Great Ormond Street Hospital for Children NHS Foundation Trust

Policy

Surgical Count Policy

Key Points

In order to prevent the risk of retained foreign objects during an invasive procedure a systematic count must take place between TWO members of the surgical team.

As a minimum a surgical count must take place prior to the commencement of the procedure and a final count must be undertaken as the procedure finishes.

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Document Lead:	Shiyas Kandy
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Policy Category:	
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Target Audience:	All staff involved in the care of the patient in the intraoperative phase of treatment and in all areas where invasive surgical procedures take place.

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Document Control	
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Related Trust Documents:	
• Safeguarding Children and Young People Policy • Surgical Count clinical guideline • Consent Policy	

Contents

1. Introduction

1.1. Surgical items, such as swabs, sharps and instruments, are foreign bodies and must be accounted for in order to prevent retention and injury to the patient (Rothrock, 2015)

1.2. Retained objects are considered a preventable occurrence and strict adherence to this policy should significantly reduce, if not eliminate these incidences (AfPP, 2011)

1.3. 'Retained foreign objects post procedure' are included on the NHS England list of never events. A never event is a serious incident that is preventable due to the availability of national guidance or safety recommendations that should have been implemented by all healthcare providers (NHS England, 2015.)

2. Aims and Objectives

2.1. The aim of this policy is to provide a systematic approach that ensures all swabs, needles and instruments used during invasive surgical procedures are accounted for at all times. This system will prevent foreign body retention and subsequent injury to the patient.

3. Duties and Responsibilities

3.1. All staff within theatres including Surgeons, Nurses, Operating Department Practitioners , and, unregistered theatre practitioners including Assistant Theatre Practitioners and Health Care Support Workers involved in the intraoperative phase of care of a patient and involved in invasive surgical procedures should be familiar with and responsible for the implementation of this policy.

4. Definitions

4.1. Countable items may include but are not limited to:

- 4.1.1. Atraumatic needles (ATN's)
- 4.1.2. Blades
- 4.1.3. Bulldogs
- 4.1.4. Cotton wool balls
- 4.1.5. Cologne clips
- 4.1.6. Cottonoids
- 4.1.7. Diathermy tips & tip cleaners
- 4.1.8. Drill bits
- 4.1.9. Gauze strips
- 4.1.10. Guide wires
- 4.1.11. K- wires
- 4.1.12. Hypodermic needles
- 4.1.13. Instruments containing screws or detachable parts

4.1.14. Liga-reels
4.1.15. Laparoscopic retrieval bag
4.1.16. Malecot bands
4.1.17. Ophthalmic micro sponges
4.1.18. Patties
4.1.19. Pledgets
4.1.20. Raney clips
4.1.21. Red swab ties
4.1.22. Saw blades
4.1.23. Slings/ sloops
4.1.24. Shods
4.1.25. Tapes
4.1.26. X-ray detectable gauze swabs- mastoids (15 x 2.5cm), MLB swabs (7.5 x 7.5cm), 4 x 3 (10x7.5cm) swabs, 6 x 4 (15 x 10cm) swabs, 9 x 9 (22.5 x 22.5cm) swabs, craniotomy swabs (76 x 7.5cm).

5. Surgical Count

5.1. The surgical count involves the systematic counting of all countable items and instruments used during the intraoperative phase of patient care.

5.2. The surgical count must be undertaken by a scrub practitioner and a circulating practitioner, one of which must be a registered member of the perioperative team (registered nurse or registered operating department practitioner (ODP)). The count should not be completed between two circulators or two scrub practitioners.

5.3. Where possible, the same two perioperative personnel should perform all the counts that take place during a surgical procedure.

5.4. The scrub practitioner must take the lead for carrying out the surgical counts. This must be done in a systematic manner involving the circulating practitioner. Both members must count audibly and in unison with each other to acknowledge the items.

5.5. A surgical count must be performed for all invasive procedures and recorded instantly. The scrub and circulating practitioners' must sign the patient's care plan to document each count has taken place in accordance with this policy.

5.6. The theatre environment must have a dry-wipe board, which is pre-printed and displays all the significant items used. The board must be a permanent fixture within the theatre and be visible and accessible to every member of the team.

5.7. When undertaking a procedure in an area not within the theatre environment a paper record of the count must be completed and placed in patient's notes.

5.8. An initial full surgical count must be completed prior to the surgery commencing.

5.9. A first closure count must be completed before the closure of a cavity or a cavity within a cavity.

5.10. A final count must occur at the commencement of the closure of skin or at the end of the procedure.

5.11. In all cases involving surgery within a natural cavity (e.g. mouth, vagina, anus), a final count must be performed at the commencement of the closure of the wound with a further consolidation count at the end of the procedure prior to the scrub trolley being removed from the surgical field.

5.12. The operating surgeon and the scrub practitioner must equally be responsible for the returning of all countable items to the scrub practitioner after use. The operating surgeon must ensure that the scrub practitioner is given adequate time to perform the checking of all countable items and instruments . On completion of the final count, the scrub practitioner must communicate to the operating surgeon that the cavity/ final surgical count is correct and that all items are accounted for. The operating surgeon must also verbally acknowledge the fact that he or she has heard the scrub practitioner. Please see section 10 for guidance in the event that the final count is not correct.

5.13 .Should it be necessary to replace the Scrub Practitioner during the procedure a full count must be performed, and the location of all disposable items in use verified, recorded and signed by the incoming and outgoing practitioner. The names of both practitioners should be recorded in the Perioperative Record of Care/Operation Register/theatre register/Electronic Patient Record (future state)
Should it be necessary to replace the Scrub Practitioner temporarily a check of all countable items must be performed by the incoming and outgoing practitioner and the location of any instrumentation in use verified.

5.14. When a surgical count is taking place there should be no interruptions. Once a count has been started it should be completed. If interrupted, the count must resume at the last recorded item.

5.15. Additional items required during the surgery must be counted when given onto the sterile field and recorded on the dry wipe board/ paper count by the person who opened the item.

5.16 If there is no scrub practitioner required during a procedure e.g. Dental Extractions or Cystoscopy, the circulating practitioner should either be a Registered Practitioner, or an unregistered practitioner who is trained and competent to perform the count with another member of the theatre team or the operating surgeon . The count must not be completed between two unregistered practitioners.

6. Instrumentation

6.1. The instrument check lists must be available and provide an accurate record of the instruments on the set. This must be used to check the instruments at the beginning of every case.

6.2. The instruments must be counted in an audible, organised style, following the pre-printed check list. The circulating practitioner can then use the checklist to document that instruments are correct and complete the tracking documentation.

6.3. Instruments that have the potential to be disassembled (i.e. removable parts or screws) must have all components checked and accounted for.

6.4. Instruments should be counted before they are separated and organised by the scrub practitioner, for example setting up of a mayo table.

6.5. Any instruments that are found to be damaged or not working must be removed from use and labelled for repair.

6.6. Staff involved in the surgical counts must be able to recognise and identify the instruments they are counting.

6.7. If an instrument tray is incorrect when doing the initial count, it should be either removed and a new one opened or continue to be used only if the scrub practitioner is satisfied that the instrumentation required for the procedure is present. However, in both circumstances, the missing instruments must be documented on the instrument check list and sterile services informed.

6.8. If any supplementary instruments are opened, the packets must be retained with the instrument checklists for reference during cavity and the final counts.

7. Swabs

7.1. All swabs, including mastoids, pledgets, neurosurgical patties and packs must have an X-ray detectable marker throughout the width of it for all invasive procedures.

7.2 Swabs must not be cut or altered in size, except cottonoid swabs which may be cut into groups of FIVE appropriately sized pieces when used for neurosurgical procedures. Neurosurgical patties used for ENT surgery may also be cut, with the excess pieces being counted, sealed in a clear bag and disposed of in the clinical waste bin in the sluice room.

7.3. All swabs, including mastoids, pledgets, neurosurgical patties and packs must be counted in the numbers they are packaged in, e.g. swabs in bundles of 5 and neuro patties in bundles of 10. This includes cotton wool balls that are used for ear, nose and throat surgery.

7.4. If there is a package containing less or more than the number that should be there, they are to be collected, passed off to the circulating practitioner, bagged and labelled. These swabs must then be removed from theatre and not added to the count. The batch and lot numbers must be identified and the appropriate bodies/ agencies informed.

7.5. Any tags or bands holding the swabs together must be retained and counted by the scrub practitioner as a means of checking the amount of swabs later if there are any discrepancies.

7.6. The recommended sequence for counting swabs is from small to large and in a linear fashion e.g. from the bowl stand, to the sterile trolley to the patient. The recommended counting sequence is swabs, sharps, instruments.

7.7. Items should be completely separated during the checking procedure.

7.8. The integrity of the X-ray detectable marker must be checked when the items are being counted

7.9. The integrity of swabs with tapes, e.g. abdominal packs, must be checked when items are being counted.

7.10. Swabs should be left in full view of the surgeon carrying out the procedure at all times.

7.11. Used items must be counted off the sterile field in the number they were counted in originally e.g. swabs in 5 and neuro patties in 10, as soon as possible. This must be done by opening out all items completely, counting them in unison with the circulating practitioner and placing them into a non-sterile clear bag, held open by the circulating practitioner whilst following standard precautions.

7.12. The bag must be sealed by the circulating practitioner and labelled with the size of the swab inside.

7.13. Swabs retained in the wound to act as packs intraoperatively must be documented on the wipe board designated for the surgical count with the following information:

7.13.1. Clearly defined as ‘swab(s) within the wound/ cavity.’
7.13.2. Time swab was inserted
7.13.3. Size of swabs in situ
7.13.4. Number of swabs in situ

7.14. When the swabs are removed from the wound/ cavity, the scrub practitioner must show the swabs to the circulating practitioner to both acknowledge the items and the circulating practitioner must document the swabs removed on the wipe board but not erase the entry.

7.15. Swabs must not be opened and then have the X-ray detectable marker removed and used as dressings.

7.16. Dressing gauze without an X-ray detector strip must be used for wounds that require gauze dressings and must only be opened at the closure of the skin.

8. Throat Pack

8.1. If a throat pack is required this must be discussed at team brief in order to inform the entire team. This must be a joint discussion between the surgeon and anaesthetist for each patient including who will be placing the throat pack. Please see appendix 2 for the throat pack aide memoire.

8.2. Throat packs must contain a radio opaque marker, are sterile wrapped and are to be kept in the theatre prep room. They must be opened onto the sterile trolley and collected from the trolley if being placed prior to prepping.

8.3. Throat packs are to be included in the surgical count and the insertion and removal times must be recorded on the dry wipe count board and in the care plan. As soon as possible following insertion, a throat pack sticker must be affixed to the patient's forehead and circuit filter.

8.4. The person placing the throat pack must clearly announce 'throat pack in situ' once it is placed. During the time out, if the throat pack has been placed already, this must be clearly stated again.

8.5. The person removing the throat pack should be the person who placed it and must clearly announce 'throat pack removed' once they have removed it. The removal and time of removal must be clearly documented on the dry wipe count board, in the care plan and on the operation report.

8.6. The final count cannot be deemed correct until the throat pack is removed and the sign out should not be completed until the throat pack is removed.

9. Sharps and other items

9.1. Hypodermics, blades and sutures must be counted before the invasive procedure starts. These must be collectively counted and added to the dry wipe board.

9.2. Any additional sharps that are given during the surgery must be individually counted and added to the wipe board, according to the number in the packet and a running total of the number of sharps recorded.

9.3. Suture packets must be retained by the scrub practitioner until the final count has been completed and correct. These must be counted as part of the first closure count and final count to confirm dry wipe board total is correct then corresponding atraumatic needles must be counted.

9.4. In all cases involving a natural cavity (i.e. mouth, anus, vagina) hypodermic needles used for injecting local anaesthetic must be used in conjunction with a luer lock syringe.

9.5. If at any point during the surgery a sharp breaks, the scrub practitioner must be aware of it and have all the pieces returned for correct disposal onto the sharps pad. All pieces must be accounted for at the end of the procedure. If the broken piece is dropped or contaminated see section 11.6.

9.6. If the broken piece is lodged into bone and difficult to remove (e.g. drill bit or screw) it is up to the surgeon to decide whether or not this is to remain in situ or be removed. In either case this must be documented in the patient's care plan and communicated to patient/ parents.

9.7. If surgical nylon tapes or silicone vessel loops are cut for the purpose of the procedure being carried out, they must be documented on the dry wipe board and all pieces accounted for when subsequent counts are being carried out.

9.8 Ophthalmic micro sponges must not be cut or altered in any way. They must be counted before the invasive procedure starts and added to the dry wipe board.

10. Count discrepancy

10.1. If at any point during an invasive procedure the surgical count is incorrect, the surgeon must be notified, another count carried out and a thorough search of the surgical field and surrounding area started.

10.2. If the missing item(s) are not recovered after a recount and the search has been completed, the patient must have a plain film X-ray taken of the operative site before leaving the theatre complex.

10.3. If the missing item(s) are microscopic needles of 7/0 gauge or smaller (8/0, 9/0 etc) and there is potential for them not to show up on an X-ray this will need to be documented on the patients care record, the theatre register, an incident form must be completed and the patient/ parents informed. This is the only time the surgeon may use their discretion as to whether to X-ray for the item(s).

10.4. If there are any concerns regarding the locating of the missing item(s) the theatre co-ordinator or theatre manager should be contacted in hours and the CSP out of hours.

10.5. All the missing item(s) must be documented on the patient's care record, the theatre register, a Trust incident form completed and the patient/parents informed. The type of item(s) missing and the action taken must be included in the report.

10.6. The only exception to this procedure is if the patient is deemed too unstable and this must be documented in the patient's care record, a Trust incident form completed and the patient/parents informed.

11. Other information

11.1 Items which are to remain in the patient by intention e.g. pacing wires, swabs drains and catheters must be recorded in the Perioperative Record of Care/local document, patients notes/electronic patient record(future state). Countable items may be left in a wound intentionally e.g. when an abdominal cavity is packed with large swabs with X-ray detectable marker to aid haemostasis for a limited period. These must be documented in the Perioperative Record of Care/theatre register, patient's notes/electronic patient record(future state) and handed over to the recovery/ ICU staff including the location, size, number and anticipated date of removal ,and the family must be informed of the same.

11.2 During team brief and/or time out for review/repeat /re-exploratory surgery/, the operating surgeon must check and identify any countable items that had been intentionally left in the patient during the initial surgery. The scrub practitioner must confirm this with the perioperative record of care/theatre register. The scrub practitioner must document their removal including time, date and identity of the practitioner removing the item in the patient's notes/electronic patient record at that point of care.

11.3. All items used for the surgical procedure are to remain within the theatre environment until the surgery is finished and the final count completed. This includes all clinical and non-clinical waste products and theatre laundry.

11.4 If a patient is undergoing more than 1 surgery under the same general anaesthetic, all the countable items for each procedure must be counted in , accounted for and counted out as per section 5, before the next surgical procedure on the same patient commences. Separate clinical waste bags must be used to dispose countable items from each procedure on the same patient . These bags must be changed before the next surgical procedure on the same patient begins and are to remain within the theatre environment until all the planned surgeries on the same patient are finished.

11.5. All waste bins and laundry bags must be changed between cases.

11.6. If any item is dropped at any time during the invasive procedure, it should be collected by the circulating practitioner and the scrub practitioner must be notified. It must then be placed in an appropriate area, away from the sterile field but not out of the theatre environment.

11.7. If the patient requires urethral catheterisation at any point, only dressing gauze must be used and not X-ray detectable swabs.

11.8 At all times during the surgical procedure, the scrub practitioner must be aware of the location of all swabs, sharps and instruments. It is recommended that neatness should be encouraged so to ensure that only essential items are in use at any given time.

11.9 Any swabs that are to be used as surface dressings must NOT be X- ray detectable. Swabs that are to be used for this purpose must not be opened until the skin has been closed. They must NOT be X-ray detectable, as it must be demonstrated that all X-ray detectable swabs have been removed from the patient post operatively.

11.10 Any sterile swabs used for anaesthetic procedures should be coloured or must NOT be X-ray detectable . In extremis where non x-ray detectable swabs are unavailable for anaesthetic procedures, x-ray detectable swabs can be used. In these cases the x-ray detectable swabs should be counted as per policy and disposed of prior to the operative procedure commencing to prevent the event of confusing the anaesthetic swabs with those used during the invasive procedure and to prevent the risk of swabs being retained from an inaccurate count.

12. Training requirements

12.1. All staff and students within theatres must read this policy as part of local induction.

12.2. Student nurses must be supernumerary and supervised by a qualified member of the perioperative team whenever taking part in a surgical count.

12.3. All registered staff, Student Operating Department Practitioners and Support Workers must be deemed competent using the departmental guidelines and assessment tools to take part in a surgical count by a registered practitioner and documentation of this assessment should be available.

13. Monitoring arrangements

13.1. This document will be monitored as part of the central monitoring of the WHO checklist, which is conducted via an automated email based system daily by the Surgery Service Manager and relevant administrative support staff.

13.2. Any count discrepancies should be reported via Datix incident reporting system. The person in charge of the specific surgical list must ensure a Datix report is raised should a discrepancy in count is identified. This will be

followed up as per the Incident reporting policy by the surgical risk action group.

13.3. This document will be reviewed and updated by the Theatre Practice Education Team every 2 years.

14. Equality Impact Assessment

14.1. Please see appendix 1.

15. Associated Documents (Procedures and Forms)

15.1. Great Ormond Street Hospital Surgical Count Clinical guideline
15.2. Incident reporting policy

16. References

16.1. Equality Act 2010

16.2. Association for Perioperative Practice (AfPP) 2012 Swab, Instrument and Needle Count IN *Association for Perioperative Practice, Standards and Recommendations for Safe Perioperative Practice*, 3rd edition, Harrogate, AfPP

16.3. Association of Perioperative Registered Nurses (AORN) (2010) Recommended practices for sponge, sharp and instrument counts AORN In: *AORN standards, recommended practices and guidelines*. Denver, AORN

16.4. Rothrock, J 2015 Alexander's Care of the Patient in Surgery, 15th edition, Mosby, Missouri.

16.5 The Never Events List; 2015/16 update March 2015.

https://www.england.nhs.uk/wp-content/.../never-evnts-list-15-16.pdf

Appendix 1: Equality Analysis Form – Surgical Count policy

Title of Document:	Surgical count policy
Completed By:	Shiyas Kandy
Date Completed:	10/11/2017
Summary of Stakeholder Feedback:	

Potential Equality Impacts and Issues Identified		
Protected Group	**Potential Issues Identified**	**Actions to Mitigate / Opportunities to Promote**
Age	None	N/A
Disability (Including Learning Disability)	Hearing impaired staff may have difficulty hearing the count through a mask.	Encourage all scrubbed staff to speak clearly and loudly. Ensure all staff seek clarification if communication issues arise.
Gender Re-Assignment	None	N/A
Marriage or Civil Partnership	None	N/A
Pregnancy and Maternity	None	N/A
Race	None	N/A
Religion or Belief	None	N/A
Sex	None	N/A
Sexual Orientation	None	N/A

Appendix 2: Throat pack aide memoire