

DEPARTMENT OF THE ARMY  
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND  
2050 Worth Road  
Fort Sam Houston, Texas 78234-6000

MEDCOM Regulation No. 40-49  
Change 1

3 May 2005

Medical Services  
**SURGICAL COUNTS**

Supplementation of this regulation and establishment of forms other than MEDCOM forms are prohibited without prior approval from HQ MEDCOM, ATTN: MCHO-CL.

MEDCOM Regulation 40-49, 21 March 2005, is changed as follows:

1. **HISTORY.** This publication was originally printed on 21 March 2005. This printing publishes Change 1.
2. Material which has been added or modified is indicated by an asterisk.
3. Page 6. Paragraph 8g. PROCEDURES FOR INCORRECT COUNT. Change paragraph to read:
  - g. In the event of a lost needle(s), a vigorous search of the surgical field must be done and documented on the intra-operative record. \*Needles carrying  $\geq$  7-0 suture may be difficult to detect by plain x-ray. Decisions to x-ray the wound in this situation will be dictated by local MTF policy.
4. File this change in front of the publication for reference purposes.

**The proponent of this publication is the Office of the Assistant Chief of Staff for Health Policy and Services. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, U.S. Army Medical Command, ATTN: MCHO-CL, 2050 Worth Road, Fort Sam Houston, TX 78234-6010.**

FOR THE COMMANDER:



JOSEPH G. WEBB, JR.  
Major General  
Chief of Staff

CHARLES C. HUME  
Colonel, MS  
Assistant Chief of Staff for  
Information Management

**DISTRIBUTION:**

This publication is available in electronic media only and is intended for MEDCOM distribution As (4) 1 ea, (10) 20 ea, (14) 2 ea, (16 thru 18) 1 ea, (25 and 26) 5 ea; Cs (1 thru 7) 5 ea; Ds (1 thru 6) 10 ea, (7 thru 24) 5 ea, (26 thru 34) 5 ea, (38 and 39) 5 ea.

**SPECIAL DISTRIBUTION:**

MCHC (Stockroom) (1 cy)  
MCHS-AS (Forms Mgr) (1 cy)  
MCHS-AS (Editor) (2 cy)

DEPARTMENT OF THE ARMY  
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND  
2050 Worth Road  
Fort Sam Houston, Texas 78234-6000

MEDCOM Regulation  
No. 40-49

21 March 2005

Medical Services  
**SURGICAL COUNTS**

Supplementation of this regulation and establishment of forms other than MEDCOM forms are prohibited without prior approval from HQ MEDCOM, ATTN: MCHO-CL.

- 1. HISTORY.** This is the first printing of this publication.
- 2. PURPOSE.** To provide guidelines for accountability of sponges, needles, various sharps, and instruments used during a surgical procedure and to ensure that they are not retained in a patient undergoing a surgical intervention.
- 3. REFERENCES.** References are listed in appendix A.
- 4. APPLICABILITY.** This policy applies to all healthcare professionals in U.S. Army Medical Command facilities involved in inpatient and outpatient care where surgeries/procedures are performed irrespective of where in the military treatment facility (MTF) they are performed. This regulation outlines which items (that is, sponges, sutures, needles, radiopaque-equipped hand towels, safety pins, scalpel blades, cautery tips, hypodermic needles, vessel loops, bulldogs, umbilical tapes, cottonoids, scratch pads, Kitners, vessel clamps, and other items deemed necessary by the circulating nurse) are to be counted as well as when, how, and by whom.
- 5. EXPLANATION OF KEY POINTS.**
  - a. Counts are fundamental to the surgical process and are the responsibility of the operating room team (circulating nurse, scrub, and surgeon).
    - (1) A perioperative registered nurse must be present for all counts.
    - (2) In an emergency situation, a surgeon or anesthesiologist/anesthetist may participate in completion of the count. Counts omitted due to a life-threatening emergency must be documented on the intra-operative nursing record and incorrect count protocol followed.

- b. A counting board and/or counting sheet must be used to track counted items.
- c. Sponge bag holders must be used on every procedure that requires the use of surgical sponges.
- d. It is recognized that in emergent, life- or limb-threatening situations, where time is a factor, it is not always possible to perform a full count. All such procedures without correct or complete counts require an x-ray of the surgical site prior to the patient leaving the operating room.
- e. In every instance where the surgical counts are not performed according to policy, a quality improvement/risk management document must be completed by the circulating nurse.
- f. If an initial count is not performed, an x-ray must be done at the end of the case. A final count is done to validate sponge groupings.
- g. Items are counted by the scrub and the circulator prior to the beginning of a procedure and as additional items are presented during the procedure. If a second cavity is opened, such as the uterus or bladder, an additional count is required. Counts will be done whenever there is a change of scrub or circulator (for example, lunch breaks and shift changes) or anytime it is judged necessary by the circulator.
- h. A separate count will be taken on each phase of a two-phase procedure (for example, laparoscopy – laparotomy).
- i. X-ray detectable sponges will never be used for dressing sponges. The use of counted sponges as post-operative packing is highly discouraged; however, if counted sponges are intentionally used as packing and the patient leaves the operating room with the packing in place, the number and type of sponges retained must be documented on the intra-operative record.
- j. If a package is opened and has an incorrect number of sponges, that entire package of sponges should be removed from the operating room suite.

## **6. POLICY.**

- a. The scrub and circulator must count together audibly.
- b. The circulator records each item added to the field on the count sheet/counting board. Relief personnel will initial for items they add to the field.
- c. Scrub personnel count sponges and sharps and should provide them to the surgeon on a one-for-one exchange basis, if at all possible.

d. Countable items are never taken from the operating room for any reason after the procedure begins or before it is completed.

e. Needles, sharps, instruments, or miscellaneous items broken or cut during a procedure must be accounted for in their entirety.

f. Used needles on the sterile field should be kept in a disposable, puncture-resistant needle container. Collecting used needles in a container helps ensure safe sharps containment on the sterile field and minimizes the risk of injury to the scrubbed person.

g. All items inserted into the wound will contain an x-ray detectable element.

h. Only radiopaque-equipped surgical hand towels will be passed to the surgeon for use as packing or for placement under a retractor (for example, O'Connor - O'Sullivan retractor). When used, these radiopaque-equipped surgical hand towels are accounted for during the closing count procedure. Surgical technicians and circulating nurses will track the number of surgical hand towels, time, and place used by the surgeon on any given case.

i. Sponges passed off the surgical field should be placed in the sponge bag holders that render each sponge visible for verification.

j. Instrument sets will consist of the minimum essential number of instruments required and count sheet detailing each item within the set. The instrument sheet will include an identifier of the person(s) (that is, printed name and signature) assembling the set.

k. Instruments are counted on all surgical procedures in which the likelihood exists that an instrument could be retained. These include procedures where the abdominal, thoracic, pelvic, or retroperitoneal cavities are opened.

l. When laparoscopic procedures are performed, an initial instrument count is performed as a precautionary measure (in case the surgery evolves to an open procedure).

m. When a patient expires in the operating room suite, a final instrument count is performed for inventory control purposes.

n. If there is a discrepancy on the instrument count sheet within a set, the discrepancy will be annotated on the count sheet. Inform the department that assembled the set of this discrepancy.

o. All counts, and the names of the personnel completing them, will be documented on the patient's intra-operative record (electronic or hardcopy).

## 7. PROCEDURES.

- a. All like items will be counted together. Counts are taken–
  - (1) Prior to the time the incision is made.
  - (2) Before the closure of a body cavity, or a cavity within a cavity.
  - (3) At the beginning of skin closure.
  - (4) At the time of lunch relief and permanent relief of scrub person and/or circulating nurse.
  - (5) Any time count needs to be reassessed for accuracy by circulator or scrub.
- b. Method of counting sponges and radiopaque surgical hand towels.
  - (1) Separate sponges, remove pins or bands, then separate each sponge from the pack. Lap sponges will be opened.
  - (2) The scrub and circulator will count audibly together. The circulator will verify audibly with the scrub that the annotated initial count is correct.
  - (3) The circulator immediately records the count.
  - (4) If the number of sponges added to the field is incorrect (according to the standard 5 or 10), the entire package is removed from the room.
  - (5) The radiopaque-equipped surgical hand towels will be counted in the same way that sponges are counted.
  - (6) The closing count order for all items will start at the surgical field, progress to the Mayo stand, and then to the back table.
- c. Method of counting sharps.
  - (1) Both the scrub and circulator together will count sharps at the beginning of each case.
  - (2) The circulator will keep a tally of the number of countable sharp items given to the scrub on the count sheet and/or counting board and will make additions as necessary during the case.
  - (3) The scrub person should be certain that for every suture or needle packet opened, there is a corresponding needle or needles.

(4) The scrub person will be held accountable for all loose needles on the field.

(5) All used and unused needles will be placed in the disposable needle-count device to ensure proper safe disposal.

(6) Open and unopened suture packets will be retained on the sterile field.

(7) All needle packets must be opened, counted, and verified prior to actual use. Sharps broken during the procedure should be accounted for in their entirety.

d. Method of counting cottonoids. Cottonoids will be counted individually and annotated by size (for example,  $\frac{1}{4} \times \frac{1}{4}$ ).

e. Method of counting instruments.

(1) All instruments on the sterile field will be counted to include all parts (for example, winged nuts, separate blades of a retractor, trocar and sleeve, etc.). Other instruments added to the sterile field will be added to the count list by name and number.

(2) Any instrument removed from the operating room to be autoclaved must be returned to the room. If the instrument is removed permanently from the room, a note should be made on the count sheet explaining why, where taken, and who removed the instrument from the room.

(3) Instruments broken or disassembled during a procedure must be accounted for in their entirety.

f. Method of accountability for used countable items.

(1) Upon completion of the prep, remove and close the kick bucket liner with prep sponges and place in a bag for trash in the room. Counted sponges should not be used for the prep.

(2) Place all used sponges separately in a location (for example, count bags) that can be readily seen by the anesthesia personnel for calculating blood loss.

(3) The scrub will discard used sponges into an appropriately placed kick bucket.

(4) The circulator will then remove the discarded sponges and lap tapes from the kick bucket using standard precautions.

(5) Surgical sponges are placed in sponge counting bags. Each sponge is opened to ensure that there is only one. Each sponge is checked for an x-ray detectable element.

(6) Do not remove any counted sponges from the room until the patient leaves the room.

g. Methods for accounting items in the sterile field.

(1) Raytec sponges should not be used within the peritoneum or deep cavities. This particular item is highly susceptible to retention.

(2) Stick sponges are to be used on sponge forceps and Kitners on an appropriate instrument (for example, Kelly or Rochester Pean, not on criles or tonsil clamps).

(3) Keep 4x8 raytec sponges and lap tapes separate on the sterile field.

(4) Keep 4x8 raytec sponges and lap tapes away from other articles such as ligaclips and needles that could inadvertently hook onto a sponge and be transported into the wound.

## **8. PROCEDURES FOR INCORRECT COUNT.**

a. An incorrect count for any countable item will be reported to the surgeon and operating room floor coordinator immediately so that appropriate corrective actions can be initiated. If available, an additional circulator will be sent to assist in the search.

b. Repeat the entire count.

c. The circulator will make a thorough search of the room, including but not limited to trash receptacles, linen hampers, and the area underneath the operating room tables.

d. Scrub personnel will make a thorough search of the sterile field.

e. The surgeon will recheck the operative field, cavity, and wound.

f. If the count is still incorrect following the search, an x-ray must be taken before the patient leaves the operating room. If the surgeon refuses to have an x-ray taken after the missing item is reported, the Chief of Surgery will be verbally notified prior to removing the patient from the operating table. This refusal must be documented in the comment section of the intra-operative notes.

g. In the event of a lost needle(s), a vigorous search of the surgical field must be done and documented on the intra-operative record. Needles carrying  $\leq 7-0$  suture may be difficult to detect by plain x-ray. Decisions to x-ray the wound in this situation will be dictated by local MTF policy.

h. The circulator will complete an Incident Report annotating incorrect count and actions taken.

## **9. UNUSUAL SITUATIONS.**

a. If the patient's wound is packed with lap sponges, note the number and type of sponges left in the wound in the comments section of the intra-operative documentation (electronic or hardcopy). The count is considered correct if this mandatory nursing documentation note has been made.

b. If the staff changeover count is incorrect, the nurse and/or technician who is being relieved will not leave until steps following the procedure for incorrect count have been completed.

## **10. DOCUMENTATION**

a. At the completion of each closing count, the surgeon and anesthesia provider are informed of the count status.

b. The circulator will document the closing count status on the intra-operative nursing record (either electronic or hardcopy).

c. The name of both the nurse and the technician verifying the final count will be listed.

d. A count sheet or counting board will be used to keep a running record of all countable items used during the surgical procedure.

## **Appendix A**

### **References**

#### **Related Publications**

A related publication is merely a source of additional information. The user does not have to read it to understand this publication.

Association of Perioperative Nurses Standards and Recommended Practices, 2004 edition.

Alexander's Care of the Patient in Surgery; 11<sup>th</sup> edition; M.H. Meeker, J.C. Rothrock, eds.; (St. Louis: Mosby, Inc., 1999); pp. 21-48.

Perioperative Patient Care: The Nursing Perspective, 3d edition, J.A. Kneeder, G.H. Dodge, (Boston: Jones and Bartlett Publishers, Inc., 1994), pp. 334-335.

"Identifying Lost Surgical Needles Using Radiographic Techniques," M. Macilquham, R. Riley, P. Grossberg; AORN Journal 78 (July 2003); pp. 73-78.

**The proponent of this publication is the Office of the Assistant Chief of Staff for Health Policy and Services. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, U.S. Army Medical Command, ATTN: MCHO-CL, 2050 Worth Road, Fort Sam Houston, TX 78234-6010.**

FOR THE COMMANDER:



JOSEPH G. WEBB, JR.  
Major General  
Chief of Staff

CHARLES C. HUME  
Colonel, MS  
Assistant Chief of Staff for  
Information Management

**DISTRIBUTION:**

This publication is available in electronic media only and is intended for MEDCOM distribution As (4) 1 ea, (10) 20 ea, (14) 2 ea, (16 thru 18) 1 ea, (25 and 26) 5 ea; Cs (1 thru 7) 5 ea; Ds (1 thru 6) 10 ea, (7 thru 24) 5 ea, (26 thru 34) 5 ea, (38 and 39) 5 ea.

**SPECIAL DISTRIBUTION:**

MCHC (Stockroom) (1 cy)  
MCHS-AS (Forms Mgr) (1 cy)  
MCHS-AS (Editor) (2 cy)