NURSES AND SURGICAL TECHNOLOGISTS

Action	Rationale
Develop a standardized counting method that must be used by all perioperative personnel in ALL operating rooms for ALL cases throughout the facility.	Develop a standardized way to display the surgical count in each OR so all personnel can readily see it. Insure that the information displayed in each OR is standardized. All hospitals follow AORN guidelines in requiring surgical counts but most do not have specific standardized practices for HOW the sponges are accounted for. In addition, OR staff often follow the practices they were taught in the school they attended hence there can be a wide variety in actual practice depending on where the personnel trained. These differences are manifested by variable counting practices in different OR's on different days in different cases depending upon the constellation of personnel.
For lap pads and raytex 4x4's or 4x8's, manual sponge counting is usually performed using kick buckets/ring stands and plastic bags or hanging plastic sponge holders. We recommend the use of the plastic sponge holders because it is a verifiable, transparent, inexpensive system. See guidelines for *Use of Hanging Sponge Holders*	Other techniques are usually used to track the miscellaneous other sponge types. Peanuts and twists are usually passed on a clamp or ring forceps. The use of the hanging holders is for sponges that are used "free". That is they are passed back and forth between scrub and surgeon without the use of an instrument.
Develop a standardized nomenclature, "a common language" for all the sponges used in the OR.	Different people call the same type of sponge by different names often depending upon where they were trained e.g. cottinoid vs pattie, kitner vs peanut. It is important for communication with surgeons that everyone agrees to the same terminology and most important for communicating with radiologists when an xray is obtained to look for a missing item. If radiologists "know" what they are looking for on an xray there is a greater chance they will be able to "see" it. The radiographic stripe of a lap pad is very different from that of a raytex 4x4 or a "peanut". When calling for an xray in the OR to look for a missing surgical item, it is important to specify on the requisition what is being looked for. Radiologists can learn the terminology.

Action	Rationale
Write the count for sponges on the dry erase board in a superscript running total format written: Laps: $10^{10}\,20^{10}\,30^{10}\,40$ Raytex: $10^{10}\,20^{10}\,30$ Do not make extraneous marks or initials. Alternatively use a vertical format: 10 10 20 10 30 10 40	A readily visible display board or dry erase board in each OR is a transparent and widely used method to keep track of the surgical counts. The information on the board should be displayed in the same fashion in every OR so any personnel going from one room to another will look for the same information in the same place on each board. Consider making permanent notations and categories on the boards in each room. The usual method of documenting the sponge count (e.g. 5+5+5 for laps) requires individuals to do arithmetic under stressful situations and isn't transparent i.e. at any given time you don't immediately know the total count. You have to add up the numbers to get the sum, rather than just looking at the last number and knowing how many sponges are out. This methodology for documenting the count is clear and familiar since needles have long been recorded in this manner. The dry erase boards should have clear labeling and differential positioning of the sponge, needle/sharp and miscellaneous item counts.
All laps and raytex are added to the field in multiples of 10 The count is always in a multiple of 10 Laps and raytex are placed in the 10 pockets of separate holders	Sponges are placed in the pockets with the blue radiopaque markers facing forward (not dangling out of the pockets) which distinguishes surgical sponges from dressings.
At the time of the final count all sponges must be in the hanging sponge holders. A holder will always have 10 sponges – no empty pockets. The surgeon can easily verify with the nurse that all sponges have been accounted for and we can be sure that there is "NoThing Left Behind"	Having the laps and raytex on the field in multiples of 10 means that at the final count, when all the sponges are off the field all pockets in the sponge holder will be full. Just looking at the full holder you will know you have 10. That is why we use the term sponge holders and not sponge counters. They are holding the sponges so you can see that all have been accounted for. It will be an easy visual to account for all the sponges. The count is kept in multiples of 10 and there needs to be a running total e.g. 40 laps means there should be 4 hanging holders full of sponges at the Final Count. Eventhough laps come in packs of 5 they should be kept on the field in multiples of 10. Miscounts have occurred and sponges have been retained because of confusion about whether there were 5 laps out or 5 laps in the patient or 5 laps were not recorded. **The rule of 10 means no empty pockets!** At the end of the case discard the full sponge holders in red biohazard bags

ACTIONS TO TAKE IF THERE IS AN INCORRECT COUNT

Action	Rationale
If the nurses respond back there is a missing sponge, STOP closing the wound. If the body cavity has been closed, remove enough sutures and use retractors to allow visual and tactile exploration. See Yield Poster Actions to Reconcile an Incorrect Count.	In cases where there has been a retained sponge in the setting of an incorrect count, the most frequent error is the surgeon has failed to stop closing the wound and do a thorough exploration. Surgeons often are sure the sponge is NOT in the wound and this perception affects their ability to actually find the sponge. Often the sponge is "right there" but the surgeon doesn't feel it.
If the item is not immediately found, call for additional nursing personnel to come to the room and help.	Having "new eyes" in the room to search for the missing sponge can reduce the time spent looking and provide more personpower to aid in the search.
Place a sterile drape or non-radiopaque towel over the wound and call Radiology to obtain an xray. Make sure the xray includes the entire operative field. This may require more than one film. In the chest consider taking an oblique film to detect sponges behind the heart. In the abdomen be wary of abnormalities in the midline and take an oblique if there are any questions. In obese patients, overpenetration while taking the film is recommended.	It should be mandatory OR policy, in the setting of an incorrect count, if the sponge is not found, an xray must be obtained. If the patient is clinically stable, the safe strategy is to obtain an xray. Sponges can be difficult to detect with intraoperative xray. They have been missed when they lie over the spine or are behind the heart. Tell the radiologist what kind of sponge is missing. If they know what to look for they have a better chance of seeing it.
Unless the object is found, wait to see the film before reclosing the site. If there is any question that the object may still be within the patient bring another set of hands and eyes to the field to explore the wound. A new pair of hands may bring new perspective.	Sponges do not have wings. The missing item must be found or confirmed not to be in the patient before the patient leaves the OR. If there is no radiologist available, the surgeon should read the film but expert radiologist review should be required within 12 hours.
Dictate in the operative report what actions were taken in response to the incorrect count, and if not found disclose to the patient that a sponge is missing. It may be necessary to obtain more xrays or a CT scan to definitively rule out that there is NoThing Left Behind.	If the item is found, the final count for the case is "correct". If the item is not located the final count remains "incorrect" and an incident report should be filed through the OR quality improvement or incident reporting system. See Incorrect Count Report. These cases should be investigated the same day and efforts made to locate the item or rectify or explain the incorrect count.

