PERIOPERATIVE PRACTICE GUIDELINE

Sharps Counts & Miscount Management

Integrating the Sharps Finder into your count policy

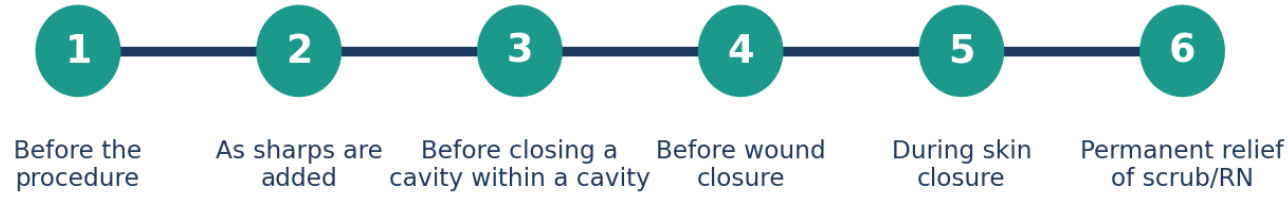
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Every perioperative nurse knows the moment: the final count comes up one needle short, the room goes quiet, and closure stops. What the team does next determines how quickly the patient can be safely closed, and whether an X-ray, added anesthesia time, or a retained item follows. AORN's Guideline for Prevention of Unintentionally Retained Surgical Items supports the use of adjunct technology to supplement manual counts. This guideline shows how to add the Sharps Finder to an existing sharp count policy as that adjunct, never a replacement for the manual count, to speed up miscount resolution and add an extra layer of patient safety in high-risk scenarios such as emergent cases, unplanned procedure changes, and long or complex procedures.

1. WHEN SHARPS ARE COUNTED

Sharps are counted on all procedures at each of the points below. Sharps added to the field during the case are counted and recorded when they are added.



2. HOW SHARPS ARE COUNTED

- **Audibly,** using the read-back method, the person recording confirms each number aloud.
- **Visually and concurrently,** by two people viewing the items at the same time, one of whom is the circulating RN.
- **In sequence,** moving from the surgical site outward, following the same order every time.

COUNT IN THE SAME SEQUENCE EVERY TIME — AUDIBLY, VISUALLY, WITH READ-BACK

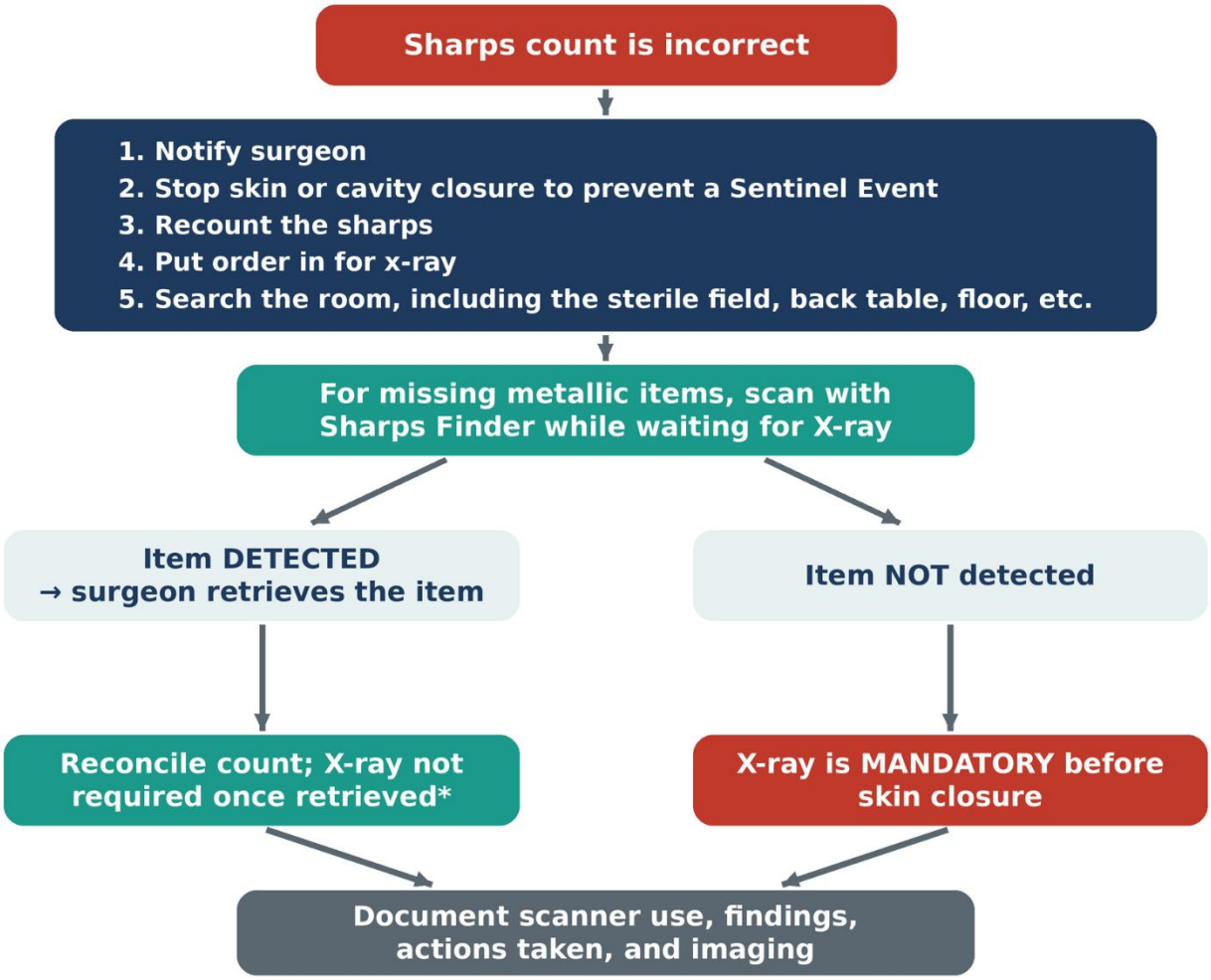


3. SHARPS HANDLING STANDARDS

- **Sutures packaged in fluid** (e.g., natural sutures) are counted by the number of needles listed on the package and verified when the package is opened.
- **A suture pack with a needle discrepancy** is removed from the sterile field, bagged, labeled, and isolated from the rest of the needles.
- **All sharps on the field** are contained and counted in the needle counter box.
- **Broken sharps** are accounted for in their entirety, including every fragment.
- **All sharps** remain in the OR, including trash and linen, until the final count is verified. Afterward, sharps are disposed of according to hospital policy.

4. WHEN A COUNT IS INCORRECT

A count discrepancy is a team event, not just a nursing task. At minimum, the team takes the steps below, and the skin or cavity is not closed until the discrepancy is resolved.



***Scanner use and imaging.** Use the Sharps Finder according to its Instructions for Use (IFU). A scan does not replace radiologic verification unless the device detects a foreign object and the surgeon retrieves it, as specified in the IFU. If no item is detected, an X-ray remains mandatory as another intervention to help prevent a retained item and avert patient harm. The device detects metallic items only and does not replace X-ray imaging for non-metallic items. If a missing item is not X-ray detectable, the attending surgeon determines the appropriate surgical action (e.g., re-exploring the wound).

5. DOCUMENTATION

Every count discrepancy is documented in the intraoperative record, including:

- ☐ Item missing (type and size) and when the discrepancy was identified
- ☐ Surgeon notified (name, time)
- ☐ Whether the Sharps Finder was used
- ☐ Scanner findings: item detected / not detected
- ☐ Actions taken based on findings
- ☐ Whether imaging was performed or canceled, and results

6. WHEN TO USE THE SHARPS FINDER BEYOND AN INCORRECT COUNT

In addition to an incorrect count, adjunct technology is recommended to supplement the manual count in these four circumstances:

- **Broken instruments or suspected fragments.** Any piece not recovered in its entirety.
- **Too many instruments for an expeditious count,** when the surgical team unanimously agrees the volume of instruments used prohibits one.
- **Emergency care without time to count,** when clinical circumstances require it.
- **Higher-than-usual risk for a retained surgical item (RSI),** when any member of the surgical team considers the procedure to be at elevated risk (e.g., more than 100 sharps used).

7. PUTTING IT INTO PRACTICE

- **Keep it within reach.** Stock the Sharps Finder in each OR or with your count-discrepancy supplies, so no one has to leave the room to find it.
- **Make the scan a named step.** When scanning is a written step in the policy, no one has to decide under pressure whether to use it.
- **Train to the IFU.** Include scanning in orientation and annual count competencies and run periodic mock-miscount drills.
- **Align the team first.** Agree with surgeons, anesthesia, and radiology in advance on when imaging is and isn't required under this policy.
- **Track your outcomes.** Monitor miscount events, time to resolution, scanner use, and intraoperative X-rays to see what's working.

> *“The goal isn’t to replace a careful count. It’s to give the team a clear, immediate next step the moment a count comes up short.”*
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> — Mary Anne Toledano, MSN, RN, CNOR