Banner Health

Title: Counts: Sponge, Sharp, and Instrument	
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Approved by: PolicyTech Administrators	
Discrete Operating Unit/Facility: Banner Baywood Medical Center Banner Boswell Medical Center Banner Casa Grande Medical Center Banner Churchill Community Hospital Banner Del E Webb Medical Center Banner Desert Medical Center Banner Estrella Medical Center Banner Fort Collins Medical Center Banner Gateway Medical Center Banner Goldfield Medical Center Banner Heart Hospital Banner Ironwood Medical Center Banner Lassen Medical Center Banner McKee Medical Center Banner North Colorado Medical Center Banner Payson Medical Center Banner Thunderbird Medical Center Banner--University Medical Center Phoenix Banner--University Medical Center South Banner--University Medical Center Tucson East Morgan County Hospital Ogallala Community Hospital Page Hospital Platte County Memorial Hospital Sterling Regional Medical Center Torrington Community Hospital Washakie Medical Center Wyoming Medical Center Wyoming Medical Center	

I. Purpose

A. To provide guidance to perioperative personnel for preventing retained foreign objects (RFOs) during operative or other invasive procedures. The expected outcome is that the patient remains free from unintended retained foreign objects.

II. Definitions

A. **Baseline Count**: The count against which all subsequent counts are compared. Performed at the beginning of each case, before the patient arrives in the operating room.
    1. Exception to performing the baseline count before the patient arrives in the Operating Room: If a dedicated secondary team is available to perform an uninterrupted count.

B. **Cavity/Space**: Any space including, but not limited to abdomen, thorax, pelvis, stomach, bladder, heart, lungs, uterus, vaginal vault, colon, or any area that has a potential space for the retention of items**.**
C. **Closed incision**: The incision is considered closed after the last suture, or the last staple has been placed.
D. **Closing Count**: A count performed just before, or at the start, of closing the first layer.
E. **CSPD Count Sheets** – Central Sterile Processing Department count sheets including contents of tray, name of item and quantity, printed from CSPD system (ex. SPM Sterile Processing Micro-system)
F. **Drop Count**: A method of counting sponges whereby the scrub person disbands and separates each sponge by laying each sponge one on top of another.
G. **Emergency**: An occurrence involving a patient (Adult, peds, fetus in case of pregnancy) who has a life-threatening or deteriorating situation. Patient demise is imminent if the surgical procedure is not immediately initiated.
H. **Final Count**: A count performed at the closing the final layer.
I. **Incorrect Count** – a count discrepancy that occurs when the number of items counted does not accurately reflect the number of items present and cannot be reconciled through repeated counting, methodical wound exploration, and room exploration.
J. **Instruments**: Surgical tools or devices designed to perform a specific function, including but not limited to cutting, dissecting, grasping, holding, retracting, or suturing.
K. **Intraoperative Imaging (for purposes of identifying retained items)**: Imaging for the prevention of retained surgical item(s) using x-ray, fluoroscopy, or other means of medical imaging. Will be completed in the intraoperative phase of care prior to skin closure unless the patient is unstable, in which case it can then be completed in the Post Anesthesia Care Unit (PACU) or next level of care.
L. **Invasive Procedure**: Invasive procedure is defined as a procedure in which skin or mucous membranes and/or connective tissue are incised or punctured, an instrument is introduced through a natural body orifice, or insertion of foreign material into the body for diagnostic or treatment-related purposes. Examples of invasive procedures include central line and chest tube insertions, biopsies and excisions, and all percutaneous procedures regardless of location. Exclusions include venipuncture, which is defined as a collection of blood from a vein.
M. **Miscellaneous Surgical Items**: Items that are small enough to be retained in a surgical wound including but not limited to vessel loops, clip bars/racks, umbilical tape, hernia tape, vascular inserts, cautery tips, scratch pads, trocar sealing caps, suture reels, safety pins, disposable bulldogs, disposable heparin tips, vascular clamp inserts, defogger solution bottle, cap and sponge, and Raney clips.
N. **Miscount** – a count discrepancy that occurs when the number of the items counted does not reflect the number of the items present but is able to be reconciled.
O. **Organ Procurement Organization (OPO):** is a non-profit organization that is certified by CMS to be responsible for recovering organs from deceased donors for transplantation in the U.S.

P. **Pause for the Gauze:** An uninterrupted pause point for all counts. During which, eam creates a no-interruption zone that prohibits nonessential conversation, activities or rushing of the count process
Q. **Placed Sponge:** Any soft good used to stop bleeding or absorb liquid or used in conjunction with an instrument or the surgeon's hand to obtain traction, and that is intentionally left in location.
R. **Permanent Relief-** At shift change during an active surgery where relief of the off going nurse or scrub tech requires a permanent replacement for relief.
S. **Qualified Practitioner or Designee:** Any licensed practitioner with sufficient training to conduct a delegated component of a procedure without the need for more experienced supervision and who is approved by the hospital for these operative or patient care responsibilities. A licensed practitioner who has been credentialed/approved to perform surgery and has been determined to have appropriate licenses, qualifications, training and experience to safely perform specified Non-Critical Component(s) of a procedure under the appropriate supervision of a Primary Surgeon or Proceduralist consistent with this policy and, as applicable, any other practice agreements, supervisory arrangements, protocols or other written guidelines intended for the guidance of the practitioner.
T. **Radio frequency identification (RFID):** A system that locates and transmits the identity of an object (in the form of a unique serial number) wirelessly, using radio waves.
U. **Retained Foreign Object (RFO):** Any item or foreign object that is unintentionally left inside a patient after surgery or invasive procedure (The Joint Commission):

> "After surgery or invasive procedure" is defined as any time after the documented end of the procedure (eg. Once the surgical incision is closed, endoscope/instrument removed, etc.), even if the patient is still in the procedural area or in the operating room under anesthesia. This definition is based on the premise that a failure to identify and correct an unintended retention of a foreign object prior to that point in the procedure represents a system failure, which requires analysis and redesign. It also places the patient at additional risk by extending the surgical procedure and time under anesthesia."

V. **Sharps**: Includes but not limited to suture needles, scalpel blades, electrosurgical cautery tips, hypodermic needles, disposable scissor tips.
W. **Soft Goods**: Cotton disposable cloth, textiles, and gauze items of various sizes used as adjuncts to an operative procedure. Within the category of soft goods are surgical sponges (which contain a radiopaque marker) and radiopaque towels that are used within the surgical wound. These include but are not limited to: laparotomy sponges of all sizes, raytec, peanuts/kittners/rosebuds, tonsil balls, cottonoids/patties (various sizes), or cotton balls.
X. **Standard OR White Board** – White board posted in every operating room and c-section suite used to visually communicate status of counts, staff information, safety information, and other pertinent case information
Y. **Tissue Recovery Technician (TRT or Preservationist):** Responsible for assisting and carrying out Organ Procurement Organization (OPO) mission to maximize donation. They shall be available to assist with donor activity. The Tissue Recovery Technician shall perform tissue recovery procedures according to OPO protocol and policy, as well as, maintain a clean, safe operating room environment. All responsibilities should be performed within the scope of the Food and Drug Administration guidelines, Eye Bank, Association of American Medical Standards, American Association of Tissue Bank guidelines, and OPO departmental standard operating procedures. The TRT will maintain an environment that supports professionalism, teamwork, effective communication and displays OPO core values daily.
Z. **Waived Count**: A surgical count not performed due to the deterioration of the patient's condition including trauma, and\or patient demise is imminent if the surgical procedure is not immediately initiated or when time required to perform the count may prevent an unacceptable delay in patient care (i.e. trauma).
AA. **Wound Exploration**: Visual and/or manual inspection of the wound cavity for the purpose of ensuring that surgical items are not unintentionally retained.

III. Policy

A. All perioperative team members will engage in safe practices that support prevention of RFOs including Pause for the Gauze and appropriate use of adjunct technology.
B. Whenever there is an incorrect closing or final count, a mandatory search (methodical sweep of the wound, surgical field, floor, trash, linen, shoes, and equipment) must be performed. If the missing item is not found, intraoperative imaging must be taken (see Count Discrepancies)
C. If there is a miscount of soft goods and the soft good(s) is found inside the surgical wound, intraoperative imaging prior to skin closure is required to ensure cavity has no retained foreign objects.
D. Intraoperative imaging of all quadrants of the cavity for retained surgical item will be required in these situations, unless the patient is unstable, in which case it can then be completed in the Post Anesthesia Care Unit (PACU) or next level of care:
    a. Emergency and trauma situations where the patient's condition prohibits counting of soft goods and instrumentation prior to and throughout the surgical procedure
    b. Procedures in which accurate instrument counts may not be achievable or practical, such as complex procedures involving large numbers of instruments (e.g., total joint replacement, CV, spine, trauma, etc).
    c. Procedures that require complex instruments with numerous small parts
    d. In joint replacements when circumstances do not allow for timely interoperative imaging, imaging can then be completed in the post anesthesia care unit (PACU) or next level of care.
    e. Broken instruments, sharps, explants, etc. if the broken or missing part(s) cannot be accounted for.
    f. When instrument counts are waived
E. An online event report will be completed for any incorrect count or adverse event.
F. Organ Procurements/Tissue Recovery will follow all prescribed counting procedures of this policy.

IV. Roles

A. The RN circulator will:

    a. Perform a room survey for open countable items from a previous procedure (e.g., patient ID stickers removed, count record on white board erased, kick buckets emptied) before conducting a baseline count
    b. Verify the Standard OR White Board does not contain information from a previous procedure
    c. Initiate the baseline count prior to patient entry
    d. View and concurrently count out loud the surgical items being counted
    e. Record the counts of soft goods, sharps, miscellaneous items, and items intentionally placed in the wound on Standard OR White Board
    f. Record instrument counts on CSPD count sheet
    g. Document actions taken to resolve count discrepancies, any intraoperative imaging taken and verify and document results of the final count in Surginet Documentation

B. The scrub person will:

    a. Maintain an organized sterile field according to the standardized sterile setup for the procedure type with minimal variation between scrub persons
    b. Maintain awareness of the location of soft goods (i.e. radiopaque sponges, towels, textiles), sharps, and instruments, explants on the sterile field and in the wound during the course of the procedure;
    c. Know the character and configuration of items that are used by the surgeons and assistants

d. Verify the integrity and completeness of items when they are returned from the surgical site

C. The surgeon and first assistant will:

a. Use only radiopaque soft goods in the wound
b. Communicate placement of surgical items in the wound to the perioperative team for notation on Standard OR White Board
c. Perform a methodical wound exploration before closing the wound, using both visualization and touch.
a. For gynecological cases a manual cavity sweep must be completed in the vaginal vault even if vagina is not primary surgical site in order for count to be considered final.
d. Communicate and document items left intentionally as therapeutic packing during debriefing and in operative report.
e. Document actions taken to resolve count discrepancies, any intraoperative imaging taken and verify and document results of the final count in surgeon's operative report.

D. The anesthesia professional will:

a. Plan anesthetic milestone actions (eg, emergence from anesthesia) so that these actions do not pressure the perioperative team to circumvent safe counting practices
b. Not use items that have been included in surgical count
c. Communicate to the perioperative team when throat packs, bite blocks, and other similar devices are inserted in the oropharynx and upon removal.

E. All Perioperative team members will:

1. Immediately inform the RN circulator and other members of the perioperative team if they observe an item dropped from the surgical field
2. All countable items dropped from surgical field will be retrieved by RN Circulator and included in final count
3. Items will not be subtracted or removed from the count
4. Participate in Pause for the Gauze and speak up when any discrepancy exists
5. Yield anytime a count is requested by any member of the surgical team
6. Keep all counted items within the OR/procedure room until the counts are completed and reconciled.
a. Linen and waste containers will not be removed from the OR/procedure room until the counts are completed and reconciled and the patient has been transferred out of the room.
7. Facilitate a structured hand-over communication at times of relief of the RN circulator or scrub person.
a. A complete count will be performed when there is a permanent relief of the RN circulator or scrub person.
b. Soft goods, sharps and miscellaneous items will be accounted for when there is temporary relief of the RN circulator or scrub person for short durations.
8. Inform the RN circulator about any countable items added to the sterile field by any surgical team member.
a. RN Circulator will promptly record added items on Standard OR White Board or CSPD Count Sheet
9. Not perform counts during critical phases of the procedure; including but not limited to
a. time-out periods,
b. critical dissections,
c. confirming and opening implants,
d. induction of and the patient's emergence from anesthesia, and
e. care and handling of specimens.

10. Not consider final count 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.

V. What to Count

A. The following items must be counted:
   a. Sponges/Towels (soft goods) for all cases
   b. Needles for all cases
   c. Miscellaneous surgical items
   d. Instruments must be counted any time a body cavity is entered (i.e. chest, abdomen: peritoneum, retroperitoneum, pelvis, vaginal vault

B. Counts of surgical items are performed for all procedures in which the likelihood exists that a surgical item could be retained.

VI. When to Count

A. 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.
B. When closing a cavity within a cavity a complete count, including instrumentation, must be completed.
C. A complete count, including instrumentation is conducted at the start of closing the first layer (i.e. peritoneum, fascia and muscle, skin)
D. At the start of closing the skin layer. In addition, if instruments were part of the set up and unable to be counted at the fascia layer, they will be counted at this time in a complete instrument count. “The Surgeon should perform a methodical wound exploration (i.e. top to bottom, quadrant to quadrant) for radiopaque surgical soft goods before closing the wound, using both visualization and touch when feasible.”
E. Vaginal instruments are to be included in the final count, regardless of patient positioning throughout the case
F. Separate counts must be conducted and documented.
   1. For each site when multiple procedures involving multiple sites are performed.
   2. Prior to closure, account for any explants, if needed. Xray to confirm prior to final closure.
   3. At the time of permanent relief of the RN 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.
   4. Whenever a member of the surgical team has concerns about the accuracy of the count.

VII. How to Count

A. Counts will be performed concurrently and audibly by two individuals, one of whom should be the RN circulator. When possible, counts during a procedure should be performed by the same two individuals.
B. The count of each category (i.e. soft goods, sharps, instruments) of items must be uninterrupted. If the count is interrupted, then the category of the item(s) in which the interruption occurred must be recounted.
C. Count packaged items according to the number that the item is packaged in. Packages containing an incorrect number of items or items with a manufacturing defect (i.e., missing marker, tag, or chip) should be excluded from the count, removed from the field, isolated from the rest of the countable items in the OR, and labeled. These should be removed from the room or isolated.
D. Sponges
   1. When counting sponges, both counting professionals must directly view the radiopaque marker.

2. The scrub person counting will break the banding tape and separate each sponge by drop count.
3. Soft goods are recorded on the whiteboard by the RN circulator and verified by the scrub person. The tally is compared with the number listed on the package. Sponges are tracked according to how they are packaged (i.e. Laps 5, Raytec 10, etc.).

E. All radiopaque surgical soft goods placed or packed in the surgical wound or other cavities (i.e. throat, vagina) should be audibly communicated and recorded on the Standard OR White Board upon placement and removal.

F. Needles
1. Needles are counted and the tally is compared with the number listed on the package, if applicable.
2. Needles are tracked on the Standard OR White Board

VIII. Procedure Interventions

A. 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. If gauze sponges are placed in vagina use radiopaque, counted sponges.
    b. Do not use radiopaque sponges as postoperative dressings.
    c. If use of towels in the surgical wound are necessary, use white towels with radiopaque markers.
2. Withhold non-radiopaque dressing materials from the field until the surgical wound is closed. If non radiopaque gauze sponges are included in surgical pack, isolate from counted radiopaque sponges.
3. Do not cut or alter surgical soft goods in any way.
4. When counting radiopaque surgical soft goods use drop count technique
5. Audibly communicate and record on Standard OR White 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, using both visualization and touch.
    a. For minimally invasive surgery, the surgeon should perform a methodical wound exploration before camera removal.

b. Pocketed Bag System

a. Organize radiopaque surgical soft goods (eg, 4 x 4 gauze, laparotomy sponges) using a pocketed sponge bag
b. If a sponge is dropped from the sterile field, retrieve it using standard precautions, show it to the scrub person, and place it in the pocketed bag system.
c. Throughout case place all used sponges in a standard location (eg cottonoids, peanuts on table, larger soft goods in kick bucket) until transferred to a pocketed bag system. Do not retain used soft goods on sterile field.
d. Use standard precautions to retrieve sponges, then completely open and separate each sponge before placing it in a pocketed bag system.
e. Place the radiopaque marker of the sponge facing forward so that it is readily visible in the pocketed bag system.
f. Do not drape sponges over the sides of the kick bucket in lieu of pocketed bag system utilization.

b. Therapeutic Packing

i. When radiopaque surgical soft goods are intentionally used as therapeutic packing and the patient leaves the OR with this packing in place,
ii. Document the number and types of items placed in the surgical wound in the medical record
   a) as reconciled and confirmed by the surgeon when this information is known with certainty, or
   b) as incorrect if the number and the type of sponges used for the therapeutic packing is not known with certainty.
iii. When the patient is returned to the OR for a subsequent procedure or to remove therapeutic packing,
   a) Determine from the previous intraoperative record of the surgery the number and type of radiopaque soft goods to be removed,
   b) Document in the current intraoperative record the number and type of radiopaque soft goods removed,
   c) Isolate the removed radiopaque sponges from previous surgery and do not include them in the counts for the removal procedure,
   d) Surgeon should perform a methodical wound examination and order an intraoperative imaging.
   e) Document the count for the removal procedure as correct/reconciled if all expected radiopaque soft goods have been accounted for.
iv. The surgeon should inform the patient or patient's representative of any surgical soft goods intentionally placed in the wound at the end of the procedure and the plan for removing these items.
v. Negative Pressure Wound Therapy (NPWT): packed in the wound, including instruments and number of Wound Vacs sponges
   a) Intentionally retained NPWT dressing items must be documented (size, shape, color, etc.) and written on the provided label or in indelible ink on the external dressing to include number and type of dressing items.
   b) Intentionally retained NPWT dressing items must also be documented (size, shape, color, etc.) in both the physician and RN circulator operative reports.
   c) Minimize the number of dressings (foams, gauze, and contact layers) used to fill the wound bed.
   d) Dressing items applied into a wound tunnel or undermining should maintain a visible tail for ease of access or removal.
   e) Communication of NPWT dressing/packing to occur with each hand-off report
vi. Tracheostomy packing:
   a) Tracheostomy packing must be identified by using an external piece of tape and writing the number of pieces and type of packing used on a highly visible but non-obtrusive part of the patient's trach tie using indelible ink.
   b) Use of packing is to be documented in in both the physician and RN Circulator operative reports
   c) Communication of packing to occur with each hand off report

B. Sharps and Miscellaneous Items

1. Count all suture needles, regardless of size, for all surgical procedures.
2. Account for all miscellaneous items including but not limited to:

catheter sheaths,	bulb syringes,
electrosurgery scratch pads,	trocar sealing caps,
endostaple reload cartridges,	umbilical and hernia tapes,

guidewires	vascular inserts,
cervical cups,	vessel clips
specimen bags,	vessel loops.
stapler anvils,	explanted hardware or devices

3. The scrub person should account for and confine all sharps in a sharps containment device on the sterile field until the final count is complete.
4. Use sharps containment devices that are puncture resistant, labeled or color coded in accordance with the bloodborne pathogens standard, and leakproof on the sides and bottom.
5. Use a new container when a sharps container on the sterile field is full.
6. Include the full container in the count and do not remove container from the OR until the final count is completed and the patient has been taken from the room.
7. Remove free clips (eg, open staples) from the abdominal cavity when possible.
8. The surgeon should confirm removal of implants or explants in their entirety.
9. 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.
    a. Depending on the clinical situation, make an attempt to locate and retrieve the item.

C. Instruments

1. Count instruments for all procedures in which a body cavity (including but not limited to, thorax, abdomen, pelvis, peritoneum, retroperitoneum, and vaginal vault) is entered.
2. Count instruments
    a. In each category individually in the order they are listed on the CSPD Count Sheet
    b. By ones (i.e. 1,2,3), not by other increments (i.e. 2,4,6)
3. RN will document the number of counted instruments in each category by writing the number next to the inventory number on the CSPD Count Sheet

a. Account for individual pieces of assembled instruments (eg, suction tips, wing nuts, blades, sheaths) separately and document on the CSPD count sheet.

4. Keep all counted instruments within the OR/ procedure room during the procedure until all counts are completed and reconciled.

IX. Measures to Prevent Retention of Device Fragments

A. Account for items used in the surgical wound in their entirety by inspection for breakage or fragmentation immediately on removal from the surgical site.
B. If a broken item is returned from the surgical site, the scrub person should immediately notify the perioperative team.
C. If a broken instrument with a missing fragment is identified during reprocessing, sterile processing personnel should notify the perioperative team immediately.
D. When notified of a missing device fragment, the perioperative team should immediately investigate and follow established count reconciliation procedures.
E. In the event that a device fragment is retained, the surgeon should weigh the risks and benefits of retrieving the fragment.
    1. Risk Management must be notified.
    2. All parts of the broken item and all packaging must be saved until Risk Management is notified and releases or sequesters the items (See Policy 168, Safety Manual: Equipment Management - Medical Equipment Medical Device Failure (SMDA)
F. Disclosure: Communication and Optimal Resolution (CANDOR) of Unanticipated Outcomes).

a. The patient will be informed of the broken part (see Policy 910, Disclosure: Communication and Optimal Resolution (CANDOR) of Unanticipated Outcomes).

G. If a sharp, instrument, or miscellaneous item is broken, all parts of the item(s) must be documented on the CSPD Count Sheet or Standard OR White Boardand removed from the field.

H. If a broken part cannot be accounted for, a methodical search must be completed (i.e. wound, surgical field, linen, floor, under the bed, trash, etc.).

I. The broken part must be noted in the intraoperative report and an online event report must be completed.
   1. The patient will be informed of the broken part (see Policy 910)

J. If the broken item(s) is not located in this search, notify the Coordinator/Charge Nurse immediately and state what is broken/missing. The RN circulator must call for an intraoperative image. The intraoperative image must be read by a radiologist while the patient and surgeon remain in the OR.
   a. An intraoperative image taken in the event of a broken item will screen all quadrants of the cavity in which the surgery was performed.
   b. If the broken item is an unusual or rarely used item, a sample of the item will be sent to radiology to compare with the intraoperative image.

K. Intraoperative imaging may be waived in these circumstances:
   a. If the patient's condition is deemed to be unstable a peri-operative image may be performed in the next level of care.
   b. Items that have the potential of not being image detectable, such as needles smaller than 10 mm (retained item size)
   c. If waived, documentation must occur in the intraoperative report and in an online event report.

L. In the event that an unretrieved device fragment is intentionally left in the surgical wound, the surgeon should inform the patient or patient's representative of the nature of the item and the risks associated with leaving it in the wound and should provide the following information to the patient:
   1. risks and benefits of leaving the device fragment in the wound
   2. material composition of the fragment (if known)
   3. size of the fragment (if known)
   4. location of the fragment
   5. potential mechanisms for injury (eg, migration, infection)
   6. procedures or treatments that should be avoided, such as MRI examinations in the case of metal fragments.

X. Count Discrepancies

A. All perioperative team members should take immediate action to resolve any count discrepancy.
B. If the missing item is not recovered, perform intraoperative imaging to rule out a retained item before final closure of the wound.
C. If missing item is a soft good and has been found inside the surgical wound, intraoperative imaging prior to skin closure is still required to ensure cavity has no retained foreign objects.
D. Intraoperative imaging must be read by a radiologist to confirm absence of radiopaque foreign objects prior to final closure
E. In facilities without immediate access to a radiologist, every attempt will be made to submit radiographs to a radiologist to read and report as close to surgery time as possible. The surgeon may do a preliminary reading of intraoperative imaging for patient to leave OR where radiology is not available.
    1. If the patient's condition is unstable, take the radiograph as soon as possible in the next phase of care.
F. Document unresolved count discrepancies in the patient's record, including all measures taken to recover the missing items, description and location of the item (if known), patient notification and consultation, and the plan for follow-up care.
G. Roles
    1. RN circulator:
        a. 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.
        b. 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.
    2. Scrub person
        a. Organize the sterile field, search the sterile field, including the drapes and tables, and recount with the RN circulator.
    3. Surgeon and surgical first assistant
        a. Suspend closure of the wound if the patient's condition permits.
        b. Conduct manual and visual methodical cavity sweep
        c. Participate in the attainment of intraoperative imaging modalities as indicated to find the missing item.
        d. Remain in the OR until the item is found or it is determined not to be in the patient.
    4. Anesthesia professional
        a. Plan anesthetic milestone actions (eg, emergence from anesthesia) so that these actions do not pressure the perioperative team to perform insufficient count reconciliation practices.

XI. Solid Organ Procurement and Tissue Recovery

A. Solid Organ Procurement - After all solid organ procurements are complete, a final count will be performed with the OPO Surgeon(s) or delegated to a Qualified Banner Practitioner.
    1. Cases that are isolated to only the heart and lungs, the OPO Surgeon(s) must remain in the room for final counts.
    2. Organ Procurements will follow all prescribed procedures of this policy, i.e. imaging for count discrepancies and documentation for packing.
B. Tissue Recovery - After final counts, the OPO Tissue Recovery Technician Preservationist is authorized to complete Tissue Recovery after the Organ Procurement has finished.
    a. Tissue Recovery may occur outside the Intraoperative area once final counts have been completed.

XII. Documentation

A. The RN circulator will document soft good, sharp, miscellaneous item, and instrument counts, and measures taken to prevent RFOs on the patient's intraoperative record, including:
   a. the types of counts (eg, 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 (ie, correct, incorrect)
   e. surgeon notification of the count results
   f. any adjunct technology that was used (RFID) 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
   k. the outcome of actions taken.

A. Additional Information:

A. N/A

B. References:

A. Phillips, N. (2017). Berry & Kohn's Operating Room Technique (13th Ed.).
B. Rothrock, J.C. (2019). Alexander's Care of the Patient in Surgery (16th Ed.). St. Louis: Mosby.
C. AORN Perioperative Practice Guidelines 2020 Edition (Ed. 1)
D. Centers for Medicare & Medicaid Services (August 1, 2022). CMS-3380-F Medicare and Medicaid Programs; Organ Procurement Organizations Conditions for Coverage: Revisions to the Outcome Measure Requirements for Organ Procurement Organizations; Final rule CMS-3380-F_11-20-20_updated@430.docx

C. Other Related Policies/Procedures:

A. Consent Policy
B. Event Reporting
C. Disclosure and Communication and Optimal Resolution (CANDOR) of Unanticipated Outcomes
D. Safe Surgery Policy
E. Negative Pressure Wound Therapy, Adults
F. Safety Manual: Equipment Management - Medical Equipment Medical Device Failure (SMDA)

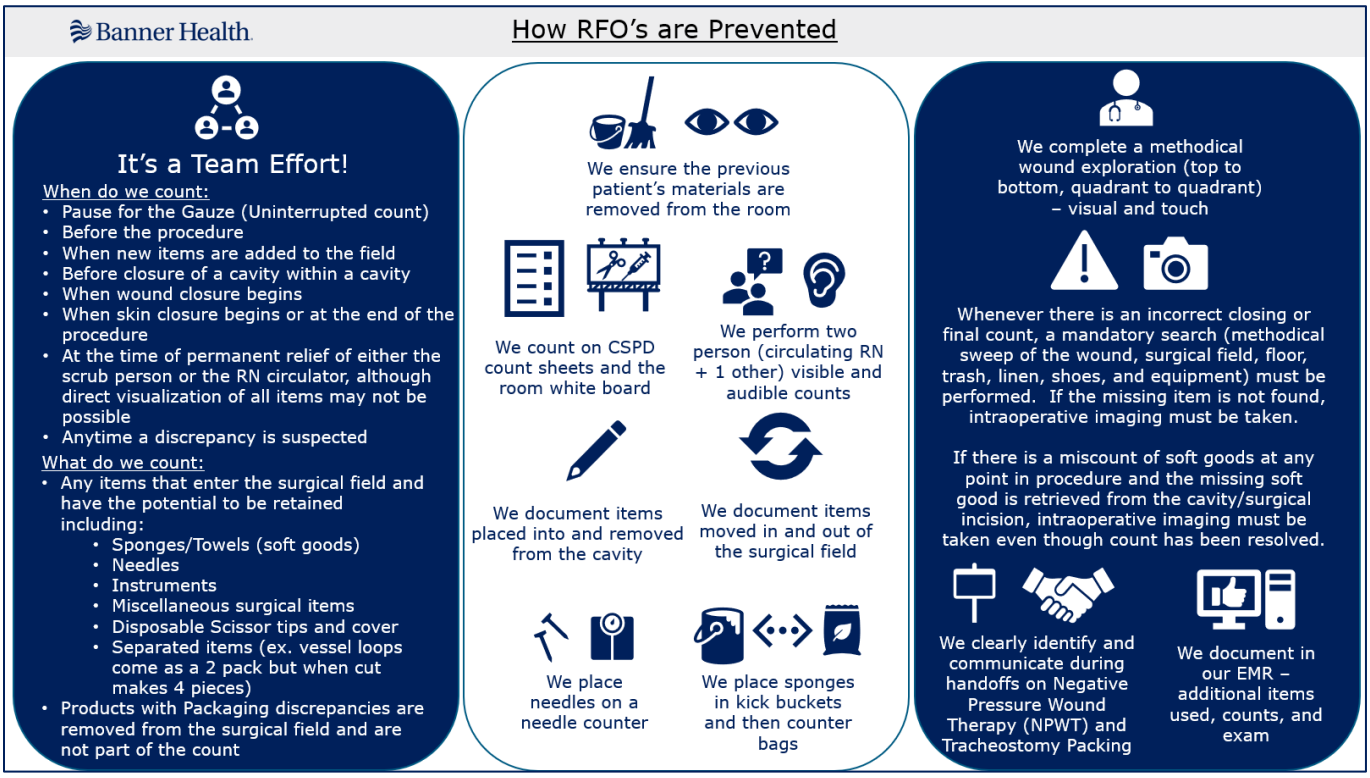
D. Keywords and Keyword Phrases:

A. Count(s)
B. FB
C. Instruments
D. Needles
E. OR
F. Perioperative
G. Perioperative Services
H. Retained foreign body
I. Retention of foreign body
J. RFB
K. Sharps
L. Surgery

E. Appendices:

A. RFO Prevention Visual Aide
B. Standardized White Board
C. Counting Workflow Visual Aide
D. Radio-frequency identification (RFID)

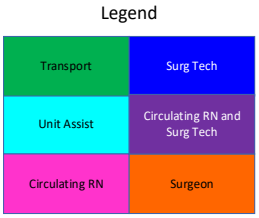
Appendix A: RFO Prevention Visual Aide



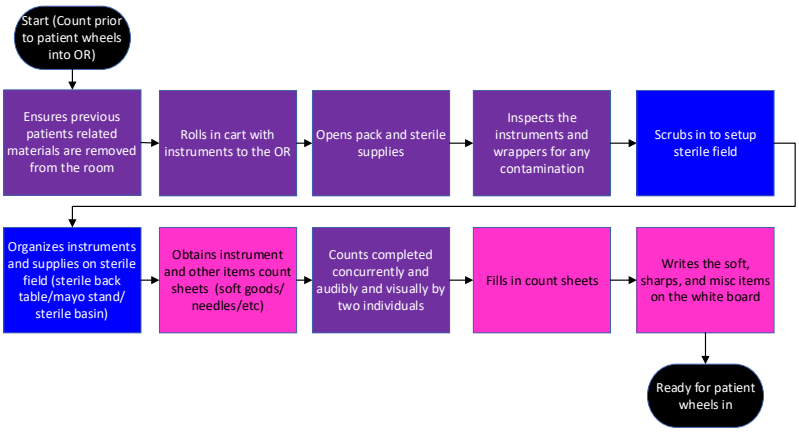
Appendix B: Standardized White Board

Patient Information	Date:			Pre-Procedure Counts			
Patient Name:	Time in/out Room:			Laps:			
	Surgical Time Out:						
	Surgeon:						
Allergies:	Fellow:						
	Resident/FA/APP(s):			Raytecs:			
Pre-Op Antibiotics (include Start and Redose Time):	Anesthesiologist:						
	CRNA/Resident:						
	Nurse(s):			Needles:			
Procedure (include Laterality) - ensure Marking Visible:	Surgical Tech:						
	Student/Vendor:						
	Other:			Blades:			
	In/Out	In	Out	Bovie Tips:			
Specimen(s):	Laps:			Clip Racks:			
	Raytecs:			Cottonoids:			
	Towels:			Hypos:			
				Peanuts:			
Retained/Packed Foreign Objects:				Scissor Caps:			
				Shods:			
				Vessel Loops:			

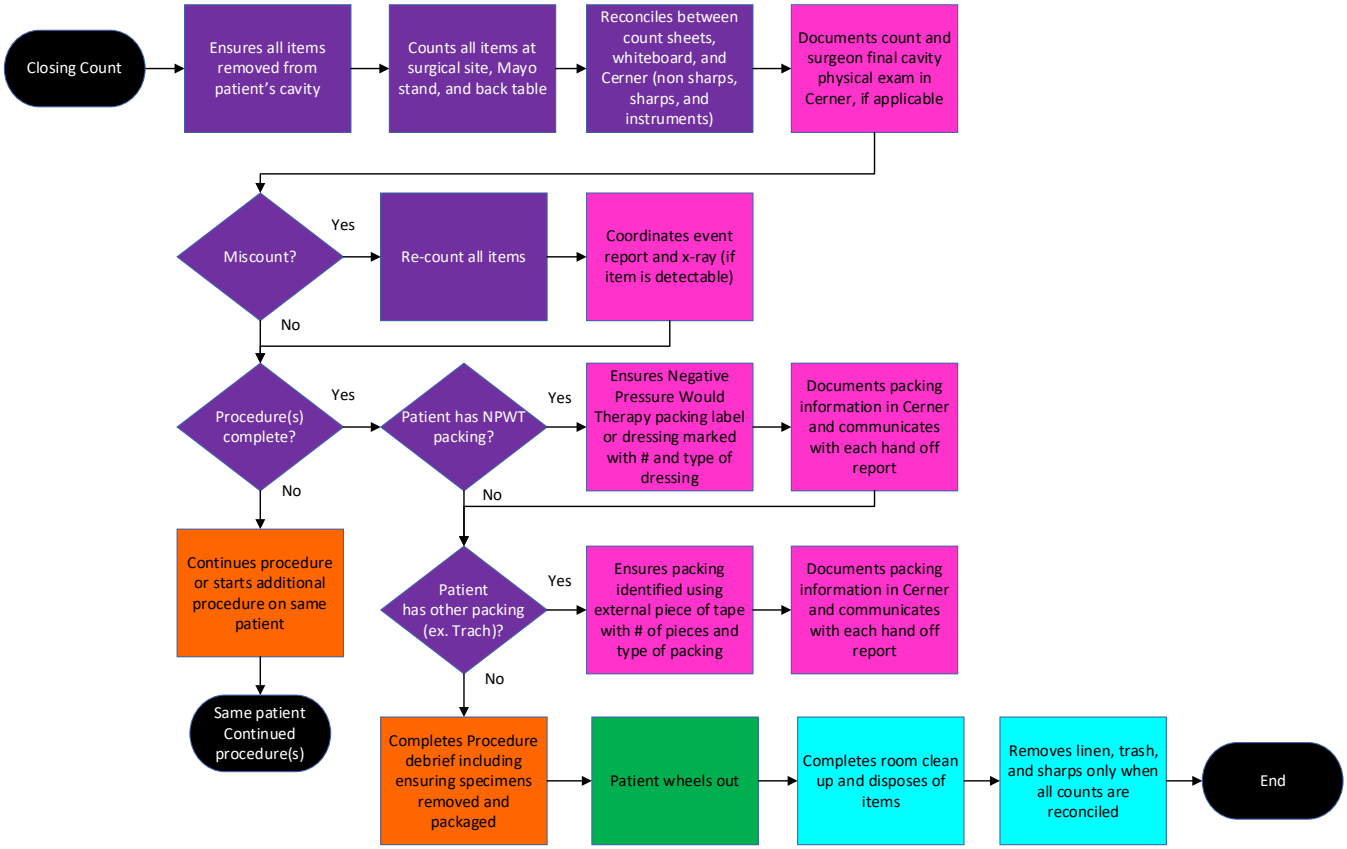
Appendix C: Counting Workflow Visual Aide



Count – Prior to patient wheels into OR:



Maintaining Counts during the Procedure/Surgery – Prior to Closing:



Appendix D: Radio-frequency identification (RFID)

Supplemental counting procedures for facilities employing RFID adjunct technology (BHH & BUMC-T)

A. RFID soft goods are used for all open procedures

B. Removal of non-RFID soft goods from packs (laps, raytecs, and tonsil sponges)
    a. Prior to initial count and before entry of patient to the room
    b. Removed from sterile field, room and labeled

C. Scanning procedures
    1. For any case in which soft goods are counted, the RFID wand and/or mat will be utilized.
        a. The use of RFID detection technology does NOT replace other required counting activities. RFID technology is to be used in conjunction with counting procedures in this policy.
        b. If a RFID mat is to be utilized, verify placement of mat under entire surgical site with label side up, below other non-metal devices.
            i. NOTE: Surgical site must be included fully with the surface area of the RF mat. If the mat cannot be moved to include the entire surgical site without difficulty, a wand scan should be performed
        c. Scanning method utilized for each case is at the discretion of the surgical team (mat, wand, or combined).
            i. NOTE: Mat only scan can take place in cases where the depth of the area scanned is not more than 16 inches. For cases where the depth of the scan area is greater than 16 inches, a wand only scan or a mat and wand scan will be performed.
        d. Any RF mat scan which is inconclusive must be accompanied by use of the RF wand.
        e. RF wands must be covered with a sterile drape, using aseptic technique.
        f. RFID scan must be completed before final closure of surgical wound.
        g. Final counts are documented in the operative report with the final ‘clear’ confirmation code indicating a scan has been performed.

D. RFID soft goods intentionally left in the wound
    a. The final ‘clear’ scan is documented as N/A
    b. Upon return to the OR, the count is resolved, and a final scan is completed and documented with a ‘clear’ confirmation code in the EMR operative report.