**1. Signage & Posting Requirements**

* **General Signage**: Signage such as: Patient Bill of Rights, HIPAA Privacy Notification, OSHA/Right to Know/Worker’s Comp Poster
* **Specialized Signage** (if applicable):
	+ Malignant Hyperthermia Poster
	+ Laser Warning Signage
	+ Radiation Warning Signage
	+ Eyewash Station
	+ Other state-specific required signage

**2. Facility Walk-Through Checklist**

* **Operating Rooms**:
	+ Ensure all equipment is biomedically inspected and appropriately maintained.
	+ Backup power source is functional and sufficient for safely terminating procedures.
	+ OR lighting, cleanliness, and organization meet standards.
* **Post-Anesthesia Care Unit (PACU)**:
	+ Biomedical inspections of monitors and other equipment.
	+ Monitors available for each patient.
	+ Maintain cleanliness of all equipment and surfaces.
* **Sterilization & Clean/Dirty Areas**:
	+ Equipment inspected, sterilization logs maintained.
	+ Ensure proper labeling of sterilized packs with date and initials.
	+ Single-use items are not re-sterilized.
	+ Biological indicators are utilized according to manufacturer’s guidelines.
* **Crash Cart**:
	+ Ensure all medications and supplies are present and within expiration.
	+ Check and log expiration dates, medications, and required supplies (e.g., Ambu bag, end tidal CO2 monitor, intubation equipment, defibrillator, oxygen supply).
* **Malignant Hyperthermia Kit** (if applicable):
	+ Maintain adequate supply of Dantrolene or equivalent.
	+ Ensure kit includes required medications, syringes, needles, stop-cocks, Foley catheter, and ice packs.

**3. Documentation & Logs**

* **Surgical Log**:
	+ Document each case with information as specified in your accrediting body standards and state regulations
* **Narcotics Log**:
	+ Maintain inventory counts and document narcotic administration and waste for each patient.
	+ Inventory counts should be performed twice daily when narcotics are in use and weekly if not.
* **Sterilization Logs**:
	+ Record all loads, spore tests (performed weekly), and cleanings.
	+ For facilities with multiple autoclaves, label and specify autoclave used for each load.
* **Implement Safety Logs**:
	+ Daily logs: Medication Refrigerator Temperature, OR Temperature and Humidity, AED/Defibrillator check, Blanket Warmer Temperature, housekeeping, infection control, and pathology.
	+ Weekly logs: Medical gas checks.
	+ Monthly logs: Fire extinguisher, emergency backup power, emergency lights, exit lights, eyewash station, smoke detectors, and crash cart inspection.
	+ Annual logs: Lead apron coverage (if radiation is used).

**4. Employee Files & Credentialing**

* **Personnel Files**:
	+ Ensure current credentials, certifications, and training records are up to date and available for inspection.
* **Required Documentation**:
	+ CV, medical license, board certifications (if applicable), ACLS or BLS certification, signed acknowledgments, and insurance or malpractice waivers.
* **Staff Training**:
	+ Staff should complete annual training on HIPAA, Fire Safety, Risk Management, OSHA, and any other facility-specific policies.
	+ Document completion dates and maintain training logs for survey readiness.

**5. Emergency Preparedness & Drills**

* **Emergency Protocols and Drills**:
	+ Conduct and document annual drills for scenarios like airway obstruction, cardiac arrest, allergic reactions, malignant hyperthermia, and local anesthetic toxicity.
	+ Assign roles by position and maintain sign-in sheets for drill participants.
* **Risk Management Policies**:
	+ Ensure policies are up to date, covering infection control, adverse incident reporting, and staff responsibilities during emergencies.

**6. Patient Records & Chart Requirements**

* **Pre-Operative Documentation**:
	+ Initial consultation and pre-op H&P by the surgeon, pre-anesthesia evaluation, informed consents for procedures and anesthesia, HIPAA consent, allergy and smoking acknowledgments.
* **Intra-Operative & Anesthesia Records**:
	+ Record anesthesia time-out, end-tidal CO2, vitals every 5 minutes, start/stop times, and medication totals.
* **Post-Operative Documentation**:
	+ PACU record with vitals every 15 minutes for the first hour, every 30 minutes thereafter.
	+ Document discharge criteria met, signed by the surgeon.
* **Special Consents**

**7. Quality Assurance & Performance Improvement (QAPI)**

* **QAPI Program**:
	+ Implement and document quality improvement studies focused on patient safety and procedural outcomes.
	+ Review, update and approve new and existing policies and procedures as needed.
	+ Perform quarterly assessments of patient care; evaluate patient care statistics, conduct root-cause analyses for occurrences required correction, utilize Risk Assessment tools to asses facility incident rates and potential areas of risk.
	+ Conduct Governing Body meetings and document meeting minutes.
	+ Regularly review patient satisfaction surveys and incorporate feedback into improvement plans.
* **Committee Meetings**:
	+ Hold and document quarterly QAPI committee meetings.
	+ Ensure meeting minutes reflect discussions on patient safety, quality improvement initiatives, and incident reviews.

**8. Infection Control & Safety Protocols**

* **Infection Control Policies**:
	+ Document protocols for instrument sterilization, environmental cleaning, and high-touch surfaces.
	+ Maintain logs of infection control audits and cleaning schedules.
* **Personal Protective Equipment (PPE)**:
	+ Ensure PPE is available throughout the facility and used by staff as appropriate.
* **Exposure Control**:
	+ Keep policies up to date for bloodborne pathogen exposure, sharps injuries, and other potential hazards.

***Note:*** *This is a generalized overview of action items while pending an accreditation survey. This list is not exhaustive.. For more information on how your facility can meet total compliance with your accrediting agency, contact Universal Healthcare Consulting at 888-457-0393 or visit* [*www.universalhc.com*](http://www.universalhc.com) *for more information*