

PROTOCOL FOR: Counts: Sponge, Sharp, Accessory Item and Instrument

- POLICY:
1. Sponge counts should be performed on all procedures in which the possibility exists that a sponge could be retained. Throat packing will be counted as a distinct category whenever used. Procedures excluded from a sponge count requirement include:
 - a. superficial hand procedures
 - b. cystoscopic procedures
 - c. ophthalmologic procedures
 - d. superficial dermatologic procedures
 2. Sponge counts should be performed:
 - a. before the procedure to establish a baseline,
 - b. before closure of a cavity within a cavity,
 - c. before wound closure begins,
 - d. at skin closure or end of procedure, and
 - e. at the time of known or potential permanent relief of either the scrub person or the circulating nurse (although direct visualization of all items may not be possible).If a single-layer closure is performed, only one closing count is required.
 3. Sharps and other miscellaneous items must be counted on all procedures. Sharps counts should be performed:
 - a. before the procedure to establish a baseline,
 - b. before closure of a cavity within a cavity,
 - c. before wound closure begins,
 - d. at skin closure or end of procedure, and
 - e. at the time of known or potential permanent relief of either the scrub person or the circulating nurse (although direct visualization of all items may not be possible).If a single-layer closure is performed, only one closing count is required.
 4. Instruments should be counted for all procedures in which the likelihood exists that an instrument could be retained. Procedures that must have an instrument count include those open procedures in which the thoracic, peritoneal, retroperitoneal or pelvic cavities are entered. Instrument counts should be performed:
 - a. before the procedure to establish a baseline,
 - b. before wound closure begins (cavity within a cavity *prn*),
 - c. when feasible, at the time of known or potential permanent relief of either the scrub person or the circulating nurse (although direct visualization of all items may not be possible).
 5. An initial count of all instruments used in minimally invasive procedures performed in the thoracic, peritoneal, retroperitoneal, or pelvic cavity will be done prior to incision. A closing count will be taken only in the event that there is conversion to an open procedure.
 6. An RN circulating nurse must participate in all counts. All counts must be performed by at least two people, both of whom can view the items being counted.
 7. Permanent relief counts will be performed as follows:
 - a. if both the scrub person and the circulating RN are being relieved, both incoming staff members and the outgoing circulating RN perform the count, while the outgoing scrub person continues to

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- assist with the procedure;
 - b. if only the scrub person is being relieved permanently, the remaining circulating RN will perform the count with the incoming scrub person, while the outgoing scrub person continues to assist with the procedure;
 - c. if only the circulating RN is being relieved permanently, the count will be performed by the remaining scrub person and both circulating RNs.
8. The names / initials of all persons performing counts will be documented in the nursing record along with the results of the counts. If no count is performed per policy, the names / initials of the staff determining this will be entered in the record along with the entry of no counts performed (e.g., n/a in the perioperative on-line documentation system.
 9. Counts will be included during hand-offs at changes of personnel, according to policy statements 1, 2 and 3 and as follows:
 - a. Temporary relief (ie, breaks): sharps must be accounted for; other items to be counted are at the discretion of the staff involved, with agreement by all staff members involved;
 10. Extreme patient emergency may necessitate the omission of counts, which must be documented in the nursing record.
 11. Whenever the initial count has been omitted, an x-ray will be taken to confirm the absence of radiopaque items prior to closure unless unstable patient condition contraindicates doing so, per physician judgment.
 12. In addition to appropriate closing counts, to minimize the risk of unintentionally retained foreign bodies associated with procedures, especially those in which the thoracic, peritoneal, retroperitoneal, or pelvic cavity is entered, an x-ray may be taken at the surgeon's discretion prior to closure in the following circumstances:
 - a. procedure duration exceeds 8 hours;
 - b. nursing staff involved is three or more persons sequentially in either role of circulating nurse or scrub person; and
 - c. unexpected change in procedure.
 13. Any unintentionally retained item that is removed during a subsequent procedure must be sent to Anatomic Pathology for processing as a permanent specimen.
 14. To prevent intermingling of sponges and unintended retention of counted sponges post-operatively:
 - a. non-radiopaque gauze dressing materials should be withheld from the sterile field until the wound is closed or the case is completed;
 - b. counted sponges will be removed from the sterile field upon correct outcome of the final closing count, unless the sterile field is maintained until the patient is transferred from the OR and in which case the counted sponges will be sequestered;
 - c. no counted sponges will be used for patient hygiene at the end of the procedure.
 - d. after completion of closing counts but prior to transferring the patient out of the OR, verify that all counted gauze sponges (used

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and unused) are placed in sponge count organizers and accounted for.

15. Materials Management will attempt to procure radiopaque items whenever the items may be used on the surgical field.

DESIRED PATIENT OUTCOME: The patient will have no injury related to extraneous objects, as evidenced by no unintentionally retained sponges, sharps, small items, throat packing, or instruments within the operative site.

- CLINICAL ASSESSMENT AND CARE:
1. Initial counts of sponges, sharps, small / accessory items, throat packing, and instruments will be done according to procedure prior to incision or start of the operation and will be documented per policy.
 2. Closing counts of sponges, sharps, small / accessory items, throat packing, and instruments will be done according to procedure prior to closure of the incision or conclusion of the operation and will be documented per policy.
 3. Permanent relief counts of all visible sponges, sharps, small / accessory items, throat packing, and instruments will be done according to procedure whenever persons in either the scrub or circulating role are relieved permanently and will be documented per policy.
 4. When initial counts cannot be completed according to procedure, an x-ray will be obtained to confirm no retention of sponges, sharps, small / accessory items, and instruments.
 5. Incorrect counts will be addressed according to procedure.

EQUIPMENT: Kick buckets
EZ Count Sponge Counter Bags
Intraoperative Count Worksheet
Sponges: raytex, lap sponges, T&As;
Sharps: blades, surgical and hypodermic needles;
Small / accessory items: including but not limited to those items listed on the *Intraoperative Count Worksheet*, such as cottonoids, vessel loops, fish / visceral retainers ; and
Instruments
Traylists

PROCEDURE:

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Initial Count Process

1. Perform initial inventory count of instrument sets on every case at setup.

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2. Remove all securing devices from each package of sponges, sharps or miscellaneous items being counted. Visualize radiopaque indicator on each item that should have one. Count concurrently and aloud all sponges, sharps, and miscellaneous items according to the unit in which they are dispensed (units of 5, 10, etc.).

To ensure that each sponge is clearly visible, the scrub person should

- a. pick up the pack and break any paper band,
- b. shake the pack of sponges gently if possible to separate them,
- c. pull each sponge separately from the pack, and
- d. number it aloud while placing it onto the sterile field

3. All needles contained in multi-packaging must be viewed during the initial count or when added to a count.
4. If counting instruments, the scrub person will pass instrument tray lists off the sterile field to the RN circulating nurse.

5. Count all other items as miscellaneous items and keep a tally of all pieces of each type of item.

6. Record quantities on the *Intraoperative Count Worksheet* according to type and amount

2. Initial counts of sponges, sharps, towel clips, and miscellaneous items, such as cottonoids, "fish" (visceral retainers), etc., are done prior to every procedure. Drill bits will be measured against drill bit template. If a template is not available, the scrub person will mark the ends of the bit and label the size on the back table cover in the presence of the circulating nurse for verification at the end of the case. The RN circulating nurse will note any miscellaneous item(s) not printed on the count worksheet and all items will be accounted for.

To ensure Each individual item should be clearly visible, such as space between every sponge rather than grasping them as a group and fanning them out for the count.

3. The scrub person will save packages for count verification.

Needles and all other sharps should be handled carefully during initial count and throughout procedure to minimize risk for sharps injuries. (MGH 1b, p. 126)

4. Tray lists should be passed off the sterile field without being contaminated. To promote safety and improve visibility when counting instruments, scrub personnel should use an instrument such as an unloaded knife handle to divide instruments neatly by type.

Individual pieces of assembled instruments (i.e. suction tips, wing nuts, blades, sheaths) should be accounted for separately on count sheet. (MGH 1c, p. 126)

6. When multiple, distinct surgical sites are involved, counts must be done per policy for each incision and the final count must be correct for all surgical sites.

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7. Hand off any package containing more or less than the standard number of sponges, sharps, or miscellaneous items.	7. Item(s) will be labeled as miscounts and will be retained in the room until the procedure has been completed.
8. In the event of an emergency and the initial count cannot be performed, the RN circulating nurse should attempt to keep an accurate accounting, noting what types and amounts of counted items have been used.	8. Although a final count cannot be deemed "correct" in the absence of an initial count, attempts to keep an accurate account of all items used may expedite closure and minimize the risk of a retained foreign body.
9. Handle any contaminated sponges, sharps, instruments, and / or miscellaneous items according to established Infection Control policies and OSHA recommendations. (MGH 1a, p. 126)	

Counted Items During Procedure

1. Discard used sponges from the surgical field in a plastic lined kick bucket.	1. Kick bucket should be placed in a location that the scrub person can easily visualize and place used sponges in without contamination.
2. Use EZ Count system for all procedures in which sponges are to be counted.	2. Consistency in counting process across all types of procedures reduces the potential for human error / unintentionally retained foreign bodies.
3. Completely open and separate all sponges that have been discarded during the procedure. Examine each discarded sponge to be sure no other saturated sponge is entangled with it.	3. Circulating RN should always wear gloves to avoid transmission of blood borne pathogens. Wear protective eyewear if there is any possibility of splashing from saturated sponges.
4. Organize sponges in EZ Count organizer bags in the same amounts that they are originally dispensed (5 laparotomy sponges, 10 ORs / raytec sponges), filling from bottom to top: a. use one pocket for each OR / raytec sponge; b. break the inner divider of a 10-count organizer bag for laparotomy sponges so that 5 sponges are displayed in each divider c. keep filled EZ Count organizer bags on hooks throughout case for ease of viewing throughout procedure.	2. Position EZ Count equipment so scrub person can see it easily. Filling sponge organizer from bottom to top enhances ability to see missing items. c. Circulating RN should ensure anesthesia providers are aware of discarded sponges for accurate ongoing EBL calculations.

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5. Sponges and other counted items should be left in their original configuration and should not be cut. Altering a sponge generally invalidates subsequent counts and increases the risk of a portion being retained in the wound. If an item nevertheless is altered by surgeon request, a running tally should be kept of the total number of pieces created and must be accounted for in their entirety.	5. Counted sponges are not to be passed off with specimens or used for any other purpose. Telfa or other dressing-type materials used during a procedure to collect specimen(s) should be handed to the surgical team on an "as needed: basis.
6. Retain miscellaneous items on the sterile field; when the original grouping has been used (eg, five dental pledgets), they may be counted and passed off the field, and contain them as above, or they may remain on the sterile field in a protected location.	
7. Filled EZ Count organizer bags, filled needle counters, or any other counted item used in counts done for separate procedures performed on the same patient must remain in the OR to be accounted for at the time of the closing count.	7. Retain all counted items on or off the sterile field in a location where they can be readily seen throughout the procedure. Do not discard or remove any item during a procedure, except for instrumentation as described in step 9 above.
8. Pass instrument traylists off to the circulating nurse whenever an instrument count will be done or patient implants/chargeable items from the sets will be used.	
9. Retain counted instruments in the room until case is completed unless removed for reprocessing.	9. Permanent removal of counted instruments will be so noted on the count worksheet.
10. Clearly visualize all counted items throughout operative procedures whether they are on or off the sterile field, unless the items are contained within the surgical wound.	
11. The circulating RN may note on the worksheet that items have been grouped during counts, have been passed off the sterile field, or any other activity or information that may be related to counts.	11. Information noted on the worksheet does not preclude the need to account for all items used during procedures in any closing counts performed per policy.

Closing Count Process

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1. Perform closing counts in the same sequence each time, beginning at the surgical site and the immediate surrounding area, proceeding to the Mayo stand and back table(s), and ending with items off the sterile field, including but not limited to all sponges in kick buckets and / or organized in EZ Count organizer bags. Counts should also consistently proceed from largest to smallest in size.
 2. Perform closing count of instruments whenever the thoracic, peritoneal, retroperitoneal, or pelvic cavity is entered. The first closing count performed when a cavity within a cavity is entered will be performed when the inner cavity is being closed and will include an instrument count.
 3. Perform closing counts of sponges, sharps, miscellaneous items, and throat packing on every case prior to wound closure, paying close attention to the integrity of sharps and drill bit tips.
 4. Towel clips will be counted during the final closing count, as well as in the closing set inventory count.
 5. Additional closing counts of any type may be done at the discretion of the nursing personnel.
 6. Report aloud the results of all closing counts to the attending surgeon or designee'.
 7. Closing inventorying of instrument sets and other instrumentation is done following completion of every case.
 8. Account for all gauze sponges at end of procedure by placing them in EZ Count organizer bags
2. Subsequent instrument counts are optional when a cavity within a cavity has been entered. The closing instrument count should not be considered complete until those instruments used in closing the wound are removed from the wound and returned to the scrub person (refer to count worksheet for tracking removal of visceral retainer / fish). (MGH 1d, p. 126)
 3. Broken or altered items will be accounted for in their entirety. X-ray detectable sponges should not be used for dressings. Drill bits will be measured against the drill bit template or ruler / table marking for tip integrity.
 6. To maintain validity of final closing count, discard all counted radiopaque gauze sponges once count has been completed.
 7. All instruments should be accounted for and removed from the room during clean-up to facilitate inventory control and patient safety.
 8. Seeing all sponges in organizer at end of case minimizes potential for false correct counts and unintended retention of counted gauze sponges in the wound(s)

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Incorrect Closing Count Process

1. Repeat count.
 2. Notify surgeon, team, and charge nurse, as appropriate, of incorrect count.
 3. Search for missing or broken item(s) in wound, on sterile field and floor, and in linen and trash bags.
 4. If mobile image intensifier (C-arm, mini c-arm) is being used for procedure, surgical site can be imaged initially to locate missing item(s). If item(s) cannot be located, notify Radiology of need for permanent x-ray film, specifying that the purpose of the x-ray is to rule out a retained foreign body. Request that the x-ray be read by a radiologist, for greatest accuracy.
 5. Document all steps taken to resolve count, personnel notified, and result of any x-ray taken and name of interpreting radiologist, if known.
 6. File a psn report in the event of any incorrect count.
2. Nursing staff should receive acknowledgement of incorrect count from surgeon whenever discrepancy is identified. (MGH 1f, p. 126)
 4. In general, obtain a radiograph and strong consideration should be given to not having the patient leave the OR until the x-ray is reviewed by a radiologist. In general, a permanent x-ray film should be taken whenever an item cannot be located by mobile image intensifier, as fluoroscopy may not allow for the image quality necessary to detect retained items. However, the attending surgeon may exercise some discretion regarding the risks and benefits of obtaining a radiograph; if s/he elects not to obtain the radiograph, s/he must enter a note in the patient record indicating why the radiograph was not obtained and s/he must disclose the situation to the patient / family.

Surgeon may defer x-ray if patient instability precludes it.

Do not take x-ray for needles that are smaller than 17mm, as they may not be consistently visible on x-ray. Do not take x-ray for items that are known to be non-radiopaque.
 5. Documentation of a count discrepancy should include all measures taken to recover the missing item and communications made regarding the outcome, per prompts from electronic documentation system when incorrect count results are entered. (MGH 1e, p. 126)

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Intentionally Retained Counted Sponges

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| <p>1. In certain circumstances, such as when counted sponges are intentionally used as packing and the patient leaves the OR with this packing in place, document the number and types of sponges retained and the reason for the variation in the nursing record as correct and confirmed by the surgeon.</p> <p>2. When the patient returns to surgery and the packed items are removed, identify the number and type(s) of sponges or packing items removed and note this in the nursing record. Counts for the subsequent procedures should be performed as usual, but the outcome recorded as incorrect for sponges or miscellaneous items, as appropriate, and an explanatory note entered in the record.</p> | <p>1. The outcome of the counts performed for the initial procedure will be considered correct and a note should be entered in the Counts documentation to describe what items have been packed in the patient and the surgeon's confirmation of that description.</p> <p>2. The items removed should be isolated and not included in the counts for the subsequent procedure. If the sponges are removed in an area other than the OR, the number removed should be noted on the patient record.</p> <p>An x-ray should be taken to confirm all radiopaque items have been removed prior to closure of the wound. Complete a psn report, as for any other incorrect count.</p> |
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APPROVAL: Nursing Standards Committee

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Appendix - Needles smaller than 17mm, in the event of an incorrect needle count, are not visible on x-ray and do not require an x-ray to be taken if missing:

Taper-point Micro		Taper-cut Micro		Taper-point CV		Taper-cut	
Ethicon	USSurg	Ethicon	USSurg	Ethicon	USSurg	Ethicon	USSurg
All BVs	All MVs	V-75	MVK-70	All BVs	CV/CV-1	CC	KV-1
		V-100	MVK-100	C-1	CVF	CC-1	KVF-1
Reverse Cut Plast		V-130		RB-3	CVF-1		KV-11
Ethicon	USSurg			RB-2	CV-11		KVF-11
P-6	P-16	Reverse Cut Cutic		TF	CV-20		
P-1	P-10	Ethicon	USSurg		CV-21		
P-3	P-13	C-2	C-1		CV-22		
PS-6	P-22	M-1	C-21		CVF-22		
PC-1	PC-13	SC-1	SC-11				
All Ophthalmic needles unless size is greater than 13mm							