

Mock Survey Tracer: Patient tracer

Part 1 of 3. Walk one real patient record with one surveyor. Fill it in as you walk, not afterwards.

How to use

Pick a patient from the previous 24 to 48 hours and walk the record with one surveyor. Never write the patient name: use the MRN, and keep this sheet with the survey records.

Tick Met or Not met and write the short evidence you saw, with the date of the entry. Anything Not met goes on the part 3 summary with a risk level, an owner and a date.

Write your own prompts where these do not match your service: a tracer only works if the prompts are written down before the walk.

Unit	Date of tracer walk	Time started
Internal surveyor	Patient identifier (MRN)	Diagnosis category

Admission and registration

From arrival to the documented admission record.

Observation: good practice to look for	Met / Not met	Notes: what you actually saw
Is the admission assessment completed and signed within the required time?		
Is the patient identified correctly before any procedure or handover?		
Are consent and allergy status recorded where the care requires it?		
Is the admission note in the chart, not only in the handover sheet?		

Initial assessment

The first clinical assessment after admission.

Observation: good practice to look for	Met / Not met	Notes: what you actually saw
Is a full initial assessment recorded, including risk and functional status?		
Are abnormal results flagged to the responsible clinician and the flag documented?		
Is pain assessed on arrival and at every reassessment?		

Care plan

The plan of care and how it moves with the patient.

Observation: good practice to look for	Met / Not met	Notes: what you actually saw
Is the care plan documented and updated after reassessment?		
Does the plan name who is responsible for each entry, not only what is to be done?		
Are changes to the plan recorded with a reason and a date?		

Medication

Prescribing, administration and reconciliation.

Observation: good practice to look for	Met / Not met	Notes: what you actually saw
Is the medication chart complete and legible, with dose, route and time?		
Are allergies and interactions checked, and is reconciliation done at admission, transfer and discharge?		
Are unadministered doses justified in the chart?		

Infection prevention

Hand hygiene, isolation and equipment.

Observation: good practice to look for	Met / Not met	Notes: what you actually saw
Is hand hygiene observed at the five moments, and are supplies within reach at the bedside?		
Is isolation signage and PPE consistent with the documented precautions?		
Are single-use items single use, and are reusable items cleaned between patients?		

Patient and family education*What the patient was told, and evidence that they understood.*

Observation: good practice to look for	Met / Not met	Notes: what you actually saw
Is education documented with the topic, who taught it and what materials were given?		
Was teach-back used for self-management, and was it recorded?		
Are language and accessibility needs met before discharge?		

Discharge planning*Planning from admission, not on the day.*

Observation: good practice to look for	Met / Not met	Notes: what you actually saw
Is the discharge destination and expected date documented early in the stay?		
Are medication, equipment and follow-up needs arranged before the day of discharge?		
Is there a record of the information given at discharge and of questions asked?		

After the walk*Count what you ticked, then sign it off. This is the evidence that the tracer happened.*

Sections walked	Prompts checked	Prompts not met
Time taken	Chart or record reviewed	Follow-up needed?

What the walk showed about this unit

Internal surveyor (name and signature)

Date

Unit manager (name and signature)

Date

Mock Survey Tracer: System tracer

Part 2 of 3. Follow one process end to end across the departments it touches.

How to use

Choose the process the survey is most likely to test. Interview the people who do the work, not only the people who write the policy: ask what happens when the usual route is blocked.

Then write the findings table at the foot of this page: one line per observation, with the risk and what you did about it on the spot.

System or process traced

Date

Surveyor

Departments involved

Process steps followed

Write each step as the staff describe it, in their words. The columns on the right are for the answers you expect to hear.

#	Ask this	What you were told (in their words)	Record that proves it
1	How does a normal day start for this process, step by step, from the first step to the last?		
2	Which record proves each step happened, and where is that record kept?		
3	Who can interrupt or override the process, and how is that recorded?		
4	What is the trigger that starts the process, and who checks that the trigger was seen?		
5	Where does the process usually fail, and what is done about it when it does?		
6	Which step depends most on one person being there, and what happens when they are not?		

Staff interviewed

Job title and the part of the process they own. Names are optional and are not needed for a tracer.

Job title	Part of the process they own	How they described the step

Documents reviewed

What you asked for, and what was actually produced. "Not produced" is itself a finding.

#	Document or record requested	Produced?	Where it was found, and any gap
1			
2			
3			
4			
5			
6			

Findings from this system tracer

One line per observation. The same observations go on the part 3 summary.

Ref	Observation	Met / Not met	Risk	Action taken at the time

What went well, and what to change
Two columns, one line each. This is the part the unit manager wants to read.

What went well (keep doing it)	What to change, and who owns it

Internal surveyor (name and signature)
Date

Process owner (name and signature)
Date

Mock Survey Tracer: Findings summary

Part 3 of 3. Every finding from part 1 and part 2 ends up here, with an owner and a date.

How to use

One row per finding. The related standard ID column stays blank until you read it out of your own licensed copy of the standards.
Risk is your judgement: High means a patient could be harmed or the process could fail badly, Medium means a gap that will grow, Low is a tidy-up.
Give every High and Medium finding an owner and a due date before you leave the unit. An unowned finding is the same as no finding.
This summary is the first draft of the corrective action plan. Keep the wording of the finding as written here so the plan can be traced back to it.

Total findings raised

Date of this mock survey

Survey lead

Report sent to

Finding (as written)	Related standard ID	Risk	Owner (name and job title)	Due date

Risk definitions

Risk	What it means on a tracer
High	A patient could be harmed, or the process could fail without anyone noticing. Fix it before the survey.
Medium	A gap that works today but will fail under pressure, staffing change or volume. Fix it with a date.
Low	A tidy-up. Log it so it is not rediscovered at the next mock survey.

Survey lead (name and signature)Date

Quality office (name and signature)Date

Related standard IDs come from your facility's licensed copy of the CBAHI standards. Do not paste standard text into this sheet.