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# Sharps, Sponges and Instrument Count, 88.09.00

**Document Type: Policy, Procedure**

**SUPERSEDES**: 8/13, 3/13, 7/05, 3/04, 11/02, 7/02, 12/01,5/96, 7/92, 3/87

## PURPOSE:

Retained surgical items are preventable events that can be reduced by implementing multidisciplinary system and team interventions.

## POLICY:

A consistent multidisciplinary approach for preventing RSIs should be used during all surgical and invasive procedures. Soft goods (e.g., sponges, towels, textiles) opened onto the sterile field should be immediately counted, visibly recorded, and accounted for during all procedures. All sponges used during the surgical procedure will be X-ray detectable and shall not be cut. Initiation of counts is the responsibility of all team members. Sharps shall be handled in a similar fashion.

Instruments should be accounted for on all procedures in which the likelihood exists that an instrument could be retained. Standardized measures for investigation and reconciliation of count discrepancies should be taken during the closing count and before the end of surgery. When a discrepancy in the count(s) is identified, the team should carry out steps to locate the missing item.

Baseline sponge and sharp counts shall be established prior to the beginning of all cases.

Subsequent sponge and sharp counts shall be taken:

- before closure of a cavity within a cavity (i.e. the uterus during a C-Section),
- before wound closure begins
- at skin closure or end of the procedure, and
- at the time of permanent relief of either the scrub person or circulating nurse.

Baseline instrument counts shall be established prior to the beginning of any cases when a body cavity is being entered. Subsequent instrument counts will be performed before wound closure begins.

## X RAY TO VERIFY CORRECT SPONGE, SHARP AND INSTRUMENT COUNT

1. **Criteria for High Risk situations requiring radiologic imaging post-op**: :
   - Emergent Cases (Chest, Abdomen and Pelvis) when a pre-operative count was not possible.

- BMI greater than 35 for open cases
  - Unexpected change in procedure- closed case to an open case.

2. A diagnostic image will be at the Surgeon's discretion for the following criteria:
   - Multiple surgical teams
   - Shift changes
   - Blood loss greater than expected.

3. Exceptions to post-op radiologic imaging:
   - C-Sections meeting BMI criteria when a pre-surgery count is performed
   - Anterior Spinal Fusion – The instrument count will be waived. A C-arm x-ray will be done at closure for instrument count verification and read by the surgeon.
   - Open Heart procedures meeting BMI criteria pre-op, **only** when transferred immediately to ICU bed and post-op tube placement imaging is performed. An additional note on the radiology request should state BMI criteria met for x-ray and to investigate for potential retained surgical item.

4. **In the event of an incorrect or questionable count, the surgeon is notified, a recount is taken, a search is made for the missing item and, if not found, an x-ray will be taken before the patient leaves the OR suite.**
   - Images are provided on either digital or portable films. C-arm can be utilized as a third option.
   - The surgeon will read and verbally confirm x-ray verifies no counted item seen. This will be dictated in the operative report.
   - The Radiologist will provide an over read with a report in the record.

- **\*NOTE: In addition to these recommended counts, additional counts can be initiated and performed at the discretion of either the scrub person, circulator or surgeon during the procedure.**

## EQUIPMENT:

Count sheet for any instrument tray
White count board
C-Arm

## PROCEDURE:

| ACTION | RATIONAL |
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| 1. Counts will be performed audibly and concurrently viewed by the scrub and Circulating RN. Documented on the intraoperative record by the registered nurse. Sponges will be separated during the initial count. Suture needles will be counted according to the number of needles marked on the outer package and verified by scrub and circulator at the time of use. Subsequent counts should be performed according to the manufacturer's packaging (5 laps, 10 raytec, multipack needles, etc.) | **1. The initial sponge count is performed to determine all packages of radiopaque sponges/sharps contain the correct number and appropriate radiopaque marker or identification bar code, tag or chip. Incorrect numbers of items or product defects within a package do occur. If found, these items should be removed from the OR suite immediately and not included in the count.** |

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| 2. An initial count shall be taken on all procedures, prior to making an incision. | 2. Performing and recording initial counts establishes a baseline for subsequent counts on all procedures. |
| 3. When additional sharps, sponges, or instruments are added to the field, they will be counted and recorded immediately on the visible white board as part of the count. No distractions should keep the count from being seen immediately. | 3. Counting and recording additional sharps, sponges, or instruments as they are added to the field is required to account for all items at the conclusion of the procedure |
| 4.Counts should be performed in the same sequence each time. | 4.The count should begin at the surgical site and the immediate surrounding area, proceed to the Mayo stand and back table and finally, to counted items that have been discarded from the field. |
| 5. The use of counted sponges as postoperative packing is not allowed except when specifically designated for hemostasis and the count reflects the number of sponges in the abdomen. | 5.If counted sponges are intentionally used as packing and the patient leaves the OR with this packing in place, the number and type of sponge retained must be documented on the intraoperative record, the progress notes and be included in the handoff. |
| 6. The surgical team will account for all disassembled or broken instruments or sharps in their entirety. | 6. In the event that an unretrieved device fragment is left in the surgical wound (eg, broken instrument tip), the surgeon should inform the patient of the nature of the item and the risks associated with leaving it in the wound. |
| 7. All sponges used during the surgical procedure will be X-ray detectable and shall not be cut. | 7. Altering a sponge by cutting or removing radiopaque portions invalidates counts and increases the risk of a portion being retained in the wound. |
| 8. Linen and waste containers should not be removed from the room until counts are completed and resolved. | 8. The missing item could be in the linen or waste container |
| 9. All sponges, sharps, and instruments shall be accounted for and removed from the room during end-of-procedure cleanup. | 9. Removing all counted items from the room helps avoid potential incorrect counts on subsequent procedures. |
| 10. In the event of an incorrect or questionable count, the surgeon is notified, a recount is taken, a search is made for the missing item and, if not found, an x-ray will be taken before the patient leaves the OR suite. If the item is not found on the x-ray, documentation of result is recorded on the record. If x-ray indicates the item is retained in the patient, document this finding and the course of action taken. | 10. Contact lead nurse/ manager to initiate no patient charge for the x-ray. |

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| 11. Anterior Spinal Instrument Count Verification<br><br>   a. Prior to closure, the instrument count is waived and x-ray with c-arm sweep will be taken by the x-ray technician.<br><br>   b. The surgeon will read and verbally confirm x-ray verifies no instrument seen. This will be dictated in the operative report.<br><br>   c. The circulator will document the x-ray result for confirmation of instrumentation on the OR record. An annotation shall be made as to the outcome of the x-ray findings. | 11. Procedures in which accurate instrument counts may not be achievable include, but are not limited to,<br>  • Complex procedures involving large numbers of instruments (eg, anterior-posterior spinal procedures,<br>  • Procedures where the width and depth of the incision is too small to retain an instrument |
| 12. Documentation of counts includes but is not limited to:<br>  • Types of counts (sponge, sharp, instrument)<br>  • Names of personnel performing the counts<br>  • Results of surgical counts<br>  • Notification of the surgeon<br>  • Items remaining with and/or in the patient<br>  • Actions taken if count discrepancies occur, and<br>  • Electronic QRR | 12. Documentation of nursing activities related to the patient's perioperative care provides an accurate picture of the nursing care administered and the outcomes of the care delivered. Extreme patient emergencies may necessitate waiving counts. Documenting the omission and rationale provides a record of the occurrence. |
| 13. Robotic (DaVinci) cases: During all robotic cases when passing any routinely counted item through the trocar, the person performing this will verbally announce "needle in, needle out," with each motion. If a soft good is passed through the trocar, the same verbal announcement will be made. This alerts all team members of this action and affirms its removal. It specifically alerts the surgeon while in the console. The verbal announcement is particularly important to affirm passing of countable items due to the limited field of vision inherent in robotic procedures. | |

## Attachments:

No Attachments