**Survey Unit Checklist**

**Physical Environment**

* Confidentiality/Privacy of Information maintained
* Equipment clean/dirty identified and stored separately
* Medical equipment has PM tag and due date
* Halls clear
* Exits/fire extinguisher/pull stations not blocked
* Electric and medical gas panels not blocked
* No open junction/electrical/IT boxes
* Needle boxes secured and not more than ¾ full
* No storage under sinks or on floors
* Storage 24” from ceiling in non-sprinkled facilities/Storage 18” from tip of sprinkler head
* Full and empty Oxygen cylinders stored separately
* Oxygen cylinders are secured in a stand, rack, or cradled beneath a stretcher
* No more than 12 full cylinders stored outside of a one-hour fire-rated room per smoke cell
* Lids closed on trash, biohazards bins
* Multi-dose vials labeled, and expiration does not exceed 28 days
* Med Refrigerator/freezer temps documented daily - out of range temp-follow-up action documented
* Med rooms/Pyxis machine: Make sure both are clean, wipe down the screens and remove dust
* Med storage: No expired meds, secure all meds - none left on counters or unsecured carts, all med-rooms or med-cart drawers secured (check Anesthesia carts/areas)
* Pill cutters and crushers: single use or no residue or dirt if multi-use
* If unit closed - temp tracked if meds are kept in refrigerator
* No expired items of any kind
* Glucometer strips/Glucometer solutions labeled and not expired
* Process exists to monitor temp for Glucose strips per IFUs
* No open single use items (includes saline bottles)
* Warming cabinet temps recorded daily (out of range temp has follow-up action doc)
* Crash Cart/Defibrillator /Emergency kits secured and checks recorded daily – ensure time is correct on defibrillator, especially if time has changed
* Precaution rooms are equipped with appropriate signage and PPE is available
* If eyewash station present, ensure access is not locked/blocked and checks are recorded weekly
* If negative pressure room used - verify that daily checks documented and within limits - out of range follow-up action documented
* No drinks/food at nursing stations or on cows
* Ceiling Tiles: Ensure all ceiling tiles are not stained or damaged
* Lights: Make sure all are functioning and not dusty
* Soap, Hand Sanitizer, and Paper Towels: Ensure proper function, availability and not expired
* Splash zones are clean with nothing stored or there is a splash guard/barrier
* Clear hallways of all beds, stretchers, and linen
* Waiting rooms/patient rooms/conference rooms: All furniture and equipment must be clean and free from tears and rust and wood is sealed.
* Supply storage areas: Make sure all dates are current on items (no expired items)
* Vents (including exhaust & A/C): Make sure vents are clean and free of dust
* Cabinets/Counters: Make sure there are no chips in laminate or caulking
* Check for visible chips/cracks on walls/paint and arrange for repair
* Storage: Remove all items below sinks.
* Verify all items are stored at least 8” off the floor. (Check under shelves and supply carts, Solid bottom shelf liner present)
* Carts: Lock all medication, crash, anesthesia, and EVS carts. Test the security of the sharps boxes
* Toilet seats: Check for loose toilet seats
* Shower heads/shower curtains: Ensure they are clean and free of soap scum or calcium buildup. Make sure that EVS has a process and knows frequency for cleaning curtains.
* Patient room care boards are updated
* Patient room curtains: Make sure that EVS has a process and knows frequency for cleaning curtains.
* Dirty Linen: Remove linen from the floors, put in linen bag and close the flap. Move soiled linen to the soiled utility room.
* Clean Linen: linen cart/rack has solid bottom shelf, linens are covered (unless in a dedicated room), all linen is free from holes/tears
* Water Pitchers: Make sure water pitchers are labeled with patient first and last name and date it was put into use
* Bedpans/other patient care items: Make sure bedpans are labeled with patient first and last name and date it was put into use
* Mattresses and pillows should be free of tears, holes, or rips
* Discard any damaged pillows and replace with an intact pillow
* Soiled Utility: ONLY dirty items are stored in this room
* Toilet Hopper: Make sure it is running properly and that there is no build up (pink growths or other)
* Clean Utility: ONLY clean items are stored in this room
* Cardboard on floor: Remove
* Refrigerators: Make sure dates are current on items in refrigerator, check for cleanliness, no open items, patient/family food is labeled and dated, temps recorded daily - out of range temp follow-up action documented
* Ice machines/Water fountains: clean, rust free, no pinkish growths (check waterspout and ice chute), no scaling and working correctly
* Microwaves: Check microwaves (inside/outside) for cleanliness and good repair - do not use for storage
* Food storage areas: Nourishment areas are clean – check drawers and food bins - remove all crumbs - no expired items - no open items

**Staff Knowledge**

Unit staff can verbalize unit/facility policy/process for:

* Unit Performance improvement efforts/projects/data (if applicable)
* Unit infection rates/efforts/hand hygiene
* Location of policies & procedures for downtime process
* Patient identification – check process for neonates
* Assessment/Reassessment
* Meds brought from home
* Med reconciliation
* Med self-administration
* Medication rights
* Narcotic counts
* Two-Nurse checks
* Blood administration
* Under what circumstances can they mix meds/IVs
* High alert/hazardous meds & Look-alike-sound-alike med list posted
* Reporting system for adverse drug reactions
* Reporting system for errors & near misses
* Telephone/verbal orders read back & signed/timed/dated
* Critical results reporting and read back process
* Labeling of specimens in presence of patient
* Clinical Alarms - set & audible
* Initiation of isolation
* Site-marking
* Time-out process (No activity – all members engaged)
* Location of med gas shut-off valves and who can shut off
* How complaints/grievances are handled
* Interpreter process
* Infant/pediatric abduction code and process
* Emergency numbers
* Fire response plan/RACE/PASS
* Restraint Documentation requirements - Non-Violent & Violent restraints
* Suicide risk assessment for all patients (Centra policy)
* Hourly/multi-disciplinary rounding
* Nursing bedside shift reporting/handoff process
* Patient education/teach back/verification of patient’s understanding
* IPOCs – updates and measurable goals
* Discharge planning/instructions
* Discharge criteria – check PACU (Aldrete)
* Moderate Sedation – scope of practice, meds that require Anesthesia provider, competencies, discharge instructions/precautions
* Unit-specific/population-specific competencies

**Unit/Department Leaders**

* Policies/procedures are up to date – **do not update policies and procedures during survey or without going through the usual review & approval process**

**Leaders - Staff Files**

* Attendance/completion of New-employee orientation/annual AME, education and competencies
* Preceptor/New-employee Orientation complete – items scored out negatively require follow-up and verification of competency prior to performing the task independently
* Annual evaluations completed
* All licenses/certifications current and on file
* All competencies complete (including population-specific/unit-specific)
* Facility verifies contract staff competencies/licenses
* Contracted services – leaders are accountable for contract oversight and familiar with contract language/expectations/performance measures

**Medical Record Review**

* Authorization/consent to treat signed, completed and on chart
* Other consents signed, dated and timed before procedure
* All medical record entries (including orders/progress notes) signed, dated and timed
* Telephone/Verbal orders authenticated/signed/dated/timed within state requirements (72 hrs. in Virginia)
* DNR order on chart and documentation noted in progress notes
* Advance Directives requested, documented/signed/dated/timed and on chart as applicable
* H&P (or H&P update if applicable) on chart
* Restraint orders documented per requirements and signed/dated/timed by provider
* Restraint assessments and IPOC documentation complete
* Meds administered as prescribed or orders clarified/revised
* Titration orders contain all elements required
* No pre-timed entries
* Plan of Care problems, goals and interventions documented and updated
* No unapproved abbreviations without clarifications
* Medication reconciliation is signed, dated and timed as appropriate (Admission, Transfer, Post-op, D/C)
* Allergies reconciled and documented
* Anticoagulant education documented for each anticoagulant if applicable
* Pain initial assessment & shift reassessment documented
* For each episode of pain med administration - pain reassessment is documented in accordance with facility/unit policy
* If patient stated “goal not met” action taken is documented
* If PRN med has more than one indication, clarification is documented, and instructions are clear which med to give
* Fall assessment is personalized to the individual patient and preventative interventions documented, no fall flags left from last patient – must be personalized to current patient
* Initial suicide screening completed and suicide assessment, when applicable
* Blood transfusion documentation is complete including all vital signs
* If there are critical results they are reported & documented
* Post procedure note complete (all required elements) & on chart immediately following procedure
* “Time Out” documented with all elements validated
* If MDRO “+” education is present
* Interpreter service documented

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| **Notes:** |
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