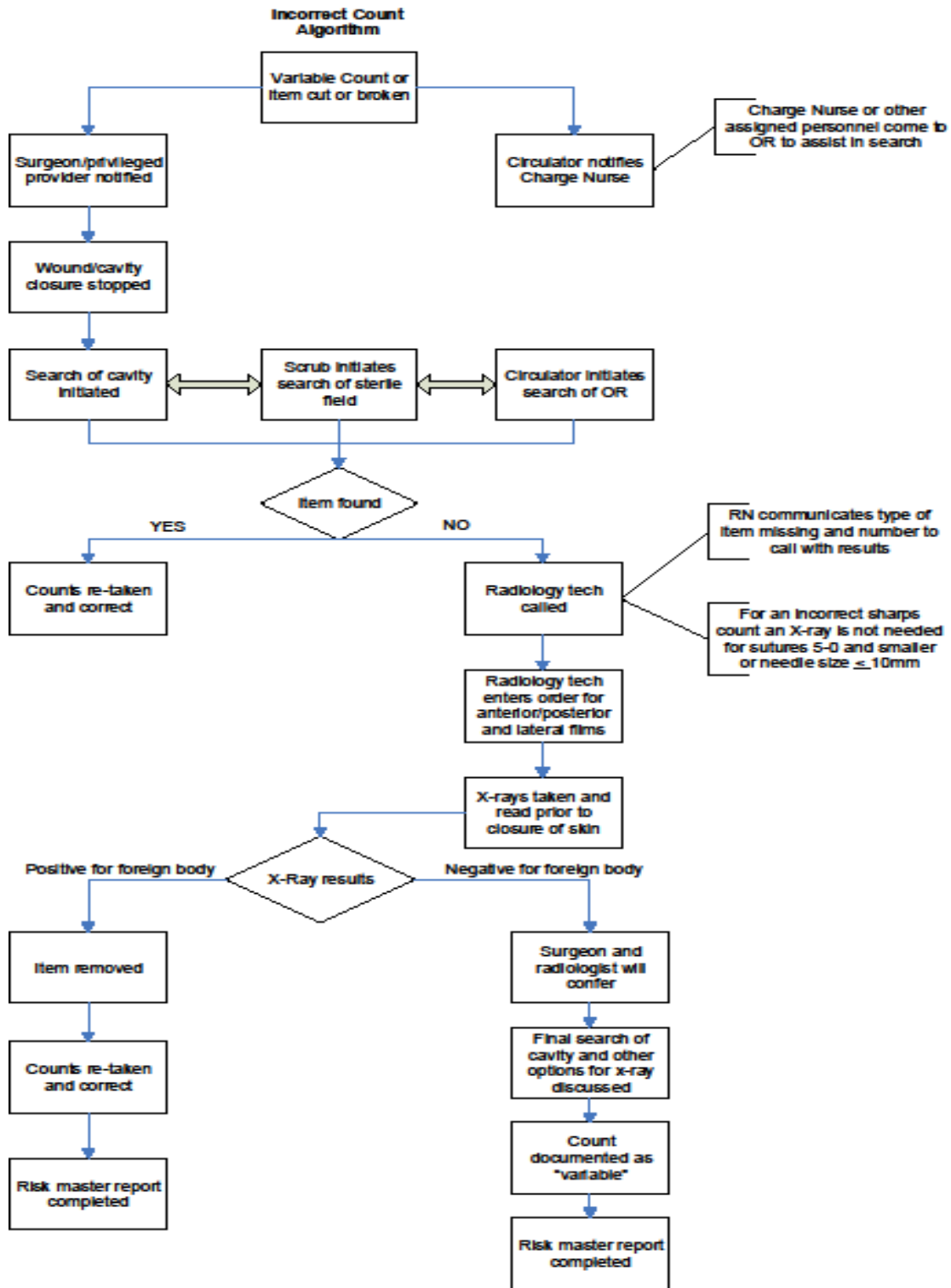
- a) The types of counts (e.g., radiopaque sponges, sharps, instruments, miscellaneous items);
- b) The number of counts;
- c) The names and titles of personnel performing the counts;
- d) The results of surgical item counts (i.e., correct, incorrect);
- e) Surgeon notification of the count results;
- f) Any adjunct technology that was used and any associated records;
- g) An explanation for any waived counts;

- h) The number and location of any instruments intentionally remaining within the patient or radiopaque sponges intentionally retained as therapeutic packing;
- i) Actions taken if count discrepancies occurred, including all measures taken to recover the missing item or device fragment and any patient communication regarding the outcome;
- j) A rationale if counts were not performed or completed as prescribed by policy; and the outcome of actions taken

V. References

Petersen C, ed. Retained foreign object. In: *Perioperative Nursing Data Set*. 3rd ed. Denver, CO: AORN, Inc; 2011:146-149.

Guideline for prevention of retained surgical items. In: *Guidelines for Perioperative Practice*. Denver, CO: AORN, Inc; 2016:369-414.



VI. Dates Approved or Amended

<i>Originated: 12/21/2007</i>	
<i>Reviewed with Changes</i>	<i>Reviewed without Changes</i>
1/07/2011	
11/21/2014	
09/28/2016	
01/11/2017	
06/05/2018	
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VII. Contact Information

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