JCAHO Accreditation Survey Findings
Requirement(s) for Improvement

Assessment and Care/Services

**PC.2.120** – The hospital defines in writing the time frame(s) for conducting the initial assessment(s).

**Element of Performance #7** – Some of these elements may have been completed ahead of time, but must meet the following criteria, updates to the patient’s condition since the assessment(s) are recorded at the time of admission.

**Findings:** One surgical record contained an H&P that was not updated at the time of admission for surgery.

**PC.11.40** – Any use of restraint (to which these standards apply) is initiated pursuant to either an individual order (standard PC 11.50) or an approved protocol (standard PC 11.60), the use of which is authorized by an individual order.

**Element of Performance #7** – Such renewal or new order is issued no less often than once each calendar day and is based on the licensed independent practitioner’s examination of the patient.

**Findings:** During tracer activity it was noted that daily renewal orders are not obtained when patients in the MICU are placed in restraints for medical reasons. This was noted in one medical record and interviews with the staff revealed that this is the common practice.

Information Management

**IM.6.30** – The medical record thoroughly documents operative or other procedures and the use of moderate or deep sedation or anesthesia.

**Element of Performance #3** – Operative reports dictated or written immediately after a procedure record the name of the primary surgeon and assistants, findings, procedures performed and description of the procedure, estimated blood loss, as indicated, specimens removed, and postoperative diagnosis.

**Findings:** In two (2) instances in one medical record operative reports were not dictated immediately after the surgical procedure. The policy has been to allow 24 hours for dictation. Another record contained a dictated operative report that was not recorded until the 5th post-operative day.
Medication Management

MM.3.20 – Medication orders are written clearly and transcribed accurately.

Element of Performance #9 – In addition, the hospital specifies that blanket reinstatement of previous orders for medications are not acceptable.

Findings: During an individual tracer, two unclarified blanket orders (“resume previous orders” and “resume all trauma service orders”) were noted in one postoperative record reviewed.

Patient Safety

PC.13.20 - Operative or other procedures and/or the administration of moderate or deep sedation or anesthesia are planned.

Element of Performance #9 – The site, procedure, and patient are accurately identified and clearly communicated, using active communication techniques, during a final verification process, such as a time out, prior to the start of any surgical or invasive procedure.

Findings: A final verification process for invasive procedures done in areas other than the operating room has only recently been implemented. The policy was outlined three months prior to survey and finally approved just prior to the survey.

IM.6.40 – For patients receiving continuing ambulatory care services, the medical record contains a summary list of all significant diagnoses, procedures, drug allergies, and medications.

Element of Performance #2 – The list is always stored in the same location to help practitioners access needed information quickly and easily.

Element of Performance #3 – The list contains the following information:

- Known significant medical diagnoses and conditions
- Known significant operative and invasive procedures
- Known adverse and allergic drug reactions
- Known long-term medications, including current prescriptions, over-the-counter drugs, and herbal preparations.

Note: “Known” refers to information gathered during ambulatory care assessment and treatment.

Findings: The problem summary list when used is in varying places in each ambulatory department record. It is a paper list in pediatrics, it is an electronic record in geriatrics, and it is not available in dermatology, plastic surgery, or the comprehensive cancer center.
Four of six active ambulatory records laced a complete summary list of all significant diagnoses, procedures, drug allergies, and medications. Only geriatrics, family health center, infectious disease, and general pediatric clinics maintained summary lists.