JCAHO OR Survey
APRIL 5TH, 2000
Survey Questions and Answers
(Survey Questions were compiled by an OR nurse.
Surveyor's question is listed first, then the nurse's answer/or tip is provided)

1. What method do you use to schedule cases? Do you use block scheduling?
2. Explain the scheduling process. How would I schedule a case?
3. How do you determine which surgeon gets which day? (I flipped open my "JCAHO" book and showed him our utilization studies which is broken down by surgeon)
4. How do you know if the surgeon has privileges to do a certain case?
5. If there is a mismatch in case listed and surgeon's privileges is there a plan of action in place to deal with this event? What is it and how does it work?
6. What if a surgeon is not credentialed to do a procedure?
7. Asked about same day/in-patient ratio.
8. Asked about nursing assessment. Asked us to explain our perioperative nursing record. Our plan of nursing care.
9. When are the patients seen by anesthesia? How far in advance?
10. Asked about pre-op assessment. (ASU, anesthesia and perioperative nurses).
11. When is the consent for surgery accomplished? How long is it good?
12. What is the process the day of surgery? Describe the complete process.
13. When the patient arrives at the pre-op holding area what happens?
14. How do you confirm the surgical site is correct? Liked our "Sign your Site" policy.
15. What are the two leaders in wrong site surgery besides ortho? (Urology and Neurosurgery). – trivia question!
16. Do you do any blocks in pre-op prior to going to the O.R.?
17. Does the weekly scheduling board help with utilization? (We have both a daily and weekly scheduling board. The weekly board helps with utilization because other surgeons can see unused time and use it. Our utilization went up 10% when we instituted the board. Now rate ranges 86 -93%)
18. How do you measure utilization?
19. Does the board have patient names on it? Would this be a violation of patient rights/confidentiality? Board is located in a secure location with limited access to it. Although ours doesn't have pt names, surveyor stated it would be okay to include.
20. Do all anesthesia machines have the same equipment?
21. Checked the drawers on the anesthesia machines, wanted to know the contents of each drawer.
22. Saw bottles of inhalants in anesthesia machine drawer. Commented that in many hospitals that housekeeping has access to OR to do major cleaning at night—asked if our housekeeping had access at night. (yes) Storage of inhalants in unlocked drawers. Must be contained in a locked area. (TYPE 1 WRITE-UP for anesthesia)! (I warned them, brothers and sisters! The only thing not locked up in the whole department!)

23. Inspected stickers and tags on machines.
24. Do we flash sterilize? When? How often?
25. Checked flash logs and requested to see the printout. Ensured the name of the patient and the sticker on the back of the printout matched. (Suggested we put why item had to be flashed on the log. Stated would give us data to justify buying new instruments.)
26. What type of cases done in the room? Is it only one service specific? (The specific room we were in at the time was an ortho room and we are heavy ortho, they operate every day so the answer was yes).
27. Are the anesthesia carts secured at night? (Yes, they each have locks on them and at the end of the day are taken to the anesthesia workroom, which is also locked).
28. Where is the crash cart maintained? How is it tested? (# of joules, plugged in and unplugged, pharmacy exchanges drawers after use).
29. What are the practices in regard to medications and how are the anesthesia carts restocked?
30. How do you account for destruction of drugs?
31. How are they inventoried?
32. Who re-supplies the anesthesia carts?
33. What role does pharmacy play in anesthesia and restocking carts?
34. He liked the practice of drugs taken out of Pyxis on a patient-by-patient basis. Does not want to see drugs taken out for all day or week.
35. Liked that the Pyxis was set up for a provider-by-provider cart inventory basis.
36. Asked about conscious sedation?
37. Who monitors patient during conscious sedation?
38. What is the process for monitoring patients during the procedure?
39. Commented on Conscious Sedation policy and procedure – suggested it should be submitted for best practice.
40. Where does recovery take place?
41. Where are drugs stored?
42. Reviewed chart of a patient in PACU. Looked at each form pertaining to the perioperative period in chart. Asked us to explain each form.
43. Asked about the complete perioperative care plan?
44. When and by whom is patient consent completed and witnessed? How long is it good?
45. Wanted to see surgeon op note. (He could actually read it!)
46. Are all anesthesia records reviewed by an anesthesiologist?
47. What are the criteria for patient discharge from PACU. Who developed?
48. Commented on consent note by surgeons. Besides the consent form signed by patient and witnessed, surgeons write in the progress note that procedure was explained to patient including the risks, benefits, alternatives…any additional personnel that may be in the room during surgery (PA students, sales reps, etc) and that patient consented for surgery. This is a hospital policy. Surveyor really liked this.
49. When is the perioperative nursing record filled out?

50. Excellent job documenting functional, nutritional assessments, advanced directives by perioperative nurses. Even commented on this during Care of Patient Interview.
51. Pre-op Checklist : (completed by ASU) What do you do if something not checked off?
52. Are H & P's dictated?
53. Explain the flow pattern (patient, clean and dirty instruments, etc)

ENDOSCOPY

1. Any diagnostic bronchoscopy?
2. Explain process.
3. How do you monitor patients?
4. Where does first phase for recovery take place? Second phase?
5. Where do you keep sedating medications? (From pyxis on patient-to-patient basis).
6. Where do you store clean instruments?
7. How many procedures do you do per month?
8. Where is the crash cart?

EXTRAS

a. Have you considered clinical pathways? May (?or will) become mandatory next year.
b. What is your surgical site infection rate? (I had chart in my "JCAHO" book, flipped it open and showed him!)
c. Asked what else was in my book! (Had he not asked, I would have shown him anyway!) First portion, "our staff" listed number of nurses with Master's, BSN's (we are military so BSN is minimum requirement), number CNOR (of eligible, only 1 not certified – shame on him!), additional certifications (laser, ortho, infection control, etc); listed number of technicians with degrees (two working on Master's, one in education, one in computers. Again, we are military and earning these degrees is a long process and after that many years in the military, they aren't likely to throw away the retirement benefits to go to work elsewhere, at least until their 20 years are in.) CST's, additional certifications. How we do our competency assessments. Second portion, "our patients" – patient demographics. Graph depicting ASA's, age spread, and top 10 procedures. If our population had a prevailing second language, I would have included that here as well. Next portion, "our docs". Specialties we have, number of procedures and utilization per doc, etc. Graph depicting how our caseload has grown over the years. Next portion, our current process improvements (this is where I had the Red-Away graph depicting our significant reduction in red bag trash), turnovers, infection rates, returns to surgery, unscheduled admissions, cancellations on day of surgery – with these, the graphs depicted the national average and where we stood in comparison. And finally, the portion on our plan of action for the future process improvement initiatives. (Lots of work but well worth the effort. Surveyor commented on excellence of perioperative nursing in outbrief!).

d. How do you monitor unscheduled admissions? -- If we don't know it by the time the patient leaves the OR, PACU and ASU track it and report it to us in the Surgical Services Committee.

We started our walk through with personnel from anesthesia, OR, ASU, PACU, and endoscopy. I made sure every available nurse and technician was present for the entire time. I wanted them to have the experience as part of their own growth and development. We made a huge group trudging along the way but I wasn't worried about anyone's answers because I've grilled them for 6months … emails with "tip of the day", staff meetings always included at least one JCAHO standard and how we addressed it, potty-training – nope, can't get away from tips even in the potty! I compiled a list of JCAHO questions that I collected from all my friends, answered each one and emailed the entire thing to all staff members … when I encountered staff in the hall, I asked a question. A correct answer was worth 2 points, an incorrect answer, minus a point …then a reward system was set up. No, they didn't run when they saw me coming and they will probably remember the mission and vision statement until the day they die! To correct bad habits such as pulling the mask down and letting it dangle around the neck, I posted "violation" signs (similar to speed limit signs) along with consequences (e.g., mask down equals one point), the person with the least amount of points won a dinner for two at a popular restaurant. Corny? Maybe, but it worked!