Endoscopy: Joint Commission “Just in Time” Checklist

Physician, Nurse Practitioner, Fellow, etc.

Medical Record:

☐ Sign verbal orders
☐ Speak to how to meet medication reconciliation
☐ Assure that PAM lists are complete for your patient
☐ Be sure handwriting and MD code number are legible
☐ Check for unacceptable abbreviations (edit with single line drawn through error, indicate "error," inset correct information, date, time and initial correction)
☐ Assure your physician number follows your signature on medical records
☐ Prescriptions are on tamper-proof pads
☐ Assure all entries in medical record are dated, timed and signed

Reminder:

☐ Maintain privacy during H & P’s and in waiting rooms
☐ Log off computer screens

Procedure Area:

☐ Presence of informed consent and witness including time and date
☐ H & P and pre-sedation assessment done within 24-hours of registration of case or updated or “no change” documented if original H&P done within last 30-days. Update notes not performed prior to actual patient exam- patient must be registered and present to complete Update Note
☐ Demonstrate the “universal protocol” (e.g. pre-procedure verification process, site marking and time out)
☐ Enter operative/procedure note immediately after case, prior to patient being transported to recovery, including all six (6) required elements: Surgeon and Assistant names, procedure performed, procedure finding(s), estimated blood loss, specimens removed, pre & postop diagnosis
☐ Complete final post-procedure note within 7 days of procedure (brief-op note can be Final note if all the elements are present). Note must include all elements of the brief-op note plus a detailed description of procedure.
☐ Documentation of advance directive
☐ Staff verbalize the preoperative verification process
☐ Staff verbalize where timeout is documented and when it is to be conducted (immediately before starting procedure)
Know the sedation protocol if administer or recover for sedation

Staff verbalizes that patients are discharged from a recovery room area by [WHO] and by approved criteria

Verbalize how specimens are handled during case; Label the specimen source on the container, etc.; Specimen source must match requisition

Staff verbalize labeling of medications used in a case (medication name, strength, amount, expiration date if expires within 24 hours); If medication is immediately used after being drawn up, labeling is not required. Medications are discarded at the end of the case

The unit will be expected to maintain a continuous preparedness during inspection week.

General Reminders:

- All staff have the right to report to Joint Commission any patient safety or quality concerns without fear of retaliation (use department chain of command to try to resolve first.)
- Know your role in a disaster. Know where to find policies related to disaster management.
- Review your Clip’s Tip’s
- Always wash or sanitize hands after contact with patients or contaminated equipment.
- Know how you would get material safety data sheets (MSDS) on common chemicals you use.
- Be prepared to speak to the performance improvement initiatives for your area
- If talking to surveyors, be friendly, offer assistance, if you don’t know an answer let them know how you would find the information (e.g. I would discuss this with my supervisor.)