SURGICAL COUNTS:
DON'T MAKE A CASE OF IT!

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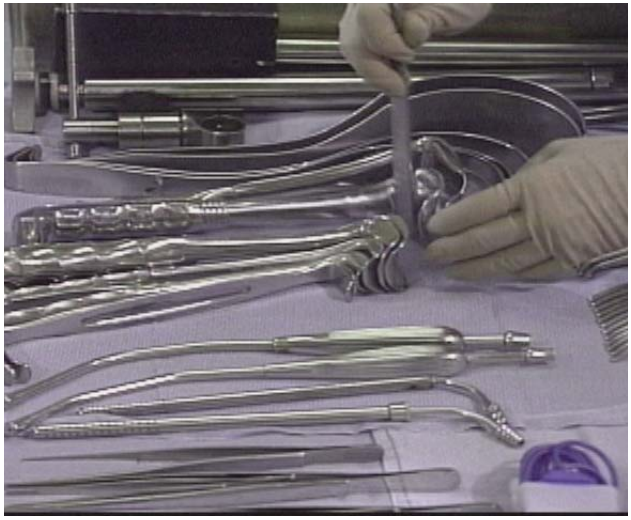
AORN INDEPENDENT STUDY ACTIVITY STUDY GUIDE WITH VIDEO



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INTRODUCTION

Every day, in thousands of hospitals across the country, surgical counts are performed meticulously and successfully. It is the rare instance that all perioperative nurses fear and dread when an item is retained in a patient.

This video and study guide discuss the AORN recommended practices for surgical counts, legal issues that exist when an item is retained in a patient, and prevention of incorrect surgical counts by developing and implementing facility-specific count policies based on AORN recommended practices.

GUIDELINES FOR SURGICAL COUNTS

AORN first established guidelines for surgical counts in 1976. Subsequent revisions and updates have resulted in the current recommended practices for surgical counts. These recommended practices are meant to be used as guidelines for practice and represent an optimal level of function for the postoperative nurse.[1]

LEARNER OBJECTIVES

After viewing the video and completing the study guide, the learner will be able to:

1. List techniques to avoid count variances.

2. Discuss the use of AORN recommended practices to enhance an existing or develop a facility-specific surgical count policy.

SURGICAL COUNTS: THE LEGAL ISSUES

Performing surgical counts, the activity of accounting for items used on a surgical procedure, is the primary responsibility of the perioperative nurse and the scrub person. The accountability for the surgical count is shared by the surgeon. This is in contrast to the "captain of the ship" doctrine that previously had protected both the nurse and the facility from liability.

The "captain of the ship" doctrine is part of the "loaned servant" principle in the Law of Agency. This means that the surgeon will assume responsibility for the actions of a nurse or other assistant even though they are employed by a different person or entity. The "captain of the ship" doctrine suggests that the physician directs or otherwise controls the actions of the nurse or assistant. In today's health care environment, the actions of the nurse often are directed by facility policy.[2]

All operating room personnel should be aware of the threat a retained item poses to a patient's safety. There is minimal, if any, legal defense possible in a case in which a foreign body is retained.

If a situation occurs in which an item is retained in the patient, the perioperative nurse may be determined to be negligent based on evidence presented at trial. The jury will be encouraged to look at a number of things, such as:

- Did the perioperative nurse act as any prudent, reasonable, professional nurse would to account for items prior to closure?
- The testimony of an expert witness.
- The AORN recommended practices.
- The facility policy.[3]

For example, in the case of Van Hook vs. Anderson (824 P. 2d 504-WA [1992]) the perioperative nurses informed the surgeon that the surgical counts were correct. While dictating his operative report, the surgeon became concerned because he could not recall removing one of the sponges. When questioned, the nurses told the physician that they had counted that particular sponge while it was still in the patient's body.

The nurses in this case were found to be negligent and the hospital, as their employer, was found liable for their actions. The physician was found to be free from any liability.[4]

In the case of North Eastern Alabama Regional Medical Center v. Robinson (548 So. 2d 439-AL [1989]), a patient who had undergone a vaginal hysterectomy reported to her physician that she was experiencing nausea, vomiting, dizziness, and inability to sleep. A sonogram revealed a mass behind the vaginal cuff that the surgeon tentatively diagnosed as an ovarian cyst. A subsequent laparotomy revealed a retained laparotomy sponge that had been cut in half.[5]

In the case of Sparger v. Worley Hospital et al. (547SW. 2d 582-TX [1977]), a sponge was left in a patient's abdominal cavity. The scrub person and circulating nurse, both employees of the hospital, performed the surgical counts and found them to be correct. The court found that the nurses, as hospital employees, were obligated to follow the facility policies, which specified sponge counts. This case emphasized that nurses are responsible for their own actions and that they have a legal duty to follow hospital policy.[6] The patient sued the hospital, nurses, and physician for damages. The jury found the surgeon not liable for the retained sponge. The nurses, however, were held liable because they had performed the surgical counts and found them to be correct.[7]

The law provides that if a foreign body is left in a patient, the patient can sue the individual or individuals responsible for resulting injuries. AORN states that nurses can prevent sponge, sharp, or instrument retention by counting these items.[8]

There is little or no justification for an operating room protocol that omits practices necessary to avoid retention of items used during surgery. X-ray of every patient, a practice performed by some facilities, is inappropriate because counting is an effective means of controlling item retention. Also, intra-operative x-rays expose the patient and the OR staff members to unnecessary radiation. The cost of x-raying all surgical patients to avoid retention of a foreign item is, in itself, prohibitive.

DEVELOPING A FACILITY-SPECIFIC COUNT POLICY

Because the importance of a facility-specific count policy can not be overemphasized, AORN recommends that policies and procedures for sponges, sharps, and instruments be written and reviewed annually. These policies should be readily accessible in the practice setting and serve as an operational guideline for the surgical and nursing staff.

"The facility policies and procedures establish authority, accountability, and responsibility for sponge, sharps, and instrument counts. These policies and procedures should include:

- items to be counted,
- direction for performing counts,
- procedures in which initial or subsequent counts may be deleted, and
- nursing actions or protocols for incorrect counts."[9]

The facility-specific count policy must be provided to all staff members. Through inservice education and group discussion, questions concerning the count policy can be answered and issues can be addressed. New personnel must be educated about the count policy during their orientation. Compliance with the count policy, as with all facility policies, is imperative.

The individuals developing the policy should ask themselves these questions: If a situation should arise concerning this issue, what will concern the prosecutor? What would an expert witness say about our policy? What are the AORN recommended practices? The law requires that foreign bodies not be negligently left in patients, and it is up to the surgeon, nurses, and facility to determine how they will comply with this requirement.[10]

The process of developing a facility-specific count policy should begin with a review of the AORN recommended practices for surgical counts. The recommended practices should be used to establish a "working" count policy. There may be issues presented in the recommended practices that are not useful or feasible in every operating room. It is the responsibility of the individual nurse and facility to determine what is feasible in their particular environment.

A review of count policies in area facilities will guide the nurse in establishing a policy that corresponds to the standard of care in his or her community. This is important because "standard of care" in a given community often directs practice in that community.

The surgical count is comprised of three major components: sponges, sharps, and instruments. Miscellaneous items (eg. reels, vessel loops, umbilical tapes) also must be accounted for during surgical procedures.

SPONGES

AORN recommended practices state, "sponges should be counted on all procedures in which the possibility exists that a sponge could be retained." The recommended practices also state, "Sponge counts should be taken

- before the procedure to establish a baseline,
- of additional sponges added to the sterile field,
- before closure of a cavity within a cavity,
- before wound closure begins, at skin closure or end of the procedure, and at the time of permanent relief of either the scrub person or the circulating nurse."[11]

The initial count provides a baseline for subsequent counts. Established policies should address when initial and subsequent counts must be performed and when they may be deleted (eg. cystoscopy, endoscopy, ophthalmology procedures).[12]

Sponges are counted audibly and viewed concurrently by two individuals, one of whom should be a registered nurse.[13] An extra margin of safety is provided by having two individuals perform the surgical count.[14]

Sponges are separated so that each one can be seen clearly by both individuals performing the count. This is necessary to ensure that the number stated on the sponge package matches the number contained inside. Also, a sponge may be folded among the other sponges.

It is rare that a package contains an incorrect number of sponges. If this should happen, the entire package should be removed from the sterile field, bagged, labeled, and isolated from the rest of the sponges in the operating room.

"Sponge counts should be performed in the same sequence each time. The count should begin at the surgical site and the immediate surrounding area, proceed to the Mayo stand and back table, and finally to sponges that hve been discarded from the field. A count procedure that follows the same sequence assists in achieving accuracy, efficiency, and continuity among perioperative team members."[15]

Sponges used during the surgical procedure must be x-ray detectable. This will facilitate locating the sponge if it is lost or left in the patient.

AORN discourages altering the normal configuration of surgical sponges. Cutting a surgical sponge could result in loss of radiopaque indicators, which would make locating a lost portion by x-ray virtually impossible.

Counted sponges must remain in the OR during the procedure to reduce the possibility of an incorrect count. All trash receptacles and linen hampers must remain in the OR until the surgical count is completed and resolved.

Dressing sponges should be non-x-ray detectable. AORN discourages the use of counted sponges for packing. In the event that a wound is intentionally packed with x-ray detectable sponges and the patient leaves the OR with these sponges, the number and type of sponges must be documented on the intraoperative record. X-ray detectable sponges used as dressings may appear as a foreign object on postoperative x-ray studies or invalidate a subsequent count if the patient is returned to the OR.[16]

Universal precautions, as outlined by the Occupational Safety and Health Administration (OSHA), must be observed when handling and disposing of contaminated sponges.

SHARPS

AORN Recommended Practices state, "sharps should be counted on all surgical procedures. Sharps counts should be taken

- before the procedure to establish a baseline,
- of additional sharps added to the sterile field,
- before closure of a cavity within a cavity,
- before wound closure begins,
- at skin closure or end of the procedure, and
- at the time of permanent relief of either the scrub person or the circulating nurse."[17]

AORN recommends that an initial sharps count be performed on all surgical procedures. This count provides a baseline for subsequent counts. Facility policy should address when subsequent counts can be deleted.

Sharps are counted audibly and viewed concurrently by two individuals, one of whom should be a registered nurse. This practice assists in ensuring an accurate count.[18]

AORN Recommended Practices also address suture needle counts. “Suture needles should be counted according to the number marked on the outer package and verified by the scrub person and the circulating nurse when the package is opened.” The Recommended Practices explain that opening all packages during the initial count could create additional opportunity for needles to be lost during the surgical procedure.

To ensure accuracy, efficiency, and continuity among the perioperative team members, sharps should be counted in a sequence. “The count should begin at the surgical site and immediate surrounding area and proceed to the Mayo stand and back table and finally to the sharps that have been discarded from the field.”[19]

If a sharp is broken during the surgical procedure, it must be accounted for in its entirety. This will help ensure that a foreign body is not retained in the patient.

During the procedure, sharps should remain in the OR. Waste receptacles and linen hampers must remain in the OR until the counts are completed and resolved. “If a counted sharp is passed or inadvertently dropped off the sterile field, the circulating nurse retrieves it, shows it to the scrub person and isolates it from the field to be included in the final count.”[20]

Needles that have been used on the sterile field should be contained in a puncture-resistant, disposable needle container. This will help ensure containment on the sterile field and minimize the risk of injury to the scrub person.

Handling and disposal of sharps should be done observing universal precautions that have been outlined by OSHA and AORN’s recommended practices. This will minimize the risk of exposure to HIV, hepatitis B virus (HBV), and other blood-borne pathogens.

INSTRUMENTS

AORN Recommended Practices state that “instruments should be counted on all procedures in which the likelihood exists that an instrument could be retained. Instrument counts should be taken:

- before the procedure to establish a baseline,
- when additional instruments are added to the sterile field,
- before wound closure begins, and
- at the time of permanent relief of either the scrub person or the circulating nurse.”[21]

Perioperative literature supports performing an instrument count for all surgical procedures. Traditionally, many facilities have established policies that direct personnel to count instruments when a major body cavity is entered or the depth or location of the wound is such that an instrument could be retained. Facility policy should address when instruments must be counted and when the count can be deleted.[22]

Instrument sets should be standardized with a minimal number and types of instruments. Instruments that are not used frequently should be removed from the sets and wrapped separately. Specialty instruments should be wrapped separately to be opened only if needed. Standardizing the instrument sets makes counting easier and more efficient and provides a means of inventory control and cost containment.

Instruments must be counted audibly and viewed concurrently by two individuals, one of whom should be a registered nurse. Concurrent verification of counts by two people helps to ensure accurate counts.[23]

Documentation of the instrument count can best be accomplished using a preprinted count sheet that is identical to the standardized sets. The preprinted count sheet allows the circulating nurse to count more efficiently and in an organized fashion. Space should be provided for any additional or specialty instruments that the surgeon may want.

Instruments should be counted in the same sequence, beginning with the surgical site and surrounding area, moving to the Mayo stand and back table, and ending with any item that has been discarded from the surgical field. This will ensure that the count is performed as accurately and efficiently as possible.

Counted instruments are confined to the OR during the surgical procedure. If an item drops from or is handed off the sterile field, the circulating nurse shows it to the scrub person and isolates it from the field to be included in the subsequent counts.[24]

Instruments with multiple, detachable parts must be accounted for in their entirety. If an instrument breaks during surgery, all pieces must be accounted for by members of the surgical team. Verification that all pieces are present will prevent inadvertent retention of a foreign body in the patient.[25]

All items that come in contact with the surgical field are considered contaminated. Universal precautions must be observed when handling soiled instruments to prevent exposure of the health care worker to bloodborne pathogens.

One of the many important aspects of performing surgical counts is documentation. All nursing activity related to the patient should be documented to provide an accurate picture of the nursing care delivered and the outcomes of that care. "Documentation of the surgical count should include, but not be limited to,

- types of counts performed (ie, sponges, sharps, instruments, and miscellaneous items) and the number of counts,
- names and titles of persons performing the counts,
- results of surgical item counts,
- notification of surgeon,
- instruments remaining with the patient or sponges intentionally retained as packing,
- actions taken if count discrepancies occur, and
- rationale if counts are not performed or completed as dictated by policy."[26]

CONCLUSION

A major goal of the perioperative nurse is to provide safe, appropriate nursing care to the surgical patient; therefore, careful attention to the surgical count is essential. Retention of a foreign item can cause life threatening injury to the patient and increase the liability of the surgeon, nurse, and facility.

The expected patient outcome is that the patient will be free from injury associated with foreign body retention. Criteria that demonstrate this outcome include:

- absence of unexplained pain or fever;
- absence of abscess formation; and
- no retained sponge, sharp, or instrument on x-ray.

It is imperative that perioperative nurses be cognizant of the impact of their actions on patient outcomes. Following a well-documented, established, implemented surgical count policy is a critical component in achieving the perioperative nurses' established goals.

FOOTNOTES

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9. AORN, Inc., "Recommended practices for sponge, sharp, and instrument counts. "*Standards, Recommended Practices, and Guidelines* (Denver: AORN, Inc., 2004) 225.

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POSTTEST

1. **Who is responsible for the surgical count?**
   a. The perioperative nursing team present on the case and the surgeon.
   b. The nurse manager.
   c. The central supply personnel who assembled the tray.
   d. None of the above

2. **When documenting the surgical count, it is necessary to document**
   a. items added to the surgical field during the case.
   b. items on the sterile field to begin the case.
   c. any item that potentially could be retained in the patient.
   d. all of the above

3. **When looking for a lost sponge during a surgical procedure, the circulating nurse should include in his or her search**
   a. the trash can
   b. the drain in the substerile room
   c. the scrub sink outside the room
   d. the doctors' lounge

4. **Upon being informed that the count is incorrect, the surgeon should**
   a. ignore the wound because the lost item is never there.
   b. have the circulating nurse call for an x-ray.
   c. re-open the wound to search for the missing item.
   d. send for another surgeon so a search can be instituted.

5. **The scrub person is counting rapidly and counts one group of sponges on top of another. The circulating nurse's best response is to**
   a. not worry about it; you could see all the sponges, so it's all right.
   b. inform the scrub person that his or her technique is inappropriate, describe the correct way to count groups of sponges, and encourage the scrub person to read the facility policy.
   c. make the scrub hand off all sponges; the count will never be right now!
   d. report the scrub person to the charge person.

6. **An emergency patient is rolling into the OR suite. The instrument tray is not open yet, the patient is obviously bleeding from an abdominal wound, and the doctor is already scrubbed. You have no time to count. What is the best course of action?**
   a. Hold up the surgery to do a count.
   b. Refuse to give the surgeon a towel to dry his or her hands until you are counted and ready.
   c. Inform the surgeon of the count omission and call x-ray to do a postoperative film.
   d. Tell the scrub person to count, and you will listen while you move the patient.

7. **Sponges are counted in groups of _____ and_____ depending on how they are packaged.**
   a. 5s, 10s
   b. 1s, 10s
   c. 3s, 5s
   d. 20s, 10s

8. **During the surgical procedure, a needle is broken into two pieces. You should**
   a. count the two pieces as one whole piece.
   b. count each piece separately.
   c. forget about counting it - it's broken anyway.
   d. hand off the pieces to the circulator who can throw them away.

9. A retractor with numerous pieces is on the table for an abdominal case that you are about to begin. How should it be counted?

a. Count all the pieces separately.
b. Count all the pieces together as one. There is no way a piece can be left behind.
c. Tie all the pieces together so there is no risk of leaving them in the patient.
d. Don't count it at all - it's too complicated.

10. Which of the following items must be documented on the surgical count sheet?

a. Surgical gloves
b. Suture reels
c. Light handles
d. Mesh instrument trays

11. Surgical counts should be performed by the scrub person and circulating nurse

a. quickly and haphazardly.
b. silently and slowly.
c. quickly and silently.
d. concurrently and audibly.

12. The scrub person begins the surgical count before you are ready and watching. Your best response is to

a. let the scrub person go, knowing he or she is in a hurry.
b. rush over and quickly document everything the scrub person counted.
c. stop the scrub person and make him or her recount the items that you missed.
d. tell the scrub person to forget it and do the count yourself.

13. When documenting an incorrect count, it is necessary to include

a. all nursing actions to prevent injury to the patient.
b. whether an X-ray was performed of the surgical site.
c. whether the item was located.
d. all of the above

14. AORN Recommended Practices state that documentation of surgical count should include

a. types of items to be counted
b. names and titles of individuals performing the counts.
c. results of each count.
d. all of the above

15. _____ should not be placed on the field until final counts are completed.

a. Facial stitches
b. Skin stapler
c. Dressing sponges
d. Irrigating fluid

16. Surgical count policy development should involve the

a. OR manger.
b. perioperative nurses.
c. surgeons.
d. all of the above

17. When developing a count policy, the perioperative nurse should look at

a. the floor plan for the OR.
b. AORN standards and recommended practices.
e. the basic nursing text from his or her freshman year of nursing school.
d. both a and b.

18. Why should an initial count be performed on all cases?

a. It provides a baseline for subsequent counts.
b. Some surgical procedures have the potential for change in or additions to the scheduled procedure.
c. So that instruments can be contained from one case to the next.
d. All of the above.

19. Community _____ is important to consider when developing a count policy.

a. interest
b. standard of care
c. nursing shortage
d. none of the above

20. Facility policies serve as an _____ for the surgical team members.

a. area of ridicule
b. outlet
c. operational guideline
d. all of the above

Surgical Counts: Don't Make a Case of it
Answer Sheet

Question	Answer
1	A
2	D
3	A
4	B
5	B
6	C
7	A
8	A
9	A
10	B
11	D
12	C
13	D
14	D
15	C
16	D
17	B
18	D
19	B
20	C