ARC/STSA
Accreditation Review Council On Education
In Surgical Technology And Surgical Assisting

Clinical Case Log Policy for Surgical Technology Programs

Relevant Standard:

Standard III.C. Curriculum

The ARC/STSA Clinical Case Log Policy establishes provisions and requirements related to clinical case definitions, clinical case requirements and required elements of the clinical case log. This policy supplements clinical case documentation criteria found in the most recent edition of the *CAAHEP Standards and Guidelines for the Accreditation of Educational Programs in Surgical Technology.*

Purpose: The purpose of the clinical case log is to demonstrate student completion of required clinical cases as defined by the most current edition of the *Core Curriculum for Surgical Technology*. Clinical case logs fall into two categories, summative and formative.

Definition of a Summative Clinical Case Log

The summative clinical case log is the required, final (end of program) log that includes all student clinical experiences and confirms student completion of clinical case requirements as defined by the most current edition of the *Core Curriculum for Surgical Technology*.

The summative clinical case log must be signed and dated by the program director and student to ensure completion of required clinical cases. The summative clinical case log must:

- Be comprehensive of all clinical experiences.
- Be organized by surgical specialty and include all surgical cases completed within each specialty.
- Clearly indicate the total number cases completed in each specialty.
- Clearly identify the role of the student in each case (first scrub, second scrub, observation) as defined by the current edition of *Core Curriculum for Surgical Technology*.
- Be signed and dated by the program director and student.
- Be maintained by the program for no less than five years.

Clinical cases are counted according to surgical specialty as defined in the current edition of the *Core Curriculum for Surgical Technology*.

- Observation cases cannot be applied to the required 120 case count but must be documented.
- One pathology is counted as one procedure.
- Programs may count more than one case on the same patient provided there are two different pathologies or two different set-ups for two separate specialties.
- A surgical procedure not specifically listed in the most current edition of the *Core Curriculum for Surgical Technology* may be counted according to the surgeon's specialty or sub-specialty.
- A surgical procedure listed in the most current edition of the *Core Curriculum for Surgical Technology* and performed by a surgeon with a subspecialty certification may be counted as either specialty or sub-specialty.

The program may determine whether a surgeon has a sub-specialty certification by checking either their practice website or entering their information at the following website: https://www.certificationmatters.org/find-my-doctor/.

There must be evidence that the student has been apprised of their progress towards meeting clinical case requirements at a regularly established interval during their clinical experience. This may be accomplished by periodic review of the summative case log or via a formative case log review process. Review of clinical case logs should be synchronous, with the program faculty and student meeting in real time to assess the student's clinical progress.

Definition of Formative Clinical Case Log

The formative clinical case log may be utilized to track student progress through the required clinical rotation for the program. The formative case log process is not required by the ARC/STSA.

It is best practice to employ some mechanism of tracking of clinical cases throughout the student's clinical experience. Utilization of student evaluations* (to verify student participation), development of a daily or weekly clinical case tracking document (formative clinical case log), program-developed electronic tracking documents and/or use of a clinical log management platform may be utilized by the program. Tracking documentation should provide verification that the student has completed the listed procedure. It is at the program's discretion if case completion verification is done by program faculty or clinical preceptor staff.

*Student clinical evaluations and corresponding documentation should not be utilized as a formative clinical case log.

The formative clinical case log should include the following:

- Date of procedure
- Procedure performed
- Surgical specialty
- Role of the student (first scrub, second scrub, observation)
- Including verification signatures (student and program faculty or student and clinical preceptor) and date of review with student is at the discretion of the program. The ARC/STSA recommends verification of formative clinical case logs.

Clinical Case Log Verification

Electronic formative and summative clinical case logs developed by the program and/or clinical case logs via commercial software applications must meet the same verification requirements listed for formative and/or summative case logs. Electronic signatures and time stamps used to verify case logs are acceptable. Electronic case logs and/or commercial software applications that do not have electronic signature and time stamp capability may be used, however, the program must provide supplemental evidence of synchronous evaluation, required signatures, and date of review.