(A) Policy Statement

Sponges, sharps (needles and items that may cause a puncture), instruments, and other materials deemed appropriate, are to be counted on surgical procedures.

(B) Purpose of Policy

To provide a method of accounting for items placed on the sterile field for use on a surgical procedure when the depth and location of the wound is such that the item could be lost or retained in the patient. To prevent hazards to the patient’s health and promote optimal healing and well-being.

(C) Procedure

GENERAL RULES

1. All counts are completed audibly by two Registered Nurses (RNs) or a RN and a Surgical Technologist (ST), while each item is being viewed. The circulator nurse will direct the counts and document all counts on the operative record.

2. Sponge, sharp, and instrument counts, should be performed in the same sequence defined as cavity, patient, mayo, back table, and off the field.

3. Staff will wear disposable gloves and protective eyewear whenever grossly contaminated items are handled.

4. A radio frequency scan (RF) is to be performed on all cases where RF items are on the sterile field. This is to be done prior to the removal of the sterile drapes.

5. All counts are documented on the OR Record with the following information:
   a. Type of count.
   b. Names of OR personnel completing the count.
   c. Result of each count (correct or incorrect).
   d. Action taken if count is unresolved by RF technology (e.g. surgeon informed, x-ray taken and read by attending radiologist, immediate supervisor notified of occurrence).

6. RF technology scanning will occur after final counts are completed and prior to removing sterile drapes.
   a. RF scanning is to be used as a confirmation of correct counts.
   b. Wandmg may occur at any point in the procedure when there is a discrepancy or at the request of any team member, but must occur after final counts.
   c. The confirmation number is documented in the counts comment box under ‘procedure counts’.

7. In the event that a count is incorrect, the RN Circulator notifies the surgeon and Operations Supervisor or charge nurse, and a search is initiated. All counts that are either incorrect or have a discrepancy whether resolved or unresolved, are to be documented in the Patient Safety Net on-line occurrence reporting system.
8. In the event RF technology fails to result in a correct count, an X-Ray must be taken while the patient is still on the OR table and interpreted by the attending radiologist prior to cavity closure. The x-ray taken will be documented in the operative record. Deviations from this policy will be reported to the Nurse Manager, Operations Supervisor, or designee. Or staff will communicate to the Radiology Department information regarding the need for an x-ray, including description of missing item if applicable.

9. On all high risk procedures for retained foreign bodies, a RF technology mat will be placed on the bed prior to patient positioning and will be used in conjunction with the RF wand. If a mat is not used, an x-ray will be done prior to the patient leaving the OR (even when surgical counts are correct). High risk procedures include open chest, abdominal and pelvic cavity procedures in which any of the following circumstances occur:
   a. Emergency surgery when an initial count is not completed.
   b. Any unexpected change in surgical procedure.
   c. Patient with BMI greater than 40.
   d. Greater than 80 sponges used in a procedure.
   e. Greater than eight OR staff involved in case.

10. When available, an additional scrub person will scrub in and participate in the final verification that the sponge, instrument, and needle counts are correct. This person will be in addition to the staff assigned to the procedure. The initial scrubbed person will remain at the field to assist the surgeon in closing the surgical wound and the additional scrub person will participate in the final count.

11. The only exclusion for omission of counts is in an emergency. Documentation of the omission and variation in procedure should be documented in the operative record and the Patient Safety Net.

12. If additional instruments, sharps, sutures, and sponges are never to be brought in from another room (i.e., transplant).

SPONGE COUNT

1. Sponge counts are completed on all procedures. Sponges are to be separated, counted audibly and concurrently viewed during the count procedure by two RNs or a RN and a ST. As additional sponges are added to the field, they are to be counted at that time and recorded as part of the count.

2. RF sponge items are to be used in the sterile field and are to be marked with a radio-opaque element.
   a. Sponges should be in their original configuration and should not be cut.

3. Only towels with radiopaque markers and RF technology can be used in the wound.

4. When sponges are counted in the OR suite by the RN and the Scrub RN/Technologist, they are counted:
   a. Prior to the beginning of the procedure as a baseline or initial count.
   b. When new items are added
   c. Before closure of any deep or large incision or body cavity (i.e., uterus, bladder, pericardium, hip capsule).
   d. When the skin closure is started or immediately before completion of surgical procedure.
   e. When more than one incision and/or procedure on the same patient.
   f. With permanent change of either scrub or circulating nursing personnel in the room.

5. Sponges shall be discarded from the field onto an impervious barrier (chux). They shall be separated by OR staff who utilizes universal precautions (wearing gloves and adequate eye protection). As each group of designated number of items (i.e., 5-laps, etc.) is present, two RNs or a RN and a ST will count the items together and the items shall be placed into plastic bags which are available in each room.

6. All counted sponges will remain within the OR suite and/or sterile field:
   a. Linen and trash bags are not removed from the OR Suite until the end of the procedure and patient leaves the room.
   b. No sponges will go with the specimen or transplant organ.
c. X-ray detectable sponges will NOT be used for wound dressings.

7. The RN Circulator informs the Surgeon of the sponge count status at end of cavity closure and end of case.

8. The RN Circulator maintains an accurate status of the sponge count on a count board throughout the procedure.

9. In the event an incorrect number of sponges are found in a package, the entire package will be removed from the field, the discrepancy noted on the package, and the package of sponges isolated. These sponges will not be included in the total counts.

10. Non-radiopaque gauze dressing materials should be withheld from the field until the wound is closed or case completed.

11. Counted sponges will not be used as postoperative packing. In emergency circumstances, if sponges are intentionally used as packing and the patient leaves the OR with the packing in place, the number and type of sponges retained and the reason will be documented in the ‘Counts Comments Box’ under ‘Procedure Counts’ in the electronic health record (EHR). When removing the packing, on return to the OR, the counted sponges should be reconciled, bagged, labeled and isolated from the field with documentation in the operative record.

SHARPS/MISCELLANEOUS COUNTS

1. Sharps and miscellaneous items are counted on all cases. These include all needles used within the sterile field, scalpel blades, and electrosurgical tips. The following are examples that are considered miscellaneous items and must be counted at the same time as sharps: vessel loops, suture boots, umbilical tape, bulldogs, suture reels, vessel cannulas, vessel inserts, trocar caps, defogger solution bottles including caps, and clip cartridges.
   a. When additional needles/sharps/miscellaneous items are added to the field, they should be counted at the time and recorded as part of the count.

2. Needles/sharps/miscellaneous items are counted in the OR Suite by two RNs or a RN and a ST at the following times:
   a. Prior to the beginning of the procedure.
   b. When new items are added.
   c. At the closure of any deep or large incision or body cavity.
   d. When the skin closure is started or immediately before completion of the surgical procedure (i.e., when surgical site is intentionally left open).
   e. More than one incision on the same patient.
   f. Permanent change of either scrub or circulating nursing personnel in the room.

3. Suture needles should be counted according to the number marked on the package and verified by two RNs or a RN and a ST when the package is opened.

4. All counted needles/sharps will remain within the OR Suite and/or sterile field.

5. Sharps/needles broken during a procedure are accounted for in their entirety.

6. Sharps shall be contained in a puncture resistant, disposable, needle-count device.

7. If the needle count device becomes full, a count is completed and the device is handed off the sterile field. The RN Circulator notes the number of needles in the needle device and marks the needles as “removed from the field” on the count board. The full, closed needle count device is placed within the case cart until the case is completed.

8. Suture and needle packets will remain on the back table until the end of the case.

INSTRUMENT COUNTS
1. Instrument counts may be deferred when there is no perceived risk of retained instruments. However, instruments should be counted when the possibility exists of an incision being extended to allow for more extensive procedure than anticipated.

   a. The following cases are examples of cases where instrument counts may be deferred:
      (1) Carpal Tunnel Release
      (2) AV fistula Creation
      (3) Port Insertion
      (4) Trigger Finger Release
      (5) Cataract Extraction
      (6) Tonsillectomy
      (7) Burr Holes

2. In cases where the likelihood exists that an instrument could be retained, two RNs or a RN and a ST will participate in the initial inventory count and the closing count. In addition, any permanent change in either scrub or circulator in the room will require an additional count whenever possible.

3. An initial inventory count should be performed by the scrub personnel on all procedures. In addition, a final count should be done at the beginning of wound closure.

4. When additional instruments are added to the field, they should be counted at the time and recorded as part of the count. In cases where the likelihood exists that an instrument could be retained, the additional instruments will be counted by two RNs or a RN and a ST.

5. Instruments removed from the OR suite prior to the end of the procedure must be accounted for in the final count. Removed instruments will be counted using the count sheet prior to leaving the OR suite and documented with the handoff communication.

6. Count sheets are included in instrument sets. Instruments found to be missing from a set should be indicated and communicated to staff in the room using the count board and count sheets. Count sheets must be used to perform counts in cases where the likelihood exists that an instrument could be retained.

7. Instruments broken or disassembled during a procedure must be accounted for in their entirety. Place broken instrument in a ziplock bag and tag with a defective instrument tag. Place on top of case cart with documentation and description of what is defective, date, and initials of person reporting the defect. Broken instruments are to be documented in the Patient Safety Net.

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Approved by:

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It is the responsibility of the reader to verify with the responsible agent that this is the most current version of the policy.