The Joint Commission Survey (Part 1:)
Maximizing Tracer Activities –
A Dialogue with Surveyors

June 21, 2012
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# TABLE OF CONTENTS

- Program Summary ................................................................................................................................................. 4
- Continuing Education (CE) Credit ........................................................................................................................ 5
- Program Outline ..................................................................................................................................................... 6
- Maximizing Tracer Activities ................................................................................................................................ 7
- Appendix A: How to Conduct a Mock Tracer .............................................................................................................. 17
- Appendix B: Sample Mock Tracers .......................................................................................................................... 27
- Appendix C: Faculty Biographies ............................................................................................................................. 38
- Appendix D: Post-Test ............................................................................................................................................... 39
- Appendix E: Resources and Related Information .................................................................................................... 41
- Appendix F: Continuing Education Credit Information .............................................................................................. 42
- Appendix G: Discipline Codes: Instructions ................................................................................................................ 43
- Appendix H: JCR Quality & Safety Network Contact Information .................................................................................. 44
Program Summary

This page provides an overview of the program content and learning objectives. Please refer to the Table of Contents and Program Outline for a detailed list of the topics covered. The information included in this Resource Guide is intended to support but not duplicate the video presentation content. There may be additional information available online for this topic.

Program Description

What are your questions or insights about The Joint Commission's tracer methodology? Now is the time to speak up! This special videoconference – broadcast live from Joint Commission headquarters and featuring a studio audience – is completely based on questions and comments from our viewers.

Tracer methodology is an evaluation method – used both by surveyors and organizations themselves – wherein the record of a patient is used as a roadmap to move through the organization and assess and evaluate compliance with selected standards and systems of providing care and services. Tracers are powerful and valuable tools when used correctly and when they focus on appropriate processes. Designed for organizations that want a better understanding of tracer implementation and methodologies, this 60-minute live activity provides the information and tools needed to make the most of the opportunities tracers provide.

To help us achieve a highly effective educational exchange of ideas for this program, on behalf of all participants, please e-mail us at questions@jcrqsn.com with your questions or comments about tracer activities, to be answered by our faculty during the broadcast. We welcome your input!

Program Objectives

After completing this activity, the participant should be able to:

1. Identify various tracers that focus on care processes and systems.
2. Prioritize tracer data to determine the effectiveness of process design in the delivery of safe, high-quality care.
3. Improve systems and processes through use of tracer methodology and aggregation of tracer findings data.

Target Audience

This activity is essential for those in your organization who are responsible for assessing the quality and safety of care provided throughout the organization, as well as those responsible for accreditation compliance, including survey coordinators, risk managers, performance improvement (PI) coordinators, department managers, and others who have a hands-on role in The Joint Commission accreditation process or assessing the systems and processes within the organization.
Continuing Education (CE) Credit

After viewing the JCR Quality & Safety Network presentation and reading this Resource Guide, please complete the required online CE/CME credit activities (test and feedback form). The test measures knowledge gained and/or provides a means of self-assessment on a specific topic. The feedback form provides us with valuable information regarding your thoughts on the activity’s quality and effectiveness.

NOTE: Effective April 1, 2012, the Learning Management System web site URL changed as noted below.

Prior to the Program Presentation Day
1. Login to the JCRQSN Learning Management System web site at http://twnlms.com/
2. Enroll yourself into the program
   Note: Your administrator may have already enrolled you in the program
   • Select All Courses from the courses menu.
   • Select the course category for the current year, 2012 Programs.
   • Select the course for this program, The Joint Commission Survey (Part 1): Maximizing Tracer Activities – A Dialogue with Surveyors
   • When prompted, choose Yes to confirm that you would like to enroll yourself.
3. Display and print the desire documents (Resource Guide, etc.).

Online Process for CE/CME Credit
1. Read the course materials and view the entire presentation.
2. Login to the JCRQSN Learning Management System web site at http://twnlms.com/
   Note: This assumes you have already been enrolled in the program as described above.
4. If you didn’t view the broadcast video presentation, view it online.
5. Complete the online post test.
   • You have up to three attempts to successfully complete the test with a minimum passing score of 80%.
   • Physicians must take the post test to obtain credit.
6. Complete the program feedback form.
7. On the top right corner of the main course page, you will see your completion status in the Status block.
8. Select Print Certificate from within the Status block to print your completion certificate.

Process for VA Knowledge Network Participants
1. Read the program’s Resource Guide and view the entire video presentation (speak with your administrator for broadcasting times – do NOT log in to view the program).
2. Complete the Viewer Response form (speak with your administrator to obtain a paper copy that will be completed manually – do NOT log in to take the online test).
3. Complete the Program Evaluation.
4. Record the answers to the post test where indicated on the Viewer Response form.
5. Return the Viewer Response form by the program due date listed in the upper left corner of the page. Forms received after this due date will not be eligible for CE credit.
6. Please allow 6 weeks for processing your Viewer Response Form.
   * If you have any questions, please contact Joshua Smith at (562) 826-5505, extension 3962.
Program Outline

The Joint Commission Survey (Part 1): Maximizing Tracer Activities – A Dialogue with Surveyors
June 21, 2012

I. Introduction
   A. Program Content
   B. Objectives
   C. Faculty

II. Background Information on Tracers

III. Tracers as Part of the Survey Process

IV. Tracers for Performance Improvement

V. Using Tracer Data

VI. Conclusion

VII. Post-Program Live Question and Answer Session
   A. Audio only telephone seminar with program faculty – for 30 minutes following the program.
   B. Call 1-888-206-0090; enter conference code: 7925428.
      Or e-mail your questions or comments to: Questions@jcrqsn.com

<table>
<thead>
<tr>
<th>Program Broadcast Time</th>
<th>Eastern: 2:00 p.m. to 3:00 p.m.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Central: 1:00 p.m. to 2:00 p.m.</td>
</tr>
<tr>
<td></td>
<td>Mountain: 12:00 p.m. to 1:00 p.m.</td>
</tr>
<tr>
<td></td>
<td>Pacific: 11:00 a.m. to 12:00 p.m.</td>
</tr>
</tbody>
</table>

During the live airing of this program on June 21, 2012, you may be able to talk directly with the faculty when prompted by the program’s host. After this date, your message will be forwarded to the appropriate personnel.

Immediately following the program, we invite you to join in a live discussion with the program presenters. Call 1-888-206-0090 and enter Conference Code: 7925428 to be included in the teleconference.

To submit your question ahead of time or for additional details, please send an e-mail to questions@jcrqsn.com. If you submit your questions after this date, your message will be forwarded to the appropriate personnel.

You can also receive answers to your questions by calling The Joint Commission’s Standards Interpretation Hotline at 630-792-5900, option 6.
Maximizing Tracer Activities

Strategy: “Maximizing Tracers”

Tracer Activity

- Tracer activity as a component of ongoing readiness
  - Establish a person/process to facilitate oversight of tracer activities
  - Create tools to be used for tracing in each department
  - Identify local management responsible for conducting tracers in each department
  - Track tracer activities
  - Review tracer tools with tracer staff

Strategy

- Establish guidelines for conducting individual patient tracers and other tracers
  - Frequency of patient tracing in each department
  - Tools to be used for tracing
  - Tools to be used to submit tracer results
  - Timeframes for submission of data
- Establish frequency and type of data reporting
  - Weekly reports to senior leadership
  - Weekly reports to chapter champions
  - Monthly reports to department directors
  - Monthly reports to medical staff leadership

Linking Tracers...Maximizing Tracers

- To quality and safety standards compliance
- To S3
- To pay for performance (PFP)
- To identifying high-risk areas
- To potential adverse outcomes
Follow Patient’s Care Journey

- HR – Human Resource=SQE
- EOC – Environment of Case=FMS
- FIN – Finance
- IT – Information Technology=MOI
- IC – Infection Control=PCI
- L – Leadership=GLD
- G – Governance=GLD

Tracer Activity Diagram

Involvement of Physicians
- As part of the individual (patient) tracer
- As a member of the systems tracer
- As an evaluator conducting the tracers
- As an auditor of compliance to the MS chapter
- As part of the team developing actions and strategies to make corrections and define indicators to measure organizational performance improvement (PPR)
Types of Tracers

- Individual tracers
  - Following care recipients through the related systems experienced as care is provided
- System tracers
  - Focus on system issues identified during the individual tracers
- Program-specific tracers
  - Related to specific accreditation programs
Individual (Patient) Tracer

The surveyor “traces” the course of care provided to the recipient

= Standards evaluation opportunities related to individual care recipient experiences across multiple functions (for example, dispensing and administration in medication management).
Individual Tracers – High-Risk

How to select high-risk patient populations:

- Vulnerable
  - Investigational, new, risky
- Fragile
- Unstable

Identifying outcomes of failing to provide the right care in the right way

Just a Word About Interviewing…

- Knowing which questions to ask
- Asking in the right way
  - Be relaxed and yourself
  - Take your time
  - Listen/pause
  - Manage your reactions
- Keeping the tracer on track
- Following the tracer where it takes you
- Making connections to the broader issues affecting quality and safety

Program-Specific Tracers

- Continuity of Care (AHC)
- Elopement (BHC)
- Continuity of Foster/Therapeutic Foster Care (BHC)
- Suicide Prevention (BHC/HAP)
- Violence (BHC)
- Laboratory Integration (HAP/CAH)
- Patient Flow (HAP/CAH)
- Staffing (LTC)
- Resident Centered Care (LTC)
- Equipment and Supply Management (HME)
- Fall Reduction (OME)
- Hospital Readmission (OME)
Using & Understanding Data: Why Aggregate the Data?

- To get a complete picture of performance in care and safety issues
- To identify problematic processes which can lead to patient safety issues
- To generate ideas for improving performance in areas of non compliance
- To reduce duplicative effort
- To identify best practices in the organization
- To celebrate successes

Aggregating Tracer Findings

- After all the tracer exercises are completed, it is important to aggregate the issues and link them to the standards
- Helpful to prioritize, in order, to risk potential
- May need to do additional tracer exercises in order to validate conclusions
- Use as an ongoing monitoring tool for standards compliance
<table>
<thead>
<tr>
<th>Unit/Department Serv/Program</th>
<th>Individuals Providing Care</th>
<th>Issues</th>
<th>Standards</th>
<th>Priority Focus Areas</th>
</tr>
</thead>
</table>
| Ortho                       | Sally J. (RN)               | Pain Assessment – not complete M504 – abbreviation Initial assessment not within 24 hours Intra operative care planning – none No gloves worn during dressing change Computer screen in hallway in view of visitors Unsecured ICU unit Self-medication process | PC. 3.10 (EP. 1) IM. 3.10 (EP. 2) PC. 4.10 (EP. 1) PC. 4.10 (EP. 1.2, 3) IOIC. 4.10 R. 5.1.30  
B.3.1.10 (EP. 4) MM. 5.20 (EP 1.2.3) | Assessment/Care Information Management Rights / Ethics Medication Management |
| CT Scan                     | Phillip (Tech)              | 2 identifiers - not used No report received from unit | PC. 5.10 (EP. 4) PC. 6.60 (EP. 2) RI. 2.60 (EP. 6) | Assessment/Care Rights / Ethics |
| Pre-Op Holding              | Kate (RN)                   | Site Verification – Not understood Free-flow pumps not understood Alarms turned off Reassessment process for pain not completed Unapproved abbreviations | APR. 19 (# 2) APR. 20 APR. 21 (#2) PC. 3.10 (EP. 1) IM. 3.10 (EP. 2) | Patient Safety Assessment/Care Information Management |
| OR                          | Harry (RN)                  | No immediate pre-anesthesia assessment Anesthesia Carts – meds not labeled Meds left out – not secured Final time out not conducted High Risk Medication (Conc. K4) not stored properly MD Verbal abuse reported by nurses when trying to conduct time out process | PC. 13.20 (EP. 12) MM. 4.30 MM. 2.20 PC. 13.20 (EP. 8) | Assessment/Care Medication Management Leadership |
| PACU                        | Melissa                     | No intra operative care planning process Range orders for pain meds – not consistently understood Legibility issues Immediate post-op not note recorded Verbal orders not read back | PC. 4.10 MM. 3.20 MM. 6.30 (EP. 2) | Assessment/Care Medication Management Information Management |
# Patient Tracer Summary

**Assess & Care/Services**  |  **Patient Safety**  |  **Communication**  |  **Medication Management**  |  **Information Management**  
--- | --- | --- | --- | ---  
- No needs identified  | - No needs identified  | - No needs identified  | - No needs identified  | - No needs identified  
- H&P  | - Patient ID  | - Chain of command  | - Order completeness  | - No needs identified  
- Initial nursing assess  | - Critical results  | - Interdisciplinary  | - Med knowledge  | - Backup systems  
- Plan of care  | - Universal Protocol  | - Patient/family ed  | - Teaching/monitoring  | - Privacy/confidentiality  
- Pain management  | - Discharge planning  | - Facility handoff  | - Range/prn meds  | - Locating Policies  
- Falls  | - Occurrences  | - Verbal orders  | - Prepara  | - Chart navigation  
- Restraints  | - Verbal orders  | - Verbal orders  | - Security  | - Do-not-use abbreviations  
- Procedural care  |  |  | - Storage  |  

**Equipment Use**  |  **Infection Control**  |  **Physical Environment**  |  **QI Expertise/Activities**  |  **Core Measures**  
--- | --- | --- | --- | ---  
- No needs identified  | - No needs identified  | - No needs identified  | - No needs identified  | - No needs identified  
- Precautions  | - Cleaning  | - Eye splash  | - QI activities  | - Patient identification  
- Training  | - Isolation precautions  | - MSDS  | - Hand hygiene  |  
- Breakdown process  | - MDRO  | - Fire  | - Core Measure Traced  | - CAP  
-  | - CAC/TI  | - O2 cut-off  |  | - AMI  
-  | - SSI  | - O2 cylinder storage  |  | - HF  
-  | - CLABSI  | - Equipment in hal  |  | - SCIP  
-  | - VAP  | - Electrical appliances  |  |  

**Rights & Ethics**  |  |  |  |  
--- | --- | --- | --- | ---  
- No needs identified  |  |  |  |  
- Advance Directives  |  |  |  |  
- Consent  |  |  |  |  
- Care provider  |  |  |  |  

**Directions:** Complete two tracers in 2010; optimally one tracer between January–May and one tracer between June and November. Mark the boxes below when the RN does not know the answer; requires prompting or is unable to provide a satisfactory response. If no learning needs identified, mark, “No needs identified.” FAX completed form to 4698 or interoffice to Performance Improvement, Administration Office.
## Priority Focus Area Data Collection Tool

### Organization: ____________________________

<table>
<thead>
<tr>
<th>Priority Focus Area</th>
<th>Problematic Standards/Elements of Performance</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment and care/services (analytic procedures for the lab setting)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credentialed practitioners (does not apply in all health care settings)</td>
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<td></td>
</tr>
<tr>
<td>Equipment use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication management (does not apply in all health care settings)</td>
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<td></td>
</tr>
<tr>
<td>Organizational structure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orientation and training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient safety</td>
<td></td>
<td></td>
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<tr>
<td>Physical environment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix A: How to Conduct a Mock Tracer

NOTE: “How to Conduct a Mock Tracer” is excerpted from More Mock Tracers, Copyright 2011, The Joint Commission. For more information on this book, please visit Joint Commission Resources’ Web site (www.jcrqsn.com). Due to space considerations, other pages in the book that are referenced here are not included.

The main activity during a Joint Commission or Joint Commission International (JCI) survey of any type of health care organization is the tracer (see the sidebar “Tracers at a Glance,” at right). A mock tracer is a practice tracer meant to simulate an actual tracer. During a mock tracer, one or more people may play the role of a surveyor. Some organizations develop teams of such “surveyors” and repeatedly conduct mock tracers as part of an ongoing mock tracer program.

Mock tracers are done for several reasons:
- To evaluate the effectiveness of an organization’s policies and procedures
- To engage staff in looking for opportunities to improve processes
- To be certain the organization has addressed compliance issues and is ready for survey at any time

What follows is a 10-step primer for how to conduct a mock tracer. It addresses the process in four phases:
- Planning and preparing for the mock tracer
- Conducting and evaluating the mock tracer
- Analyzing and reporting the results of the mock tracer
- Applying the results of the mock tracer

Each step within these phases includes suggested approaches and activities. You might want to use the “Mock Tracer Checklist and Timeline” on page 19 to guide you through the phases. The primer also explains how to use the scenarios, sample worksheets, and appendixes in this workbook to conduct mock tracers. Note that the primer can be modified to suit any health care organization.

Tracers at a Glance

**Duration:** A Joint Commission individual tracer (see “Individual tracers” on page 18) is scheduled to take 60 to 90 minutes but may take several hours. During a typical three-day survey, a surveyor or survey team may complete several tracers; during a single-day survey, it may be possible to complete only one or two tracers. Tracers constitute about 60% of the survey.

**Survey team:** A typical Joint Commission survey team includes one or more surveyors with expertise in the organization’s accreditation program. For domestic (not international) hospitals and critical access hospitals, a Life Safety Code® Specialist is also part of the team. A team leader is assigned for any survey with more than one surveyor. A surveyor typically conducts a tracer on his or her own and later meets up with the rest of the team to discuss findings.

**Tracer activity:** During tracer activity, surveyors evaluate the following:
- Compliance with Joint Commission standards and National Patient Safety Goals and, for international organizations, JCI standards and International Patient Safety Goals
- Consistent adherence to organization policy and consistent implementation of procedures
- Communication within and between departments/programs/services
- Staff competency for assignments and workload capacity
- The physical environment as it relates to the safety of care recipients, visitors, and staff

(continued)

*Life Safety Code is a registered trademark of the National Fire Protection Association, Quincy, MA.*
Tracers at a Glance (continued)

**Range of observation:** During a tracer, the surveyor(s) may visit (and revisit) any department/program/service or area of the organization related to the care of the individual served or to the functioning of a system.

**Individual tracers:** Individual (patient) tracer activity usually includes observing care, treatment, or services and associated processes; reviewing open or closed medical records related to the care recipient’s care, treatment, or services and other processes, as well as examining other documents; and interviewing staff as well as care recipients and their families. An individual tracer follows (traces) one care recipient throughout his or her care in the organization.

**System tracers:** A system tracer relates to a high-risk system or the processes that make up that system in an organization. Currently, three topics are explored during the on-site survey using the system tracer approach: medication management, infection control, and data management. The data management system tracer is the only tracer that is routinely scheduled to occur on regular surveys for most organizations; it may include evaluation of data for medication management and infection control, as well. Other system tracers take place based on the duration of the on-site survey; the type of care, treatment, or services provided by the organization; and the organization’s accreditation history. Lab accreditation programs do not have system tracers.

In international organizations, data system tracers are called “improvement in quality and patient safety” tracers and are not individual based.

**Program-specific tracers:** These are tracers that focus on topics pertinent to a particular accreditation program and the associated care, treatment, or service processes. These processes are explored through the experience of a care recipient who has needed or may have a future need for the organization’s care, treatment, or services. Examples include patient flow in a hospital or suicide prevention at a residential program. Lab accreditation programs do not have program-specific tracers.

**Environment of care tracers:** Although the environment of care (EC) tracer is not one of the defined Joint Commission system tracers, it is similar to those types of tracers. Like system tracers, EC tracers examine organization systems and processes—in this case, systems related to the physical environment, emergency management, and life safety. Also, like system tracers, an EC tracer is often triggered by something observed during an individual tracer, as surveyors notice environmental-, emergency management-, and life safety-based risks associated with a care recipient and the staff providing care, treatment, or services to that person. A surveyor may also be assigned to do an EC tracer as part of a comprehensive survey process. Note that EC tracers are performed only in facility-based accreditation programs and do not apply to community-based programs and services, such as those provided by some behavioral health care accreditation programs. For international organizations, EC is referred to as “facility management and safety.”

**Second generation tracers:** A surveyor may see something during a tracer involving select high-risk areas that requires a more in-depth look. At that point, the surveyor may decide to conduct a second generation tracer, which is a deep and detailed exploration of a particular area, process, or subject.

Planning and Preparing for the Mock Tracer

**Step 1: Establish a Schedule for the Mock Tracer**

Careful planning is necessary for any successful activity, including a mock tracer. Consider the following when establishing a schedule for mock tracers in your organization:

- **Schedule by phase:** Allow adequate time for each phase of a mock tracer. The focus of each phase outlined in this primer is shown in the checklist “Mock Tracer Checklist and Timeline” (see page 19) with suggested time frames, some of which may overlap. Suggested approaches and activities for each phase comprise the remainder of this primer.
Mock Tracer Checklist and Timeline

<table>
<thead>
<tr>
<th>✓ Planning and Preparing for the Mock Tracer</th>
<th>✓ Conducting and Evaluating the Mock Tracer</th>
<th>✓ Analyzing and Reporting the Results of the Mock Tracer</th>
<th>✓ Applying the Results of the Mock Tracer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1: Establish a Schedule for the Mock Tracer</td>
<td>Month 1</td>
<td>Step 5: Assign the Mock Tracer</td>
<td>Month 2</td>
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<tr>
<td>Step 2: Determine the Scope of the Mock Tracer</td>
<td>Month 1</td>
<td>Step 6: Conduct the Mock Tracer</td>
<td>Month 3</td>
</tr>
<tr>
<td>Step 3: Choose Those Playing the Roles of Surveyors</td>
<td>Month 1</td>
<td>Step 7: Debrief About the Mock Tracer Process</td>
<td>Month 3</td>
</tr>
<tr>
<td>Step 4: Train Those Playing the Roles of Surveyors</td>
<td>Months 1 and 2</td>
<td>Step 8: Organize and Analyze the Results of the Mock Tracer</td>
<td>Month 4</td>
</tr>
<tr>
<td>Step 9: Report the Results of the Mock Tracer</td>
<td>Month 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 10: Develop and Implement Improvement Plans</td>
<td>Months 5-7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: To follow up on findings and sustain the gains, periodically repeat mock tracers on the same subjects.

- **Make it part of your regular PI program:** Make mock tracers part of your ongoing performance improvement (PI) program. Schedule mock tracers for different departments/programs/services several times a year.

- **Share the plan with everyone:** Let everyone in your organization know about the mock tracers being planned. No set dates need to be given if the mock tracers are to be unannounced, but communication about planned and ongoing mock tracers is necessary for recruitment of those who will play the roles of surveyors and for cooperation from all departments/programs/services.

- **Understand the Joint Commission survey agenda:** A mock tracer typically simulates only the tracer portion of a survey, which constitutes the foundation of the survey. By understanding the survey activities, however, those who are playing the roles of surveyors can better simulate tracers to help your organization prepare for a survey. Joint Commission surveys follow a tight agenda. Check the Survey Activity Guide (SAG) for your accreditation program(s). The guide outlines what happens in each survey activity. All accreditation program SAGs are posted on the Web site for The Joint Commission. They are also available on your Joint Commission Connect™ extranet site if yours is an accredited health care organization or an organization seeking Joint Commission accreditation. International organizations should consult the International Survey Process Guide (SPG), which is sent to applicants seeking international accreditation and is also available to order on the JCI Web site.

- **Relate it to the date of the last survey:** Joint Commission surveys are typically conducted on a regular, triennial basis. For most accredited organizations, the survey will occur within 18 to 36 months after an organization’s last survey.
although laboratory surveys and certification program reviews are on a two-year cycle. With the exception of critical access hospitals and office-based surgery practices, organizations accredited by The Joint Commission must conduct Periodic Performance Reviews (PPRs) between full surveys. The PPR is a management tool that helps the organization incorporate Joint Commission standards as part of routine operations and ongoing quality improvement efforts, supporting a continuous accreditation process. A mock tracer can help by giving the organization more insight into compliance issues. Conducting the mock tracer before a survey date allows time to address compliance issues prior to the PPR deadline; conducting a mock tracer shortly after the last survey is helpful for assessing compliance with problems highlighted in that recent survey. Note that the PPR is not applicable to the Medicare/Medicaid certification-based long term care accreditation program. For international organizations, the survey will occur within 45 days before or after the accreditation expiration date. International certification programs are on a three-year review cycle. Also, although international organizations are not required to complete PPRs, JCI recommends that organizations do a self-assessment of compliance between surveys. (International certification programs have a required intra-cycle review process.)

**Step 2: Determine the Scope of the Mock Tracer**

Assess your organization to determine where to focus attention. By listing problems and issues in your organization, the scope of the mock tracer—whether comprehensive or limited—will become clear. One or more of the following approaches may be used to determine a mock tracer’s scope:

- **Imitate the Priority Focus Process**: The Priority Focus Process (PFP) provides a summary of the top clinical/service groups (CSGs) and priority focus areas (PFAs) for an organization. The CSGs categorize care recipients and/or services into distinct populations for which data can be collected. The PFAs are processes, systems, or structures in a health care organization that significantly impact safety and/or the quality of care provided (see Appendix A). The PFP is accessible on the Joint Commission Connect site for domestic organizations and provides organizations with the same information that surveyors have when they conduct on-site evaluations. Address all or some of the areas generated in that report. International organizations do not have PFPs; however, it may be helpful and important to look at your last survey results and target areas of greatest concern.

- **Reflect your organization**: Start with your organization’s mission, scope of care, range of treatment or services, and population(s) served. Choose representative tracers that support and define your organization. You might want to use an assessment tool, such as the Comprehensive Organization Assessment, to gather this data. (See Appendix C).

- **Target the top compliance issues**: Review the Joint Commission’s top 10 standards compliance issues, published regularly in *The Joint Commission Perspectives*® (available for subscription and provided free to all accredited organizations). Also check any issues highlighted in *Sentinel Event Alerts*, which are available on the Joint Commission Web site, at http://www.jointcommission.org/sentinel_event.aspx. Address compliance issues that are also problem prone in your organization. Be especially mindful to note if any of these top compliance issues have been noted in current or past PPRs. International organizations can request top compliance issues from this address: JCIaccreditation@jcrinc.com.

- **Review what is new**: Address any new Joint Commission or JCI standards that relate to your organization. New standards and requirements are highlighted in the binder version (although not in the spiral-bound book version) of the most recent update of the *Comprehensive Accreditation Manual* for your program. Also focus on any new equipment or new programs or services in your organization. Consider mock tracers that will allow opportunities to evaluate newly implemented or controversial or problematic organization policies and procedures and how consistently they are being followed.

- **Start with the subject**: Look at typical tracers from any past surveys and choose several common or relevant examples for the types of tracers defined in the Introduction to this workbook. Or, if your organization has never had a survey, consider the guidelines described in the sidebar “Choosing Tracer Subjects” on pages 21-22.

- **Cover the highs and lows**: Focus on high-volume/high-risk and low-volume/high-risk areas and activities. Ask questions about demographics for those areas or activities to help determine whether care, treatment, or services are targeted to a particular age group or diagnostic/condition category. Then pick corresponding tracer subjects.
• **Target time-sensitive tasks:** Look at time-sensitive tasks, such as frequency of staff performance evaluations, critical result reporting, and the signing, dating, and timing of physician orders, including whether they are present and complete. These are often challenging compliance areas.

• **Examine vulnerable population(s):** Review the risks in serving particularly vulnerable, fragile, or unstable populations in your organization. Select tracer subjects (care recipients, systems, or processes) that might reveal possible failing outcomes. Address related processes of care, treatment, or services that are investigational, new, or otherwise especially risky.

**Step 3: Choose Those Playing the Roles of Surveyors**

If your goal is to conduct more than one mock tracer, either concurrently or sequentially, you will want to develop a mock tracer team. Careful selection of those playing the roles of surveyors is critical. A general guide for a mock tracer team is to follow the number and configuration of your last Joint Commission or JCI survey team (see the sidebar “Tracers at a Glance” on pages 17-18). However, you might want to involve more people or have multiple mock tracer teams; try to allow as many people as possible to be exposed to the tracer process and to learn more about the surveyors’ angle on the process. If your organization has not had a survey yet, aim for five to eight team members, or select one team member for each department/program/service in your organization plus one for each type of system tracer and one for the EC. Consider the following when choosing those who will play the roles of surveyors:

• **Include administrators:** Administrators, managers, and other leadership should be not only supportive of mock tracers but also involved. Include at least one administrator or manager on the team. Include executive-level leaders in the early stages to provide input and model team leadership. Also, staff may need time off from their regular duties to participate in various phases of a mock tracer, so team members should be sure to get the approval of their managers.

• **Select quality-focused communicators:** Sharp, focused professionals with excellent communication skills are needed to play the roles of surveyors. Recruit people who are observant, detail oriented, and committed to quality and professionalism. Those playing the roles of surveyors should be articulate, polite, personable, and able to write clearly and succinctly. They should be comfortable talking to frontline staff, administrators, and care recipients and families.

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**Choosing Tracer Subjects**

**Individual tracers:** For individual mock tracers, adopt the way actual surveyors choose care recipients. In U.S. health care organizations, select them based on criteria such as (1) whether they are from the top CSGs in the PFP; (2) whether their experience of care, treatment, or services allows the surveyor to access as many areas of the organization as possible; (3) whether they qualify under the criteria for any accreditation program-specific tracer topic areas; or (4) whether they move between and receive care, treatment, or services in multiple programs, sites, or levels of care within your organization. Also, consider tracing care recipients who have been recently admitted or who are due for discharge.

In international organizations, use information provided in your organization’s accreditation survey application to select tracer care recipients from an active list that shows who has received multiple or complex services.

**System tracers:** Care recipients selected for tracing a system typically reflect those who present opportunities to explore both the routine processes and potential challenges to the system. For example, to evaluate medication management systems, select care recipients who have complex medication regimens, who are receiving high-alert medications, or who have had an adverse drug reaction. To evaluate infection control, select someone who is isolated or who is under contact precautions due to an existing infection or compromised immunity. These same care recipients could be the subjects for data management system tracers, as each might be included in performance measurement activities such as infection control surveillance or adverse drug-reaction monitoring data.

In international organizations, data system tracers are called “improvement in quality and patient safety” tracers and are not individual based.

**Program-specific tracers:** The focus for these tracers may include programs such as foster care, patient flow, continuity of care, fall reduction, and suicide prevention. For example, to evaluate a falls reduction program in a long term care facility, you... (continued)
Choosing Tracer Subjects (continued)

would select a resident identified as being at risk for falls to trace components of the program, such as care recipient education, risk assessment, and falls data.

Environment of care tracers: Subjects for an EC mock tracer may include systems and processes for safety, security, hazardous materials and waste, fire safety, utilities, and medical equipment. For example, an EC mock tracer might examine the security in the neonatal intensive care unit, the safety of hazardous materials that enter through the loading dock, or the installation of and maintenance for new medical equipment. Be sure also to include emergency management and life safety issues as topics for mock tracers. In international organizations, EC is referred to as “facility management and safety.”

Second generation tracers: Subjects for second generation tracers grow naturally out of tracers involving high-risk areas because this type of tracer is a deeper and more detailed exploration of the tracer subject. Areas subject to second generation tracers include cleaning, disinfection, and sterilization (CDS); patient flow across care continuum; contracted services; diagnostic imaging; and ongoing professional practice evaluation (OPPE)/focused professional practice evaluation (FPPE).

- Don’t forget physicians: Because they are a critical part of any health care organization, physicians should be involved in mock tracers—and not always just as interview subjects. Recruit physicians to perform the roles of surveyors. This angle of participation will not only allow them to apply their expertise and experience but will also allow them to add to that expertise and experience.

- Draft from HR, IM, and other departments or services: Those playing the roles of surveyors may also be drafted from among the staff and managers of nonclinical departments, including human resources (HR) and information management (IM). Housekeeping and maintenance staff are often valuable as “surveyors” for their unique perspective of daily operations.

Step 4: Train Those Playing the Roles of Surveyors

All staff trained to portray surveyors need to have both an overview and more detailed knowledge of tracers as part of their training. Even those who have been through a survey need training to play the role of a surveyor. Those who will be acting as surveyors should do the following as part of their training:

- Get an overview: Take some time to learn the basics of tracers. The Introduction to this workbook provides a good overview. As a next step, read the Survey Activity Guide for your program, which is posted on the Web site for The Joint Commission and on Joint Commission Connect. The guide explains what surveyors do in each part of the different types of tracers. The JCI Survey Process Guides are provided to international organizations applying for accreditation and are also for sale on the JCI Web site.

- Learn the standards: Challenging as it may be, it is essential that those who are playing surveyors become familiar with current Joint Commission requirements related to the targeted tracer. They must gain a solid understanding of the related standards, National Patient Safety Goals, and Accreditation Participation Requirements. To learn about changes and updates to Joint Commission standards and how to interpret and apply them, they should read the monthly newsletter Joint Commission Perspectives (available for subscription and provided free to all domestic accredited organizations). Be particularly careful to give those who are playing surveyors sufficient time to learn the standards for the department or area in which they will conduct a mock tracer. A least one month is advised (see the sidebar “Mock Tracer Checklist and Timeline” on page 19). International organizations should be familiar with JCI standards and International Patient Safety Goals, as outlined in the current relevant JCI accreditation manual. Updates, tips, and more are provided free via the online periodical JCIInsight.

- Welcome experience: Staff and leaders who have been through a tracer can be valuable resources. Invite them to speak to the tracer team about their experiences with tracers and with surveys in general.

- Examine closed medical records: Closed medical records are an excellent practice tool for individual tracers and individual-based system tracers. Examine closed (but recent) records and then brainstorm the types of observations, document review, and questions that a surveyor might use to trace the subject of the record.
• **Study mock tracer scenarios:** Tracer scenarios, like those in this workbook, will help familiarize team members with the general flow of a tracer as well as the specific and unique nature of most tracers. The questions that follow each tracer scenario in this workbook can be used to populate a form for a mock tracer on a similar subject in your organization (see Appendix B). The sample tracer worksheet at the end of each section in this workbook provides a model for how someone playing the role of a surveyor might complete a worksheet based on such questions. Note that scenarios with international content appear in the final section of the workbook, but issues addressed in scenarios for domestic settings may be transferable to international settings.

• **Practice interviewing:** Since a large part of a tracer is spent in conversation, people who are filling the roles of surveyors should practice interviewing each other. Although these people should already be good communicators, a review of common interview techniques may be helpful (see the sidebar “Interviewing Techniques” at right).

### Conducting and Evaluating the Mock Tracer

#### Step 5: Assign the Mock Tracer

A mock tracer team may have one member play the roles of surveyor in a specific mock tracer, or the team members may take turns playing the role during the tracer. With repeated mock tracers, every team member should have the opportunity to play a surveyor. Consider these options when assigning role-playing surveyors to mock tracers:

- **Match the expert to the subject:** Match a “surveyor” who is an expert in a department/program/service to a mock tracer for a similar department/program/service—but for objectivity, do not assign them to the same specific department/program/service in which they work.

- **Mismatch the expert to the subject:** Match a “surveyor” to a department/program/service that is new to him or her. This may enhance the objective perspective. Of course, that person will have to prepare in advance to become familiar with the requirements for that new department/program/service.

- **Pair up or monitor:** Pair “surveyors” so they can learn from and support each other, or allow one “surveyor” to follow and monitor the other for additional experience. One of those in the pair might be the mock tracer team leader.

#### Interviewing Techniques

- **Take your time.** Speak slowly and carefully.
- **To help set the interview subject at ease,** try mirroring: Adjust your volume, tone, and pace to match those of the person to whom you are speaking. (If the subject is nervous or defensive, however, use a quiet and calm approach to encourage that person to match your example.)
- **Use “I” statements (”I think,” “I see”)** to avoid appearing to challenge or blame the interview subject.
- **Ask open-ended questions (to avoid “yes/no” answers).**
- **Pause before responding to a subject’s answer to wait for more information.**
- **Listen attentively, gesturing to show you understand.**
- **Listen actively, restating the subject’s words as necessary for clarification.**
- **Manage your reactions to difficult situations and avoid using a confrontational tone,** even if your subject sets such a tone. Take a deep breath and wait at least three seconds before responding.
- **Always thank your interview subject for his or her time and information.**

#### Step 6: Conduct the Mock Tracer

All departments/programs/services in your organization should already have been notified about the possibility of staff conducting mock tracers. Unless mock tracers are announced, however, there is no need to notify interview subjects when the tracer is scheduled to occur. During the mock tracer, team members should do the following:

- **Collect data:** Like real surveyors, those playing the roles of surveyors must collect data that help to establish whether your organization is in compliance with applicable accreditation requirements. They should do this by taking notes on their observations, conversations, and review of documents. Notes may be entered on an electronic form (using a laptop computer) or on a paper form.
• **Be methodical and detail oriented:** To help establish and simulate an actual tracer, those portraying surveyors should strive to be as methodical and detail oriented as actual surveyors. The following techniques may be useful:
  – Map a route through the mock tracer, showing who will be interviewed in each area. It is helpful to interview the person who actually performed the function targeted by the tracer, but any person who performs the same function can be interviewed.
  – Identify who will be interviewed in each area, using specific names (if staffing schedules are available) or general staff titles. For example, if you have singled out a particular care recipient to trace, identify which staff members cared for that care recipient. Of course, this may not be possible to do because staff to be interviewed may depend on what is found in the targeted area, where the care recipient travels within the organization, and what procedures are performed.
  – Note the approximate amount of time to be spent in each department/program/service. That will help keep the tracer on schedule. Notwithstanding any tentative scheduling of the tracer, however, you may uncover unexpected findings that will necessitate either spending more time in a particular location or going to locations that were unforeseen at the time the tracer started. Flexibility is a key attribute of a good surveyor doing tracers.
  – Take notes on a form, worksheet, or chart developed by the team for the purpose of the mock tracer. (The mock tracer worksheet form in Appendix B can be used for this purpose.)
  – Surveyors are directed to be observant about EC issues. Some EC issues may be photographed for the record, provided that no care recipients are included in the photos.
• **Share the purpose:** Whenever possible, remind tracer interview subjects of the purpose of tracers and mock tracers: to learn how well a process or system is functioning (not to punish a particular staff member or department/program/service).
• **Maintain focus:** Keep the process on track and continually make connections to the broader issues affecting care recipient safety and delivery of care, treatment, or services.
• **Be flexible and productive:** If a person playing the role of a surveyor arrives in an area and has to wait for a particular interview subject, that time can be filled productively by interviewing other staff and making relevant observations and notes. If more than one mock tracer is scheduled for the same day—as in a real survey—“surveyors” may cross paths in an area. One “surveyor” should leave and return at a later time.
• **Address tracer problems:** Be prepared to identify and address any problems with the mock tracer process encountered during the mock tracer, including practical arrangements (such as the logistics of finding appropriate staff), department/program/service cooperation, team dynamics, and staying on schedule. Decide in advance whether to address such problems in an ad hoc fashion (as they are encountered) or as part of a debriefing after the mock tracer to prepare for subsequent mock tracers.

**Step 7: Debrief About the Mock Tracer Process**

After each mock tracer, and particularly after the first few, meet as a team as soon as possible to evaluate and document how it went. (Note: This debriefing session should focus on the mock tracer process, not what the mock tracer revealed about your organization’s problems or issues. That will be done in Step 8: “Organize and Analyze the Results of the Mock Tracer”; see page 25.) You may choose to use one of the following approaches:

• **Hold an open forum:** An open forum should allow all team members to discuss anything about the tracer, such as methods, logistics, and conflict resolution. For a broader perspective, invite interview subjects from the mock tracer to participate.

• **Let each member present:** In a direct, focused approach, team members can present their feedback to the rest of the team, one at a time. Each person playing the role of a surveyor can be given a set amount of time to present, with questions to follow at the end of each presentation.

• **Fill out a feedback form:** Team members and mock tracer participants can complete a feedback form in which they record their impressions of the mock tracer and suggestions for improvement of the process. These can be vetted and then discussed at the next team meeting to plan for the next mock tracer.
Analyzing and Reporting the Results of the Mock Tracer

**Step 8: Organize and Analyze the Results of the Mock Tracer**

Conducting a mock tracer is not enough; the information gained from it must be organized and analyzed. The problems and issues revealed in the mock tracer must be reviewed, ranked, and prioritized. You might want to use one or more of the following suggested methods to do this:

- **File the forms**: If the mock tracer team used forms—either electronic or paper (such as the form in Appendix B), those can be categorized for review. The forms might be categorized by types of problems/issues or by department/program/service.

- **Preview the data**: Those who played the roles of surveyors should be the first to review the data (notes) they collected during the mock tracer. They should check for and correct errors in the recording of information and highlight what they consider to be issues of special concern.

- **Rank and prioritize the problems**: The team, led by the team leader, must carefully evaluate all of the team’s data. Critical issues or trends can be identified and then ranked by severity/urgency with regard to threats to life or safety, standards noncompliance, and violations of other policies. Prioritizing is the next step and will require considerations such as the following:
  - What is the threat to health or safety? What is the degree of threat posed by the problem—immediate, possible, or remote?
  - What is the compliance level? Is the problem completely out of compliance? That is, does the problem relate to a standard that always requires full compliance (that is, Category A standards) or one for which you may be scored partially compliant or insufficiently compliant (that is, Category C standards)?
  - What resources are required? How much staff time and resources will likely be needed to correct the problem? Depending on the threat to health or safety and compliance level, there may be a time limit imposed on how soon the problem must be corrected (for example, immediately or within 45 or 60 days).

**Step 9: Report the Results of the Mock Tracer**

An organization’s reaction to a mock tracer will depend largely on the results of the mock tracer, including how—and how well—the results are reported. In all reports, it is important to avoid having the tracer appear punitive or like an inspection, so do not include staff names or other identifying information. Following are several ways to report results effectively:

- **Publish a formal report**: Compile all documents and carefully edit them. Determine which documents most clearly summarize the issues. Submit a copy of the report to the appropriate leadership.

- **Present as a panel**: Invite leadership to a panel presentation in which team members present the results of the tracer—by department/program/service or by other arrangement (for example, problems with staffing, infection control, handoff communication, or transitions in care, treatment, or services).

- **Call a conference**: Set up an internal conference event in which you present the results. They could be presented on paper, delivered by speakers from a podium, and/or delivered using audiovisual formats. Invite leadership and everyone who participated in the mock tracer. Keep the conference brief (no more than two hours), being considerate of attendees’ time. Make the content easier to digest by color-coding the level of priority and using other keys to signal the types of problems and their severity. Open up the conference to feedback with breakout brainstorming sessions on how to address the problems.

- **Post for feedback**: Post the results on a secure organization intranet and ask for feedback and suggestions from participants and others in your organization. A bulletin board in the lunchroom works, too. After a week, remove the report and incorporate any new information to present to leadership.

- **Report in a timely way**: One goal of a mock tracer is survey preparedness via standards compliance, so addressing problems before a survey is vital. All reports should therefore be made within one month after completion of a mock tracer to allow plenty of time to correct compliance problems.

- **Accentuate the positive**: Remember to pass on positive feedback that comes to light during the mock tracer and data analysis. To encourage continued success as well as future positive interactions with the mock tracer process, reward or acknowledge departments and individuals that participate or are especially cooperative and responsive.
Applying the Results of the Mock Tracer

Step 10: Develop and Implement Improvement Plans

Your reports should indicate which problems must be addressed immediately and which can wait, which require minimal effort to correct and which require extensive effort. Employ one or more of the following improvement plan approaches to help address corrective actions:

- **Hand off to managers:** Hand off any easily addressed corrective actions that are particular to one department/program/service to the relevant managers. Inform them of your estimates of time and resources necessary to address the problem. Offer to work with them on more complex corrective actions. Offer to repeat mock tracers to confirm findings.

- **Work with PI:** Most of what will need to be done will require integration into your organization’s PI program. Follow the required approach in addressing corrective actions.

- **Check your compliance measures:** Be sure to check which elements of performance (EPs) for a Joint Commission standard require a Measure of Success (MOS). These are marked with an "M." At least one measure demonstrating the effectiveness of recommended changes should be included in the Plans of Action addressing compliance for those EPs with an "M," and it must be included if the findings will be integrated into a PPR. There is no MOS for JCI standards. Standards are Fully Met, Partially Met, Not Met, or Not Applicable. JCI requests that a Strategic Improvement Plan (SIP) be developed by the organization for any Not Met standard(s)/measurable element(s) and/or International Patient Safety Goal(s) cited in the survey report when the organization meets the conditions for accreditation. International organizations do not complete PPRs. (See the discussion of PPRs in “Relate It to the Date of the Last Survey,” under “Step 1: Establish a Schedule for the Mock Tracer,” on pages 19-20.)

- **Share the plans:** Make sure the entire organization is aware of the corrective actions proposed as a result of the mock tracer. Cooperation and support during future mock tracers depend on awareness of their value and follow-through. Activities and results can be shared in internal newsletters or staff meetings.

- **Monitor the plans:** The mock tracer team is not responsible for completing all the corrective actions, but it is responsible for working toward that goal by monitoring any plans based on findings from the mock tracer. Give deadlines to heads of departments/programs/services and others involved in corrective actions (in accordance with any PI policies). Check regularly on progress and make reports to leadership and the PI program on progress and cooperation.

- **Prepare for the next round:** After a few mock tracers, most organizations discover the exponential value of such exercises. They then develop a mock tracer program that allows for periodic mock tracers, sometimes with several running at one time.
Appendix B: Sample Mock Tracers

NOTE: “Sample Mock Tracers” is excerpted from Mock Tracer Workbook, Copyright 2009, The Joint Commission. For more information on this book, please visit Joint Commission Resources’ Web site (www.jcrqsn.com). Due to space considerations, other pages in the book that are referenced here are not included.

This section contains individual, systems-based, and program-specific tracer exercises for hospitals. Each exercise contains a scenario that represents what might happen when a surveyor conducts that type of tracer in a hospital. Based on the scenario provided, the exercise includes a list of sample tracer questions that might be asked of the chosen tracer patient or staff members involved in that patient’s care, treatment, or services. At the end of the section is a sidebar of tips that staff can consider when conducting their own tracer activities in a hospital.

Please keep in mind that each tracer is unique; the questions asked or hospital areas visited during a tracer will vary depending on the patient or system chosen to follow. No two tracers are the same. There is no way to know all of the questions that might be asked during a tracer, because the possibilities are limitless. These exercises are examples to show how that type of tracer can be conducted and to put the sample questions into context. Use these tracer scenarios and sample questions as educational or training tools for yourself and your staff, or use them as a starting point to conducting your own tracers.

**Individual Tracer Exercises for a Hospital**

### Exercise 1-1. Individual Tracer in a 500-Bed Hospital

**Summary:** In the following scenario, a surveyor conducts an individual tracer at a 500-bed hospital, where she explores issues relating to the Priority Focus Areas of

- Communication
- Medication Management
- Patient Safety

The surveyor conducted an individual patient tracer in a 500-bed hospital. She selected a surgical patient who had been in the hospital for eight days. The patient was admitted to the hospital via the emergency department following a motor vehicle accident. The patient had multiple injuries, including a ruptured spleen, fractured ribs, and a fractured femur. The patient went immediately to the operating room (OR) from the emergency department, and was subsequently admitted to the surgical intensive care unit (ICU). She was transferred from the surgical ICU to the surgical unit on the sixth day. At the time the tracer was conducted, the patient was still on the surgical unit.

The surveyor went first to the surgical unit, where she met with the nurse caring for the patient and asked her to review the patient’s record. The review revealed that an open reduction repair was performed on the left sided femur fracture. The patient also had a splenectomy. The surveyor asked the nurse to review the course of the patient’s treatment. The nurse indicated that the patient’s condition was improving and that she would potentially be discharged from the hospital to a rehabilitation facility in a few days. She said that the patient had come to this unit from the surgical ICU. The surveyor determined that after review on this unit, she would also visit the surgical ICU, the OR, and the postanesthesia care unit (PACU) to trace the care and treatment provided to this patient. She did not think there would be enough time to also visit the ER on this tracer, but would ask relevant questions during another tracer visit that would take her to the ER. The organization had an electronic patient record, so it would be possible to perform record review with staff in each of these locations.

The nurse reviewed the patient’s record with the surveyor. The nurse was asked if she had received the patient when she was transferred from the surgical ICU and how staff received information about a patient upon transfer. The nurse was also asked about the patient’s learning needs, and if staff members had provided education to the patient. The nurse was also asked if the patient experienced pain and, if so, how it was being managed. The physician also joined the nurse and surveyor, and he was asked to discuss similar issues regarding communication and pain management. He was also asked about the patient’s medication profile.
The nurse and physician explained the medication reconciliation process and how medications were reconciled when the patient was transferred from the ICU to this unit. The nurse and physician also explained the patient’s discharge plan. They added that the social worker was trying to get her placed into a rehabilitation facility for short-term therapy.

The surveyor also met with the patient and asked her about the education she received from staff and her knowledge of her medications. The patient described how the physician and nurse spent time explaining her condition and the treatment before it was provided. She also knew the names of her medications, the potential side effects, and why she was taking them. She also showed the surveyor a brochure explaining each medication that she said she planned to use at home. When the surveyor asked about her pain and if she felt it was well managed, she added that staff responded quickly if she felt pain or any discomfort. She was able to describe her pain, including the use of the visual analog scale.

The surveyor then went to the surgical ICU, where she met with a nurse who cared for the tracer patient. The nurse was asked to review the tracer patient’s course of care and treatment. This nurse was also asked about the patient’s education and about handoff communication regarding patient information.

During a visit to the OR suite, the surveyor met with the charge nurse and asked her to describe the course of treatment that the tracer patient received there, from entrance to the pre-operative area, through the OR, and to the PACU.

An OR nurse, who was the circulating nurse for the tracer case being reviewed, was also asked to explain how the Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™ was applied, including the use of the preoperative checklist, site marking, and the time-out process.

The surveyor then went to the PACU and observed the handoff communication process as another patient was being admitted from the OR following a procedure. Staff members were also asked about which criteria were used to determine when a patient would be discharged from the PACU.
Sample Tracer Questions

Questions for Clinical Staff:

- How was information communicated to you regarding the patient’s care and treatment upon transfer to this unit?
- How is patient information communicated from shift to shift, from discipline to discipline, and between care providers?
- Have you provided education to this patient?
  - What have you or others educated her about?
  - How is it documented?
  - How is the effectiveness of your education evaluated?
  - Has education also been provided by other caregivers?
  - How do you support one another’s educational endeavors?
  - Have you or anyone evaluated the patient’s ability and willingness to learn, and also her preferred method of learning?
- Can you tell me about the patient’s pain management program?
- Do you use telephone or verbal orders? If so, can you explain how the process works at this hospital?
- Please explain the medication reconciliation process. Show me how it is documented.

Questions for the Patient:

- How have staff members provided you education and information about your illness?
- What do you know about your medications?
- How do staff identify you before giving medications?
- What do you know about your discharge plan?
- If you have questions, are you comfortable that you can get the answers you need in a way that you can best understand?
- Have you experienced pain? If so, how has it been managed?
- When will you be leaving the hospital? What is the plan for the next steps in your recovery?
- Who has met with you to discuss your discharge plan?

Questions for the Operating Room Staff:

- Please tell me how the patient is positively and definitively identified from entrance to this area and then throughout the entire operative process.
- Please show me your preoperative check sheet and explain the preoperative verification process.
- How is the time-out performed?
- How is the operative site marked? How do you confirm that the correct site has been accurately marked?
Scenario

The surveyor focused a portion of the review on this small rural hospital’s proactive risk assessment. He asked that those people who were involved in the current proactive risk assessment attend this portion of the data management review.

The surveyor asked the team to explain the process it uses to conduct its proactive risk assessment. The team members informed him that they use the failure mode and effects analysis (FMEA) approach, and that all members of the team have been trained in the use of FMEA tools and process. They said that they had only recently completed the last FMEA for the prior year and that they were just selecting a new process for this coming year. He asked them to present the full process and study that had recently been completed, and also to use data and analysis to support the process being presented.

The team was lead by the performance improvement manager, who had also trained the team members on the FMEA tools and process. He explained that they selected a new project each year. They had just completed an FMEA on the medication management process, having studied all of the potential risk areas from prescribing all the way through to the delivery of the medications to the patient. They also recognized that there were additional medication-related problems with the medication reconciliation process, but hoped that they would address that as a separate issue on this next year’s FMEA. The driving force for the study were medication-error rates and potential failures to recognize possible errors in prescription, transcription, filling of orders, mixing of intravenous (IV) medications, and dispensing of medication to the patients.

The team presented its process, starting with a flowchart of the current medication process. The members then identified ways and steps in the process that could potentially break down. They explained that they used currently available data, such as medication-error and discrepancy reports, and that they also addressed additional areas where data were not yet readily available for them, such as near misses. They explained that they asked nursing and pharmacy staff to begin collecting data on near misses and that they provided them with check sheets to use so that the near-miss data would be objectively collected. They gathered this data for three months and then analyzed all of the data to identify potential failure modes. They then implemented improvement strategies using the staff from each of these areas as special members to assist in developing safer interventions. They then studied the results and compared the processes. They said they believed that the system was made safer by changing processes and by educating staff about the potential results of unidentified near misses. They said they would continue to study the process over time to ensure that their improvements were indeed sustainable.

As a result of this study, the team members believed that the probable area of focus for the next FMEA was the medication reconciliation process because the required steps in the process were being done differently in various locations of the hospital. They believed that the current system needed better direction and that staff needed more education in the process in order to standardize it.

The performance improvement manager said other potential areas had also been identified for the next FMEA, but that they were having some difficulty prioritizing which process they should address at this time. Other potential topics were non-medication related, but the current team was committed to moving along to another medication-related issue. Since the hospital could only focus on one major topic at a time, prioritizing the appropriate high-risk areas to be studied was a challenge.
Sample Tracer Questions

Questions for the Performance Improvement Manager:

- What process is used in this hospital to study and conduct proactive risk assessments?
- How do you identify and prioritize the processes to be studied?
- Who determines the right membership and mix of participants on the FMEA team?
- How are data collected? How are they analyzed?
- To whom are the results of FMEAs reported? How frequently are they reported?
- Who sets the priorities for studying high-risk areas? How is it determined which proactive risk assessment will be studied next?
- How are other identified high-risk processes addressed when they are not studied as an FMEA?

Questions for Members of the Proactive Risk Assessment Team:

- Are the analysis and use of information gained from the FMEA used to improve patient safety? Tell me how.
- Has the FMEA enabled you to identify system or process failures or risks for failure?
- Have you been able to build a safer system as a result of the FMEA proactive risk assessment process?
  - Is it sustainable?
  - How do you know?
  - How will you know if you have improved the processes and systems over time?
- Why were you selected to participate on this team?
  - Did you also have ad-hoc, or “just-in-time,” members as they might have been needed?
- How are lessons learned disseminated to all staff involved in the process?
- Have you had “push-back” from any members of your staff? If so, how is this handled?
- Do you think that your involvement on this team has been a positive experience in terms of promoting patient safety in your hospital? How do you know?
Scenario

A surveyor conducted this medication management system tracer at a 220-bed hospital. She asked the pharmacy director and members of the pharmacy and therapeutics committee to meet with her during the first part of this review. The surveyor also asked the chemotherapy pharmacist to attend this meeting. She asked them to present the medication requirements for the oncology program, regarding the use of chemotherapeutic medications. Following the meeting, she visited the oncology patient treatment area and the oncology mixing area in the pharmacy to observe the storage, mixing, dispensing, and disposal of chemotherapeutic medications and related supplies and equipment. She conducted an oncology medication-focused patient tracer for an oncology patient who was receiving infusion on that day.

Staff described the ordering process and policy, and also explained the steps implemented to ensure that the right dose of the right medication was always administered to the right patient at the correct infusion rate. Staff collected data on each of these steps and explained that they had no known errors that involved unsafe administration in the last year. They had experienced some near misses, but those errors were caught prior to dispensing because the system required two signatures for each step in the process. The staff’s data and analysis for medication errors for the past two years showed they had reduced the error rates significantly since making changes to the mixing and dispensing processes.

The oncology pharmacist was asked about his training and preparation and how he stayed up to date on important information. He was also asked about coverage when he was not on duty or was not available. He said he was the only oncology pharmacist, but that another pharmacist was trained on the requirements so he could provide backup for the oncology mixing and preparation.

The surveyor selected a patient to trace who was scheduled to receive chemotherapy infusion during the surveyor’s visit (onsite survey). She went to the oncology treatment area and was introduced to the patient. The patient was in the process of finishing her infusion and agreed to be interviewed. The patient said she received safe treatment from very caring and knowledgeable staff. She further described her medications and their risks and side effects.

The surveyor was introduced to the nurse caring for the patient and observed her discontinuing the infusion at the end of the treatment. She watched how the nurse used specially identified receptacles to dispose of the tubing and the bag. She then reviewed the patient’s record with the nurse. She asked the nurse about any education provided to the patient and how and where it was documented.

The surveyor visited the pharmacy and met with the chemotherapy pharmacist. The pharmacy had a separate intravenous mixing room that was used only for the preparation of chemotherapy medications. The pharmacist was asked to explain how the safe storage and preparation of these medications were assured, and also how the accuracy and appropriateness of prescriptions were assured. He was also asked to explain the quality control processes required for this area. The oncology pharmacist said he was the only designated oncology pharmacist and that he had special training and certification for this role. In case of his absence, another pharmacist had been trained on the required process and policies to serve as a backup.
Sample Tracer Questions

Questions for the Pharmacy Director:
• What are the high-risk medications and processes that have been identified?
• How do you reduce risk in the oncology preparation areas?
• What segregated areas are available for the storage and preparation of oncology admixtures?

Questions for the Oncology Pharmacist:
• What are your training and credentials for the job that you do?
• How do you assure safe mixing of oncology medications?
• What do you do if a spill or a splash occurs?
• How do you ensure that the right medication and safe dosing have been prescribed?
• Who prepares the oncology admixtures when you are not present or available?
  – What training have they received? How do you ensure their competency?
  – Who oversees the process to ensure there is consistency in meeting safe practice requirements?

Questions for the Nursing Staff:
• How do you ensure that you have the correct admixture?
• How do you ensure that you are administering the IV preparation to the correct patient?
• How do you ensure that you are administering the infusion at the correct rate?
• How do you dispose of chemotherapeutic supplies?
• Do you provide education and training to the patients? If so, where and how do you document it?
• Are all nurses who work in this area trained and deemed competent for the administration of chemotherapy medications?
• What does your training consist of? And how does your manager assess your competency?

Questions for the Oncology Patient:
• How does staff identify you prior to starting an infusion?
• Do you feel that your privacy and dignity are respected in this area?
• What kind of education have you received regarding your chemotherapy? Who has provided it?
• Do you feel that your questions are adequately addressed?
The surveyor conducted this patient flow program-specific tracer during a hospital accreditation survey in a 300-bed tertiary care hospital. During a previous individual tracer, he noticed a backup of patients in the halls of the emergency department, and discussions with staff indicated this was a common occurrence. The surveyor went back to the emergency department to focus on the patient flow-related issues and to trace how the backup affected other areas of the hospital.

The surveyor met with emergency department staff and asked them to explain how they move patients through the system. They noted how certain times of the day posed greater challenges to them, such as late afternoons and evenings. The organization recently expanded the emergency department, but staff said it still experienced backup situations at times. Patients were observed on stretchers and beds in the corridor, close to the nursing station. Staff said some of those patients waited to be seen and others waited to be admitted. The surveyor asked if any areas of the hospital experienced the longest waits for admission. Staff responded that the intensive care units often had the longest wait periods. They added that overnight and early in the day patients might be backed up in the emergency department awaiting admission to beds on the general medical and surgical care units. Patients who were discharged generally did not leave until midday, which seemed to cause delays in admissions and transfers from the intensive care unit (ICU) to those beds.

The surveyor asked the emergency department staff if they were able to provide the same level of care and services to patients in the emergency department as they would receive if they were admitted to the level of care they were waiting for.

Staff said they could provide the same care and services and that, at times, an ICU nurse would come to the area to care for the patient awaiting admission to the emergency department. But they added that the patients would be better served if they were transferred to the appropriate hospital bed sooner. The surveyor noted he saw a lot of proximal activity, discussion regarding other patients, and a noted lack of privacy for the hall patients in the emergency department. Staff said screens were available and could be used, but only two screens were observed in use while eight patients were observed on stretchers and beds in the corridor.

The surveyor then visited the medical intensive care unit. He met with staff and asked them if they were awaiting any patient admissions from the emergency department. He also asked them to explain how they made beds available and assured rapid admission of patients awaiting transfer to the medical intensive care unit. The staff responded that they also had difficulty transferring patients out of their unit because beds are often not available on the regular units until patients have been discharged. They have a step-down unit, but the same backup occurs there because it is only a four-bed unit. The surveyor asked the staff if they had admission and discharge criteria defined for the ICU and step-down units.

The surveyor then met with staff leaders to discuss the patient flow issues. They explained that the organization’s patient flow team met monthly and included representatives from all areas of the hospital. They also attempted to implement a discharge process requirement earlier in the day to allay some of the problems with patient backup, but they had difficulty getting the physicians to see the patients sooner and write earlier discharge orders. Other difficulties included the patients not being picked up early enough from the hospital. They further described how they expanded and redesigned the emergency department and created the step-down unit to help allay some of the patient flow-related issues, but some issues have not been fully resolved. They added they were very aware of the patient flow issues and tried to implement safe systems to assure that the appropriate level of care and service were applied to every patient, but the patient backup still posed challenges. The surveyor asked them to review the data they collected, as well as the changes and policies implemented to date. They shared the information and pointed out some of the improvements that occurred that could be supported by the data.

Scenario

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Sample Tracer Questions

Questions for Emergency Department Staff:
- Can you tell me about the reasons for the backup of patients in the emergency department?
- How do you protect and respect the privacy and dignity needs of patients in the emergency department, especially those who are located in the corridor?
- What are you doing to improve patient flow conditions?
- Can you assure that the appropriate level of care and services is provided to every patient in the emergency department who is awaiting admission to the hospital? How?
- How has the expansion and redesign of the emergency department helped allay any of the patient flow issues?

Questions for Intensive Care Unit Staff:
- Do you have admission and discharge criteria for the intensive care unit?
- What criteria do you use to discharge patients from the intensive care unit?
- How often do you need to move patients because you must make room for other patients awaiting admission?
- Have you seen improvements with patient flow since the step-down unit was created?
- Are there admission and discharge criteria for the step-down unit?

Questions for Leaders:
- How do you identify patient flow-related issues?
- Who is involved in the patient flow team? How are they chosen for the team?
- What are the “bottlenecks” that you have identified?
- What have you done, and what are you planning to do to address these patient flow issues?
- How are data collected and measured regarding patient flow issues?
- Have you seen improvements since implementing some of your interventions?
- How are you addressing issues that have not shown improvement?
Scenario

The surveyor conducted this suicide prevention program-specific tracer during an accreditation survey in a hospital with a psychiatric inpatient care unit. The surveyor went to the psychiatric care unit and interviewed staff about their efforts to prevent suicide and to identify patients who might be at risk for committing suicide. She asked them about their initial assessment and ongoing risk assessments.

For this tracer, the surveyor selected a patient who had been initially assessed as being at risk for suicide. She asked staff to review the patient’s file with her, starting with the initial assessment. The file stated the patient had attempted suicide at home by taking an overdose of sleeping medication. She was admitted to the hospital via the emergency department and from there was transferred to the medical intensive care unit. After the patient was medically stabilized, she was transferred to the inpatient psychiatric care unit. This was a 28-year-old patient with a history of depression and one prior known suicide attempt. She was admitted to the hospital 10 days prior to this survey review, and was transferred to this unit on day 3 of her hospital admission.

Staff said the patient seemed quiet, but participated in therapy and group sessions. She had not demonstrated any further suicidal ideations or any signs of suicide attempts since her admission. The surveyor asked the staff to review the patient’s plan of care and discuss how the plan was developed and how often it was revised. They were planning to discharge her in about a week, to be followed up by her private psychiatrist and outpatient group sessions. The surveyor asked them about family involvement. She also asked them if they educated the patients and their families about access to a hotline as part of their discharge planning. She asked to see documentation regarding this patient’s education. The staff indicated that they provided brochures, conducted one-on-one discussions, and offered phone numbers for a crisis hotline, but no documentation was kept as evidence that this education and information was provided to this patient or her family.

The surveyor then visited the medical ICU to interview staff about the care provided to this patient. She asked them if they were aware of the patient’s suicide attempt, and also if they conducted a suicide risk assessment on her. They said the emergency department had done the initial assessment, which identified her as being a suicide risk. The surveyor asked the staff to explain how they protected this patient and provided her with a safe environment while she was a patient in their area.

The surveyor then visited the emergency department to inquire about the assessment, care, and treatment this patient received there. Staff said the patient was not responsive while she was a patient there, but they relied on the family history provided by her mother. They assessed her as being a suicide risk based on an interview with the mother and her present condition. The patient received one-to-one care from a nurse, who also transferred her to the medical ICU. The surveyor inquired about the competency of the nurse caring for this patient, in regard to her ability to care for an at-risk suicidal patient. The nurse explained how she attended classes and received ongoing training to care for these types of patients. She also indicated that she had been deemed competent for care of behavioral health and potentially suicidal patients.

Summary:

In the following scenario, a surveyor conducts a suicide prevention program-specific tracer at a small rural hospital with a psychiatric inpatient setting, where she explores issues relating to the Priority Focus Areas of:

- Assessment and Care/Services
- Patient Safety
- Communication

Exercise 1-9. Suicide Prevention Program-Specific Tracer at an Inpatient Psychiatric Care Unit
Sample Tracer Questions

Questions for Staff in the Psychiatric Care Unit:

• How do you assess patients who might be at risk for suicide?
• Has this patient expressed any further suicidal ideations? If so, how is that handled?
• How are you addressing the immediate safety needs of this patient?
• How are you addressing the long-term safety needs for this patient?
• If this is not the most appropriate setting to meet the safety needs of this patient, how will the patient’s needs best be met?
• How do you provide information to patients and their families regarding access to a crisis hotline?
• How do you develop a treatment plan or plan of care? Who is involved in this process?
• Can you show me the patient’s treatment plan?

Questions for Emergency Department Staff:

• How do you assess patients who might be at risk for suicide?
• How do you protect patients who might be at risk for suicide while they are in the emergency department?
• Who assesses and cares for patients in the emergency department?
• Are your staff in this area trained and competent to assess and care for patients who might be at risk for suicide?
• What is your process to ensure there are no dangerous items with the patient?
• What is your monitoring system?
• Who cares for patients with extended emergency department stays while conducting bed search?

Questions for the Intensive Care Unit Staff:

• How did you assess this patient as being at risk for suicide?
• What interventions were taken to protect this patient?
• Are staff in this unit trained and competent to care for potentially suicidal patients?
• What type of ongoing training or education do you receive to help you care for suicidal patients?
Appendix C: Faculty Biographies

Susan Hill, R.N., M.A.
Surveyor
The Joint Commission

Susan Hill has surveyed with The Joint Commission since 1997. She surveys the hospital, long-term care, home care, and behavioral healthcare programs, and she is a small integrated hospital specialist. Ms. Hill participated in the development of The Joint Commission's revised accreditation process which became effective at the start of 2004, including conducting pilot surveys prior to the launch. She also has participated in new surveyor training as a faculty member.

Prior to surveying, Ms. Hill was Vice President of Clinical and Leadership Education for a tri-state healthcare corporation providing acute and long-term care. She also has served as the Director of Education, Quality Assurance and Risk Management for a community hospital. Her clinical background includes Labor/Delivery and Critical Care. She has experience in developing and implementing performance improvement, prospective payment, and risk reduction processes. Ms. Hill is also a Joint Commission Certified Yellow Belt.

Ms. Hill received her R.N. from the Pasadena College School of Nursing, California. Her B.A. and M.A. degrees are from the University of Redlands, Redlands, California. Ms. Hill is a member of Sigma Theta Tau and the Organization of Healthcare Educators of Los Angeles, California.

Ms. Hill is an employee of The Joint Commission.

Jacquelyn W. Duplantis, R.N., M.S.N.
Surveyor
The Joint Commission

Ms. Duplantis has surveyed with The Joint Commission since 1993. She is currently trained and certified to survey hospitals, long-term care, critical access hospitals, and home care.

Prior to her work as a surveyor, she was the Vice President of Patient Services for a moderate-sized community hospital. Ms. Duplantis also served as the Director of Nursing, as well as Director of Women’s and Children’s Services. Her clinical background includes Staff Nursing (general surgery, newborn nursery, medical nursing units, and OB/GYN physician's office), Inservice Education Instructor Manager (general surgery unit, gynecology/OB overflow/IVF unit, and a bone marrow transplant unit), and an Adjunct Instructor for a Master's Program at the University of Texas Health Science Center of San Antonio, San Antonio, Texas.

Ms. Duplantis received her BSN degree from the University of Texas, Austin, Texas, and her MSN degree from the University of Texas Health Science Center of San Antonio, San Antonio, Texas. She has been licensed as a registered nurse in Texas since 1970. Currently, Ms. Duplantis is a member of Sigma Theta Tau, the Oncology Nursing Society, The American Organization of Nurse Executives, and the American Nursing Association.

Ms. Duplantis is an employee of The Joint Commission.
Appendix D: Post-Test

To be eligible for CE credit, you MUST view the video presentation and read the Resource Guide first. Then complete the post-test at http://twnlms.com/ by the due date listed online.

1. The tracer methodology is a systems improvement tool that can be used by hospitals, and it is employed by Joint Commission surveyors as well.
   a. True
   b. False

2. Which type of tracer follows a patient's progression through a healthcare organization to provide insights into the organization's provision of care and services?
   a. Program-Specific Tracer
   b. Individual Tracer
   c. Environment of Care Tracer
   d. System Tracer

3. In selecting mock tracers to conduct, which of the following can help organizations to choose appropriate patients to follow?
   a. Clinical Service Groups
   b. Priority Focus Areas
   c. Either/both of the above.
   d. None of the above.

4. After all mock tracer exercises are completed, it is important to aggregate the issues and link them to Joint Commission standards.
   a. True
   b. False

5. For 2012, which of the following is a program-specific tracer for hospitals/critical access hospitals?
   a. Violence
   b. Equipment/supply management
   c. Suicide prevention
   d. Continuity of care

6. During an individual patient tracer, the surveyor may observe _____.
   a. the care, treatment, and services provided to that patient
   b. medication management processes
   c. infection control issues
   d. All of the above.

7. A mock survey should never include an interview with a patient because of confidentiality concerns and the inconvenience created for patients and their families.
   a. True
   b. False
8. Which type of tracer focuses on system issues identified during individual tracers?
   a. Program-Specific Tracer
   b. Leadership Tracer
   c. System Tracer
   d. Environment of Care Tracer

9. It is a Joint Commission requirement that organizations use the tracer methodology as part of the organization's quality improvement process.
   a. Never.
   b. Only if the organization has experienced a sentinel event.
   c. Only if the organization is due for its onsite survey within the next six months.
   d. Only after an accreditation decision of Preliminary Denial of Accreditation.

10. Why should an organization aggregate the data that is received via mock tracers?
    a. To get a complete picture of performance in care and safety issues.
    b. To identify problematic processes which can lead to patient safety issues.
    c. To reduce duplicative effort.
    d. All of the above.
Appendix E: Resources and Related Information

Electronic Resources

The Joint Commission: http://www.jointcommission.org
Joint Commission Resources: http://www.jcrinc.com/

NOTE: The Internet is an ever-evolving environment and links are subject to change without notice.
Appendix F: Continuing Education Credit Information

Accreditation Council for Continuing Medical Education

Joint Commission Resources (JCR) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. JCR takes responsibility for the content, quality, and scientific integrity of this CME activity. JCR designates this educational activity for the listed contact hours of AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

American Nurses Credentialing Center's Commission on Accreditation

JCR is also accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. JCR designates this continuing nursing education activity for the listed contact hours.

JCR is a provider approved by the California Board of Registered Nursing, provider number CEP 6381 for the listed contact hours.

American College of Healthcare Executives

Joint Commission Resources is authorized to award the listed contact hours of pre-approved ACHE Qualified Education credit for this program toward advancement, or re-certification in the American College of Healthcare Executives. Participants in this program wishing to have the continuing education hours applied toward ACHE Qualified Education credit should indicate their attendance when submitting application to the American College of Healthcare Executives for advancement or re-certification.

National Association for Healthcare Quality

This activity has been approved by the National Association for Healthcare Quality (NAHQ) for 1.0 Certified Professional Healthcare Quality (CPHQ) CE credit.

Accreditation Council for Pharmacy Education (ACPE)

Educational Review Systems is accredited by the Accreditation Council for Pharmacy Education (ACPE) as a provider of continuing pharmaceutical education. The live activity is approved for 1 hour (0.1CEU). ACPE # 0761-9999-12-084-L04-P The enduring activity is approved for 1 hour (0.1CEU). ACPE # 0761-9999-12-085-H04-P

Successful completion of this CE activity includes the following:

- View the presentation and read the accompanying Resource Guide.
- Complete the online Evaluation Form and Post Test.
- A CE certificate/statement of credit can be printed online following successful completion of the Post Test and the Evaluation Form.

NOTE: This information applies to The Joint Commission Resources Quality & Safety Network program titled, The Joint Commission Survey (Part 1): Maximizing Tracer Activities – A Dialogue with Surveyors, originally presented on Thursday, June 21, 2012 from 2:00 - 3:00 p.m. ET.

There is no individual participant fee for this educational activity.
Appendix G: Discipline Codes: Instructions

Some of our programs are accredited for more than one discipline. To ensure that we issue each participant a certificate by the appropriate accrediting body, we ask that you supply us with the following information:

1. The two-digit discipline code
2. Followed by the position code

Example: For a medical doctor, use: 10 MD

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<td>Dietary Manager</td>
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<td></td>
<td>OCT Other Counselor/Therapist</td>
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<td>45 CNA</td>
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<td>Laboratory</td>
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<td>LT Laboratory Technician</td>
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<td>LS Laboratory Supervisor</td>
<td>EMTI</td>
<td>EMT, Intermediate Level/EMT2/EMT3</td>
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<td></td>
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<td>EMTP</td>
<td>EMT, Paramedic Level/EMT4</td>
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<td>Physical Therapist</td>
<td>55 CHUC</td>
<td>Health Unit Coordinator, Certified</td>
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<td>PTA Physical Therapy Assistant</td>
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<td>Occupational Therapy</td>
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<td>Other Medical Professional</td>
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<td>OTA Occupational Therapy Assistant</td>
<td>27 OTH</td>
<td>Other Medical Professional</td>
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Appendix H: JCR Quality & Safety Network Contact Information

General information, customer service issues, or program reception problems?
If you have questions or need technical assistance, please contact the JCRQSN Customer Service Team via e-mail at support@jcrqsn.com or call toll-free 1-888-219-4678

To provide feedback or comment on JCRQSN educational programming
Please contact:
George Riccio
Associate Director of Video and Satellite Service
Joint Commission Resources 630-792-5428

Continuing education questions?
Please contact:
JCRQSN Continuing Education Support Team 1-888-219-4678
support@jcrqsn.com

Questions about standards?
Standards Interpretation Group 630-792-5900

Questions about JCR education or other resources?
JCR Customer Service Center 877-223-6866

VA Knowledge Network Questions?
Contact Joshua Smith 562-826-5505, extension 3962