



Surgical Office-based and Ambulatory Surgical Center Self-assessment Checklist

Surgical office-based practices must have office systems in place to identify and manage inherent risks and implement a risk management plan that ensures patient safety. Building office systems to address primary areas of risk will promote optimum patient safety and protect the practitioner against liability. Below is a checklist of essential risk management strategies when offering a surgical office-based practice.

Patient Screening and Selection	Yes	No
Written preoperative assessment guidelines outline appropriate patient selection for anticipated procedures and anesthesia.		
The duration and complexity of procedures assure same-day patient discharge to home.		
Each patient receives a preoperative assessment and meets the approved selection criteria.		
Other: Specify		
Plan of Anesthesia Care	Yes	No
Written anesthesia policies and procedures are consistent with the American Society of Anesthesiologists' (ASA) best practice guidelines.		
When a physician is required to supervise the administration of anesthesia by a CRNA the supervising physician:		
Assures an appropriate pre-anesthetic examination		
Prescribes the anesthesia drugs to be administered		
Is available for diagnosis, treatment, and management of anesthesia-related complications or emergencies		
Prescribes post-anesthesia medications		
Signs the anesthesia record		
Assures the provision of indicated post-anesthesia care including:		
Documented post-anesthesia evaluation includes respiratory function (rate; airway patency; oxygen saturation), cardiovascular function (pulse rate; blood pressure), mental		

status, temperature, pain, nausea and vomiting, and postoperative hydration		
Written discharge instructions address both the procedure performed and the anesthesia received		
Monitoring equipment, medications, and resuscitative capabilities are present for all patient populations, i.e., pediatric and bariatric.		
Other: Specify		
Credentialing and Staff Competence	Yes	No
Credentialing of all health care practitioners is established by written policy.		
Provider credential files include evidence of:		
Current licensure		
Board certification or eligibility		
An approved delineation of privileges		
Privileges include supervision of CRNA when required		
Privileges to perform equivalent or greater procedures at a local hospital		
Documented training to perform privileged procedures		
Evidence of competencies required by regulation or policy		
Evidence of CME		
ACLS/PALS certification		
Periodic review as established by policy		
CRNA credential files include evidence of:		
Current licensure		
Scope of practice		
An approved delineation of privileges		
Supervisory plan		
Documented training to perform privileged procedures		
Evidence of competencies required by regulation or policy		
Evidence of CME		
ACLS/PALS certification		
Periodic review as established by policy		
Staff competence includes:		
Current licensure		
Scope of practice		
Evidence of continuing education		
Evidence of competencies required in the job description		
Other: Specify		

Informed Consent Process	Yes	No
The physician performing the procedure obtains the patient's consent.		
The physician conducts a comprehensive informed consent discussion with the patient, or legal surrogate, which covers the necessity, appropriateness, and risks of the proposed surgery, treatment alternatives, including no treatment, probability of success, name of other practitioners and significant tasks performed, and the patient or legal surrogate's recount of what he or she has been told, including an acknowledgment that their questions, if any, were answered and that they have an understanding of the procedure, including any risks or benefits.		
The individual responsible for administering the anesthesia obtains the patient's or legal surrogate's consent for the anesthetic, discussing possible complications and alternatives of administering anesthesia, and the patient's or legal surrogate's recount of what he or she has been told, including an acknowledgment that their questions, if any, were answered.		
The use of a written consent form for the procedure and for the anesthetic, including a timed and dated patient signature indicating he or she understands the discussion and accepts the risks outlined is recommended. Physicians and anesthesia providers also should sign the form and document the consent discussion in the medical record.		
Evidence of patient education about their care and consent to the procedure and anesthetic is documented in the patient's medical record with the use of patient "teach-back" or a similar form of assurance of patient understanding of their health status and procedures to be performed.		
Other: Specify		
Pre-op Process	Yes	No
Site marking are done by the surgeon while the patient is fully alert, and participates in the process.		
Uniform pre-op patient education is provided and documented for specific procedures.		
Other: Specify		
Intra-operative Process	Yes	No
Average length of time of procedures is less than 6 hours.		
Procedures are limited to 2 hours or less and 20% of total body surface area, if warming devices (Bair hugger), forced air warmers, or IV warmers are not available.		
Intra-operative physiologic monitoring including:		
Continuous monitoring by an individual not participating in the procedure with knowledge and skill to recognize and treat airway complications		
Assessment of ventilation		
Oxygenation		
Cardiovascular status		
Body temperature		
Neuromuscular function and status		
Patient positioning		

"Time out" was conducted with the operative team to verify the correct patient, correct side and correct site, agreement on the procedure to be done, correct patient position, and availability of special equipment and materials.		
Medication safety including:		
Medications and solutions both on and off the sterile field are labeled		
Drug concentrations are standardized		
Emergency medications are located in the surgical procedure area		
Supply counts are performed (sponges, sharps, and miscellaneous items):		
Before the procedure to establish a baseline		
Before the closure of a cavity within a cavity		
Before wound closure begins		
At skin closure or end of procedure		
At the time of permanent relief of either the scrub person or the circulating nurse		
Other: Specify		
Post-operative Care		
A staff member trained in post-op recovery stays with the patient at all times until fully recovered.	Yes	No
A physician is physically present during the intra-operative period and is available until the patient has been discharged home from the office.		
At least one person, with training in advanced resuscitative techniques, (ACLS or PALS) is immediately available until all patients are discharged.		
Physician defined discharge criteria are in writing and require stable vital signs, responsiveness and orientation, voluntary movement, controlled pain, and minimal nausea and vomiting.		
An anesthesia provider completes a post-anesthesia evaluation when sedation or higher levels of anesthesia are received by the patient during the procedure, the evaluation includes:		
Alert and oriented at their baseline mental status		
Vital signs, pain and pulse oximetry within acceptable limits/stable		
Return to baseline ambulation status, except in the case of lower extremity procedure (e.g. ankle reduction and splint application)		
No nausea/vomiting		
Properly hydrated		
Other: Specify		
Patient Discharge		
Uniform post-op patient education provided for specific procedures.	Yes	No
Written instructions provided and documented in the record including:		
An emergency phone number to contact for any questions or emergencies		
Pain management plan		
Post-procedure diet		
A complete list of medications, including any changes		
Acceptable activities		
A follow-up appointment		

A phone number to call in case of questions or emergencies		
Requirement that the patient must leave with a responsible adult who has been instructed with regard to the patient's care, when sedation, regional block, or general anesthesia has been used, only after a post-op anesthesia evaluation has been completed by the anesthesia provider. Discharge instructions must reference the anesthetic used and any discharge instructions specific to post-anesthesia care, and should include a phone number to call in case of questions and should state if there is an emergency, the patient should call 911.		
Other: Specify		
Infection Control	Yes	No
Infection control policies and procedures are in place to prevent, identify and manage infections and communicable diseases and are in accordance with state and federal CDC guidelines.		
Staff has annual documented training in universal precautions, practices of infection control, and disposal of hazardous waste.		
A procedure and a quality control audit are in place for cleaning, disinfecting, and sterilizing equipment and patient care items.		
Other: Specify		
Emergency Equipment	Yes	No
Patient monitoring equipment is available.		
Emergency medications (atropine, epinephrine, rescue drugs: Narcan and Romazicon).		
A defibrillator or AED.		
A latex allergy cart or tray.		
An ambu-bag for positive pressure ventilation.		
A safe and reliable source of oxygen.		
At least two sources of suction.		
Pulse oximetry, capnography.		
Warming blankets.		
IV catheters and IV fluid warmers.		
Other: Specify		
Emergency Transport	Yes	No
There is a written emergency plan including written protocols for the timely and safe transfer of patients to a hospital within reasonable proximity when extended care due to slow recovery, complications, or emergency services is needed.		
There is a written transfer agreement with a reasonably convenient hospital(s) where all physicians performing surgery have admitting privileges or transfer of patient care may be arranged at the facility.		
All information relevant to a patient is readily available to authorized health care practitioners and there is a process for providing information to the receiving facility/provider. Written policies and procedures including an identified medical director and written policies describing the organizational		

structure, including lines of authority, responsibilities, accountability, and supervision of personnel.		
Written policies and procedures identify the medical director, and organizational structure, including lines of authority, responsibilities, accountability, and supervision of personnel.		
A process is in place to inform the primary care provider of the patient's status.		
Other: Specify		
Policies/Procedures: Additional	Yes	No
There are clinical policies/guidelines for surgical procedures performed.		
There are procedure-specific checklists to assure the completion of tasks associated with the pre-op preparations for surgery.		
There are written policies/procedures to ensure necessary personnel, equipment, and procedures are available for emergencies/disaster preparedness, e.g., surgical and other fires, power outages, weather disasters, cardiopulmonary arrest.		
There are policies and procedures for the maintenance of accurate patient medical records including pre-and post-operative information; process to transfer files if requested.		
Other: Specify		
Quality Improvement	Yes	No
There is a written process that reviews, tracks, and trends patient outcomes for the purpose of identifying risk and modifying, as appropriate, care provided to improve patient outcomes.		
There is a process in place to audit medical records for operative procedures which includes pre-procedural documentation, intra-procedural documentation, post-procedural care, and discharge instructions. Identify opportunities for improvement and implement remedial actions through the practice's performance improvement processes.		
Other: Specify		
Risk Management Notes:		

Medical Mutual's "Checklists" are offered as reference information only and are not intended to establish practice standards or serve as legal advice. MMIC recommends you obtain a legal opinion from a qualified attorney for any specific application to your practice.