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Ambulatory Care Patient Tracer

Requirement	Met	Not Met	Comments
General Entrance			
Waiting Room appears clean and uncluttered			
No torn or non-maintained upholstery			
Designed to meet Social Distancing Requirements			
Hand Sanitizer Available			
Patient Rights Posters are visible			
Patient Privacy and Confidentiality maintained			
No full names, low volume voice, respectful tone			
Registration Area			
Two patient identifiers are used to confirm patient identity			
Consents - signed, dated and timed			
Caregiver/Support person identified on the MR			
Patient Rights (written copy) are available on request			
Advanced directives are placed on medical record, if available			
Advanced directives are available upon request			
Preferred language identified in the medical record			
Department Tour			
Hand Hygiene- done by all, properly			
PPE- Use/Staff Knowledge			
Flu Vaccine/exemption – all staff			
Equipment Cleaning Procedure followed – Point of Use			
Hallways are not cluttered			
No PHI visible to patients			
Hand Sanitizer is readily available			
Emergency Equipment readily available			
Fire Extinguisher location is easily located			
Fire Extinguisher is checked monthly and noted on tag			
Fire Exit signs are easily visible and illuminated			
Fire doors properly close			
Fire drills completed as required			
Staff knowledgeable in what to do in the event of a Fire			
No stained or missing ceiling tiles			
Staff food and drink are only present in Hydration Station locations. Drinks are covered.			
Employee ID badges are worn above the waist			
Storage is less than 18” from bottom of sprinkler head			
Full and empty Oxygen cylinders are separated, secured, labeled, no more than 12 full cylinders in one place)			
Eyewash stations properly tested, contain cover lids, tepid water			

Applicable to the following Accreditation Programs: ( ) Hospital ( ) Critical Access Hospital ( ) Behavioral Health (X) Ambulatory Care (X) Office Based Surgery ( ) Disease Specific Certification ( ) Staffing Certification

Regulatory Information may change over time as healthcare expectations change. This document is current as of the date noted within this footer

Requirement	Met	Not Met	Comments
Medical equipment is inspected and in good working condition			
Furnishings in good repair – no tears, cracks, peeling, worn items			
Utility system failure – back-up processes			
Security – staff control access to area			
General space in good condition – no holes in walls, carpet, material or curtains			
No high dust, minimal low dust			
Papers are laminated and hung with double sided tape			
Pt refrigerator /freezer temperatures are monitored, and appropriate action is taken when out of range			
Ice machines ae free to lime/mold			
General Exam Rooms			
Upholstery is well-maintained			
Equipment is cleaned before and/or after use per organization policy			
High Level Disinfection and Sterilization, where applicable			
No unsecured sharps in the room			
Used sharps containers are available, if injections are provided in the room			
Sharps containers are not portable - attached to wall, counters, etc.			
No medications are stored within the exam room unless in a locked cabinet			
Extension cords are not used on patient equipment			
Equipment in the room is BioMed checked and within date			
Privacy curtain in place			
Stirrups are free of dust and residue			
OB-GYN exam rooms: Right to have third party present for exam			
Provision of Care			
Assessment - Initial Assessment completed per policy			
Patient Allergies are documented			
Reason for the visit is noted in record			
Reassessment - per policy			
Screenings – Triggers **See below**			
Care Plan individualized, goal oriented, time oriented, initiated, updated			
H&P/ H&P Update – where needed			
All physician orders are signed, dated and timed			
Orders of Physician Assistants are co-signed			
Patient ID is on all pages			
No Do Not Use Abbreviations in the medical record			
Discharge Plan- provided to patient, understandable to pt.			
Physician Privileges- accessible to staff, staff knowledge			

Requirement	Met	Not Met	Comments
Follow most current order/have an order			
Entries in the Medical Record are all dated/timed/legible according to policy			
Pain Screening			
Initial inquiry for presence of pain			
Pain Assessment completed on patient's expressing pain present			
Fall Risk			
Fall Risk assessment completed upon admission			
Screening for Abuse			
Screening for Abuse, Neglect, Exploitation completed			
Referral to Physician completed when positive screening			
Record of care reflects actions taken			
Functional Screening			
Functional Screening not completed			
Referral to Rehab Services not completed when positive screening			
Rehab Services Referral evaluation not completed w/i prescribed timeframe			
Nutritional Screening			
Nutritional Screening not completed			
Referral to Clinical Nutrition not completed when positive screening			
Clinical Nutrition Referral evaluation not completed w/i prescribed timeframe			
Skin Assessment			
Skin Assessment Not Completed			
Referral to Wound Specialist not completed when positive screening			
Wound Specialist Referral evaluation not completed w/i prescribed timeframe			
Braden Risk Assessment			
Braden Risk Assessment Not completed upon admission			
Braden Risk Assessment Not Reassessed per policy frequency			
Braden Risk Assessment not reflective of patient condition			
Communication Needs			
Preferred language is documented			
Language/Deaf Access – accommodations made, if needed/requested			
Record reflects use of communication tools (translation phone/whiteboard/sign language interpreter			
Evidence of documents provided in patients preferred language			
Psychosocial Needs Assessment			
Psychosocial Needs Assessment Completed			
Referral to Resources completed for positive screening			
Educational Needs			

Requirement	Met	Not Met	Comments
Preferred learning style identified as part of Educational assessment			
Preferred learning language identified as part of Educational assessment			
Learning Barriers identified as part of Educational assessment			
Cultural, and religious beliefs are incorporated into the educational plan when applicable			
Patient/Family Education			
Education provided aligns with the patient's problems			
Documentation of patient/family understanding of education or progression toward understanding			
Problem/Summary List			
Problem /Summary List on chart			
Patient Safety			
Medication Reconciliation			
Current list of patient's home meds documented on admission			
Evidence that home meds were compared to new medications			
Med Reconciliation completed at discharge			
Patient Identification Process			
Staff able to verbalize the two-patient identifier process			
Staff observed following patient identifier process			
Critical results			
Staff able to verbalize Critical Results process			
Staff observed following critical results process			
Communication of result to physician/MLP documented w/i 1 hour of reported results or per organization's policy			
Read-Back and Verify- documented			
High-Risk Medications			
Staff able to verbalize High-Risk Meds process			
Staff observed following High-Risk Meds process			
High-Risk Medications are identified as such			
Look–alike/Sound-alike Medications			
Staff able to verbalize process to be used with Look-alike/Sound-alike meds			
Staff observed following Look-alike/Sound-alike meds process			
Sound Alike/Look Alike medications have Tallman/Shortman lettering			
Hazardous Medications			
Staff able to verbalize the process to be used with Hazardous meds			
Staff observed following Hazardous meds process			
Staff disposal of Hazardous medication/wrappers properly			
Hazardous medications are identified as such			
Medication Storage Locations			

Requirement	Met	Not Met	Comments
Medications are locked/secured			
Needles are locked/secured			
Medications are properly stored according to the manufacturer's directions			
List of High Risk, Hazardous medications, and LASA meds are posted in medication storage/preparation areas, available on the intranet or medication dispensing system.			
Medication refrigerator /freezer temperatures are monitored, and appropriate action is taken when out of range			
There is a dedicated space for medication preparation when needed			
Unused medications are properly discarded			
Crash carts are checked daily			
Anesthesia carts are locked when unattended			
Anesthesia does not pre-stage medications for upcoming cases			
Malignant Hyperthermia Cart – lock, integrity, checked (if available)			
Single Dose Vials/ Multi-dose vials- 28 days beyond use date listed			
Medication vials are cleaned with alcohol prior to withdrawing medication			
"Scrub the Hub" is practiced prior to administration of IV medications			
Needles are changed if it is necessary to re-enter a file for additional medication			
Ambiguous Orders- clarified			
Protocols – approved by P&T and MEC			
Therapeutic Duplications- clarified			
Surgical /Procedural Patients Documentation			
H&P updated if older than 30 days			
Pre-anesthesia assessment is completed			
Anesthesia Consent- signed dated timed prior to procedure			
Airway Assessment completed and documented			
ASA Class- assigned and documented			
Immediate Pre-induction Assessment- completed and documented			
Anesthesia Plan is documented			
Time Out- properly performed and documented			
Immediate post-op note is completed by the surgeon/proceduralist			
Discharge Order by the Surgeon			
Anesthesia Order for discharge after Discharge Criteria are met			
Surgical Procedure Set-Up Observation Section			
Medications are stored properly during Procedure Set-Up			
Medication containers, syringes, and bowls are labeled when set up for the procedure			

Requirement	Met	Not Met	Comments
Staff could verbalize the procedure for labeling medication containers			
Masks, caps and PPE worn properly			
Pre-procedure checklist used			
Two patient identifiers checked			
Paperwork (H&P, consent, images) verified using two identifiers			
Procedural Site is marked			
Sufficient time is permitted to allow flammable skin preps to completely dry (x minutes)			
Site is visible after draping			
Time out conducted immediately prior to the start of the procedure			
Team members give their undivided attention to the time out process			
Falls Section			
FALLS SECTION NOT ADDRESSED			
Initial Fall Assessment not completed			
Fall Interventions not in place			
Fall Interventions not documented			
Patient Education does not address falls			
Fall Risk assessment not completed per policy			
Care plan for falls not initiated			
Missing physician order to initiate/discontinue fall interventions			
Pain Section			
PAIN SECTION NOT ADDRESSED			
Comprehensive Pain Assessment not completed			
Pain scale used not appropriately			
Missing documentation of what makes pain worse			
Missing documentation of what makes pain better			
Location of pain not documented			
Pain assessment not completed every shift			
Pain reassessment not completed w/i 1hour of intervention or per organization's policy			
Pain reassessment documentation not sufficient			
Care plan for pain not initiated			
Performance Improvement			
Department level PI- defined, measured, posted for staff			
Facility Level PI – Staff knowledge			
PI studies are approved, and results are reported to the Board			
Organization process understood by staff			
Waive Testing			
Competencies			

Requirement	Met	Not Met	Comments
Solutions and Strips dated – no expired agents for test strips			
Lancets are noted with an expiration date			
Controls are performed when machine is in use and documented			
Glucometer is cleaned per the IFU			
Results of waive testing are documented in the patient's medical record with the normal ranges noted			