Oxford University Hospitals
NHS Foundation Trust

# Swabs, Sharps Instrument and Accountable Items Policy on a Page

**All clinical staff must read this policy. The accountable items process is a critical safety measure in surgery/invasive procedures, ensuring that all items used are accounted for, before closing the surgical site, to prevent retained surgical items and the associated risks to the patient.**

## AfPP Standards

- All members of the perioperative/procedural team must operate within their proven levels of competency.
- A count of swabs, sharps, instruments and accountable items must be performed for all clinically invasive procedures.
- A standardised count sheet and/or count board should be used for all invasive procedures.
- Interruptions to the count should be avoided. Once counting begins, it should proceed without stopping. If interrupted, resume from the last recorded item.
- The scrub practitioner must always be aware of the location of all swabs, sharps, instruments and accountable items and handle in accordance with Infection Prevention & Control Procedures.
- All accountable items, clinical waste, and linen must stay in the procedure area until the Scrub Practitioner confirms the final count is correct. Bags should be labelled with the operation date, theatre/procedural room identity, and case number.
- Where possible the theatre/procedural team should remain the same throughout the procedure to ensure patient safety and continuity of care.

## Count Discrepancy

**In the incidence of a count discrepancy,**

- **Scrub Practitioner** must repeat the count & inform the Surgeon/Operator the count is incorrect
- **Scrub Practitioner & Surgeon/Operator** must ensure all members of the MDT in the room are aware the count is incorrect
- **All members of the team MUST STOP and follow** all prompts as per the Swab Count Discrepancy process immediately (see Appendix 10).
- The Count Discrepancy Poster should be available locally in each theatre or interventional area that you are working in (see Appendix 10).
- Formal plain film X-Ray to be taken whilst patient in Operating/Procedure room. (C-arm it Fluoroscopy is not sufficiently sensitive).

## Intentional Retention of Objects

- Document any intentionally retained items in both perioperative and procedural notes, and verbally confirm their removal plan during the 'Sign Out' stage of the surgical safety checklist (AfPP 2023).
- Use documentation made when intentional retained items were left in situ to determine the number and location of the item(s) for removal during a later procedure (AfPP 2023).

Full Swabs, Sharps Instrument and Accountable Items Policy

# Count Discrepancy

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**Key:** Item found → Item not found →

**Count discrepancy noted** with swabs, sharps, instruments or any accountable item

**Recheck** the count

**STOP!**

**Immediately inform the Surgeon/Operator** if discrepancy remains

Scrub Practitioner and Surgeon/Operator must ensure **all members** of the MDT in the room are **aware the count is incorrect**

**Scrub Practitioner** rechecks trolley and sterile field

**Operator** checks wound and surrounding sterile area

**Other staff** search area, including:
- Drapes
- Floor
- Previously bagged swabs
- Specimen container(s)
- Clinical waste bins/bags
- Linen/laundry bags
- Patient's bedding

**Item located?**

YES

- **Communicate** with team present that item has been located.
- **Confirm** with team when recheck count has been completed and confirmed as appropriate.
- **Continue** with wound closure.
- **Check** with co-ordinator whether an Incident Report required.
- **Discuss** the event in the team debrief.

NO

**Inform and ask Co-ordinator** to count and confirm discrepancy

**Is item detectable on X-ray?**

NO

For micro-sized items, consider additional search with microscope or magnet

**Item located?**

YES

NO

YES

Team discusses whether to request X-ray

Request for formal plain film X-ray to be taken whilst patient in operating/procedure room.

(C-arm or Fluoroscopy is not sufficiently sensitive)

YES

**Item located?**

NO

YES

Remove item and recheck count

**Is the count correct?**

YES

END

NO

**Restart process**

**Search for missing item is halted when whole team present is in agreement that systematic search is completed.**

**Inform Theatre/Departmental Manager** for escalation of issues with lack of co-operation with this process. **Escalate** to Clinical Director/Divisional or Deputy Medical Director/Duty Manager. **Document** the event and actions taken in:
- **Patient's medical notes**
- **Intraoperative care plan**
- **Report incident on Ulysses**
- **Inform patient, Duty of Candour**

# Swab, Sharps Instrument and Accountable Items Count Policy

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|---|---|
| **Category:** | Policy |
| **Summary:** | This policy provides guidance for all Healthcare Groups involved in the counting and checking process of any accountable items that may be used during an invasive procedure, minimising the risk of any unintentional retention. |
| **Equality Impact Assessed:** | October 2025 |
| **Valid From:** | January 2026 |
| **Date of Next Review:** | January 2028 |
| **Approval Date/Via:** | Cross Divisional Theatre Group,<br>Clinical Policy Group, December 2026 |
| **Distribution:** | Trust-wide |
| **Related Documents:** | Association for Perioperative Practitioners – Standards and Recommendations for Safe Perioperative Practice (2023)<br>Gynae SOP for removal of intentionally retained packs<br>Maternity Swabs, Sharps and Instruments LocSSIP<br>National Safety Standards for Invasive Procedures (NatSSIPS2)<br>Positive Patient Identification (PPID) Policy<br>The Prevention and Management of Sharps & Splash Injuries Procedure<br>Freedom to Speak Up – Raising Concerns (Whistleblowing) Policy<br>Infection Prevention and Control Policy<br>Standard IPC Precautions<br>SOP Safe Discharge of Patients from Gynaecology Ward and DSU<br>WHO Surgical Safety Checklist Policy<br>Wound Assessment and Management Policy<br>Incident Reporting, Investigation and Learning Procedure<br>National Standards For Invasive Procedures 2 |
| **Author(s):** | Scrub Clinical Educator, Gynae & Obstetric Theatres<br>Senior Staff Nurse, JR Theatres<br>Surgical Care Practitioner Churchill Theatres<br>Sister, Cardiothoracic Theatres |
| **Further Information:** | Policies@ouh.nhs.uk |
| **This Document replaces:** | Swabs, Sharps, Instruments and Accountable Items Policy, Version 5.1 |

**Lead Director:** Chief Medical Officer

**Issue Date:** January 2026

## Document History

| Date of revision | Version number | Author | Reason for review or update |
|---|---|---|---|
| September 2012 | 1.4 | Theatre Manager | Amendments and incorporation of maternity as Appendix. |
| February 2014 | 2.0 | Theatre Manager | Amended to include section on definition of cavity included process for Radiology |
| February 2016 | 3.0 | Deputy Chief Nurse | Alignment to revised Never Events Framework 2015<br>Improved clarity of content as recommended following retained swab incidents |
| Dec 2017 | 3.1 | Deputy Chief Nurse | Appendix containing Count discrepancy poster updated |
| September 2018 | 3.2 | Clinical Policies and Safety Standards Practitioner | Appendix added: Gynaecology Swabs, Needles and Instruments added. |
| January 2019 | 4.0 | Clinical Policies and Safety Standards Practitioner | Expiry of policy; interim policy in current Trust template to allow full Trust-wide review. |
| July 2020 | 5.0 | Scrub Clinical Educator, Gynae & Obstetric Theatres<br>Senior Staff Nurse, JR Theatres<br>Matron, Theatres SuWOn<br>Matron, Theatres NOTTSCAN<br>Senior Staff Nurse, Churchill Theatres<br>Surgical Care Practitioner Churchill Theatres<br>Sister, Cardiothoracic Theatres<br>Deputy Matron, NOC Theatres | Full review following Trustwide review |
| February 2023 | 5.1 | Matron SuWON Theatres | Information of removal of retained vaginal pack. Updated due to recommended actions from incident |
| October 2025 | 6.0 | Matron SuWON Theatres<br>Deputy Matron SuWON Theatres | 3 yearly review |

## Consultation Schedule

| Who?<br>Individuals or Committees | Rationale and/or<br>Method of Involvement |
|---|---|
| Cross-Divisional Theatre Group | Review and approval. |
| Clinical Policy Group | Review and approval. |
| Safe Surgery and Procedures Implementation Group (SSPIG) | Virtual review. |
| Trust-wide consultation | Review. |

## Contents

**Who should read this document?**

1. This policy should be read by all clinical staff across the Trust.

**Key Standards/Messages**

| | |
|---|---|
| **Key Standard 1:** | Each member of the procedural team must operate within their proven levels of competency. The theatre team should ideally remain the same throughout the theatre list, to ensure patient safety and continuity of care. Breaks should be planned and provided by the members of the same team. |
| **Key Standard 2:** | The scrub practitioner must always be aware of the location of all Swabs, Sharps, Instruments, and Medical Equipment (AfPP 2023) and handle items in accordance with infection control, standard precautions and safe handling of sharps policies. |
| **Key Standard 3:** | A count of swabs, sharps, instruments or accountable items must be performed for all clinically invasive procedures. All counts must be recorded immediately on approved documentation. A record should be retained in patient notes, unless electronic records are utilised (AfPP 2023). |
| **Key Standard 4:** | If a count discrepancy is identified all members of the team **MUST STOP** and follow the count discrepancy process as documented in appendix 10 |
| **Key Standard 5:** | Provision should be made to facilitate standardised methods for recording items during an invasive procedure (AfPP 2023). A count sheet **and/or** count board should be used for all invasive procedures. The board is recommended to be a standardised pre-printed white count board which states all relevant items used following the same sequence of the theatre count with space to add extra items. It should be permanently fixed to the wall at a height and position that facilitates access and visibility (AfPP 2023). |
| **Key Standard 6:** | A count sheet should be in a standardised format. Count sheets may be modified to suit the service and specialty, but any modifications must be in line with this policy, and approval given via the Departmental Governance Group. It should follow the same sequence of the theatre count and would be best matched to the layout of the theatre board. |
| **Key Standard 7:** | Where possible, interruptions to the count should not occur. Once the count has started, it should continue until complete. If the count is interrupted, it should resume at the end of the last recorded item (AfPP2023). |
| **Key Standard 8:** | During the procedure all accountable items, clinical waste and linen are to remain in the procedure area and are only to be removed on the instruction of the **Scrub Practitioner** once the final count has been completed and confirmed correct. Bags are |

labelled with Date of Operation, Theatre Identity and Case Number. For comprehensive information on waste management and segregation, please refer to the Waste Management intranet page.

**Key Standard 9:** Surface dressings and dressing gauze should only be taken onto the surgical set up on final skin closure. Where dressings are part of a speciality procedure pack these should be recorded as part of the count.

**Key Standard 10**: Intentionally retained items such as a vaginal pack, intraabdominal pack or the application of Topical Negative Pressure Therapy must be recorded (and verbally communicated with transfer of care) on the Perioperative Documentation & the Operation/Procedure notes with a clear plan for removal.

**Background/Scope**

2. This document represents the minimal standard of swab, needle, instrument and accountable item counts for all patients at Oxford University Hospitals (OUH) NHS Foundation Trust to reduce the risk of incidents. (Appendix 12 details accountable items).

3. NHS England states that all items should be accounted for and nothing is unintentionally left in a surgical site, inside a body cavity, on the patient body, or in clothing or bedding (NHS Improvement 2015).

4. There is potential for an item to be retained inadvertently during any surgical, invasive and interventional procedure regardless of the type or complexity of the procedure and irrespective of the clinical setting (AfPP 2016).

5. Unintentionally retained objects are considered a preventable occurrence and may constitute a 'Never Event', where careful counting and accurate documentation can reduce or eliminate instances of retained items (NHS Improvement 2018/2021).

6. Intentionally retained objects must be documented with a clear plan for removal as well as a verbal handover to relevant clinical staff (see section on intentionally retained items).

7. This policy applies to all employees working within the OUH, including third party, voluntary, students, locums and agency staff involved in areas where surgical or invasive procedures are undertaken, across all sites.

8. This policy applies to both adult, and child patient groups who may be receiving care in an inpatient or outpatient setting.

**Key Updates**

9. Key updates to the policy include:

   9.1. Transitioning to electronic documentation

   9.2. Monitoring compliance through the OUH Assurance Hub

9.3. Ensuring alignment with current Association for Perioperative Practitioners (AfPP) guidance for swab counts

9.4. Revision of Maternity Swabs section and Removal of Vaginal Packs in Gynaecology.

**Aims**

10. This policy aims to:

10.1. Provide guidance that ensures a consistent and accepted method of counting, in line with Association for Perioperative Practitioners (AfPP) – Standards and Recommendations for Safe Perioperative Practice (2023) , (NatSSIPS2 2023) National Safety Standards for Invasive Procedures (NatSSIPS2) and AFPP2023 book Available in theatres).

10.2. Ensure staff involved in counting can define what is deemed as an accountable item that may be used during an invasive procedure, for example swabs, guidewires and packs.

10.3. Support good clinical practice within the perioperative and peri-procedural environment with all staff involved in the counting procedure to maintain patient safety in line with National Guidelines.

10.4. Clarify roles and responsibilities of those involved in counting of, and accounting for items.

10.5. Standardise and harmonise practice across OUH departments, to reduce risk of an inaccurate count.

10.6. Promote good communication and teamwork to avoid ambiguity or misunderstanding between team members.

10.7. Provide clear points of action of what steps to follow in the adverse event that a discrepancy in the count may be found.

10.8. Provide overarching principles to support the development of local service or area specific documents.

**Safety steps/Individual patient pathway**

**Organisational Counting Techniques**

11. The Team brief should include the discussion of staff allocation. Where it is known that a procedure may take longer than 6 hours, a plan for case continuance should be agreed among the team (AfPP 2023).

12. Staff replacement during a perioperative intervention is not recommended. Periods of handover are recognised as potentially high risk. Unless it is absolutely necessary, the scrub practitioner and circulating nurse should not be changed during the procedure. If there is a need for change of staff, a full count must be completed.

13. Where departments have procedures which regularly exceed six hours a risk assessment (see Appendix 5) should be undertaken to ensure individual practitioners are fit to practice. Staff delegated to perform the interventional

procedure should alert their line manager in advance if they feel that they are not fit to practice for reasons of health or competence.

14. Prior to the commencement of any invasive procedure, the procedure area must be thoroughly checked to ensure it is free from any items from the preceding case and any whiteboards wiped clean.

15. Neatness, standardisation, and consistency in setting up of trolleys should be encouraged (AfPP 2023).

16. The count must be conducted by two members of staff, one member of the team must have a professional **registration with either HCPC or NMC**. The other may be a **non-registered** practitioner who is in training for a registerable qualification (student Nurse or ODP) or is in training for or who has attained the following vocational awards or equivalent local training and documented assessment;
    - Health (Perioperative Care Support) Level 2 and 3.
    - Health (Obstetric Theatre Support) Level 2 and 3.
    - Health (Anaesthetic/PACU Support) Level 2 and 3.

17. Staff involved in the surgical counts must be able to recognise and identify the items and instruments they are counting.

18. Ideally, the same **two practitioners** who complete the initial count should continue to complete the remaining counts together during the surgical or invasive procedure, which must be audible and in unison using a 'Show, See and Tell' process (AfPP 2023).

19. Both practitioners must confirm independently that the items are correct and that the record on the white board/paper **(see Appendix 6)** corresponds. in accuracy and completeness (AfPP 2023).

20. If X-ray detectable swabs are used for catheterisation or other preoperative procedures they should remain in theatre and be included as part of the count (AfPP 2023).

21. **Non radio-opaque swabs must not be used for any invasive procedures**.

22. If a **Scrub Practitioner** is not required, for example during a minor procedure, the **Circulating Practitioner** should be a registered practitioner with whom the operating surgeon should perform each count. Both members of the team should sign the patient documentation (AfPP 2023).

23. In non-Theatre settings a Circulating Practitioner may not be registered but must be competent to perform a count with the Operator and both team members should sign the patient documentation. Individual areas are responsible for local competency assessment & sign off aligned with Swab, Needles & Instrument Accountable Items Policy and departmental LocSSIPS.

24. The **initial** count (prior to commencement of surgery) begins with the counting of instruments on the request of the **Scrub Practitioner**.

25. It is recognised as 'custom and practice' that the scrub practitioner implements the checking procedure (AfPP 2023).

26. The integrity and completeness of each item should include X-ray detectable markers, tapes on swabs, and detachable parts on equipment which must be checked during the count to ensure that equipment is clean, present and in good working order. Any missing, damaged or sub-standard item must be identified, and a replacement may be sourced in a timely manner before the WHO Surgical Checklist Time Out is commenced.

27. Equipment trays should contain a pre-printed detailed and comprehensive list to provide an accurate record, (NHS England 2015). The list should be used to check instruments prior to the start of the procedure and at the completion of the procedure. Specialist trays in Orthopaedics also have photographic lists which can be used to check instruments.

28. If the instrument tray is deemed incorrect at the preparation stage this should be noted on the tray list and reported as per the traceability system of reporting. The set should only be used if considered safe to do so.

29. The **Circulating Practitioner** leads the count by either reading the named instruments from the instrument tray list, or by showing the specialist instrument lists to the **Scrub Practitioner**. The **Scrub Practitioner** will vocalise confirmation that the instrument is present and correct by repeating the item/s out loud, back to the **Circulator**. For example; **Circulator** would read or show "3 towel clips", and the **Scrub Practitioner** would confirm "towel clips, 1, 2, 3".

30. All supplementary items and any accompanying labels must be included in the count at the commencement and at the end of the procedure (AfPP 2023). There should be a traceability system in place to account for instruments used (AfPP 2023).

31. The count order must be performed in a standardised manner and a systematic way in terms of what is counted, when it is counted and where it is counted from, for example:

    31.1. Red ties must be secured safely on the sterile trolley and kept for use during a check back process.

    31.2. Swabs counted small to large (AfPP 2023), sharps (including blades, hypodermic needles, and sutures), additional accountable items, and instruments.

    31.3. Systematically, for example 'off the patient', the sterile trolley, 'on the patient'.

    31.4. Opening all suture packets at the initial count is not recommended (AfPP 2023).

    31.5. Suture packets should be retained on the sterile trolley and used for a check back process.

    31.6. Swabs must NOT be cut to size or modified in any way during the operating procedure; sharps should be given a designated sharps area.

After use they should be retained in a disposable, puncture resistant container.

31.7. A swab count should be completed **three times** during a surgical intervention, and will be called an **initial** count, a **closing** count and a **final** count. It is accepted practice that some minor diagnostic or surgical procedures such as Cystoscopy, Hysteroscopy, Incision & Drainage of an Abscess, only require an **initial** and **final** count.

32. A swab, needle, instrument & accountable items count must be undertaken:

32.1. **Prior** to the commencement of any surgical or interventional procedure as an **initial count**.

32.2. At the **commencement of closure of any cavity** and cavity within a cavity e.g. stomach/uterus/joint cavity/abdominal peritoneal/pelvic peritoneal as a **closing count**.

32.3. At any other time deemed necessary (this can be initiated or requested by any member of the procedure team).

32.4. At the point before the **final closure of skin** layer, or before the end of the procedure if no wound cavity as a **final count**.

33. During each count, swabs must be opened, the integrity of the X-ray detectable markers in swabs, packs, Lahey swabs/pledgets/peanuts etc., as well as the integrity of tapes on abdominal swabs/packs, must be checked.

34. All surgical swabs and packs must be white and packed in bundles of five, be of a uniform size and weight, and should be held together with a red tie. Red ties should be removed before counting. Swabs are counted individually and opened fully and not added to those swabs already counted until number and integrity has been verified (AfPP 2023).

35. Any package found to contain fewer or more than the stated five, the entire packet contents must be isolated and removed from theatre immediately (AfPP 2023). An incident report form should be completed after the procedure to ensure appropriate risk escalation, recording the Batch and LOT numbers. The procurement manager should be informed to ensure the removal of matching stock items. The supplier/manufacturer should be notified to inform them of the anomaly.

36. All swabs, including pledgets, neuropatties, and packs that are used during invasive procedures must have an X-ray detectable line that should be visible and secure. Tapes on swabs should be pulled to check that they are attached securely (AfPP 2023).

37. Red ties from swabs must be carefully secured on the sterile trolley, counted and documented. They form the beginning of the checking process to indicate the number of bundles of swabs that have been taken onto the sterile field.

38. Care must be taken when using items which are not X-ray detectable e.g. liga clip cartridges, slings, nylon tape.

39. The WHO Time Out can commence when the **Scrub Practitioner** has confirmed both sterility of instruments and **initial count** complete. The **Scrub Practitioner** must verbalise that they are happy to proceed.

40. No item should be handed to the **Operator** until the **initial count** is complete and has been accurately documented.

41. The **Operator** must inform the **Scrub Practitioner** of the placement of any item inside the patient, and this should be recorded on the white board.

42. Once the initial count is recorded as per guidelines, any additional items added to the sterile field should be counted aloud with both the **Scrub Practitioner** and **Circulator** and then documented to ensure that the count is current and accurate.

    42.1. Swabs (including Pledgets) are added in multiples of 5 e.g. From starting with three lots of swabs, and adding one more would give a total of 4 lots, and would look like this:

    **Large Abdo 30x30 = 5 5 5 5**

    42.2. Blades, sutures and accountable items are added by scoring through the last number **diagonally** once, so that the number is still legible, and writing a new total e.g. If adding 3 more sutures to your current total of 12 it would be similar to this:

    **Sutures = ~~12~~ 15**

43. When adding this number to the count, it is best practice for the **Circulator** to verbalise the new total, for example after counting the additional 5 Large Abdo, the circulator must say “plus 5 abdo”.

44. Where possible, **interruptions to the count should not occur.** Once the count has started, it should continue until complete. If the count is interrupted, it should resume at the end of the last recorded item (AfPP 2023). For example, if you are halfway through an instrument count sheet whilst counting 5 large clips and are interrupted, you should restart the count at the beginning of the 5 large clips**.**

45. Before an item is added to the sterile field, the item in question must be shown to the **Scrub Practitioner** by the **Circulator** to confirm the item is correct, within date and intact. On agreement, the item is then opened and presented to the **Scrub Practitioner** to take.

46. Before opening an implant, the **Scrub Practitioner** and **Operator** must be part of the checking process, confirming that the item is correct, within date, and intact, before the item is opened and presented to the **Scrub Practitioner** (refer to Prosthesis Verification Policy)

47. Items should NOT be cut or altered unless specifically intended for that purpose. If alteration is made for any reason, it should be documented in the patient’s records, including EPR, highlighted on the white board and included in the count. It is recommended that such incidents be reported as potential patient safety incidents to facilitate full investigation to establish why a suitable

item was not available. Where necessary a Risk Assessment should be undertaken.

48. Swabs must be counted off in bundles of five. The technique used should be safe and incorporate measures in conjunction with the Infection Prevention and Control Policy & Standard IPC Precautions. Clear plastic bags of appropriate varying sizes are recommended for this purpose (AfPP 2023).

49. When counting swabs off the sterile field, the **Scrub Practitioner** will fully open and check them before carefully handing them out in multiples of five to the **Circulator**. The bags should be clearly labelled as a minimum with the size, number, date and time e.g. 30x30 x5 17.07.2019 @15:30 and the **Circulator's** initials.

50. When counting off, the **Circulator** would immediately record their actions on the written documentation; the count board and/or count sheet, by crossing through the number counted out.

**Large Abdo 30x30 = 5 5 5 5**

51. When documenting the counting off on the whiteboard, it is good practice for the **Circulator** to verbalise this action, for example after counting off the additional 5 Large Abdo, the **Circulator** may say "5 abdo out".

52. Bagged swabs should remain in the sight of the operating team in a designated area within theatre and kept until the final count has been confirmed for all the intended procedures. These swabs are only discarded at the end of a surgical intervention on the agreement of the **Scrub Practitioner** after the final count is correct**.**

53. Swabs which have been bagged and handed out may be weighted to ascertain an Estimated Blood Loss (EBL), in which case this should be immediately documented and recorded on an Estimated Blood Loss form and in the EPR.

54. If a counted item is inadvertently dropped off the sterile field, the **Circulator** should retrieve it safely, show it to the **Scrub Practitioner** and place it in an appropriate contained disposal system. Dropped items should be included in any subsequent counts and if necessary, the intraoperative record should be updated in conjunction with the scrub practitioner. For example, needles should be saved safely on an adhesive pad, so that they are visible to the **Scrub Practitioner** for checking (AfPP 2023).

55. A count may be requested by any member of the perioperative team. All staff should be encouraged to immediately speak up about any concerns they may have regarding any aspect of the surgical count (AfPP 2023).

56. Prior to the closure of any cavity, the **Operator** is responsible for performing a thorough visual and palpation inspection of the cavity/wound for any retained items before commencing closure.

57. The surgical team must allow time for the swab, needle, instrument and accountable items count to be undertaken without pressure (AfPP 2023).

58. The scrub practitioner and circulator should ensure that all items being counted are complete and undamaged. Suture needle should be checked against the corresponding suture packet to confirm the integrity of the needle when returned from the operative field.

59. On completion of the final count, verbal statement should be made by the scrub practitioner to confirm that all swabs, needles, instruments and accountable items are accounted for, including the intended removed implant. Verbal acknowledgement should be received from the operating surgeon to prevent any misunderstanding. A pause should be held in all procedures before the reversal of anaesthesia in which there is confirmation between the **Operator**, **Scrub Practitioner** and **Anaesthetist** that all items have been accounted for.

60. The packaging for dressing swabs should only be opened at skin closure. It is recommended that surface dressings are a different colour, non X-Ray detectable and easily distinguishable from white Raytec gauze so that they are easily distinguishable.

61. If a surgical cavity pack is required, use Detex Gauze Rolls (Gynae Rolls). If possible, the entire length of the roll should be used, however if cut this must be clearly documented in perioperative documentation and the surgical op note.

62. At the end of the surgical procedure the circulating and scrub practitioners must record in the relevant documentation that satisfactory checks have been completed. This may include the perioperative documentation, theatre records, computerised systems, electronic patient record (EPR) and patients notes (AfPP 2023).

63. On completion of the count and the confirmation that all items have been accounted for and correct, this should be confirmed and documented during the 'Sign Out' phase of the surgical safety checklist (AfPP 2023).

64. All items, including laundry, clinical waste and patient specimens, except for Frozen Sections, must remain in the operating theatre until the procedure has been completed and all counts have been performed satisfactorily. Clinical waste bags should be labelled with the case number, date of operation and theatre identity. In an Emergency Operating Theatre case numbering should begin at midnight through a single twenty-four-hour period.

**Emergency Cases**

65. In the event of an immediate life-threatening emergency, it is preferable to maintain agreed counting standards as per the policy, although occasionally it is recognised that it may not be feasible to perform a timely initial count. This might occur inside or outside of the theatre setting e.g. the Emergency Department, Critical Care, Cardiac Catheter Labs or on admission of a Category 1 Obstetric patient.

66. In these rare circumstances, all packaging must be retained to facilitate a count to be undertaken at the earliest appropriate opportunity. The packaging should be kept for reconciliation at the end of the case.

67. If the patient is transferred to another department with swabs or packs retained, a full hand over of the accountable items should be given to the receiving

Healthcare Professional, which must be clearly documented together with a plan for future removal.

68. If the patient returns to theatre with swabs in situ, these must be included within the count. On removal from the patient, they must be handed out to the circulator and placed in an appropriate contained disposal system, documented intraoperatively and included as part of the standard count.

**Obstetric Theatres/ Maternity Swabs**

69. If it is clinically necessary to transfer a patient to theatre after a procedure pack has been opened, a full count must take place and be documented on Badgernet under the "Swab & Needle Check" before the patient is transferred to theatre. (See Maternity Swabs, Sharps and Instruments LocSSIP).

70. If it is clinically necessary to transfer a patient to theatre with an accountable item in situ, the remaining swabs/items must be placed in a bag (available in the delivery pack or with the delivery equipment), along with the red string and transferred to theatre together with the patient. If multiple packs have been opened, all swabs and red strings must be transferred. bag.

71. All members of the team must be made aware of the swabs/accountable items in situ.

72. Instruments should not be transferred to theatre. If a clamp is required on the cord, for example Manual Removal of Placenta, this must be swapped to a plastic cord clamp and all instruments left in the room.

73. The transferring **Midwife** and **Scrub Practitioner** will count the swabs/accountable items together, the Midwife will document on Badgernet to state the swabs are handed over. The circulating practitioner in theatres will document on the count board the accountable items transferred with the patient. If the patient is transferred to theatre with no swab in-situ, all swabs opened in the room and red strings will remain in the room. No swabs or strings should be transferred to theatre. The **Midwife** will document and sign their swab and instrument count on Badgernet prior to patient transfer. Please

**Vaginal Packs**

74. When a vaginal/vulval pack (VP) is placed inside the patient's vagina this must be clearly documented in the medical records. In addition, one VP sticker must be placed on the patients' hand. The VP sticker is made up of a Mepore 6x7cm dressing with the initials "VP" written in red on it. This indicates to all staff the presence of a vaginal pack.

75. The insertion of a VP must be documented in EPR in the operation notes, the perioperative care plan, and the WHO Checklist. In addition, there must be a verbal handover to the team taking over the patients' care and when appropriate to the patient.

76. In the operation notes the components of the VP must be documented with a clear plan for the removal of the pack, by the **Operator**. The operation sheet

contains a checklist asking about histology, drains and packs. If a VP remains in situ, then the operation notes checklist should be ticked appropriately.

77. Documentation of the care plan must be completed by the **Scrub Practitioner** and **Circulating Practitioner**. Under the section 'skin closure/dressing', documentation should be completed with the number and components of the VP individually listed. This should be carried out by two members of clinical staff.

78. On the WHO Gynaecology checklist, the following must be completed. Any packs/ tampons/ drains left inside? If yes, has the description, location and components of the pack been described? Has a Vaginal Pack/ Plan (VP) sticker been placed on the patients' hand?

79. Prior to transfer, the patient should be educated for the reason for the VP being retained, the purpose of the VP sticker, and the plan for removal. This should be undertaken at the point of handover from Recovery to the ward nurse collecting the patient and then discussed again with the patient on the ward when the patient is more alert. It should also be discussed pre-operatively as a possibility by the responsible Consultant.

80. When the patient is handed over to another member of staff, information regarding the VP must be handed over, in particular the contents of the VP and plan for removal.

**Throat Packs**

81. The retention of throat packs after surgery can lead to potential obstruction of a patient's airway: Organisations were mandated in 2009 (NPSA, 2009) to take action to reduce the risk of these packs being retained.

82. The decision to insert a throat pack should be justified by two people e.g. anaesthetist and surgeon for each patient. The person inserting the throat pack should assume responsibility for ensuring the chosen safety procedures are undertaken.

83. Only radiological detectable throat packs should be used.

84. The clinician responsible for the throat pack must ensure that the insertion of the throat pack is documented in the patient's care plan/anaesthetic chart.

85. In order to prevent the retention of the throat pack, in addition to a documented record of the use of a throat pack, at least one visual identifier marker should also be used. The required process is summarised in **Appendix 9**.

86. Additional visual markers to highlight the presence of a throat pack includes:

    86.1. **Visual identification label/mark placed on the patient/artificial airway device**

        86.1.1. The individual inserting the throat pack is identified as being responsible for the application of the label/mark and its removal.

        86.1.2. The label should be robust, strong and adherent that will remain on the patient throughout a range of surgical procedures.

86.1.3. The label should clearly state “Throat Pack” or “TP” and should be easily visible.

86.1.4. Location of label/mark should be of a consistent choice and may be determined locally and according to type of surgery being undertaken.

86.1.5. The label/mark should remain in place until the throat pack is removed.

86.1.6. When using a mark, it should be clear this is ‘throat pack’ and not a ‘surgical site mark’. The mark for throat pack may be “Throat Pack” or “TP” not an arrow.

86.2. **Attaching the throat pack securely to the artificial airway device**

86.2.1. Clearly identify if the surgical procedure and the type of airway is suitable for this method and ensure that this is communicated to all staff involved.

86.2.2. The individual who has taken responsibility for the insertion of a throat pack should be responsible for securing it to the artificial airway device.

86.3. **Leave part of the throat pack protruding externally**

86.3.1. Clearly identify the surgical procedures and the types of airways that are suitable for this method and ensure that this is communicated to all staff involved.

86.3.2. Clearly identify the available designs of throat packs that can be used for this technique.

86.3.3. The individual who has taken responsibility for the insertion of a throat pack should be responsible for ensuring that the throat pack is positioned appropriately with one end protruding externally.

87. When the throat pack has been inserted in the anaesthetic room, the **Anaesthetist** must inform the **Scrub Practitioner** who will then instruct the **Circulator** to document this on the whiteboard by writing “Throat Pack in Situ”.

88. For the entire team to be aware of the presence of the throat pack, this information should be made known at the “Time Out” period of the Surgical Safety checklist process.

89. When the throat pack has been removed, the Scrub Practitioner should instruct the Circulating Practitioner to draw a line through the white board wording “Throat Pack in Situ”.

90. When the throat pack has been removed, the “Throat Pack” sticker or mark must be removed from the patient before they leave the theatre area.

91. Removal of the throat pack must be confirmed during the “Sign Out” stage of the Surgical Safety Checklist and newly developed checklists should have this prompt included.

### Pre-Surgical Procedures

92. If sterile items are required for undertaking a pre-surgical procedure e.g. urinary catheterisations, then every attempt should be made to undertake this in the anaesthetic room prior to transfer into the theatre. These items must be accounted for, documented disposed of in the anaesthetic area. Responsibility for counting, documenting and disposal is with the practitioner who had performed the pre-surgical procedure.

93. Where pre-surgical procedures are performed in the theatre area, the items used must of a different colour (e.g. green) or format (e.g. balls) to the surgical swabs and must be disposed of prior to the start of the case. These items must be accounted for and documented.

### Multiple Simultaneous Procedures

94. In cases requiring the intervention of more than one surgical team at the same time, an additional scrub and circulating team is required, each maintaining accountability for their swabs and accountable items, using separate counts.

95. If one surgical team is performing multiple procedures sequentially, and there is no reason to change instrumentation, all items must be counted at the end of each stage, and at closure. It is good practice to count off swabs, bag and document, and store in theatre for the remainder of the procedure with an indication for which stage they were used. Fresh swabs are then counted and added to the board.

### Organ Donation/Transplant Preparation

96. For back table organ preparation, a separate swab, needle, instrument and accountable items count must be undertaken.

97. **Kidney only** – a Scrub Practitioner is not required; however, the Operator must conduct the count with a registered practitioner. The Operator is required to ensure that sharps/needles are safely secured and disposed.

98. **Pancreas/Kidney** or **Small Bowel** – a Scrub Practitioner is required and will be responsible for ensuring a full count is undertaken with a Circulator.

99. **Simultaneous back table and recipient surgery**; a separate scrub team is required, ensuring separate documentation of counts is recorded.

## Deviations

### Count discrepancy

100. In the incidence of a **count discrepancy**, please refer to the Count Discrepancy Poster immediately and follow the flowchart as described. The Count Discrepancy Poster should be available locally in each theatre or interventional area that you are working in (**see Appendix 10**).

101. If a count discrepancy is identified, the **Scrub Practitioner** should repeat the count, inform the **Operator**, and follow all prompts as per the Swab Count Discrepancy Poster (**see Appendix 10**).

102. If the discrepancy remains, the **Operator** should:

102.1. Search for the missing item(s) in the sterile field area and also in any open wounds or cavities.

102.2. Return any accountable items to the **Scrub Practitioner,** or if this is not possible, the accountable items should be shown to both the **Scrub Practitioner** and **Circulator** so they can be accounted for.

102.3. All other activity should be suspended if clinically safe to do so whilst the search for the missing item(s) is carried out.

102.4. Other staff in the theatre or interventional/procedural area should conduct a search for the missing item(s). It may be necessary to use a microscope or magnetic roller. Areas of searching should include, not necessarily in this order:

102.4.1. Accountable items which have been counted out/bagged
102.4.2. Clinical waste bins/bags
102.4.3. Drapes
102.4.4. Surrounding floors
102.4.5. Packaging
102.4.6. Linen/laundry bags
102.4.7. Patient's bedding/clothing
102.4.8. Specimens

103. If the discrepancy is resolved this should immediately be communicated to the **Operator** so that the intervention may continue as planned.

104. Escalation must be initiated if discrepancy is confirmed. The unit **co-ordinator** must be informed so any delays can be taken into account for planning and escalation can be facilitated if required, and the consultant responsible for the patient informed.

105. If the item is potentially detectable on **X-ray** imaging, a request should be made for a plain X-ray. Fluoroscopy or image intensifiers should not be used in these instances as the imaging result is not always sufficiently sensitive to detect the presence of a foreign object. (MHRA 2005).

105.1. The **Radiographer** will take an image which will be available to view via PACS. If the operator fails to find the item on the image, a **Radiologist** should be consulted to confirm the findings.

105.2. If the missing item is a fine suture smaller than 10mm which cannot be detected, or fragments of suture needles which are so small in size that they might not be viewable then **X-ray** imaging may be performed at the discretion of the Consultant Surgeon. These missing micro items must be recorded in the patient's medical record.

105.3. If it is safe to do so, the patient should remain in the operative or interventional area and under anaesthesia or sedation until the search is conducted and confirmation of the count is concluded.

105.4. Cavity or wound closure should stop until the missing item is located.

105.5. If the missing item is shown on X-ray to be in the patient, but it is considered that the patient is not fit for further examination in order to remove the item, the **Consultant** should make the decision in the best interests of the patient. The outcome of this decision should be escalated immediately to the **Theatre Manager** or **Manager** who will then inform the relevant **Clinical Director**.

106. If it is considered after X-ray that the item has **not** been retained within the patient, **all staff** involved in the procedure must unanimously agree. This is not to be solely based on the conclusion of the **Operator**.

107. All actions and interventions must be comprehensively documented in the patient's medical record and other locally available electronic or paper-based records in use. The documentation should clearly state what the missing item is.

108. Should it be suspected that an item has been retained, under the duty of candour; the **Operator** is responsible for informing the patient at the earliest opportunity. Additionally, information should be given relating to ongoing risks or concerns.

109. An incident report form should be completed irrespective of the outcome, for **ALL** instances of a missing item from the count. Subsequent investigation and trend analysis is potentially helpful for identification of actions and interventions that can prevent reoccurrence and will also raise awareness of the importance of the count process.

**Intentional Retention of Objects**

110. The intentional retention of any item should be documented and verbally confirmed along with a plan for removal at the 'Sign Out' stage of the surgical safety checklist (AfPP 2023).

111. On occasions, there may be instances when the balance of risk is assessed, and an item is left permanently in place rather than remove it. For example, a fragment of a broken screw in a bone may be considered safer to leave than to risk further injury in removing it. These decisions and subsequent explanations to the patient must be clearly documented in the patient's medical record.

112. Swabs and dressings that are to remain in situ for wound packing **must** be documented including the precise location and size. The use of a diagram or graphic representation may help. This must be verbalised to the team during the 'Sign Out', and count confirmed as intentionally incorrect.

113. The documentation that was completed at the time that the retained items were left in situ should be used to determine the number and location of the item(s) to be removed and retrieved. The process of removal and retrieval should be

completed by a registered practitioner and clearly documented in the patients record (AfPP 2023).

**Special Circumstances**

114. In the case of minimal access surgery, if a swab is required by the surgeon to be used within the operating field, this should be the biggest usable product to reduce the risk of the item being lost. For example, a mastoid should be used in preference to a pledget. If it is deemed necessary to use a pledget then a stitch (left long) should be placed through it before it is used to aid locating it.

115. In the event that an invasive procedure may take longer than 6 hours, comfort breaks should be planned in advance. Where possible, the **Operator** could pause surgery at a moment which is deemed safe, where the patient is stable, and before the next stage of the operation. Only then may the **Scrub Practitioner** temporarily step away from the sterile field.

116. Consultation must take place between the **Operator**, **Scrub Practitioner** and **Anaesthetist**, but the final decision about whether the **Scrub Practitioner** may step away from the patient, and responsibility for this assessment remains with the **Operator**.

117. The **Operator** will cover the wound with a swab and cease all activity until the **Scrub Practitioner** has returned to the operating table and is ready to continue.

118. If it is necessary to replace the **Scrub Practitioner** with another during a procedure for a **changeover**, a full **handover** count should be performed counting swabs, sharps, instruments and accountable items.

119. If a **handover** count is necessary, it must include the outgoing **Scrub Practitioner**, the incoming **Scrub Practitioner**, and the **Circulator** who would be likely to continue with the closing and final counts.

120. Should it be necessary to replace the **Scrub Practitioner** due to an unforeseen event, where the outgoing **Scrub Practitioner** is unable to perform a count, the incoming **Scrub Practitioner** should immediately begin a full **handover** count with the **Circulator** as soon as is practical, counting swabs, sharps, instruments and accountable items.

121. Documentation of the **handover** should be recorded, signed and timed by all participating members both on paper and in the EPR. The notes will read ‘correct – all items seen’, or in rare circumstances ‘incorrect – some items not seen’, with a description e.g. ‘incorrect – 2 large swabs inside’.

122. If any accountable item such as a suture, blade or instrument is **broken**, the **Scrub Practitioner** will ensure that all pieces have been returned and accounted for.

123. **Damaged instruments** must be immediately taken out of use and labelled for repair. It may be necessary to inform the sterile supplies department, the manufacturer and/or the Medical and Healthcare products Regulatory Agency (MHRA) (AfPP 2023).

124. The **white board** may be used to share patient information. Information may include but is not limited to, Procedure, Name, DOB, MRN, and allergies. There is opportunity to record any speciality related patient information on the white board, for example, prosthesis required, lens size, tourniquet up and down times, haemostatic drugs given, estimated blood loss (EBL), or a reminder to retrieve surgical trimmings.

**Single Operator Interventions**

125. Occasionally invasive procedures such as line insertions, are a **single operator task** and there is no assistant or additional practitioners in attendance.

126. Whilst the key principles of this document remain relevant, the responsibilities for ensuring that swabs, sharps, instruments and accountable items are appropriately and correctly accounted for are those of the **Operator**.

**Handover, post-procedure handover, and discharge planning**

127. The counts must be recorded immediately as soon as is possible on approved documentation, ensuring the names and signatures of the two staff members responsible for the count are eligible and apparent. A record should be retained in the patient's documentation unless electronic records are utilised (AfPP 2023). An example of the count sheet can be found in the appendices (**see Appendix 11**).

128. The WHO Surgical Safety Checklist "Sign Out" is a tool that prompts the formal confirmation of the counting process to the team at the end of a procedure. The **Scrub Practitioner** or **Healthcare Professional** will ensure that it has been fully completed.

129. When patient care is verbally handed over from one healthcare professional to another, it is the responsibility of the **Healthcare Professional** handing over to ensure that all relevant documentation is complete and recorded accurately, including the patient encounter, the correct final count and any items which will intentionally remain in the patient.

130. The **theatre register** must include the names and signatures of the **Scrub Practitioner** and the **Circulator** responsible for the final count, with confirmation of information regarding any retained items.

131. If wound packing is required after a wound breakdown, the documentation of non-dissolvable packing products must be documented as advised by the Tissue Viability Service.

132. In the case of a patient being discharged to the care of the District Nurse with a Vaginal Pack in situ, the VP sticker can be removed once the subsequent removal plan has been made, documented, handed over and the District Nurse has agreed to manage and remove the pack in the community. A record of this discussion or referral must be documented in the medical notes or on electronic patient records (EPR).

## Reportable Patient Safety Events

This table states the potential patient safety incidents relevant to the invasive procedure, reporting mechanism and documentation to be completed. For example:

| Reportable condition | Report to: | Documentation |
|---|---|---|
| Accountable items discrepancy (Resolved Near Miss) | Operator<br>Anaesthetist<br>Theatre Team<br>Co-ordinator<br>Theatre Manager<br>Matron<br>Patient Duty of Candour | Integrated Governance System – Incident reporting module |
| Accountable items discrepancy (Unresolved) | Operator<br>Anaesthetist<br>Theatre Team<br>Co-ordinator<br>Theatre Manager<br>Matron<br>Clinical Director<br>Divisional Team<br>Deputy Chief Medical Officer<br>Chief Medical Officer<br>Patient Duty of Candour | Integrated Governance System – Incident reporting module |
| Damaged or broken instrument, blade, suture or equipment | Operator<br>Anaesthetist<br>Theatre Team<br>Matron<br>Procurement (single use item)<br>TSSU (reusable item)<br>Clinical Engineering (single use, reusable & equipment)<br>Cross Divisional Theatre Matrons (where there is a risk to other staff/patients) | Integrated Governance System – Incident reporting module |

## Documentation

139. The following essential information must be recorded in all areas within OUH to promote the sharing of patient information between individuals and teams at points of handover, and forms a record for future reference:

    139.1. Pre-procedural assessment and planning, the conduct of anaesthesia or sedation, the invasive procedure itself and post-procedural care

    139.2. Competency of the operator will be documented as per Appendix 3 of this policy.

## Review

140. This policy will be reviewed every 3 years, as set out in the *Policy for the Development and Implementation of Procedural Documents*.

## References

141. Association for Perioperative Practice (2023) Standards and Recommendations for Safe Perioperative Practice (section 8.1) Harrogate: AfPP

142. Centre for Perioperative Care (2023) National Safety Standards for Invasive Procedures (NatSSIPs) 2. Available at 1. CPOC_NatSSIPs_FullVersion_2023_0.pdf

143. NHS Improvement (2018, updated 2021) Never Events List 2018. Available at; 2018-Never-Events-List-updated-February-2021.pdf (england.nhs.uk) (accessed November 2023)

144. NHS England and NHS Improvement (2018) SBAR Communication Tool. Available at; Layout 1 (england.nhs.uk) (accessed November 2023)

145. Royal College of Surgeons of England (2014) Good Surgical Practice. Available at; https://www.rcseng.ac.uk/-/media/Files/RCS/Standards-and-research/Standards-and-policy/Good-Practice-Guides/New-Docs-May-2019/RCS-_Good-Surgical-Practice_Guide.pdf (accessed November 2023)

146. World Health Organisation (2009) WHO Guidelines for Safe Surgery: safe surgery saves lives. Available: at; WHO Guidelines for safe surgery: safe surgery saves lives (accessed November 2023)

## Appendix 1: Responsibilities

| Role | Responsibilities |
|---|---|
| Chief Executive Officer | 1. Has the overall responsibility and accountability for the safety and care of patients in the OUH. |
| Chief Medical Officer | 1. Dissemination of this policy in areas where invasive procedures are performed.<br>2. Where local policies exist in relation to invasive procedures, they are in line with the requirements outlined in this policy document and National Safety Standards for Invasive Procedures (NatSSIPs).<br>3. Processes and programme of audit of compliance is established and conducted regularly with results reported to the **Trust Board** via the **Clinical Governance Committee**.<br>4. Inclusion of the learning and participation from NatSSIPs and locally developed practices as part of the process for medical revalidation. |
| Divisional Directors and Clinical Directors | 1. Dissemination and implementation of this policy across their areas of responsibility.<br>2. Ensuring that when required, locally specific standards and procedures are developed and are compliant with this policy and those detailed in the NatSSIPs document.<br>3. Ensuring and promoting the collaborative working of relevant healthcare professionals to enable the development of any local standards and procedures.<br>4. Addressing shortfalls in compliance with this policy in the areas of responsibility. |
| Divisional Nurses or Professional Leads | 1. Dissemination and implementation of this policy across their areas of responsibility.<br>2. Ensuring administrative and documentation processes, (electronic and/or paper) are in place to enable compliance with the requirements of this policy.<br>3. Collating evidence to demonstrate compliance with this policy.<br>4. Overseeing any actions to address shortfalls in compliance with this policy |
| Patient Safety and Effectiveness Committee | 1. Scrutinise adverse incidents and near misses related to surgery and invasive procedures from Divisional reports.<br>2. |
| Safer Surgery & Procedures Implementation Group | 3. Review audits and compliance with LocSSIPs. |
| Clinical Manager | 1. Implementation of this policy in their areas of responsibility. |

| Role | Responsibilities |
|---|---|
| | 2. Identification of staff training requirements and provision of support and opportunity in order for them to participate in training. This training should be for all team members and should be in place to allow roles to be fulfilled safely, effectively and consistently.<br>3. Formulating and implementing local orientation processes and familiarisation for non-substantive staff so that these staff members are aware of the expectations placed upon them in meeting the requirements of this policy.<br>4. Ensuring records of training and competencies are maintained which would be readily accessible for assurance purposes.<br>5. Ensures the regular Audit of Swab, Needle, Instrument and Accountable items procedure, and shares with local governance and management systems (**see Appendix 11).**<br>6. Collates relevant briefing and debriefing documentation and shares information with local governance and management systems.<br>Additionally, the Clinical Manager is responsible for;<br>1. Confirming the availability of appropriately trained staff for each operating theatre or invasive procedural area prior to the start of any list of session.<br>2. Providing arrangements for the local orientation to the environment of newly appointed or temporary staff including surgeons and locums and ensure evidence is available to provide assurance that this has occurred. |
| Sterile Services Manager | 1. Instrument sets are regularly reviewed to ensure they are fit for purpose and are rationalised to contain the minimum amount of required equipment and where possible, content is standardised.<br>2. Instruments of similar type should be listed together and set out in similar ways.<br>3. Comprehensive contents lists are provided in the instrument sets to enable checking before and after use.<br>4. Equipment that can be disassembled is clearly described on the instrument list and includes the number of parts. |
| Department Co-Ordinator | 1. Should confirm the availability of an appropriate workforce for each invasive procedure before the start of any list or session which is communicated at the daily Safe Staffing meeting or Safety Huddle. |
| Operator | 1. The Team Brief must be performed for every surgical intervention to ensure all team members are both introduced and prepared for the patients on the theatre list ahead. |

| Role | Responsibilities |
|---|---|
| | 2. Prior to the start of the planned procedure, opportunity must be given to ensure that all staff present, and are in agreement in confirming the identity of the patient and the site of and type of procedure using the consent form and wristband in accordance with the Positive Patient Identification (PPID) Policy.<br>3. Work/activity is **paused** to permit completion of the Surgical Safety Checklist without unnecessary distraction or interruption.<br>4. Must not remove instruments from the prepared trolley or instrument area but must request them from the **Scrub Practitioner**.<br>5. As most frequently the user of the swabs, sharps, instruments or accountable items, they are returned to the **Scrub Practitioner** after use to enable subsequent reconciliation counts.<br>6. Must verbalise with the scrub practitioner any placement of accountable item inside of the patient, such as a swab or patties.<br>7. They verbally acknowledge the **Scrub Practitioner's** report of the surgical count at both the closing and final counts. This must be a three way check with the **Anaesthetist**.<br>8. Where a **Scrub Practitioner** is not required, the contents of any packaged items are checked and confirmed that all required parts are present as listed or as expected.<br>9. Where a **Scrub Practitioner** is not required, the operator is aware of the number and whereabouts of swabs, sharps, instruments and accountable items in use during the procedure.<br>10. The Operator is responsible to complete an operation note at the end of Surgery which must include details of intentional retained items and a removal plan<br>11. The Operator is responsible to document on the operation note swabs and dressings that are to remain in situ for wound packing including the precise location and size. |
| Anaesthetist or Surgeon | 1. Ensure there is clinical justification for each patient regarding decision to use a **throat pack** and that the required safety procedures are undertaken.<br>2. Ensure documentation of the use of **throat pack** has occurred in addition to ensuring a visual marker is utilised.<br>3. Remove the **throat pack** at a clinically appropriate time ensuring that a visual check be performed to ensure that it has been fully removed and documented. |

| Role | Responsibilities |
|---|---|
| | 4. Final count confirmed with **Operator** and **Scrub Practitioner** before reversal of anaesthesia. |
| Scrub Practitioner | 1. The practitioner attends the daily Safety Huddle to attain any issues for the day that may affect safe staffing.<br>2. Staffing levels, skill mix, and the anticipation of procedures longer than 6 hours to be discussed during a WHO Surgical Safety Checklist Brief.<br>3. To be familiar with this document before committing to surgical counts.<br>4. Should complete a Swab, Sharp, Instrument and Accountable Items competency within the department they are working in (**see Appendix 12).**<br>5. Ensure competence is updated and confirmed yearly**.**<br>6. Verbalise any concerns to the operative team in an appropriate manner.<br>7. Complete correct documentation, including the utilisation of a **Count Board** during the intervention, and ensuring the **Count sheet** is completed correctly after confirmation.<br>8. Checking and confirming the contents, and dates, of any sterile packs and that all the required parts are present as listed or as expected. This process should be counted audibly and individually and viewed by the **Circulating Practitioner**.<br>9. Being aware of the number of and whereabouts of swabs, sharps, instruments and accountable items in use during the procedure.<br>10. Maintaining a neat and orderly organisation of items in use.<br>11. Ensuring any updates to the count are verbalised and recorded when counting on, counting off, placing a pack or swab inside, or removing a pack or swab from a cavity.<br>12. Presenting any swabs or items removed from the wound or cavity to the **Circulating Practitioner** in order that removed items can be acknowledged and recorded.<br>13. The initiation of a count at the required stages, and more if required, ensuring that the appropriate theatre personnel are present and aware that this is being undertaken.<br>14. Ensuring the verbal confirmation of the count status with the operator at the closing count, the final count, and any subsequent count.<br>15. Final count is verbalised and confirmed with operator and anaesthetist before reversal of anaesthesia. |

| Role | Responsibilities |
|---|---|
| | 16. The Scrub Practitioner/s are responsible to ensure all perioperative nursing documentation is completed at the end of surgery.<br>17. The Scrub Practitioner present at the end of the procedure is responsible to ensure swabs and dressings that are to remain in situ for wound packing are documented in the nursing perioperative documentation and details must include, the precise location and size |
| Circulating Practitioner / Circulator | 1. Removal and safe storage of presented items from the **Scrub Practitioner** to be counted.<br>2. Ensuring accurate written documentation of the count on the white board and/or count sheet<br>3. Safe quarantine and subsequent disposal of sharps in accordance with the **Prevention & Management of Sharps & Splash Injuries.**<br>4. Should complete a Swab, Sharp, Instrument and Accountable Items competency within the department they are working in (**see Appendix 12).**<br>5. Ensure competence is updated and confirmed yearly**.** |
| Practice Development Staff and Education Leads | 1. Assist with embedding best practice as outlined in this document.<br>2. Identify and deliver local training requirements and priorities in conjunction with the Clinical Manager.<br>3. Oversee competency assessment process for non-medical staff. |
| Midwife | 1. To be familiar with this document before committing to Swab, Needle and Instrument counts.<br>2. Should complete a Swab, Sharp, Instrument and Accountable Items competency within the department they are working in (**see Appendix 12**).<br>3. Ensure competence is updated and confirmed yearly.<br>4. Complete correct documentation, including the utilisation of a Count Board when required.<br>5. Checking and confirming the contents and dates of any sterile packs, ensuring that all the required parts are present as listed or as expected.<br>6. Being aware of the number of and whereabouts of swabs, sharps, instruments and accountable items in use during the procedure. |

| Role | Responsibilities |
|---|---|
| | 7. Maintaining a neat and orderly organisation of items in use.<br><br>8. Final count is verbalised and confirmed with another member of the team. |
| All Staff | 1. Working within their scope of professional practice.<br>2. Adhering to the principles and process as detailed in this policy and being aware of their specific responsibilities and duties.<br>3. When involved with the counting or reconciliation processes, be able to accurately and consistently identify items that are being counted or referred to and be aware of what are considered as accountable items.<br>4. Undertaking required training and maintaining skills and competence according to role.<br>5. Participating fully in the safety checks outlined in this document.<br>6. Challenge non-participation of others irrespective of professional boundaries.<br>7. Verbalising concerns relating to any possible discrepancies and to ensure that all other staff present have also had opportunity to be heard.<br>8. Reporting and escalating concerns related to practice to their manager or someone else in accordance with the Freedom to Speak Up – Raising Concerns (Whistleblowing) Policy. |

## Appendix 2: Abbreviations and Definitions

| Term/Abbreviation | Definition |
|---|---|
| Accountable item | An item subject to being counted during an invasive procedure that has the potential to be retained within a body cavity. These may include, but are not limited to swabs, needles, instruments, and anything taken into the sterile field at the beginning, or during the procedure (**see Appendix 13).** |
| Aseptic Non Touch Technique (ANTT) | A specific way of working which is designed to significantly reduce healthcare associated infections within a healthcare setting. The model focuses on avoiding the contamination in all clinical procedures and provide a framework for standardised practice. |
| Board Meeting/Safety Huddle/ Departmental Team Meeting | A daily meeting normally performed at the beginning of a shift where staffing, equipment and relevant issues are communicated with the whole team on shift. |
| Circulating Practitioner / Circulator | A member of the team who may be registered or non-registered and is trained and competent in supporting the scrub practitioner or healthcare professional during an interventional procedure. They have a responsibility to ensure additional requests are upheld, ensuring ANTT is adhered to in order to maintain the sterile field, and acts as the external partner in the reconciliation of swabs, sharps, instrumentation and accountable items. |
| Count Board | This may also be referred to in local areas as a dry-wipe board, wipe board or white board. They are used to display the date, patient identification, and essential information such as patient allergy and is the primary tool for the surgical count. They should be both accessible and in view to the whole interventional team, and should be pre-printed. There may be a section in which tourniquets, throat packs, drug administration or blood loss may be recorded (**see Appendix 5).** |
| Count Sheet | This is a paper document to record the count for an invasive procedure, and includes a section to record the details of the staff responsible for the count. This document remains in the patient's paper notes (**see Appendix 10).** |
| Counting Off or Counting Out | The systematic way in which the scrub practitioner counts off swabs or sutures to the circulating practitioner during a surgical intervention. |
| Handover | Transfer of responsibility for the care of the patient from one health care professional or team to another. |

| Term/Abbreviation | Definition |
|---|---|
| Health Care Professional | A generic term used to refer to a professionally trained and registered member of staff e.g. Doctor, Nurse, Midwife, Dental Nurse, Operating Department Practitioner, Radiographer. |
| Interventional Procedure | As defined by the National Institute for Health and Care Excellence (NICE), this is procedure used for diagnosis or for treatment that involves:<br>Making a cut or a hole to gain access to the inside of a patient's body - for example, when carrying out an operation or inserting a tube into a blood vessel, or<br>Gaining access to a body cavity (such as the digestive system, lungs, womb or bladder) without cutting into the body - for example, examining or carrying out treatment on the inside of the stomach using an instrument inserted via the mouth, or<br>Using electromagnetic radiation (which includes X-rays, lasers, gamma-rays and ultraviolet light) - for example, using a laser to treat eye problems. |
| Invasive Procedure | These are considered more specifically in that they are procedures which have the potential to be associated with a Never Event if safety standards are not set and followed, and will include:<br>All surgical and interventional procedures performed in operating theatres, outpatient treatment areas, labour ward delivery rooms and other procedural areas within an organisation.<br>Surgical repair or episiotomy or genital tract trauma associated with vaginal delivery.<br>Invasive cardiological procedures such as cardiac catheterisation, angioplasty and stent insertion.<br>Endoscopic procedures such as gastroscopy and colonoscopy.<br>Interventional radiological procedures.<br>Thoracic interventions such as bronchoscopy and the insertion of chest drains.<br>Biopsies and other invasive tissue sampling. |
| LocSSIPs | Local Safety Standards for Invasive Procedures are locally developed standards of practice by Organisations for specific procedures and interventions. These incorporate the key safety steps outlined in the NatSSIPs document and are to harmonise practice across an organisation. |

| Term/Abbreviation | Definition |
|---|---|
| NatSSIPs | National Safety Standards for Invasive Procedures is a multi-professionally produced document commissioned by NHS England to outline the key safety steps necessary for safe care of patients undergoing invasive procedures. It is intended that these processes that underpin patient safety are standardised and form the basis of LocSSIPs. |
| Never Event | A serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented. These are treated by the Organisation as a Serious Incident Requiring Investigation (SIRI) irrespective of the level of harm. Discovery or identification of a Never Event requires immediate escalation to the relevant Clinical Director or Duty Director if this occurs during evenings, weekends and public holidays. |
| Operator | This will include the surgeon, endoscopist, cardiologist, obstetrician, midwife, radiologist or other healthcare professional or practitioner performing the invasive procedure. |
| Pack | An X-ray detectable swab of varying size used to temporarily manipulate tissues, absorb fluids or reduce haemorrhage. When used it is clearly documented on the whiteboard and verbally announced to the team once placed and removed. |
| Practice Assessor | Assessors are previously known as mentors. Practice Assessors assess and confirm a student's overall achievement of practice on placement. |
| Practice Supervisor | Registered colleagues who contribute to the students learning experience. |
| Procedure | This is not an exhaustive list but the term will include surgical operations, invasive cardiology procedures, endoscopy, interventional radiology, thoracic procedures and biopsies. |
| Procedure Team | This is to include all of those involved in the performance of the procedure and will include doctors, registered nurses, registered midwives, Operating Department Practitioners, Health Care Assistants/Healthcare Assistants, Nursing Assistants, technicians, scientists and any others directly involved with the performance of the procedure. |
| Reconciliation | The verification that the process of counting swabs, sharps, instruments or other accountable items, and checking that those values are in agreement with the initial count made. If these values are not identical, the Count Discrepancy process should be followed (**see Appendix 9).** |
| Scrub Practitioner | This will include any healthcare professional taking the role in the operating theatre with primary responsibility for managing the equipment and instruments during a procedure, ensuring sterility and participating in the reconciliation of swabs, sharps, instruments and other accountable items. |

| Term/Abbreviation | Definition |
|---|---|
| Senior Operator | The clinician with overall responsibility for the procedure. |
| Serious Incident Requiring Investigating (SIRI) | Serious Incidents are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Additionally this presents an opportunity for wider learning and preventative measures being put in place within other similar clinical areas. |
| Student | A non-registered practitioner who is in training for a Registerable Qualification (ODP/Nurse). |
| Supernumerary Status | Registered and non-registered personnel who are new to theatres, and becoming familiar with their surroundings, working additionally to the team. |
| Surgical Count | The concurrent audible and visual counting of accountable items to be used or following use in a surgical or interventional procedure. With the exception of single operator procedures, this should be undertaken by two people, one of whom should be a registered professional. |
| Surgical Safety Checklist | Often referred to as the “WHO” checklist or “WHO Surgical Checklist” is the process and associated documentation used in invasive procedure areas that prompt attention and focus on key patient safety elements. |
| Swab | Consideration should be given to standardising the terminology used to describe different sizes and types of swabs across the organisation (AfPP, 2016). A swab may be described as an absorbent pad or piece of material used in surgery. We mostly use X-ray detectable gauze swabs and the terminology will normally address it by size. Please see below for a terminology used in describing different sizes;<br>Extra Small = 3”x4” = 7x10cm<br>Small = 6”x4” = 10x15cm<br>Medium = Tails = 22.5x22.5cm<br>Large = Packs = Abdos = 30x30cm<br>Pledgets = Peanuts = Lahey Swabs<br>Throat Swabs = Mastoids = Tonsil Swabs<br>Terminology for different types of swabs may include the following;<br>Patties = NeuroPatties (available in different sizes)<br>Ophthalmic Micro Sponges = Arrows |

| Term/Abbreviation | Definition |
|---|---|
| Team Brief/Debrief | Included in the '5 Steps to Safer Surgery' campaign as described in the WHO Surgical Safety Checklist Policy. The **pre-list team briefing** helps to develop a shared mental model of an operating list and highlights concerns regarding a patient's clinical status, or other system or task related factors that may impact on the list and the performance of the team.<br>The **post-list team debrief** takes place after the procedure or at the end of a list. It provides an opportunity for all team members to reflect on performance, enhances learning from incidents, and allows teams to remedy any issues identified during the procedure or list (e.g. equipment issues). |
| Throat Pack | An X-ray detectable pack constructed of a woven gauze/swab inserted by anaesthetists or surgeons in order to: Absorb material created by surgery created in the mouth, Prevent fluids or material entering the oesophagus or lungs, Prevent escape of gases from around tracheal tubes, and Stabilise artificial airways. |
| TNPT | Topical Negative Pressure Therapy<br>Topical Negative Pressure Therapy (sharepoint.com) |

## Appendix 3: Education, Training and Competencies

1. Each member of the procedural team must practise within the limits of the below proven and agreed competence including induction requirements:

| Role | Minimum competencies |
|---|---|
| Registered practitioners employed by the trust<br>(such as Nurses, ODPs, Nursing Associates, Dental Nurses, Radiographers) | 1. Must have received a copy of this document during the orientation to the department.<br>2. Completed competency for Swab, Sharp, Instrument, and Accountable Items.<br>3. Must complete a yearly competence update which should be confirmed yearly and kept within the department. |
| Non-registered colleagues employed by the trust<br>(such as Theatre Support Workers, Nursing Assistants and Maternity Support Workers) | 1. Must have received a copy of this document during the orientation to the department.<br>2. Completed a competency for Swab, Sharp, Instrument, and Accountable Items.<br>3. Must complete a yearly competence update which should be confirmed yearly and kept within the department. |
| Medical Staff | 1. Must have received a copy of this document during the orientation. |

## Appendix 5 Monitoring Compliance

1. Compliance with the document will be monitored in the following ways.
2. All monitoring is completed electronically via OUH Assurance Hub via Ulysses

| What is being monitored: | How is it monitored: | By who, and when: | Minimum standard | Reporting to: |
|---|---|---|---|---|
| Swab & Instrument Count Audit | Documentation & Observational Audit | Theatre Manager, Matron or equivalent Senior<br>monthly | 100% | Divisional Governance via Directorate Quality Reports |
| WHO Surgical Safety Checklist | Documentation audit and observational audit | Theatre Manager, Matron or equivalent Senior<br>monthly | 100% | Clinical Governance Committee via Divisional Quality Reports |
| Reported incidents of missing items or retained accountable items. | Incident Reporting System | Theatre Manager, Matron or equivalent Senior<br>Per Incident | Per incident | Clinical Governance Committee via Divisional Quality Reports |

## Appendix 5: Risk Assessment

### General Risk Assessment Form

| | | | |
|---|---|---|---|
| Site | John Radcliffe Hospital | Division | all |
| Directorate | ALL | Department | Theatres |
| Location Exact | Theatres | Date | 13/8/2014 |

| Name(s) of Assessors(s) | | Job Title(s) |
|---|---|---|
| 1 | Theresa Lowry | Theatre Matron |
| 2 | Caroline Tomkins | Theatre Matron |

| The Hazard or perceived risk |
|---|
| Some surgical procedures can take over 6 hours to perform which means that the scrub practitioner may be required to remain scrubbed longer than 6 hours without a break. |

| Description (Identify who will be affected and how; include the context e.g. clinical, health and safety, financial etc) |
|---|
| Breaks should be taken after 6 hours in order to comply with health and safety legislation and to ensure that the practitioners maintain their hydration and concentration levels.<br><br>Some surgical procedures will take longer than 6 hours to perform and this particularly affects Scrub practitioners as they are required to scrub ahead of a procedure in order to prepare the instrument trays and perform all the checks for accountable items before the procedure commences, so may have been scrubbed for longer than 30 minutes before the first incision is made. Some cases may exceed 6 hours by only a few minutes whilst others may identified as significantly longer than this.<br><br>The scrub practitioner is accountable for ensuring that surgical counts are performed at the start and end of a surgical procedure and during the procedure when any cavity is closed. For the scrub practitioner to be relived during a procedure requires a full handover count to be performed and may be distracting and disruptive for the operating surgeon depending on the complexity of the procedure and the patient condition.<br><br>Whilst relief can be provided it is not actively recommended due to the increased risk of an incorrect count.<br><br>Before any known long procedure commences the team will discuss the case in detail as part of the team brief.<br><br>The scrub practitioner will be aware of the potential length of surgery and will identify before undertaking the case if there are any issues with being scrubbed for a prolonged period of time.<br><br>The theatre team will organise themselves to ensure that the scrub practitioner has had a comfort break before scrubbing in preparation for the case.<br><br>The team will discuss as part of the team brief whether breaks are going to be 'planned' into the surgical procedure and it will be the operating surgeon who determines when is a suitable and safe opportunity for these to occur.<br><br>The rest of the team can be relieved by others throughout the procedure and the operating surgeon can determine suitable points in the procedure where breaks may taken without compromising the patient and the procedure.<br><br>In the event that the practitioner does take a break, either as a planned break or due to an unforeseen event from the procedure the actions identified in the special circumstances section of the policy must be followed.<br><br>Scrub practitioners are registered practitioners and would also be responsible for identifying if they required relief at any point during the planning, briefing or during the procedure. |

*Refer to the Risk Matrix overleaf to calculate the risk level (risk score)*

| | | | | | |
|---|---|---|---|---|---|
| Predicted Frequency (likelihood) | 4 | Predicted Outcome (consequence) | 2 | Initial Risk Score | 8 |

| Precautions in place at the point when risk was identified (Initial Controls) |
|---|
| Policy in place detailing actions in the event of a handover during a procedure<br>Team brief processes in place |

| Additional precautions implemented by the assessor (Current Controls) | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| Predicted Frequency | 4 | Predicted Outcome | 2 | Current Risk Score | 8 |

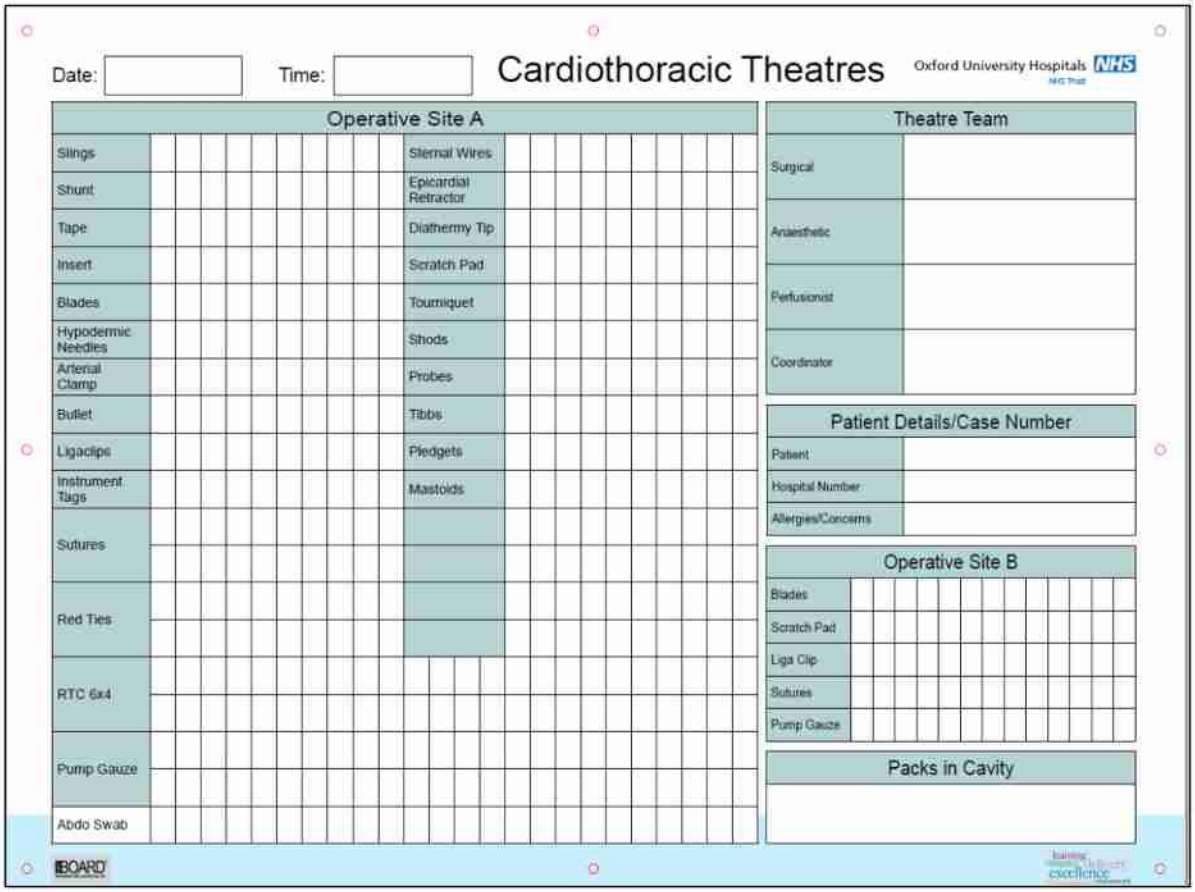
| Best precautions that can be implemented (Best Controls) | | | | |
|---|---|---|---|---|
| RFI tracking for all instrumentation and wands that would identify missing instrumentation from sets which would then enable primary focus to be on the other accountable items rather than instrumentation. | | | | |
| Action Plan to Implement Best Controls | | | | |
| No | Action | Responsibility of (Name and Job Title) | By when | Status (Pending, In progress or Complete) |
| 1 | RFI processes being looked at as part of the SSD plan as part of OBC | Darren Carter | March 2020 | In progress |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |

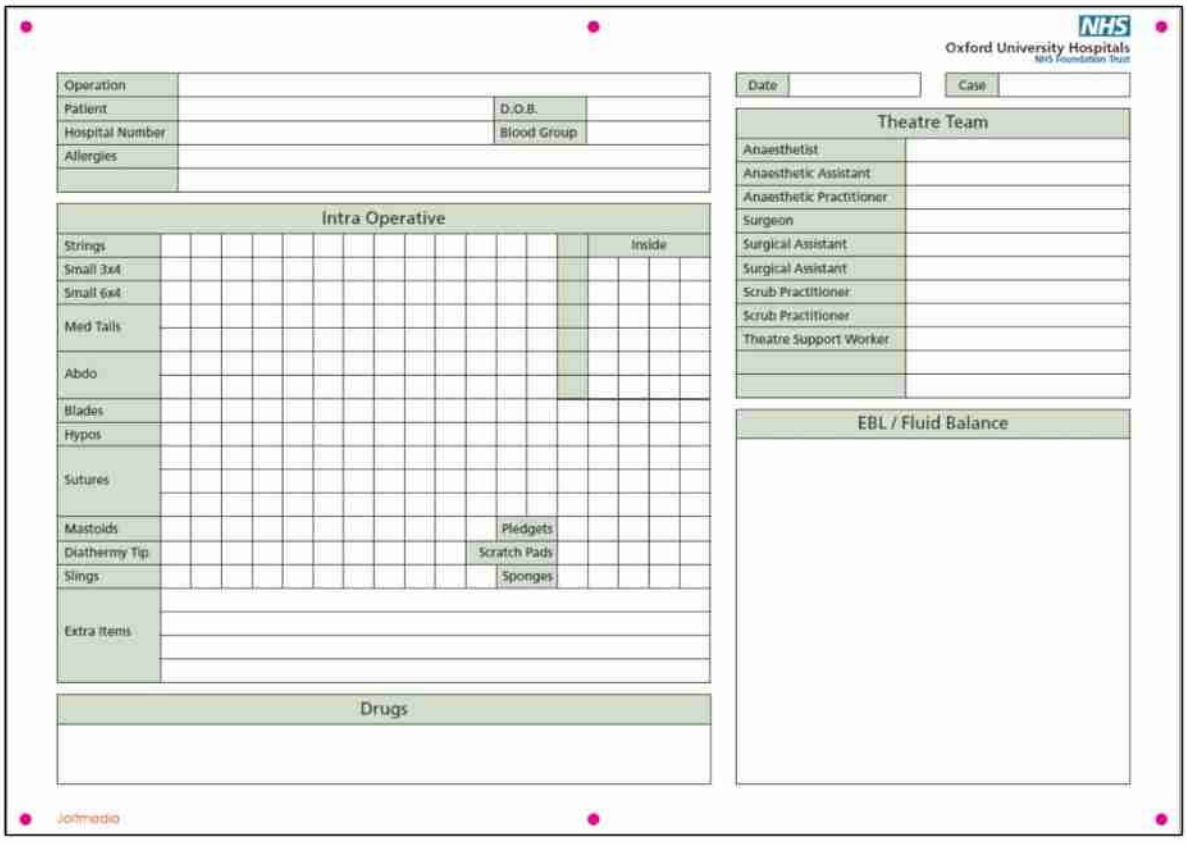
| Risk Rating (if any) after Implementation of Best Controls | | | | | |
|---|---|---|---|---|---|
| Predicted frequency | 1 | Predicted Outcome | 1 | Target Risk Score | 2 |

Reassessment of risk is required periodically after completion of action plan if risk(s) have not been resolved; please ensure this is tracked via your risk register. The minimum timescale for review based on the current risk level is outlined below:

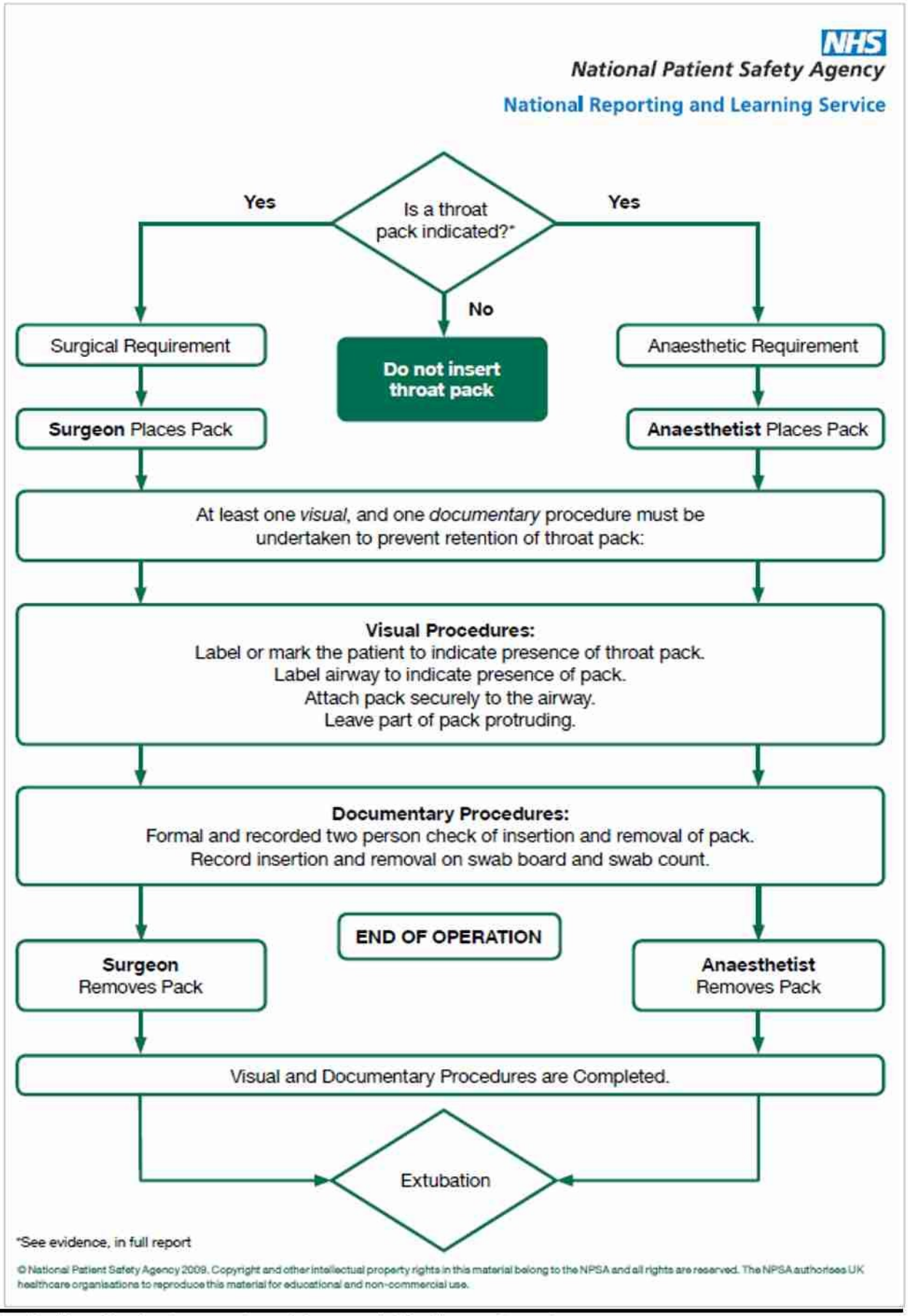
If the current risk rating is Extreme (RED); the action plan should be reviewed monthly as a minimum.
If the current risk rating is High (Orange); the action plan must be reviewed every 3 months as a minimum.
If the current risk rating is Moderate (Yellow); the action plan must be reviewed every 6 months as a minimum.
If the current risk is Low (Green); the controls/action plan must be reviewed on an annual basis as a minimum.

## Appendix 6: Count Board Examples

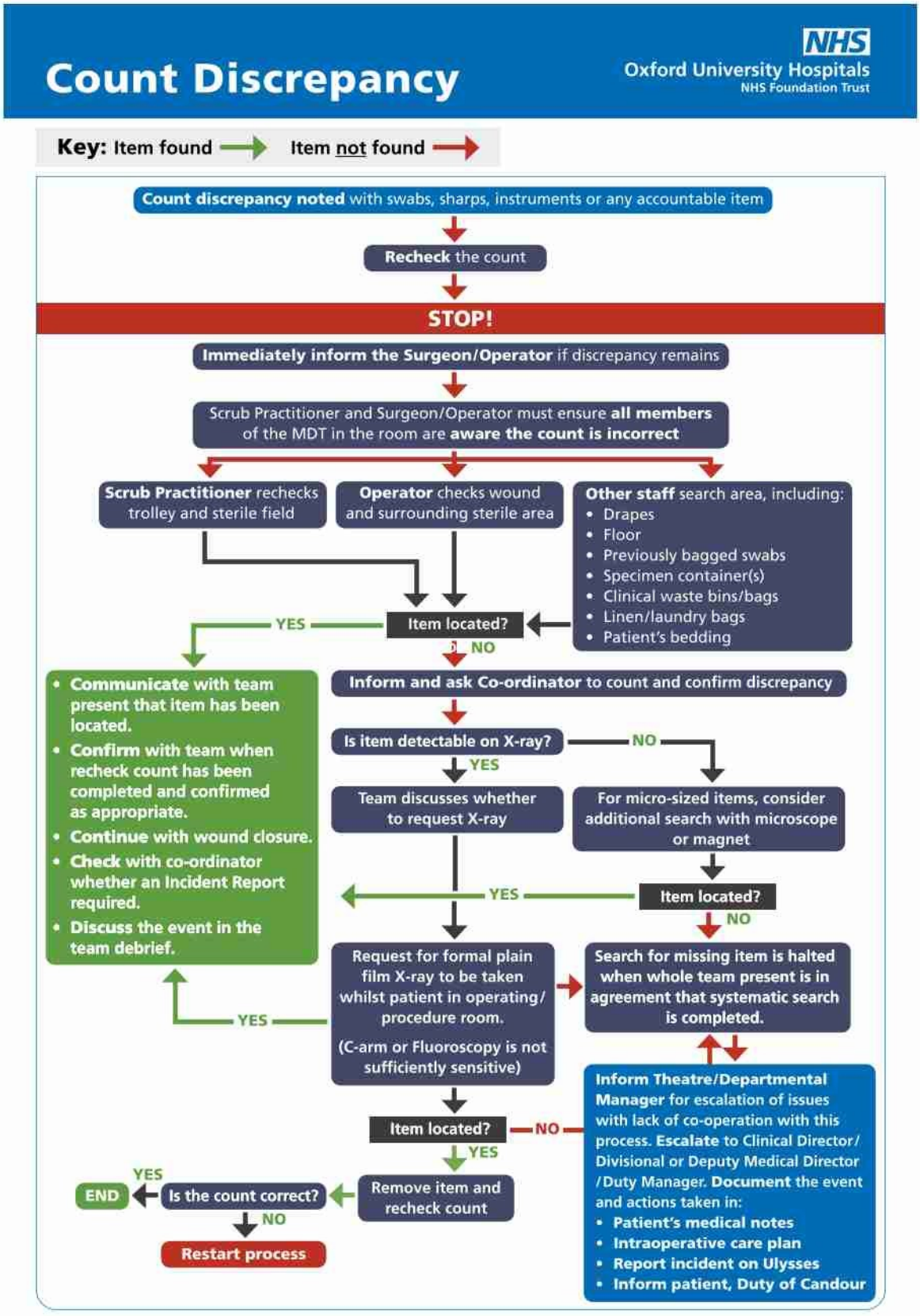


## Appendix 9: Throat Pack Summary



## Appendix 10: Count Discrepancy Poster



## Appendix 11: Example of a surgical count sheet

| PATIENT STICKER | | | DATE: | | THEATRE: | | PROCEDURE: | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| RED STRINGS | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 6" X 4" SWABS | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| 30 X 30 (Abdo) | | | | | | | | | | |
| | | | | | | | | | | |
| MASTOID | | | | | | | | | | |
| PLEDGETS | | | | | | | SPONGES | | | |
| LABELS | | | | | | | | | | |
| | | | | | | | | | | |
| DIATHERMY TIP | | | | | | DIATHERMY SCRATCH PAD | | | | |
| BULLDOG CLAMPS | | | | | | FOGARTY INSERTS | | | | |
| VESSEL SLINGS | | | | | | NYLON TAPES | | | | |
| HYPODERMIC | | | | | | SCREWS | | | | |
| LIGAREELS | | | | | | JACQUES OR UMBILICAL CATHETER | | | | |
| BLADES | | | | | | RUBBER SHODS | | | | |
| VENFLON | | | | | | PORT SEAL | | | | |
| TIBBS | | | | | | BATTERIES | | | | |
| LIGACLIPS | | | | | | | | | | |
| SUTURES | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| LEGEND: | X - USE WHEN COUNTING OFF SWABS FROM STERILE FIELD | | | | | Ⓢ - ENTERED IN ERROR (circle incorrect entry) | | | | |
| SIGNATURES ON OTHER SIDE | | | | | | (continue counts on a separate sheet if necessary) | | | | |

# Appendix 11: Example of a surgical count sheet (continued…)

| | | | | |
|---|---|---|---|---|
| PRE-OP COUNT | CIRCULATING SIGNATURE | | CIRCULATING PRINT NAME | |
| PRE-OP COUNT | SCRUB SIGNATURE | | SCRUB PRINT NAME | |
| | | | | |
| FIRST CLOSING COUNT | CIRCULATING SIGNATURE | | CIRCULATING PRINT NAME | |
| FINAL CLOSING COUNT | CIRCULATING SIGNATURE | | CIRCULATING PRINT NAME | |
| FIRST CLOSING COUNT | SCRUB SIGNATURE | | SCRUB PRINT NAME | |
| FINAL CLOSING COUNT | SCRUB SIGNATURE | | SCRUB PRINT NAME | |
| | | | | |
| HANDOVER COUNT | | | | |
| HANDOVER COUNT | CIRCULATING SIGNATURE | | CIRCULATING PRINT NAME | |
| HANDOVER COUNT | 1ST SCRUB SIGNATURE | | 1ST SCRUB PRINT NAME | |
| HANDOVER COUNT | 2ND SCRUB SIGNATURE | | 2ND SCRUB PRINT NAME | |
| HANDOVER TIME | | | | |
| HANDOVER COUNT DETAILS: (DETAIL ANY MISSING ITEMS OR ITEMS NOT VISUALISED DURING HANDOVER COUNT, ENSURE SURGEON IS INFORMED) | | | | |
| | | | | |
| | | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| INCORRECT COUNT | | | | | | | | | | |
| TIME | | SURGEON INFORMED? | BY WHOM? | X-RAY? | YES/NO | | INCIDENT FORM COMPLETED? | YES/NO | INCIDENT FORM NUMBER | |
| | | If no - please state reason on | | If no - please state reason on accompanying incident form | | | | | | |
| DETAILS OF ITEM MISSING: | | | | | | | | | | |

| | | | |
|---|---|---|---|
| CATHETERISATION PACK | | | |
| Correct | PRACTITIONER SIGNATURE | | PRINT NAME |

## Appendix 11: Competency Assessment

| Dimension HWB2: Assessment and care planning to meet Health & Wellbeing needs<br>Dimension HWB5: Provision of care planning to meet Health & Wellbeing needs | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Competency** | | | **Formative Assessment** | | | | | | **Summative Assessment** | | |
| **1** | **AIM: The practitioner should be aware of the swab, needle & instrument count policy and practice accordingly** | **Minimum accepted standard** | **Pr** | **M** | **Signature & date** | **Pr** | **M** | **Signature & date** | **Pr** | **M** | **Signature & date** |
| **Skills** | | | | | | | | | | | |
| 1.0 | Demonstrates effective documentation in practice relating to swab counts | C | | | | | | | | | |
| 1.1 | Demonstrates effective documentation in practice relating to needle counts | C | | | | | | | | | |
| 1.2 | Demonstrates effective documentation in practice relating to instrument counts | C | | | | | | | | | |
| 1.3 | Demonstrates correct practice in relation to swab counts | C | | | | | | | | | |
| 1.4 | Demonstrates correct practice in relation to needle counts | C | | | | | | | | | |
| 1.5 | Demonstrates correct practice in relation to instrument counts | C | | | | | | | | | |
| 1.6 | Demonstrates assertiveness as a scrub practitioner to ensure counts are not interrupted | C | | | | | | | | | |
| 1.7 | Demonstrates the correct procedure when counting off used swabs during the procedure | C | | | | | | | | | |

| Dimension HWB2: Assessment and care planning to meet Health & Wellbeing needs<br>Dimension HWB5: Provision of care planning to meet Health & Wellbeing needs | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Competency** | | | **Formative Assessment** | | | | | | **Summative Assessment** | | |
| **1** | **AIM: The practitioner should be aware of the swab, needle & instrument count policy** | **Minimum accepted standard** | **Pr** | **M** | **Signature & date** | **Pr** | **M** | **Signature & date** | **Pr** | **M** | **Signature & date** |
| **Knowledge** | | | | | | | | | | | |
| 1.8 | Identifies the reason for the swab, needle & instrument count policy | C | | | | | | | | | |
| 1.9 | Identifies when counts should take place | C | | | | | | | | | |
| 1.10 | Describes why swabs have an black line through them | C | | | | | | | | | |
| 1.11 | Describes when waste bags & linen may be removed from theatre and why | C | | | | | | | | | |
| 1.12 | Can explain what process should be followed regarding red strings | C | | | | | | | | | |
| 1.13 | Can explain the process to follow if a blade or needle breaks intra-operatively | C | | | | | | | | | |
| 1.14 | Can explain the correct procedure for checking instruments on a tray | C | | | | | | | | | |
| 1.15 | Can explain the procedure, which should be followed if there is an incorrect count. | C | | | | | | | | | |

## Appendix 12: Accountable Items

Items to include but are not limited to:

- Bite Blocks
- Blades
- Bulldogs
- Bungs
- Cotton wool balls
- Diathermy tips
- Diathermy tip cleaners
- Digital Tourniquets
- Gauze strips
- Guidewires
- Instruments with their detachable parts (e.g. screws and blades)
- Lahey swabs (Peanuts, Pledgets)
- Liga clip cartridges
- Liga-reels
- Needles (dental, hypodermic, spinal, infiltration, cardiac pacing)
- Ophthalmic micro sponges
- Packs
- Patties
- Red ties from swab packs (these also act as an additional check for swab accuracy)
- Retrieval bags
- Shods
- Slings/Loops
- Sponges
- Sutures
- Tapes
- X-ray detectable gauze swabs

**Appendix 13: Equality Impact Assessment**

## 1. Information about the policy, service or function

| | |
|---|---|
| **What is being assessed** | Existing Policy / Procedure |
| **Job title of staff member completing assessment** | Clinical Policies and Safety Standards Practitioner |
| **Name of policy / service / function:** | Swab, Sharps, Instrument and Accountable Items Count Policy |
| **Details about the policy / service / function** | This policy provides guidance for all Healthcare Groups involved in the counting and checking process of any accountable items that may be used during an invasive procedure, minimising the risk of any unintentional retention. |
| **Is this document compliant with the Web Content Accessibility Guidelines?** | *Delete as appropriate*<br>Yes |
| **Review Date** | January 2029 |
| **Date assessment completed** | October 2025 |
| **Signature of staff member completing assessment** | [redacted] |
| **Signature of staff member approving assessment** | [redacted] |

## 2. Screening Stage

**Who benefits from this policy, service or function? Who is the target audience?**
*Delete as appropriate*

- Patients
- Staff

**Does the policy, service or function involve direct engagement with the target audience?**
*Delete as appropriate*
Yes - *continue with full equality impact assessment*

## 3. Research Stage

**Notes:**

- If there is a neutral impact for a particular group or characteristic, mention this in the 'Reasoning' column and refer to evidence where applicable.
- Where there may be more than one impact for a characteristic (e.g. both positive and negative impact), identify this in the relevant columns and explain why in the 'Reasoning' column.
- The Characteristics include a wide range of groupings and the breakdown within characteristics is not exhaustive, but is used to give an indication of groups that should be considered. Where applicable please detail in the 'Reasoning' column where specific groups within categories are affected, for example, under Race the impact may only be upon certain ethnic groups.

### Impact Assessment

| Characteristic | Positive Impact | Negative Impact | Neutral Impact | Not enough information | Reasoning |
|---|---|---|---|---|---|
| **Sex and Gender Re-assignment** – men (including trans men), women (including trans women) and non-binary people. | | | X | | This policy aims to standardise practice for all patients, including those with protected characteristics. |
| **Race** - Asian or Asian British; Black or Black British; Mixed Race; White British; White Other; and Other | | | X | | |
| **Disability** - disabled people and carers | | | X | | |
| **Age** | | | X | | |
| **Sexual Orientation** | | | X | | |
| **Religion or Belief** | | | X | | |
| **Pregnancy and Maternity** | | | X | | |
| **Marriage or Civil Partnership** | | | X | | |
| **Other Groups / Characteristics** - for example, homeless people, sex workers, rural isolation. | | | X | | |

**Sources of information**

- *Centre for Perioperative Care National Safety Standards for Invasive Procedures (NatSSIPs)2*
- Association for Perioperative Practitioners (2023) Standards and Recommendations for Safe Perioperative Practice

**Consultation with protected groups**

*List any protected groups you will target during the consultation process, and give a summary of those consultations*

| Group | Summary of consultation |
|---|---|
| N/A | |

**Consultation with others**

*List any other individuals / groups that have been or will be consulted on this policy, service or function.*

## 4. Summary stage

**Outcome Measures**

List the key benefits that are intended to be achieved through implementation of this policy, service or function and state whether or not you are assured that these will be equitably and fairly achieved for all protected groups. If not, state actions that will be taken to ensure this.

1. Provide guidance that ensures a consistent and accepted method of counting, in line with National Guidelines.
2. Ensure staff involved in counting are able to define what is deemed as an accountable item that may be used during an invasive procedure, for example swabs, guidewires and throat packs.
3. Support good clinical practice within the perioperative and peri-procedural environment with all staff involved in the counting procedure to maintain patient safety in line with National Guidelines.
4. Clarify roles and responsibilities of those involved in counting, and accounting for items.
5. Standardise and harmonise practice across OUH departments, to reduce risk of an inaccurate count.
6. Promote good communication and teamwork in order to avoid ambiguity or misunderstanding between team members.
7. Provide clear points of action of what steps to follow in the adverse event that a discrepancy in the count may be found.

Provide overarching principles to support the development of local service or area specific documents.

**Positive Impact**

List any positive impacts that this policy, service or function may have on protected groups as well as any actions to be taken that would increase positive impact.

This policy will standardise the treatment of patients irrespective of any protected characteristic. Patients from all protected groups will be treated equally under this Policy.

**Unjustifiable Adverse Effects**

List any identified unjustifiable adverse effects on protected groups along with actions that will be taken to rectify or mitigate them.

No unjustifiable adverse effects are anticipated in the implementation of this Policy.

**Justifiable Adverse Effects**

List any identified unjustifiable adverse effects on protected groups along with justifications and any actions that will be taken to mitigate them.

No unjustifiable adverse effects are anticipated in the implementation of this Policy.