



International Federation of Perioperative Nurses

IFPN GUIDELINE

For

Surgical Counts

Sponges, Sharps, Instruments & All Items used during Surgical intervention that present the potential to be inadvertently retained.

Purpose:

To promote global, consistent and safe evidenced based quality perioperative patient care. This recommended practice is intended to standardise 'the count' as a basic principle to be adapted in all areas where surgical/invasive or interventional procedures are performed on patients, and includes procedures related to childbirth, cardiology, interventional radiology, endoscopy and anaesthesia.

Recommendations

It is recognised globally that there is the potential for an item to be retained inadvertently during any surgical procedure regardless of the type or complexity of the procedure and irrespective of the clinical setting. This standard therefore applies to all areas as outlined above, to ensure that all items used during perioperative or interventional procedures are accounted for during the procedure and are reconciled at the end, in order to prevent items being unintentionally retained.

The Standard Policy for surgical counts should specify when counts should be performed, by whom, items to be counted, documentation of counts, including incorrect counts, and any additions or deletions of counts for specified procedures (e.g. cystoscopy, ophthalmology) according to defined risk. A count must be undertaken for all procedures in which swabs, instruments, sharps or other items could be retained. Reconciliation must be the default expectation during and at the end of all surgical invasive interventions, and process should be in place to address any variance.

A full count of sponges, sharps, instruments, and all miscellaneous items that have the potential to be inadvertently retained during the surgical procedure should be performed to ensure that all items are accounted for. The registered nurse is accountable for counts during the surgical procedure. Count procedure should be performed by two persons (scrub and circulating nurse), one of whom should be a registered nurse.

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For procedures where there is no scrub nurse, the count should be done with the surgeon and circulating nurse, and appropriately documented.

The same two persons should perform all counts. When there is a change in personnel, a complete count should be performed.

Items should be viewed and counted audibly and concurrently.

All items should be completely separated during a count.

Counts should be performed in the same sequence: sponges, sharps, miscellaneous items, and instruments.

Items added during the procedure should be counted immediately and recorded on the white board and/or count sheet for retention in the patients' medical notes.

The scrub nurse should be aware of the location of all counted items throughout the procedure.

Items should not be removed from the operating room until the final count is completed and correct, and the patient has left the operating room.

Results of all counts should be announced audibly to the surgeon, and verbal acknowledgment received from the surgeon.

In the event an incision is reopened after the final count, closure count shall be taken again.

The Count- All items-sponge-sharps-instruments-miscellaneous items that have the potential to be inadvertently retained

A count should be undertaken for all procedures as follows.

- Before the start of the procedure- (prior to knife to skin)
- When individual body cavities are entered, reconciliation must occur at the closure of each cavity

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- At skin closure
- At any other time that it is deemed necessary or as requested by any member of the team

Sponges-Swabs

Only X-ray detectable sponges should be used, which should be standardised in established number of multiples such as 5 and counted in multiples of five.

Sponges should be completely separated (one by one) when counting, both prior to, and after use.

Packages containing incorrect number of sponges should be bagged, marked, and isolated from the rest of the sponges in use, and documented as such.

Sponges and attached tapes should not be cut or altered in any way.

X-ray detectable sponges should not be used as dressings. In the event that patients require packing to remain in situ, as **packing intentionally**, the number, size and type should be recorded and documented on the count sheet and within the patients' care plan record.

Dressings should only be added at skin closure, and where possible should be a different colour (blue swabs).

Soiled sponges should be discarded from the sterile field, then handled using protective equipment (gloves, forceps), and after counting contained in plastic bags in the established number of multiples.

Soiled dissecting sponges should be kept in their original container or small basin until counted.

Sharps

Suture needles should be counted according to the marked number on the package. Multiple suture needles in a package should be verified with the circulator when a package is opened.

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Needles should be contained in a needle counter or container, loaded on a needle driver, or sealed packages.

Needles should be handed to the surgeon on exchange basis.

Hands free, no touch technique is recommended for passing scalpels.

Used needles and blades should be contained in a disposable puncture resistant container.

All parts should be accounted for if a needle or blade breaks.

If a needle puncture occurs, the needle, glove(s) should be removed from the sterile field. Policy for puncture wounds should be followed.

Instruments

Instrument sets should be standardised (same type and same number of instruments in each named set).

Instruments with component parts should be counted singly, not as a whole unit, with all component parts listed (e.g. one balfour retractor, one blade, three screws).

Instruments should be inspected for completeness.

If an instrument falls to the floor or is passed off the sterile field, it should be kept in the Operating Room until after the final count.

All parts of a broken or disassembled instrument should be accounted for in its entirety.

All instruments should be removed at the end of the procedure, and never before the patient has left the operating room.

Any instrumentation that is required to be **intentionally retained** by the patient must be communicated to all professionals involved in the patients care and recorded on the patients count sheet and within the patients care record.

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Miscellaneous-Other

Local policy should detail all other items that need to be included in the count process. A generic list of items should be in use, and periodically reviewed, taking account of identified potential risk from new or existing items.

A final reconciliation should occur prior to the removal of equipment and the patient from the operating room. This prevents items being inadvertently left under the patient, in the linen or lost in waste.

Pharyngeal Packs

Pharyngeal packs should contain a radio opaque marker. The anaesthetist is responsible for 'throat' packs placed in the patient prior to or during an operation. The insertion and removal of the pharyngeal pack should be documented on the anaesthetic record and the theatre dry white count board and should be visible to the theatre team; to identify placement and safe removal of the pack.

Documentation

All 'Counts' should be recorded on a dry white board, and/or count sheet as part of the patients record, together with the names and designations of personnel performing the counts.

Results of surgical counts shall be recorded as correct or incorrect.

Instruments and sponges specifically left with the patient should be documented on the count sheet and the patients' record.

Any action taken in the event of a count discrepancy should be documented on the patients' record and reported as an adverse patient outcome as outlined in local hospital policy.

Reasons for not conducting a count should be documented on the patients' record. It is recognised that occasionally in emergency situations, a full count is not possible prior to the commencement of a surgical intervention. In this case, it is recommended that a full count is conducted as soon as haemostasis has been achieved, and it is considered safe to

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do so. All packaging should be kept, to support the undertaking of a full and comprehensive account when deemed appropriate to do so.

Count Discrepancies

When the count is incorrect:

- Perform a recount
- Notify the surgeon and perioperative supervisor
- Conduct a search (floor, garbage, linen)
- Request X-ray to be taken
- Document outcome on the count sheet, and patients' record

When the count is not performed prior to the commencement of the procedure:

- Notify the surgeon and perioperative supervisor
- Undertake a full count as soon as deemed appropriate and safe to do so, for example once haemostasis has been achieved
- Document the count as not undertaken in line with standardised practice, prior to the commencement of the procedure, outlining the reason why, and describe the actions taken to mitigate risk; defining what subsequent efforts were made in terms of performing a count and the final outcome.

References:

- ACORN (2018) Australian College of Operating Room Nurses: Standards for Perioperative Nursing.
- AfPP (2016) Association for Perioperative Practice: Harrogate UK: Standards and Recommendations for Safe Perioperative Practice.
- AORN (2019) Association of peri-Operative Registered Nurses: Denver USA: Perioperative Standards and Recommended Practices.
- ORNAC (2017) Operating Room Nurses Association of Canada: Standards for Perioperative Nursing Practice.

IFPN acknowledges 3M for the support provided to enable review of this perioperative standard.

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