Title: Counts: Sponge, Sharp, and Instrument

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<th>Number</th>
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<tr>
<td>227</td>
<td>16</td>
<td>05/29/2020</td>
<td>06/03/2020</td>
<td>06/03/2020</td>
<td>06/03/2023</td>
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Approved by: BH System Practice Oversight Team, Perioperative Service Line Operations Oversight Team, 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 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
- McKee Medical Center
- North Colorado Medical Center
- Ogallala Community Hospital
- Page Hospital
- Platte County Memorial Hospital
- Sterling Regional MedCenter
- Torrington Community Hospital
- Washakie Medical Center
I. Purpose/Population:
   A. Purpose: Counts are performed to account for items and to prevent injury to a patient as a result of retained surgical items.
   B. Population: All Employees

II. Definitions:
   A. **Baseline Count**: The count against which all subsequent counts are compared. It is performed at the beginning of each case, before the patient arrives in the Operating Room.
   B. **Cavity/Space**: Any body space including, but not limited to: abdomen, thorax, pelvis, stomach, bladder, heart, lungs, uterus, vaginal cavity, 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. **Drop Count**: A method of counting sponges whereby the scrub person breaks the tape and separates each sponge by laying each sponge one on top of another.
   F. **Emergency**: An occurrence involving a patient who presents to the operating room with a life-threatening situation or whose condition changes during the procedure to a life threatening situation. Patient demise is imminent if the surgical procedure is not immediately initiated.
   G. **Final Count**: A count performed at the start of closing the final layer.
   H. **Instruments**: Surgical tools or devices designed to perform a specific function, including but not limited to cutting, dissecting, grasping, holding, retracting, or suturing.
   I. **Miscellaneous Surgical Items**: Items that are small enough to be retained in a surgical wound including but not limited to vessel loops, clip bars, umbilical tape, hernia tape, vascular inserts, cautery tip, scratch pads, trocar sealing caps, suture reels, safety pins, hemoclip racks, disposable bulldogs, disposable heparin tips, vascular clamp inserts, defogger solution bottle, cap and sponge, and Raney clips.
   J. **Open Procedure**: A procedure where the skin integrity is breached and there exists the possibility that a counted item could be retained.
   K. **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 left in location for much of the procedure.
   L. **Perioperative Imaging**: Imaging for the prevention of retained surgical item(s) using x-ray, fluoroscopy, or other means of medical imaging. Perioperative will include all areas of surgical care including, includes preoperative, intraoperative, and PACU.
   M. **Sharps**: Suture needles, scalpel blades, electrosurgical cautery tips, hypodermic needles, disposable scissors.
   N. **Sponges/Towels (Soft Goods)**: Cotton disposable cloth or 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 pads (18"x18"), mini laps (12"x12"), laminectomy (4"x18"), raytec (4" x 8"), peanuts/kitners/rosebuds, cottonoids/patties (various sizes), or cotton balls.
   O. **Waived Count**: Surgical procedures in which accurate accounting for sponges, instruments, and miscellaneous items is determined to be unachievable or in situation in which the time

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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.
required to perform the count may prevent an unacceptable delay in patient care (i.e. trauma).

P. **Wound Exploration**: Visual and manual inspection of the wound cavity for the purpose of ensuring that surgical items are not unintentionally retained.

III. **Policy**:
A. Counts of surgical items are performed for all procedures in which the likelihood exists that a surgical item could be retained. If there is any doubt or concern a count will be performed.
B. Instruments are counted any time an anatomical plane is crossed into an open space.
C. Counts will be performed by two individuals one of whom will be an RN circulator.
D. Whenever there is an un-reconciled closing or final count, a mandatory search (wound, surgical field, floor, trash, and linen) must be performed. If the missing item is not found, an intra-operative X-ray must be taken.
E. Perioperative imaging of all quadrants of the cavity for retained surgical item will be required for, but is not limited to:
   1. 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);
   2. Emergency and trauma situations where the patient’s condition prohibits counting;
   3. Procedures that require complex instruments with numerous small parts;
   4. In cases with correct sponge and needle counts, where instruments are not counted at the beginning of the case, and fluoroscopy is used throughout the case, the surgeon must validate the absence of retained surgical instruments by reviewing fluoroscopy images.
   5. In cases with Broken Instruments, Sharps, etc. if the broken part cannot be accounted for.
   6. Exceptions to the required perioperative imaging include endoscopic procedures such as colonoscopy, esophagoscopy, bronchoscopy, laryngoscopy and cystoscopy where a baseline count was not required to be performed.
F. Devices used during the course of surgery are inspected for structural integrity and completeness and will be accounted for both prior to entry into the body and after removal.

IV. **Procedure/Interventions**:
A. **Room Survey**:
   1. The RN circulator or scrub person will perform a room survey before each case to ensure that all evidence from the previous patient and procedure has been removed (e.g., patient ID stickers removed, count record on white board erased). The room survey will be performed after the patient leaves the operating room and before the baseline count is conducted for the next case.
B. **What to Count**:
   1. The following items must be counted:
      a. Sponges/Towels (soft goods)
      b. Needles
      c. Instruments must be counted any time an anatomical plane is crossed into an open space.
      d. Miscellaneous surgical items
C. **How to Count**:
   1. The scrub person and the circulator must directly view each counted item as they count out loud together.
2. The count of each category (e.g., laps, needles) of items must be uninterrupted. If the count is interrupted, then the category of items in which the interruption occurred must be recounted.

3. If the count of any of the following items in a package is incorrect (i.e., if there are not 10 [or five] sponges in the package), the entire package and its contents are isolated from the field and removed from the OR.

4. Sponges
   a. When counting sponges, both people must directly view the radiopaque marker.
   b. The person counting will break the banding tape and separate each sponge by drop count
   c. Sponges and soft goods are tracked on the whiteboard

5. Needles
   a. Needles are counted and the tally is compared with the number listed on the package.
   b. Needles are tracked on the whiteboard

6. Instruments
   a. Each instrument in each category will be counted individually (e.g., 1, 2, 3, as opposed to 2, 4, 6,).
   b. The order in which they are counted will follow the order in which the categories are presented on the instrument list.
   c. The circulating nurse will document the number of counted items in each category by writing the number next to each category of instruments.
   d. Instruments with removable parts are counted as individual pieces (e.g. Balfour wingnut, Bookwalter retractor, Charnley retractor, Poole suction, uterine manipulator).

D. When to Count:
   1. At the beginning of each case, before the patient arrives in the OR, a complete count must be conducted in order to establish the baseline count.
   2. When closing a cavity within a cavity a complete count, including instrumentation, must be completed.
   3. A complete count, including instrumentation is conducted at the start of closing the first layer (Example: peritoneum, fascia and muscle, skin)
   4. 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.
   5. All cases in which the patient is in lithotomy position a cavity exam must be completed along with the final count and documented in the surgical debriefing.
   6. Separate counts must be conducted and documented.
      a. For each site when multiple procedures involving multiple sites are performed.
         i. All counted items must be kept in the OR until all procedures are completed.
      b. At the time of permanent relief of the circulator and/or scrub person. Although the ability to directly see items in the wound may not be possible, they must still be accounted for.
      c. Whenever a member of the surgical team has concerns about the accuracy of the count.
   7. Items added to the field during the case must be counted and documented on the white board.
   8. Temporarily placed items must be accounted for and documented on the white board.

E. Baseline Count:
   1. The RN circulator will record, and scrub person will verify, the baseline count of all items except instruments on a white board.
2. The RN circulator will record, and scrub person will verify, the baseline count of all instruments on the preformatted instrument count sheet.
3. All countable items must be included in the baseline count.
4. The baseline count is the standard against which all subsequent counts are compared.
5. A baseline count of all general instruments will be counted for all minimally invasive. A final instrument count does not need to occur if the case did not convert to an open procedure. In the event that either procedure becomes an open procedure a final count will occur.

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

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

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

I. How to Organize Used Countable Items:
(This will facilitate efficient counting for closing and final counts.)
1. Sponges are thrown in a kick bucket.
2. Throughout the case the circulating nurse retrieves sponges from the kick bucket and places each used sponge in a compartment of a sponge counter bag.
   a. Compartments are used based on the sponge original packaging, one item per compartment.
      i. Each size sponge will be placed into a separate bag i.e. 4x4 vs. Regular laps vs, baby laps.
3. Needles are placed on a needle counter.

J. Verifying Counts: After each count is completed, the circulating nurse should verify and document the count was completed in the EMR. In addition to final count documentation the final cavity exam should also be documented.

K. Broken or Cut Instruments, Sharps, Sponges, Miscellaneous:
1. If a sharp, instrument, or miscellaneous item is broken all parts of the item must be documented on the instrument count sheet and removed from the field.
2. If a broken part cannot be accounted for, a mandatory search must be completed (wound, surgical field, floor, trash, and linen).
a. The broken part must be noted on the Operative Report and an Event Report must be completed.
b. The patient will be informed of the broken part (see Policy 910 Disclosure: Communication and Optimal Resolution (CANDOR) of Unanticipated Outcomes).

3. If the broken item is not located in this search, notify the Coordinator/Charge Nurse immediately and state what is broken/missing. The circulating nurse must call for an X-ray. The X-ray must be read by a radiologist while the patient remains in the OR.
   a. An X-ray taken in the event of a broken item will screen all quadrants of the cavity in which the surgery was performed.
      i. If the broken item is an unusual or rarely used item, a sample of the item will be sent to radiology to compare with X-ray.
      ii. An X-ray may be waived if the surgeon considers the patient’s condition to be too unstable to wait for an X-ray or the item has the potential for not being X-ray detectable, such as needle smaller than 10 mm (retained item size). This must be documented on the Operative Report and an Event Report.
      iii. 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 the surgery time as possible. The surgeon may do a preliminary reading in those situations where radiology is not available.
   b. Risk Management must be notified.
   c. 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)).
   d. The patient will be informed of the broken part (see Policy 910, Disclosure: Communication and Optimal Resolution (CANDOR) of Unanticipated Outcomes)

4. If a counted item is inadvertently cut or altered in any way all parts of the item must be accounted for, documented on the white board and removed from the field.

5. If a vessel loop, umbilical tape or any other items are purposely cut, each piece will be documented on the white board and accounted for at the end of the procedure.

L. Incorrect Closing Count:
   1. If the closing count is incorrect, the following steps are taken:
      a. Notify the surgeon immediately.
      b. A recount must be conducted.
      c. If the item is still missing after the recount, the surgeon must search the wound and the scrub team must search the drapes, field, Mayo stand, and the back table. At the same time, the circulating nurse must search the sponge count bags, trash, linen, floor, and all items that have been counted off the field.
      d. If the item is located in this search, a complete recount must be conducted and the correct count documented.
      e. If the item is not located in this search, notify the Coordinator/Charge Nurse immediately and state what is missing. The circulating nurse must call for an X-ray. The X-ray must be read by a radiologist while the patient remains in the OR.
         i. An X-ray taken in the event of an incorrect count will screen all quadrants of the cavity in which the surgery was performed. If the missing item is an unusual or rarely used item, a sample of the item will be sent to radiology to compare with the x-ray.
         ii. An x-ray may be waived if the surgeon considers the patient’s condition to be too unstable to wait for an x-ray or the item has the potential of not being x-ray detectable, such as needles smaller than 10 mm (retained item size). This must be documented on the Operative Report and Event Report.
         iii. 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 the surgery time as possible.

time as possible. The surgeon may do a preliminary reading in those situations where radiology is not available.

f. For all incorrect counts in which the item is not located, the circulating nurse must do the following:
   i. Submit Event Report
   ii. Document the following items on the OR nursing record and in the Event Report:
      (i) The incorrect count;
      (ii) All steps taken to resolve the count, including the X-ray results and the name of the radiologists who read the X-ray; and
      (iii) The name of the surgeon who was notified that the count is incorrect.

g. The patient will be informed of an unresolved count (see Policy Disclosure: Communication and Optimal Resolution (CANDOR) of Unanticipated Outcomes).

M. Counts Not Done Due to Life-Threatening Emergency Situation:
   1. If counts cannot be carried out because of a life-threatening emergency situation this must be noted on the Operative Report and an Event Report must be completed.
   2. A perioperative image of all quadrants of the cavity should be taken as soon as possible to identify any possible retained surgical items.

N. Instrumentation/sharps/sponges and other items left in wound intentionally:
   1. When the surgeon intentionally leaves instrumentation, sharp(s) or sponge(s) in the patient’s wound, the name and quantity of the instrumentation and/or type of sponge/item left in the wound must be documented in the Operative Report.
   2. In cases when sponges are intentionally left in the wound, sponges that are x-ray detectible should be used.
   3. If the final count—with the exception of the intentionally left items—is reconciled, then the Operative Report reflects a correct count.
   4. The number and types of sponges and other items should be reported to the department to which the patient is transferred (i.e., sponges, drains, etc.).
   5. On subsequent visits the patient’s medical record will state the number and type(s) of sponges used previously for packing and other items intentionally left in the wound. When the previous packing is removed the sponges used will be reconciled with the type and number previously documented in the patient’s medical record. If the number of packing sponges removed concurs with the number documented on the patient’s medical record, then it should be recorded as such. If the wound is repacked, this process should be repeated—the sponges used to repack the wound are again documented on the patient’s medical record.
   6. After any visit, if the number of packing sponges removed from the wound does not concur with the number documented in the patient’s medical record, an Event Report must be completed.
   7. An X-ray must be taken of all quadrants of the cavity to ensure that all sponges have been accounted for, after the wound is finally closed.

O. Negative Pressure Wound Therapy (NPWT):
   1. Intentionally retained NPWT dressing items must be written on the provided label or in indelible ink on the external dressing to include number and type of dressing items.
   2. Minimize the number of dressings (foams, gauze, and contact layers) used to fill the wound bed.
   3. Dressing items applied into a wound tunnel or undermining should maintain a visible tail for ease of access or removal.

P. Miscellaneous:
   1. Linen and trash containers must not be removed from the OR until all counts are completed and reconciled and the patient leaves the room.
   2. Sharps must not be discarded in the sharps container until the final count has been reconciled.
3. Counted items must not be removed from the OR while the case is in progress.
4. A counted item found outside the room cannot be used to correct the count, as it cannot be guaranteed that the item was in the OR.
5. After the final count has been reconciled all non-sharp items (e.g., raytec sponges, laps) are contained and disposed of in the appropriate bag.
6. Once the patient leaves the OR all counted items are removed from the OR. Accounting for and disposing of all counted items at the end of procedure clean-up will help to avoid potentially incorrect counts on subsequent procedures.

V. Procedural Documentation:
A. Counts correct/incorrect will be recorded on the Patient OR Record
B. Incorrect counts require an Event Report and documentation in EMR

VI. Additional Information:
A. N/A

VII. References:

VIII. Other Related Policies/Procedures:
A. Consent Policy
B. Event Reporting
C. Disclosure: 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)

IX. 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

X. Appendix:
A. N/A