Massachusetts General Hospital
Patient Care Services Office of Quality and Safety
Joint Commission Readiness Checklist
Documentation

Criteria	Met	Not Met	Comments
Confidentiality ▪ Patient information is protected from unauthorized access			
Health Care Proxy ▪ Healthcare proxy / Advance Directive dated and present in the record ▪ Evidence (documentation) of follow-up is present if patient/family unable to be asked on admission. ▪ Patient does not have a Healthcare Proxy and is given information			
INA Completed within 24 hours ▪ All elements in the INA are completed or addressed ▪ Consults initiated as required based on initial screening ▪ Evidence that follow-up are consults done			
Care plans: ▪ Admission EBridge note outlines initial Plan of Care (POC) ▪ Problems are patient specific ▪ Update/resolved problem(s) and evaluate patients response in progress note each shift			
Patient Education ▪ Assess and document patient's ability to learn: o Preferences, desire, motivation, and readiness o Cultural and religious practices o Emotional, physical, and cognitive factors o Health literacy level or language barriers o Are the learning needs skills or knowledge based ▪ Patient is informed of patient "Bill of Rights" ▪ Patient is informed of how to contact the Office of Patient Advocacy, DPH, The Joint Commission ▪ Patient/family education includes but is not limited to: o Hand hygiene (documented on or near admission) o Respiratory hygiene (documented on or near admission) o Precautions relevant to patient & family o Medications, procedures o Discharge ▪ Relevant patient education is documented			
Medication Reconciliation ▪ PAML done on admission and discharge ▪ Evidence (comments) if unable to complete medication reconciliation			
Anticoagulation ▪ Upon admission, Warfarin history is checked in AMS ▪ Patients who will be discharged on Warfarin have or will be given the Warfarin Guide			

Massachusetts General Hospital
Patient Care Services Office of Quality and Safety
Joint Commission Readiness Checklist
Documentation

Criteria	Met	Not Met	Comments
Handoffs ▪ How is transfer of care communicated on the care unit? ▪ Transfer note is present when patient arrives from ED, another unit, or procedural area ▪ Sticker to ride complete when patient is transferred to test or procedural area			
Fall Risk ▪ Fall risk scale completed on admission, daily, and if there is a change in patient's status ▪ Interventions match risk factors ▪ Evaluation of patients response and interventions are documented in progress note ▪ Staff describe unit-based strategies in place to eliminate falls ▪ Staff knows how unit is doing with fall prevention and knows where to find Quality data			
Skin Integrity ▪ Braden scale completed on admission, daily, and if there is a change in patient's skin status ▪ If impaired skin integrity, description and stage of pressure ulcer documented per standards ▪ Interventions documented in progress note and match Braden scale risk factors ▪ Evaluation of patients response and interventions are documented in progress note ▪ Staff describe unit-based strategies in place to eliminate pressure ulcers ▪ Staff knows how unit is doing with pressure ulcer prevention and knows where to find Quality data			
Infection Control ▪ Describe proper technique for use of PPE when caring for patients on precautions ▪ Describe measures to prevent central line-associated bloodstream infection (CLABSI) ▪ Describe measures to prevent urinary catheter-associated infections (CAUTI) ▪ Describe measures to prevent surgical site infection ▪ How is staff notified of need for patient to be placed on precautions ▪ How is patient monitored regarding ongoing need for precautions			

Massachusetts General Hospital
Patient Care Services Office of Quality and Safety
Joint Commission Readiness Checklist
Documentation

Criteria	Met	Not Met	Comments
Pain ▪ Appropriate scale used for patient population/condition ▪ Assessment is performed on admission or transfer ▪ Assessment is performed before analgesia given ▪ Re-Assessment is performed after analgesia given ▪ Effectiveness of opiate administration is evaluated within 1 hour of administration and every 4 hours ▪ Effectiveness of Epidural opiate administration is assessed every 4 hours while infusing ▪ Effectiveness of Duramorph administration is assessed every 30 min x 4 hours then hourly until done (at 20 hours) ▪ Alternative interventions for pain relief are documented ▪ Pre and post intervention pain assessments are documented ▪ Effectiveness of intervention is documented in progress notes			
Blood Transfusion ▪ Date, Time and Vital Signs documented on Blood Transfusion Record per policy (Start of infusion 5-20 min after start, at end of infusion) ▪ Two-person verification done and documented on Blood Transfusion Record (two legible signatures with credentials). ▪ RN's describe signs of blood transfusion reaction ▪ RN's describe procedure if there is suspicion of a blood transfusion reaction			
Restraint ▪ Type of restraint in place matches the Provider Order ▪ Order written prior to initiation of restraint unless an emergency ▪ Order is rewritten before each new episode of restraint ▪ Specific behaviors requiring restraint are documented ▪ Least restrictive interventions considered are documented each shift ▪ Use of non-behavioral vs. behavioral matches patients behavior ▪ Restraints are not used on an "as needed" basis e.g. ordered but not on patient ▪ Side rails are considered a restraint if used to restrict movement out of bed; they are not considered a restraint if used to keep patient from falling out of bed e.g. rotating, seizure precautions, sedated, unconscious			
Two patient identifiers ▪ Inpatient, name and MRN; Outpatient, name and DOB			

Massachusetts General Hospital
Patient Care Services Office of Quality and Safety
Joint Commission Readiness Checklist
Documentation

Criteria	Met	Not Met	Comments
Phlebotomy/ Specimen collection/Point of Care Testing ▪ Provider Order for test is present ▪ Pt identified using two patient identifiers ▪ Staff completed MGH training and demonstrated competency ▪ Name of person who drew blood is documented in treatment sheet ▪ Specimens are labeled in the presence of the patient ▪ Describe labeling process when a patient is on precautions			
Critical Results ▪ The Lab staff will call the inpatient care unit with the critical result value and ask to speak with a nurse ▪ The Lab staff will request receivers name, licensure and a "READ BACK " of the critical result with the patient's name and MRN			

Additional Comments: