AORN SYNTEGRITY®

PERIOPERATIVE DOCUMENTATION SOLUTION

Example: Crosswalk Positioning Devices

Phase of Care : IntraOperative

Documentation Content : Documentation Data Sets

Grouping : Sponge, Sharp and Instrument Counts

Primary Field : Counts

Grouping	Primary Field	Organization	Standard/Regulation Code	Standard/Regulation Type	Statement
Sponge, Sharp and Instrument Counts		Healthcare Facilities Accreditation Program	10.01.15	Accreditation	**Documentation of Complications** - requires the healthcare organization's patient medical record contain documentation regarding complications, hospital acquired infections and unfavorable reactions to drugs or anesthesia.
Sponge, Sharp and Instrument Counts		Accreditation Association for Ambulatory Health Care, Inc.	10.I - X	Accreditation	**Surgical and Related Services** - requires an accreditable healthcare organization to utilize a process that addresses when sponges, sharps, and instruments counts will occur, items to be counted, and types of procedures requiring counts.
Sponge, Sharp and Instrument Counts		Association of periOperative Registered Nurses	Guideline for Patient Information Management, Recommendation IV.a.3	Standard/Recommendation	states, "Perioperative nursing documentation should correspond to established guidelines for perioperative nursing care. Elements of perioperative guidelines that should be incorporated into clinical documentation include: aseptic technique maintenance; local anesthesia administration; medication administration practices (e.g., use of abbreviations); moderate sedation/analgesia administration; patient care considerations (e.g., latex allergy, implanted electronic device, dentures); patient positioning; patient information exchange; safety precautions including electrical, environment of care preparation (e.g., device alarms, blanket warmer temperatures), equipment use (e.g., laser, MRI), fire prevention, human tissue procurement, processing, and preservation, infection prevention, tissue protection, radiation exposure prevention, retained surgical items prevention, correct site, side, person surgery processes, and skin preparation and antisepsis; specimens and tissues; sterilization/disinfection practices; and traffic control measures."
Sponge, Sharp and Instrument Counts	Counts	Association of periOperative Registered Nurses	Guideline for Prevention of Retained Surgical Items, Recommendation I.e	Standard/Recommendation	states, "The RN circulator should record the count: immediately after each type of item is counted (eg, laparotomy sponges, suture needles); on a standardized template; in a location that is visible to the surgical team (eg, count board); and in agreement with the scrub person. The collective evidence and guidance from the ICSI support recording the count in one standardized, visible location. Recording of the count on a count board (eg, whiteboard) in a visible location allows all team members to view the count independently, and confirm the accuracy of the counted items."
Sponge, Sharp and Instrument Counts	Description, Location and Quantity of Items Retained for Hemostasis or Packing	Association of periOperative Registered Nurses	Guideline for Prevention of Retained Surgical Items, Recommendation II.e	Standard/Recommendation	states, "All radiopaque surgical soft goods placed or packed in the surgical wound or other cavities (eg, throat, vagina) should be audibly communicated and recorded in a visible location (eg, count board) on placement and removal. The practice of verbalizing and documenting placed or packed radiopaque sponges is supported in a cohort study."
Sponge, Sharp and Instrument Counts	Description, Location and Quantity of Items Retained for Hemostasis or Packing	Association of periOperative Registered Nurses	Guideline for Prevention of Retained Surgical Items, Recommendation II.h.1	Standard/Recommendation	states, "When radiopaque surgical soft goods are intentionally used as therapeutic packing and the patient leaves the OR with this packing in place, the number and types of items placed should be documented in the medical record: as reconciled and confirmed by the surgeon when this information is known with certainty; or as incorrect if the number and type of sponges used for therapeutic packing is not known with certainty."
Sponge, Sharp and Instrument Counts	Description, Location and Quantity of Hemostasis or Packing Items Removed	Association of periOperative Registered Nurses	Guideline for Prevention of Retained Surgical Items, Recommendation II.h.3	Standard/Recommendation	states, "When the patient is returned to the OR for a subsequent procedure or to remove therapeutic packing: the number and type of radiopaque soft goods to be removed should be determined from the intraoperative record of the surgery during which the packing was placed; the number and type of radiopaque soft goods removed should be documented in the medical record; the radiopaque sponges removed should be isolated and not included in the counts for the removal procedure; the surgeon should perform a methodical wound examination and order an intraoperative radiograph; and the count on the removal procedure should be noted as reconciled if all radiopaque soft goods have been accounted for."
Sponge, Sharp and Instrument Counts	Risk for Retained Surgical Items	Association of periOperative Registered Nurses	Guideline for Prevention of Retained Surgical Items, Recommendation IX.c	Standard/Recommendation	states, "Based on risk analysis, the health care organization should establish policies that define when additional measures for RSI prevention should be performed or when they may be waived (eg, trauma, cystoscopy, ophthalmology)." "The collective evidence and professional organizations support considering additional measures, such as radiographic screening of high-risk patients, as an adjunct to surgical item accounting procedures. The following risk factors have been significantly associated with RSI: incorrect count; unexpected change due to intraoperative factors; more than one surgical team; no count (due to inability or emergent situations); more than one procedure; long procedure; blood loss > 500 mL; high BMI; emergency procedure; and occurrence of a safety variance during the procedure. Because of these identified risk factors, Lincourt et al recommended routine radiographic screening for emergency procedures and when multiple major procedures are being performed because this indicates the presence of multiple surgical teams. Gawande et al recommended routine intraoperative radiographic screening for select, high-risk patients (ie, emergency procedures, unplanned changes in procedure, high BMI) to detect RSIs."
Sponge, Sharp and Instrument Counts	Unresolved Count Outcome Comment	Association of periOperative Registered Nurses	Guideline for Prevention of Retained Surgical Items, Recommendation V.h	Standard/Recommendation	states, "Unretrieved device fragments must be documented in the patient's record. Documentation should include the: material composition of the fragment (if known); size of the fragment (if known); location (if known); manufacturer; measures taken to recover the fragment; and patient notification. The Centers for Medicare and Medicaid Services requires surgical complications to be documented in the operative report."
Sponge, Sharp and Instrument Counts	If Item Deemed Missing - Recount Incorrect	Association of periOperative Registered Nurses	Guideline for Prevention of Retained Surgical Items, Recommendation VI.c	Standard/Recommendation	states, "If a missing item is not recovered, intraoperative imaging should be performed to rule out a retained item before final closure of the wound, if the patient's condition permits. If the patient's condition is unstable, a radiograph should be taken as soon as possible in the next phase of care."
Sponge, Sharp and Instrument Counts	Intraoperative Radiograph Performed	Association of periOperative Registered Nurses	Guideline for Prevention of Retained Surgical Items, Recommendation VI.c.1	Standard/Recommendation	states, "When accurate counting of surgical items is not possible, intraoperative imaging should be performed before the patient is transferred from the OR."
Sponge, Sharp and Instrument Counts	Counts	Association of periOperative Registered Nurses	Guideline for Prevention of Retained Surgical Items, Recommendation VI.d	Standard/Recommendation	states, "Unresolved count discrepancies must be documented in the patient's record, including all measures taken to recover the missing item, description and location of the item if known, patient notification and consultation, and the plan for follow-up care. The Centers for Medicare & Medicaid Services requires surgical complications to be documented in the operative report. The collective evidence and guidance from professional organizations support documenting count reconciliation measures and consulting with the patient or patient's representative regarding the plan for follow-up, including additional imaging and possible risks of a potentially retained item."
Sponge, Sharp and Instrument Counts	Adjunct Technolgies Used, Counts, Intraoperative Radiograph Performed	Association of periOperative Registered Nurses	Guideline for Prevention of Retained Surgical Items, Recommendation VIII	Standard/Recommendation	states, "Documentation should reflect activities related to prevention of RSIs."
Sponge, Sharp and Instrument Counts	Counts	Association of periOperative Registered Nurses	Guideline for Prevention of Retained Surgical Items, Recommendation VIII.a	Standard/Recommendation	states, "The RN circulator should document soft good, sharp, miscellaneous item, and instrument counts on the patient's intraoperative record. Documentation of nursing activities related to the patient's perioperative care provides an account of the nursing care administered and provides a mechanism for comparing actual versus expected outcomes."
Sponge, Sharp and Instrument Counts	Adjunct Technolgies Used, Counts, Intraoperative Radiograph Performed	Association of periOperative Registered Nurses	Guideline for Prevention of Retained Surgical Items, Recommendation VIII.b	Standard/Recommendation	states, "Documentation of measures taken for the prevention of RSIs should include, but not be limited to: types of counts (eg, radiopaque sponges, sharps, instruments, miscellaneous items); number of counts; names and titles of personnel performing the counts; results of surgical item counts; surgeon notification of count results; any adjunct technology that was used and any associated records; an explanation for any waived counts; number and location of any instruments intentionally remaining with the patient or radiopaque sponges intentionally retained as therapeutic packing; unretrieved device fragments left in the wound, including, material composition, size, location (if known), and manufacturer; actions taken if count discrepancies occur, including all measures taken to recover the missing item or device fragment and any communication regarding the outcome; rationale if counts are not performed or completed as prescribed by policy; and the outcome of actions taken."

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