

Policy for Swab Counts in the Operating Theatre

| Issue Date | Review Date | Version |
|------------|-------------|---------|
| April 2018 | April 2023 | V6 |

Purpose

This policy identifies the correct procedure for counting swabs in the operating theatre and interventional areas.

Who should read this document?

This policy applies to personnel employed by Plymouth Hospitals Trust (PHNT) and to personnel working in satellite facilities under the remit of PHNT

Key Messages

This policy will ensure that there is a system in place for the safe handling and management of surgical swabs used in clinically invasive procedures and that they are accounted for at all times to prevent foreign body retention and subsequent injury to the patient.

This policy is compliant with National Safety Standards for Invasive procedures (NatSSIP's).

Core accountabilities

| | |
|----------------------|---|
| Owner | Cindy McConnachie – Senior Matron Theatres and Anaesthetics Theatre Policy and Standards Committee. |
| Review | Theatres and Anaesthetics Clinical Governance Committee |
| Ratification | Theatres Service Line Clinical Director/Clinical Governance Lead. |
| Dissemination | Cindy McConnachie Senior Matron – Theatres and Anaesthetics, Quality, Governance and Strategy |
| Compliance | Theatres and Anaesthetics Clinical Governance Committee |

Links to other policies and procedures

Throat Pack Use in Theatre SOP 12/04/18

Policy for Instrument Counts during invasive procedures V6 July 2017.

SOP “Counting on you” – Standardising theatre counts

NHS England (2015) *National Safety standards for invasive procedures (NatSSIPs)*, London

Policy for management of sharps in Operating Theatres and Procedural rooms V5 2018

Version History

| | | |
|-------------|------------|--|
| V1 | 02/09/2008 | Final review by the Theatre Policy, Practice and Procedure Group, for signing through the Theatre Management Board |
| V1.2 | 28/01/2009 | Reviewed following several serious incidents |
| V1.3 | 31/09/2009 | Additional comments incorporated following risk management meeting |
| V1.4 | Jan 2011 | Policy reviewed and changed to accommodate swabs retention incident |
| V2 | June 2012 | Policy reviewed and changed to stand alone swab policy |
| V3 | June 2013 | Policy reviewed and changes approved |

| | | |
|-----------|---------------|--|
| V4 | December 2015 | Policy reviewed and changes approved |
| V5 | August 2016 | Trust policy compliant with National Safety Standards for Invasive Procedures (NatSSIP's) (NHS England, 2015). |
| V6 | April 2018 | Revised in to new template |

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents on StaffNET. Larger text, Braille and Audio versions can be made available upon request.

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1 Introduction

Plymouth Hospitals NHS Trust is committed to ensuring the safety of patients undergoing surgical procedures and recognises the need for a standardised procedure for counting swabs in the Operating Theatre environment and areas where surgical or invasive procedures are undertaken.

Clear policies, enable the implementation of standard practice and reinforces the principle of consistency. This policy has been developed to ensure that all swabs are accounted for and that no item is left unintentionally retained in a surgical site, body cavity, on the surface of the body.

All theatre staff have a responsibility to themselves, their colleagues and patients to safely handle, monitor and dispose of swabs. As Health Care Practitioners, the law is clear that they have a duty of care and are accountable for the care that is delivered. Health Care Practitioners must ensure that no harm is caused by leaving foreign objects in cavities during invasive procedures or disregard this policy.

2 Purpose

- 2.1 To provide a safe system for the use and disposal of swabs.
- 2.2 To eliminate the likelihood of a “Never Event” and promote engagement in the Surgical Safety Checklist process.
- 2.3 To identify responsibilities of staff for counting and recording.
- 2.4 To provide a standardised counting and recording system.
- 2.5 To provide a safe system to be followed when discrepancies occur.

This local safety standard/policy (LocSSIP) has been reviewed to ensure that it is compliant with National Safety Standards for Invasive Procedures established by NHS England (2015).

3 Definitions

3.1 A swab may be defined as any porous material used in an open wound during surgery to absorb blood and other fluids in the sterile intra-operative field.

3.2 All swabs have the potential to become a foreign body if left in a wound and **must** be included in the general counts for all invasive procedures, including minimally invasive procedures.

3.3 Countable items may include, **but are not limited to:**

- X-ray Detectable Gauze Swabs (for the purpose of this policy the word swab will be used to refer to all x ray detectable gauze swabs, regardless of their size – e.g small swabs, small mops, large mops)
- Cotton Wool Balls (ENT)
- Gauze Strips/rolls
- Nylon Tapes
- Ophthalmic Swabs

- Throat Packs
- Nasal and mastoid packs
- Vaginal packs
- Neuro Patties
- Pledgets (peanuts) + Pin if appropriate
- Red Pack Ties (strings)

4 Duties

4.1 The Trust Board is responsible for:

- Ensuring that local standards (LocSSIP's) are created for all invasive procedures, and that they are harmonised with national standards (NatSSIP's).
- Ensuring employees involved in the performance of invasive procedures are educated in good safety practice, train as teams, and understand the human factors that underpin the delivery of ever safer patient care.

4.2 The Medical Director and Director of Nursing are responsible for:

- Ensuring all areas where invasive procedures have been identified.
- Ensuring local standards exist and are compliant with NatSSIP's.
- Ensuring audit of compliance with swab practice is conducted regularly and that the results of the audit are reported to trust board and acted upon appropriately.

4.3 Local Governance or safety lead is responsible for:

- Ensuring local standards for prevention of retained foreign body are in place or developed which meet the minimum requirements within NatSSIP's.

4.4 Clinical Director/Manager/Head of Nursing of Care Group is responsible for:

- Ensuring local standards for prevention of retained foreign body have been developed for invasive procedures undertaken within area of practice.
- Ensuring that the healthcare professionals directly involved in the delivery of invasive procedures work together to create, adapt and adopt local standards that are compliant with NatSSIP's.

4.5 Theatre Policies and Standards Group is responsible for:

- Writing the Policies and procedures used in Theatres.

4.6 Theatre Governance Committee is responsible for:

- ensuring that the Theatre Policies and Procedures are followed,

4.7 Senior Matron Theatres and Anaesthetics

- Senior Nurse in overall charge of theatres and responsible for safety, quality and efficiency.
- Responsible for coordinating the audit process and monitoring overall compliance with swab practice.

4.9 Theatre Team Leaders are responsible for:

- Conducting regular audit of practice and ensuring their teams are practicing according to the policy and undertake annual review of practice.

5 Process to follow:

5.1 Invasive Procedures

- Each count for invasive procedures must be performed by two members of staff, one of which must be a registered perioperative practitioner Registered Nurse (RN), Operating Department Practitioner (ODP) or trained and competent Perioperative Assistant Scrub Practitioner (ASP, Band 4).
- Whenever possible, the same two perioperative staff should perform all the counts that are done during the surgical procedure.
- No swabs, packs or instruments will be removed from the area until the operation is complete and the Scrub Practitioner is satisfied that the final count is correct and the Surgical Safety Check List “sign out” has been completed.
- All swabs/packs must then be placed into the patient’s labelled clinical waste bag/container. Laundry and rubbish must remain in the theatre until the final swab count is completed.

5.2 Minimally Invasive Procedures

- For minimally invasive procedures, such as excisions of lesions and biopsies carried out within a minor operations list, performed under a local anaesthetic, the count will be performed by two practitioners one RN/ODP or one ASP (band 4) and one other.

6 Preparation and packaging.

6.1 Preparation

- Prior to commencing the surgical procedure, the swab bag collection system must be prepared and positioned for collection of used swabs.

NB: It is imperative to ensure that all used swab bag collection systems have been removed from the theatre prior to progressing to the next case.

6.2 Packaging

- Swabs and packs used for invasive surgical procedures must be white.
- All swabs including pledgets (peanuts) that are used during invasive procedures must have an x-ray detectable marker fixed securely across the width of the swab.
- All swabs must be packed in bundles of five (5), with the exception of Neuro patties, which are in bundles of ten (10).

7 Times of the count

7.1 A full count **must** be performed at each of the following stages:

- Just before the start of the operation
- Prior to the insertion of an implant, prosthesis or cement
- At the start of closure of a cavity
- On completion of wound closure

NB. Laparoscopic procedures - swab count will be performed at final port closure

- After the insertion of packs (e.g. vaginal)
- Whenever there is a change of the Scrub Practitioner (see Appendix 3)
- At any other time it is deemed necessary

On completion of the final count the Scrub Practitioner **must** make a verbal statement to the Surgeon that all swabs are correct, the Surgeon will verbally acknowledge confirmation of “swab count correct” at completion of invasive procedure.

8 The counting environment

Counts **must** be carried out using ‘silent cockpit’ principle

- During counts the ‘count time out’ is established. Music is turned off, phones/pagers are left unanswered and all unnecessary conversation **must** cease until the count is finished and is reported as correct. **All** members of the multi-disciplinary team are responsible for adhering to and enforcing the “Silent Cockpit” principle.
- At the end of the final count the Surgical Safety Checklist “sign out” should immediately be performed to finalise the end of the procedure.

9 Method

9.1 Counts are carried out by two people, counting out loud and simultaneously (Appendix 2)

- The Scrub Practitioner removes the red string from each bundle of swabs, securing the red string on a sterile armoured discard-a-pad that is retained on the sterile field.
- The Scrub Practitioner with the circulator counts the red string. The number of red strings corroborates the number of swabs used.
- All swabs **must be separated and opened** to check integrity and tapes **must** be pulled to ensure they are secure. **NB:** Cardiac swabs may not have tapes attached, check outer packaging information.
- In the event of any discrepancy when opening swabs, the whole bundle **must** be removed from theatre. The details of the Lot No. and batch information **must** be retained and then forwarded to the manufacturer. An Electronic Trust Incident report **must** be completed and the occurrence escalated to Theatre Matron, in order that it is communicated across all surgical directorates, to ensure that the entire batch is quarantined.
- The counted items **must** be recorded by the Circulating Practitioner on the whiteboard in theatre.
- When the count is performed in a prep room, or where the practitioners cannot see the whiteboard, all counted items **must** be recorded onto a “*first count transfer*” pad and then transferred onto the whiteboard. The “*first count transfer record*” is thrown away, when the Scrub Practitioner has confirmed the whiteboard is correct.
- Any additional swabs that are required during surgery are given to the Scrub Practitioner maintaining the integrity of the sterile field and swab count performed at earliest opportunity.
- Following counting of additional swabs the circulator **must** record on the whiteboard the addition of swabs, recording in a logical sequence that indicates how many swabs are in use.
- During the surgical procedure the Scrub Practitioner **must** be aware of the location of all swabs, at all times.
- The swab board will be wiped clean only after the patient has left theatre.

NB: In the event of a life-threatening emergency it is not always possible to perform a swab count before surgery starts. In these circumstances, **all** packaging **must** be retained to allow a count to be performed as soon as possible. Rationale for non-compliance to follow policy **must** be documented in the patient’s Perioperative Integrated Care Pathway. (PICP).

10 Discarded swabs

- Used swabs **must** be opened and checked by the Scrub Practitioner before being discarded from the sterile field. The swabs must be clearly separated and not discarded in a bundle.
- Discarded used swabs from the sterile field are placed into an unsterile bowl by the Scrub Practitioner. Several swabs may be discarded into the bowl at the same time, but they **must** be placed separately so that it is clear how many swabs are there.
- Used swabs **must** be transferred and displayed into the swab bag collection system in the full view of the Scrub Practitioner. Swabs **must** be placed in the swab bag collection system starting from the bottom column and moving to the top.
- The Circulating Practitioner will use the swab bag system to display the discarded swabs. Swabs **must not be** removed from theatre, until the final swab count has been performed

Swabs may be “counted down” when the following numbers are reached:

- 50 swabs
- 50 small mops
- large mops

A full count **must** be performed when swabs are “counted down”.

- The swabs that have been “counted down” are placed and secured in a clear bag and the amount of swabs is recorded on the bag.
- Pledgets can be counted off the sterile field in groups of 5 and transferred to one packet of bag collection system/5 pledgets.
- Patties can be counted off the sterile field in groups of 10 and transferred to one packet of bag collection system/10 pledgets.
- Following “count down” of the swabs the Circulator **must** record on the whiteboard the amount of swabs counted down.
- The number of swabs on the whiteboard will be changed to show how many swabs are still in use. A single line is crossed through the previous number and the remaining swabs still in circulation are recorded. A continuous record remains in case of later count discrepancies.
- The “counted down” swabs **must** be recorded in the counted down section on the whiteboard.
- At the end of the procedure when all counts are completed, swabs are collected and deposited in designated orange clinical waste bag and secured with clinical waste bag tie prior to being disposed into clinical waste bin.

The whiteboard is not to be wiped clean until the end of the case and patient has left theatre.

11 Documentation

- The counts will be recorded in the patient's PICP.
- At the end of a procedure, the Scrub Practitioner **must** check that the record of intra-operative counts, has been signed in the PICP document and the Surgical Safety Checklist has been completed.

12 Further Considerations

12.1 Swab weighing and Blood Loss Calculation

- Swab weighing is used to determine blood loss and is normally requested by the anaesthetist.
- Blood loss measurements are determined by deducting dry swab weight from used swab weight.
- Various manufacturers' swabs and mops have different dry weights, so dry swabs and packs/mops should be weighed to determine the actual weight, unless the specific weights are already known.
- Swabs can be weighed singly, or in multiples of five according to the degree of blood loss and the age of the patient (blood loss being more critical in children).
- Blood clots and contents of suction containers must be included in the blood loss total.
- A running total of blood loss is recorded on the 'Blood Loss Form' and documented on the Theatre whiteboard for the anaesthetist. This form **must** be filed in the patient's notes. (See Appendix 3)
- To estimate blood loss, fluids used surgically should be deducted from the total.
- Scales **must** be calibrated annually by MEMs

13 Discrepancies/failed reconciliation

- If the count is incorrect, the operating Surgeon **must** be informed at once and a second count undertaken.
- If there is a discrepancy, the circulating staff in theatre will carry out a thorough search for the missing item.

- When a missing item is found, the count **must** be repeated and the Surgeon informed by Scrub Practitioner that it is now correct. Wound closure should be delayed until item is found unless there is a clinical need to close.
- If the item is still missing following a recount and search of the area, there should be a pause during which a verbal discussion **must** take place with the team to risk assess the need for an on table x-ray, with consideration of course of action that is in the 'best interest' of the patient.
- The failed reconciliation process should specify when an image intensifier or plain xray is used and the opinion of a radiologist concerning the image should be sought. It should be noted that 'Raytec' swabs cannot be reliably identified with an image intensifier.
- There will be occasions of failed reconciliation, but when the operator is certain that there is no foreign object remaining in the patient. Under these circumstances, the agreed processes for failed reconciliation should proceed unless, and until, the whole procedural team is agreed that there can be no foreign objects left in the patient.
- The theatre team must escalate to their team leader/matron should an event occur when there is failed reconciliation at the earliest opportunity and wherever possible at the time of the event. The team leader is required to attend the theatre and will be available to support the team, agree next steps and also to provide a third/independent confirmation on the count.
- In the event that the patient's condition does not allow for an on table x-ray, **escalation** to the senior practitioner on duty i.e. Band 6/7 or Perioperative Theatre Matron **must** occur. During which time a verbal discussion **must** take place with the team, to risk assess the agreed immediate actions and taking into consideration the "best interest" of the patient.
- When an x-ray is not performed and a swab remains missing, the On Call Duty Manager and Patient Safety Team **must** be informed, so that the event may be discussed with the patient's next of kin or significant other.
- The patient's clinical condition **must** continue to be monitored, until the earliest opportunity that it improves sufficiently to allow for an x-ray to be taken to confirm the missing swab presence or absence of the missing swab. If it is confirmed that a swab has been retained, the patient should at earliest opportunity be returned to theatre for removal of missing retained swab. The Surgeon, Scrub Practitioner and Senior Nurse **must** be informed of the x-ray result and the image must be reviewed by a Radiologist.

14 Trust Electronic Incident Reports

If a missing swab is not found, the Scrub Practitioner must complete a Trust Electronic Incident Report. The matter is brought to the attention of the On Call Manager, and person in charge and the Patient Safety Team must be notified by telephone.

- A "near miss" is reported using the Trust Electronic Incident Report

- If the swab is found prior to the patient leaving theatre, the incident is classed as a “near miss.”
- A Trust Electronic Incident report **must** be completed if an x-ray is performed to locate a missing swab.
- If an event occurs that there is a “count discrepancy “i.e. additional swab not accounted for in previous counts, the incident **must** be reported as a “near miss”,
- A record of the incident should be made in the patient’s PICP.
- Should an incident occur involving a retained swab, the patient will need to be informed. Apology issued and full duty of candour applied. This should be documented in PICP and Datix.

15 Deliberately Retained Swabs

- In some surgical procedures, the surgeon may make the decision to insert a pack. In these circumstances, the following process should be observed.
- Packs remaining in the patient must be recorded by type and number in the designated section of the PICP record.
- This must then be signed and dated by the Scrub Practitioner and Circulating Practitioner.
- The PICP must be signed and have an alert sticker attached at the front, indicating that ‘Swabs Remain in situ’. (Appendix 4)
- At handover, a verbal report will be given to the receiving practitioner.

16 Process for Managing a Patient Returning to Theatre, for Removal of Retained Swabs.

- At “Time Out” check patient PICP alert sticker from previous surgical event to confirm location and number of retained swabs.
- On the whiteboard the procedure will be identified as “Removal of Pack” e.g. 3 Large Mops
- Circulator will document on whiteboard the number of retained swabs documented in the previous PICP. The number of retained swabs must be recorded as a number, e.g. 3 Large Mops.
- The retained swabs are identified as a “Retained Swab” by the Scrub Practitioner and kept in a designated place (e.g. kidney dish on the scrub trolley/bowl).When all Retained Swabs are accounted for, the Scrub Practitioner counts them with the Circulator into a clear bag.

- All Retained Swabs counted off the sterile field must be placed in the same bag, which is sealed by the Circulator who records on the outside, the content and amount e.g., “Retained Swabs – 3 Large Mops”.
- The Circulator records on the whiteboard when the Scrub Practitioner confirms all Retained Swabs removed e.g. “3 Large Mops removed”.
- A line is placed through the number on the whiteboard, by the Circulator.
- The clear bag containing the “Retained Swabs” remains in theatre until the end of the surgical procedure and final count is performed
- The Scrub Practitioner must acknowledge at final count that “Retained Swabs” have been removed and accounted for and confirmation given to Surgeon.
- On completion of the surgical event, the Scrub Practitioner documents that “Swabs removed at start of case,” on the alert sticker located in PICIP of previous surgical event.
- In the event of “Deliberately retained swabs” being grossly contaminated, the Surgeon may choose to remove them prior to scrubbing up. The swabs will then need to be placed by the Surgeon into an unsterile receptacle and on confirmation that **all** “retained swabs” have been removed, the swabs are counted into a clear bag by the circulator and scrub practitioner
- It is routine practice for all Retained Swabs to be identified and removed at the start of the procedure; however, the Surgeon may decide to repack the wound with new swabs. In this event the Scrub Practitioner will perform a full swab count as per Swab Count policy and record the number of Retained Swabs in the patient’s PICIP and place another “Swabs Remain in situ,” alert label on the front of patients notes.
- The Surgeon also documents in patient’s surgical procedure notes that there has been an incidence of “Planned Retained Swabs”.

17 Accidentally Retained Swabs

In the event of a “Never Event” and a patient having to return to theatre for the removal of accidentally retained swabs, the procedure is the same, although there will not be an alert sticker to confirm presence of swabs in the PICIP.

18 General Points

- Staff and learners must not be involved with counting procedures until assessed and signed off as competent.
- A formative assessment is a stage in developing competency in this process and is not sufficient to allow the learner to act as second checker, without supervision from a competent practitioner, who will countersign the swab count documentation.
- Dressings must not be x-ray detectable.

- All swabs used by anaesthetists and during endoscopic procedures **must** be coloured green and contain a radio opaque strip.
- All swabs used in theatre e.g. catheterisation, pre-surgery skin preparation or wound irrigation, **must** be counted and recorded as part of the general swab count.
- The surgeon or assistant **must not** remove swabs or mops from the instrument trolley without the express knowledge of the Scrub Practitioner
- The surgeon **must** be responsible for informing the Scrub Practitioner that a swab has been placed inside the patient. The Scrub Practitioner is responsible for ensuring the inserted pack is recorded on the whiteboard.
- When small swabs or pledgets are used internally it is advisable to mount them on an appropriate instrument.
- Swabs/Mops **must not** be cut or used as dressing material and items should not be cut or altered unless specifically designed for the purpose.
- In the event that different surgical procedures are occurring simultaneously, with 2 different scrub practitioners; each scrub practitioner is responsible for their swab count. In this event the individual Scrub Practitioner and circulator performing final swab count **must** indicate and record which surgical procedure they participated in and that they performed the final swab count for that surgical event in PICP as separate swab count events.

6 Overall Responsibility for the Document

Senior Matron Theatres and Anaesthetics – Cindy McConnachie

7 Consultation and Ratification

The design and process of review and revision of this policy will comply with The Development and Management of Formal Documents.

The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be reviewed by the Theatres Policy and Standards Committee group or committee and ratified by the Service Line Clinical Director/Governance lead.

Non-significant amendments to this document may be made, under delegated authority from the Service line Clinical Director, by the nominated owner. These must be ratified by the Service line Clinical Director.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes.

8 | Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document owner will be responsible for agreeing the training requirements associated with the newly ratified document with the named Service Line Clinical Director and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

9 | Monitoring Compliance and Effectiveness

The Theatre Board will be responsible for investigating any incidents reported via the Trusts Electronic Reporting system.

Monthly auditing of swab practice must be undertaken. Theatre team leaders compliance recorded to theatre governance.

10 | References and Associated Documentation

Association for Perioperative Practice (2011) AfPP Standards and Recommendations for Safe Perioperative practice pp323 - 329

NatSSIPS

Procedural documents

| Dissemination Plan | | | |
|--|--|-------------|-----------------------------|
| Document Title | Policy for Swab Counts in Operating Theatres | | |
| Date Finalised | June 2012 | | |
| Previous Documents | | | |
| Action to retrieve old copies | Yes – archived by the Theatre Policy Group and Trust Document Controller | | |
| Dissemination Plan | | | |
| Recipient(s) | When | How | Responsibility |
| All Trust staff | | Vital Signs | Information Governance Team |
| Review Checklist | | | |
| Title | Is the title clear and unambiguous? | Yes | |
| | Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP? | Yes | |
| | Does the style & format comply? | Yes | |
| Rationale | Are reasons for development of the document stated? | Yes | |
| Development Process | Is the method described in brief? | Yes | |
| | Are people involved in the development identified? | Yes | |
| | Has a reasonable attempt has been made to ensure relevant expertise has been used? | Yes | |
| | Is there evidence of consultation with stakeholders and users? | Yes | |
| Content | Is the objective of the document clear? | Yes | |
| | Is the target population clear and unambiguous? | Yes | |
| | Are the intended outcomes described? | Yes | |
| | Are the statements clear and unambiguous? | Yes | |
| Evidence Base | Is the type of evidence to support the document identified explicitly? | Yes | |
| | Are key references cited and in full? | Yes | |
| | Are supporting documents referenced? | Yes | |
| Approval | Does the document identify which committee/group will review it? | Yes | |
| | If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document? | N/A | |
| | Does the document identify which Executive Director will ratify it? | Yes | |
| Dissemination & Implementation | Is there an outline/plan to identify how this will be done? | Yes | |
| | Does the plan include the necessary training/support to ensure compliance? | Yes | |
| Document Control | Does the document identify where it will be held? | Yes | |
| | Have archiving arrangements for superseded documents been addressed? | Yes | |
| Monitoring Compliance & Effectiveness | Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document? | Yes | |
| | Is there a plan to review or audit compliance with the document? | Yes | |
| Review Date | Is the review date identified? | Yes | |
| | Is the frequency of review identified? If so is it acceptable? | Yes | |
| Overall Responsibility | Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document? | Yes | |

| Core Information | |
|---|--|
| Date | June 2012 |
| Title | Policy for Swab Counts in Theatre |
| What are the aims, objectives & projected outcomes? | These guidelines have taken into consideration the cultural/religious and gender needs of patients. There is no impact on equality groups and no further action is required. |
| Scope of the assessment | |
| | |
| Collecting data | |
| Race | |
| Religion | |
| Disability | |
| Sex | |
| Gender Identity | |
| Sexual Orientation | |
| Age | |
| Socio-Economic | |
| Human Rights | |
| What are the overall trends/patterns in the above data? | |
| Specific issues and data gaps that may need to be addressed through consultation or further research | |

| Involving and consulting stakeholders | | | | |
|---|-------|-------|-----------------|-----------------|
| Internal involvement and consultation | | | | |
| External involvement and consultation | | | | |
| Impact Assessment | | | | |
| Overall assessment and analysis of the evidence | | | | |
| Action Plan | | | | |
| Action | Owner | Risks | Completion Date | Progress update |
| | | | | |

List of Approved Minor Procedures

Appendix 3

- Skin tags / Skin biopsy
- Incision & drainage of an abscess
- Warts
- Mole removal
- Biopsy of skin growths
- Verrucae
- Benign skin naevi
- Hairy moles
- Penile & vaginal warts
- Spider veins
- Haemorrhoids excision treatment
- In-growing toenails
- Lipomas / Fatty tumours
- Laceration / Incision / repair of skin & soft tissue
- Leg vein treatment
- Joint injections
- Triggerpoint injections
- Dorsal slit for phimosis
- Breastbiopsy / Endometrial biopsy sample
- Bartholins cyst / abscess
- Vulval biopsy / Cervical polyps
- Cervical loop excision biopsy
- Fine needle aspiration cytology & biopsy
- Foreign body removal from skin & soft tissue
- Insertion of contraceptive coils
- Epidural injections

Date:

Place addressograph
label here

Surgeons Name:

Anaesthetists Name:

NB: Swabs from different companies may have different dry weights.

| Company | Swab Type | No of Dry Swabs | Dry Weight |
|---------|-----------|-----------------|------------|
| | | | |
| | | | |

| Swab Description | No of swabs | Dry weight | Used weight | Blood loss | Sub Total | Suction | TOTAL |
|------------------|-------------|------------|-------------|------------|-----------|---------|-------|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

1 gm = 1 ml

ATTENTION

SWABS REMAIN IN SITU

| No. | TYPE | INITIAL & DATE |
|-----|------|----------------|
| | | |

- The change of Scrub Practitioners should be kept to a minimum.
- A discussion within the team, should take place before a practitioner scrubs for a long procedure, to assess their suitability and their shift times to reduce requirement for change of scrub practitioner.
- In the event that it is necessary to change Scrub Practitioners (through illness or prolonged procedures) the first scrub practitioner will remain scrubbed until they have completed a full count and handover; unless there is a significant reason to not perform full handover. (through illness or very long procedures)
- A complete count must be performed by both practitioners simultaneously and with another circulating person who will remain until the end of the surgical procedure.
- The change of scrub practitioner and handover must be recorded in the patient integrated care pathway.
- If any discrepancies occur, please refer to Section 6.2 of this SOP