SCOPE OF PRACTICE – SURGICAL TECHNOLOGIST

Age Range of Patient Population:
(Please check) _____ Pediatric _____ Adult _____ Geriatric

TITLE
Surgical Technologist (ST)

DEFINITION
The Surgical Technologist prepares and maintains the sterile field and instruments for surgical cases. Counts according to policy in conjunction with a Registered Nurse, (RN). The Surgical Technologist demonstrates accountability by: 1) Maintaining continuing education relative to practice, 2) Conducting self in a professional manner, 3) Adhere to health system policies and procedures and 4) Demonstrates competence.

Qualifications are a high school diploma and successful completion of a formal Surgical Technology Program. A surgical technologist cannot perform procedures that require licensure and cannot function as a First Assistant in New York State.

PRACTICE RELATIONSHIPS
Surgical Technologists may be employed and supervised by a licensed physician. In the operating room the ST also functions under the supervision of the Registered Nurse. It is the responsibility of the employing physician to assure that the surgical technologist is competent to perform those duties requested and functions within the scope of the ST’s practice.

COMPETENCIES
A. At initial appointment to the Kaleida Health Medical/Dental Staff, the Surgical Technologist must supply documentation of successful completion of an approved Surgical Technology Program.
B. The Surgical Technologist must be certified with the National Board of Surgical Technology and Surgical Assisting (NBSTSA) or another national certification program within two (2) years of becoming a member of the Kaleida Health Medical/Dental Staff. Certification must be maintained to remain on the Kaleida Health Medical/Dental Staff.

CORE PRIVILEGES
A. Create and maintain the sterile field.
B. Assist the licensed practitioner in moving and positioning patients for surgery.
C. Assist in non-invasive prepping of the skin’s surface and draping patients for surgery.
D. Under the supervision of the physician, holding retractor to expose the operating filed after the retractor is placed by the licensed professional.
E. Assist the surgeon’s provisions of homeostasis during a surgical procedure by engaging in such activities as holding instruments.
F. Anticipate instrument needs of a surgeon.
G. Perform any and all tasks required by the surgeon incidental to the particular procedure, except tasks that fall within the scope of practice of a license profession.
Surgical Technologist

Name: __________________________________

SPECIALTY RELATED COGNITIVE SKILLS – SUPERVISING PHYSICIAN MUST COMPLETE THIS SECTION by checking one of the following:

_____ a) I, as supervising physician, have personally observed ___________________________(applicant’s name) in the clinical setting and can attest he/she has the cognitive/psychomotor skills appropriate for a Surgical Technologist.

_____ b) I, as supervising physician, have not personally observed ___________________________(applicant’s name) in the clinical setting and recommend he/she be given a six (6) month provisional approval with direct supervision at the end of which an attestation as to competence will be required.

EXCLUSIONS:

According to the NYS Education Department, Office of the Professions, an unlicensed individual, example - surgical technologist, CANNOT: 1) independently position patients for surgery, 2) independently prep and drape patients for surgery, 3) independently retract tissue to expose the operating field during an operative procedure, 4) administer any medication, this included intra-operative local and topical medication, 5) place homeostatic instrument or device or apply cautery, 6) assist surgeon in identifying structure that should not be ligated, 7) anticipate the moves of the surgeon by performing licensed functions, 8) tie off bleeders, apply sutures and wound dressing or assist in closure of the wound.

I attest that I have read, understand, and agree to abide by the exclusions noted above:

_________________________________________ Date

Practitioner’s Signature

_________________________________________ Date

Physician Supervisor’s Signature

_________________________________________

Physician Supervisor’s Name (Print)

_____ Request Approved:  _____ Request Denied*

_________________________________________ Date

Chief of Service Signature

_________________________________________

Advanced Practice Provider Committee

*NOT APPROVED DUE TO: (Provide Details if necessary)

_____ Lack of Documentation –

_____ Lack of Required Training/Experience

_____ Lack of Current Competence

12/2014