Preparing for a survey by the Joint Commission on Accreditation of Healthcare Organizations is almost a thing of the past. Starting in January, the accrediting body will move to unannounced surveys.

The intent is to encourage continuous compliance with the standards. “This is not something you can prepare for—you prepare to care for patients every day,” said JCAHO’s president, Dennis O’Leary, MD, speaking at the Association of periOperative Registered Nurses Congress in April in New Orleans.

One of the best ways to always be ready is to practice using JCAHO’s tracer methodology. Most of the on-site survey is driven by the tracer process. There may be 8 to 12 tracers in a survey, occupying 50% to 60% of the surveyors’ time, notes Dr O’Leary. In a tracer, surveyors select a patient and use the patient’s record as a roadmap to move through the organization, checking on standards compliance and the overall system for delivering care and services.

“If you really walk staff through the tracer methodology, it’s an incredible educational experience,” says Michelle Pelling, RN, MBA, of the ProPell Group, Newberg, Ore, who consults on survey readiness.

“It really gives you a better understanding of how well your care processes are working.” She suggests preparing for unannounced surveys by using tracers to drill down into care processes.

“By performing individual tracers on your more complex patients, you are able to ‘stress test’ your processes and determine where you need to improve.”

Two questions to ask in preparing for an unannounced survey, she says:
- Do your policies and procedures support compliance with the standards?
- Where do you need to improve?

The tracer process allows surveyors “to connect the dots” to see how care is actually delivered. “If there’s any kind of a breakdown in the process, it’s pretty apparent,” Pelling comments.

If you stress-test your processes, improve where necessary, and hold the staff accountable for following procedures, most of the time you will meet the standards or other regulatory requirements as a by-product, she says.

“What I like about doing tracers routinely is that it helps you continually evaluate and improve what you should be doing for your patients. Then when the surveyors come, you can say, ‘This is the way we do it here,’” she says.

Types of tracers

The 2 kinds of tracers are:
- individual patient tracers
- system tracers.

Individual tracers follow the care of a specific patient. System tracers focus on areas JCAHO knows to be problematic, such as medication management, infection control, performance improvement, and staffing.

Surveying the continuum

The tracer process will bring the surveyors to surgical services—perhaps several times—as part of the continuum of care. In contrast to previous surveys, surveyors may come to the surgery department more than once as they follow the care of surgical patients.

“They will look for patients who may have gone directly from the emergency department or a critical care unit to the OR as well as those who come for planned or elective surgery,” Pelling says.
How are tracer patients selected?
Knowing how JCAHO selects patients for tracers is important because it can help you decide which patients to choose for mock tracers, Pelling notes.
Surveyors will select patients from your organization’s clinical service groups (CSGs), which are patient populations your organization serves. They may also select:
- patients who cross programs, such as medical patients who suddenly require surgery
- patients who have complex surgical procedures and require critical care
- patients who have special communication needs, such as those who don’t speak English or who are aphasic because of a stroke.

What happens during tracers?
When tracing a surgical patient, surveyors move through the continuum, typically including the preop unit, the holding area, surgery, postanesthesia care, and the postoperative unit. One typical approach is to start with a patient on a medical-surgical unit and review the medical record, mapping the patient’s course of care through the process. Examples of questions they might ask about a surgical patient:
- How was informed consent obtained?
- Is there an advance directive?
- What kind of teaching did the patient receive prior to surgery?
- How is the patient’s pain assessed and documented?
- Did the patient have a history and physical (H&P) on the chart prior to surgery?
- Was the H&P updated as required under PC.2.120?
- When did the anesthesia provider do an assessment, and does the documentation comply with the organization’s policies?
- Were preoperative antibiotics ordered? If so, were they given within the timeframe identified by your organization?
- For equipment used in the OR, how do you maintain this equipment? How were you trained to use it?
  “If the documentation is flawless, they may have limited questions. But if they question compliance with a standard, say in the preop holding area, they will ask more questions. They may ask to review more records to evaluate compliance with the standard in question,” Pelling comments.
  Once in the OR department, surveyors will check for compliance with other standards, as they always have. Examples are security of medications and narcotics, security of gases, sterilization processes, and equipment management and storage. They may ask the staff what they would do in the case of a disaster.
  Managing OR fires is likely to come up because it was the subject of a Joint Commission Sentinel Event Alert.
  “They may ask about the fire triangle and what special training the staff has had to manage a fire in the OR,” Pelling says. “They may ask if you have guidelines for minimizing oxygen concentration under the drapes,” a major hazard for surgical fires. Other fire-related questions may concern education for the staff, surgeons, and anesthesiologists on controlling heat sources and managing fuels.

Patient safety goals
Count on the National Patient Safety Goals being surveyed during the tracer process. In preparing your staff, think about how the safety goals apply in surgical services. For example, under the goal for reducing the risk of health care-associated infections, surveyors are likely to observe how your hand hygiene practices comply with the Centers for Disease Control and Prevention guidelines (www.cdc.gov/handhygiene). The 2006 goals were announced May 31 (related article).
Surveyors are sure to query how you’re complying with JCAHO’s Universal Protocol for preventing wrong surgery and may ask to observe the process during a procedure. The Universal Protocol includes 3 steps for surgical site verification:
- preoperative verification
- marking the operative site
• a “time-out” immediately before starting the procedure.
   The time-out means that prior to starting the procedure, the surgical team pauses to review these 6 elements:
• correct patient identity
• correct side and site
• correct procedure to be done
• correct patient position
• special equipment
• correct implants, if applicable.


What’s the best way to be ready for a survey?
Probably the best method to ensure continuous readiness is to do plenty of mock tracers with the staff, Pelling says. Mock tracers should include persons across all disciplines—nurses, physicians, and ancillary staff from physical and occupational therapy, nutrition, social work, and respiratory therapy. Don’t overlook temporary and per diem staff.

Be sure to provide training to those who will lead tracers, she adds.
“People doing the tracers need a general understanding of what the standards are,” she advises. They also need a good understanding of professional practice so they can assess processes as they go along to see if changes are needed. For example, if a tracer reveals that the pain standard isn’t being complied with, the tracer leader needs to know what steps are needed to correct practice.

Pelling’s clients often ask her for a list of mock tracer questions. But she advises thinking beyond a list of questions.
“People may think they’re doing tracers when they go to different departments and ask a series of questions. That is not what a tracer is,” she notes. “Others may use the questions to quiz the staff but not in relation to a particular patient. That may help establish a baseline of knowledge about the standards, but it doesn’t really prepare people to talk about the process of care for an individual patient.”

Instead, it’s more meaningful to select a patient, map the patient’s course of care, and ask questions that elicit information about how care is given for that individual.

“If you have a general knowledge of what the Joint Commission expects and know the general process of care for certain types of patients, such as those having coronary artery bypass, questions can flow naturally from the care process itself,” comments Elizabeth Lemons, RN, BSN, CPHQ, vice president of quality for 683-bed Baptist Hospital in Nashville, Tenn. She has found this method works better than trying to think of tracer questions to match each of the standards.

The standards tend to flow in the same order that patient care happens, she notes.
Pelling suggests starting with questions about when the patient first enters the organization, such as “When the patient came in, how did she receive information about her care? How is the patient involved in her care? Is the informed consent present? The advanced directive?” Then move into the assessment: “Is the history & physical present? Was it done within 24 hours of admission? Is the nursing assessment present and complete? What problems need to be addressed? And so on.”

It’s important to focus not just on what your policies say but whether the care given is consistent with the policy, she adds.
For example, the question might be, “How often do we reassess a patient for pain after surgery?” Your policy might say every 4 hours for the first 48 hours, unless the patient complains of pain. Though this is the policy, is the staff actually doing that? If not, that should be addressed.

To develop an understanding of tracers, Joint Commission Resources (www.jcrinc.com) has videos, books, conferences, and other resources. These have scenarios and examples for tracers, including some for surgery. (See Resources.)

How much practice?
How many mock tracers should you do?
“Every organization is different,” Pelling says. The value is in thinking of tracers as a tool that can help you evaluate your processes of care and systems of communication regardless of whether you are preparing for a survey or not.

“Going through tracers is a wonderful learning experience for the staff. You should do as many tracers as you think necessary to determine how well you are doing and to give the staff an opportunity to participate,” she says. “You want to see whether the different departments are working together.”

It’s important not to overdo it. Tracers can get a bad name if they take the staff away from their duties for too long. She’s heard of 6-hour tracers that turn everyone off.

Tracers, she says, are really 2 tools in one:

- An assessment tool for asking, “How are our processes working? Do they need to be modified? Can the staff describe what they do? Are we compliant with the standards and with our own policies and procedures?”
- A tool for educating staff about the critical nature of hand-offs, potential breakdowns in the course of care, and the importance of communication, not only orally but through documentation in the medical record.


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**Resources**

*Tracer Methodology: Tips and Strategies for Continuous Systems Improvement.* (Cat no. JTM-04R, $65). Book provides an overview of the tracer process with tips and examples of tracers.

*Shared Visions—New Pathways: Joint Commission’s Redesigned Accreditation Process.* (Cat no. V0408, $275). Video with versions for each type of organization covers the new process.

Phone Joint Commission Resources at 877/223-6866 or visit www.jcrinc.com.

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**Tips on getting ready for tracers**

These tips from Roberta Froth, RN, PhD, CNAA, were provided in a Joint Commission Resources audioconference earlier this year:

**Prepare the team**

Explain the new survey process and purpose of tracers. Focus on the standards and your processes and practices.

“The aim is not to find out who is ‘not doing it right,’” Froth says. “Rather, it is to look at your processes and set up a system so it is easy to do the right thing and hard to do the wrong thing. Ask yourself, ‘What do we have to do to make it a stronger system?’”

**Practice with a closed medical record**

Practicing with a closed record can help ease anxiety for staff who may be apprehensive about tracers. Though this doesn’t provide the depth you get with a current patient, it gives the staff a chance to practice on questions about issues such as informed consent, advanced directives, and medication management.

**Do demonstrations and role playing**

Have someone pose as a surveyor and practice with a closed record. For example, the mock surveyor might say to a staff nurse: “I see this patient received pain medication. Can you show me where in the record this was assessed and documented?” After giving the nurse a chance to find the information and respond, the mock surveyor could say: “Now was this pain reassessed? What pain scale do you use?” The nurse would then identify those in the record.

**Provide sample questions**
Sample open-ended questions can help the staff practice responses, especially in the early phases of preparing for tracers.

**Make standards, policies available**

Make sure the staff has access to the Joint Commission standards, policies, and procedures. Many organizations provide these electronically so they are easy to access.