Olive View-UCLA MEDICAL CENTER

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES

Policy Title:	**SPONGE, SHARPS, AND INSTRUMENT COUNTS – PERIOPERATIVE SERVICE**		
Category:	1 - Provision of Care	**Policy No.:**	176
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Distribution:	**Hospital-Wide** ☒	**If not Hospital-Wide, Other:**	

PURPOSE:

A. To provide safety rules for registered nurses and surgical technicians in the performance of sponge, sharp, instrument and miscellaneous item counts.

B. To provide safety rules for surgeons in the performance of a methodical wound exam and actions to prevent unintentional retention of surgical items.

C. To provide safety rules for radiology technologists and radiologists in the performance of intra-operative x-ray examination and information to aid interpretation and read back of intra-operative x-rays.

D. To provide safety rules for anesthesiologists and anesthesia personnel in preventing unintentional retention of surgical items.

E. To encourage and support all efforts to improve teamwork.

F. To assist in accounting for all surgical items and minimize inventory loss.

DEFINITION(S):

None

POLICY:

A current verification of sponges, sharp counts, and miscellaneous items by the circulating nurse and surgical technician/ scrub nurse must be performed on all surgical cases.

1. A baseline count of all sponges, sharps, and miscellaneous items for all surgical cases must be performed prior to patient arrival in the surgical suite or initial incision.

2. An instrument count must be done on:
   - All abdominal cases
   - All open chest cases
   - All OB- GYN cases
   - All mastectomy cases
   - All tram flap cases

3. The white board is used as a communication and verification tool for the sponge, instrument, sharp, and miscellaneous medical/surgical items counting process and the notation of items tucked in the wound.

   Sponges, instruments, sharps, and miscellaneous medical/surgical items added are recorded as a part of the count documentation on the white board.

4. Documentation of counts and/or any other pertinent information related to counts will be recorded on the electronic medical record.

5. After the final count, and prior to the patient leaving the operating room, RF mat scan will be done to confirm that no sponges were left.

A. Surgical counts of sponge/sharps/instrument count(s) must be taken:

The In Counts:

a. **Initial baseline count** conducted before the case begins
b. Count conducted **whenever new items are added** into the field.

   1. The IN counts are performed to establish the baseline number of items, detect packaging error and provide knowledge on how many items are being used during the case

   2. Whenever possible the initial IN counts will be performed before the patient enters the OR.

The OUT Counts:

a. The Final Count:

   1. The final count occurs when the skin is closed or the case is completed but before the patient is awakened from the anesthesia and before drapes are removed.

   2. FINAL Count performed after skin closure, when surgical items are no longer in use and ALL are passed off the field.

   3. ALL surgical items including sponges, sharps, instrument and miscellaneous items are included in the final count.

   4. A member of the surgical physician team will remain scrubbed in during the Final Count.

   5. The circulator will announce “Final Count”

6. Every team member will acknowledge the verification process and will not interrupt the counting process.

7. Upon completion of this final count, the circulator will notify all in the room that the count is complete and whether the count is correct or incorrect.

8. The final count can only be recorded as CORRECT or INCORRECT.

9. The Final count will be performed in the following sequence each time:

    a. Dry Erase Board
    b. Safe repository where dropped or contaminated items have been placed.
    c. Holders or counter boxes.
    d. Kick buckets or containers which hold discarded items.
    e. Back table
    f. Mayo stand
    g. Sterile field
    h. Surgical site

b. Interim Count (sponges, sharps, and miscellaneous items on dry erase board)

1. CAVITY/Closing Count – performed before closure of a wound or cavity (e.g. peritoneum).

2. RELIEF Count – performed at the time of permanent relief of either the surgical technician or circulating nurse.

3. ANYTIME Count – performed at the discretion of any member of the OR team.

B. The following counts are to be validated by the circulating nurse and surgical technician/ scrub nurse and be documented on the Record of Operation by the circulator nurse:

- Baseline count (defined as the count that is done before the case begins) and includes a count of sponges, sharps, instruments and miscellaneous items.
- Cavity /Closing Count - Before closure of a cavity and before skin closure or end of procedure to include sponges, sharps and miscellaneous items.
- Final count - To be done after skin closure, before the patient is awakened from anesthesia and before drapes are removed to include sponges, sharps, instrument and miscellaneous items.

C. Items must be counted audibly with the circulating nurse and scrub technician/scrub nurse concurrently viewing each item as it is counted.

PROCEDURE:

I. SPONGE, NEEDLES, SHARPS, INSTRUMENT, AND MISCELLANEOUS COUNTS

A. SPONGES (Soft Goods), includes:
- Lap sponges
- 4x8 sponges (Ray-tech)
- Tonsil sponges
- P-nuts/Rosebuds
- Cottonoids
- X-ray detectable towels

All sponges used on the sterile field must be radiopaque. Sponges with Radio Frequency Identification (RFID) technology must be utilized if the sponge type is available with RFID equipped. RFID sponges are used in all operating room area.

A1. All sponges must be counted.

1. Plastic hanging sponge counting bag must be used for all surgical cases. Each holder contains 5 pouches. Each pouch has a thin center-divider that separates each pouch into 2 pockets. One sponge is placed in each pocket so one holder can hold 10 sponges.

2. Used sponges coming from the operative field should be placed into a clear plastic bag-lined receptacle (e.g. kick buckets or ring stands).

3. At the time of the final count, ALL used sponges MUST be in the sponge holders and the circulating nurse and scrub technician/ nurse viewing the sponge holders must make the final verification.

4. Only one sponge should be placed in each pocket of the holder. Put the first sponge in the last pocket in the bottom of the holder. Load the holder horizontally from the bottom row to the top row, filling first the bottom two pockets and continuing upwards ("bottoms up").

5. The circulator and surgical technician/ scrub nurse must audibly count the sponges and visualize each sponge.

6. Count all sponges, separate and examine for any defects, i.e., missing parts, lint, etc.

7. Keep a running total of the sponges added to the surgical field on the dry erase board using the same format that is used to count needles. The last number should always be the total number of sponges opened during the case. (e.g.10+10= 20+10= 30) means that 30 sponges are in use and must be accounted for at the end of the case.

8. The circulator and surgical technician/ scrub nurse should never assume a manufacturer's prepackaged item is correctly counted. A package of sterile sponges that contains an incorrect number of sponges should be removed from the sterile

field, bagged, labeled as incorrect and the number of sponges in the bag, and placed away from the rest of the sponges in the O.R. However, do not remove the bag from the OR until the procedure has been completed.

9. Use only x-ray detectable sponges and RFID equipped sponges on mayo stand and back table until incision closed and final count completed.

10. All packing/sponge gauze used for packing during a case must be x-ray detectable and RFID equipped.

11. Do not remove counted sponges from the operating room until final count is completed.

12. Report count status verbally to surgeon after count is completed.

13. Sponges used on all surgical procedures must never be cut or altered in any way.

14. Only non-x-ray detectable sponges are to be used for dressings.

15. When counted X-ray detectable/RFID equipped sponges/towels are intentionally used as packing, the number and types retained and the reason for the variation will be documented on the Online Real-time Centralized Health Information Database (ORCHID) by adding the segment “Counted Retained Items” in the intraoperative documentation. This will also be communicated to the receiving unit by adding the “Departure from OR” segment. This documentation is viewable in “PowerChart”. If and when this patient returns to surgery and the packed sponges are removed, the number and types must be reconciled with the number and types that were originally recorded on the ORCHID Record of Operation on the day of initial surgery. The number and types of removed items must be noted in the current patient’s record of operation. After the final count, and prior to the patient leaving the operating room, RF wanding/mat scan will be done to confirm that no sponges were left in the cavity. The count for this subsequent case should be noted as correct after all sponges have been accounted for.

16. If the sponges are removed in an area other than OR, the number removed should be noted on the progress notes by the person removing them. The number and types must be reconciled with the number and types that were originally recorded on the Record of Operation on the day of initial surgery. After the final count, an X-Ray or RF wanding/RF mat will be done to confirm that no sponges were left in the cavity.

17. Raytex (4x8) sponges are pulled for the case per Surgeon’s Preference Card and are only opened upon request of the surgeon.

18. The dressing material is to be opened onto the sterile field by the circulator only after the skin incision of the surgical wound is fully closed.

19. Place all the sponge holders in a plastic bag for disposal at the end of the case. If the sponges are very bloody the holders should be placed in a red biohazard bag. Putting all the holders with all the sponges in one disposal bag may aid in ensuring that all sponges are removed from the OR at the end of the case and prevent a sponge count discrepancy in the next case.

A2. RF Technology Use

The RF Assure **Detection Mat** is a "foam-cushioning" pad that contains six (6) radiolucent (x-ray compatible) coils that can detect retained sponges in the surgical field. A mat scan is a hands-free scanning method used for core cases.

The **Blair-Port Wand** is a reusable, handheld, motion-based device for detecting RF tagged surgical sponges in both the surgical field as well as in the surrounding environment (i.e. trash, linens, and drapes). Where the mat is utilized for core cases, the wand can be used for cases including and beyond the core area (i.e., extremities, head and neck). The wand can also be used in conjunction with the mat to extend the detection range in core procedures such as in abdominal or thoracic cases.

Important: RF Detect Premium surgical sponges must be used in order for the system to function.

1. RF Technology will be used for all surgery procedures.

2. The use of RF detection technology does NOT replace other required counting activities. This technology is to be used in conjunction with the previously established counting procedure.

3. All RF console will be documented in ORCHID by serial number. The final Scan confirmation number and the scan method used shall also be recorded.

4. If RF mat is to be utilized, verify placement of mat under entire surgical site with label side up, below other non-metal devices.

   Key Point:

   Surgical site must be included fully within the surface area of the RF mat.

5. RF mat will be utilized on each case.

   Key Point:

   Mat only scan can take place in cases where the depth of the area scanned is not more than 18 inches. For cases where depth of the scanned area is greater than 18 inches, a wand only scan or a mat and wand scan will be performed.

6. Any RF mat scan which is inconclusive *must* be accompanied by use of the RF wand.

7. RF wands must be covered with a sterile drape, using aseptic technique.

B. SHARPS, includes:
- Free needles
- Keith needles
- Blades
- General closure needles
- Gastro-intestinal needles
- Safety pins
- Hypodermic needles
- Vascular needles
- Cautery blades

B.1. Counting Sharps:

1. Sharps must be handled according to OSHA guidelines. Used sharps present hazard of inflicting injury to and inducing microorganisms in both the patient and personnel.

2. Sharps must be counted on all cases.

3. Whenever possible, sharps must be handed to and from the surgeon on an exchange basis using a “Neutral Zone” or “Hands Free” technique to minimize needlestick injuries.

4. Management of all sharps on the sterile field is continually maintained by the surgical technician/ scrub nurse.

5. All sharps must be counted separately according to the individual category.

6. The circulator will be responsible for keeping a record of sharps being used during procedure utilizing the white board. When additional sharps are added to the field, they are recorded on the count board. A running total format is used throughout the procedure.

7. Sharps broken during a procedure must be accounted for in their entirety.

8. A magnetic needle pad must be utilized on all surgical procedures containing sharps with exception of Ophthalmology procedures.

9. Sharps must be disposed of properly in the red sharp containers in each operating room suite only after a correct final count.

B.2. Counting Needles:

1. Suture needles must be counted according to the number marked on the outer package and verified by the surgical technician/ scrub nurse and circulating nurse when the outer package is opened.

2. Staff must record small and large needles separately. Small needles are defined as needle attached to sutures size 7-0 or smaller, with lengths of < 15 mm. Large needles are defined as needles attached to suture sizes 6-0 or larger, with lengths of > 15 mm.

3. A disposable puncture-resistant needle counter should be used for containment of used needles and sharps. Used needles should be put in the needle counting boxes by placing one needle per marked slot in the box. Placing more than one needle in the marked slot defeats the purpose of the needle box which is designed to aid in the organization and correct counting of the needles e.g. a full 20 slot needle box should not have more than 20 needles in it.

4. If there are a large number of needles used during a case, at various times during the case a defined number of needles may be counted by the surgical technician/ scrub nurse and circulating nurse, placed in a counter box and the box labeled, closed and held on the back table in preparation for the final count.

5. The needle packages should remain in a small basin or container or in a defined space on the back table until the final count is completed.

C. INSTRUMENT Counts:
   1. An instrument count must be done on:
      - All abdominal cases
      - All open chest cases
      - All OB- GYN cases
      - All mastectomy cases
      - All Tram Flap cases

   2. Only an initial instrument count is required on laparoscopic cases in which an incision <1inch is present. Any laparoscopic case which converts to open or has an incision made ≥1inch should have complete instrument counts performed.
      - This does not apply to GYN surgical procedures in which all GYN procedures require an initial counts and final counts.

   3. The instrument count is performed by the circulating nurse and surgical technician/scrub nurse concurrently utilizing the Instrument Tray Recipe which accompanies each tray.

   4. Instrument counts will be taken before the case begins and at the Final count.

5. During initial count, the Instrument Tray Recipe will be used to count instruments. The initial count will be documented in ORCHID perioperative charting to verify that what was on the Instrument Tray Recipe during assembly and agrees with what was present in the sets at the start of the case.

6. Any additional instruments opened during the case will be counted, written on the white board as added instruments in order to be counted with other counts at the end of the case.

7. Under no circumstances should counted instruments leave the room before the final count is completed.

8. If an instrument is contaminated it should be shown to the surgical technician/scrub nurse and if not needed, secured and remain in the room.

9. If instruments have multiple parts, all pieces must be accounted for.

10. If the surgical technician/scrub nurse receives an instrument back missing a part or is broken, the surgical technician/scrub nurse must speak up and tell the team to look for missing pieces.

11. If there are missing instruments and you need to add that instrument to the tray by utilizing OR Peel Pack Inventory or opening another tray, all added instruments must be counted, added to the initial count, added to the bottom of the Instrument Tray Recipe, recorded on the dry erase board as added instruments in order to be counted with other counts at the end of the case.

12. Instruments with removable parts, disassembled or broken during a case must be accounted for in their entirety.

D. MISCELLANEOUS ITEMS:
- Umbilical Tape (2/pack)
- Vessel Loops (2/pack)
- Bulldogs
- Suture Reels
- Other (ANY ITEM (S) USED ON SURGICAL FIELD)

1. All miscellaneous items must be counted separately on each case.

II. INCORRECT COUNTS

A. The following steps must be followed:
1. Upon discovery of incorrect count, the incorrect portion of the count should immediately be repeated and surgeon must immediately be notified.

2. Every attempt must be made to locate missing item, i.e., thoroughly check trash, drapes, linen, floor, etc. If unable to locate missing item, notify nursing supervisor.

3. The surgeon has to perform a methodical wound search to examine and explore the site.

    a. For cases with a missing sponge equipped with RFID technology:
        i. RF wand or mat should be performed immediately. If the RFID sponge is detected and retrieved, an x-ray is not necessary. A recount is performed once sponge is retrieved, and the count is deemed correct.
        ii. If any RF wand or mat scan remains unresolved or inconclusive, an x-ray is performed.

4. If unable to resolve incorrect count, per hospital policy, an x-ray must be taken prior to patient leaving the O.R. suite with the exception of small needles (defined as needle attached to sutures size 7-0 or smaller, with lengths of < 15 mm). Ordering of an x-ray for lost small needles will be left to the surgeon's discretion. In an event that an x-ray is not ordered, the surgeon must disclose the unaccounted needled to the patient.

    a. A disclosure must be documented in the patient's medical record by the surgeon.
    b. A documentation of the incorrect count is done by the RN.

5. X-ray to rule out any retained surgical item must be read by the Attending Surgeon or by a Radiologist with report given to the surgeon prior to the patient leaving the operating room.

6. Once the retained item is located, it must be removed immediately.

7. An Event Notification must be completed via UHC Safety Intelligence and Nurse Manager or Supervisor must be notified prior to end of the work shift.

8. Document incorrect count and actions taken on intra-op electronic record. Document RF Scan Confirmation Number.

III. DOCUMENTATION

A. A registered nurse is responsible for medical record documentation in ORCHID.

B. Specific terminology for sponge, sharp, instrument and miscellaneous item counts will be used in the medical record depending on the vendor or format of the operation or procedure report.

C. Counts and other required information should be entered concurrently with an occurrence or at the end of the case.

Documentation in the medical record serves as legal evidence of what practices were performed.

If any count is not performed according to policy the rationale must be documented in ORCHID and the primary decision-maker identified e.g. surgeon declared case an extreme emergency condition and no initial count was performed.

D. The final count can only be recorded as CORRECT or INCORRECT.

E. If a package of any surgical item is found to be defective when opened (e.g. wrong number, damaged, contaminated) the package and its contents will be removed immediately from the field, bagged, labeled and taken from the operating room. The charge nurse should be notified and the packaging error documented. The inventory information should be given to supply purchasing for notification of the distributor and staff should be told about the packaging error at staff educational meetings.

F. If a medical device or instrument breaks or fragments, all effort should be made to retrieve the separated parts. The device and its parts should be removed from the field. The charge nurse should be notified of the device or equipment malfunction.

ATTACHMENTS/FORMS:

None

REFERENCE(S)/AUTHORITY:

- AORN Standards and Recommended Practices –2017
- Gibbs, Verna C. NoThing Left Behind:Prevention of Retained Surgical Items Multistakeholder Policy. February 2011.
- RF Surgical Manufacturers Manual 2015

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