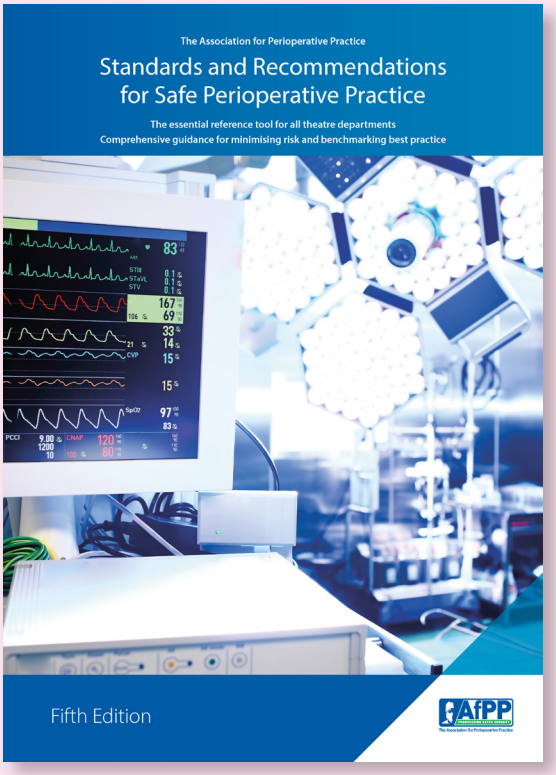
Clinical effectiveness: Accountable items



The following is an extract from ***Standards and Recommendations for Safe Perioperative Practice*** (Fifth Edition), published by The Association for Perioperative Practice. The extract covers training, governance, documentation and handover of care, count discrepancy and intentional retention of objects.

Training

8.1.49 An introduction to the swab, instrument and sharp policy should be included in the new staff orientation/ induction programs.

8.1.50 All members of the multidisciplinary team should undergo documented competency assessment prior to participating in the count process. This should include nurses, ODPs, medical staff, support staff and students.

8.1.51 Students in the perioperative environment (including pre-registered nursing students, student ODPs or student assistant theatre practitioners) should have supernumerary status until they have been deemed competent by assessment to assist with the count. It is recommended that it should be the designated registered practice supervisor who makes this determination. After competency has been assessed the student must not sign the legal record for the swabs being correct. This must be carried out by a registered practitioner who has observed the count.

8.1.52 The practitioner acting as perioperative practitioner must be focused upon the management of the intraoperative care required by the patient and therefore must not assume the additional duties such as that of the surgical first assistant (SFA). Performing the dual role must not compromise aspects of the perioperative practitioner role, including the swab, instrument and needle count.

In the event that an employer considers that a dual role is required in minor surgery, then this must only be undertaken by a registered practitioner and the decision should be endorsed by a policy that fully supports this practice and should also be based on a risk assessment of each situation to ensure patient safety (PCC 2018).

Governance

8.1.53 The count process should be regularly audited and breaches addressed to promote learning and adherence to local policy.

8.1.54 There should be a requirement for staff to report unsafe practice and the process for doing so should be endorsed, encouraged and actively promoted by all staff and the organisation. All staff should be encouraged to report breaches of the count process as patient safety incidents and/ or near miss incidents.

8.1.55 There should be a clearly defined processes in place to ensure that the detail and learning from clinical incidents and 'near miss' situations are shared and disseminated to all staff.

8.1.56 Provision should be made in all areas where surgical interventional procedures are undertaken, across the organisation, to facilitate standardised methods of recording items in use during a surgical/ invasive procedure.

This includes maternity departments and interventional radiological suites. All perioperative staff caring for patients in these areas, will need to comply with the local policy all practitioners should be aware of and familiar with the policies within these departments.

8.1.57 The method can be electronic, paper or dry wipe board or a combination. If a dry wipe board is used it is recommended that it be pre-printed to state all relevant items in use, with a space to add extra items as used during the case. This board should be permanently fixed to the theatre wall and be at a height and in a position that facilitates access and visibility to the multidisciplinary team but especially the perioperative practitioner and the circulator.

Documentation and handover of care

8.1.58 The point at which the care of a patient is transferred between professionals is recognised as high risk in relation to the retention of foreign objects. It is therefore essential that the handover process is robust. Organisations should have policies in place to ensure that the count is accurately continued and communicated when care is transferred between care settings (e.g. during transfer to and from maternity theatre).

8.1.59 It is the responsibility of the perioperative practitioner to ensure that documentation for completion of the count is recorded accurately.

8.1.60 A copy of the count sheet should be retained in the patient's notes indicating the names of the perioperative and circulating staff responsible for the final count. Where electronic records are utilised the record should indicate the names of the perioperative and circulating staff responsible for the final count.

8.1.61 Items which are to remain in the patient by intention (e.g. packing gauze, drain tubes, catheters) must be recorded in the intraoperative record/theatre register/ patient's pathway or electronic record. Their removal must also be recorded, including the time, date, name and designation of the practitioner removing the item.

8.1.62 Where it is known that the operative procedure may take longer than six hours to complete, a risk assessment should be undertaken to ensure that the perioperative and circulating practitioners are fit to practice for the duration of the case. Staff delegated to perform the task

should inform their line manager well in advance of the planned procedure if they do not feel fit to practice for reasons of health or competence.

8.1.63 During a procedure lasting more than six hours, the operating surgeon is responsible for determining a suitable time for any member of the operating team to leave the table for a comfort break. The operating surgeon should cease all activity until the perioperative practitioner has returned to the operating table and is ready to continue. Local agreement/policy should state if a count should be carried out by the perioperative practitioner before they leave the table and upon their return.

Count discrepancy

8.1.64 If any discrepancy in the count is identified, the operating surgeon must be informed immediately, surgery must cease, if safe to do so and a thorough search implemented.

8.1.65 If the item is not located the consultant with overall responsibility for the patient should be informed.

8.1.66 It may be necessary to utilise a microscope or other equipment (e.g. magnetic roller) to locate a missing needle.

8.1.67 It should be noted that evidence is conflicting in relation to how effective imaging is in detecting small suture needles. Studies have demonstrated that needles 10mm and smaller may not be consistently visible on imaging. Organisations should consider defining needle size limit criteria where imaging may effectively assist in identifying retained needles (AORN 2019).

8.1.68 If a thorough search does not locate the item, a patient X-ray should be considered. The failed reconciliation process should specify when an image intensifier or plain X-ray is used, and when the opinion of a radiologist concerning the image should be sought. It should be noted that "Raytec" swabs cannot be reliably identified with an image intensifier (NHS England 2015).

8.1.69 The patient should not leave the operating theatre until the missing item is accounted for. In situations where this is not possible (and this may be in the patient's best interest) the reason and forward plan should be documented by the consultant with responsibility for the patient.

8.1.70 Comprehensive documentation concerning any unaccounted items must be added to the patient's record. Under the duty of candour, patients must be made aware of any unintentional retention of a foreign object and detail of impact this may have on their health (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

8.1.71 Any investigation that may follow should be in accordance with local policy. An incident form should be completed detailing the issues and investigation implemented as soon as possible following the event, and in compliance with local policy.

Intentional retention of objects

8.1.72 On occasions items are intentionally left permanently in place. For example, the surgeon may on balance decide that it is safer to leave a fragment of broken screw in a bone than to risk further injury or >>

damage in an attempt to retrieve it. This decision and subsequent verbal explanations to the patient must be documented in the patient record.

8.1.73 It is recommended that a process guided by policy be implemented to manage the risk of retention when an item is intentionally left insitu (e.g. wound or vaginal pack, drain or catheter (other than urinary). The process should identify the presence and plan for removal, especially when the patient's care is continued in another department or environment. (This could include another department, ward or hospital.)

8.1.74 Patients must be made aware of any object intentionally retained after a procedure and also the plan for its removal. Where possible they should be informed, as part of the consent process before the procedure, so that the patient knows what to expect.

8.1.75 The surgical care plan which the operating surgeon documented at the time the retained items were left in situ, should be used to determine the number and location of the item(s) to be removed. The process of removal should be completed by the operating surgeon and clearly documented in the patient's record.

References and further reading

Association of periOperative Registered Nurses 2019 Recommended practices for sponge, sharp and instrument counts. In: **Perioperative Standards and Recommended Practices** Denver, AORN Inc

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 **Duty of Candor** Part 3 Section 2.20 [online] Available from: http://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents [Accessed March 2021]

NHS England Patient Safety Domain 2015 **National Safety Standards for Invasive Procedures (NatSSIPs)** [online] Available from: http://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/09/natssips-safety-standards.pdf [Accessed March 2021]

Operating Room Nurses Association of Canada 2005 Module 3 Safety/risk prevention and management 5 Surgical Counts. In: **Recommended Standards, Guidelines and Position Statements for Perioperative Registered Nursing Practice** Kingston, Ontario, ORNAC

The Perioperative Care Collaborative 2018 **Position Statement: Surgical First Assistant** [online] Available from: http://www.afpp.org.uk/careers/Standards-Guidance [Accessed March 2021]

World Health Organisation 2009 **WHO guidelines for safe surgery: Safe surgery saves lives** [online] Available from: http://www.who.int/patientsafety/safesurgery/tools_resources/9789241598552/en/ [Accessed March 2021]