University Hospitals of Derby and Burton NHS Foundation Trust

MANAGEMENT OF SWABS NEEDLES AND INSTRUMENTS STANDARD OPERATING PROCEDURE (SOP) - BURTON SITES ONLY

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Theatre Swab, Needle and Instrument Count Procedure

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Burton Hospitals NHS Foundation Trust

Theatre Swab, Needle and Instrument Count Procedure

1: INTRODUCTION

1.1 All items used for clinically invasive procedures or interventions must be accounted for. This includes all swabs, needles and instruments. This is to prevent foreign body retention and any subsequent injury to the patient.

1.2 Retained items are considered a preventable occurrence and careful counting and documentation can significantly reduce, if not eliminate, these incidents. Retained swab/instrument post-operation is categorised as a 'Never Event'. A count must be undertaken for all procedures in which swabs, instruments and sharps could be retained.

2: SCOPE AND OBJECTIVE

2.1 This procedure is for use in the operating theatres and is to provide patient safety by ensuring that swab, needles and instruments are accounted for at the end of the operation.

2.2 The aim of the SOP is to assist all perioperative staff to carry out their duties in the checking and recording of swabs, packs, tapes, sharps, instruments, slings and other miscellaneous items in the operating departments. The SOP is designed to guide staff when discrepancies occur and ensure that the patient receives optimum care in the perioperative journey. In addition it has been developed to ensure that the perioperative staff do not breach their duty of care and are aware of each individual's responsibility and accountability for counts during a surgical procedure.

2.3 The overriding principal is to ensure that all instruments, swabs, needles and other miscellaneous items are accounted for throughout an invasive surgical procedure to prevent foreign body retention and subsequent injury to the patient. Although it is the responsibility of the surgeon to return all items, the Scrub Practitioner implements the checking procedure in order to be able to confirm that all items have been returned and are accounted for.

3: DEFINITIONS

Countable items shall include, but are not limited to: x-ray detectable gauze swabs, throat packs, post nasal packs, pledgetts, ophthalmic micro sponges, gauze strips, needles, instruments, including screws or detachable parts, blades, local infiltration needles, tapes, slings, loops liga-reels, bulldogs, red swab ties, cotton wool balls and disposable items, diathermy tips and tip cleaners, merocel packs, retrieval bags and any bungs and caps off the ends of instruments.

4: EDUCATION AND TRAINING

4.1 This SOP must be included in the local induction programme for all new theatre staff, including temporary staff. All staff will receive appropriate training and undergo competency (Appendix 1 & 2) in the checking procedure for

instruments, swabs, needles and other miscellaneous items, and safe confinement in the sterile field (NMC, 2015).

4.2 Healthcare Support Workers will be permitted to participate in the count following satisfactory competency assessment, by an appropriately qualified member (must be a registered and competency assessed) of the perioperative team.

4.3 Student ODP's, Student Nurses, and newly appointed nursing staff are not to undertake the role of 'second check' independently, until deemed competent for this activity as above.

4.4 A yearly competency/testimony must be achieved by all theatre staff by assessment from a qualified member of the perioperative team who is deemed competent (Appendix 3). This will form part of the appraisal process.

5: PROCEDURE

5.1 Counting Procedure

A swab, instrument and needle count should be performed for all clinically invasive procedures by:

- Two members of staff, one must be a competent Registered Practitioner; the second checker must have passed the competency for swabs, needles and instruments.
- The same two staff should perform all the counts. For any staff changes another full instrument, needle and swab count must be completed and names recorded appropriately in the operating register and the electronic care plan.
- The Scrub Practitioner should remain scrubbed for the length of the operation, but if unforeseen circumstances occur and the Scrub Practitioner needs to be replaced, a full surgical count must be undertaken and documented within the patients care notes and the theatre register. A clinical incident form must be completed.
- If the Scrub Practitioner is not required during small procedures, the Circulating Practitioner should be the Registered Practitioner with whom the Operating Surgeon should perform the count.
- If the Scrub Practitioner is a Theatre Assistant Practitioner then the count must be performed with a Registered Theatre Practitioner who has passed all the relevant competencies.

5.2 X-ray detectable swabs used during catheterisation should be included as part of the count if the patient has been catheterised in theatre.

5.3 When a double-ended suture is used, each needle must be counted as a single item. Suture packets must be retained by the Scrub Practitioner until the final count is completed.

5.4 Instrument sets contain a pre-printed detailed and comprehensive list of the instruments to provide an accurate record of instruments in the set. The list should be used to check the instruments and any detachable parts, including number of detachable pieces.

It is recognised during major joint surgery and when using loan kit, when multiple trays of instruments are required, that scrub and circulating staff may not be familiar with the individual instruments and their name, therefore instruments will be counted for the number of components and documented accordingly on the tray list"

Should there be a discrepancy when checking the number of components in the set in this way the set list must be used to identify what is missing and report it. The surgeon will need to allow time for the instrument to be identified.

5.5 The first full count of swabs, needles and instruments **MUST** be made prior to the start of surgery. All red swab ties must be removed and safely retained, the swabs separated and counted individually. When counting, both practitioners must count aloud and in unison. When the surgical count is taking place there should be no interruptions. Once a count has been commenced it should be completed. If interrupted, the count should resume from the beginning of the interrupted count. The counting sequence must be logical, from small to large and there should be no interruptions. The recommended sequence is swabs, needles and instruments. The X-ray strip and the integrity of the swab and tapes must be checked by opening out the swabs. All red ties must be retained until the end of the case. Suture packs must be retained and used as a check-back procedure if required. Raytex swabs must not be altered in size under any circumstances.

5.6 All sheaths, caps and bungs must be immediately removed and discarded off the sterile working trolley into the clinical waste bag

5.7 The scrub practitioner can at any time during the procedure request that swabs, sharps & instruments are checked.
It is essential that a full swab, sharps & instrumentation check is completed and correct before closure of the major cavity / layer i.e. abdominal cavity.
However, during a procedure with more than one cavity a count of swabs and sharps must be completed at the closure of each cavity. The Scrub Practitioner must inform the Surgeon that the check is correct and will then elicit a response from the surgeon that they heard and understood.

It is recognised that some minor procedures (non-cavity) will only require a swabs, needles and instrument count at the beginning and the end, For example injection list, phaco list, flexible cystoscopies and minor lesions.

5.8 A final count **MUST** be performed at the commencement of skin closure. All counts must be audible to the scrub team and a verbal statement made by the Scrub Practitioner to the effect that all swabs, needles and instruments are accounted for. Again a verbal acknowledgement must be received from the Operating Surgeon in order to prevent any misunderstanding.

5.9 Used needles in the sterile field must be stored in a disposable sharps pad. In accordance with Association for Peri-operative Practice, a receiver must be used to transfer and receive all sharps between Surgeon and Scrub Practitioner, to create a neutral zone, unless a formal risk assessment is in place, which supports alternative practice. Whenever possible, the Scrub Practitioner should

take the used needle on a needle holder from the Surgeon before passing there placement. The needle should be passed guarded by the Surgeon.

5.10 If at any point during surgery there is a breakage of equipment or consumables etc., the Scrub Practitioner must be made aware and the surgeon notified. All parts must be retained and accounted for at the end of the procedure. This should be reported to the Theatre Co-ordinator and an adverse incident form completed by the Scrub Practitioner, recording the lot number and batch details. All the parts must be retained for further investigation.

5.11 Additional swabs/sharps/instruments required during the procedure must be counted and added to the swab board. Swabs should not be added to the board until the number in the pack has been verified. The additions should be in multiples of five.

5.12 The circulating assistant responsible for handing and counting items to the scrub nurse is solely responsible for documenting the items onto the board.

5.13 During an operation any swabs left inside the patient for temporary packing **MUST** be communicated to the Circulating Person by the Scrub Practitioner. This must be recorded on the swab board, defined clearly as swab in wound cavity stating the size and number. When removed from the cavity, this must be communicated by the surgeon and the circulating practitioner must draw a single line through the documentation on the board.

5.14 At all times during a surgical procedure the scrub practitioner must be aware of the location of all swabs, instruments and sharps. Neatness in approach is to be encouraged to ensure that only necessary equipment is in use at any given time. Should any swabs/needles/equipment fall to the floor they should be collected by the circulating practitioner and placed appropriately outside of the sterile field but within the theatre. The Scrub Practitioner must be notified.

5.15 Used swabs and packs should be counted off the sterile field. All items should be fully opened by the circulating practitioner and placed in the appropriate disposal system.

5.16 Each patient must have an individual clinical waste bag, labelled clearly with the patient's identity number, date and theatre. This **MUST** remain in theatre until the end of the case and all counts are correct.

5.17 At the end of the case the Scrub Practitioner and second person involved in the counts must sign the theatre register to confirm all counts are correct. Electronic records should also be completed with the same details.

5.18 Swabs intentionally retained in the patient's wound must be documented in peri-operative care plans and in the theatre register stating clearly the quantity and type of swabs retained. The Surgeon is responsible for documenting this action in the patient's surgical record. The Scrub Practitioner must verbally handover this information to the receiving Recovery/Maternity /ICU/HDU staff responsible for the patients care.

5.19 When the patient returns for the removal of the intentionally retained swabs, the Scrub Practitioner and Surgeon identify the size, number and type of swab. The circulating practitioner will cross reference this information on previous record of swab count in the peri-operative care plan/ patient's surgical record. This should be documented on the swab board as previously retained swabs.
On removal the swab must be checked to confirm that the tape is intact on. The Scrub Practitioner shows the opened swab to the circulating practitioner who places the swab(s) into a separate plastic bag indicating number and type of swab(s). This must then be crossed off the swab board. This should be kept separate from the procedure count.

5.20 Instruments with screws, removable parts or those that are disassembled into their component parts must be individually checked and accounted for. Instruments should also be examined for defects and discarded prior to use if faulty. If the content of an instrument tray is incorrect when performing the initial count, the discrepancy should be recorded on the instrument set check list, reported to Hospital Sterile Supply Unit manager and a non-conformance form completed in addition to an adverse incident form.

5.21 Any malfunctioning or damaged instruments must have a red tag for damaged or a yellow tag for sharpening attached to it at the end of the case. The Scrub Practitioner must inform the circulating assistant to document on the instrument checklist and complete a repair form.

5.22 In the event of a surgical wound being re-opened one of the following procedures is employed:

a) If the instruments are still sterile and the count is correct this is deemed equivalent to a 'prior to operation' check and the re-operation continues.

b) If the instruments from the original operation are un-sterile the re-operation commences with new instruments, swabs and drapes and the case follows the procedure for a new operation.

5.23 Instrument tray lists should be completed. Any instrument tray deemed to be incorrect should be documented appropriately using the local reporting system.

5.24 Throat Packs

Throat packs should contain a radio opaque marker. The person making the decision to use a throat pack (usually an Anaesthetist) retains responsibility that it is removed at the end of the procedure. The decision to use a throat pack should be noted as part of the preoperative team check. A radio-opaque pack should be used, with the end obviously protruding from the mouth. Presence of a throat pack should clearly be documented on the theatre board. The throat pack should be removed whilst the patient is in theatre at the end of the case and included in the final "sign out" swab check.

5.25 Obstetric Protocol

To avoid discrepancies, when transferring patients from delivery rooms for 2nd or 3rd Degree Tears/Post-Partum Haemorrhage:

a) The labour room documentation must be made available for the theatre team brief and for the whole duration of the case.

b) Any swabs/packs in situ must be transferred to the patient's peri-operative care plan and placed on the swab board.
c) The scrub practitioner must assist the Obstetrician during the case and follow the normal count protocols prior to the commencement of the case.
d) If the swabs/packs are removed, they must be placed into a plastic bag marked delivery room, and its contents identified on the outside of the bag, along with the patient's hospital number, and crossed out on the swab board.
e) At the end of the case, the labour room documentation, along with the swabs/packs which have been removed, bagged and labelled must be returned to delivery suite.
f) If swabs/packs are left intentionally in situ, then the protocol for intentional swabs must be adhered to.

5.26 Discrepancy Procedure

The Surgeon and Co-ordinator must be informed immediately of any discrepancy and a thorough search implemented.

5.27 The Scrub Team must then initiate a recount to include a thorough check of all swabs including counted down bags and all waste / linen bags. Red ties to be cross referenced with swabs.

5.28 If the item is not located then an X-ray should be taken before the patient leaves the theatre, or if this is not possible the theatre department. Plain X-ray is recommended (MHRA 2005b) as image intensifier and fluoroscopy may fail to locate radio opaque swabs.

5.29 The discrepancy needs to be considered to determine if it is a Never Event

The Definition of a Never Event is:

Unintended retention of a foreign object in a patient after surgical intervention, including interventional radiology, cardiology and vaginal birth

a) Includes swabs, needles, implants, fragments of screws, instruments and guide wires.
b) Excludes where any relevant objects are missing prior to the completion of the surgical intervention and may be within the patient, but where further action to locate and/or retrieve would be more damaging than retention, or impossible.

5.30 Where a swab, needle/miscellaneous item or instrument has been retained in the patient following completion of the procedure and closure of the surgical site (post-operatively) this must be considered to be a Never Event, and escalated immediately to
In Hours: Clinical Theatre Manager, Consultant (if not in the theatre) and Head Nurse
Out of Hours: The Site Practitioner and Manager On-Call

5.31 This must be documented in the patient's notes (written & electronic), theatre register and the patient informed. A critical incident form must be completed as soon as possible and the Clinical Governance Department informed to enable reporting to the appropriate authorities.

5.32 Microscopic missing item(s) that do not show up on an x-ray, such as fine needles are to be documented on the intra-operative care plan, the theatre register and within the patient's surgical record. An X-ray request in this instance is at the Surgeon's discretion and the action documented. A microscope or magnet may be requested.

5.33 Where a decision is made by the Surgeon not to X-ray the patient, it must be recorded on the critical incident form and in the patient's medical record that an X-ray of the patient was requested by the Scrub Practitioner.

5.34 All missing items must be documented and recorded in the patient's notes, perioperative care plan both manually and electronically and documented in the theatre register.

5.35 Unused Items

Should instruments (swabs, needles & instruments) not be used during a case, they should be disposed of and labelled as per used swabs/needles/ instruments. At no time should these be covered over and used for another case.

5.36 Comfort Break

It is recognised that a comfort break is required by the scrub team for procedures lasting more than 6 hours. The Operating Surgeon is responsible for determining a suitable time for any member of the operating team to leave for a comfort break. The Operating Surgeon should cease all activity until the Scrub Practitioner has returned to the operating table and is ready to continue.

6: DOCUMENTATION

6.1 Documentation for completion of the counts must be recorded accurately on both the paper and electronic version of the peri-operative care plan, and manually in the theatre register. It is the responsibility of the Scrub Practitioner to ensure their completion and accuracy.

6.2 When the surgical procedure is scrubbed for by a Theatre Assistant Practitioner the documentation must have a Registered Theatre Practitioner signature as the second person checker.

6.3 The WHO checklist "sign out" procedure is completed as applicable. It should be in the presence of and heard by all the theatre team.

7: PROCEDURAL EFFECTIVENESS

The above procedure is subject to audit within the Theatre Assurance process. The swab, needle and instrument check forms part of the Perioperative Care records and Theatre register and are subject to the Trust Records Management Policy which requires audits of healthcare records to be undertaken at least annually in specialities involving high-risk patients.

8: REFERENCES

Standards and Recommendations for Safe Perioperative Practice (2007)
Association of Perioperative Practice

Journal of Perioperative Practice (2009) Volume 19. Issue 10. Progressing Safer Surgery

Nursing & Midwifery Council (April 2015) **The Code** - NMC-UK.Org.
National Patient Safety Agency (2009) **Never Events Framework 2009/2010**

Association of Perioperative Practice (AfPP) (2007) **Swab, Instrument and Needle Counts – Managing the Risk** - Harrogate, NATN (AfPP)

Appendix 1

Name	**Date:-**		
Competency: CHECKING AND RECORDING OF SWABS, SHARPS AND INSTRUMENTS AND OTHER MISCELLANEOUS ITEMS.	**COMPETENT YES/NO**	**SIGNATURE OF EMPLOYEE**	**SIGNATURE OF ASSESSOR**
1. Explain the principles for performing a swab, sharps and instruments check and safely Demonstrate the checks performed at all stages of the procedure.	YES		
2. Perform an initial check correctly and demonstrate the correct documentation of the swab, Sharps and instruments.	YES		
3. Demonstrate the correct procedure for checking and recording:- • Swabs • Extra instruments • Blades • Suture Needles • Throat packs • Disposable items	YES		
4. Discuss what steps to take when a discrepancy in a count occurs.	YES		
5. Discuss or demonstrate how to document a swab left inside during the operation.	YES		
6. Demonstrate and explain how to dispose of used swabs during the operation.	YES		
7. Demonstrate communication to the lead surgeon following all counts.	YES		
8. Explain the action taken when a changeover of circulating staff occurs.	YES		
9. Perform the correct procedure when surplus items are given to the scrub practitioner.	YES		
10. Demonstrate sound knowledge of the following:- • The phases of counts • Method of counting • Storage of swabs on trolley • Additional items when requested	YES		

Appendix 2

Swab, Sharps and Instrument Competency and SOP

1. **Who's responsibility is it for the documentation of the accountable items onto the board?**

2. **When should you perform a full instrument, swab and sharps count?**

3. **What should be done if there was found to be a discrepancy with the swab count?**

4. **What items need to be documented onto the board during a procedure?**

5. **How are swabs intentionally retained in the wound documented?**

6. **What should take place when a changeover of staff come into theatre to circulate?**

7. **What should be observed on a swab check?**

8. **How do you correctly document and account for the following:-Sutures**
   Blades
   Swab red tapes
   Extra instruments
   Swabs 18 x 18
   Syringes
   Retrieval bags

Appendix 3

Yearly Swab Competency Form

Name:-

	Year	Practical	Theory	SOP	Date/ Signature
First Assessment	**1**				
Self-assessment of competency	**2**				
Self-assessment of competency	**3**				
Full assessment	**4**				
Self-assessment of competency	**5**				
Self-assessment of competency	**6**				
Full assessment	**7**				

**** Full assessment – Practical, Theory and SOP**