Interim Facility Site Review Tool

PCP/Clinic Name:		**Phone:** **Fax/Email:**	
Site Address:		**Office Contact:**	**County**: Riverside
Last Full Scope FSR: **MRR**: **FSR Score:** **MRR Score:**		**Health Plan:** IEHP	**Reviewer:** Aileen Concemino, RN

Please have the physician or designee complete the form below and return within ten (10) business days. If the completed form is not received within the allotted time frame, an Onsite Interim Review maybe performed. If the answer is "No" to any of the questions, a Corrective Action Plan (CAP) must be submitted to the Health Plan.

Please send completed form and documents to: IEHP QM Coordinator Leonardo-K@iehp.org or (909) 890-5746 (fax).

Check the appropriate Yes/No/NA response below & include any comments. Please note, this form has 2 pages

Physician Coverage is available 24 hours a day, 7 days a week	Compliant	Non-Compliant	N/A	Comments
1. After-hours emergency care instructions/telephone information is made available to patients	Yes ☐	No ☐		After Hours Access Method: (i.e. phone services/exchange)
CRITICAL ELEMENT	Compliant	Non-Compliant	N/A	Comments
1. Exit doors & aisles are unobstructed and egress (escape) accessible • Accessible pedestrian paths of travel provide a clear circulation path. • Escape routes are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other emergency. • Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. • Cords or other items are not placed on or across walkway areas.	Yes ☐	No ☐		
2. Airway Management • Must have a wall oxygen delivery system or portable oxygen tank that is maintained at least ¾ full. Portable oxygen tank must have a flow meter attached. • There is a method/system in place for oxygen tank replacement. • There are various sizes of oral oropharyngeal airways devices appropriate to patient population available on site. • There is a nasal cannula or mask available and various sizes of ambu-bags appropriate to patient population available on site.	Yes ☐	No ☐		Name of person checking supplies:
3. Emergency medicine • Emergency medicine such as asthma, chest pain, hypoglycemia and anaphylactic reaction management: Epinephrine 1:1000 (injectable), and Benadryl 25 mg. (oral) or Benadryl 50 mg./ml. (injectable), Naloxone, chewable Aspirin, Nitroglycerine spray/tablet, nebulizer or metered dose inhaler and glucose. • Appropriate sizes of ESIP needles/syringes and alcohol wipes. All emergency medication in the Emergency kit/ Crash cart must have dosage charts. Package inserts ARE NOT acceptable.	Yes ☐	No ☐		Name of person checking supplies:
4. Qualified personnel prepare/administer medication • There must be a licensed physician physically present in the treatment facility during the performance of authorized procedures by the Medical Assistant(MA). • There must be a process in place and verbalized by the MA(s), at the time of survey, that the pre-labeled medication container and prepared dose are shown to the licensed person prior to administration. The supervising physician must specifically authorize all medications administered by an MA.	Yes ☐	No ☐	N/A ☐	Name of *MD/NURSE ONLY* checking MA administered meds:
5. Timely review & follow-up of referral/consultation reports & test results • Site staff can demonstrate the office referral process from beginning to end. • Referral process must include physician review (e.g. x-ray, labs, specialist notes). • A process for follow-up of referral/consultation reports and diagnostic test results is in place	Yes ☐	No ☐		*Please provide referral logs for past 3 months.* Name of person tracking referrals:
6. Authorized persons dispense medications • Drug dispensing is in compliance with all applicable State and Federal laws and regulations. • Drugs are dispensed only by a physician, pharmacist or other persons lawfully authorized to dispense medications upon the order of a licensed physician or surgeon.	Yes ☐	No ☐		Name of *MD/NURSE* dispensing drugs:
7. Drugs and Vaccines are prepared and drawn only prior to administration. • Personnel are able to demonstrate or verbally explain procedure(s) used on site to confirm correct patient/dosage and vaccine are prepared and drawn only prior to administration. ACIP discourages routine practice of prefilling syringes	Yes ☐	No ☐		
8. Personal protective equipment • PPE is available for staff use on site & includes water repelling gloves, water-resistant gowns, face/eye protection (e.g. face shield or goggles), & respiratory infection protection (e.g. mask).	Yes ☐	No ☐		

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CRITICAL ELEMENT	Compliant	Non-Compliant	N/A	Comments
9. Needle stick precautions are practiced on site • Engineered Sharps Injury Protection (ESIP) devices are used on site • Contaminated sharps are discarded immediately. • Sharps containers are: 1) located close to the immediate area where sharps are used; 2) inaccessible to unauthorized persons; 3) secured (locked) in patient care areas at all times; and 4) not overfilled past manufacturer's designated fill line or more than ¾ full.	Yes ☐	No ☐		*Please provide proof of purchase of ESIP (Engineered Sharps Injury Protection) devices/ Safety Needles used onsite.*
10. Blood and other infectious materials storage and handling • Containers for blood and other potentially infectious materials (OPIM) are closable, leak proof, and labeled and/or color-coded (e.g. red bags). • Double bagging is required only if leakage is possible.	Yes ☐	No ☐		
CE 11-14 Please mark NA if no Cold Sterilization or Autoclave onsite	Compliant	Non-Compliant	N/A	Comments
11. Staff demonstrate/verbalize necessary steps/process to ensure sterility and/or high-level disinfection to ensure sterility/disinfection of equipment. • Product manufacturer's directions are strictly followed for instrument pre-soaking treatment, solution preparation, solution exposure procedures, safety precautions (e.g., room temperature, area ventilation), and post-sterilization processes. • Sterility is not verified or assured with cold chemical sterilization and/or high-level disinfection. The first choice is always heat sterilization. • The CDC refers to heat sterilization as "the method of choice when sterilizing instruments and devices. If an item is heat sensitive, it is preferable to use a heat-stable alternative or disposable item." • The use of liquid chemical sterilant should be restricted to reprocessing devices that are heat-sensitive and incompatible with other sterilization methods. All other items should be heat sterilized or disposable.	Yes ☐	No ☐	NA ☐	
12. Appropriate PPE is available, exposure control plan, MSDS and clean up instructions in the event of a cold chemical sterilant spill. • Always consult the manufacturer for safety precautions and MSDS information. The appropriate PPE must be used to avoid inhalation or skin contact exposure during the cold chemical sterilization/high level disinfection process.	Yes ☐	No ☐	NA ☐	
13. Spore testing of autoclave/steam sterilizer with documented results (at least monthly). • Autoclave spore testing is performed at least monthly.	Yes ☐	No ☐	NA ☐	*Please provide spore test results for the last 3 months.* Date of last spore test:
14. Management of positive mechanical, chemical, and/or biological indicators of the sterilization process. • Sterilization failure can occur for reasons such as slight variation in the resistance of the spores, improper use of the sterilizer, and laboratory contamination during the culture. • Sterility is not verified or assured with cold chemical sterilization. • Written procedures for performing routine spore testing and for handling positive spore test results are available on site to staff. • For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. • Procedures include: report problem, repair autoclave, retrieve all instruments sterilized since last negative spore test, re-test autoclave and re-sterilize retrieved instruments.	Yes ☐	No ☐	NA ☐	
Initial Health Assessment (IHA) • Reviewed the Initial Health Assessment attached criteria, including how to locate my newly assigned membership on the IEHP website.	Yes ☐	No ☐		

Attestation: I hereby affirm, the information indicated on this form and any documents thereto is true, current, correct and complete to the best of my knowledge, belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges or physician participation agreement

PCP/Representative Signature & Title: _____ Date: _____

Print Name & Title: _____

MEDICAL GROUP OR HEALTH PLAN USE ONLY		
Interim Review Approved: ☐ Yes ☐ No	Follow-up Required: ☐ Yes ☐ No	Date CAP Due:
Nurse Comments:		
Nurse Reviewer Signature:		Date: