

Surgical Count Protocol (PHC)

Site Applicability

St. Paul's Hospital and Mount St. Joseph Hospital Operating Rooms and Procedure Rooms

Practice Level

- RN, LPN – Basic Skill

Need to Know

The count procedure is determined by the ORNAC standards, the surgical procedure booked and performed, and the patient's condition. Also, if one of the nurses wishes to perform an additional count, the count is done.

See [Appendix A](#) for MIS count procedure.

Protocol

1. A count of sponges, sharps, and miscellaneous items shall be performed for all procedures.
Exceptions: transurethral scope procedure, closed reduction, percutaneous wiring of a digit, percutaneous procedure without a cut-down, split-thickness skin graft (not included with another procedure), superficial debridement, and organ procurement.
For arthroscopy, if the puncture sites are not extended and no other procedure is performed, a closure count is not necessary.
For ophthalmology procedures:
 - Cataract: Count suture needle, if used.
 - Cornea and glaucoma: Count suture needle, cannula, injection needle and cap.
 - Retina: Count suture needle, cannula, vent, injection needle and cap.
2. A count of sponges, sharps, miscellaneous items, and instruments is performed for all procedures when the following body cavities are entered (for MIS surgery, see [Appendix A](#)):
 - peritoneal
 - pelvic
 - retroperitoneal
 - thoracic
3. All items to be counted must be separated, clearly seen by both nurses, and counted aloud.
4. Sponges shall be counted twice at each count.
5. Remove packages of sponges with the incorrect number from the room.
6. A count of sponges, sharps, and miscellaneous items is performed when closing a cavity within a

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cavity (e.g. uterus closure within the peritoneal cavity).

7. Count the small items (i.e. the “front page”) at permanent relief of the scrub and/or circulating nurse. The outgoing nurse(s) must remain until the count is verified.
8. The recommended sequence for the closure count is: items off the sterile field, back table, mayo stand, operative site.
9. Intraoperatively, if items are counted off (i.e. crossed off on the count sheet), they must be isolated. Sponges must be covered in a bucket, sharps contained in a closed box, instruments and all other items placed inside a closed case cart.
10. The final (i.e., skin) count is done once the surgery is complete and items have been removed from the field.

11. The procedure in the event of a count discrepancy is:

NOTE: A count discrepancy is one or more items recorded but not found, or one or more items on the set-up but not recorded.

- Inform the surgeon and other members of the team.
- Search the area; recount.
- For a discrepancy in an ophthalmology procedure, the operative site is examined with the microscope.
- For all other cases, if the count remains incorrect, a portable x-ray should be taken in the OR. This is entered in Cerner as a verbal order, priority “STAT”. If you are x-raying more than one area, you need to enter two separate orders.
- State the indication for the x-ray is “incorrect count”, and clearly explain what the discrepancy is (i.e., specifically what item(s) is/are missing or extra). Also add the “provider callback number”, usually the local of the OR theatre.
- Add the “Incorrect Counts Action Taken” segment in the IntraOp document.
- The x-ray must be read by a radiologist, and the result reported verbally to the surgeon in the OR. If the radiologist does not call within 10 minutes after the x-ray has been taken, contact the “hot seat”/on call radiologist via the Radiology main desk (62780/62781).
- Document the name of the radiologist and the reported result in the segment text box.

FINAL OUTCOME:

- If the item(s) is/are found on x-ray or examination with the microscope and retrieved, the count is reported as “correct”. Document the steps taken to reconcile the count in the “Incorrect Counts Action Taken” segment. Complete a PSLS to record the “near miss” or close call as a learning opportunity.
 - If the count discrepancy is not resolved, state what item(s) is/are missing or extra, and the actions taken. Complete a PSLS.
12. If a counted item cannot be seen (e.g., closure of cavity within a cavity or permanent relief), mark the item you cannot see with an asterisk. Do not put a check in the column.
 13. If counted items are intentionally left IN the patient, do not cross them off at the final count.

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Document exactly what was left in the patient in the “Dressing/Packing” segment in Cerner. Record the count as “incorrect”. Complete the “Incorrect Count” segment in Cerner. No x-ray is required; document reason as intentionally retained item. Complete a PSLS.

If or when the patient returns to the operating room:

- The items left in the patient at previous surgery will be removed from the sterile field, bagged and identified.
- The type and number of items removed from the wound shall be reconciled with the previous case(s) documentation and documented on the current Count Verification segment, comments. If the surgical site is being permanently closed, an x-ray should be completed prior to the patient leaving the operating room.
- If the patient again leaves the OR with counted items, follow the steps above.

Documentation

1. Use the appropriate count sheet – service-specific for general surgery (OR087), gynecology (OR086), urology/thoracic (OR085), open heart surgery (OR004), or OR088 for anything else. It is also acceptable to use a generic count sheet (OR088) for any complex open procedure.
2. For surgery that requires two set-ups, use two count sheets (e.g., abdominal-perineal resection).
3. If there is no scrub nurse, an RN counts with the surgeon and records the surgeon’s name on the sheet.
4. For the initial count; mark the number of counted items adjacent to the item listed on the count sheet and sign your name on the “In Count” space. For subsequent counts, check each item in the closest available column and describe the count in the corresponding row at the bottom of the sheet (for first closure count at peritoneum, check all items in column 1 and at the bottom write “1. Peritoneum”).
5. All additional items are counted, documented, and initialed as they are opened.
6. When sponges or other items are counted off during the procedure, put a single stroke through the number.
7. At the skin closure, put a single stroke through the numbers to indicate the items have been counted.
8. If you add an item after the final count has been done, record the item on the count sheet, and cross it off.
9. If you have a large number of needles, you may write the subtotal during the case, and circle it. For example,

$$9 + 6 + 4 + 2 + 2 = \textcircled{23}$$

10. For cases when opening is a possibility, count all instruments initially. If the surgery remains MIS or percutaneous, check the No Instrument Count Out Required box on the back of the count sheet.
11. Document a correct count in the “Counts Verification” segment in Cerner.
12. Several MIS instruments are counted as “complete”. See the photos in [Appendix B](#)

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Definitions for Documentation Purposes:

- A double-armed suture is recorded as 2 needles.
- Pacing wires are recorded as 2.
- All staplers are recorded as 1, which means 1 complete stapler.
- When a linear stapler is opened, the cartridge in it is recorded under “cartridges”.
- A syringe is recorded as 1, which means 1 complete syringe.

Related Documents

[BCD-11-11-40012](#) - Surgical Count

References:

1. ORNAC. (2021). *The ORNAC standards, guidelines, and position statements for perioperative registered nurses* (14th ed.), 3-75 to 3-88.
2. NoThing Left Behind®: A National Surgical Patient Safety Projects to Prevent Retained Surgical Items. Retrieved from: <https://nothingleftbehind.org/Home Page.html>

Persons/Groups Consulted

Clinical Practice Committee, OR, SPH

CNL Group OR, Thelma Velasco, Nurse Educator OR, MSJ

Developed By

Nurse Educator OR SPH

Susan Wynne, Consultant OR

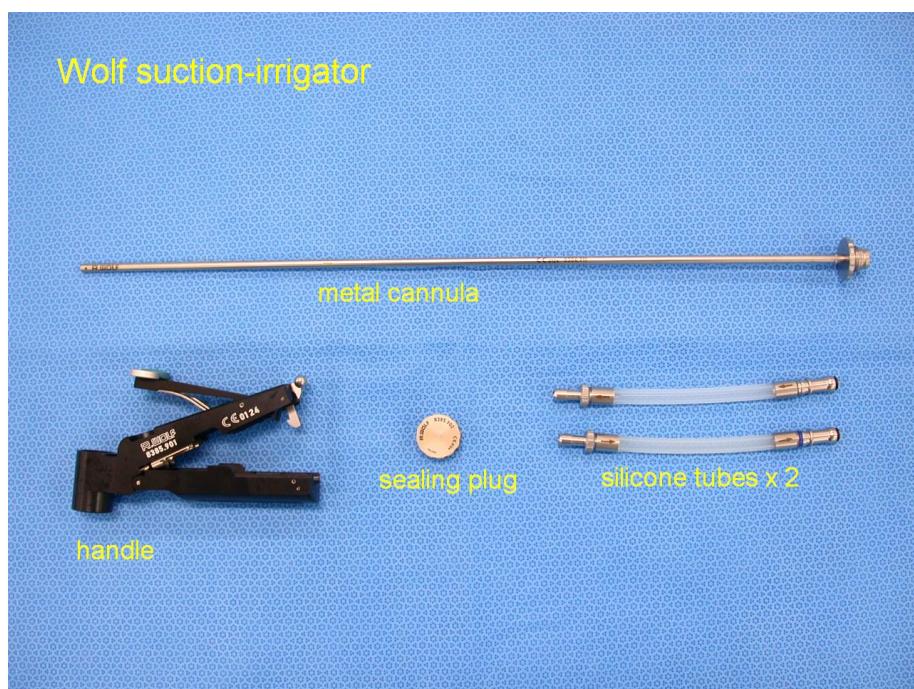
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	Operating Rooms

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Appendix A: Count for MIS Surgery (abdominal, retroperitoneal, chest)

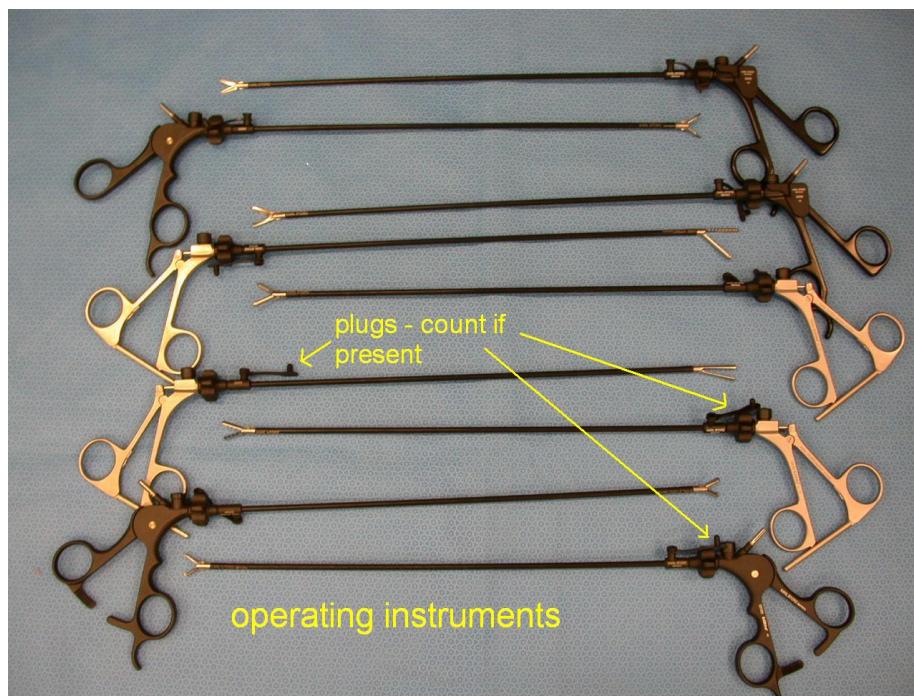
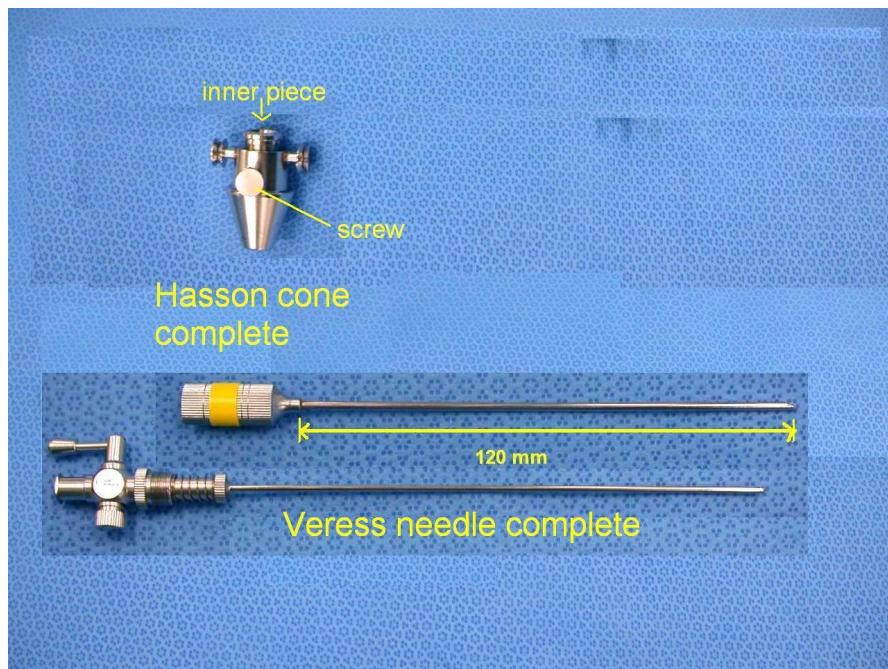
1. Select the service-specific count sheet, and count any item listed on the count sheet when setting up for the case.
2. If the case **remains MIS**, at skin closure count the small items on page 1 of the count sheet.
Definition of “remains MIS”: No trocar ports were extended, except to insert a larger trocar through a port. No separate incision was made to remove the specimen.
3. If the ports were extended, or a separate incision was made in the abdomen, a full closure count (MIS and non-MIS instruments and items) must be done.
4. For laparoscopic hysteroscopy, if the cuff is sutured vaginally or vaginal morcellation is done, a full closure count must be done.

Appendix B - Instruments

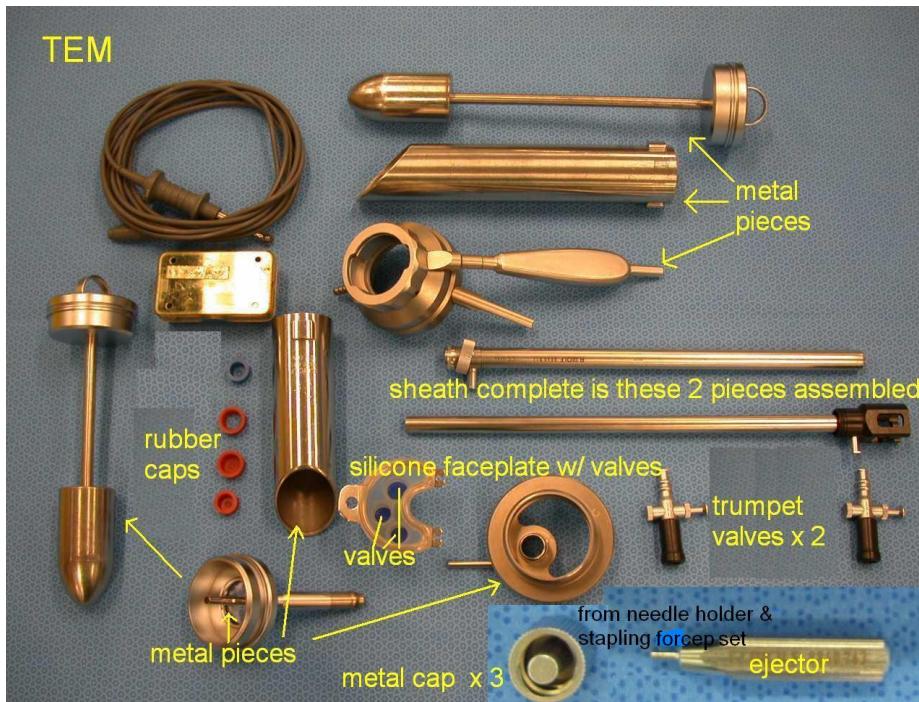


General Surgery and Gynecology

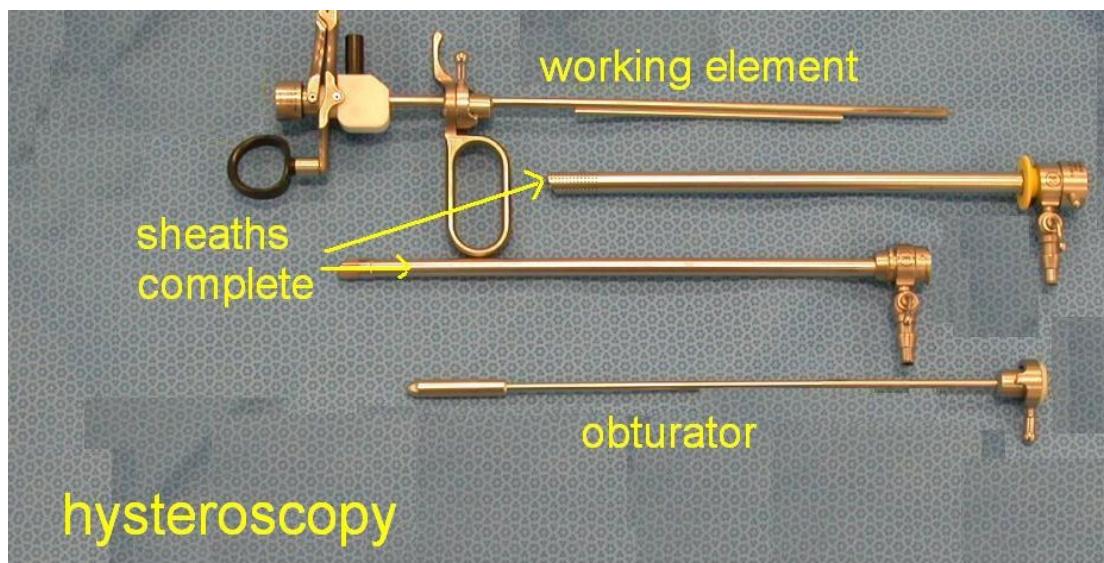




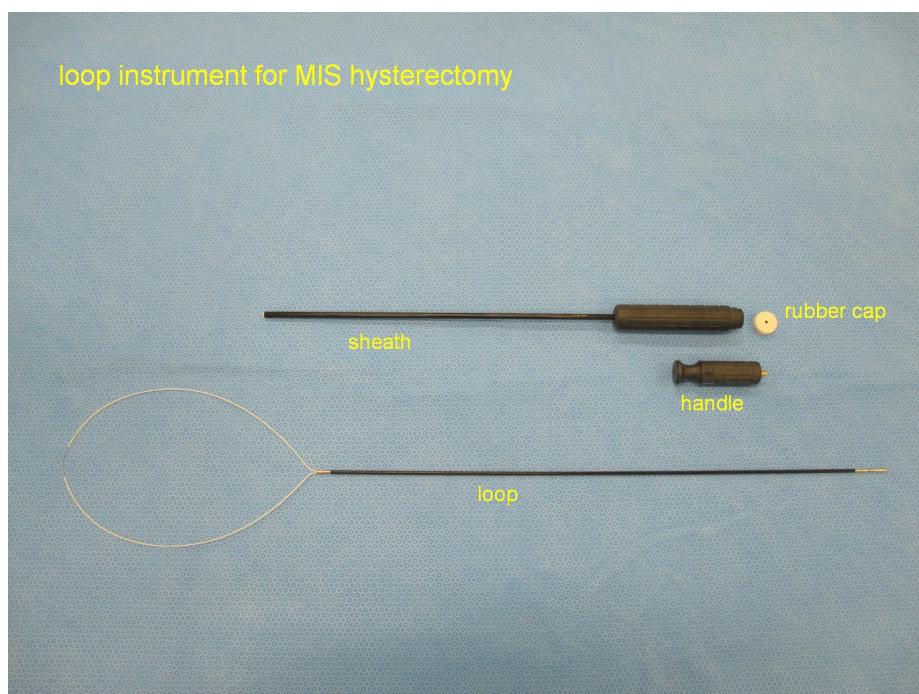
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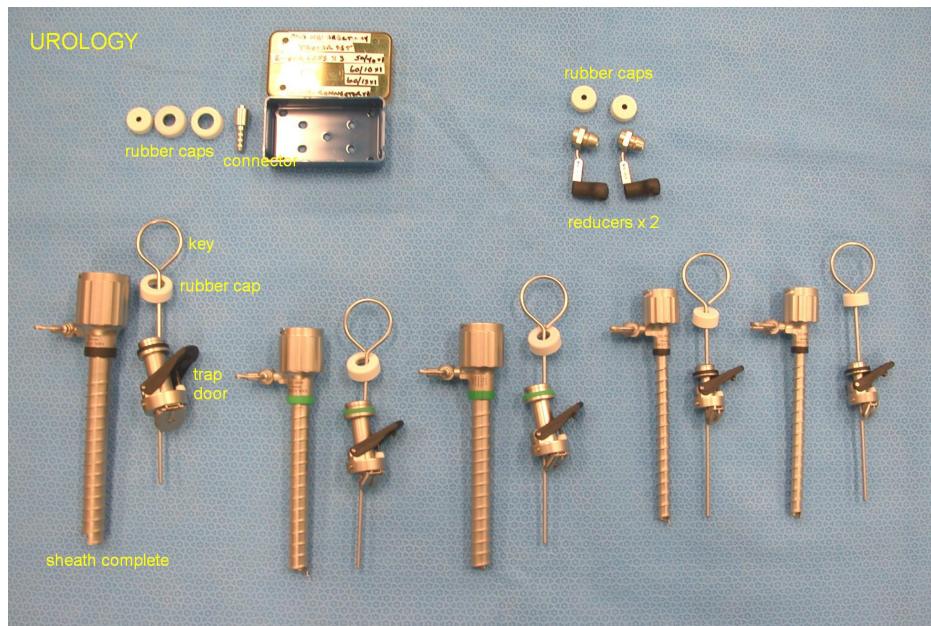


NOTE: There is also a telescope in the hysteroscopy sets. Count "telescope – complete".





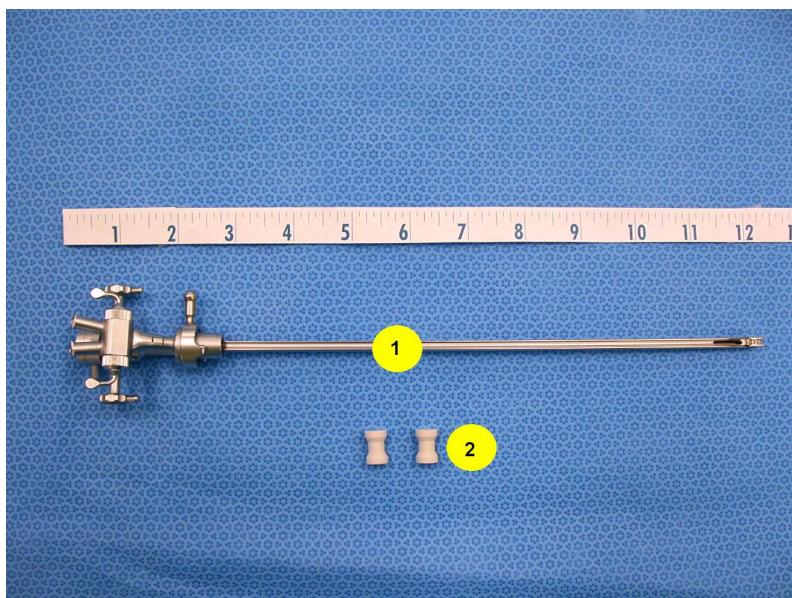
2. Urology



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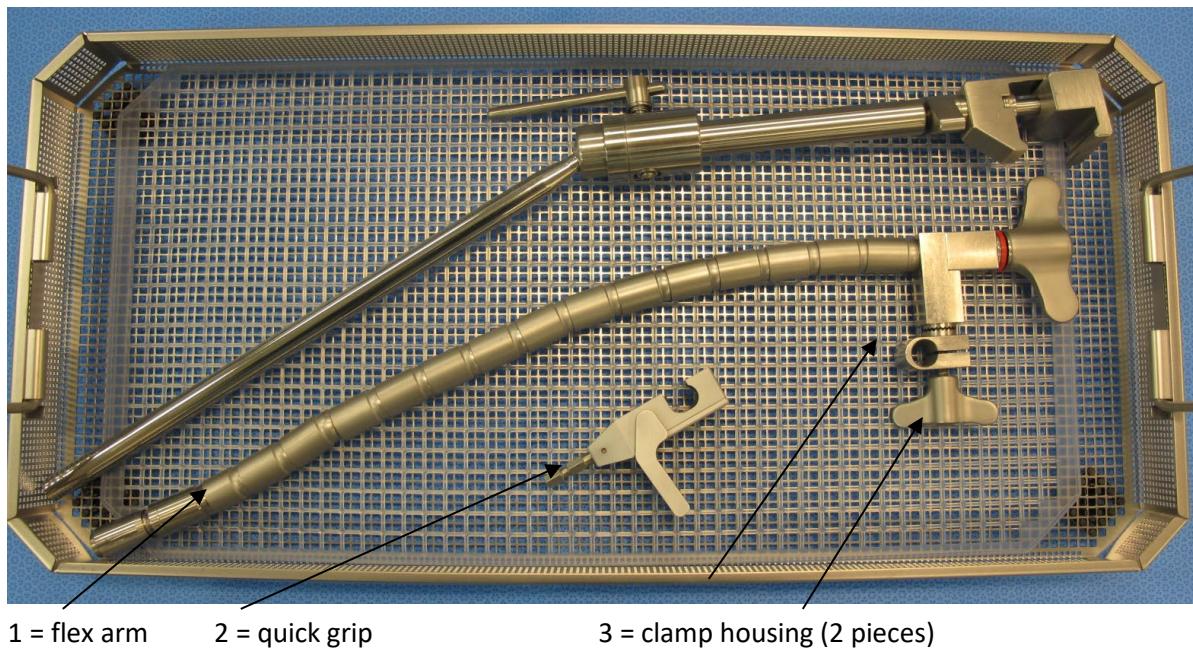
There are metal caps for the needle drivers. Count plugs if present.



This is the deflector unit for the cystoscope. Count deflector complete + rubber caps.

SCOPE HOLDER:

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1. Thoracic



Count plugs if present.



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