

RADIOLOGY GUIDELINES

Require that an xray of the operative field be taken in the event of an incorrect count. Call for Xray early, do not argue.

Develop a standardized process for requesting intraoperative xrays to look for missing surgical items.

Develop a standardized process for radiologist read-back of requested intraoperative films

See *Guidelines for Intraoperative Radiographs*

Ensure radiology technician training in performance of intraoperative portable xray especially with attention to obtaining films of the entire operative field, adequate films in obese patients and lateral/oblique films on the OR table.

Xray technicians should be available 24/7 if the OR is available during those times and technician response times to the OR should be <20 mins. Radiologist read-back confirmation to the OR should be able to be obtained within 20 mins.

If no radiologist is immediately available for xray review, the films should be read by the surgeon but reviewed within 12 hours by a radiologist.

Recognition of various surgical items and their radiographic appearance should be a part of residency training in radiology and part of radiologist annual competency training, education and review

If the patient is stable, OR policy should make it mandatory to take an xray when the closing count is called incorrect and the object is not immediately found. It should not be “surgeons choice” to take an xray in the setting of an incorrect count. Nurses want the xray to demonstrate that the missing object is not in the patient. Surgeons have voiced concern that if there is a mandatory xray policy nurses won’t count diligently and won’t look for missing items and always express concern about the delay in case progression if an xray has to be taken. Clear communication and a trustful working environment is necessary to maintain. Quick response times and good service can minimize the delays for xrays. Newer technology that improves count accuracy or improves detection of objects (at least for sponges) are anticipated to reduce reliance on xray for sponge detection.

Mandatory xrays in special circumstances – e.g. unplanned procedures or obese patients, are unlikely to be cost or time effective especially if the xrays are obtained for detecting sponges. Sponges are often difficult to detect with intraoperative portable xray especially when a specific object is not being sought. Plain radiography is very effective for locating instruments, hence the value in having a mandatory xray policy in lieu of instrument counts. Also, in trauma cases or high sponge count cases (>100 sponges) some centers require a mandatory xray of the operative field in the immediate post/op care setting which of course will not prevent retention but hopes to allow for early detection should a retained object occur.

Sponge ACCOUNTing System Guidelines for Intra-operative Radiographs

On occasion, an incorrect count is obtained and under these circumstances or when indicated by OR policy an intra-operative radiograph is required.

1. A written request for a “STAT image for foreign body detection” will be generated by the circulating nurse in a specific operating room under the name of the attending surgeon listed in the operation record as being responsible for the conduct of the operation.

The request will specify:

- a. The name of the attending surgeon,
- b. The kind or type of foreign body being looked for. Sponge, needle, name of instrument, other item. If a sponge is the missing item specify the type e.g. lap pad, raytex, towel
- c. The OR room number and the telephone number for that room
- d. The name of the circulating nurse or designated person in room to receive call back information
- e. The nurse will note on the written request the time the request was submitted

2. Upon receiving the request a radiology technologist will take a radiograph of the appropriate site as requested by OR personnel. This should be accomplished expeditiously, but the elapsed time should not exceed twenty minutes. The technologist will note time request received and time radiograph taken on the request slip.

3. The technologist taking the radiograph will call ahead to alert the radiologist on duty that a wet read to r/o retained (specify) item is needed from a specific OR.

4. The technologist will notify the radiologist by phone when imaging has been completed, and note the time the radiologist was notified that the study is available for viewing. The technologist should remain on the phone with the radiologist in case additional views are required.

5. The technologist will return to the OR to take a hard-copy film to the OR if requested by the peri-operative care personnel in the OR or if requested to take additional views (e.g. oblique view)

6. The radiologist on duty will review the film or the digital images of the radiographs and will call the specified OR with the results of their examination or with a request for additional views to be obtained. This should be accomplished expeditiously. The elapsed time should never be greater than twenty minutes.

7. In the event that the radiologist on duty should require additional assistance or consultation to establish a diagnosis, the OR should be notified that such a secondary review is underway.

8. The person who answers the phone in the operating room and receives the results must be a member of the operating team – nurse, surgeon or anesthesiologist. The results must have “read back” confirmation and the findings documented in the operative record.

9. The radiologist will dictate the report following verbal transmission of the findings. The name and identifying number of the individual to whom the information was provided must be on the report or if “read back” was provided, indicate as such. The radiologist will note the time the information was transmitted.

10. Performance audits can be conducted to determine if timeliness guidelines have been met.

**Sponge ACCOUNTing System
Guidelines for the Anesthesia Provider**

Separate surgical and anesthesia-related trash and equipment.

1. Use a trash receptacle that is visually distinct from any used for the surgical field.
2. Do not discard anesthesia-related equipment into “kick buckets” or other surgical receptacles.
3. Do not allow surgical equipment to be discarded into the anesthesia trash.
4. Do not borrow equipment such as scissors or sponges from the surgical field.
5. Be sure to remove any equipment used for anesthesia procedures (such as clamps and needles used for central line placement and dressing sponges) from the operating table before surgery starts.

Be careful when adding or removing items from surgical field or tables.

6. If items fall from the surgical field, be sure to inform the surgical team, including the circulator, immediately. Dropped items need to be appropriately managed to ensure that they are properly counted.
7. If you assist the scrub team by retrieving items such as extra sutures or sponges for the instrument table, inform the circulator promptly of exactly what was opened. Opening extra equipment without properly adding items to the count will lead to discrepancy at the end of the procedure.

Don't distract the nurses during counting procedures.

8. During team accounting procedures, try not to disturb or distract unless absolutely necessary.

Plan anesthetic milestone actions so that these actions don't pressure the surgical team to do a less than diligent accounting or wound exam.

9. When performing milestone actions such as reversal of neuromuscular blockade or extubation, be aware whether or not the final count is completed. If the count is incorrect, plan the patient's emergence from anesthesia accordingly. In most cases it is desirable to keep the patient anesthetized until all items have been accounted for.
10. If the patient's medical condition is such that prolonged anesthesia or further delay is in your opinion inappropriate, discuss this directly with the surgical team so that a joint decision can be made which weighs the relative risks of a possible retained item versus the risks of continuing anesthesia and surgery.

Make sure that throat packs, bite blocks, and other such devices are removed from the oropharynx at the appropriate time