SURGEONS:

Action	Rationale
Use only radiographically detectable sponges or towels in the surgical wound. Don't cut or alter them. Small sponges (peanuts, cottonoids) should be passed and returned attached to an instrument. Try to avoid the use of "free" (passed without an instrument) small sponges (raytex 4x4's) in large spaces.	All commercially available sponges and pads have a radiographic marker, tag or strip sewn into or woven within the interstices of the cotton gauze. Similarly, white surgical fine grade cotton towels that have a radiographic marker are available. Only radiopaque towels should be used for packing or retraction. These towels should be sterilely packaged separately, added to the field on an as needed basis and included in the surgical count. All new technology sponges and towels have radiographic markers in addition to the matrix labels, radiofrequency tags or radiofrequency identification chips.
A "swish" or a "sweep" before closing is an inadequate examination. Look for the sponges and do your best to get them out so the nurses can do the count. Perform a thorough, methodical wound exploration trying to see and touch, before asking for closing suture for every wound, every time. See guidelines for *Methodical Wound Examination*	Retained sponges have been reported in wounds of every size and in practically every place in the body. Bloody sponges can be difficult to recognize so looking must be an active process. Use two sensory modalities. The raytex 4x4 is the usual culprit in small wounds. The wound exam is performed to get all the sponges out so the nurses can put them in the sponge holders and account for them.
Call out "I think all the sponges are out" and take a "pauze for the gauze" allowing the nurses/scrub assistants to perform the closing count using two sensory modalities.	There are three major counts – the in count(s), the closing count and the final count. The closing count is an important event to prevent a retained sponge. Nursing personnel are trained to count with each other and are supposed to "see, separate and say". The "pauze for the gauze" allows focused performance of the task. The nurses should then respond back "the closing count is correct/incorrect".
After skin closure before leaving the OR or during the debriefing, look at the hanging sponge holder(s) and verify that all the free sponges used in the case are in the pockets. This should take less than a minute and reassures the surgeon that all sponges have been accounted for.	This is the final count "Show Me" step to make sure there is "NoThing Left Behind"
Dictate in the operative report "A thorough wound examination was performed and I saw that items were accounted for"	

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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.

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