Records Management in a Surgical Facility

“Managing Your OR” focuses on various aspects of aesthetic surgery in the ambulatory surgical setting.

When a patient first arrives in the plastic surgeon’s office or in the ambulatory surgical facility, the paper trail begins. Well-documented records are imperative to ensure quality patient care while promoting the efficient and effective use of the ambulatory surgical facility.

Patient education is the first step in making a patient aware of the services offered by a facility. It also can serve as a deterrent to litigation. Many malpractice cases are the result of a patient’s misunderstanding or lack of information with regard to what the physician can and cannot realistically accomplish. Through the paper trail used in patient education, prospective patients are better able to understand their problems, the desired outcome from surgery, and information about the facility and alternative locations for surgery. This process must be documented with the patient’s signature, indicating that he or she has received and read all the required forms.

As the complexity of the paperwork continues to escalate each year, it is even more imperative that the facility’s staff understand the importance of the forms and the need to complete them in a timely manner to ensure that each patient’s care and overall surgical experience are adequately documented. These forms, which make up the medical record, should include, but are not limited to, patient information, financial information, medical history, clinical data, preoperative and postoperative instructions, physician’s orders, history and physical, surgical consent, special consent forms (for example, laser or computer imaging), surgery record, and an operative report.

The medical record may be the surgeon’s number one defense in a malpractice case. I have been involved in two malpractice cases, as a witness for the defense, where the cases were lost solely because of altered medical records. (There are many techniques available to identify such alterations.) The clear message here is to have adequate and complete records and under no circumstances alter the record, unless it is done honestly and with complete documentation as an addition or change.

The paper trail in the plastic surgeon’s office or ambulatory surgery facility involves every staff member in the patient’s overall surgical experience. Guidelines for documentation are established through the facility’s policies and procedures, and it is critical that all documentation be in strict compliance with those policies. Inconsistencies between policies and procedures and the actual medical record can jeopardize the quality of patient care and the accreditation status of an ambulatory surgical facility.

Facilities accredited by the American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF) have these important forms in place and are using them before accreditation. AAAASF provides a valuable Resource Guide for Accreditation of Ambulatory Surgery Facilities. This guide provides forms and policies ranging from sample recovery room records to minimal requirements for a Medicare history and physical examination to “What to Expect From an OSHA House Call,” and other unusual problems confronting the physician in managing a surgical facility.

Through the inspection process, AAAASF helps facility management ensure the development and use of an appropriate paper trail. Its “Checklist/Questionnaire for Accreditation of Ambulatory Surgery Facilities” is the backbone of the inspection process, and includes sections on records, peer review and quality assurance, and governance. AAAASF offers inspectors training courses detailing the process of accreditation at the annual meetings of the American Society for Aesthetic Plastic Surgery and the American Society of Plastic and Reconstructive Surgeons. For further information about AAAASF accreditation, call 847/949-6058.

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