I. Purpose:

To provide maximum safety against accidental sharps, sponges, 4x4’s, vaginal packing, and Kerlix™ (to be referred to as objects) retention within the vagina and to ensure that these objects are accounted for at the end of all vaginal deliveries.
II. Policy:

To outline the procedure for counting objects at the beginning and end of every vaginal delivery and identify personnel who are responsible for the counts. The implementation of accurate count procedures promotes an optimal patient outcome. Counts are performed and documented in the electronic medical record.

III. Specific Information:

Classification of items to be counted:

A. Countable sponges include, but are not limited to: 4x4’s, 4x8’s, lap sponges, and Kerlix™.

B. Countable sharps include but not limited to: Suture needles, hypodermic needles, electrocautery needles, and scalpel blades.

IV. Procedures:

A. Counts are performed simultaneously by two personnel: A licensed RN or OB Provider and either another licensed RN, OB provider or scrub tech.

B. Countable sponges and sharps are counted at the beginning and end of the vaginal delivery.

C. Counts are performed in the same sequence each time.

1. An initial count is performed when:
   a. The delivery table is initially opened; and/or
   b. Prior to the delivery procedure.

2. After delivery and any repair of tissue is completed, the count is repeated with two personnel and a sweep of the vagina is performed by the provider.

3. Additional counts are required when there is a personnel change or if multiple teams will be working in the same site (e.g. repair of extensive laceration). Counts are completed at the conclusion of each procedure and documented in the Labor & Delivery record.
D. Sponges are:

1. Separated, counted audibly and viewed by two personnel: A licensed RN or OB Provider and either another licensed RN, OB provider or scrub tech to determine if a sponge has been added or deleted from a sterile package.

2. Packages containing an incorrect count are removed from the sterile field, placed in a clear bag, labeled, dated and retained in the LDR until the procedure is completed. These sponges are NOT added to the count.

3. Audibly counted and visualized by both parties as they are added to the sterile field.

4. Used sponges are separated, counted audibly, and viewed by: A licensed RN or OB Provider and either another licensed RN, OB provider or scrub tech.

E. Any sponges used prior or during a procedure (i.e., for prepping) are included in the count.

F. Sponges used in a body orifice for packing, such as vaginal or rectal packing, are accounted for at final sponge count.

G. At End of Case: The provider is notified of the first and final counts.

H. The results of the count are documented in both the Labor and Delivery summary and the provider’s delivery note in the electronic medical record, or paper-equivalent during downtimes.

I. Procedure for incorrect count:

1. Manual inspection of cavity is performed by OB Attending if count is not reconciled.

2. If following manual inspection or manual inspection is unable to be performed, proceed to Radiology Imaging per below:

   a. Radiology technologists are paged when a portable x-ray image is required.

   b. If more than one body cavity is involved, specify on the x-ray order the exact areas to be viewed, along with the possible foreign body type.

   c. Digital image(s) are developed and sent to IMPAX.

   d. The licensed circulator calls the ED Reading Room at 343-
7185 or pager 835-1239 for STAT read by a senior radiologist (resident or faculty).

e. The senior radiologist on duty is responsible for communicating directly by telephone with the OB Attending. The conversation is documented by the senior radiologist in a dictated reading of the film.

J. Intentionally retained sponges/planned packed cavities:

1. The provider confirms the number and location of intentionally retained sponges with the scrub person and/or RN.

2. The number of intentionally-retained sponges is documented in the nursing record and the provider’s delivery note. Documentation includes the following:

   a. Type and number of packing placed;
   b. When the packing is to be removed; and
   c. The service responsible for removal of the packing.

K. There are no exceptions to this policy.

V. Patient/Family Education:

Educate patient/family at the level of their understanding of the following:

A. In the event of intentionally retained packing, the patient needs to be educated on the plan of care involving the removal of the packing.
B. The patient is notified of who will remove the packing and when the packing should be removed.
C. Signs and symptoms of infection associated with retained packing. These include: drainage, fever, and/or odor.

VI. Documentation:

A. The resulting count is documented in both the Labor & Delivery summary and the provider’s delivery note in the electronic medical record, or paper equivalent during downtime.

B. The number of intentionally retained sponges is documented in the nursing record and the provider’s delivery note. Documentation includes the following:

   1. Type and number of packing placed;
2. When the packing will be removed; and
3. The service responsible for removal of the packing.

VII. References:


ECRI. Sponge, sharp and instrument counts.


VIII. Endorsement:

OB-PCC Committee March 2011

IX. Approval:

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