RETAINED SURGICAL ITEMS
Guideline at a Glance

RN CIRCULATOR

• Ensure no open, countable items are in the room from a previous procedure.
• Verify that count boards and count sheets do not contain information from a previous procedure.
• Initiate the count.
• View the surgical items being counted.
• Record in a visible location (count board) the counts of soft goods, sharps, miscellaneous items, and items placed in the wound.
• Record instrument counts on pre-printed count sheets.
• Report any count discrepancy.

Accurately accounting for items used during a surgical procedure is a primary responsibility of the RN circulator. The RN circulator plays a leading role in implementing measures to account for surgical items.

SCRUB PERSON

• Maintain an organized sterile field and standardize instrument setups.
• Perform counts in a manner that allows the RN circulator to see the surgical items being counted.
• Know the location of soft goods, sharps, and instruments on the sterile field and in the wound.
• Know the character and configuration of items used by the surgeon and first assistants.
• Inspect items for breakage or fragmentation before use and immediately after removal from the surgical site.
• Speak up when a discrepancy exists.

Accurately accounting for items used during a surgical procedure is a primary responsibility of the scrub person. Maintaining an organized sterile field facilitates accounting for all items during and after the procedure. Standardized sterile setups established by the health care organization’s policy reduce variation and may lessen the risk for error.
SURGEON AND SURGICAL FIRST ASSISTANT

• Use radiopaque surgical items (soft goods) in the wound.
• Maintain awareness of the location of items in the surgical wound.
• Communicate placement of surgical items in the wound for notation in a visible location (count board).
• Acknowledge awareness of the start of the count process.
• Notify the team if any supplies will be needed on the sterile field before the start of the closing count.
• Remove unneeded counted items from the surgical field at the initiation of the count process.
• Notify the scrub person and RN circulator about items returned to the surgical field to complete the final count.
• Perform a methodical wound exploration before closing the wound.
• For surgical soft goods, instruments, and miscellaneous items intentionally left in the wound, establish a standardized procedure that includes communication of the location of the item, transfer-of-care information, and the plan for postoperative removal.
• Verify the results of the final count.

ANESTHESIA PROFESSIONAL

• Plan anesthetic milestone actions (such as emergence from anesthesia) with the surgical team so they do not interfere with counts.
• Do not use counted items.
• Document placement and removal of throat packs, bite blocks, and similar items in the accounting of surgical items.
• Communicate placement and removal of items to the surgical team.

Surgical counts and anesthetic milestones such as emergence from anesthesia are critical phases of the procedure during which distractions should be minimized. Planning and coordination will allow the perioperative team to focus on each of these critical portions of the procedure with less distraction.

Accurately accounting for items used during a surgical procedure is a primary responsibility of the surgeon and the surgical first assistant. Use of radiopaque items in the surgical wound provides a mechanism for locating misplaced items as part of resolving count discrepancies.
TIMING OF THE COUNT

- Perform a surgical count:
  - before the procedure to establish a baseline (initial count)
  - when new items are added to the field
  - before closure of a cavity within a cavity (for example, the uterus)
  - when wound closure begins
  - when skin closure begins or at the end of the procedure when counted items are no longer in use (final count)
  - at the time of permanent relief of either the scrub person or RN circulator
  - for counted items in use when there is relief of the RN circulator or scrub person for short durations (a break)
  - any time a discrepancy is suspected
  - when requested by any perioperative team member

- Do not perform surgical counts at critical phases of the procedure, such as:
  - time-out periods
  - critical dissections
  - confirming and opening of implants
  - anesthesia induction and emergence from anesthesia
  - care and handling of specimens

Counts occur at specified times to ensure surgical items are accounted for before the next stage of the surgical procedure, such as before the closing of a cavity within a cavity or the skin closure.

THE COUNT PROCESS

- Minimize distractions, noise, and unnecessary interruptions.
- Conduct the initial count before the patient enters the OR.
- Use a consistent accounting method for all surgical counts.
- Have two individuals, one of whom is the RN circulator, concurrently view the items and count audibly.
- Separate and point out items while counting audibly.
- Count sponges, towels, textiles, and sharps.
- Count miscellaneous items as defined by your health care organization.
- Count instruments in procedures as defined by your health care organization.
- Count instruments for all procedures in which a body cavity is entered, such as the thorax, abdomen, and pelvis.
- Count packaged items to the number the item is packaged in. Exclude and remove packaged items that have an incorrect number or configuration due to a manufacturing defect.
- Record the count immediately after each type of item is counted.
- If the count is interrupted, resume the count, starting by recounting the item that was being counted during the interruption.
- When unable to record on the count board and concurrently see the items being counted, document the count on a standardized count sheet then transfer the items to the count board later.
- Use a surgical checklist to verify the final count.
- Obtain intraoperative radiograph imagining in situations when accurate counting of surgical items is not possible.

Performing the initial count before the patient enters the room gives the perioperative team the benefit of reduced interruption from patient care distractions. Developing standardized protocols for RSI prevention and consistent count policies improves communication between team members, and decreases variability in count processes that may contribute to RSIs.
SUBSEQUENT COUNTS

- Maintain the count running total in one location.
- Immediately record items added to the sterile field after the initial count.
- If an item is passed from or dropped from the sterile field, retrieve it and show it to the scrub person, isolate the item from the sterile field, and include it in the final count.
- Use a pocketed sponge bag system.
- Do not subtract or remove items from the count.
- For multiple procedures or multiple sterile fields, count all items together at the final count.
- Keep all items that are part of the count within the OR or procedure room until the counts are completed and reconciled.
- Do not remove linen or waste containers until counts are complete and reconciled and the patient has been transferred out of the room.
- Consider using FDA-cleared adjunct technologies as a supplement to manual count procedures.
- Perform a structured hand over of accounting procedures at times of relief of the RN circulator or the scrub person.

RECONCILIATION

- Standardize measures for reconciling count discrepancies.
- Inform the team and receive verbal acknowledgment from the surgeon in the event of a count discrepancy.
- Suspend closure of the wound and perform a methodical wound examination while actively looking for the missing item.
- Call for assistance, search the sterile field, search the room, and recount.
- Do not change personnel until the count is resolved.
- Do not resolve the count with packages.
- When the missing item is found, recount the item type (eg, laparotomy sponges, suture needles).
- If the missing item is not found, obtain intraoperative imaging before wound closure as the patient’s condition allows and before the patient leaves the OR. If the patient is unstable, obtain a radiograph as soon as possible in the next phase of care.
- Notify environmental services and the next perioperative team in the room about items reported missing in an unresolved count discrepancy.

Recording of the count in a visible location allows all team members to view the count independently. Immediate documentation of counted items may reduce the risk of a count error by reducing reliance on memory accuracy and attentional demands that compete with counting tasks.

An incorrect surgical count is a risk factor for an RSI. Use of a standardized, goal-oriented approach to resolving count discrepancies, including standardized recounts, wound explorations, and radiography may prevent RSIs.
DOCUMENTATION

Document measures taken for the prevention of RSIs; include:

- types of counts
- number of counts
- names and titles of personnel performing the counts
- results of surgical item counts (correct or incorrect)
- surgeon notification of count results
- use of adjunct technology
- an explanation of any waived counts
- number and location of any instruments intentionally remaining with the patient or radiopaque sponges intentionally retained as therapeutic packing
- actions taken if a count discrepancies occurred, including all measures taken to recover the missing item or device fragment and any communication regarding the outcome
- rationale if counts were not performed
- the outcome of actions taken

*Documentation facilitates continuity of patient care through clear communication and supports collaboration among health care team members.*