Survey tracker

Surveyors’ approach takes one hospital by surprise

You can spend months planning for a JCAHO survey, and staff may have every Patient Safety Goal down pat, but last-minute surprises can strike. Prepare for the unexpected, such as finding out that surveyors will address priority focus areas you didn’t anticipate, quiz one of your housekeepers about an alarm, or discover that a blood vial isn’t labeled with a patient’s birth date.

“I was nervous going into the survey, and there were a lot of surprises, but that’s okay. The new survey process makes a lot of sense, and it can only help us continue providing the best care for our patients,” says Susie Weeks, RN, CPHQ, director of performance improvement and risk management for Keokuk (IA) Area Hospital.

Weeks’ hospital underwent a three-day survey by a physician and a registered nurse in April. Following are some of the highlights of her experience with the JCAHO’s new survey process.

Be prepared for surprises

Two weeks prior to survey, Weeks went online to visit the JCAHO’s website. "I found the submission of ESC much easier than in the past—the JCAHO just wants your action plans—no forms, no policies,” says Mac McCarthy, BSN, RN, CPHQ, safety and regulatory coordinator with the Bellin Health System in Green Bay, WI.

Consultant Bud Pate, REHS, > p. 5

Five tips for submitting evidence of standards compliance reports

There may be 13 pages of guidelines for submitting an evidence of standards compliance (ESC) to the JCAHO, but don’t let that scare you. We polled your peers, and the majority of them say it’s a better process.

“No more mounds of paperwork,” echoes Cherry Bass, RN, director of quality/risk management at Jacksonville (AL) Medical Center.

Deloris Cooper, RN, manager of the accreditation regulatory standards at Sentara Hospitals in Norfolk, VA, agrees that submitting an ESC is easier than ever, but says it can be tricky when describing your corrective actions and evaluation methods. She completed her hospital’s ESC in June.

Stay tuned

JCAHO is about to announce its new Patient Safety Goals. Keep an eye on our upcoming issues for the latest information.

Are you waiting for the next wave of changes from the JCAHO? BOJ will be taking a front row seat at this year’s Executive Briefings Conference to help you stay ahead of the game. Look for our special report in October.

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Dietary

Turn to a nutritional assessment form that pleased the JCAHO on p. 3.

Evidence of standards compliance

Check out sample standard compliance guidelines on p. 5.

Patient flow

Learn three thrifty ways to improve patient flow on p. 7.

Infection control

Tackle the JCAHO’s infection control standards on p. 9.

Provision of care

How to address PC.13.20, the presedation/preanesthesia assessment on p. 10.
JCAHO's extranet and learned that her hospital’s priority focus areas would be quality improvement, information management, organizational structure, and staffing.

“I was actually surprised that these were our priority focus areas, especially with all of the hot spots that I had been hearing about,” says Weeks. She thought surveyors would be more interested in patient safety, medication management, and infection control.

Get ready to pull out the policies and procedures

During the on-site visit, surveyors scrutinized the following 11 policies and procedures:

- Restraint policy
- Hospital and medical staff bylaws
- Variance reporting policy
- Sentinel event policy and procedure
- Admission assessment
- Performance improvement plan and process
- Patient safety plan
- Credentialing and reappointment policy
- Patient identification policy
- Medication administration
- Transfer policy

Surveyors spent about two hours reviewing the hospital’s policies. They also reviewed open records and requested closed records when they needed to validate something in the open ones. They spent a significant amount of time on the credentialing and reappointment policy.

“I think they read that one line by line,” says Weeks. However, the majority of the surveyor’s time was spent tracing patients.
Memorize those National Patient Safety Goals
Before the actual tracing of patients, both surveyors took a tour of the hospital and focused heavily on the National Patient Safety Goals. They spoke with every surgical staff member in the operative suite. Surveyors asked them what steps they had taken to address the areas of prevention of surgical fire and wrong-site surgery.

Next, the physician surveyor donned hospital scrubs and roamed the surgical department, including recovery, ambulatory, and anesthesia.

“He didn’t miss a spot,” says Weeks. He had every staff member review the hospital’s policy and procedures on marking surgical sites and the time out. Surveyors were impressed by the hospital’s patient safety boards displayed in the operating suites. The boards covered the hospital’s patient safety issues, citing specifics about procedures and information about drug allergies.

Focus on medication management and alarms
Both surveyors concentrated in all areas involving medication management and safety. The survey was running smoothly until they noticed the antianxiety agent, Ativan, in an unlocked refrigerator.

“We certainly don’t keep Ativan there now, but we did then,” says Weeks.

Sample nutritional assessment form

<table>
<thead>
<tr>
<th>Subjective:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appetite: good/fair/poor</td>
</tr>
<tr>
<td>Food allergies/intolerances:</td>
</tr>
<tr>
<td>Patient comments:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diet order:</td>
</tr>
<tr>
<td>Height:</td>
</tr>
<tr>
<td>Weight changes:</td>
</tr>
<tr>
<td>Diagnosis:</td>
</tr>
<tr>
<td>History:</td>
</tr>
<tr>
<td>Pertinent medications:</td>
</tr>
<tr>
<td>Pertinent lab:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nausea</th>
<th>Vomiting</th>
<th>Diarrhea</th>
<th>Constipation</th>
<th>Difficulty chewing or swallowing</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Assessment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of nutritional risk:</td>
</tr>
<tr>
<td>Estimated caloric needs:</td>
</tr>
<tr>
<td>Estimated fluid needs:</td>
</tr>
<tr>
<td>Comments:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended diet change:</td>
</tr>
<tr>
<td>Monitor intake/calorie count:</td>
</tr>
<tr>
<td>Between meal nourishment/supplement:</td>
</tr>
<tr>
<td>Provide diet counseling:</td>
</tr>
<tr>
<td>Monitor diet tolerance/diet progression:</td>
</tr>
<tr>
<td>Reassess in ___ days:</td>
</tr>
<tr>
<td>Goals:</td>
</tr>
</tbody>
</table>

Dietitian signature: ____________________________ Date: ______________

Source: Keokuk (IA) Area Hospital. Reprinted with permission.
Survey tracker

The nursing areas within the emergency room and med/surge units were also targets for investigation. Surveyors questioned the staff about narcotics to verify whether they followed hospital procedures. At the same time, they searched for outdated supplies and checked clinical alarms.

As a test, surveyors left the door of a refrigerator open long enough to set off the alarm. Then, they located a nurse at the end of the hall and asked her what she heard and what it meant.

Housekeeping staff didn’t escape surveyors’ questioning either. Surveyors noticed one housekeeper working in the hallway and set off a nearby sense attack alarm. This particular alarm alerts staff when a patient tries to get out of bed. The surveyors were satisfied when they watched the housekeeper check the situation by going into the room and turning on the light for the nurse.

Be mindful of exits

The physician surveyor focused on the environmental care and a building tour. He even pretended he was a visitor during an emergency situation looking for the exit. He was impressed to find everything was in order.

“I never had a surveyor do any of these kinds of [tests] before,” says Weeks, who quickly adds that surveyors were friendly and not intimidating. She was particularly impressed with how much they covered in only three days. Neither of them had down time. “They were so busy, they didn’t even stop for lunch on the first day,” says Weeks. “I have always felt very strongly that surveyors needed to get out of books and into patient care, and that is what they did.”

Warm up for patient tracers

Surveyors selected seven patients to trace. They chose complex situations in which patients received care or services in multiple areas. These tracers took surveyors into nearly every department—the emergency room, surgery, radiology, lab, cardiopulmonary, and the sleep lab—as they followed

- two medical/surgical patients (i.e., one appendectomy, one diabetic)
- one patient who had a cesarean section
- one patient with pneumonia
- one patient with chemical exposure in the critical-care unit
- one cerebrovascular accident stroke victim
- one psychiatric care unit patient on suicide precautions

Note: The patients arrived at Keokuk in various ways: One came as a direct admission from the physician office, and the rest came via the emergency room.

The surveyors traced each patient’s care from arrival to discharge. They also talked with dietitians during three patient tracers and were especially impressed by the department’s assessment tool, because it was so concise. (See the form on p. 3).

Unfortunately, surveyors found that a home health staff member had brought in a blood vial that wasn’t labeled with the patient’s birth date—one of the hospital’s identifiers for patient identification.

“They wrote us up for one tube of blood,” says Weeks. Despite the error, she says surveyors complimented the hospital in other areas because the staff on all units discussed patient rights and the National Patient Safety Goals.

No rest for the weary

The week after their JCAHO survey, Keokuk Area Hospital had another visitor. Medicare arrived to conduct a validation survey. “It was incredibly more intense than the JCAHO survey—they even opened every drawer in the hospital,” says Weeks.
practice director for clinical operations improvement for The Greeley Company, a division of Marblehead, MA–based HCPro, Inc., which publishes BOJ, has spent this year counseling a number of hospitals with their ESCs. Following are Pates and Coopers’ tips:

1. After you receive your accreditation report, develop a solid corrective action plan (CAP) and be certain to complete all sections of the CAP within the first or second month of your 90-day deadline to the JCAHO.

2. Elect someone accountable for managing the assigned actions and ensuring that everyone stays on target. Remember, you no longer tell the JCAHO what you are going to do to stay in compliance—you must demonstrate that you are compliant.

3. Create a one-page template to help guide you when writing your CAP (see a sample from Cooper on p. 6). And to make things easier, develop your measure of success (MOS) while working on your CAP.

4. Keep month three of your 90-day deadline free to concentrate on completing the evaluation process, including audits. Remember, if you have a category “C” standard or MOS attached to a request for information that requires an audit, you must provide the JCAHO with a random sample.

5. Submit a prefinal version of your ESC two to three weeks before your 90-day deadline and ask the JCAHO to provide a preliminary read. You’ll have a better chance of your ESC being accepted the first time.

Sample evidence of standard compliance guidelines at a glance

If you have been too busy to sift through the JCAHO’s new guidelines, the following chart gives a quick overview of everything you need to know. Of course, we hope you don’t have to submit one at all.*

<table>
<thead>
<tr>
<th>Documentation</th>
<th>Requirement</th>
<th>To do</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective action(s) taken</td>
<td>(Required)</td>
<td>Write a detailed account of each corrective action.</td>
<td>Corrective action have been completed prior to submitting the ESC.</td>
</tr>
<tr>
<td>Evaluation method</td>
<td>(If required)</td>
<td>Note your methods for assessing the corrective action. List the sources of data, and include how many times the evaluation occurs. (Note: The JCAHO requires that you collect assessment data on a monthly basis.)</td>
<td>Methods of assessment have been completed prior to submitting the ESC.</td>
</tr>
<tr>
<td>Measure of success goal</td>
<td>(If required)</td>
<td>Provide the JCAHO with an estimation of your desired success rate based on your proposed corrective action (include as a percentage).</td>
<td>After the JCAHO approves your ESC, continue to carry out your approved methods for evaluating your corrective action. After four consecutive months, provide the JCAHO with your actual level of compliance by calculating your overall average MOS rate during that course of time.</td>
</tr>
<tr>
<td>Clarification</td>
<td>(Optional)</td>
<td>Submit an adequate explanation about why surveyors didn’t have access to information at the time of your survey.</td>
<td><em>(The information you provide to the JCAHO must be a result of the recommendation made by the surveyor during your on-site visit. Otherwise, the JCAHO won’t consider it.)</em></td>
</tr>
</tbody>
</table>

Source: www.jcaho.com. Go to bottom of the home page, click on “search,” and type “ESC” to read the complete set of guidelines.
**Sample: Evidence of standards compliance corrective action plan**  
*Source: This chart was created by Deloris Cooper, RN, manager of the accreditation regulatory standards at Sentara Hospitals in Norfolk, VA. Reprinted with permission.*

**Requirement for improvement**—Care and services are provided in an interdisciplinary, collaborative manner as appropriate to the needs of the patient and the hospital’s scope of services.

CAP implementation/completion responsible person—**nurse executive**

ESC due to the JCAHO—**July 6**

<table>
<thead>
<tr>
<th>Actions</th>
<th>MOS = 90%</th>
<th>Completion date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Evaluate required actions based on the JCAHO’s ESC guidelines and communicate to Sentara Bayside Hospital vice president and nurse executive. Recommend measure of success (MOS).</td>
<td>The JCAHO coordinator</td>
<td>4/19/04</td>
</tr>
<tr>
<td>2. Kick off meeting with key disciplines and support personnel to communicate expectations for compliance, plan required actions, and assign responsibilities.</td>
<td>Nurse executive and vice president</td>
<td>4/19/04</td>
</tr>
</tbody>
</table>
| 3. Communicate ESC and interdisciplinary-care planning requirements to the medical staff and determine medical staff required actions:  
  • Medical executive committee prep  
  • Hospital’s continuous quality improvement/clinical effectiveness  
  • Medical executive committee | Nurse executive and vice president | 4/30/04 | 4/21/04 | 4/26/04 | 4/27/04 |
| **Note:** Vice president of medical affairs assigned responsibility for medical staff actions/compliance. | | |
| 4. Reeducate key disciplines regarding the interdisciplinary-care planning process and documentation requirements.  
  • Education tools and examples of patient problems/needs and goals shall be provided by __________. | Team members | 4/30/04 |
| 5. Development/design of an audit tool, random sampling process, and database.  
  • Determine whether open or closed medical record review will be audited. | The JCAHO coordinator | 4/30/04 |
| 6. Implementation of the interdisciplinary process and documentation on the interdisciplinary-care plan by all appropriate disciplines. | Above department managers | 5/01/04 |
| 7. Periodic review/monitoring of the effectiveness of the process:  
  • Adopt discipline specific auditing processes  
  • Reeducation of staff as deemed appropriate  
  • Adopt other required actions as deemed appropriate | Above department managers | 5/01/04–5/31/04 |
| 8. Periodic meetings with “kick off” team members to assess compliance status. | Nurse executive | 5/01/04–5/31/04 |
| 9. Complete the first random sampling audits to assess compliance:  
  • A minimum of 30 medical records must be audited. | Nurse executive | 6/1/04–6/30/04 |
| 10. Submit ESC report to the JCAHO. | Nurse executive and the JCAHO coordinator | 7/2/04 |
| 11. Ongoing random sampling audits to assess compliance. | Nurse executive and the JCAHO coordinator | July–October |
| 12. Submit MOS report to the JCAHO. | Nurse executive and the JCAHO coordinator | To be determined |
Three cost-cutting ways to improve patient flow

Improving your patient flow doesn’t have to be expensive. Just ask the emergency department (ED) staff at St. Rose Hospital in Haywood, CA. By purchasing colorful popsicle sticks, a grease board, and making better use of existing space, the hospital has watched ambulance-diversion rates drop and its patient satisfaction rates rise.

In fact, the hospital’s simple, cost-effective changes to improve patient flow have already caught the eye of JCAHO surveyors. During the hospital’s February on-site visit, surveyors raved about the ED. They were especially impressed with the working relationship between the medical department emergency director, the emergency room manager, and the other hospital departments.

Patrick Evangelista, RN, MBA, clinical nurse manager, who oversees the ED at St. Rose, says that within the past year the department has made an effort to work together to improve its patient flow problems. With the support of Armando Samaniego, MD, medical department emergency director with California Emergency Physicians, the hospital has opened up emergency beds, improved its diversion rates, reduced employee stress levels, and increased patient satisfaction.

Multidisciplinary team tackles gridlock

To address patient flow and bottlenecks, the hospital, in January 2003, created an Emergency Performance Improvement Committee (EPIC), a multidisciplinary team made up of nursing staff, medical staff, licensed practical nurses, emergency room technicians, clerks, radiologists, laboratory technicians, and housekeeping staff.

The team looked at how much money the hospital spent per hour on diversion issues. Staff didn’t realize how much money the hospital lost whenever ambulances were sent to a different hospital because the ED was too full. “It just isn’t cost effective to go into diversion if you multiply the 184 hours we spend diverting ambulances by $1,000 per hour,” says Evangelista. “That’s lost revenue if you think of admissions compared to ambulance traffic.”

The team then mapped out the typical emergency room visit process: Patients sign in, sit in the lobby, meet with a triage nurse, and return to the lobby until they see a physician.

“We got away from this serial process and moved to an overlapping approach,” says Samaniego. “If a bed is available, it’s important to get the patient in the room and triage at the bedside, so we see the patient as soon as possible.”

Seeing patients sooner is critical because the number of emergency visits to the hospital has increased dramatically over the past two years. Samaniego reports that in 2002, 28,000 patients were treated at St. Rose’s emergency room. The number increased to 32,000 in 2003, and he predicts the visits will surpass that figure in 2004.

“In December 2002 we saw 2,400 patients. [In December 2003] we saw 3,500. That’s a huge influx,” he says.

All of St. Rose’s improvement have allowed the ED to treat most patients without turning ambulances away to other hospitals. Instead of a two-hour wait to see a physician, patients now wait approximately 39 minutes.

Evangelista noticed the dramatic differences the changes made during the December influx. “We only needed a total of 10 hours diversion time for a month when there was a surge of 1,000 patients in the ED,” he says.

“A year ago we had [two] to three times those amount of hours, and the percentage of patients who left without being seen went from 13 to 14 patients a day to the single digits.”

The following are three steps the hospital and the EPIC team took to improve patient flow without spending a lot of money:  

> p. 8
1. **Use colored sticks to identify tests ordered**
Samaniego developed a simple idea that allowed nurses to immediately see when doctors ordered tests without ever speaking to them. He purchased three dozen multicolored popsicle sticks to identify when a physician ordered a lab test, respiratory test, or an electrocardiogram (EKG).

Once a physician orders a test, the unit assistant places the order and puts the colored stick in the chart.

“No now I can sit in my office and from a distance see a red stick or purple stick and know that a patient needs to get an EKG done or a lab drawn,” says Evangelista. “That was pretty significant because it helped the entire process and it only cost a few dollars.”

2. **Use a grease board to track your patient status**
The team also purchased a large grease board to track patient status for $500. The board keeps track of each patient and costs far less than the $350,000 software tracking programs the hospital was evaluating. “We can see by looking at the board whether a patient is having an EKG or if she needs a lab,” Evangelista says. “It’s really improved the flow because we can look at the board and see that a patient doesn’t necessarily need to take up a bed, but can stay in the holding area while waiting for a lab.”

3. **Make better use of dead space**
The hospital also created a “Medical Express Unit,” which uses dead space in the hospital to move patients off monitors in the ED and free-up beds. The operating room manager allots Evangelista one to two beds in the morning and five beds in the afternoon. “This way I can move five monitored patients to the med/surg in the OR recovery room where there is a nurse with no patient load. The only cost is one nurse, and it frees up space.”

Once the patients are out of the hectic, chaotic atmosphere of the ED, they are much happier, Evangelista says. “They are in a calm environment and they have a nurse that can [administer] them medication, feed them, and care for them,” he says.

“Our satisfaction is up, and the express units eliminate much of the need to divert. We’ve made effective use of our dead space, and we’ve maximized our resources. It’s worked very well because it’s opened up beds for the ED and reduced the stress loads on nurses.”

—Ilene MacDonald
Imacdonald@hcpro.com
Create a committee to tackle the JCAHO’s IC standards

Creating a committee to handle infection control (IC) issues is one way to comply with the JCAHO’s revised IC standards, which emphasize a collaborative approach to prevention and control. The revised standards take effect January 1, 2005 (see the box below for a list of the JCAHO’s proposed standards).

Although the JCAHO doesn’t require the creation of a formal interdisciplinary IC committee, it is one way to ensure that your hospital complies with the requirements, says Tammy Lundstrom, MD, vice president and chief quality and safety officer at Detroit Medical Center.

Establish a committee to meet your needs
The IC committee at Detroit Medical Center includes physician leaders, administrators, risk managers, pharmacy staff, nursing staff, operating room (OR) staff, and other frontline healthcare workers, Lundstrom says. Organizations can add other representatives depending on the services they provide.

Spaulding Rehabilitation Hospital Network in Boston began an infection control task force in January 2001, says Lark Dupont, MSN, RN, CIC, coordinator of IC and patient care services for regulatory compliance. The long-term acute care and rehabilitation hospital had numerous IC issues.

These issues included everything from hand hygiene to equipment disinfection to staff education. Each program—Spaulding’s equivalent of a unit—has a liaison who attends monthly meetings, Dupont says. Spaulding’s IC task force includes nurses, educators, physical therapists, occupational therapists, therapy students, and nursing and rehabilitation aides.

Provide unit-specific education
The liaisons pass on major news from meetings to their staff, Dupont says. They can also answer IC questions from staff or address any concerns at the next meeting.

Discuss concerns in an open forum
An interdisciplinary IC committee can help you draft new policies that comply with the JCAHO standards and still allow departments to function efficiently without extra burden, Lundstrom says. The IC committee can draft a policy, and department leaders can then bring that policy back and discuss it with their staff to make any necessary changes.

“When you have the opportunity to discuss it in an open forum,” she says, “you have a better result than sitting down at a desk and drafting policies.”

—Matt Bashalany, associate editor
mbashalany@hcpro.com

Infection control standards

The JCAHO’s proposed infection control (IC) standards for 2005 are as follows:

• IC.1.10: Facilities minimize the risk of healthcare–acquired infections (HAIs) through an organizationwide IC program.
• IC.2.10: The IC program identifies infection and transmission risks on an ongoing basis.
• IC.3.10: Based on risk, the organization sets priorities and goals to prevent HAIs.
• IC.4.10: Facilities carry out strategies to meet their IC goals.
• IC.5.10: Facilities must evaluate the effectiveness of their IC interventions and redesign programs as necessary.
• IC.6.10: As part of its emergency management activities, the facility prepares to respond to an influx, or the risk of an influx, of infectious patients.
• IC.7.10: Organizations must effectively run the IC program.
• IC.8.10: Leaders from different areas of the organization must collaborate with IC program managers to assess the adequacy of resources and the outcomes of goals, and must revise the program to improve outcomes.
• IC.9.10: Organization leaders must provide adequate resources for the IC program.
Put PC.13.20 to sleep: How to address the preanesthetic/presedation assessment

Surveyors checked to ensure that physicians conducted an airway assessment prior to sedation during a survey in February at the Hospital of Saint Raphael in New Haven, CT. Linda Pello, RN, MBA, CPHQ, director of quality improvement, says they were looking for documentation.

It’s likely that surveyors will diligently focus on preanesthetic/presedation assessments now that the JCAHO announced its list of the top compliance issues for 2003. It ranked the standard at number five in a top 10 list of continuing pain points for hospitals. (See the “JCAHO’s top problematic standards for all of 2003,” on p. 5 in the July BOJ).

John Rosing, MHA, FACHE, senior consultant with The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, lists the three standard sticklers:

1. Lack of documentation of the airway assessment, which involves looking at the patient’s ability to hyperextend his or her neck, as well as checking for loose teeth, dentures, and any other visible signs of obstruction.
2. Not performing an airway assessment prior to creating a sedation plan.
3. Failure to document a reassessment of the patient just prior to beginning the case.

“There are confusing aspects to this last point that can easily trip up physicians,” says Rosing.

The JCAHO standard regarding reassessment is worded for cases when a physician completed the first patient exam, including an airway assessment within hours or days before a procedure.

In these cases, reassessment seems logical, because a patient’s condition may have changed within that time frame. But in many instances, the first evaluation takes place just before the case begins, and it may seem unnecessary to do a reassessment only a few minutes later.

The standard insists that no matter how much time has elapsed between the first assessment and the beginning of the case, the physician must do a reassessment before continuing with the procedure, says Rosing. This applies to moderate sedation and all forms of anesthesia.

“My feeling is that 99% of the time physicians do the assessment. They just fail to capture their excellence in writing,” says Elizabeth DiGiacomo-Geffers, RN, MPH, CNAA, BC, a consultant in Trabuco, CA. They forget to document the full assessment, or sign it, date it, or time it.
Sample premoderate sedation assessment record

Editor’s note: This form is to be completed and signed by the physician performing the procedure/the physician administering the sedation.

<table>
<thead>
<tr>
<th>Age:</th>
<th>years</th>
<th>Sex:</th>
<th>Male</th>
<th>Female</th>
<th>Weight:</th>
<th>kg</th>
<th>Patient I.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposed procedure:</td>
<td>❑ Side and site verified</td>
<td>Preop diagnosis:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PAST MEDICAL HISTORY (H&P REVIEWED)**

No ❑ Yes

- ❑ Allergies: _____________________________________________________________
- ❑ Medications: __________________________________________________________
- ❑ Previous sedation/anesthesia problems (including family history): _________________
  __________________________________________________________________________
  __________________________________________________________________________
  __________________________________________________________________________

- ❑ Previous surgery: ______________________________________________________
- ❑ Pertinent medical history: _______________________________________________
  __________________________________________________________________________
  __________________________________________________________________________

- ❑ Alcohol/drugs: __________________________________________________________
- ❑ Smoking: _______________________________________________________________

**PHYSICAL EXAM**

NORMAL? ❑ Yes ❑ No

<table>
<thead>
<tr>
<th>AIRWAY</th>
<th>DENTAL</th>
<th>CARDIAC</th>
<th>CHEST/RESP</th>
<th>LEVEL OF CONSCIOUSNESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**PERTINENT LAB/DIAGNOSTIC TESTS**

**PLAN FOR SEDATION**

Medication: __________________________________________________________

Plan: ________________________________________________________________

- ❑ Post sedation plan of care:
  - ❑ PACU ❑ Monitored bed ❑ Holding area
  - ❑ ICU ❑ Nonmonitored bed ❑ Home

- ❑ Patient reevaluated immediately prior to moderate (“conscious”) sedation

Attending Physician ❑ I.D.# ❑ Date ❑ Time

Source: The Greeley Company in Marblehead, MA.
Four quick ways to help staff comply with the preanesthesia/presedation standard

1. Educate medical staff on the definitions of moderate and deep sedation. Be sure your entire organization understands your definitions of moderate and deep sedation and what constitutes a complete assessment of a patient.

If they don’t, redefine your terms and educate them, says Glenn D. Krasker, MHSA, president of Critical Management Solutions, a consulting firm that specializes in medical error risk reduction in Wilmington, DE.

2. Provide a preanesthesia checklist. Make preanesthesia assessments quick and easy with a tool, such as a checklist.

Standardize it, and ensure that all departments use it, says Krasker. (For a sample checklist, see p. 11).

3. Assign a gatekeeper. Elect a person with the approval of management and medical staff leadership who have the authority to stop procedures that don’t have a complete assessment, says Krasker.

4. Do a chart audit. Ask every physician involved in presedation/preanesthesia assessments to give you three of their patient charts, suggests John Rosing, MHA, FACHE, senior consultant with The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

Review them to make sure physicians are using the same forms and filling them out correctly. If you find something missing or inaccurate use it as an opportunity to give gentle coaching on how they should complete assessments at your hospital.