Please complete the self-assessment of your facility’s compliance to the DHCS Critical Element Criteria noted below and return **the completed document within 3 business days of receipt** to: **CCAH ATTN:** **Facility Site Review Team (831) 430-5890.** Per DHCS APL 20-006 plans may conduct a random survey at any time to verify the findings of this audit.

|  |  |  |  |
| --- | --- | --- | --- |
| **Site Name:** |  | **Date Sent:** |  |
| **Site Address:** |  | **Site ID:** |  |
| **Contact Name/Title:** |  | **Reviewer:** |  |
| **Phone #:** |  | **Review Cycle:** |  |

| **Critical Element Criteria** – See “Site Review Standards” for references | **Yes** | **No** | **N/A** |
| --- | --- | --- | --- |
| 1. (I.C4) Exit doors and aisles are unobstructed and egress (escape) accessible |  |  | - |
| 2. (I.D4) Airway management: oxygen delivery system, nasal cannula or mask, bulb syringe (per population served) & Ambu bag |  |  | - |
| 3. (I.D5) Emergency medicine for 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 81 mg, Nitroglycerine spray/tablet, bronchodilator medication (solution for nebulizer or metered dose inhaler), and glucose. Appropriate sizes of safety needles/syringes and alcohol wipes |  |  | - |
| 4. (II.C1) Only qualified/trained personnel retrieve, prepare or administer medications |  |  | - |
| 5. (III.E2) Physician review and follow-up of referral/consultation reports and diagnostic test results |  |  | - |
| 6. (IV.C4) Only lawfully authorized persons dispense drugs to patients |  |  |  |
| 7. (IV.C.5) Drugs and Vaccines are prepared, verified with a licensed staff member and drawn only prior to administration |  |  | - |
| 8. (VI.B.1) Personal Protective Equipment (mask, goggles/face shield, gloves, water repelling gown) for Standard Precautions is readily available for staff use |  |  | - |
| 9. (VI.B.2) Safety needles & needleless systems are used on site (use of Sharps Injury Log, reporting policy) |  |  | - |
| 10. (VI.B.4) Blood, other potentially infectious materials, and Regulated Wastes are placed in appropriate leak proof, labeled containers for collection, handling, processing, storage, transport or shipping |  |  | - |
| 11. (VI.D.3b) If your site does not use cold chemical sterilization (i.e. glutaraldehyde) answer N/A for # 11 & 12. If cold chemical sterilization is used does staff demonstrate and/or verbalize necessary steps/process to ensure sterility and/or high-level disinfection to ensure sterility/disinfection of equipment? |  |  |  |
| 12. (VI.D.3c) Is appropriate Personal Protective Equipment, exposure control plan, Material Safety Data Sheets (MSDS) and clean up instructions available in the event of a cold chemical sterilant spill? |  |  |  |
| 13. (VI.D.4c) If your site does not use an autoclave answer N/A for both #13 & 14. If an autoclave is used, is spore testing of the autoclave/steam sterilizer conducted with documented results (at least monthly)? |  |  |  |
| 14. (VI.D.4d) Is the sterilization process monitored by documenting: time, temperature, pressure of each load, and chemical/biological indicator used (internal and external indicator to confirm that the autoclave is functioning properly)? |  |  |  |

I have completed the Critical Element assessment for the stated office. I hereby authorize the reviewing health plan to furnish to all collaborative health plans, any government agencies that have authority over the health plans, and authorized county entities in the State of California, the Corrective Action Plans (CAP) and related review tools for this facility. If any of the Critical Element Criteria are found to be deficient on the next full scope review it will prompt a CAP on the entire tool. **If a CAP is required due to the results of this survey, the CAP will be due in 10 calendar days** and verified on site by the nurse reviewer within 30 calendar days. Failure to complete the CAP within a timely matter may result in closure of future member linkage or removal from the Alliance network of providers.

**My signature indicates that I understand and accept the stated terms:**

Physician/Designee

Name/Title: Signature: Date

**\*\*\***

| **Central California Alliance for Health USE ONLY** | **Yes** | **No** | **N/A** |
| --- | --- | --- | --- |
| Monitoring Review Approved? |  |  | - |
| Follow-up Required? |  |  | - |
| If CAP is issued, date CAP is due: |  | |  |

Nurse Reviewer signature: Date signed: