NATIONAL ORGAN RETRIEVAL SERVICE

Guidance for Surgical Count

PURPOSE:

This guidance aims to standardise safe practice and the operative environment for organ donors, NORS teams and donor hospital staff. This statement is in response to several incidents associated with missing Raytec swabs. Although our patients are deceased, families have a right to expect the same high standards of surgical care in organ donation as for any other patient. A retained item can bring untold donor family distress, and we must strive to minimise this possibility.

AIM:

To ensure safe practice it is essential that each team attending a multi organ retrieval undertakes an independent two-person surgical count of instruments, sharps, swabs and packs prior to knife to skin. **All Raytec swabs and packs should be recorded and collected in a central location in theatre.**

RATIONALE:

The nature of the retrieval procedure means the cardiothoracic team leaves the donor theatre prior to the end of the operation, therefore the abdominal scrub practitioner is responsible for the full final check of remaining accountable Raytec items.

SAFETY BRIEF:

At the team safety brief the procedure for the surgical count must be discussed and agreed.

PRACTICE:

As the cardiothoracic team prepare to leave the table, the CT scrub practitioner must undertake an accountable item check. The CT scrub practitioner will take responsibility for their instruments and safe disposal of their sharps and will advise the abdominal scrub practitioner of the outcome.

All swabs and packs will be collected in a central location in theatre.

The Abdominal team will proceed with the retrieval of the abdominal organs and complete the retrieval process. Prior to closure, a full check of remaining accountable items inclusive of **all** swabs and packs must be undertaken and documented.

ACTIONS:

In the event of a miscount, local policy must be followed, acknowledging that the donor thoracic and abdominal cavity is easily inspected for retained Raytec items. Any untoward incidents must be reported via the incident reporting tool.

https://www.odt.nhs.uk/odt-structures-and-standards/governance-and-quality/tell-us-about-an-incident/

The surgical count should not distract the scrub practitioners from the principal of safe removal and timely despatch of organs to recipient centres.

Thank you for your continuing effort ensuring we maintain high standards of practice, respect for the donor whilst minimising risk of family distress, a safe surgical environment and standardisation of practice for all involved in the organ retrieval process.