Surgical Count Practice Variability and the Potential for Retained Surgical Items

ELIZABETH MORELL EDEL, MN, RN, CNOR, CNS

ABSTRACT

Validating existing count practices and reducing individual practice variance are necessary to decrease the risk for retained surgical items. A quality improvement project was undertaken at one large city hospital to identify best practice and eliminate variability in count practices. The project included an analysis of 20 surgical count policies from hospitals across the country and a review of count practices among nurses and surgical technologists at the facility. Assessment of the policies and practices indicated that clinical practice requirements in the policies varied greatly, and there was a high degree of count practice variability among staff members. The facility OR manager and OR quality coordinator collaborated with staff nurses and surgical technologists to identify practices that created variability and then addressed each one to create a new count policy and reduce the risk of retained surgical items. AORN J 95 (February 2012) 228-238. © AORN, Inc, 2012. doi: 10.1016/j.aorn.2011.02.014

Key words: retained surgical items, surgical counts, policies and procedures for counts, perioperative counts.

Retention of surgical items is a sentinel event, according to The Joint Commission.1 It is imperative that OR managers look for any variations in practice and promote a single, unified count practice to ensure that correct counts are obtained. Some variation in practice is acceptable; however, broad ranges of policy interpretation can result in many different practices that vary from stated policy and procedure. Reducing practice variation reduces the risk for count errors.

The counting of sponges, sharps, and instruments is performed for every surgical procedure in which the possibility for a retained item exists. Counting is a high-risk, high-frequency activity, and policies that pertain to it require annual validation for consistency and validation of best practice application among all surgical team members. Hospital policies and procedures exist to direct staff members in performing specific practices and to provide a consistent platform to promote best practices. Count policies outline criteria that must be met by all perioperative staff members, independent of their level of experience or years of employment.

Perioperative staff members may receive orientation to the OR in different ways (eg, formal programs, on-the-job training). Most perioperative
staff members work with different and multiple preceptors as they learn new practice areas, and opportunities exist for practitioners to develop their own styles and independent ways of interpreting and following policies and procedures. It is crucial, therefore, for managers to validate with staff members what best practices entail and how these relate to existing policies to ensure consistency in patient care, which is especially important to prevent count issues that can result in retained surgical items.

Staff members must be included in discussions of existing variations in practice and in choosing which element of the variation meets published standards and written facility policies to ensure team adherence. Best practice can then be established as a benchmark. Content should be taught after variations in practice are eliminated and a new policy is developed to promote new practices. New practices are validated through demonstration by the OR educators and preceptors, and return demonstration by the staff members. Surgical count competency needs to be validated annually through various methods, including administration of a post-test on learned content, return demonstration to validate technique and policy compliance, and auditing of newly validated processes. These audits provide coaching opportunities to reinforce the new or updated practice performance.

### QUALITY IMPROVEMENT PROJECT

To improve patient safety at St Luke’s Episcopal Hospital in Houston, Texas, I led a quality improvement project in collaboration with the facility’s OR quality coordinator to review and revise our count policies. The project was precipitated by an interest in implementing best practices across three OR departments and labor and delivery, and to ensure consistent practice during high-risk procedures. The goals of the project were to

- review current count policy practices and identify any necessary clinical updates for the ORs and labor and delivery ORs;
- observe staff members to determine whether the count policy, as written, was being followed;
- identify and clarify current count practices and any variations in practice;
- define a new count policy based on the assessment of staff member practices; and
- raise awareness about counts and foster intellectual curiosity by using discussion, staff participation, and teamwork.

After patient risk was identified, the components of the project included soliciting analysis of current procedures, reviewing current literature, obtaining written policies from other facilities, reviewing policy and procedure documents and St Luke Hospital’s written procedures, observing practice and interviewing staff members, and revising the procedures.

### Supporting Evidence

Variation in practices related to the count process may take place in the same OR and even during the same surgical procedure. According to Verna Gibbs, MD, director of the NoThing Left Behind® surgical patient safety project, “this lack of standardized practice leaves opportunities for errors to occur.”2(p1)

Examining actual practice compared with written policy identifies gaps that may need to be addressed to ensure consistency in practice. In 2009, Woodhead stated,

> Events related to the surgical count have identified that there are opportunities to review our practice in order to reduce risks to surgical patients. The Safe Surgery Saves Lives Campaign highlights this aspect of perioperative patient safety, ensuring that poor processes and poor communication are often the reasons for retained surgical items.3(p358)

In a study of retained foreign objects after surgery, Lincourt et al4 noted heightened risk with multiple major surgical procedures being performed at the same time and an incorrect instrument or sponge count. Identification of
these risk factors using case-control analysis should influence operating room policy and reduce these types of errors.\textsuperscript{4(p170)}

Policy compliance ensures the safest care for the patient. Expected patient outcomes can vary when there is variation in how policies are practiced. Adherence to AORN recommended practices for counting and to facility counting policies can protect both patients and practitioners.\textsuperscript{5,6}

Count policies should be reviewed regularly, and counting practice should be validated to determine opportunities for educational updates or interventions. This review and validation provides an opportunity to discuss changes in policy with staff members who must be accountable to each other and help support each other in the OR as they practice the policy and eliminate variables. Coaching or reminding one another when an old count habit is seen will assist staff members in becoming comfortable as practices are changed.

\textit{Relationships between members of the surgical team and the complexity of striking a balance between organizational policy and professional judgment has implications for patient safety as the surgical count is governed through communication interactions.}\textsuperscript{7(p369)}

**Setting**

St Luke’s Episcopal Hospital is a large city hospital with 46 ORs and three separate surgical departments: cardiovascular, thoracic, and transplant; inpatient (ie, main OR); and ambulatory. Registered nurses and surgical technologists may rotate among different OR service departments depending on their competencies. As staff members rotate from one OR to another within their assigned services, they work with others who may have different work styles than those to which they are accustomed. The opportunity for different practices in performing the count exists for many reasons. For example, an outpatient procedure might be a closed orthopedic reduction or a cardiovascular vein harvesting that does not require a closing count in one OR. In the inpatient OR, however, staff members perform opening and closing counts for all abdominal procedures, and, if other procedures are performed at the same time, then counting is required. In addition, many staff members practice at different hospitals before they arrive at St Luke’s; orientation programs vary in length, competency validation, classroom content, and preceptor training; and the follow-up and enforcement of existing policies differs among different facilities. This creates practice variations that do not always comply with stated policy and procedure.

Policies at St Luke’s are reviewed every three years unless practice changes are brought to light through a literature review, there are changes in practice standards, or patient risks are identified. When we identified patient risks in perioperative services at St Luke’s, we analyzed our current practice through a literature review and a review of AORN’s practice recommendations to identify opportunities to promote patient safety as well as opportunities to reduce variation in practice so that expected outcomes could be promoted. The goal of the project was to review our current count policy, observe actual practice in the OR, and determine whether any practice changes were needed or whether any updates to the existing policy needed to be made.

**Variations in Count Performance**

As patient advocates, we believe that count policies and procedures must be established and followed to ensure better outcomes for patients. In January 2009, an audit of count practice showed variations compared with the count policy, as well as variation in accountability among individual practitioners and different teams in the ORs. We also solicited policies from hospitals across the country. The OR director and OR quality coordinator reviewed these for content by using a checklist for components of the count and specific processes.

The only consistency that we found at St Luke’s and in the 20 other count policies and
procedures that we reviewed was the SBAR report (ie, the formal situation, background, assessment, and recommendation hand-off tool that is commonly used in the OR). Communication among team members may vary. Communication among perioperative staff members was limited because of individual practice variations and staff member discomfort with addressing peers about their individual practices. Tools used in the OR for documenting count numbers and changes to the count, including intentionally packed items, also varied among hospitals. Variability in count policies existed regarding the type and format of tools used for count communication and seemed to be based on the individual preferences at each hospital, as indicated by the lack of uniformity in content and the variation in the details and depth of count procedures.

Methods
The OR director and OR quality coordinator conducted group interviews, during which the groups were told that the data would be compiled and shared with all staff members, with the intent of discussing which count practices would be accepted and validated, and which would be eliminated. We interviewed a total of 120 staff members from three OR departments as well as the labor and delivery department. Staff members were encouraged to speak freely so that the current practice could be understood and validated by the group. We intentionally kept the groups small, no more than eight staff members, so that every voice could be heard and to ensure time for discussions.

We explained the project objectives to each group, which included eliminating variation in count practices, reinforcing staff member accountability, ensuring open communication without repercussions, advocating for patients, respecting and adhering to count practice requirements, and eliminating excuses for not following facility count policy. We reinforced that patient safety and advocacy, showing respect for one another, and adhering to the count practice requirements were paramount and that excuses would not be accepted for failing to follow the new policy. We discussed the expected outcomes and explained that staff members would be held accountable for following the new policy. We focused the discussions on components of the count and comparing actual practice to the existing policy.

During the interviews, all staff members identified variations in practice. The interviews indicated that staff members were adhering to the existing policy; however, the extent of practice variability and policy interpretation was wide. For example, the nurses were documenting counts correctly but were using the instrument count sheet or blank pieces of available paper (eg, glove wrappers) to do so. It was easy for staff members to misplace this form of documentation, and often this created confusion during the change-of-shift handoff. Staff members also had questions regarding what items actually needed to be counted. Although items to count were included in the policy, staff members identified other items over time that should be counted; because these were not included in the policy, which items were counted became random. For example, we needed to define all “small items” that needed to be counted so that everyone was clear about this. When an incorrect count occurred, the circulating nurse requested an intraoperative radiograph; however, the interpretation of that radiograph (ie, surgeon or radiologist interpretation) needed to be consistent in terms of the methodology used across every OR.
We discussed the role of the anesthesia professionals because they often use nonradiopaque sponges during their patient care that are not used during the surgical procedure. The OR managers at St Luke’s needed a procedure that outlined how to keep those sponges separate from the surgical sponges and the surgical field.

The OR managers looked carefully at the practice of removing items from the OR, because some individuals were keeping sponges in the OR that had not been correctly packaged (eg, wrong number in the package) whereas other staff members removed them from the OR immediately. The OR director and OR quality coordinator discovered that the timing of counts varied based on the complexity of the procedure and the amount of time needed to prepare the OR; circulating nurses also performed counts before interviewing the patient or after they brought the patient into the OR.

The OR director and OR quality coordinator discussed the opening sponge count and closing sponge count policy in detail and documented variations that individuals practiced or witnessed. It was important to evaluate these practices because variability was possible during each of these time frames. For example, on opening counts some items were included in the count based on individual practitioners’ decisions, not on policy. For example, some practitioners held 4 × 4 sponges or laparotomy sponges in one hand and counted them as a group fingering across the top of each sponge while counting to separate them. Our decision was that each sponge should be individually separated from the group and placed on the back table during the count. Similarly, the instrument stringers used to hold the instruments in a line to facilitate cleaning and counting often were not removed before counting. Decisions about how to handle missing radiograph detectable sponges or sponges passed off the field or deposited in the kick bucket as well as throat packs, tear seals, and umbilical tapes needed to be made so that counting and storing processes for these items for the count were uniform.

We found individual variation in the use of count boards and in knowing what the functions of the count boards were. Although it is important that patient information remain visible, the individual use of count boards and the means of recording counts varied greatly. In addition, we noted that individual practice dictated the timing of counts, what items were counted, and when it was appropriate to throw items away. Individuals also made decisions regarding counting with two people, using count bags and rolling bags, whether to fan sponges or separate them when counting, whether to bag incorrect sponges, and bag variances (ie, what was used or not used to bag sponges) independent of stated policy. On closing, practitioners made the decision about when to count, when to have relief counts, when to use two people to count, what the order of the count would be, and where it would start (eg, sterile field, back table).

Because of these variations, there was confusion at change of shift; incoming staff members thought the policy would be followed one way and it was not. Discrepancies in count procedure raised questions about the count during surgical procedures and the effects on count accuracy because count information was not always recorded in the same place. Our objectives were to standardize count procedures, keep patient information visible, reduce counting errors, and reduce the possibility of retained items. We used a shared governance approach to decide which practices would be adopted and which practices would be replaced by the new policy.

We also detailed variations in both opening and closing sharp counts. We noted that some people opened and counted multipacks, some counted miscellaneous items that others did not (eg, scratch pads, electrosurgical pads), and needle count boxes and count bags were not used consistently. Some practitioners discarded suture packages and others did not. In addition, the
cardiovascular service had a specific structure for counting needles that included not reconciling needle counts with sponge packages.

There was some variation between other specialties as well. In cardiovascular surgery, items specific to that service line were counted, but these items were not found in general surgery, urology, neurosurgery, or other services. Staff members who floated to different areas needed to know what specific items to count. Confusion and questions regarding what to count were eliminated by the identification of required counted items for each service. We added these items to the count/time out board that was in place so that it would be visible to all team members in every OR.

On evaluation of opening and closing instrument count practices, we noted that count sheets varied in their content and whether they were used to count. We noticed similar variations to soft goods and needle count practices (eg, number of persons involved in the count, how counts were recorded, how discrepancies were handled, how instruments were organized, how broken or malfunctioning instruments were handled), and we found that multitasking often was required of the people who were counting, thus distracting them from focusing on the count in progress. As was noted with soft-goods counting, there was variation among specialty areas practices that mirrored the sponge counting variations (eg, where to record added items, what to do with a dropped item).

We reviewed the tools used for counting by both the RN and the surgical technologist. We considered these to be communication tools, and we noted that the following areas varied greatly:

- how counts were documented (eg, boards, tally sheets from the OR, computer tally, other sources of paper);
- whether kick buckets or count bags were used;
- how dressings, needles, miscellaneous items, and drains were counted;
- how incorrect counts were handled;

Communication and documentation were among the topics that the OR director and OR quality coordinator discussed during the interviews, including current practices and the need for change (Table 1). We also discussed obstacles and factors nurses and surgical technologists encountered that affect performing the count (Table 2).

During the team interviews, we developed a cause-and-effect diagram to help us identify inconsistencies and the need for change (Figure 1). The OR director chose the application model applied to our assessment, the Ishikawa Diagram.8

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**TABLE 1. Areas of Variation in Communication and Documentation of Counts**

- Timing of counts
- Which small items are required to be counted during the opening count
- Whether order of instrument string matches instrument count paper
- Which items are removed from the OR
- Method of recording the count (ie, documentation)
- Communication about an incorrect count
  - When intraoperative radiographs are mandatory (ie, specialty specific)
  - When to call a manager if problems arise
- Procedures for counts occurring during a shift change
- Procedure for dealing with surgeons who are uncooperative with incorrect count procedures
- Variations caused by staff members being rushed during the count
- Policy for addressing an incorrect count:
  - count again
  - inform the surgeon
  - perform an intraoperative radiograph
  - wait for radiologist interpretation
  - notify personnel
  - radiologist communication with the attending surgeon
- Anesthesia professional counting
- Role of anesthesia technician during intubation and the opening count

- when radiographs were determined to be necessary; and
- who was notified.

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to systematically identify and present all the possible causes of variability identified in a surgical count and subsequently present all the possible causes of this particular issue in a graphical format. The OR director created the model and applied it to the Ishikawa Diagram as the interviews progressed. The Ishikawa Diagram resembles a fishbone diagram and lists the possible causes of factors affecting the accuracy of the surgical count, which are presented at various levels of detail increasing as the branch goes outward. Because the outer branch is a cause of the branch to which it is attached, the outermost branches usually indicate the root causes of the problem. The intent of applying this model to our staff assessment was to enable the team to focus on why the problem occurs and to give a real-time assessment of the collective input from the team.

The evaluation process was interactive with an open dialogue among the OR director, the OR quality assurance coordinator, and the nursing and surgical technologist staff members from the cardiovascular service and the inpatient and outpatient ORs. We encouraged questions and encouraged staff members to tell us what practices they saw that varied from policy, which of the variations they wanted to see adopted, and what was working regarding the count process and what was not, as well as to identify the obstacles to counting that they faced. We had numerous discussions about the types of variations that existed as we explored what would be the best practices adopted by the department.

TABLE 2. Obstacles and Factors That Affect Accurate Counting

<table>
<thead>
<tr>
<th>Obstacles and Factors</th>
<th>Possible Causes</th>
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</thead>
<tbody>
<tr>
<td>Surgeons who are unfamiliar with the policy</td>
<td>Patient and others requiring attention at the time of the count</td>
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<tr>
<td>Patient and others requiring attention at the time of the count</td>
<td>Anesthesia professional’s needs</td>
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<td>Anesthesia professional’s needs</td>
<td>Counting while the anesthesia professional is prepping for lines</td>
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<tr>
<td>Counting while the anesthesia professional is prepping for lines</td>
<td>Poor communication between the scrub person and circulator</td>
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<td>Poor communication between the scrub person and circulator</td>
<td>Pager or telephone interruptions</td>
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<td>Pager or telephone interruptions</td>
<td>Inconsistent passing of sharps</td>
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<td>Inconsistent passing of sharps</td>
<td>Death in the OR</td>
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<tr>
<td>Death in the OR</td>
<td>Patience required</td>
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<tr>
<td>Patience required</td>
<td>First count done before the procedure</td>
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<tr>
<td>First count done before the procedure</td>
<td>Closing count performed when closing cavity</td>
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<tr>
<td>Closing count performed when closing cavity</td>
<td>Second count when closing fascia</td>
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<tr>
<td>Second count when closing fascia</td>
<td>Some counted items are not x-ray detectable</td>
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<tr>
<td>Some counted items are not x-ray detectable</td>
<td>Procedure continues while counting is performed</td>
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<tr>
<td>Procedure continues while counting is performed</td>
<td>Small items must be better defined</td>
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<tr>
<td>Small items must be better defined</td>
<td>Counted items should not be cut</td>
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<tr>
<td>Counted items should not be cut</td>
<td>Patient extubated</td>
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<td>Patient extubated</td>
<td>Radiograph required</td>
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<tr>
<td>Radiograph required</td>
<td>Multitasking</td>
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<tr>
<td>Multitasking</td>
<td>Providing help</td>
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<tr>
<td>Providing help</td>
<td>Incorrect preference list</td>
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<tr>
<td>Incorrect preference list</td>
<td>Cases requiring more support</td>
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<tr>
<td>Cases requiring more support</td>
<td>Time constraints (ie, turnover)</td>
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<td>Time constraints (ie, turnover)</td>
<td>Counting too late</td>
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<td>Counting too late</td>
<td>Having to count packed items</td>
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<td>Having to count packed items</td>
<td>Suture not in the room</td>
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<td>Suture not in the room</td>
<td>Patient safety</td>
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<tr>
<td>Patient safety</td>
<td>Count while prepping</td>
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<tr>
<td>Count while prepping</td>
<td>Cardiovascular set up and counted when the patient is in the room</td>
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<tr>
<td>Cardiovascular set up and counted when the patient is in the room</td>
<td>Equipment</td>
</tr>
<tr>
<td>Equipment</td>
<td>Instrument set is wrong</td>
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<tr>
<td>Instrument set is wrong</td>
<td>Need for the count to be completed before the time out</td>
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</tbody>
</table>

STANDARDIZING PRACTICE

After staff member interviews, direct observations of both RNs and scrub persons in the clinical arena at St Luke’s were conducted. The observations indicated that practice varied from written policy. Of note, the variations were not identified as deficiencies but as opportunities to standardize practice. We also interviewed the labor and delivery staff members and asked them to participate in the assessment of count practices. We noted similar questions and discrepancies in the labor and delivery department and believed that this was an opportunity to reduce practice variations and develop a standardized count practice in that department as well.

We identified the need to

- standardize instrument, sharp, and sponge count practices;
- strengthen a culture of accountability;
improve general communication; support patient advocacy; renew respect for count policy and procedures; and communicate concerns, problems, and variances to coworkers and managers with no repercussions.

We made revisions to the new count policy, which incorporated assessments from the staff sessions. Through shared governance and policy review, staff members identified practices that they wanted to adopt that complied with the hospital policy. They chose to use a common documentation tool and a dry-erase board, and eliminated all other means of documentation. We identified the policy to be followed when initiating the closing count and how it would occur (ie, from the sterile field to the Mayo stand, back table, sponge buckets). We outlined what count practices would occur before the patient entered the OR; what items and the timing of items that could leave the OR; procedures for improving change of shift count communication, such as the use of the count and time-out board; and instrument count sheets revisions to mirror the placement of the actual instruments on the stringer so that the count sheet was simple and followed a specific order.

**PRACTICE IMPLICATIONS**

Standardized count practices reduce independent interpretation of policy. Staff members must have clear policies to follow to support safe patient care. Staff members who float to multiple services should be able to expect that practice performance will not change from one service to another and that all staff members understand and are working from the same count policy. AORN recommended practices are guidelines for best practice. Although our written policy followed
AORN recommended practices, individual interpretation of these policies needed to be eliminated to ensure that staff members adhered to policy and procedure and best practice, and provided the safest patient care.

Permanently changing behavior so that employees adhere to a revised policy can take months. Having consistent expectations and validating performance with audits performed during daily rounds, providing reminders, and using blind reporting of current practices help staff members incorporate new practices and achieve change. Staff members are empowered to coach each other as needed. Expecting everyone to perform at a best practice level also requires strong, supportive leadership. The time invested in strengthening an OR team and a labor and delivery team is worth the effort.

As a result of our count policy project, we developed an education plan. The surgeons were included in the education plan for the count policy evaluation and revision so that they were aware of new policy developments that affect all staff members and to allow them to be supportive of the learning curve. The anesthesia team also was included in the communication. The existing count policy was revised to incorporate the consistent practices chosen by staff members and approved by perioperative managers to eliminate variations. Together, the OR managers, OR quality coordinator, and OR educator developed an online education program for all staff members to take to validate their knowledge and understanding of the newly revised policy. A passing grade of 100% was required on the multiple-choice post-test examination. Staff members were required to retake the test until they achieved a score of 100%. Staff members who had difficulty were given help in reviewing their test to see whether additional education or review of the new practice expectations was necessary.

The OR managers, OR quality coordinator, and OR educator also developed case scenarios to affirm the changes we expected to see in clinical practice. The case scenarios were used to apply real issues that the staff members might encounter in implementing a new practice. The practice questions associated with these scenarios were used to validate whether staff members understood the content and whether there was anything the OR managers would need to do to support their successful implementation of the new policy.

We reviewed with RNs documentation practices and available tools for documentation for use in SBAR reports and relief reports. This included standardized documentation on the newly implemented dry-erase count boards that we placed in every OR. Staff members who passed the examination and return demonstration after policy review were assumed to have learned the content. The OR managers, OR quality coordinator, and OR educator are conducting monthly direct observation auditing of staff members’ practices to validate that the new policy changes are being adhered to clinically.

**IMPROVING PRACTICE**

We believe recognizing variations in count practices represents an opportunity for staff members at all hospitals to attempt to standardize hand-off communication, which we expect to improve communication and reduce count variability. It is crucial to assess current practice as it relates to the count process, as well as the specific tools that are available and used for documenting and updating the count information. Obstacles to performing the count policy must be reviewed and standardized.

We did not assess all staff members’ practices, because the yield from including a larger number probably would not have identified additional variations. The number and type of practices we identified as variations became common themes in each of the education sessions. The themes were consistent among staff members. The magnitude of policy interpretation and independent practices that we observed and discussed in assessment sessions was a key revelation for those of
us participating in the evaluation of count practices. None of us imagined that there would be so much variation in this vital means to protect the patient from harm, and we realized the enormity of risks to patients if we allowed these variations to continue. Substantive changes were made after two years of work, from assessment of practice to rewriting the policy, training and validation, and design and implementation of tools (eg, count boards) in every OR. After the assessment, review of current practice and current policy, observation of practice performed across three surgical departments and labor and delivery, multiple and concurrent plans were put into place.

The management team, consisting of directors, assistant nurse managers, a quality assurance coordinator, an educator, and shared governance committee members in perioperative services, analyzed the documented findings and decided which practices were to be implemented exclusively among the documented variability. The OR managers, OR quality coordinator, and OR educator updated our existing policy and included clear definitions of terms, such as what specifically needed to be included in the sponge count (eg, cautery scratch pad). Areas of generalized statements were detailed specifically so no room for individual interpretation existed. An educational plan was implemented. This plan addressed the new policy that all team members were required to review and then pass a post-test. The management team performed a “train the trainer” session, and every management leader was checked off on being a validator of policy interpretation and return demonstration of clinical changes by the quality assurance coordinator and perioperative educator who were part of the initial assessments with the staff members.

A live demonstration of the new policy changes was given to all perioperative and labor and delivery staff members. Each individual was then validated on his or her clinical performance, and return demonstrations of practice changes were observed, such as demonstrating the individual separation of sponges while counting instead of fanning them to count. We also posted “Sink Links,” an educational tool posted at all scrub sinks with bullet point information to help staff members review critical elements while they wash their hands. Daily rounds were made to observe new practice and coach performance of the new practice.

Of critical significance is that this learning curve that addressed long-term variations and interpretations in practice was not punitive but, instead, an opportunity to gently remind. Staff members are encouraged to direct each other in the best interest of our patients. Statements such as “Hey Judy, remember we are now separating the sponges individually instead of fanning” are used to promote consistency and compliance with the new policy and are highly encouraged. This is a positive interaction and is nonthreatening in a learning environment. Team accountability is addressed when staff members remind each other about the new practices. All team members are expected to support one another and ensure policy compliance. This is not based on a person’s title but on the fact that the team members are responsible for patient care together. The surgical technologists are encouraged to communicate new policy reminders to the circulating nurses and vice versa. Daily rounds are made by the management team members to validate staff member questions and observe opportunities for reinforcing the new learning. Feedback from all staff members is compiled and continually evaluated for practice effect and to determine policy updates.

Auditing of the new practice has revealed compliance and has enforced behavior changes of performance based on a new policy to reduce practice variability. Staff members assist in the audit process so they are able to see what is working or not working, and to provide any feedback to be considered for revising the policy or for educational opportunities. Annual validation of the
Count policy now occurs to reinforce the new learned behaviors through return demonstrations and auditing of counts.

Count assessment and validation must include the opening and closing procedures of sponge, sharp, and instrument counts because variations occur in each segment. We used numerous tools and practices (eg, various count sheets, kick buckets and sponge bags for counting, needle counter boxes, timing of the counts, reconciling the count, streamlining of hand-off communications at change of shift) to standardize counting practices. Consistency in tools used must be controlled. If each practitioner records counts differently, then the risk for error escalates. Communication issues that impede a count need to be addressed, including the elements incorporating multiple specialty areas of practice. Obstacles to performing a count as dictated by policy must be identified and eliminated, if possible, or controlled so that counts may occur as outlined in policy and procedure. It is important for managers to support staff members to eliminate barriers to performing counts in a routine manner. Managers must readily address any obstacles that staff members experience in following policy (eg, pressure to perform or finish a count, coaching surgeons about policies that they need to support, making expectations of the count clear to other surgery team members so that they understand expectations). This support is imperative so that staff members are empowered to follow policies and able to address issues that arise. Impeding patient safety as a result of individual practice variations is not acceptable.

**Acknowledgment:** The author thanks Robert Graham, RN, quality assurance coordinator, Perioperative Services, St Luke’s Episcopal Hospital, Houston, Texas, for his assistance with the assessment of staff practices related to the count policy and launching a new focus on variations in practice to reduce variability, and Claudia Smith, PhD, RN, director of nursing research, St Luke’s Episcopal Hospital, for help in editing this manuscript.

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