NoThing Left Behind® is a National Surgical Patient Safety Project to Prevent Retained Surgical Items (RSI) which I started in October 2004. We have met with a great deal of success in getting hospitals around the country to zero retained surgical sponges for ≥ one year (in some instances now 5yrs) using the Sponge ACCOUNTing System (SAS) sponge management practice. This practice is one of the deliverables of the NoThing Left Behind® project. Over the past 14 years we have worked primarily with hospitals and interested healthcare entities to prevent patient harm from inadvertent retention of surgical material. We have also seen the “other side of the earth” (that is our world as seen from the moon and an MRI image of a retained lap pad on the cover) studying clinical cases (unfortunately yes, they still occur) from across the United States and have a deeper knowledge about the consistent human failures that lead to retention of surgical items.

For the prevention of retained surgical sponges the essential understanding for doctors, is to perform a methodical wound exam before closing every wound, and that includes examining the vagina after a birth. For nurses, the essential understanding is not just to “count” the surgical sponges, but to separate them (on the in and the out counts, technological adjuncts or not) and then get them all in one place so they can be accounted for. Surgeons and nurses are the primary defenders against retention and only system change can impact on shaping safer behaviors to prevent patient harm. There is new information in here on the prevention of retained small miscellaneous items (SMI), devices (e.g. guidewires) and device fragments, sharps, needles and instruments.

This policy/job-aid represents a safe, rational and reasonable set of current practices. As a practicing surgeon and surgical safety advocate, I can say without any reservation whatsoever, that there is something in here that every hospital operating room (OR), ambulatory surgery center, perinatal birthing center and procedural area can adopt to make it safer for patients that receive care in their facilities.

Much of what is in this policy/job-aid is a result of reading focused reviews, event analyses and studying clinical cases where there have been retained surgical items. Additional information has been obtained from talking with OR personnel and reviewing OR policies during the work NoThing Left Behind® has been engaged in since this project began. It is not intended to be a competitive offering to that provided by the Association of periOperative Registered Nurses (AORN) but is rather a complementary effort in ensuring OR safety. This document was sent out and reviewed by many, is being used in many hospitals and represents what I think, are best practices. It is practical and action oriented and represents a culmination of ideas and solutions from many people (surgeons and nurses) at many different institutions from around the country. This third revision from the original (February 2011) has points and suggestions for improvement which were received from OR personnel and reviewed by nurses, surgical technologists, surgeons and radiologists.

There are new sections on:
- Prevention of RSI in the Emergency Department (ED)
- Prevention of retained guidewires after central venous catheter (CVC) insertion
- An orifice packing process to prevent retained vaginal packing
- Management of hemostatic trauma pads and dressings to prevent retention
- OR towel management

Revisions and updates have been added to sections on:
Multi-stakeholder safety rules for all content experts in surgical item management - nurses and surgical technologists, surgeons, radiologists and radiology technologists, anesthesiologists

The surgeon must determine if the case is an extreme emergency condition not the nurse so appropriate confirmatory examinations will be ordered and performed as needed

Clear definitions of the IN and OUT counts (e.g. Closing versus Final count), a frequent source of communication failure, which expands upon the AORN definitions

The SAS practice incorporated into the body of the policy – as an example of how a specific practice (process steps that people follow) should be incorporated into a policy so there is a standardized process used by everyone. The intent is to remove variation in practice so you can see defects in the process as it is being used and prevent error, or if error does occur analyze when and how the mistake or slip occurred.

A SAS practice for labor and delivery and one for non-OR areas (e.g. cardiology suites)
Methodical Wound Exam (MWE) guidelines for doctors
A sample incorrect final count report
Promulgation of use of a “Chain of Command” as a communication strategy
“Out of the OR” definition of when a surgical item is considered retained
Needle count practice with X-ray exclusions
SMI, device and unretrieved device fragment (UDF) safety rules
The Missing Surgical Item (MSI) imaging primer for safe intraoperative x-rays
“Points of Discussion” to enhance understanding and implementation
Monitoring and Education guidelines with shared learnings (we call it Collective Wisdom).

The emphasis is on sharing knowledge and information through in-services, newsletters and meetings to disseminate information on a regular basis to prevent complex and intelligent failures. This is important when dealing with rare events so people can learn from the experiences of others. I hope that each individual doesn’t have to be personally involved in an event, before they will move to change unsafe behaviors.

The intent of this effort is to have a practical multi-stakeholder resource of all the necessary information in one place. While the entire document is more than 50 pages it is designed to be flexible for individual site use. There are parts that require individual site-specific definitions be developed. In the points of discussion section the evidence is case based and anecdotal. This information is from front-line communications and represents one kind of evidence. It is worthwhile to remember that there is not only experimental evidence but experiential evidence from event analyses, that are also valid.

This policy is beyond a “count” policy which directs the actions of hospital nursing and surgical technologist activities. It is a multi-stakeholder reference manual and should be thought of as the “rules of engagement” for all who take care of patients in procedural areas. Therefore medical staff and radiology staff buy-in is required. The means of policy use, approval and application will have to be determined by each facility.

Good luck.
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SAFETY RULES, PRACTICES AND POLICY RECOMMENDATIONS

I. PURPOSE:

A. To provide practices and safety rules for perioperative registered nurses and surgical technologists, to use in the management of soft goods, sharps, small miscellaneous items and instruments; and actions to prevent retention of devices and device fragments.
B. To provide safety rules for doctors in the performance of a methodical wound exam and actions to prevent unintended retention of surgical items, devices and device fragments.
C. To provide safety rules and guidelines for radiology technologists and radiologists in the performance of intra-operative x-ray examination and information to aid interpretation and read-back of x-rays obtained to find a missing surgical item (MSI) or identify a potential RSI.
D. To provide safety rules for anesthesiologists and anesthesia personnel to prevent RSIs
E. To provide safety rules for Emergency Department (ED) providers to prevent retention of surgical items used during procedures performed in the ED.
F. To assist in the accounting of all surgical items and devices and minimize inventory loss.
G. To encourage and support all efforts in OR/procedural teamwork.

II. BACKGROUND:

Prudent medical practice and laws in all states, require that medical and surgical items not intended to remain inside of patients, not be negligently left behind. Inadvertently leaving devices, needles, sponges, instruments or other miscellaneous items inside of patients (retained surgical items) is a preventable event and is generally considered to be a “never event”. An RSI is a surgical patient safety problem. An event occurs because of problems with faulty procedural practices and poor communication strategies between personnel. To prevent RSIs, it is important to change practice and the exchange of knowledge and information, with an understanding of human fallibility in perception and risk assessment. This policy/job-aid contains directives to help people implement safe practices for all to use, in all procedure areas, wherever and whenever, surgical items are used. These are the “safety rules” which all have to follow.

III. DEFINITIONS:

A. SURGICAL ITEMS – Supplies, devices and equipment used in and around a surgical site or wound, to aid in the performance of the operation or procedure, to provide exposure and to absorb blood and other body fluids.
   Taxonomy: There are two groups of surgical items.
   Group I consists of four (4) classes; (these items usually compose the surgical counts)
   1) SOFT GOODS
   2) SHARPS
   3) INSTRUMENTS
   4) SMALL MISCELLANEOUS ITEMS
1. Soft Goods are cotton, disposable cloth or gauze items of various sizes, used as dressings, drapes and adjuncts to an operative procedure (note: packs are considered dressings). Within the category of soft goods are:
   a. Surgical sponges and surgical towels (16”x26”), which are white soft goods that contain a radiopaque marker, are used within the surgical wound and are included in a surgical count. Surgical sponges include but are not limited to: standard laparotomy pads (18”x18”), mini laps (12”x12”), baby laps (4”x18”), trauma “supersize” sponges (17”x26”; 18”x36”; 36”x36”), raytex (acronym for radiopaque textile) 4”x4” or 4”x8” sponges, tonsils/roundics, peanuts/kittners and cottonoids/patties.
   b. Blue, green or unbleached drape towels are made of a coarser grade of cotton and are intended to be used as drapes, wipes or covers. They should not contain radiopaque markers and are not to be placed inside of patients and are not included in a surgical count.
   c. Dressings used for orifice packing contain a radiopaque marker e.g. vaginal lap sponges (8”x36”) and vaginal packing (e.g.1”,2”,4”x36”,48”,72”,96”). Dressings used in wound care such as dressing sponges, perineal pads, prep swabs, wound-vac sponges, iodoform gauze and ribbon gauze do not contain radiopaque markers. All are managed and documented as dressings. Dressings are not included in a surgical count.

2. Sharps are metallic, pointed or cutting objects of various sizes which include but are not limited to: suture needles, scalpel blades, hypodermic needles, cautery tips. Sharps are included in a surgical count.

3. Instruments are surgical tools designed to perform a specific function such as cutting, dissecting, grasping, holding, suturing or retracting. These items are usually stored and sterilized on surgical trays and individually may have multiple parts. Examples of such items include but are not limited to: clamps, knife handles, needle holders, malleable/ribbon retractors, scissors. Instruments are included in a surgical count.

4. Small miscellaneous items (SMI) are other objects used during surgical procedures that are often single use, often not radiopaque, may be plastic, may be composed of multiple parts and include but are not limited to: bovie scratch pads, vessel loops, rubber shods, suture booties, umbilical tapes, laparoscopic or thoracoscopic ports, disposable instrument inserts, cotton-tip applicators, marking pens, suture reels, screws, nails, safety pins, ligaclip bars, bulldogs, vascular inserts, Z fold hemostatic material, nasal suction bulbs, Asepto bulb syringes, visceral “fish” retainers. SMI are included in a surgical count.

Note: If a whole instrument is retained this would be considered a retained instrument but if an intact part of a surgical instrument or tool is retained, this is more appropriately considered a retained small miscellaneous item and is documented as such.

**Group II** consists of:
1) DEVICES which are used during operations and procedures
2) DEVICE FRAGMENTS which are the result of breakage or separation of a device.

1. Devices are essentially any piece of equipment or a tool that has a designated function used during a procedure and may have electronic or mechanical component parts. Devices include for example; staplers, drains, and catheter insertion sets and stone retrieval kits. Retained devices are intact items which may be left in any body cavity, intravascular or
interstitial space. A retained device includes the entire unbroken item such as an intact
guidewire inadvertently left in a central vein (which is the most common retained device) or
catheter sheath or introducer.

2. Device fragments are broken parts or a piece of a tool or device. Examples include drill bits,
a broken tip or part of an instrument, a broken part of a catheter or drain or piece of a stent
or tip of a guidewire. If the surgeon makes a clinical decision that a device fragment cannot
or will not be retrieved, this is an unretrieved device fragment (UDF).

B. RETAINED SURGICAL ITEM – A surgical item that was not intended to remain in a
patient and is found in any part of the patient’s body after an operation, procedure or vaginal
birth ends.

Using the National Quality Forum definition -
An operation ends after
A. all incisions or procedural access routes have been closed in their entirety,
B. devices have been removed,
C. final surgical counts have concluded
D. and the patient has been taken from the operating/procedure room.

A procedure ends when all devices and equipment have been removed from the patient
regardless of setting (e.g. post anesthesia recovery unit, cath lab, emergency room, radiology
suite, endoscopy unit).

Using an obstetrical consensus definition of when a birth ends
A vaginal birth ends after the mother’s immediate recovery period (2 hours post birth of the
fetus). This period is also referred to as the fourth stage of labor which lasts about 2 hours after
the birth of the fetus.
[As a retained surgical item is generally considered to be preventable. It is a serious reportable
event. It is also a sentinel event but The Joint Commission has a different interpretation of when
an item is considered to be retained. see Point of Discussion #1]

C. SURGICAL COUNT – A process involving two people whereby they look at the items
together, one person manually separates each item and they audibly count the number of items
(“see, separate and say” – 3S’s). The four classes of surgical items included in a surgical count
are surgical sponges and surgical towels, sharps, instruments and small miscellaneous items.
For a surgical count performed in the operating room one of the two people must be a registered
nurse.
Surgical counts must be performed in procedures in which an incision is made or a wound is
created and surgical items are used. A vaginal birth is considered a procedure and the post-birth
vagina is considered a wound.
The surgical count is performed to identify any packaging errors and to monitor the number of
items used during the operation or procedure. The surgical count is a defined process composed
of multiple steps which should be uniformly practiced.
There are six AORN defined counts: INITIAL, CAVITY, CLOSING, PERMANENT RELIEF,
ANYTIME and FINAL. These names of the counts should be used rather than referring to the
counts with ordinal numbers (e.g. 1st count, 2nd count).
[To enhance communication and reduce confusion it is important to have a common language
between personnel using the surgical counts. See Point of Discussion #2]
D. MEDICAL RECORD – The permanent paper or electronic intraoperative record of an operation or procedure usually completed by the circulating nurse (Attachment A).

E. EXTREME EMERGENCY PROCEDURE – An operative procedure conducted on an extreme emergency basis to preserve a life or prevent loss of a limb or organ or the patient status deteriorates, such that standard routine procedures may not be able to be performed or completed.

In consultation with anesthesia personnel, the surgeon must determine and verbally declare that such an extreme emergency condition exists. This circumstance must be documented in the medical record by the circulating nurse. Supplementary procedures (e.g. x-ray imaging) to prevent retention or mitigate patient harm from an RSI should be outlined on an incorrect final count report (Attachment B) when an extreme emergency procedure has been documented.

IV. SCOPE AND APPLICABILITY:

This policy/job-aid applies to all operating rooms (OR), procedure rooms, labor and delivery areas, and all other areas where a wound is created (any incision is made in the skin) or procedures are performed (including a spontaneous vaginal birth) and surgical items are used in or on a patient.

V. DOCUMENTATION AND COLLECTIVE WISDOM:

A. A registered nurse is responsible for medical record documentation.

B. Use the names (not ordinal numbers) of the six required surgical counts: INITIAL, CAVITY, CLOSING, PERMANENT RELIEF, ANYTIME, FINAL

C. Use specific terminology for sponge, sharp, instrument and small miscellaneous item counts in the medical record, depending on the vendor or format of the operation or procedure report. There should be the same means to document each class of surgical item included in the surgical counts. (Attachment A)

D. Enter the surgical counts and other required information concurrently with an occurrence or at the end of the case. Documentation in the medical record serves as legal evidence of what practices were performed.

E. Document the rationale and identify the primary decision-maker (e.g. surgeon declared case an extreme emergency procedure and no instrument counts were performed) in the incorrect final count report if any count or action is not performed according to policy. (Attachment B)

F. The final count is taken when items are no longer in use and have been removed from the surgical field. The final count can only be recorded as correct or incorrect. A final count that is unsubstantiated, pending, unresolved or incomplete is documented as incorrect.

G. In the instance of an incorrect final count, an incorrect final count report must be filled out and given to the supervisor/manager who must communicate the information up the chain of command. The report will outline all the actions that were taken during the case and actions that need to be taken at the next level of care. The report will be written in the electronic
Event Reporting System (ERS) or as a paper report depending on the reporting system developed at each facility. (Attachment B)

H. If a package of any surgical item is found to be defective when opened (e.g. wrong number, damaged, contaminated) or a device breaks (e.g. plastic sponge holder pocket tears) the package and its contents should not be used. Bad packs of sponges will be removed immediately from the field, placed in a plastic bag, labeled and taken from the operating room. Other broken or defective devices or items will be sequestered. The supervisor/manager should be notified and a miscount report completed. (Attachment C) The inventory information should be given to supply purchasing for notification to the distributor. OR staff should be told about the packaging error or defect at staff educational meetings. It is important to share information about these events and defective items to inform personnel about their frequency, which may alter staff perceptions. For example, they may realize that bad packs “can happen to them”. Device defects represent manufacturing error and with regard to surgical sponges, separating the sponges to find bad packs is an essential element in a safe sponge management practice.

I. If a medical device or instrument breaks or fragments, all effort should be made to retrieve the separated parts. The device and its parts should be removed from the field and sequestered. (Attachment D) If an intact part of a device is retained this is a retained SMI and would be considered a reportable event but if a broken fragment of a device or tool is retained and the surgeon decides that it is a UDF, these are usually not reported. For both circumstances, an incorrect final count report must be completed (Attachment B) and given to the supervisor/manager who must communicate the information up the chain of command. The retained device or UDF should be documented in the medical record and the event reported through manufacturer and regulatory reporting systems as required. A disclosure discussion with the patient should be conducted.
VII. SURGEON PROCEDURES AND SAFETY RULES

A. PERFORMANCE OF A METHODICAL WOUND EXAMINATION:

1. GENERAL CONSIDERATIONS FOR ALL WOUNDS (Attachment F)
   a. Conduct a methodical exploration of the operative wound, prior to closure in every operation, and at any time the surgeon is informed of a missing item.
   b. Carefully examine the space to be closed. Give special focus before closure of a cavity within a cavity (i.e., heart, major vessel, stomach, bladder, uterus). Placement of mesh or bone graft “closes” a cavity and a wound examination prior to their placement is a recommended practice.
   c. Strive to see and touch during the exploration; reliance on only one element of sensory perception is usually insufficient.
   d. Visually and manually determine that any item that is not intended to remain in the patient, is recognized and removed.
   e. The general process is to look and feel in the recesses of the wound and examine under fatty protuberances and soft-tissue appendages.
   f. If something was inserted or placed in the mouth, nose, rectum or vagina make sure “it” and all of its parts have been accounted for

2. ABDOMEN AND PELVIS
   Unless clinically contraindicated for a specific patient, take the following steps for procedures performed in the abdomen or pelvis using appropriate retraction to provide adequate visualization. The operative quadrant should not only be explored but all four quadrants of the abdomen examined. [see Point of Discussion #11]
   a. Lift the transverse colon.
   b. Check above/around the liver and above/around the spleen.
   c. Examine within and between loops of bowel.
   d. Inspect anywhere a retractor or retractor blades were placed.
   e. Examine the pelvis
   f. Look behind the bladder, uterus and around the upper rectum.
   g. The vagina should be examined if it was entered or explored as part of the procedure.

3. CHEST AND MEDIASTINUM
   Unless clinically contraindicated for a specific patient, the following general steps should be taken for procedures performed in the mediastinum or thorax.
   a. In a mediastinal procedure, if the mediastinal pleura were opened, examine the ipsilateral pleural cavity.
   b. In a cardiac procedure, elevate the apex of the heart and examine the retrocardiac space.
   c. Examine the transverse sinus to the right and left of the aorta and pulmonary artery.
   d. In a thoracic procedure, examine the thoracic cavity with attention to the thoracic apex and base of the lungs, paravertebral sulcus, and inferior recesses of the diaphragm.
   e. Place a hand or finger behind the lung and palpate from apex to base.
B. USE OF THE ORIFICE PACKING PROTOCOL
   a. Intra-operative orifice packing is usually used in the setting of hemorrhage. This protocol is not intended for intra-cavity therapeutic packing of the abdomen or chest. Separate guidelines are recommended for that. The most common sites are the vagina and high in the nasopharyngeal sinus, occasionally in the rectum. The packing usually is removed in the post-operative period when the patient has left the OR. (Attachment J)
   b. Only radiopaque gauze packing material should be used (e.g. vaginal packing). Radiopaque gauze packs must be available in the OR. Whenever possible only one pack should be placed in an orifice (rather than tying together multiple small packs it is better to use just one long one).
   c. The safest kind of vaginal packing should have a radiopaque marker running throughout the gauze, rather than just having a marker sewn at one end. This is to ensure that radiopaque material remains in the patient should the packing need to be cut to conform to the site. If the marker is only on one end and that end is cut off, there is no way to detect the presence of the pack should it fail to be removed.
   d. The MD will determine the packing material to use and place the pack in the orifice.
   e. After the doctor places the pack, the type, amount and location of the packing will be documented by the circulating nurse on the Packing Hand-Off Communication and Tracking tool (“The Packer Tracker”). (Attachment J)
   f. The circulating nurse will place a packing armband on the patient prior to the patient transferring to the post-operative area. The packing armband is a distinct, facility specific color (that does not compete with all the other armbands being used) and has the words “Packing in Place” on it. The armband will serve as a reminder to the staff at the next level of care and to the patient, that there is packing in place.
   g. The MD provider must write an order providing instruction on the management of the packing and specify when it should be removed.
   h. When the packing is removed it must match exactly the description of what was entered on the packer tracker when the packing was inserted. If there is any discrepancy an x-ray must be obtained. When the packing has been successfully removed the armband is cut off.
   i. If the MD determines that the patient will go home with the packing in place, when the packing is removed in the office, the armband will be cut off.
   j. The patient is informed by the handoff RN as soon as clinically possible the meaning of the packing armband and the plans for the removal of the packing.
   k. This is a complicated process because care continues over a gap (OR to PACU) and then possibly over multiple handoffs. These situations require strong communication strategies to prevent retained orifice packing.
C. CLINICAL DECISION TO LEAVE A UDF IN THE PATIENT:
   a. During use of devices and supplies in the OR, there is always the possibility of manufacturer error or defects. The user of the device is one of the people who may discover these defects. If something does not look, feel or sound exactly right - STAR (Stop, Think, Act, Review) before proceeding with the use of the device. (Attachment D)
   b. Sharps, needles, instruments and small miscellaneous items that are broken or damaged during a procedure must be accounted for in their entirety. If part of a broken item is retained in the patient and not removed, this is an unretrieved device fragment (UDF).
   c. In the circumstance of an incorrect final count of a known radiopaque item (e.g. small needle or broken device fragment) it is a clinical decision to be made by the surgeon based on best judgment whether or not the item can or will be removed.
   d. Effort should be made to retrieve any device fragments or parts if possible
   e. The decision to leave a surgical item in the patient must be documented in the medical record and an incorrect final count report completed (see Attachment B).
   f. Sequester the broken device. Do not discard it. Obtain lot and serial numbers.
   g. An unbroken device or identical surgical item can be used to measure against the residual part to determine the size of the retained fragment.
   h. Obtain X-rays, if the UDF is radiopaque, to document the position of the item and to have knowledge about composition, size and number.
   i. Inform the patient of the situation and explain any risks. Device fragments may migrate, embolize, cause thrombosis, become infected, heat during MRI or wobble and may cause injury. They may also remain stable and inert and cause no future problems. Future diagnostic testing can’t be predicted so the patient should be informed. Appropriate RSI reporting should be conducted as required. [see Point of Discussion #12]

D. OPERATIVE REPORT DICTATION
   It is good surgical practice to include in the operative dictation of the case the status of the final surgical counts and any actions that were taken during the case to prevent retention of surgical items.

E. PATIENT DISCLOSURE
   1. Upon the discovery of a retained surgical item or UDF a disclosure discussion with the patient should be conducted.
   2. There is no requirement to disclose to the patient the existence of a lost item if it is known with certainty that the item is not in the patient. The difficulty is with the determination, with certainty, that the item isn’t in the patient. Because of the quality and physical characteristics of intra-operative radiography, a negative intra-operative x-ray does not mean “with certainty”. A lot depends on what the surgical item is, but finding the physical item or everyone conclusively agreeing that the surgical item is not in the patient (e.g. because it was known by all to be on the floor or never entered into the patient in the first place) are the two best determinants to use. If an item was lost and never found and there is no agreement on where it is, then a disclosure discussion with the patient should be conducted. This is to discuss options that can be pursued depending on the patient’s best interests. A lost small
suture needle is not an uncommon situation. In that setting, a discussion with the patient can be held, outlining the risks and benefits of getting a CT scan, which will show the presence of metallic suture needles. A CT scan may show a non-radiopaque object or suggest its presence even though the item itself is not radiopaque. If the CT is negative that is the best evidence currently available that the item was not in the patient.

3. Also during disclosure would be a discussion by the surgeon of the risks and benefits of removing the surgical item should it be discovered to be within the patient.

4. If it is decided that the best course of action is to not retrieve the item, the patient should be informed of any risks associated with retention.

5. The best strategy is to develop and implement strong practices to prevent the loss of the items in the first place. This is a team based endeavor and worthy of time and attention.
X. ALL STAKEHOLDERS

A. ACTIONS TO RECONCILE AN INCORRECT COUNT:
1. The circulating nurse must inform the surgeon there is an incorrect count of an item. If the item is missing, while the OR staff are looking, the surgeon should stop closing the wound and repeat the methodical wound examination. This is a Missing Surgical Item (MSI). Use the Incorrect Count Checklist to help guide the team’s actions. (Attachment N)
2. The circulating nurse must tell the surgeon what specific type of item is missing.
3. If the item is not found, portable x-ray(s) MUST be obtained if the item is radiopaque and not a <15mm needle missing in a large cavity.
4. Cover the wound with a sterile non-radiopaque towel or plastic drape.
5. Remove extraneous objects from the field.
6. Tell the radiologist specifically what item is missing e.g. not “sponge” but lap pad, raytex
7. Help the radiology technologist obtain x-rays of the entire region of interest (side to side, top to bottom, this may require more than one film) (see Attachment G).
8. Have the radiology technologist obtain two views (AP and oblique/lateral)
9. The scrub person will search all sterile areas.
10. The circulator will search the holders, linen, drapes, floor and trash.
11. Anyone who has left the room will be contacted and the circulator will review any visitors in the room or opportunities for the item to have been inadvertently removed from the room e.g. with a pathology specimen, with a newborn taken to the nursery.
12. Wait for radiologist read-back results before completely closing the wound.
13. Follow radiologist recommendations for additional views or requests for further information before the patient leaves the OR.
14. The circulating nurse will document an Incorrect Final count in the medical record and complete Attachment B – Incorrect Final Count Report if the item is not found.
15. Notify the administration and risk manager if the item is not found.
16. Disclose to the patient if the item is not found.
17. Plan additional radiographic (e.g. CT scan) or diagnostic testing to find the object or prove with certainty that it is not in the patient.

B. ACTIONS TO TAKE IN AN EXTREME EMERGENCY PROCEDURE
1. In consultation with anesthesia personnel, the surgeon must determine and verbally declare if a case is an extreme emergency procedure. By so doing, the MD is acknowledging that some of the surgical counts may be aborted and mandatory x-rays must be obtained at the earliest and safest time.
2. This condition must be documented in the medical record by the circulating nurse and Attachment B – an Incorrect Final Count Report completed.
3. Under these circumstances standard counting practices may need to be changed. Sponge and sharp counts are usually performed but full instrument and SMI counts are usually not possible. It’s usually the inability to perform instrument counts that invokes this exclusion. Sponge counts should be performed, even if only a single person initial sponge count is done. The Sponge ACCOUNTing System should be used throughout the procedure. The circulating RN will continue to put the sponges in the holders throughout the case and use this information to aid in sponge management. Aborting a count does not mean not doing anything. It is better to
not have to rely solely on the reading of an intra-operative x-ray to determine if all sponges have been accounted for.

5. X-rays of the operative site, to rule-out any retained surgical items, must be ordered by the surgeon and reviewed by a radiologist as soon as clinically possible during or after completion of the operation. The MSI guidelines apply and the radiologist must be informed that the x-ray is being obtained in-lieu of surgical counts. Two views are optimal to call an image negative.
Attachment F

DoctoRs ClosiNg CounT

Don’t Just “Swish or Sweep”, perform a Methodical Wound Examination (MWE) in Every Case

The goal is to get all the sponges OUT so they can be accounted for.

1. A methodical exploration of the operative wound must be conducted prior to closure in every operation. The space to be closed must be carefully examined. Special focus should be given to closure of a cavity within a cavity (i.e., heart, major vessel, stomach, bladder, uterus, and vagina). Surgeons should strive to SEE and TOUCH during the exploration whenever possible; reliance on only one element of sensory perception is usually insufficient. Before closing, the surgeon should first make a best effort to remove all sponges, then the nurse and scrub person will count them and feedback to the surgeon if all have been accounted for. If told later that there is a missing sponge, always repeat the MWE before obtaining x-rays.

In MIS cases a methodical visual inspection of the operative cavity is required before camera removal. In eye cases a MWE is performed using the operative microscope.

2. The general process is to look and feel in the recesses of the wound and examine under fatty protuberances and soft-tissue appendages.

Unless clinically contraindicated for a specific patient, the following steps should be taken for procedures performed in the abdomen or pelvis.

a. Examine all four quadrants of the abdomen with attention to:
   i. Lifting the transverse colon
   ii. Checking above/around the liver and above/around the spleen
   iii. Examining within and between loops of bowel
   iv. Inspecting anywhere a retractor or retractor blades were placed
b. Examine the pelvis
   i. Look behind the bladder, uterus (if present) and around the upper rectum.
   ii. The vagina should be examined if it was entered or explored as part of the procedure.

3. Unless clinically contraindicated for a specific patient, the following general steps should be taken for procedures performed in the mediastinum or thorax.

a. In a mediastinal procedure, if the mediastinal pleura were opened, examine the ipsilateral pleural cavity.
   b. In a cardiac procedure, elevate the apex of the heart and examine the retrocardiac space.
   c. In a thoracic procedure, examine the thoracic cavity with attention to the thoracic apex and base of the lungs, paravertebral sulcus, and inferior recesses of the clavicles. Place a hand or finger behind the lung and palpate from apex to base.

FINAL COUNT

SHOW US

that there are no empty pockets!

Sponge ACCOUNTing System

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