Counting and Instrumentation Standards

(Study Module)

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PURPOSE: Counts are performed to account for items and to prevent injury to a patient as a result of a retained surgical items.

OBJECTIVE: The team will prevent inadvertent retention of instruments and sponges in surgical wounds.

PROCEDURES:

A. Room Survey:

1. The RN circulator or scrub person will perform a room survey before each case to ensure that all evidence from the previous patient and procedure has been removed (e.g., patient ID stickers
Removed, count record on white board erased). The room survey will be performed after the
Patient leaves the operating room and before the baseline count is conducted for the next case.

B. What to Count:

1. The following items must be counted:
a. Sponges/Towels (soft goods)
b. Needles
c. Instruments
d. Miscellaneous surgical items

C. How to Count:

1. The scrub person and the circulator must directly view each counted item as they count out loud together.
2. The count of each category (e.g., laps, needles) of items must be uninterrupted. If the count is interrupted, then the category of items in which the interruption occurred must be recounted.
3. If the count of any of the following items in a package is incorrect (i.e., if there are not 10 [or five] sponges in the package), the entire package and its contents are isolated from the field and removed from the OR.
4. Sponges
    a. When counting sponges, both people must directly view the radiopaque marker.
    b. The person counting will break the banding tape and separate each sponge by drop count
    c. Sponges and soft goods are tracked on the whiteboard

5. Needles

a. Needles are counted and the tally is compared with the number listed on the package.

b. Needles are tracked on the whiteboard

6. Instruments

a. Each instrument in each category will be counted individually (e.g., 1, 2, 3, as opposed to 2,4, 6,).

b. The order in which they are counted will follow the order in which the categories are presented on the instrument list.

c. The circulating nurse will document the number of counted items in each category by writing the number next to each category of instruments.

d. Instruments with removable parts are counted as individual pieces (eg. balfour wingnut, bookwalter retractor, charnley retractor, poole suction, uterine manipulator).

D. When to Count:

1. At the beginning of each case, before the patient arrives in the OR, a complete count must be conducted in order to establish the baseline count.
2. When closing a cavity within a cavity – such as uterus, bladder, or stomach.
3. At the start of closing the final layer (usually skin).
4. Separate counts must be conducted and documented.

   A. For each site when multiple procedures involving multiple sites are performed.

   i. All counted items must be kept in the OR until all procedures are completed

   B. At the time of permanent relief of the circulator and/or scrub person. Although the ability to directly see items in the wound may not be possible they must still be accounted for.

   c. Whenever a member of the surgical team has concerns about the accuracy of the count.
5. Items added to the field during the case must be counted and documented on the white board.
6. Temporarily placed items must be accounted for.

E. Baseline Count:

1. The circulator will record and scrub person will verify the baseline count on a preformatted, permanently inscribed, white board as well as on the preformatted instrument count sheet.
2. All countable items must be included in the baseline count.
3. The baseline count is the standard against which all subsequent counts are compared.

4. A baseline count of all general instruments will be counted for all laparoscopies and thoracoscopies. A final instrument count does not need to occur if the case did not convert to an open procedure. In the event that either procedure becomes an open procedure a final count will occur.

F. Items Added to the Field:

1. As counted items are added to the field, the white board/instrument count sheet must be updated.
   a. Sponges or sharps must be recorded on the preformatted white board as they are added to the field.
   b. Instruments added to the field will be documented on the instrument count sheet.

G. Temporarily Placed Items:

1. Items temporarily placed inside a cavity must be accounted for on the white board when they are placed and when they are removed.

H. Closing and Final Counts:

1. Closing and final counts must begin at the surgical site and its immediate surrounding area, proceed to the Mayo stand and back table, and then to items discarded from the field.
2. When any member of the surgical team perceives that the integrity of the count is compromised, a “Pause for the Count” for both the closing (including closing a cavity within a cavity) and final counts should be called.
3. If additional sponges are needed after skin closure, these additional uncounted sponges must not be opened on the field until the final count is completed and reconciled.
4. If there are multiple sites, uncounted sponges must not be opened on the field until the coun for the last of the sites is completed and reconciled.
5. Final counts must be done on patients who are organ donors and/or patients who expire in the OR.
6. Final counts are not complete until all items are removed from the patient unless intentionally packed in the wound.

I. How to Organize Used Countable Items:

(This will facilitate efficient counting for closing and final counts.)

1. Sponges are thrown in a kick bucket.
2. Throughout the case the circulating nurse retrieves sponges from the kick bucket and places each used sponge in a compartment of a sponge counter bag. Compartments are used based on the sponge original packaging, one item per compartment.
3. Needles are placed on a needle counter.

J. Broken or Cut Instruments, Sharps, Sponges, Miscellaneous:

1. If a sharp, instrument, or miscellaneous item is broken all parts of the item must be documented on the instrument count sheet and removed from the field.
2. If a broken part cannot be accounted for, a mandatory search must be completed (wound, surgical field, floor, trash, and linen).
   a. The broken part must be noted on the Operative Report and an Event Report must be completed.
   b. The patient will be informed of the broken part (see hospital policy)
3. If a counted item is inadvertently cut or altered in any way all parts of the item must be accounted for, documented on the white board and removed from the field.
4. If a vessel loops, umbilical tapes or any other items are purposely cut, each piece will be documented on the white board and accounted for at the end of the procedure.

K. Verifying Counts:

1. After each count is completed, the circulating nurse should verify and document the count was completed in the EMR.

L. Incorrect Closing Count:

If the closing count is incorrect, the following steps are taken:

a. Notify the surgeon immediately.

b. A recount must be conducted.

c. If the item is still missing after the recount, the surgeon must search the wound and the scrub team must search the drapes, field, Mayo stand, and the back table. At the same time, the circulating nurse must search the sponge count bags, trash, linen, floor, and all items that have been counted off the field.

d. If the item is located in this search, a complete recount must be conducted and the correct count documented.

e. If the item is not located in this search, notify the Coordinator/Charge Nurse immediately and state what is missing. The circulating nurse must call for an X-ray.2 The X-ray must be read by a radiologist while the patient remains in the OR.3

f. An event report must be completed for all incorrect counts.

g. The circulating nurse must document the following items on the OR nursing record:

i. The incorrect count;

ii. All steps taken to resolve the count, including the X-ray results and the name of the radiologists who read the X-ray; and

iii. The name of the surgeon who was notified that the count is incorrect.

h. The patient will be informed of an unresolved count (SEE HOSPITAL POLICY) Outcomes 9063).

M. Counts Not Done Due to Life-Threatening Emergency Situation:

1. If counts cannot be carried out because of a life-threatening emergency situation this must be noted on the Operative Report and an Event Report must be completed.

2. A perioperative image should be taken as soon as possible to identify any possible retained surgical items.

N. Instrumentation/Sharp(s)/Sponges Left in Wound Intentionally:

1. When the surgeon intentionally leaves instrumentation, sharp(s) or sponge(s) in the patient's wound, the name and quantity of the instrumentation and/or type of sponge left in the wound must be documented in the Operative Report.
2. In cases when sponges are intentionally left in the wound, sponges that are x-ray detectible should be used.
3. If the final count—with the exception of the intentionally left items—is reconciled, then the Operative Report reflects a correct count.
4. The number and types of sponges should be reported to the department to which the patient is transferred.
5. On subsequent visits the patient's medical record will state the number and type(s) of sponges used previously for packing. When the previous packing is removed the sponges used will be reconciled with the type and number previously documented in the patient's medical record. If the number of packing sponges removed concurs with the number documented on the patient's medical record, then it should be recorded as such. If the wound is repacked, this process should be repeated—the sponges used to repack the wound are again documented on the patient's medical record.

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