

Tool: Sample mock survey questions for Rehab unit

Notes: The following questions are from a question-and-answer form provided to staff a few days prior to a mock survey to a daily chart check of the patient care pieces that are pertinent to The Joint Commissions Patient Care chapter. These interview questions were used in one particular hospital (Loma Linda University Medical Center – East Campus), but not throughout the LLUMC organization. Detailed answers to the questions --for example, where in the chart would an item be found, etc., along with the corresponding Policy and Procedure numbers – were included.

Rehab Manager/Charge Nurse interview

What is the average length of stay on your unit?

What constitutes an appropriate patient for rehab? What is the admission criteria for rehab?

Do you have any exclusion for admissions to rehab?

Do you have a rehab policy program manual?

What is the scope of service for rehab?

What is the admitting policy?

How many patients do you have to a room?

What is your staffing plan/mix for this unit?

Rehab Staff Nurse Interview:

Prior to interview w/ surveyor be sure to say the following-

“I will be right with you as soon as I give a “Hand Off” report to the nurse who will be covering my patients.”

What can you tell me about your patient?

What is the patient Medical Record Number?

What was the date your patient was admitted?

Why was the patient admitted?

Does your patient have an Advanced Directive?

Be ready to show where the advanced directive acknowledgement form is kept in the chart

If your patient has an Advanced Directive, be ready to show where it is placed.

If your patient has an Advanced Directive on file with the hospital from a previous admission, be ready to show where it is located in the computer.

How do you communicate among staff if a pt. has an Advanced Directive?

Does your patient have signed Conditions of Admission?

Where are the Conditions of Admission/Treatment papers kept in the chart?

Who is supposed to be in charge of getting the signed Condition of Admissions/Treatment?

Where is the patient's History and Physical?

How soon after admission should the patient's History and Physical be available on the chart?

Where is the admission assessment for your patient documented?

Where is the patient's functional screen documented?

Where is pain assessed in the admission assessment?

Where are the patient's nutritional risks documented?

What is the referral pattern for nutritional risk?

Is your patient at risk for falls and where would you document this?

How is your patient identified as a Falls Risk?

Where are the patient's education preferences documented?

Where do you document if your patient needs a translator?

How often do you assess your patient for pain?

How often do you reassess your patient for pain?

What is your policy for administering range orders?

Where is medication reconciliation documented?

When would you sign the medication reconciliation form?

Do you need an order to give your patients pneumococcal or influenza vaccine?

Where is the plan of care documented for your patient?

Are all of the initial patient problems listed on the plan of care?

How soon after admission is the careplan completed?

How does the interdisciplinary team talk to each other?

How soon after admission do you start planning for the patients discharge?

How do you individualize the care plan for each patient?

How do you individualize interventions for your patients?

Source: Leslie Von Esch, RNC, BSN, PHN, Project Coordinator, Loma Linda University Medical Center – East Campus. Used with permission.

Tool: Communication tracer

Notes: Internal patient tracers are an excellent way to assess how thoroughly your policies and procedures have been ingrained throughout your hospital. These sample forms, based on priority focus areas, can help prepare your frontline staffers for actual Joint Commission tracer activity, and to gauge staff performance in the process.

Communication tracer

Tracer patient: _____

Communication	Met / 2	Partial / 1	Not met / 0	N / A	Comments
Chart audit and interview with staff					
Interdisciplinary care planning					
Interdisciplinary education for patient and family					
Goals and treatment plan communicated to patient/family					
Discharge planning needs communicated to patient/ family or receiving facility					
Transfer planning communicated to next level of care/service					
Functional needs communicated by referral to rehabilitation services					
Medication management needs communicated to staff, pharmacy, physician					
Pain management needs					

communicated to staff, pharmacy, physician					
Psycho-social needs communicated by referral to social services/chaplain					
End-of-life issues communicated to physician, staff, social services, chaplain/referral to hospice facility					
Cultural/religious/spiritual needs communicated to staff and/or referral to chaplain /dietician					
Barriers to learning communicated to staff					
Language barriers communicated to staff with referral to interpretive services as needed					
Referral of identified victims of abuse or neglect per hospital policy Dietary needs communicated to staff/referral to dietician					
Patient safety precautions communicated to staff/family (e.g., falls precautions)					
Evidence of communication of diagnostic testing performed:					
Laboratory					
Imaging services					

Cardiopulmonary					
Evidence of communication within organization from board and administration level to staff					
Evidence of communication within organization from staff level to board and administration					
Evidence of communication within departments					
Evidence of communication within committees (e.g., safety committee communicating findings to patient safety committee)					
Evidence of interdisciplinary communication					
Evidence of multiple avenues for communication within organization (e.g.,: news letter, staff meetings, town meetings)					
Evidence of communication with community					
Evidence of communication regarding outcomes of care and data monitoring					
Evidence of					

communicating performance improvement initiatives, methodology, and dissemination of findings					
Evidence of communication regarding safety concerns or safety plan					
Evidence of communication to staff regarding alternative exits during construction/reconstruction					
Brief post-op note containing the following items: name of primary surgeon and assistants, findings, procedures performed and descriptions of procedures, estimated blood loss, specimens removed, and postoperative diagnosis					
Verbal order/telephone order read-back process evident					
Use of patient identifiers prior to administration of meds/blood or taking blood					
Time-out communication prior to surgical/invasive procedures					

Source: Tracer Methodology: Frontline strategies to prepare your organization for JCAHO Survey, Second Edition, by Missi Halvorsen and Patricia Pejakovich, ©2006 HCPro, Inc. Used with permission.

Tool: Unannounced survey document list

Notes: The surveyors are here. Do you know where your documentation is? This list shows you what you'll need to have on hand for an unannounced survey, and allows you to assign responsibility for up-to-date documentation. Adapt it and distribute as needed to your survey team, and use it as a data checklist.

Documents required for unannounced surveys checklist

(Data needed: last 12 months prior to survey)

Document	Responsible person	Quarter 1 update	Quarter 2 update	Quarter 3 update	Quarter 4 update
Performance Improvement Data					
Infection Control Surveillance Data					
Environment of Care to include Statement of Conditions and plans for improvement, management plans and annual evaluations, minutes of environment-of-care team meetings					
Organizational chart					
Map of organization					
List of departments, services, units					
Name of key contact					
Priority focus process data					
Measures of success					
ORYX data					
Organ donation and procurement conversion rates					
Medical record delinquency form					
Each day of survey: <ul style="list-style-type: none"> • Census • OR schedules • Clinic visits • Home health visits if applicable 					

Source: Information Management: The Compliance Guide to The Joint Commission Standards Sixth Edition, by Jean S. Clark, ©2007 HCPro, Inc. Used with permission.