Accountable items
swab, instrument and sharps count

Although UK statute law does not dictate what system or method of accountable items, swab, instrument and sharps counts should be performed within a perioperative environment, as healthcare practitioners, the law is quite clear in that we all have a 'duty of care' to the patient.

We are accountable to our patients for the nursing care we deliver and, as such, we must ensure that we do not cause any harm to our patients by negligently leaving foreign objects within patient cavities during clinically invasive procedures.

Unintended retained objects are considered a preventable occurrence, and careful counting and documentation can significantly reduce, if not eliminate these incidents. A count must be undertaken for all procedures in which swabs, instruments, sharps or other items could be retained. Reconciliation must be the default expectation during and at the end of all surgical/invasive interventions and a process must be in place to address any variance.

These recommendations for inclusion in local policy are designed to assist perioperative practitioners performing accountable items, swab, instrument and needle counts within any perioperative setting.
Unintended retained objects are considered a preventable occurrence, and many factors, including communication, situational awareness and consistent compliance with standardised procedures have been shown to reduce the risk of an item being retained unintentionally (AORN 2014). A count must be undertaken for all procedures where countable objects (e.g. swabs, instruments, sharps) are used (APP 2016).

Although it is the responsibility of the user to return all items, the scrub practitioner implements and manages the checking procedure in order to be able to state categorically to the operating surgeon that all items are accounted for at appropriate points.

The count must be audible to those present and must be conducted by two members of staff, one of whom must be an appropriately qualified member of the perioperative team (i.e. a Registered Nurse or Operating Department Practitioner). The other staff member may be a non-registered practitioner who has attained a validated count assessment through national or locally validated training. There should be standardisation of how countable items are named/referred to across one organisation and referenced into the local policy – this minimises the risk of confusion. The list below includes common names of items and can be used as a benchmark.

Accountable items

swab, instrument and sharps count

### Education/training

When an organisation supports students in the perioperative environment, preregistered nursing students, student nurses and student health care assistants should be present at the scrub count to assist with the count should liaise with the student to ensure that all students are familiar with the process and are competent to assist with the count by the end of their training.

The count must be performed by two members of the perioperative team, with one being the circulating practitioner and the other the scrub practititioner. The scrub practititioner should complete the surgical instruments count, including the use of cotton wool balls utilised in face, nose and throat surgery.

### Countable items - Countable items may include, but are not limited to:

- Blades
- Bulldogs
- Cotton wool balls
- Diathermy tip cleaners
- Instruments including screws or detachable parts
- Larynx swabs (peanuts, ligatees)
- Liga-releefs
- Local infiltration needles
- Laparoscopic retrieval bag
- Other isolation bags
- Needles
- Ophthalmic micro sponges
- Patties
- Red ties from swab packs
- Sling/sloops
- Shods
- Sponges
- Tapes
- X-ray detectable gauze swabs
- Mops or packs - names vary according to local requirements.

### Countable items

### Checking procedure

Provision should be made in the theatre to visually record the count either on a dry wipe board or smart screen which states all relevant items used. This board should be permanently fixed to the theatre wall and be at a height in a position that facilitates access and visibility during the procedure.

Pharyngeal packs should contain a radio opaque marker. The anaesthetist is responsible for pharyngeal (throat) pack packs placed in the patient prior to or during an operation (APP 2016). The insertion and removal of the pharyngeal (throat) pack should be documented on the anaesthetic record and the theatre dry wipe count board/smart screen.

The Health and Safety Authority recommend one visual and one documented method to identify placement and removal of the pack (NPSA 2009).

The initial full swab, instrument and sharps count must be performed immediately prior to the commencement of surgery. A second count should occur before closure of a cavity within a cavity, including implant replacement and closure of the minor cavity, if the time between the first and second counts is greater than 15 minutes. A third count should occur prior to the closure of a cavity (ensuring removal of any foreign bodies) giving a total of a minimum of three counts. X-ray detectable swabs used for catheterisation procedures should remain in theatre and be part of the count.

When additional items are added to the field, they should be counted at the time and recorded on the count documentation.

In the event of a NPSD 1 immediate life-threatening emergency (NPSD 2004) it is recognised that it is not always feasible to perform an initial swab and instrument count and delay intervention. In these circumstances all packaging must be retained to facilitate a count being undertaken at the earliest and most appropriate opportunity and documented in the patient’s records.

If a pack is used, any recognition method (e.g. arterial clip on abdominal pack tie) must be risk assessed according to the surgical site and salved method. The pack should be added to the count.

In some instances, where surgical instrument bags are opened at skin closure. It is recommended that surface dressings are a different colour from white raytec gauze (e.g. blue) so that they are easily distinguishable. X-ray detectable gauze should not have the raytec removed by a member of the operating team in order to use as a surface dressing as this will affect product liability.

Any interruptions or modifications should be documented in the patient’s notes. Any haemorrhage that may follow must be in accordance with local policy and should be documented in the patient’s notes. Any subsequent care teams will be responsible for recording the ongoing care and removal of the item.

### Checking techniques

Both practitioners must count aloud and in unison. Items should be completely separated during the checking procedure. The counting sequence should be in a logical progression, for example, from small to large. The uncounted/remaining sequence of surgical items is swabs, sharps, instruments, and should be performed unimpaired if an interruption occurs, the count should be resumed at the end of the last recorded item.

The integrity of the X-ray detectable markers in swabs, packs, peanuts, etc., as well as the integrity of tapes on abdominal swab ties, must be checked during the count.

At the initial count, and when added during the procedure, swabs and packs should be counted into groups of five. These should not be added to those already counted until the number in the packet has been verified. The additions should be in multiples of five. In the event of an incorrect number of swabs or packs (i.e. not five) the entire packet must be removed from the procedure area and appropriately reported.

Hypodermics and subcutaneous needles should be recorded as a total amount at the commencement of the procedure and additional items should be added individually on the dry wipe board/smart screen according to the number marked on the sterile package. Safari packs, etc. may be retained and used for a check-back procedure if required.

Opening all packages during the initial needle count is not recommended. Unused needles on the sterile field should be retained in a disposable, puncture-resistant needle container. Swabs should be full view of the operating surgeon and surgical nurse, where applicable. If a count is not recorded on the procedure, the sterile field must be uncounted and labelled as non-sterile. The technique used should be safe and should incorporate infection control measures in conjunction with standard precautions.

All items should be fully opened by the circulating practitioner and placed into an appropriate contained disposal system for risk assessed and documented locally. If a counted item is inadvertently dropped off the sterile field, the circulating staff member should inform the theatre nurse so that the item remains in the appropriate contained disposal system to be included in the final count.

Items should not be cut or altered in any way intended for the purpose. If alteration of any item is requested by the person performing the procedure this must be documented in the patient’s notes, highlighted on the dry wipe board/smart screen and included in the count.