

Surgical Swabs, Instruments, Needles and Accountable Items UHL Policy

Approved By:	Policy and Guideline Committee
Date Approved:	9 October 2007
Trust Reference:	B35/2007
Version:	V8
Supersedes:	V7 – July 2020 Policy and Guideline Committee
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Latest Review Date	19 May 2023 – Policy and Guideline Committee
Next Review Date:	June 2026

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1 INTRODUCTION and OVERVIEW

- 1.1 This policy sets out the University of Leicester (UHL) NHS Trust's Policy and Procedures for the adherence to the safe handling of surgical swabs, instruments, needles, devices and other accountable items within UHL NHS Trust and the Alliance. Unintended retained objects are considered a preventable occurrence; careful counting and documentation can significantly reduce, if not eliminate these incidents. A count must be undertaken for all procedures where countable objects (e.g. swabs, instruments, devices, guidewires, introducers, sharps) are used.
- 1.2 The revised 'Never Events' framework includes interventions that are considered to be surgical but may be done outside a surgical environment – for example, wrong site block, biopsy, interventional radiology procedures, cardiology procedures, drain insertion and insertion of vascular access (not IV cannula).
- 1.3 It enables a standardised way of working across all areas of the Trust where invasive procedures are undertaken in an operating theatre or any other area within the Trust and the Alliance.
- 1.4 There is always the potential for a closed procedure to urgently change into an open procedure so it is essential that there is strict adherence to the count procedure to ensure safe checking of return and completeness of all items used, for example a guide wire or introducer.
- 1.5 Due to the potential risks of infection and cross infection from body tissue and fluids, all items used in any invasive procedure are to be regarded as potentially hazardous and should be treated accordingly.

1.6 Local Safety Standards for Invasive Procedures (LocSSIPs) Invasive procedures.

National Safety Standards for Invasive Procedures (NatSSIPS) were developed to set out the key steps necessary to deliver safe care for patients undergoing invasive procedures.

The introduction of the WHO Safer Surgery Checklist has been a great step forward in the delivery of safer care for patients undergoing operations. Experience with its use has suggested that the benefits of a checklist approach can be extended beyond surgery towards all invasive procedures performed in hospitals.

The NatSSIPS have been modified for UHL local use and used as the basis for the production of our Local Safety Standards for Invasive Procedures (LocSSIPs).

The local standards for a major surgical procedure performed under general anaesthesia in an operating theatre cannot and should not be identical to those being supported by the UHL LocSSIPs and the UHL Safer Surgery Policy (Safer Surgery Policy (Trust ref: B40/2100) version 5.0) and this 'Swab, Needles and Accountable Items' policy must be adhered to at all times in a theatre environment. **Safe Surgery LocSSIPs do not cover OperatingTheatres.**

It is important that LocSSIPs are acknowledged within this policy to harmonise practice across the organisation such that there is a consistent approach to the care of patients undergoing invasive procedures in any location and not just an operating theatre.

Current LocSSIPs are identified in Trusts Safer Surgery Policy (Trust ref: B40/2100) version 5.0

- 1.7 Ensure that safe standards of practise are adhered to by all staff within UHL including areas not described as an Operating Theatre (for example Catheter Suites, Clean Rooms, Interventional Radiology Suites, Endoscope Units, Outpatient minor procedure rooms, delivery suites and maternity/obstetrician led procedures; admission areas, Emergency Department and wards)
- 1.8 Ensure patient safety, decrease the risk of infection and prevent the retention of swabs, instruments, devices, guide wires, introducers or sundries being left inside the patient.
- 1.9 Ensure all Healthcare Practitioners and Medical staff (Surgical and Anaesthetic) are aware of their own and others accountability when performing counts.
- 1.10 Ensure that throughout any invasive procedure designated members of the theatre team, Catheter Lab Team, Interventional Radiology Teams, Endoscopy Teams, outpatient minor procedure room teams, delivery suite/obstetric teams, and any staff member of the Trust involved in any invasive procedure within all areas of the Trust will account for all items used.

2 POLICY SCOPE

- 2.1 This policy applies to all operations and invasive procedures undertaken within UHL and those UHL managed employees who are employed to deliver care within the 'Alliance' on Adult and Paediatric patients.
- 2.2 This policy applies to all invasive surgical procedures undertaken in an operating theatre or any other area within the Trust as defined in section 1; where there is a potential risk of retaining an accountable item, device, swab, guide wire or introducer.
- 2.3 This policy applies to scrubbed and circulating Theatre Practitioners, Associate Practitioners, Advanced Practitioners, Registered Nurses, midwives, Obstetricians, Healthcare Assistants, Theatre Support Assistants, Operating Department Practitioners, Anaesthetist Nurses, Surgical Assistants, Advanced Health Care Assistants, Radiology Assistants (RDAs), Interventional Radiology Nurses/Radiographers and Clinical Support Workers including Registered and Unregistered Bank and Agency staff.
- 2.4 This policy applies to all Medical staff; Operating Surgeons, Anaesthetists, Intensivists and interventional operators such as: Surgeon, Surgical Assistant, Cardiologist, Interventional Radiologist, Specialist Nurse Practitioners, Theatre Assistant Practitioners (TAPs) and Advanced Radiology Practitioners (who are not operators/registered professionals but practising as per localised agreements and training) **(this list is not exhaustive)**

3 DEFINITIONS and ABBREVIATIONS

3.1 **Anaesthetist:**

An authorised professional; who has lead responsibility for administering general/local/spinal anaesthesia or sedation during a procedure.

3.2 **Circulating Practitioner:**

An authorised person working under the direct supervision of a Registered Healthcare Professional; assisting with the care of patients.

3.3 **Operating Surgeon / Operator:**

An authorised professional who has lead responsibility for invasive procedures Such as a Surgeon, Surgical Assistant, Cardiologist, Interventional Radiologist, Specialist Nurse Practitioners, Theatre Assistant Practitioners (TAPs) and Advanced Radiology Practitioners (who are not operators/registered professionals but practising as per localised agreements and training) (this list is not exhaustive)

3.4 **Procedure Definition - Closed Procedure:**

Limited open access / minimal incision (for example via a guide wire procedure)

3.5 **Procedure Definition - Invasive Procedure:**

All surgical and interventional procedures performed in operating theatres, outpatient treatment areas, labour ward delivery rooms, and other procedural areas within an organisation.

- Surgical repair of episiotomy or genital tract trauma associated with vaginal delivery.
- Invasive cardiological procedures such as cardiac catheterisation, angioplasty and stent insertion.
- Endoscopic procedures such as gastroscopy and colonoscopy.
- Interventional radiological procedures.
- Thoracic interventions such as bronchoscopy and the insertion of chest drains.
- Biopsies and other invasive tissue sampling.

3.6 **'REDS' Team:**

Refers to the Resources Equipment and Devices team within ITAPS CMG and are responsible for provision of same within UHL theatres.

3.7 **Scrubbed Practitioner**

The term is used for the authorised professional; who assists the Operating Surgeon or Operator, handing the surgical instruments and other items.

3.8 **Stop the Line:**

Stop the Line is an approach that allows staff to "Stop the Line" if they see something unsafe. You can stop the line by using three simple steps:

1. Say **What** you see
2. Say **What** you are concerned about
3. Say **What** you want to see happen to keep the patient safe

'**Stop the Line**' is supported by the Trust's Freedom to Speak Up Guardian.

When you '**Stop the Line**' it is the responsibility of the clinical team to put right the safety concern. If they cannot do this, then the issue should be escalated up through line management (floor control, then CMG management).

'Stop the Line' is about keeping our patients safe and doing the right thing

4 ROLES AND RESPONSIBILITIES

4.1 **Medical Director and Chief Nurse are responsible for:**

Ensuring that appropriate management mechanisms are in place across the Trust to ensure that surgical swabs, instruments, needles, devices, guidewires and other accountable items within the operating theatre and all areas within UHL, listed in section 2 are managed safely.

4.2 **Clinical Procurement Teams within UHL are responsible for:**

Ensuring that they work alongside the clinical staff to have mechanisms in place to assure that all new suppliers of theatre items/consumables that require radio-opaque identification meet the required standards.

4.3 **CMG Management Teams are responsible for:**

- a) Ensuring all their new and existing staff are made aware of this policy through local induction and other communication methods.
- b) Ensuring that all staff within their CMG has the appropriate education and competence to safely manage surgical swabs, instruments, needles, devices, guidewires and other accountable items within the operating theatre and all areas of UHL.
- c) To ensure that It is the responsibility of the CMG management teams to ensure that:
 - Procedures in their areas of responsibility that require LocSSIPs to be written are systematically identified
 - Lead clinicians or managers are identified for each LocSSIP
 - LocSSIPs are signed off at the CMG Quality and Safety Board and comply with UHL Policy on Surgical Safety Standards for Invasive Procedures (Trust ref: B31/2016)
 - LocSSIPs are regularly reviewed to ensure that they remain up to date (minimum annually)
 - Regular audits of compliance are carried out and presented to the CMG Quality and Safety Board
 - Regular assurance is given to the Executive Quality Board that procedures are carried out in accordance with the LocSSIP.
 - Dissemination of LocSSIPs to relevant team members
 - Archiving of LocSSIPs on the intranet
- d) Ensuring compliance with any associated audit of clinical practice and competence.
- e) Ensuring that any other local operating procedures are implemented and annual review of all Standard Operating Procedures (SOPs) within this policy to ensure that they remain fit for purpose.
- f) SOPs requiring revision that are originated from another CMG will be reported to this policy author who will update in a timely manner. Relevant SOPs can be found within the IN Site UHL Staff Intranet. The SOP can be found within the 'Guidelines and Policies' section.

4.4 **Responsibilities of all UHL staff involved in performing invasive procedures:**

- (a) All members of the theatre or interventional team have equal responsibility for ensuring that the count is correct. UHL staff are all professionals in their own right and have a duty of care to the patient to ensure that counts are correct and that the policy has been adhered to and ensure that no accountable items are retained within the patient prior to leaving the theatre or treatment room or any clinical area of UHL or the Alliance. The Consultant operator/ Consultant surgeon/ Consultant Anaesthetist and all UHL staff undertaking the procedure have ultimate responsibility for a correct count in and out of accountable items within the operating theatre/delivery suite and all areas of UHL in line with the checks undertaken as part of the Safer Surgery checklist. Heads of Nursing will support safe working by making sure that authorised staff receive the appropriate training, supervised practice and assessment of competence in the management of surgical swabs, instruments, needles and other accountable items.
- (b) Maintaining accurate and up to date training records and any competence reassessment.
- (c) Contributing to all audit requirements

4.5 Staff responsible for managing surgical swabs, instruments, needles and other accountable items within the operating theatre and UHL must:

- a) Be supported by their line manager and carry out the activity as an integral part of the key responsibilities within their role.
- b) Successfully complete all appropriate education and training as detailed in section 6. All Medical staff (including medical students/trainees) should make themselves familiar with the policy as part of their 'Professional Competence'.
- c) Adhere to the procedures set out within this policy.
- d) Maintain competence and undertake any refresher training as necessary.

5. POLICY STATEMENTS

5a. All staff – non-adherence to policy Escalation Process: Theatres

(Please also refer to Page 29 of this policy for the Escalation Flow Chart)

- 5a.1 Escalation processes may need to be implemented to support team members who could be challenged about implementing the policy, within what may occasionally be a challenging and stressful environment. Team work is safe work and it is the responsibility of all professional groups to adhere to the policy. In relation to an unaccounted item being retained within the patient **under no circumstance should assumptions be made that the item is not retained and if a decision to deviate from the policy arises then it is essential that the escalation process below is invoked immediately.**
- 5a.2 The Team will **never** suggest deviation from the policy. They will comply with transferring a patient from theatre without appropriate imaging to check for an unaccounted item **only** if the patient requires to be transferred to the ITU. (Reference can be found as per Appendix Two, section 3.10 Count Procedures and Standards point (h) and point (i) for ophthalmology cases and point (j) for micro needle exceptions of this policy.) Should the Team decide that the patient is

not satisfactorily stable to remain in theatre for appropriate imaging and ongoing stabilisation within a Critical Care environment takes priority then this must be clearly documented in the Medical notes.

- 5a.3 **Appropriate Imaging:** This will need to be confirmed and considered by the lead medical staff. Radiology currently advises that normally fluoroscopy would be used in the first instance but x-ray may give better contrast and resolution; but the decision would depend on the surgery site and the missing item. For e.g. Dental Swabs and the ties from swabs missing in a thoracic or abdominal cavity would likely not show up.
- 5a.4 Should a circumstance arise that the Theatre Nurses, ODPs / midwives and HCAs / Theatre Support Assistants/Theatre Associate Practitioners (TAPS) ask for appropriate imaging as per policy within the theatre/procedure room and this request is challenged by Medical Staff then a **'Stop the Line'** moment should be declared and the **Escalation Process must be followed** Refer to Escalation Flow chart on page 29 of this Policy.
- 5a.5 The Nurse/ODP/midwife who is the 'Practitioner in Charge' of the theatre at this time must reiterate the policy with any member of the team who is wishing to deviate, and try by mutual agreement to perform an appropriate imaging investigation before the patient leaves the theatre/procedure room.
- 5a.6 If local resolution cannot be achieved then the 'Practitioner in Charge' must escalate this situation to the 'Theatre Floor' control or senior midwife within Obstetrics Theatres/Delivery Suite. Out of hours the first on call or emergency Theatre bleep holder will make the decision to follow the escalation procedure following their attempts to make resolution.
- 5a.7 The Theatre 'Floor Control' will attend the theatre in question and again reiterate policy, try to gain resolution and ensure appropriate imaging is performed prior to the patient being transferred to another care area.
- 5a.8 If the Theatre 'Floor Control' is unable to gain resolution then they will escalate to the Theatre Matron. If the Theatre Matron is on site they will attend the theatre and again try to gain resolution. If the Theatre Matron is not on site then either the Matron or Floor Control will escalate to the General Manager if on site or ITAPs 'Tactical Command' lead for that day. Tactical Command may not be available at that site but will ask to speak to the team member/members who have suggested deviation from the policy and try to gain resolution.
- 5a.9 If the following attempts at resolution are not successful then the CMG Tactical Command lead or General Manager must inform the relevant CMG Clinical Director, CMG Head of Nursing or CMG Head of Operations. A list of CMG medical leads and managers can be found on INsite as per the Trusts CMG structure, and the ITAPs Manager on call for the week is circulated locally and via the Trust global manager's rota.
- 5a.10 If resolution cannot be made out of hours the first on call/emergency bleep holder will escalate immediately to the relevant ITAPs CMG Manager on call.
- 5a.11 Any deviation from the policy must be recorded that day on the ORMIS care plan within the final count.
- 5a.12 The Practitioner in charge shall be responsible for completing a report on Datix.
- 5a.13 Out of hours staff must ensure that their site Matron is informed immediately the next working day.

- 5a.14 It is the responsibility of the CMG Clinical Director or Head of Service to discuss the rationale for deviation from the policy and to enforce the importance that there are **no acceptable deviations from the policy unless there are strong clinical benefits for the patient not to have appropriate imaging in theatre**. The only exception is that stated in **Appendix 2** section 3.10 points (h) (i) and (j) of the policy.
- 5a.15 If those responsible for taking the decision to deviate from the policy chose to continue with this deviation following discussion with the CMG Tactical Command or Manager on Call then it is the responsibility of the CMG Medical Lead to investigate the decision in detail as soon as is reasonably possible.
- 5a.16 The CMG Clinical Director following investigation must feedback to the theatre Matron and Quality and Safety Manager their findings and decisions. The Quality and Safety manager will discuss with the ITAPs Head of Nursing/CD or HOO if escalation is required to the Corporate Quality and Safety team. The investigation findings will then be tabled for discussion at the next CMG Quality and Safety Boards and identified at the next CMG performance review.
- 5a.17 The CMG Clinical Director may make the decision to escalate their findings to the Medical Director/Deputy Medical Director as well as the Corporate Patient Quality and Safety Team.

5b. All staff – Non-adherence to policy Escalation Process: Non Theatre Areas:

5b.1: This section above is specific to Theatres but the expectation is that all areas of UHL that may need to consider non adherence or deviation from the Policy should implement a local escalation process throughout their specific CMGs. **(Refer to escalation Flow Chart for ITAPs on page 27 to implement a similar process)**

5.1 POLICY STANDARDS, PROCESSES, PROCEDURES AND ASSOCIATED DOCUMENTS

This policy is supported by the standards, processes and procedures listed below found in the associated documents attached as appendices. These must be used in conjunction with this policy.

Procedure / Standard	Appendix
Items to be Counted:	1
Count Procedures:	2
3.1 Responsibility for the Count	
3.2 Changeover of Scrub Practitioner / Runner / Support Staff during the procedure	
3.3 When to Perform a Count	
3.4 Count Procedure	
3.5 Swab Handling and Counts	
3.6 Instrument Trays and Counts	
3.7 Supplementary instruments (unit packed items)	
3.8 Patient specific items for implantation	
3.9 Instrument Counts for Orthopaedic Resurfacing and Revision Hip and knee surgery	
3.10 Count Discrepancy	
3.11 Documentation of Swabs and other accountable items (Elective)	
3.12 Instrument Documentation	

3.13 Documentation of Swabs used to pack a Body Cavity	
3.14 For Emergency Surgery (surgery which must be done quickly to save life, limb, or functional capacity) or Re Opening outside of an Operating Theatre Environment (e.g. ITU / PICU / PACU / Resus / Catheter Lab/Recovery)	
3.15 Non X-Ray Detectable Swabs	
3.16 Reducing the risk of retained throat packs after Surgery	
3.17 Recommended solutions for reducing the risk of retained throat packs after surgery	
3.18 Recommended standards for reducing the risk of wrong tooth extraction	
3.19 Recommended standards to reduce the risk of retention of medical devices	
3.20 Health and Safety	
National Patient Safety Agency (NPSA) Throat Pack Insertion Flow Chart (2009)	3
Intra ocular Lens protocol	4
Standard Operating Procedure for Revision Surgery where not all the previous implants are being revised	5
Revisions post Policy review	6
Policy Summary Chart	7
Safer Surgery Check List	8
'Stop Before You Block' Poster	9
'Prep Stop Block' Poster (To be rolled out at UHL)	10
'Prep Stop Block' stages defined as per National SOP.	11

6 EDUCATION AND TRAINING REQUIREMENTS

- 6.1 Newly Registered Practitioners employed by the Trust for theatres must have completed the CMG Induction Programme, theatre induction and related Band 5 Theatre Practitioner competencies. These competencies include a preceptorship programme and assessments, 'Theatre Code of Conduct', 'Specific Theatre and Recovery Training (START Days), competency assessment and Theatre Foundation Days to assess knowledge in relation to this policy and those synonymous with it.
- 6.2 New Health Care Assistants/Theatre Support Assistants and Theatre Associate Practitioners (TAPs) employed by the Trust must have completed the Theatre CMG Induction Programme and related Health Care Assistant Clinical Competencies including Early Warning Score (EWS) training where appropriate (Recovery/PACU/TAA).
- 6.3 Staff within UHL working in non-theatre environments but involved with invasive procedures that require them to undertake the 'scrub' role or 'circulator' role must make themselves familiar with this policy. It is the responsibility of Departmental Managers to refer staff to the policy and records of compliance and training must be kept locally for such areas across the Trust. It is essential that all staff are familiar with the relevant 'Local Safety Standards for Invasive Procedures (LocSSIPs) checks and documentation that are required within their clinical areas. These should be discussed as part of their local induction.
- 6.4 The Practitioner must accept responsibility for updating knowledge and skills to maintain competence.

- 6.5 A verification of a professional competence must be kept in the CMG and transferred accordingly. All new starters will be introduced to this Policy and confirm with their Team leader and Theatres Education Lead that they have read and understood their roles and responsibilities to adhere to this policy. The education lead will keep local records in line with local induction.
- 6.6 Managers must be assured of the competency of Practitioners employed through an agency or bank. They must provide written evidence of competence. On the day of commencement the temporary staffing green book induction assessment must be completed.
- 6.7 All new staff (Medical and Non-Medical) whether on a permanent contract or a temporary contract (Bank and Agency Staff) must at date of commencement be given a copy of this policy and the 'Theatre Code of Conduct' booklet by the Theatre Matron/Team Leader or Clinical Skills Supervisor. All staff must read and sign to say that they have read and understood these policies prior to being allowed to undertake Surgical/Interventional and anaesthetic roles and the roles of Scrub/Circulating Practitioners.
- 6.8 A policy summary chart will be displayed in all theatre/procedural areas for ease of reference (Appendix 7)

7 PROCESS FOR MONITORING COMPLIANCE

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Counts must be performed for all areas of the Trust/Alliance where open and non-invasive procedures are undertaken	HoN/ DHoN/ Matrons	Quality Metrics audit and spot checks	Monthly & reported monthly	Reported to Corporate Nursing Team & reported via Chief Nurse to EQB
	HoN/ DHoN/ Matrons	Quality & Safety report; staff knowledge assessed at spot audits, monthly metric audits and service reviews.	Monthly	ITAPS Quality & Safety Board & CMG Board
	HoN/ DHoN/ Matrons	Datix overview thematic report	Weekly	ITAPS Quality & Safety Board & CMG Board – escalation to EQB
Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Counts must be undertaken by the appropriate personnel identified in the policy	HoN/ DHoN/ CMG Education Team	Completion of competency packs and induction. Observational audits	Complete up to one year	Reported locally at CMG meetings, education and practise meetings & appraisals.
	HoN/ DHoN/ CMG Education Team	One off assessment	Review if necessary	Reported locally at CMG Education and Practise meetings & Appraisals.
Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Students ODPs, Nurses and TAPs must only undertake the counts once deemed competent to do so.	Education Team and Clinical Skills Supervisor	Sufficient supernumerary status completed & competency	Daily log & mentor sign off during placement	Reported to Education Lead and Team Leader/ Mentor Support from practise placement coordinators

<p>Until such a time counts must be additionally signed & validated by appropriately registered Nurses or ODPs.</p>	<p>(CSS)/ Mentors</p>	<p>assessments reviewed & signed off by lead mentors or CSS. Ongoing observation during monthly quality metric audits and spot check observational reviews.</p>		
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Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Counts must be recorded as per policy for all areas of the Trust.	HoN/ DHoN/ Matrons and Clinical Leads	Quality metrics and review of ORMIS Care Plan documentation	Monthly	Reported to Corporate Nursing Team & EQB
	HoN/ DHoN/ Matrons and Clinical Leads	Quality & Safety Report; metrics audit and ORMIS Care plans reviews.	Monthly	ITAPs Q&S Board
	HoN/ DHoN/ Matrons and Clinical Leads	Incident reviews	Weekly	Reported via ITAPs Board/Q&S Board & EQB
Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Multi-disciplinary Team Training – CMGs must facilitate their staff being given adequate time & support to be educated in good safety practice, to train together as teams, and to understand the human factors and non – technical skills that underpin the delivery of safe patient care.	Executive Team	Quarterly 'Time to Train' afternoons for MDT. Attendance list and feedback to confirm engagement re Safer Surgery and Human Factors training.	Quarterly	Via Monthly CMG performance reviews and EQB

8 EQUALITY IMPACT ASSESSMENT

- 8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
- 8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

- 9.1 The contents of this policy reflect best practice and amalgamation of professional guidance from national bodies representing Surgeons, Anaesthetists, Operating Department Practitioners and Nurses (see references to these documents).
- 9.2 Association for Perioperative Practice *NATN Standards and Recommendations for safe Perioperative Practice* (Association for Perioperative Practice 2022)
- 9.3 *Association for Perioperative Practice (AfPP) 'Accountable items, swab, instrument and needle count* (October 2012)
- 9.4 *Safer Surgery Policy* (Trust ref: B40/2100)
- 9.5 *UHL Policy on Safety Standards for Invasive Procedures* (Trust ref: B31/2016)V3
- 9.6 *Vascular Access in Adults and Children Policy and Procedures* (Trust Ref B13/2010)V5

- 9.7 *Guideline: Insertion & Maintenance of Central Lines in Children (October 2016) (Trust Reference C112/2020)*
- 9.8 *Guidelines for Insertion of Haemodialysis Central Venous Catheters (October 2016) (Trust Reference C18/2005) (Jan 2020)*
- 9.9 *Summary report by the Healthcare Safety Investigation Branch (HSIB) – Investigation into the implantation of wrong prosthesis during joint replacement surgery (12117/010)*
- 9.10 Safer Practice Notice 'Reducing the risk of retained throat packs after surgery' National Patient Safety Agency 2009. Accessed via: <http://www.npsa.nhs.uk/nrls/alerts-and-directives/notices/throatpacks/>
- 9.11 Fish. J (1992) *an alternative to swab racks*. Nursing Standard Oct 7 Vol 7 No. 3 pg 55-56
- 9.12 National Patient Safety Agency and Royal college of Surgeons of England.(2005) *Correct Site Surgery*; NPSA
- 9.13 NATN et al (1998) *Safeguards for invasive procedures: The management of risk*. AFPP Harrogate.
- 9.14 Langslow. A. (2000) *Getting the sponge count right*. The Australian Nursing Journal. Dec. 2000 Vol.7 No. 6. P.42-43 (ISSN: 1320-3185)
- 9.15 Schmid C, Krempel, S and Scheld. H (2001) *A forgotten gauze swab, clinical and legal considerations*, The Thoracic and Cardiovascular Surgeon. June. 2001, Vol 49, No.3, p. 191-193
- 9.16 Samuels A. (2001) *The retained object: the swab (or whatever) left in the body: the legal liability of the doctor and the nurse*. Medico-Legal Journal, September 2001
- 9.17 Plowes D. (1990) *Life without swab racks*. British Journal of Theatre Nursing September 1990
- 9.18 NHS England (2015) Patient Safety Domain, '*National Safety Standards for Invasive Procedures*' (NatSSIPs) (Gateway ref: 03974)
- 9.19 <https://rcoa.ac.uk/news/salg-ra-uk-publish-national-prep-stop-block-protocol>
- 9.10 Never Events; Framework: Update for 2010/2011. NPSA, London 2010 (www.nrls.npsa.nhs.uk/resources/?entryid45=68518).
- 9.11 Wrong Site Blocks During Surgery . SALG, London 2011 (www.rcoa.ac.uk/node/631).
- 9.12 WHO Surgical Safety Checklist. WHO, 2009 (www.nrls.npsa.nhs.uk/resources/?entryid45=59860).

Related Policies

- a) **UHL Surgical Safety Policy (Trust Reference B40/2100)**
- b) UHL Policy and Procedures Cleaning and Decontamination for Infection Prevention and Control (Trust Reference B5/2006)
- c) UHL NHS Trust Hand Hygiene Policy (Trust Reference B32/2003)
- d) UHL NHS Trust Personal Protective Equipment for Infection Prevention Guideline (Trust Reference B10/2012)
- e) UHL NHS Trust Waste Management Policy (Trust Reference A15/2002)
- f) UHL Policy for Packaging, Labelling and Transport of Organs in Deceased and Living Donation and Transplantation (related to HTA/ NOP003) (Trust reference HTA 003/2012)

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

This document will be uploaded onto SharePoint and available for access by Staff through INsite. It will be stored and archived through this system.

- a. This Policy will be reviewed every three years or sooner in response to clinical/ risk issues or learning outcomes following serious incident and Never Event investigation and root cause analysis

Appendix One

Items to be counted must include where used (but not limited to)

1. Swabs / Pledgets

(All swabs that are used must have an x-ray detectable marker fixed across the width)

- Packs 45 x 45 with tapes
- Swabs 30 x 30 with tapes
- Swabs 30 x 30 without tapes
- Swabs 22.5 x 22.5 with tapes
- Swabs 10 x 7.5
- Mastoid / Tonsil swabs/ Neuro Patties – boarded under individual sizes
- Pledgets / Dabs - presented as 5 on a safety pin or plastic pocket pad.
- Dental Rolls
- Roll – presented as a continuous length of Gauze if used for packing a cavity or for retraction
- Vaginal packs
- Throat Packs
- Red ties from swab packs

2. Instruments (to include instrument pins / nappy pins)

Either presented in pre sterilised trays or as individually wrapped sterile instruments supplied by Sterile Services Departments or as single use pre packed items

3. Needles

- Hypodermic needles
- Suture needles
- Tuohy needles / spinal needles / long leur connector needles
- Loose needles / local infiltration needles

4. Other accountable items:

Tapes / nylon tapes	Medical devices – manufactured for purpose or adapted for purpose	Spears	Spinal needles
Rubber shods and bulldog clips	Vascular slings / sloops	Quills	Throat pack and mouth packs / gags
Diathermy needle / blade	BERT bags / other isolation bags	All blades	Raney clips
Visibility background	Microclips / Microvascular clamps	Fine instrument tip protectors	Liga pack reels
Snuggers	Fluid filled / inflated sterile surgical glove or uterine manipulator	All guidewires and introducers (vascular access, drain introducers)	Vaginal packs
Pain management wound catheters / infusion devices	Disposable marking pen and lid	All skin graft blades / saw blades	Scratch pads / diathermy tip cleaners

This list is by no means exhaustive and scrub practitioners should count ANY item that is used in close proximity to the surgical field and record appropriately on the count board.

5. Medical Devices Used Outside of Licensed Purpose:

- 5.1 Any medical device used for a purpose other than that which it was manufactured for must have a review by the relevant surgical service/CMG and agreed derogations must be documented by the CMG. Once all items have been identified and agreed with the other CMGs a detailed list of all items will be held by the Quality and Safety Leads for each CMG.
- 5.2 Where there is no suitable device designed for the purpose and the surgeon wishes to proceed with an adapted/improvised device there must be an agreement to acknowledge their choice and the potential risks involved including with respect to sterility and radio-opacity. In particular it must be acknowledged that some devices are not radio-opaque so cannot be picked up on x-ray if retained.
- 5.3 Records of these agreements with users must be forwarded and held within the ITAPs CMG Management Team.
- 5.4 **Intention to use a device in this way should be discussed at the Team Brief before commencement of the surgery or procedure.**
- 5.5 It is accepted that adaptation/improvisation may be necessary in an emergent situation in the interest of patient safety.

Appendix Two: Count Procedures

1. Introduction

The following sections describe in detail the count procedures

2. Scope

- 2.1 These procedures apply to all areas within the Trust.
- 2.2 These procedures apply to all healthcare staff that are responsible for or are involved in the count procedures and include outpatient minor procedure rooms, delivery suites, Catheter Room Suites, Interventional Radiology, Endoscopy, obstetric areas and areas where LocSSIPs have been developed for use in CVC insertion, bronchoscopy, chest drain insertion, endotracheal intubation, tracheostomy insertion and NG Tube insertion. For the purpose of this policy it is requested that staff also make themselves familiar with the 'UHL Policy on Safety Standards for Invasive Procedures) Trust reference B31/2016 (V1)

3. Standards and Procedural Statements

Count Procedures and Standards
3.1 Responsibility for the Count
a) Counts must always be conducted by the Scrub and Circulating Practitioners. The lead for counts in most instances will be the scrubbed Practitioner but if there is any case of doubt by a member of the circulating team then they can ask the scrubbed practitioner to undertake a count at the soonest most reasonable time within the procedure/operation.
b) It is the responsibility of the Anaesthetist and Anaesthetic Assistant to ensure that if they insert a throat pack for anaesthetic requirements that the throat pack is recorded as part of the count on the theatre count white board. It is the anaesthetist's and Teams responsibility to ensure that the throat pack is removed at the end of the case prior to the patient leaving theatre. The anaesthetists must confirm this with the circulator and the circulator must count the throat pack down once confirmed. The Surgeon and Scrub Practitioner are responsible for counting a throat pack inserted for surgical requirements and must record this on the theatre count board but this must remain a whole Team approach. It is the responsibility of the surgeon to ensure that a throat pack inserted for surgical requirements is removed but all team members must remain vigilant and ensure that the throat pack is removed and counted down at the end of the case prior to the patient leaving theatre as per the 'Sign out' stage of the safer Surgery checklist prior to the patient leaving theatre.
c) Should reinsertion of the mouth gag result in the need to re insert a swab to assist haemostasis then the surgeon must tell the Team that a swab is being inserted and the swab recorded in red on the count board.
d) The surgeon must clearly tell the Team when the swab is removed and the scrub and circulator will undertake another final count and count the swab down from the board if the count is correct.
e) Re-entry of such accountable items such as 'BERT' Bags for e.g. must be recorded on the count board.
f) If an accountable item has been purposefully amended; for e.g. the tail being cut off a Bert Bag/tail being cut off a vaginal pack then the surgeon/Operator must ensure this is clearly communicated to the Team and recorded on the count board.

- | |
|---|
| g) It is best practise to implement 'sterile cockpit' rules for item counts such as 'Quiet for the Count' to ensure focus on this essential safety check. |
| h) Standardised easily readable count boards should be introduced where possible. |
| i) Count boards must not be obstructed/obscured. |

j) The overall responsibilities for ensuring the counts are correct at each stage and at the end of the procedure (final skin closure/completion for invasive procedures/surgery) lies with the lead Operating Surgeon/Operator. Anaesthetists have overall responsibility for throat packs inserted for anaesthetic needs. In all cases it is the responsibility of the Operating Surgeon/Lead Operator/Anaesthetist and registered professional to ensure that all counts are conducted correctly and documented as per the Safer Surgery Checklist 'sign-out'.

k) Where possible the same two practitioners should perform all counts that are undertaken during the invasive procedure. If staff change then a comprehensive handover must take place at the point of transfer of staff and a full count must be made to ensure all items are accounted for(see 3.2)

- l) Where there are multiple surgical and scrub teams involved in surgery on one patient:
- Independent counts must take place for each incision.
 - The Operating Surgeon/Operator of each team assumes responsibility for the relevant incision. It is the responsibility of the final scrub team and Surgeon/Operator to ensure that a **TOTAL FINAL COUNT** of all swabs for multiple procedures / Surgeons/Operators is correct. Even if one of the operative sites is closed, all swabs must be retained in theatre to conduct a final total count of all swabs used for the procedure
 - When there are multiple procedures on the same patients by the same surgical team/Operator with a single Scrub Practitioner, then counts must take place at the end of each individual procedure/cavity and wound closure
 - There should be two separate runners if two surgical teams are operating however this can be risk assessed.
 - If it is deemed to have two scrub and circulating teams then each team must have a separate white board to record the counts. Each circulator will be responsible for ensuring that their swab and instrument counts are correct and recorded appropriately on their board. It is not good practice to change circulating teams without a thorough handover and count. To reduce risk the circulator should only be involved in the one count and not change from scrub team to scrub team during dual procedures.

3.2 Changeover of Scrub Practitioner / Runner / Support Staff during the procedure

a) The Scrub Practitioner should ideally be the same for the whole procedure but where changeovers are necessary, this should occur only once and only in agreement with the Surgeon/Operator. In exceptional circumstances where more than one changeover is undertaken this should be logged as an incident on DATIX.

b) Should it be necessary for the scrub personnel to change for any reason during the procedure, a complete count of all swabs instruments and accountable items must be performed. This should happen between incoming and outgoing scrub practitioner at the changeover of personnel before the first Scrub Practitioner leaves the theatre. The patient's records/care plan must be signed by both members of staff.

c) If there is a changeover of circulator or support staff, there must be a swab count undertaken with the Scrub Practitioner prior to the first circulator / support staff leaving the theatre area and patient records should be signed. This must be recorded on the Operating

Room Management Information System (ORMIS) and in the Theatre Register immediately after the count is confirmed as correct. At this stage of the procedure if all swabs cannot be seen then this must be noted on ORMIS, Theatre Register and recorded in red on the theatre swab board until they have been accounted for. The time of changeover must also be clearly recorded on ORMIS and the Theatre Register. Areas within UHL must also keep accurate records within their systems.

d) If there is a changeover of anaesthetic staff and there is a throat pack inserted this must be handed over, observation of label/mark made and acknowledged that the throat pack is recorded on the swab board.

3.3 When to Perform a Count

a) Immediately prior to the commencement of surgery/ invasive procedure.

b) At the commencement of the closure of any cavity

c) A final count at the commencement of skin closure – all swabs must be physically seen and no assumptions of potential placement of swabs to be made, for example, swabs under retractors, packing (must see tapes)

d) Final removal of a mouth gag.

e) Prior to handover to another practitioner

f) Prior to leaving the operating table for a period of time (for example, for a break) or leaving the procedure room/lab or other areas within UHL.

g) Immediately on return to the operating table (once re-scrubbed) or procedure room within UHL.

h) Prior to the patient leaving theatre 'sign out' as part of the 'Safer Surgical Checklist' must be completed.

i) For patients who have had a vaginal pack inserted with the intention to remain in situ, please refer to section 3.11 'Documentation of swabs and other accountable items point (h)

Note: A change of scrub personnel / leaving the operating table or suite within UHL should be maintained to a minimum and preferably not at all.

3.4 Count Procedure

- At both the start and conclusion of the procedure/surgery all swabs, instruments and accountable items must be checked by the scrub practitioner/operator/Midwives and the circulating practitioner. All items must be recorded on a dry wipe white board.

- At both the start and conclusion of the procedure/surgery all swabs, instruments and accountable items must be checked by the lead surgeon/Operator. All items must be recorded on a dry wipe white board.

- After final removal of a mouth gag.

- Circulating staff must tell the scrub staff when adding or cancelling items on the white board.

- Any unaccounted items should be written on the white board in red and the surgical/operator team must acknowledge that they are aware verbally.

- Swabs purposefully being left in the cavity should also be recorded on the white board and signed in the register. Before purposefully leaving swabs in a cavity (for example to pack a site to reduce bleeding) a thorough swab count must be undertaken to account for all swabs. Once all swabs are accounted for the Scrub Practitioner/Surgeon/Operator and Circulating personnel must count the swabs together into the site to be packed. A record must be made immediately of the number of swabs intentionally left inside a cavity on the swab board, on ORMIS and in the Theatre Register. Any purposefully retained swabs must be documented in the operation note or procedure record and handed over to the person/persons providing the patients on-going care

once the patient leaves theatre (e.g. ITU/PICU/PACU/HDU etc.)

- There should be a formal handover between circulating teams; this must include a swab count and there should be a written and signed record on ORMIS. This should be kept to a minimum.

- The Scrub Practitioner must always tell the Surgeon/Operator that the swabs, instruments, needles and other accountable items are correct at the closure of each cavity.

- The Scrub Practitioner must always receive a verbal acknowledgement from the Surgeon/Operator that he has noted the status of the swab, instrument, accountable items and needle count.

- If a throat pack has been inserted due to anaesthetic requirements the Anaesthetist must confirm removal of throat pack with the anaesthetic assistant and circulator prior to patient being discharged from theatre/areas identified within UHL as per the 'Sign out' step of the UHL Safer Surgery checklist

- If a vaginal pack has been inserted and to be left in situ, refer to section 3.11 point (h) Make sure that any swab or tampon inserted into the vagina (or other cavity) is clipped to the drapes and recorded on the whiteboard

3.5 Swab Handling and Counts

(a) At the commencement of surgery the Scrub Practitioner should only open the minimum amount of swabs deemed to be needed for a procedure. Additional swabs can be added to the table as others are correctly accounted for and counted down.

(b) Catheter Suites:

- Within the Catheter Rooms Only 10 swabs should be on the Operator's trolley at any one time.

- Red tags are to be removed from the Operator's trolley and retained for a count at the start of the procedure when the swabs are first counted.

Swabs in excess of 10 are to be counted off the trolley in multiples of 5 into a clear plastic bag by the Operator to the second checker, into which the accompanying red tag/tie is also to be placed. Each plastic bag must contain only 5 swabs and additional counts of 5 swabs must be placed into a new plastic bag with the red tag/tie.

(c) The scrub and circulating practitioners must count aloud as the numbers of swabs in each bundle are checked and swabs must be completely separated and opened fully during the checking procedure. This is to ensure that integrity of the x-ray detectable markers in swabs, packs, pledgets etc., are checked as well as the identification of the linen tape and its security.

(d) Where multiple bundles of swabs are being checked at one time these must be counted into separate groups of five. These must not be added to those already counted until verification of the number in the packet. These must be counted separately into different piles.

(e) All swabs are packed in bundles of five, any package containing fewer or more than five must be removed from the procedure area and theatre immediately. An incident report form must be completed and a record of the packet serial number/batch number must be stated on the incident form.

(f) The red tags/ties from swab bundles must be counted when opening swab packs and retained by the scrub practitioner, these must be included in all subsequent counts. The red tags must then be used to confirm accuracy of 5 swabs being counted down and each red tag must be passed out at the count to correlate with 5 swabs that are counted down. **(Please refer to point (b) for Catheter Suites)**

(g) Swabs must be retained on the table and then counted out in batches of 5 with a red tag/tie into a suitable transparent bag at an appropriate time. The bag must have an ID label stating what size the swabs are and that there are x5. Only 5 swabs must be counted down with the red tag/tie into one plastic bag; additional bundles of swabs counted down must not be added to the same plastic bag. 1 plastic bag must contain 5 swabs and tag/tie only.

(h) The bags must be tied/secured and closed immediately after the count and retained in theatre/suite/clean room. The bags of counted down swabs must not be removed from theatre/suite/clean room until the final count is deemed correct by the Surgeon, Operator, Scrub Practitioner and circulating personnel and the patient has left the theatre.

(i) Swabs should not be cut up or altered in any way. **The only exception:** A mastoid swab cut in half to leave in the superior mediastinum of small babies when the chest has been left open post cardiac surgery. Only the 'raytec' section is to be placed under the mediastinum and recorded on the ORMIS care plan and theatre register. The retention of the swab will be handed over to PICU staff as per policy.

(j) In exceptional circumstances where an x-ray detectable swab is used as a dressing, the swab must be counted within the whole count and this must be recorded on ORMIS and in the Theatre Register/patient records.

3.6 Instrument Trays and Counts

a) The Scrub and Circulating Practitioners must count aloud the number and type of instrument as that are counted. The Circulating Practitioners must physically observe the trays/instruments as they are being counted.

b) All instruments should be checked against the instrument check sheet (also may be called the 'tray list') and the date, theatre, patient identifier and name of the circulating and scrub practitioner entered at each check on the instrument check sheet (see also section 2 of Appendix 1). This must also apply to single use procedure packs; for example those used within a Catheter Suite.

c) The Scrub Practitioner must be aware of the location of all equipment at all times during the surgery/procedure.

d) If a blade, needle, instrument or device breaks during use, the Scrub Practitioner/Operator

must ensure that all pieces are returned and accounted for. Any damaged instrument will compromise patient safety and must therefore be taken out of use immediately. If an instrument breaks an incident form must be completed and a defect raised with Synergy via the portal. Action must be taken to bring this to the attention of Synergy via the 'REDS' Team as soon as possible to ensure that a set is not quarantined any longer than necessary.

e) Instruments and items with screws and/or removable parts should also be included in the count.

f) The tray of instruments must not leave theatre/areas within UHL unless all items are returned and the instrument check sheet completed, extra/supplementary instruments must not be placed on the trays without being placed within a separate bag. All sharps must be removed from the tray/set prior to it being returned to Synergy.

3.7 Supplementary instruments (unit packed items)

a) All supplementary single/unit packed instruments must be counted and recorded on ORMIS or local area documentation for procedures in the 'Supplementary Extras' part of the patient record

b) All supplementary instruments must be counted and returned in a bag or tray to Synergy.

3.8 (A) Patient specific items for implantation Please refer to section 3.8 (B) for Hip Revision Surgery

If instruments/prosthesis/patches/grafts/valves/stents/devices etc. are to be retained inside the patient as part of the planned surgery/ procedure then it is imperative that:

a) The Operating Surgeon/Operator gives a clear and accurate description of the item he requires to the scrub practitioner. (to circulating team if there is a sole Medical Operator)

b) The Scrub Practitioner/sole Medical Operator gives clear and accurate description of the item to the surgeon/sole medical operator requires to the circulator.

c) The Circulator prior to opening the required instrument / prosthesis / patch / graft / valve / stent / device etc. must check the following with the scrub practitioner and then for a second time with the surgeon or sole medical operator (the details must be read out loud by the Scrub Practitioner and implanting surgeon prior to the item being opened and decanted onto the sterile operating field.. Both scrub Practitioner and implanting Surgeon must check the boxes and details with the circulator prior to opening. The labelling on the packaging must be read slowly and clearly.

d) For orthopaedic surgery the prosthesis should be checked and opened onto the trolley before the cement is prepared and implanted. A final check must be made by the implanting surgeon prior to the cementing. This check will be supported by 'check before you cement posters' in orthopaedic theatres (appendix 6), and by the procedural pause on the Safer Surgery Checklist.

PROSTHETIC CHECKS SHOULD INCLUDE:

- Name/make/Type/Model
- Manufacturer
- Size/length
- Side i.e. LEFT or RIGHT
- Contour: i.e. Curved or straight, long or short
- Expiry date
- Integrity of sterility
- Any other relevant detail pertinent to the type of prosthesis etc. requested by the operating surgeon/sole medical operator.
- Before implantation all prosthesis must be checked to ensure that manufacturer compatibility is confirmed by the operating surgeon to the scrub and circulating Team.
- That the prosthetic checks have been undertaken and must be included on the Safer Surgery WHO checklist in the prosthetic checks and implant section

e) The Scrub Practitioner prior to handing the item to the operating surgeon must repeat the above details to the surgeon again and they must give a verbal acknowledgement to the scrub practitioner that this is the item they want before they implant into the patient There should be a pause at this point and the theatre team encouraged to raise any concerns prior to implantation.

f) For the implantation of lenses within ophthalmology there are specific checks that must be undertaken prior to a lens being implanted. Strict adherence to the 'Intra Ocular Lens Protocol' must be undertaken for each and every lens implantation. The Intra Ocular Lens Protocol can be found in appendix 4 of this policy and is also displayed within the ophthalmology theatres.

3.8 (B) Hip Revision - Patient Specific Items for Implantation (When it may be that not all parts of the prosthesis require replacement)

The process of checking the actual prosthesis for implant must be undertaken as per section 3.8 (A) above but prior to revision hip surgery the following procedures must be adhered to:

a) Prosthesis used in hip replacements come as modular components:

- Lateral stem
- Femoral Head
- Acetabular cup

b) Modular components must be from the same manufacturer and checked for compatibility

c) When revision surgery is booked, details of prosthesis size must be requested. The size of the acetabular cup should never be assumed.

- d) The check of previous implanted prosthesis size must be undertaken by two members of staff **preoperatively**, one of which must be the operating surgeon. This is to clarify the size of the current prosthesis.
-
- e) On identification of the required prosthesis this must be written on the 'UHL Safer Surgery' checklist and the white count board in theatre.
-
- f) All staff must follow the Standard Operating Procedure (SOP) for Revision Surgery where not all the previous implants are being revised. **The SOP can be found as Appendix 5 of this policy. The SOP must be displayed in all orthopaedic theatres.**

3.9 Instrument Counts for Orthopaedic Resurfacing and Revision Hip and Knee Surgery

- a) For orthopaedic 'Resurfacing' and 'Revision' (Hips and Knees) due to the volume of instrument trays and to ensure we maintain sterility in line with best practise guidance, trays will continue to be reopened at the point of need within the laminar flow environment.
-
- b) All swabs, needles and sundries must be counted as per policy. For 'Resurfacing' and 'revision' only, the final instrument counts can be completed immediately post procedure and before the next patient enters theatre. **The final instrument count must be completed before the patient leaves Theatre.**
-
- c) A confirmed instrument count must be verbally reported to the Surgeon and Team. The final instrument count must then be recorded and signed by the scrub practitioner on the patients ORMIS care plan in Recovery prior to the patient's discharge.

3.10 Count Discrepancy

- a) In the event of a count discrepancy the Operating surgeon/Operator must be informed immediately and a decision made to stop the closure of the wound if appropriate to allow the item to be found. This should be declared a '**Stop the Line**' moment.
-
- b) Immediately record the missing item on the board in red. The anaesthetist must be informed immediately if there is a discrepancy with a throat pack.
-
- c) If something is missing, until proven otherwise, it must be assumed that the item is in the wound. This policy also applies to a situation where a scrub practitioner or any member of the Team has reasonable doubt about the confirmation of the count. If an item is **thought to be missing** then the count discrepancy procedures must be invoked immediately.
-
- d) If there is a discrepancy in the swabs, throat pack, instruments /devices and sundries, the Surgeon/Anaesthetist/Operator/Scrub Practitioner must check the operating site, drapes, sterile bags, instrument trays, receivers and trolleys.
-
- e) All swab bag contents must be recounted, all rubbish bags must be opened and checked, linen bags must be checked as should the floor and anywhere else in theatre or Clinical Area.
-
- f) If the count is incorrect, the item missing must be recorded on the swab board, **in red** and

the Practitioner in Charge must inform the Theatre Coordinator/'Floor Control' and assist with the search. In any area within the Trust that does not have swab count boards: staff must ensure every effort has been made to record counts on hard copy. This also applies to an emergency situation.

g) If a thorough search does not locate the item **then appropriate imaging (refer to 5a.3) must be performed before the patient leaves theatre/other areas of UHL (for e.g. angiography suites/clean rooms).**

The only exceptions are as stated below contained in points h, I and j.

h) The decision to remove the patient from theatre or any area within UHL where this policy needs to be invoked without appropriate imaging is only as a result of the balance of risk being in the favour of the patient needing transfer to the next care area (e.g. ITU/PICU) and this need for transfer being higher than the doubt that the unaccounted item remains within a patient cavity. This decision must be made by the Operating Surgeon, Anaesthetist or Medical Operator. This must be clearly documented by the lead operating surgeon in the medical notes and ongoing plan such as for example; an X-ray once the patient has stabilised should be clearly documented and handed over to the next area of care. Theatre staff must document this decision on ORMIS and the Practitioner in Charge must complete a Datix.

i) Small items that are unaccounted for within closed ophthalmology procedures must be searched for by the senior surgeon using a microscope as this will provide the most efficient visual check as opposed to X-ray.

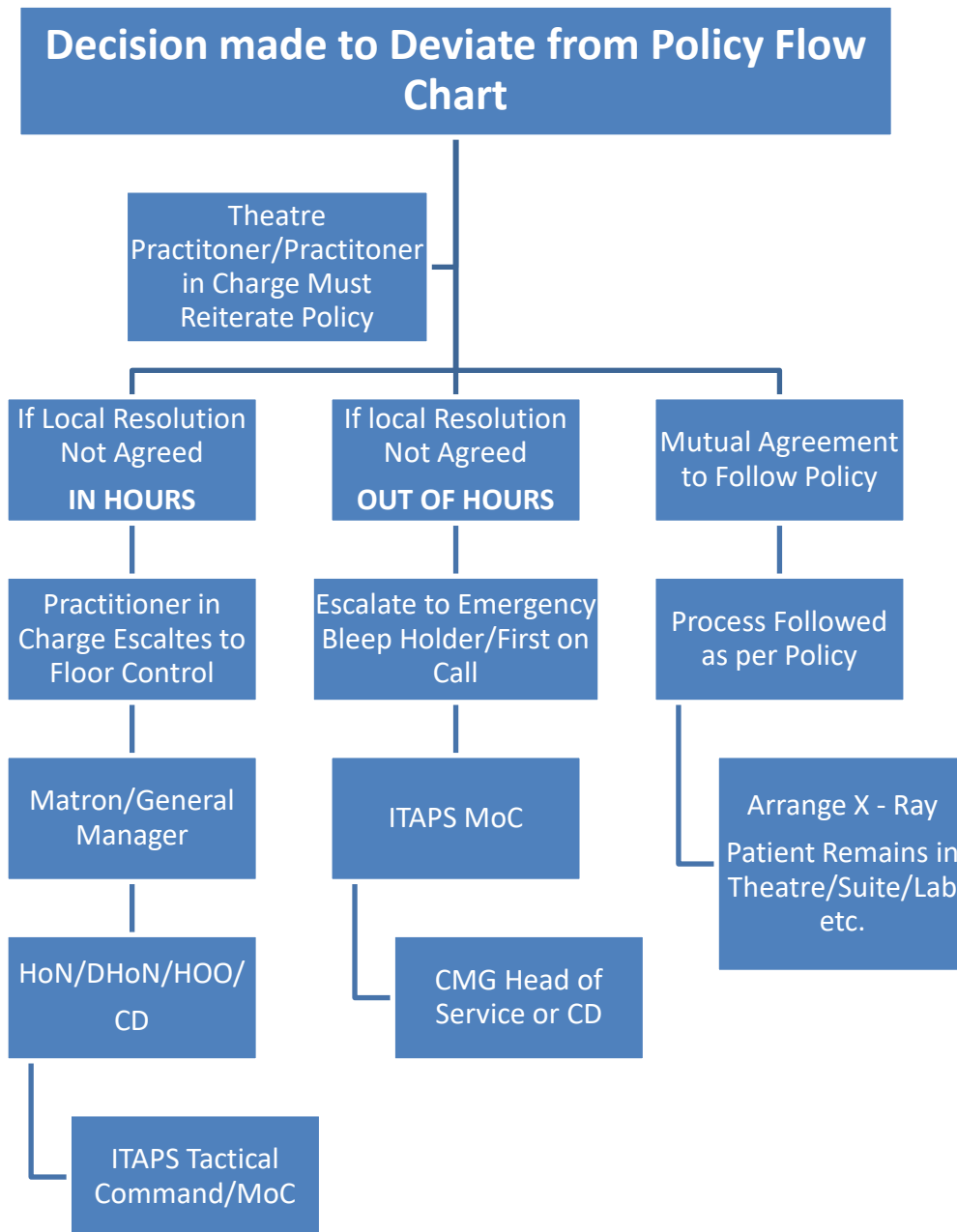
j) Searching for missing micro items (for example: needles which cannot be detected on X-ray) should be performed at the discretion of the surgeon.

- Missing micro items (e.g. needles that cannot be detected on x-ray), must be recorded on ORMIS following thorough search of the area (using the microscope where appropriate). Image intensifier should not be used as they may fail to locate radio opaque swabs and micro needles. **Point of Note:** The current position within Radiology is that a suture needle that is smaller than an 8mm needle will not be clearly visible on X-Ray. Further research is being undertaken and the latest evidence will be added to this policy immediately.
- All missing items must be documented on the final count care plan and in the operation record and signed as **incorrect** by the surgeon, the scrub practitioner and the circulating practitioner.
- The scrub practitioner must also document any discrepancy within the operating theatre register
- The scrub practitioner must complete an incident form.
- The Matron for theatres must be informed as soon as possible.
- For needles smaller than a 8.0mm it is at the surgeon's discretion to X-ray (Please refer to 'Point of Note' as above)

k) If the Operating Surgeon/Anaesthetist/Operator is not the person responsible for the patient's overall care (i.e. not the Consultant) then immediate escalation to the Consultant should take

place whilst the patient is still in the operating theatre/area of procedure and prior to closure of skin.

I) The Escalation Process documented below must be adhered to:



Team work is safe work therefore:

- Circulating staff need to communicate clearly to the theatre team if they doubt the count is correct
- Surgeon/Scrub Practitioner/Anaesthetist/Operator needs to communicate clearly to the

team if they think an item may be missing. This also applies to any member of the team.

- If something is missing then everyone needs to work to find the item
- Swabs and instruments must not be taken out of theatre/or any area within UHL as defined in section 2 without the agreement of the scrub staff.

3.11 Documentation of Swabs and other accountable items (Elective)

a) Pre-operatively/procedure and intra-operatively/procedure the live status of the count is recorded on the dry wipe white board

b) The Theatre Register should be signed by each Scrub Practitioner so that it is agreed by the scrub teams at handover that the swab, needle and instrument check was complete and correct at the handover point. For non-theatre areas then records will be as per local procedure. Theatre staff working in any other area of UHL outside of an operating theatre will make every effort to document a live count and transfer the information later to the theatre register and ORMIS.

c) A record should be made of swab counts on ORMIS and the Theatre Register at each handover. The ORMIS Care Plan must also include details of the counts for instruments, throat packs and other accountable items.

d) At the end of the surgical procedure the Scrub and Circulating practitioners must record that satisfactory checks have been completed and documented in the appropriate theatre records. As a minimum this will be the Theatre Register and the ORMIS theatre system. The names of those staff involved in the counting procedure must be clearly documented.

e) Never sign for counts that you have not taken part in.

f) Staff completing the final count must also provide their signatures in the Theatre Register and print a copy of the patient's care plan and final count from ORMIS and sign by their names on the final count sheet. The ORMIS care plans must follow the patient throughout their journey. To identify the ORMIS Care plans to on-going care areas Theatre staff must print these out on pink paper.

g) The dry wipe white board is wiped clean once the permanent record has been completed and the patient has left theatre.

h) All items that are to remain in the patient, by intention, must be recorded in the nursing care plan, surgical notes, ORMIS and Theatre Register. Items remaining in the patient must also be verbally handed over by the Scrub Practitioner to the person delivering that patient's immediate post-operative care

i) Vaginal packs that remain in situ by intention must be clearly documented in the patient's notes and handed over to the next care area. It is the responsibility of the obstetrician and midwife to ensure that the ward staff are aware that a vaginal pack has remained in situ and will need to be removed. Such instances are following insertion of a Bakri Balloon to reduce risk of post-partum haemorrhage. It must be clearly documented in the patient notes that the balloon and pack will need to be removed. A "Bakri Intrauterine Balloon and Vaginal pack insitu" form must be completed and attached to the front of the woman's hospital notes. The red in situ

sticker must be placed on every history page within the notes and on each page of the HDU chart. This is the responsibility of the operator who leaves the pack in. The pack must be removed prior to transfer to the postnatal ward.

j) Sign out within the 'UHL Safer Surgical Checklist' at the end of the procedure and prior to the patient leaving must be completed by the theatre team to check counts are correct and throat pack has been removed.

3.12 Instrument Documentation

a) The instrument check sheet must be returned with the instrument tray inside a clear plastic bag to Synergy. The list must record the date, theatre/room, patient identifier and name of the Circulating and Scrub Practitioner/sole Medical Operator responsible for the opening and final count.

b) The instrument checklist must be signed at the end of the operation by the final circulating practitioner who has physically seen the instruments and counted them with the scrub practitioner against the instrument tray list and against any supplementary outer packets.

3.13 Documentation of Swabs used to pack a Body Cavity

a) Any swab placed inside a cavity as a pack must be recorded on the dry wipe white board, for example, '*1 swab in wound 10 x 7.5cm*';/ '*Adrenaline soaked swab inserted to reduce bleeding*'. When the swab is removed it must be cancelled off the board. It is the Surgeon's responsibility to ensure that the Scrub Practitioner is aware of any pack that is to remain behind / under / around any organ or within a body cavity (e.g. vagina). The swab must be recorded on the theatre white board and counted out appropriately.

b) When these actions take place a verbal acknowledgement between the Scrub Practitioner, the operating surgeon and circulating practitioner must occur.

c) If a counted swab is intentionally used to pack a cavity and to be left in situ at the end of the procedure:

- Prior to intentionally using a swab/swabs to pack a cavity the operating surgeon must ensure he verbally communicates this to the scrub nurse **and prior to starting to insert swab/swabs/vaginal pack/ a thorough swab count must be undertaken to establish count is correct**. Once count is correct the Scrub Practitioner will inform the Circulator that swab/swab insertion count is to be undertaken and scrub practitioner will instruct count correct to surgeon and safe to commence swab packing. The Scrub Practitioner will count each swab and size in with the Surgeon and Circulator. The Circulator must keep a correct count on the white board in red of the number and size of swabs left in situ.
- This must be documented on the patient's care plan, in the Theatre Register, on ORMIS and by the Operating Surgeon in the medical notes.
- On transfer of the patient to ICU/CICU/PICU/HDU/ward area the Scrub Practitioner must accompany the patient and verbally state how many swabs are in the wound or packs in situ. ICU staff will record this on the ICU chart to ensure all clinical staff are aware.

Note: If a patient comes to theatre with an x- ray detectable swab as a dressing or pack, the

Scrub Practitioner must be informed, the swab discarded into a clinical waste bag and the bag removed from theatre. This must be recorded on the care plan and in the Theatre Register.

3.14 Emergency Surgery/Procedure (which must be done quickly to save life, limb, or functional capacity) or (re)opening of a body cavity outside of an Operating Theatre Environment (e.g. ITU/PICU / PACU / Resus / Catheter Lab/Recovery/Clean Room/Radiology suite/obstetric maternity areas / ward areas / ED)

a) Emergency surgery/procedure required outside of an operating theatre often necessitates both UHL Scrub and Circulating Practitioners to work with speed. Due to the nature of emergency surgery/procedure there is an increased risk of retaining swabs, instruments and sundries. The swab policy must be adhered to and all practical efforts made to balance the risk of the speed and urgency required to ensuring all counts are correct prior to the closure of the final wound/cavity.

b) Wherever is practically possible all instrument/tray checks should be adhered to as per policy but due to the urgency of the procedure these may need to be undertaken as per policy at an appropriate time and certainly before the final closure when the patient is stable.

c) Swab, needle, throat pack, vaginal packs, vaginal devices, Guidewires, introducers and sundries **must** be counted as per policy or relevant LocSSIP with no deviation for any area within UHL/Alliance.

d) Wherever possible a portable white board should be used to record counts for surgery/procedures within UHL outside of a designated operating theatre/procedure room.

e) Used swabs must not be thrown onto the floor or placed anywhere apart from being discarded into a swab bucket/clear plastic swab bag or appropriate receptacle.

f) Remaining swabs used once the patient is prepped and draped should be handled as per policy.

3.15 Non X-Ray Detectable Swabs

a) It is not acceptable practice to use non x-ray detectable swabs (of the type used on wards) to pack wounds or cavities unless a delay in obtaining alternatives would be a danger to the patient's life.

b) This must also be considered when using adapted equipment or devices

3.16 Reducing the risk of retained throat packs after Surgery

a) Actions outlined in the Safer Practice Notice 'Reducing the risk of retained throat packs after surgery' National Patient Safety Agency 2009. Accessed via:

<http://www.npsa.nhs.uk/nrls/alerts-and-directives/notices/throatpacks/>.

(Refer to Appendix Four – NPSA Throat Pack Flow Chart)

b) The decision to use a throat pack should be justified by the Anaesthetist or Surgeon for each patient as appropriate. This person should assume responsibility for ensuring the chosen safety procedures are undertaken. The team must ensure throat packs are included as per accountable items. Surgical requirement of throat pack must be checked and removed by the Surgeon at final count. Anaesthetist requirement of throat pack must be checked and removed by the Anaesthetist at final count but it is a whole Team responsibility to ensure that the Throat pack is removed and accounted for.

c) At least one visually-based and one documentary-based procedure should be applied whenever a throat pack is deemed necessary as per 3.17 below.

d) Any throat pack must be recorded on the count board.

3.17 Recommended standards for reducing the risk of retained throat packs after surgery

a) Procedures involving visual checks:

- Label or mark patient on the head with an adherent sticker or marker
- Label artificial airway (for example, tracheal tube or supraglottic mask airway)
- Attach pack securely to the artificial airway
- Leave part of the pack protruding

b) Procedures involving documentary checks:

- Formalised and recorded 'two-person' check of insertion and removal of pack
- Record insertion and removal on swab board
- Record insertion and removal on the ORMIS final count care plan documentation.

3.18 Recommended standards for reducing the risk of wrong tooth extraction.

Please Refer to the Safer Surgery Policy (Trust ref: B40/2100) version 3.0

a) If there is a requirement for surgeons/assistants to change sides whilst at the operating table a second count back to reconfirm the position of the tooth must be performed with the scrub and circulating team prior to any tooth extraction.

b) **'Pause before you Pull'** A 'Pause before Extraction' must be undertaken by Surgeon, Scrub Practitioner and Anaesthetist prior to extraction. They must have a stop moment to check consent and site before proceeding. If there are any distractions, the Stop Moment must be undertaken again so that it occurs immediately before extraction.

3.19 Recommended standards for reducing the risk of retention of Medical Devices; both those manufactured for that purpose and those that are not manufactured for the purpose but agreed by the user to be appropriate for that operation/procedure.

a) It is acknowledged that users will at times use a device that is not manufactured for that purpose. All devices must be risk assessed for suitable alternatives that are manufactured for purpose where possible. There is to be a signed agreement from the User agreeing that they take responsibility to continue to use a device that is not manufactured for that purpose. These records are to be retained with the CMG and forwarded to the ITAPS Management

Team.

- b) At Team Brief it is essential that the Surgeon/Operator explains their preferred technique for the surgery/procedure to be undertaken if it involves the use of a modified device.
-
- c) If after review it is agreed by the user that they will continue to use the device then these devices must form part of the count procedure and follow the stringent processes of counting and recording as outlined within this policy.
-
- d) All devices that are being used as part of the procedure must be counted and added to the count board
-
- e) All devices may only be inserted into a cavity once the surgeon has clearly verbalised to the Team that the device is being inserted. The device must then be recorded immediately on the count board.
-
- f) The same process must be followed to confirm removal; with the surgeon clearly verbalising to the Team that the device is being removed. The scrub practitioner will then confirm removal with the circulator and the device can be counted down on the board as per count process.
-
- g) Ideally the device should be handed out to the circulator but should the device be required for potential re use it can remain within the sterile field. The above process must be strictly repeated should the device be required to be used again for the surgery/procedure.
-
- h) Any such device should be considered throughout the procedure as an 'Other accountable item' as defined in Appendix One of this policy.
-
- i) The whole Team have equal responsibility in ensuring that counts are correct and for letting other members of the Team know when packs or devices are placed into a body cavity and subsequently removed.
-
- j) The use of such devices should always form part of the 'accountable items counts' and be recorded on ORMIS and reflected in the operation/procedure note.
-
- k) Surgical teams should consider the use of templates to improve the standard operation note and to include prompts regarding the use of, for example, 'specific intra-vaginal' devices.

3.20 Recommended Standards for reducing the risks of retained Guidewires/Introducers.

- a) Adhere to safety checks and processes outlined in the relevant CVC/PICC/Midline insertion LocSSIP (refer to Safer Surgery Policy)
-
- b) A named person (Nurse/ODP/HCA, TSA etc.) must be allocated to assist the operator during the insertion of central lines and to ensure completion of LocSSIP checks and

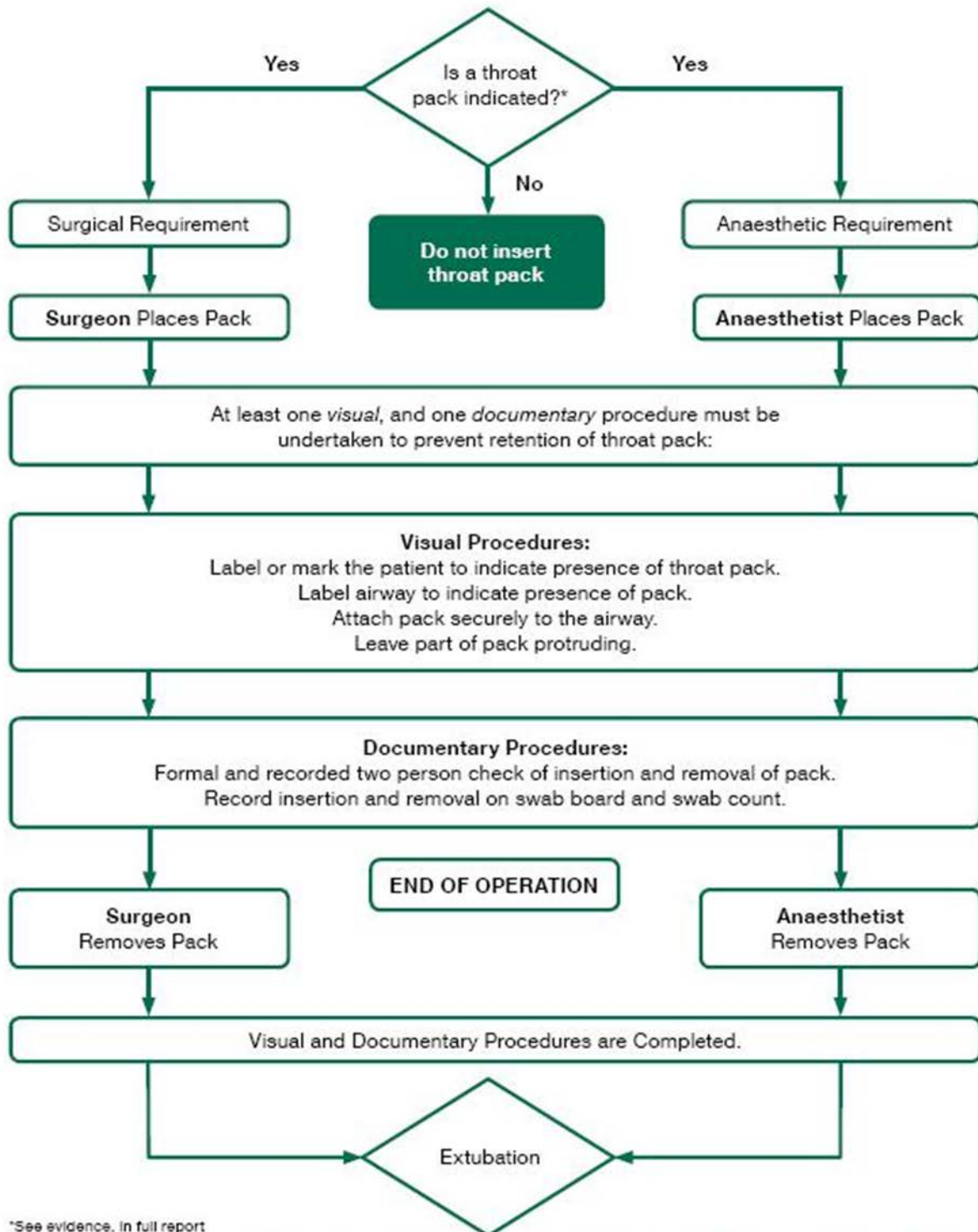
documentation.
c) All guide wires used must be accounted for and counted and checked at the end of the procedure to ensure that all have been disposed of.
d) There must be confirmation of the integrity of the guidewire/introducer prior to the final count and not just its presence. This should include consideration as to whether any of the guidewire/introducer could have broken off during the procedure.
e) Where there has been difficulty either introducing or removing the guidewire/introducer, the guidewire/introducer must be measured to confirm it is intact; and where appropriate, the clinical team should consider the need for an intraoperative x-ray if uncertainty remains. Where difficulty has been encountered, steps taken to confirm integrity of the guidewire/introducer should be recorded in the procedure note in the patient's medical record and on the theatre operating system.
f) PICC lines used at UHL are radio-opaque so therefore a guide wire should never be left in situ.
g) All guide wires must be removed by the Anaesthetist before the patient leaves theatre. The Recovery/PACU Team must never be expected to remove a guide wire.
h) Distractions should be kept to a minimum whilst inserting a guidewire/CVC. It is acknowledged that whilst there is no standard formal mechanism in place for preventing avoidable interruptions during procedures, as in all areas, we should protect patients' privacy and dignity for direct patient interventions/interactions/sensitive communication purposes.
i) Non-life/limb threatening interruptions should be avoided until patient-invasive interventions are complete. Staff must try to avoid non-time critical interruptions during invasive procedures.
j) The clinician must make sure they can visualise the guidewire at all times during the procedure.
k) All packs with guidewires opened must be accounted for at the end of the procedure.
l) Following completion of the procedure the operator must perform a sign out with their allocated assistant.
3.21 Recommended Standards to Reduce Wrong Side Regional Anaesthetic Block.
a) Continue to follow the current Trusts guidance on 'Stop Before You Block' until roll out and implementation of the new National Standards Operating Procedure ' Prep, Stop, Block '
b) Acknowledge that the original poster stated that the STOP moment should take place immediately before needle insertion and that the site should be reconciled with the surgical site mark, later research indicated that this was widely misinterpreted. The recommendation that both anaesthetist and assistant should check together was overlooked, and the 'stop' moment was too often performed at the WHO 'sign in' to the anaesthetic room which was up to 30-45 minutes before block placement.
c) Please refer to Appendix Ten 'Prep Stop Block' Poster and Appendix Eleven 'Prep Stop Block Stages as Defined by National SOP.
3.22 Health and Safety
a) Gloves must be worn for dealing with contaminated swabs
b) Prevent blood splashing as much as possible
c) Ensure that any contamination is cleaned and disinfected as per UHL Policy and Procedures Cleaning and Decontamination for Infection Prevention and Control (Trust Reference B5/2006) <i>and Decontamination agents or Methods, Actions Uses and Considerations (2007 Inside</i>

d) Ensure hand hygiene practices are followed

e) A 'safe sharp' disposal system is to be used for the storage and disposal of needles, blades and other sharp items. Under no circumstances must sharps be returned to Synergy within used instrument trays/sundries.

f) All instruments must be accounted for and removed from the theatre at the end of the procedure

Appendix 3: NPSA Throat Pack Flow Chart



*See evidence, in full report

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Appendix 4: Intra Ocular Lens Protocol

Delivery

- On receipt of delivery of bank stock lenses the lenses are to be checked against the delivery note and **always** placed directly into the appropriate bank lens stock cupboard.

Selection

- During the Team Brief prior to the commencement of the operating list any special order lens (i.e. ordered on a named patient basis) is confirmed as available within the department but **NOT** placed in theatre until the appropriate patient is in theatre.
- Once the patient has arrived in the anaesthetic room, the operating surgeon must check the biometry results with another member of the theatre team, following which the confirmed lens details must be immediately transcribed on to the theatre white board by the surgeon and the appropriate lens selected from the lens store by the surgeon.
- As part of the UHL Safer Surgery Checklist Time Out 'Before start of surgical intervention' phase on asking "**Have equipment requirements been sorted?**" there must be a further confirmation by the surgeon and a member of the theatre team that the correct lens has been selected by again referring to the patient's biometry results in the medical records.
- Prior to the opening of the lens visual and verbal confirmation is gained from the scrub and circulating practitioners and the operating surgeon checking that the correct make, model and power of the lens to be used is that stated on the white board.
- Once the lens is insitu the lens traceability stickers are placed within the patient's notes, theatre register and lens order sheet/book by the circulating practitioner.

Important

- If at any time two or more lenses are found to be in theatre mid surgery then a '*time out pause*' must ensue, where the surgical team confirm verbally and visually which is the correct lens to be used all other lenses must be immediately removed from theatre. Biometry results must be the only determining factor to select the correct lens.
- If during surgery the operating surgeon identifies a clinical need to change from the pre-selected lens then the circulating practitioner may acquire it from the lens bank stock cupboard but a '*time out pause*' must occur prior to the opening of the lens for the operating surgeon to visually and verbally confirm it is the appropriate newly chosen lens. The pre-selected lens must then be removed from theatre.
- If a lens is sited within the patient but later removed the lens traceability stickers must remain insitu in the theatre register, patient's notes and lens order sheet/book but removed written at the side/on the sticker.

Agreed by - Mr J. Dean; Head of Ophthalmology Service & Paula Higgins; Team Leader Ophthalmology Theatres & Recovery.

APPENDIX 5

STANDARD OPERATING PROCEDURE FOR REVISION SURGERY WHERE NOT ALL THE PREVIOUS IMPLANTS ARE BEING REVISED

Where possible every effort should be made to obtain previous implant details prior to patient surgery.

- 1. The notes must be checked with two people (one being the operating surgeon) to ascertain what was previously implanted in the patient, from product information labels and previous operation notes (where available)**
- 2. If available the previous operation implant details should be recorded on the swab board.**
- 3. When revising a joint that has been carried out at another hospital and product identification labels or surgical notes are not available, the explanted prosthesis should be examined for product information, size, diameter etc.**
- 4. It is essential that manufacturer details are also checked to ensure compatibility.**

Note: Healthcare Safety Investigation Branch (HSIB) has just completed a report into ‘Investigation into the implantation of wrong prosthesis during joint replacement surgery. This was completed in June 2018 so further recommendations may need to be added to this policy/ appendix prior to the next review.

Check before you cement!



Prosthesis

- ✓ Manufacturer & model
- ✓ Expiry date
- ✓ Side & Size

Why?

In 2013 in UHL we cemented a RIGHT prosthesis into a LEFT knee.
In 2014 we used a 32mm head with a 28mm cup during a THA. In
2017 a dated/expired plastic insert was used in a TKA.

In 2018 the national HSIS investigation in to the implantation of
wrong prostheses during joint replacement surgery recommended
including verification of manufacturer as part of the component
compatibility prosthetic check

Patient

- ✓ Anaesthetist aware
- ✓ Cardiovascular stability
- ✓ Vasopressors available

Why?

3% of patients drop their BP >40% during cement implantation and
up to 1% may have cardiac arrest. (AAOS guidelines 2015)

Dr J Gross, Assoc Prof R Ashford June 2018

Appendix 6

REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

V8 – April 2023 – Updated to Reflect:

General additions with word additions/ improvement in grammar and role title changes and definitions highlighted in red text throughout Policy.

(5) Policy Statements – addition of:

5a.3 Appropriate Imaging: This will need to be confirmed and considered by the lead medical staff. Radiology currently advises that normally fluoroscopy would be used in the first instance but x-ray may give better contrast and resolution; but the decision would depend on the surgery site and the missing item. For e.g. Dental Swabs and the ties from swabs missing in a thoracic or abdominal cavity would likely not show up.

(3) Standards and Procedural Statements; addition of section 3.1 to include responsibility of counts (e) – (i)

Decision made to deviate from Policy Flow Chart – Updated

3.20 ‘Recommended Standards for Reducing the Risks of retained Guidewires/Introducers’ – Additional of points (a) – (l)

Section 3.21 added – ‘Recommended Standards to Reduce Wrong Side regional Anaesthetic Block – point (a) – (c)

Additional Appendices:

(8) Safer Surgery Check List (Check ‘Stop Before You Block’)

(9) ‘Stop Before You Block’ Poster.

(10) Prep Stop Block Poster (To be rolled out at UHL)

(11) Prep Stop Block stages defined as per National SOP.

APPENDIX 7

Policy Summary Chart

Swabs and accountable items

Everyone is accountable!

- The swab and accountable items policy has been updated with changes in some processes following patient safety incidents within UHL
- **Scrub practitioner role; Team responsibility**
- Support the scrub practitioner with silence, time, and space to concentrate on their task
- **Quiet for the count!**
- Take particular care with additional extras, dental gags and throat packs, and the use of unusual items
- Assume any missing items are retained in the patient until proven otherwise
- **Always prioritise patient care**






Team safety for patient safety



Appendix 8

Safer Surgery Check List

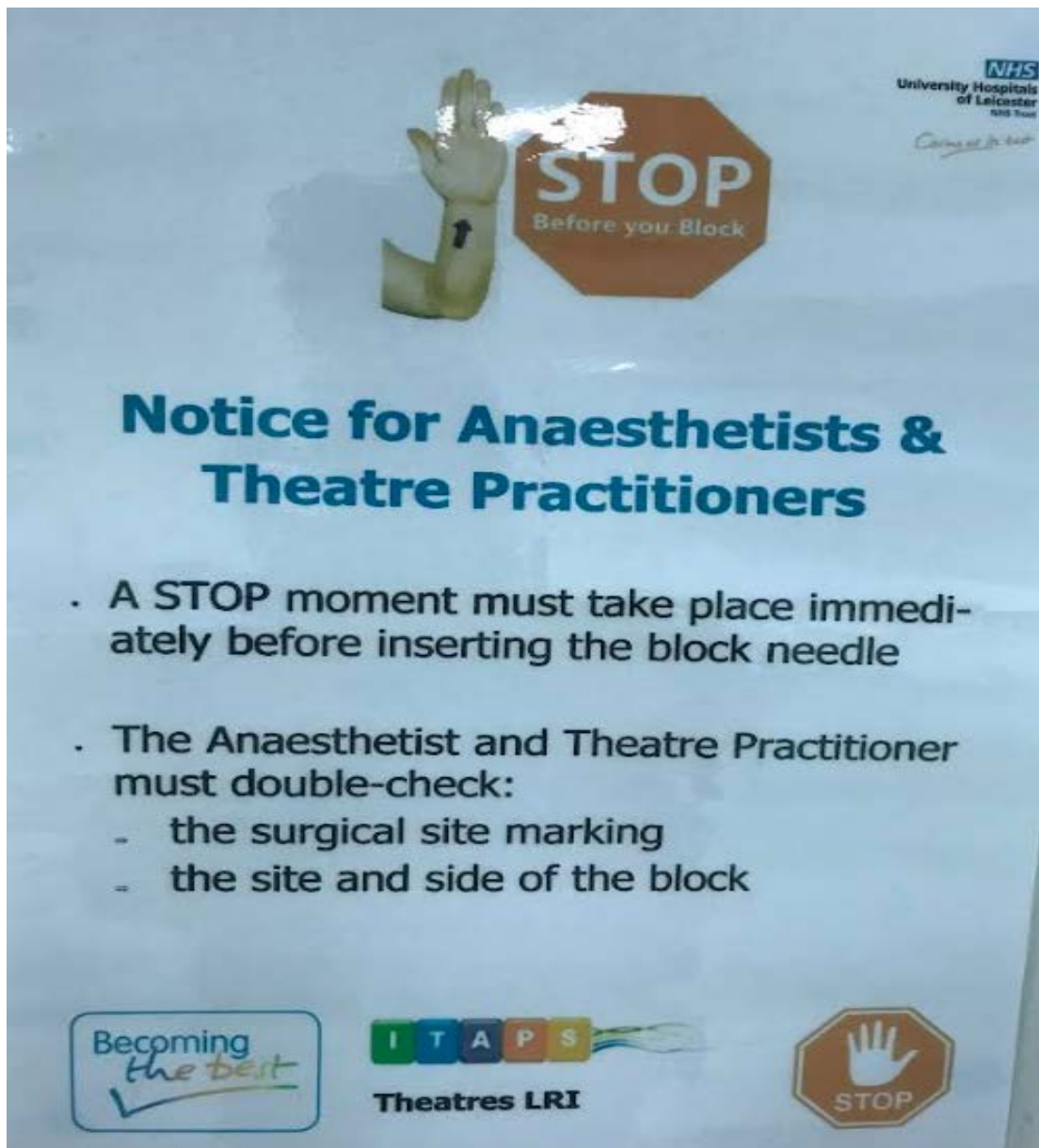
For Local Blocks it is Imperative that the ‘Stop Before You Block’ check is completed by the Anaesthetist and Anaesthetic Practitioner as per ‘Sign In’ checks identified below:

		UHL Safer Surgery Checklist			 <i>Caring at its best</i>
SIGN IN		TIME OUT		SIGN OUT	
<p>Prior to any anaesthetic intervention, in the presence of the ODP and surgeon, the anaesthetist should check against wristband, consent, and confirm verbally with patient or guardian.</p> <p><input type="checkbox"/> Confirm patient's name, date of birth and Hospital number</p> <p><input type="checkbox"/> Confirm procedure and site with patient</p> <p><input type="checkbox"/> Confirm valid consent form matches identity and expected procedure</p> <p><input type="checkbox"/> Surgical Site Marked and visualised <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Required implants / Instruments available (if relevant)</p> <p><input type="checkbox"/> Known allergy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p><input type="checkbox"/> Anticipated difficult airway or aspiration risk <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Equipment / assistance available</p> <p><input type="checkbox"/> Anticipated blood loss >500ml (>7ml/kg in a child) <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Blood products available if needed</p> <p><input type="checkbox"/> Use of cell salvage considered</p> <hr/> <p>'STOP BEFORE YOU BLOCK' done <input type="checkbox"/> Yes <input type="checkbox"/> N/A</p>		<p>After positioning and before skin incision the Surgeon, Anaesthetist and Theatre team members should verbally confirm with reference to the consent form, and wristband;</p> <p><input type="checkbox"/> Team members have introduced themselves by Name /Role</p> <p><input type="checkbox"/> Confirm patient name, Hospital number, date of birth</p> <p><input type="checkbox"/> Procedure, site and position</p> <p>Surgeon</p> <p><input type="checkbox"/> Equipment requirements</p> <p><input type="checkbox"/> Expected duration</p> <p><input type="checkbox"/> Blood loss anticipated</p> <p><input type="checkbox"/> Blood product availability +/- use of cell salvage <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Concerns or potential critical events</p> <p>Anaesthetist</p> <p><input type="checkbox"/> Patient's ASA status</p> <p><input type="checkbox"/> Patient specific concerns or serious comorbidity</p> <p>Scrub Practitioner</p> <p><input type="checkbox"/> Sterility of instruments confirmed</p> <p>Surgical site care bundle</p> <p><input type="checkbox"/> Antibiotic prophylaxis given within the last 60 minutes</p> <p><input type="checkbox"/> Patient Warming</p> <p><input type="checkbox"/> Glycaemic control <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Hair removal with clippers</p> <p><input type="checkbox"/> DVT precautions discussed and undertaken <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Essential imaging displayed or reviewed</p>		<p>Before any member of the team leaves the operating theatre, and not before completion of the first surgical closing count, the team should verbally confirm:</p> <p><input type="checkbox"/> what procedure have you performed and is it correctly recorded</p> <p><input type="checkbox"/> the count is correct for all instruments, swabs, throat packs and sharps</p> <p><input type="checkbox"/> any specimens are correctly prepared and labelled</p> <p><input type="checkbox"/> any equipment issues identified</p> <p><input type="checkbox"/> estimated blood loss</p> <p><input type="checkbox"/> any transfused blood products are recorded on Blood Track</p> <p><input type="checkbox"/> antibiotic treatment documented</p> <p><input type="checkbox"/> VTE care bundle discussed</p> <p><input type="checkbox"/> all cannulae and extensions have been flushed</p> <p><input type="checkbox"/> key concerns for recovery and postoperative management, including if higher level of care required</p> <p><input type="checkbox"/> issues for de-brief noted</p>	
		INTRA-OPERATIVE PAUSES N/A ■			
		<p><input type="checkbox"/> Prosthetic check</p> <p style="margin-left: 20px;">*Surgeon and scrub practitioner confirm correct implant and expiry date and details entered in the patient record</p> <p><input type="checkbox"/> Check before you cement - confirm with anaesthetist</p> <p><input type="checkbox"/> Pause before you pull</p> <p style="margin-left: 20px;">*Surgeon and scrub practitioner confirm dental identification prior to extraction and repeat if operator switches sides</p>			
Read out by: (PRINT) _____ Signed: _____		Read out by: (PRINT) _____ Signed: _____		Read out by: (PRINT) _____ Signed: _____	
Page 2 UHL Safer Surgery 12/17					

Appendix 9

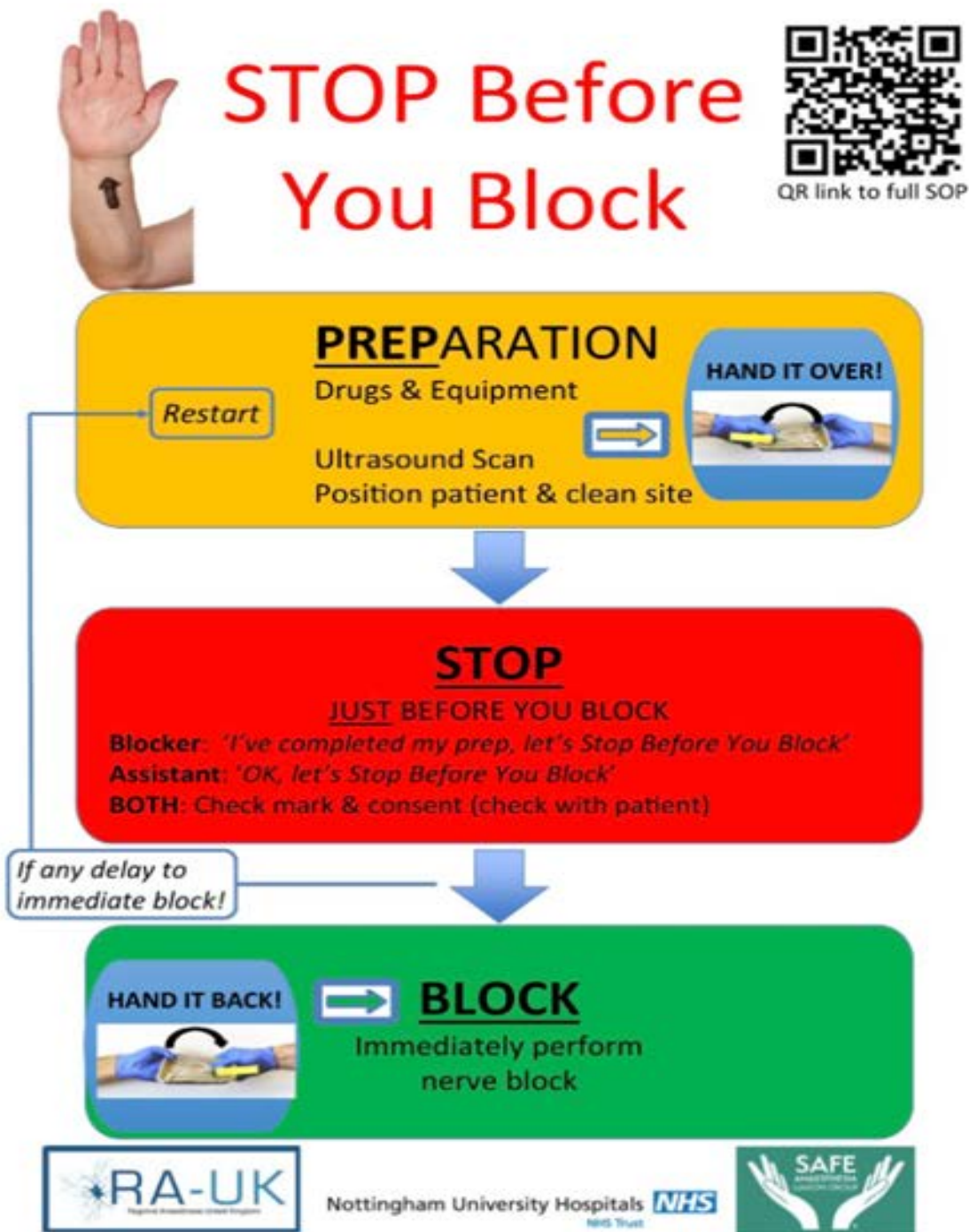
STOP BEFORE YOU BLOCK POSTER

Every Area within UHL that undertakes Anaesthetic Blocks Must Display This Poster and Adhere to the Policy



APPENDIX 10

'PREP, STOP, BLOCK' POSTER



APPENDIX 11

'PREP STOP BLOCK' STAGES DEFINED **AS PER NATIONAL SOP**

Step 1: 'Prep' Preparation:

The WHO 'Sign In' is performed on arrival of the patient in the anaesthesia room. General anaesthesia may or may not be administered first (or not at all). Regardless, the Blocker (the person who performs the block, who may commonly be an anaesthetist) prepares the local anaesthetic solution and places the labelled syringe with a suitable nerve block needle in a dedicated tray/container, which is handed over to the Assistant, out of the Blocker's immediate reach. The Blocker and Assistant should position the patient and equipment in the final position ready for the block and may perform a preliminary 'pre-scan' with ultrasound. The Blocker dons gloves and prepares the site (cleaning, draping) for the block. Where drapes cover the surgical site mark, the Assistant should ensure they can later reveal the mark for the Stop moment. Ideally, the surgical site mark should always be visible.

Step 2: 'Stop' Moment:

The stop moment is a two-person step that happens only after preparation is complete and thus immediately before needle insertion. When ready, the Blocker formally announces that they have completed all preparation and is ready to block using a consistent form of words: "I've completed my prep; let's Stop Before You Block". The Assistant similarly should reply: "OK, let's Stop Before You Block". The Blocker and Blocker's Assistant together should then check the block side by viewing the surgical site mark and verbally confirming the correct side; the Assistant reconciles this with the consent form. If the patient is awake and unsedated, they may also confirm the side is correct.

Step 3: 'Block'

Only when the correct side is confirmed does the Assistant hand the tray/container to the Blocker. The Blocker immediately performs the block. Any delay between handing back the tray and/or performing the block should require the Blocker and Assistant to re-start the SBYB process at Step 1. This re-start is to re-create a situation in which the block immediately follows the handing of tray from Assistant to Blocker. Re-start might be at the very start of the Preparation stage (e.g., if the site has become contaminated or later; but will always involve first handing the tray back to the Assistant