Perioperative Services Competency Assessment - Vanderbilt University Medical Center

Counts, Surgical	Interpretation	Rationale
A. Verbalizes what surgical items should be counted throughout the operative case.	1. Sponges (including ones used in preps). 2. Sharps. 3. Instruments when wound size is large enough to retain an instrument or a cavity is entered. 4. Miscellaneous items as identified in Counts, Sharps, Sponges and Instruments policy.	1. Prevent injury as a result of a retained foreign body. 2. Vanderbilt Policy – Counts, Sharps, Sponges, and Instruments.
B. Describes when surgical items should be counted.	1. Before incision to establish a baseline. 2. Before closure of cavity within a cavity. 3. As wound closure begins. 4. At skin closure or end of procedure. 5. At the time of permanent relief of either the scrub person or circulating nurse.	1. Accurately accounting for sponges, needles and instruments if indicated, during a surgical procedure is a primary responsibility of the perioperative nurse and constitutes a proactive injury-prevention strategy. 2. Initial counts provide a baseline for subsequent counts. 3. Accounting for and disposing of all items at end of the procedure helps avoid potential incorrect counts on subsequent procedures.
C. Demonstrates how items should be counted.	1. All items should be counted audibly and concurrently viewed during the count procedure by the scrub and circulator (initial, relief, first final and final counts). 2. Sponges should have tape broken, be separated and viewed by scrub and circulator. 3. Counts should be performed in the same sequence each time. Begin at surgical site; proceed to the mayo stand, back table and off field items. 4. Used sponges are separated, counted audibly and viewed by both the scrub person and circulator. Pocketed bag system may be used for counting used sponges. 5. The final instrument count cannot be considered complete until those instruments used in closing the wound (e.g. malleable retractor, needle holders, scissors, towel clips) are removed from the wound and surgical field and given to the scrub person for final counting with the circulator. Patient will not leave the operating room until all counts are finalized. 6. All sponges used in a body orifice for packing are accounted for before count is finalized.	1. Reduces the risk for inaccurate counts. 2. Separating sponges help determine whether a sponge has been added or deleted from the prepackaged sterilized package. 3. Assists in achieving accuracy, efficiency, and continuity among perioperative team members.
D. Demonstrates / verbalizes how to handle an incorrect number of sponges or needles in a pack.	1. Pack should be handed off of sterile field to circulator. 2. Circulator should place in a clear bag, date the bag, and store it in the room until final counts are taken. 3. Packages containing an incorrect number are not included in surgical counts.	1. Reduces confusion as to what happened to the pack containing an incorrect number.
E. Demonstrates / verbalize how to handle broken sharps and instruments or disassembled instruments.	1. Broken sharps and instruments must be accounted for in their entirety. 2. Ensure all parts of each instruments are accounted for in their entirety.	1. Helps prevent unintentional retention of foreign bodies in the patient.
F. Verbalizes how to care for patients with packed cavities.	1. When the wound is deliberately left open and packed, the sponge count will be considered incorrect with each return visit to the operating room. 2. An x-ray will be taken, read and documented, when the wound is considered closed. 3. Complete all documentation (Patient Tracker/Veritas if x-ray is taken). 4. Wounds will be considered closed when allowed to heal by granulation and/or a skin graft, when the fascia is closed, or when vicryl mesh is used for final closure.	1. Packed wounds automatically have an incorrect count due to the presence of retained sponges upon arrival to the OR. 2. The final x-ray clears the surgical wound for retained foreign bodies.

G. Identify and manage high risk patient groups for retention of foreign body.	High risk patients include: 1. All level 1 trauma cases. 2. When there is an unexpected change in procedure. 3. When there are one or more specialty surgical teams and/or service lines that are performing different unrelated procedures simultaneously in one or more body cavities. 4. When patient is morbidly obese; Body Mass Index (BMI) is equal to or greater than 40.	1. When a cavity is entered (i.e. body cavities include: thoracic cavity, pelvic cavity, abdominal cavity, retroperitoneal space, and mediastinal space), each patient is assessed by the surgical team for risk factors that may increase the potential for a retained surgical item (RSI). 2. If one or more risks factors for a retained surgical item are identified and surgical wound requires closure, an intra-operative x-ray is taken of the entire surgical area/cavity. 3. If there is any level of concern for a potential retained surgical item in any surgical case, by any member of the surgical team, an x-ray should be obtained.
H. Demonstrates / verbalize procedure for intraoperative x-rays for incorrect surgical count or high risk patients.	1. Recount. 2. Notify attending surgeon, for re-exploration of wound for (possible) foreign body removal. 3. Search trash, linen, floors, all areas of the operating room. 4. If unresolved, call for an x-ray and state what item is missing. 5. If more than one cavity is entered, images of all cavities are required. 6. Digital image(s) are developed and sent to IMPAX. 7. Notify ED senior radiologist on duty to read the x-ray and communicate to attending surgeon within 30 minutes. Sign final report before patient is discharged from hospital with exception of C-arm images. 8. Leave the patient anesthetized and draped until x-ray is read and wound is determined to be free of foreign bodies. 9. For off campus locations, where an attending radiologist is not available, the attending surgeon/proceduralist will review the x-ray. 10. Complete Veritas report documenting the x-ray findings. 11. Document incorrect count and time x-ray was taken on count sheet and face sheet of Patient Tracker.	1. Verify the incorrect count. 2. Attending surgeon must order x-ray to rule out foreign body. 3. X-ray must include complete surgical site to verify all surgical cavity is free from foreign body. 4. The patient remains anesthetized in case foreign body is retained for ease in removal. 5. Provides record of care administered and the outcomes of care delivered.