Title:	Policy Number: BC-SRG-SVCS-107
SPONGE, SHARPS, INSTRUMENTS, and INCIDENTAL COUNTS	**Page:** 1 of 4
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This policy is developed as a guideline to address general circumstances. There may be certain instances in which the exercise of professional judgment and/or discretion by the health care provider warrants taking other actions.

This **SPONGE, SHARPS, INSTRUMENTS, and INCIDENTAL COUNTS** Policy applies to BayCare Health System, Inc. and any of its affiliated entities, including those entities listed above (collectively, "**BayCare**").

PURPOSE:

The purpose of the sponge, sharp, incidental and instrument counts are to protect the patient from the injury of retained sponges and foreign objects.

POLICY:

A. Sponge, sharp and instrument counts are routinely performed.
   Exceptions:
   1. Instruments counts are not required if the wound is too small to retain or permit closure over the smallest instrument on the field.
   2. Procurement cases do not require counts.
   3. Life threatening emergencies and multi-level spinal procedures are exempt. When a count for instruments is not performed due to these exceptions an AP and Lateral x-ray is taken at the end of the case and read by a radiologist.
   4. Sponge counts and radio-frequency (RF) sponges are not required for the following cases where the incision is too small to retain or permit closure over a sponge.
      a. Procedures without incisions, i.e., closed reduction, cystoscopy
      b. Myringotomy
      c. Eye cases, i.e., cataracts, eye muscle surgery
      d. Digit surgery i.e., fingers or toes
      e. Percutaneous pinning

B. Counts are performed visually and audibly by two individuals, one of whom is an RN circulator. Both verbally acknowledge correct count.

C. When either the scrub person or circulating nurse is permanently relieved, a count is taken for sponges,

sharps, and incidentals by the relieving team member unless the case is a listed exception.

D. Any new or additional items placed on the sterile field are added to the count.

E. Linen hampers and waste receptacles and their contents that are in the room at the time of the initial count must remain in the room until the final count is completed.

F. Surgical team member can request an interim count and/or a RF wand or mat scan be performed.

G. If during the final count process any member of the surgery team has concerns regarding the accuracy of the count an x-ray of the operative site is taken and interpreted by a radiologist for confirmation.

H. Imaging results related to sponges, sharps and/or instrument counts are be interpreted and communicated directly to the surgeon by the radiologist.

I. Radio-frequency (RF) scanning is incorporated into all procedures that utilize RF sponges/products and are used as an adjunct to the count:

1. RF products are not be cut, modified, tampered with, or have the chip removed.

PROCEDURE:

A. Counts of sponges, sharps, instruments, and incidental items are performed at the following times

1. Initial count - before incision is made or cavity is entered, i.e., vaginal procedure.
2. First closure count - when a cavity is being closed (e.g., peritoneal, pleural).
3. Final count - as skin closure is begun and must be completed by final skin closure. Final skin closure will be evidenced by the application of a dressing (ie; 4x4, band-aid, steri-strips, dermabond etc.).
4. During permanent relief of either scrub or the RN circulator a count is taken for sponges, sharps and incidentals by the relieving team member.
5. Additional Counts
   a. Whenever a hollow organ (e.g., uterus) is opened - an additional count is made as the organ is closed.
   b. When the retroperitoneum is opened - an additional count is made as the retroperitoneum is closed.
   c. When a bilateral procedure is performed - a separate count is taken for each side.
   d. When a multiple stage operation is performed a separate count is taken for each stage.
   e. After the final count, items utilized in each procedure are sequestered and remain in procedure room until the end of the case.
   f. Post vaginal procedures, the vaginal cavity is checked by physician prior to re-positioning patient's legs.

Any member of the team is empowered to say "STOP" and halt the process from moving forward because they know an error has been made or feel something is not right, without fear of retribution. If at any time a member of the team feels intimidated or threatened for speaking up they are to contact their supervisor or any member of the leadership team immediately.

B. Sponge Use (items to be counted but not limited include: Laps, Tapes, Raytex, Patties, Cottonoids, and Kittners)

1. General considerations
   a. Sponges used for surgical procedures must contain an x-ray detectable element and a RF chip (if available).
   b. Sponges removed from the sterile field must remain in the room and are retained for the count.
   c. Used sponges passed from the sterile field during the procedure are to be opened and placed in the counter bags.
   d. Sponges placed inside a cavity must be announced to the team and noted by the circulator on the count tool to be referenced during final count.
   e. Used sponges must be placed in the counter bags prior to counting.
   f. Counted sponges are not used for dressings.

2. RF Technology Use
   a. The RF mat is placed directly on top of the torso surgical table pad and under positioning devices, drapes, linens, and other non-metal devices. The RF mat is not used with specialty beds (i.e.; Jackson table or Fracture table) and in Gynecological procedures the RF pad will not cover the perineal cutout of the surgical table pad, therefore the wanding method is used.
   b. Prior to final closure, an RFID mat and/or wand scan of the patient is completed.
      1) The RN circulator performs the mat scan.
      2) If the mat cannot be moved to include the entire surgical site without difficulty, a wand scan is performed by the surgical tech. The wand is covered by a sterile drape and scanned using aseptic technique.
   c. An RF mat scan which is inconclusive is accompanied by use of the RF wand.
   d. Scanning method utilized for each case is at the discretion of the surgical team (mat, wand, or mat and wand) except for cases where the depth from the mat to the top of the patient is greater than 16 inches, then a wand only scan or a mat and wand scan is performed.

e. For cases with a missing RF sponge/ product:
   1) RF wand or mat scan is performed immediately. If the RF sponge/ product is detected and retrieved, an x-ray is NOT necessary. A count is performed once RF sponge / product is retrieved and the count deemed correct. Then perform another RF wand or mat scan to ensure RF gives "clear" confirmation code.
   2) Linen and trash receptacles are scanned with the RF wand to facilitate location and retrieval of a missing RF sponge/ product.
   3) If an RF wand or mat scan remains unresolved or inconclusive or if the wand or mat scan states "clear" but the count is still not correct, an x-ray is performed. See process for x-ray E. 3.

f. If a count is omitted in the event of an emergent situation then a RF mat or wand scan and x-ray is taken at the end of the case when the surgeon deems it is safe for the patient.

g. In the event that RF vaginal packing is utilized at the end of the case, the RFID clearance must be performed, prior to vaginal packing being placed.

h. Additional Reference: Refer to the manufacturer's general information card attached to each RF console.

3. Responsibilities of the scrub person and circulating nurse

a. If there is an incorrect number of sponges in a package prior to the patient entering the room, the entire package is removed from the room. If there is an incorrect number of sponges in a package after the case has started, the entire package is removed from the sterile field, sequestered in the room, and excluded from the count.

b. The Surgical Tech is responsible for:
   1) Maintaining sterile technique when using the RF devices.

c. The circulating nurse is responsible for:
   1) Recording sponge counts on the count worksheet or count board.
   2) Recording results of sponge counts on the operative record.
   3) Initiating RF scans and recording the "clear" confirmation number in the medical record.
   4) Recording the number and kind of sponges left in place as packing on the operative record.
   5) Informing the surgeon of the count results and receiving verbal confirmation.

C. Sharp or incidental item count

1. General Considerations

a. Items to be counted include but are not limited to the following:
   1) Atraumatic needles
   2) Free needles
   3) Hypodermic needles
   4) Scalpel Blades
   5) Bulldogs
   6) Vascustats
   7) Dissectors

b. Items that have been altered or sharps broken during a procedure must be accounted for in their entirety and the surgeon notified.

c. Counts of multiple suture packages are confirmed when a package is opened at time of use. If there is an incorrect number of needles in a package prior to the patient entering the room, the entire package is removed from the room. If there is an incorrect number of needles in a package after the case has started, the entire package is removed from the sterile field, sequestered in the room and excluded from the count.

d. Sharps removed from the sterile field must remain in the operating room and are retained in the count.

e. The circulating nurse is responsible for:
   1) Recording sharps counts on the count worksheet or count board.
   2) Recording results of final counts on the operative record.
   3) Informing surgeon of the count results and receiving verbal confirmation.

D. Instrument counts

1. General considerations

a. Inspect instruments for integrity and/or signs of breakage, before and after use.

b. Instruments broken during a procedure must be accounted for in their entirety and the surgeon notified of same.

c. After the final count, items utilized in each procedure are sequestered and remain in procedure room until the end of the case.

2. Responsibilities of the circulating nurse

a. Recording instrument count on the count worksheet or count board.
b. Recording the results of the instrument count on the operative record.
c. Notifying the surgeon of the count results and receiving verbal confirmation.

E. Discrepancy in Counts
1. When there is a discrepancy in count(s), broken instrument, sharp, or incidental item, notify the surgeon and the anesthesia care provider.
2. Search is conducted of the following
   a. Operative site by the surgeon and assistants
   b. Sterile field by scrub person
   c. All linen and waste receptacles and all appropriate areas within the operating room by the circulating nurse
3. If item is not found or a count has been omitted due to above listed exception(s) the patient will remain under anesthesia until an x-ray can be obtained of the surgical site.
4. The surgeon or first assist will not complete the final skin closure until the results of the x-ray(s) are communicated to the surgeon by the radiologist. Final skin closure will be evidenced by the application of a dressing (ie; 4x4, band-aid, steri-strips, dermabond etc.)
5. Notify Imaging of item(s) in question and save all fluoroscopy images related to counts.
6. Results of the x-ray of the operative site(s) are interpreted by and reported to the surgeon by the Radiologist.
7. The surgeon will communicate radiologist findings to the OR circulator.
8. The circulating RN will notify anesthesia, and the surgeon or first assist will complete the final closure.
9. An AP and Lateral x-ray are taken for all count discrepancies.
10. Staff or surgeon may request further views to validate count.
11. RB-2 or smaller suture needles are not visible in x-ray imaging and will therefore be excluded from this process if not accounted for.

F. Patient enters the OR suite with packing in place from a previous procedure
1. The number and type of sponges removed will be documented on the medical record.
2. The sponges / packing removed is isolated and not included in the counts for the procedure.
3. An x-ray of the operative site is taken and interpreted by the Radiologist once all packing is removed. Anesthesia is notified of the plan to x-ray. Follow process in E.3- E.11 for x-ray.

G. Life threatening emergency requiring immediate transfer.
1. If the surgeon deems an immediate transfer is required due to instability of the patient, then the x-ray is taken in the next unit.
2. The OR record reflects the emergency status, if a post-operative x-ray was taken in OR, and report to transfer unit of any x-ray requirements.