CORE TOOL MONITORING INSTRUCTIONS
FY 2007

DSHS contractors are expected to ensure that their subcontractors meet DSHS requirements. Contractors should have available documentation confirming their oversight of subcontractors.

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I. Laws, Regulations and Policies	
1. The agency ensures that staff abides by the Civil Rights Act, including Title VI regarding Limited English Proficiency, the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.	The reviewer inquires as to whether changes have been made in the agency policies, or new sites opened or sites renovated. If so, the agency must complete and provide 2 copies of the appropriate self-evaluation tools and related policies to the reviewer, one of which is forwarded to the Office of Civil Rights. These self-evaluation tools may be found at http://www.dshs.state.tx.us/qmb/contractor.shtm. Any observation of violations of these laws is noted as a finding. **(Criteria pertinent to WIC only contractors are located on the WIC tool.)**
2. No federal/DSHS funds are used for abortion or for abortion-related activities.	Rider 30 to the Texas General Appropriations Act states: "It is the intent of the Legislature that no funds shall be used to pay the direct or indirect costs (including overhead, rent, phones and utilities) of abortion procedures provided by contractors of the department. It is also the intent of the legislature that no funds appropriated under Strategy B.13, Family Planning Services, shall be distributed to individuals or entities that perform elective abortion procedures or that contract with or provide funds to individuals or entities for the performance of elective abortion procedures." Texas Administrative Code, Title 25, Part I, Chapter 56, §56.7 states: "Abortion is not considered a method of family planning and no state funds appropriated to the department shall be used to pay the direct or indirect costs (including overhead, rent, phones and utilities) of abortion procedures provided by contractors." The reviewer inquires as to whether the agency provides abortion-related services, and during the review of policies and client records, notes evidence regarding the provision of abortion or abortion-related services. If the agency does provide abortion-related services, this criterion is scored "No". If the agency does not provide abortion-related services, this criterion is scored "Yes." If abortion services are provided by an affiliate in the same location,

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	the reviewer observes the signage to ensure the separate nature of the affiliate relationship is clearly reflected. **Note: There is no prohibition against providing information or referral options. (This criterion does not apply to WIC only contractors.)**
3. The agency will ensure that staff abides by the DSHS Child Abuse Screening, Documenting and Reporting Policy requirements.	The agency complies with the DSHS Child Abuse Screening, Documenting and Reporting Policy (hereafter referred to as the DSHS policy). **For School Health, Texas Health Steps, Genetics and BCCC only contractors, a-d are not applicable.**
a. The agency has adopted the DSHS Child Abuse Screening, Documenting and Reporting Policy into the agency's internal policies.	The reviewer examines the agency policy to ensure it includes the DSHS policy as written, or a statement that the agency adopts the policy. The DSHS policy is located on the web at http://www.dshs.state.tx.us/childabusereporting/gsc_pol.shtm. You may view the policies by clicking on the "Policies" tab and the "Checklist for Monitoring" tab in the left hand column. The checklist cannot be modified except at the bottom of the form. **NOTE: This criterion is not applicable for BCCC, School Health, THSteps, and CSHCN contractors.**
b. The agency has an internal policy and procedure for how it will determine, document, and report instances of abuse, sexual or non-sexual, in accordance with the DSHS Child Abuse Screening, Documenting and Reporting Policy.	The reviewer examines the agency/provider internal policy and procedure regarding how it will determine, document and report instances of abuse, sexual or nonsexual, in accordance with the DSHS policy. The agency/provider internal policy must clearly describe the reporting process for minors under the age of 14 and those 14 but under 17 including: 1. The process that will be used to determine if a report of abuse is required for minor clients who are not married or were never married 2. What constitutes abuse to match the provisions of the laws on reporting child abuse 3. The proper timeframes for reporting 4. The requirement that staff must include a statement in the individual client's file or a centralized tracking system that either a report was or was not required to be filed and the basis for that determination 5. What additional documentation, if any, the staff must include in the client file or the centralized tracking system (e.g., an affirmative defense if the minor is 14, but under the age of 17) When a report is required, the client record or centralized tracking system must reflect the documentation requirements outlined in the internal policy. **NOTE: This criterion is not applicable to BCCC, School Health,**

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	CSHCN, Genetics and THSteps contractors.
c. The agency has documentation that all staff has attended training on the policies and procedures for reporting abuse.	The reviewer examines any documentation demonstrating that all employees have attended training as required by the DSHS policy for determining, documenting and reporting instances of abuse. **NOTE: This criterion is not applicable to BCCC, School Health, CSHCN, Genetics and THSteps contractors.**
d. The agency appropriately documented and reported, according to the DSHS Child Abuse Screening, Documenting, and Reporting Policy, all clients who were unmarried minors under 14 years of age who were pregnant or had a confirmed sexually transmitted disease acquired in a manner other than through perinatal transmission or transfusion.	The reviewer asks the agency for the records from all its clinic sites of all clients under 14 years of age who were pregnant or had a confirmed sexually transmitted disease, acquired in a manner other than through perinatal transmission or transfusion, at the time of their clinic visit. The reviewer also requests to review the checklist, if not contained in the record. Each record must include documentation that a report was made. The Checklist for DSHS Monitoring may be kept either in the client's record or in a separate file and made available to the DSHS reviewer. For each incident, if a case has been reported at one clinic site and the client attends another site to receive care, the agency provides the second clinic site verification that the report was made. It is not necessary to report the incident again. A professional must report within 48 hours of a determination of abuse. A non-professional must report immediately. If a record for a client, who does not meet the above criteria, is provided to the reviewer, the record is reviewed to ensure that the agency's internal policy has been followed for determining, documenting and reporting instances of abuse. If the reviewer determines that an incident of abuse (alleged/suspected abuse) was not reported, the reviewer directs the agency to report the incident before the end of the business day and notes the occurrence as a finding. **NOTE: This criterion is not applicable to BCCC, School Health, CSHCN, Genetics and THSteps contractors.**
e. For all records reviewed, except for records referenced in 4.d. above, an evaluation has been made and documented for potential abuse according to the agency's policy and procedure for how it will determine, document, and report abuse, sexual or non-sexual, in accordance with the DSHS Child Abuse Screening, Documenting and Reporting Policy.	When reviewing records, if the reviewer encounters any records for clients 14 years through 16 years of age (or under 14 who are not included in "d" above) who were pregnant, sexually active or had a confirmed sexually transmitted disease acquired in a manner other than through perinatal transmission or transfusion at the time of their clinic visit, the records are evaluated to establish whether documentation reflects that the agency determined, documented and reported abuse according to the DSHS policy and the agency's internal policy for determining, documenting and reporting

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	instances of abuse. If the reviewer determines that a report was not documented when one should have been, the reviewer directs the agency to make a report before the end of the business day. If a client was 17 years or older on the date of the client's last visit to the agency, the record is not reviewed for compliance with this criterion. Score "N/A" when no records reviewed required screening or the agency does not see clients under age 17. **For School Health, Texas Health Steps, Genetics, CSHCN and BCCC only contractors, the reviewer should insure that documentation reflects that the agency has determined, documented and reported suspected child abuse in accordance with the Texas Family Code Chapter 261. Completing the DSHS Checklist is not mandatory for these contractors.**
II. Clinic Operations	
1. The agency has written and implemented policies pertaining to client rights that are approved and updated, according to agency policy, which address:	
a. General consent for treatment.	The policy details the process staff follow to ensure that clients are provided appropriate information regarding clinical care and procedures to make an informed decision regarding consent. Parental consent is required for all minors except in the following circumstances where minors can consent to: 1. Care related to their pregnancy (including pregnancy testing) 2. HIV/STD screening and testing 3. Family Planning services provided under Title X only, Title X/XX or Title XIX (Refer to the parental consent table on the DSHS web site or Chapter 32 of the Family Code) (**NOTE**: If there is a period of time of two years or more during which a client did not receive services, the general consent must be signed again prior to delivery of services.) Documentation of implementation of the general consent process is noted on the record review tool for each service, but any findings regarding general consent are documented on this tool. **This is not applicable for WIC only contractors or an agency that does not provide direct care services.** **NOTE FOR SCHOOL HEALTH:** HB 2202 states that a SBHC funded through this initiative may provide services to a student only if the district, or the provider with whom the district contracts, obtains the written consent of the student's parent, guardian, or other person having legal control of the

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	student on a consent form developed by the district or provider. The student's parent, guardian, or other person having legal control of the student may give consent for a student to receive ongoing services or may limit consent to one or more services provided on a single occasion. The consent form lists every service the school-based health center delivers in a format that complies with all applicable state and federal laws and allows a person to consent to one or more categories of services. The permissible categories of services are: 1) family and home support; 2) health care, including immunizations; 3) dental health care; 4) health education; and 5) preventive health strategies. The consent form clearly indicates that family planning services/counseling are not provided on-site in the SBHC or through referral as required by HB 2202.
b. Client grievance, including client involvement in the resolution of conflicts concerning care decisions.	The policy details the process clients will follow if they are not satisfied with the care received or feel that they have been discriminated against, treated inappropriately or unfairly. The policy reflects a commitment to client involvement in treatment decisions. It is recommended that this be posted for clients to see or be provided to clients in writing when enrolling for services for the first time. Any observation of unresolved client grievance is noted as a finding. **For School Health:** The agency has client grievance procedures implemented and posted. It is recommended that a contact person/number for someone not directly related to the school-based health center (SBHC) project or responsible for the daily oversight of the SBHC operation be provided (i.e. contact information for the Texas Medical Board or the Board of Nurse Examiners). Clients may first wish to communicate with SBHC staff or those directly responsible for oversight; however, if they feel their concerns have not been addressed at that level, they may need contact information for additional points of contact. **For WIC contractors, the reviewer observes for implementation of State policies CR 03.0, CR 04.0 and CR:05.0. This is not applicable to an agency that does not provide direct care services.**
c. Release of information.	The policy regarding the release of records includes: 1. To whom the records can be released 2. Who can sign the release for the record 3. Procedures to follow when a record is subpoenaed 4. Procedures to follow when dealing with a minor 5. The forms authorizing the release of records Any observation of inappropriate release of information is noted as a finding.

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	For WIC contractors, **WIC State Policy GA:01.0 meets this requirement; implementation is observed and documented on the WIC tool.**
d. Privacy and confidentiality in delivery of services including the transfer of records.	The privacy and confidentiality policy addresses how services will be provided in a confidential manner. Privacy and confidentiality are verified through observation during the eligibility determination process and during delivery of clinical services. Additional verification occurs through efforts of staff to provide, at a minimum, a screened area for determining eligibility, physical exams and consultations. White noise, such as fans or radios, may be used to ensure voice confidentiality. The policy addresses record security during transport if records are transferred from location to another. **For WIC contractors, the reviewer observes for implementation of WIC State policy GA:01.0.**
2. The agency has written and implemented policies pertaining to client records that are approved and updated, according to agency policy, which address:	
a. Format order within the record.	The agency record format policy details where specific information, e.g., allergies, lab, immunizations, x-ray reports, eligibility assessment, etc., will be located in the record. The policy is standardized for all agency clinic sites. The format order is verified during record review, and findings of failure to comply with the agency's policy are noted here. The exception to this is the subcontractors who may use different forms than the contractor. The subcontractor maintains a consistent record format order.
b. Record retention.	The agency follows the DSHS Record Retention Schedule for Medical Records. The schedule is available on the web at http://www.dshs.state.tx.us/records/medicalrec.shtm. Any observation inconsistent with the DSHS Record Retention Schedule for Medical Records is documented. **For WIC Contractors, the reviewer observes for implementation of WIC State Policy GA:03.0.**
c. Proper disposal of records.	The reviewer verifies that the agency policy describes the method used to dispose of inactive records. Acceptable methods preserve client confidentiality and include shredding, burning, pulping and de-inking. Observations of inappropriate disposal of client information are documented.
3. The agency has written and implemented an appropriate infectious disease control policy.	The agency has an infectious disease control policy for employees, which promotes safe work practices while caring for clients. The policy serves as a guide for employees to ensure proper work practices are used in providing client services, including the proper use of personal protective equipment.

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	The policy addresses: 1. Immunization requirements for employees providing client services 2. The system utilized to report communicable diseases and follow-up of cases that threaten public health 3. A plan for managing occupational exposures to blood borne pathogens, including HIV The agency identifies the resource utilized to develop the infectious disease control policy. The agency can use the DSHS Infection Control Manual to develop its policy, or it can adopt the manual by placing a cover sheet, signed and dated by the Medical Director or other appropriate authority, in the policy manual. The reviewer verifies implementation of the infectious disease control policy by examining a sample of employee immunization records, discussions with agency staff, and observation of services. Sample records are selected by the reviewer from a variety of staff positions within the clinics being reviewed. **This is applicable to CSHCN Specialty Services Contractors, but not to CSHCN Case Management contractors. For WIC contractors, the reviewer observes for implementation of WIC State Policy GA:15.0 regarding employee immunization requirements (1) as well as requirements 2 and 3 listed above.**
4. The agency has written and implemented appropriate personnel policies and procedures which address:	
a. Job descriptions containing required qualifications and licensure for all personnel including contracted positions.	Job descriptions are specific to the job functions of the position. They include the required qualifications, appropriate levels of training/education, credentials and experience required for the position. The agency has established qualifications for contractual employees and ensures all contracted employees meet these requirements. The agency has procedures to credential their clinical providers. The agency assures that all licenses, certifications and DEA numbers (as appropriate) are current. The agency contacts the appropriate licensing board (e.g. TMB, BNE) to verify current licensure. Licenses may be verified on line through the boards' websites at: 1. http://www.tmb.state.tx.us/ for physicians and PAs 2. https://www.bne.state.tx.us/olv/olverif.htm for nurses The credentialing files may be kept separate from the personnel files or the information may be kept in the individual personnel files. For RNs who

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	provide complete child health assessments that include the physical assessment, there must be a certificate of completion of Pediatric Assessment training in their personnel file**. Contractors who subcontract services shall ensure that the subcontractor has a credentialing process**. **For WIC Contractors**, the above information applies. In addition, the Commission on Dietetic Registration within the American Dietetic Association is contacted for Registered Dietitians online at http://www.cdrnet.org/. The Texas State Board of Examiners of Dietitians, within the Texas Department of State Health Services' Professional Licensing and Certification Division, is contacted to verify licensure for Licensed Dietitians. This may be verified online at http://www.dshs.state.tx.us/dietitian/dtrost.txt. The International Board of Certified Lactation Consultants (http://www.iblce.org/US%20registry.htm) is contacted for licensure verification of lactation consultants. Reviewer examination of a sample of the personnel records indicates that employees meet the requirements of their job descriptions; and that licenses, registrations, certifications, and DEA/DPS numbers are current. **For WIC Contractors, the reviewer observes for implementation of WIC State Policies CS:15.0 and GA:14.0.**
b. A written orientation plan for new staff.	A written orientation plan is designed to familiarize new staff with the agency goals, policies, and clinical operations. It includes orientation to their position, job setting and required duties. Reviewer examination of a sample of the personnel records and/or orientation sign-in sheets indicates that employees have been provided with an orientation according to the agency plan. **Note: For agencies receiving Family Planning funding, there is documentation that staff has received training on the prohibition against coercion. For agencies receiving Title X funding, there is documentation that staff has viewed the Title X Family Planning Orientation.**
c. Staff development based on employee needs.	The reviewer verifies that the staff development plan is based on an assessment of training needs, quality management indicators, and changing regulations or requirements. Indicators of staff training needs assessments may be surveys, discussions at staff meetings, employee suggestions, and performance evaluation. Staff development is documented.

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d. Annual job evaluations of personnel, to include observation of staff/client interactions during clinical, counseling, and educational services.	The agency has a standardized method to annually evaluate agency and contracted staff. The evaluation is based on job standards and expectations and includes staff observations. Observation and documentation of staff/client interactions is to be conducted no less than annually. Reviewer examination of a sample of the personnel records indicates that employees had annual job evaluations, including observation of staff/client interactions during clinical, counseling, and educational services. **WIC contractors need to follow their parent agency policy regarding performance evaluations. The DSHS WIC Program policy does not require performance evaluations for contracted Registered Dietitians (RD) and contracted Lactation Consultants.**
e. Staff who have contact with clients are appropriately identified (name badge).	The reviewer assesses the agency policy to assure it describes that all staff, administrative and clinical, in contact with clients are to be properly identified using a name badge that includes their title, and credentials if individual is clinical staff. Employees who have contact with clients are observed by reviewer(s) wearing name badges with their job title and applicable credentials.
5. The agency has a current CLIA certification appropriate for the level of tests performed.	The agency shows the reviewer their CLIA certificate appropriate for the tests performed in their lab. The agency performs only those laboratory tests for which it has been certified. The CLIA certificate of waiver does not need to be posted. **This is not applicable to an agency that does not provide lab services on-site. For WIC Contractors, the reviewer observes for implementation of WIC State Policy GA:16.0.**
6. The agency has a current pharmacy license.	If the agency dispenses medications, the appropriate pharmacy license is current. **This is not applicable for WIC only contractors or an agency that does not have a pharmacy on-site.**
7. The agency has current Protocols for Physician Assistants (PAs) and Advanced Practice Nurses (APNs), which have been reviewed, agreed upon and signed annually by the physician, PAs, and APNs.	Protocols are delegated written authorization to initiate medical aspects of patient care. Protocols are developed by or with a physician and should be appropriate for the services provided. The reviewer evaluates the agency protocols to assure the following criteria: 1. The protocols are reviewed, updated and signed annually by the authorizing physician 2. APNs and PAs operating under these protocols review and sign them annually 3. Current copies of protocols are present at all sites 4. The protocols are appropriate to the staff for which authority is being delegated

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	Refer to Title 22, Part 11, Chapter 222 of the Texas Administrative Code for rules pertaining to APNs and http://www.tmb.state.tx.us/rules/rules/193.php for rules pertaining to APNs and PAs. **The above section is not applicable to CSHCN Case Management contractors, WIC contractors, and agencies in which all staff function within their scope of practice.**
8. The agency has current standing delegation orders (SDOs).	Standing delegation orders (SDOs) are written instructions, orders, rules, regulations or procedures prepared by a physician and designed for a patient population with specific diseases, disorders, health problems or sets of symptoms. The SDOs delineate under what set of conditions and circumstances actions are to be instituted, and provide authority for use with patients prior to being examined or evaluated by a physician. The reviewer evaluates the agency SDOs to assure that the following criteria are followed: 1. The SDOs are reviewed, updated and signed annually by the authorizing physician 2. SDOs specify which acts require a particular level of training and licensure and under what circumstances they are to be performed 3. There is a method of maintaining a written record of those persons authorized to perform specific SDOs 4. Current copies of SDO manuals are present at all sites Applicable SDOs when a physician is not present on-site may include, but are not limited to: 1. Obtaining a personal and medical history 2. Performing an appropriate physical exam and the recording of physical findings 3. Initiating/performing laboratory procedures 4. Administering or providing drugs ordered by voice communication with the authorizing physician 5. Providing pre-signed prescriptions for oral contraceptives; diaphragms and contraceptive creams and jellies; topical anti-infectives for vaginal use; oral anti-parasitic drugs for treatment of pinworms; topical anti-parasitic drugs; or antibiotic drugs for treatment of venereal disease 6. Handling medical emergencies - to include on-site management as well as possible transfer of client

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	7. Giving immunizations 8. Performing pregnancy testing Refer to http://www.tmb.state.tx.us/rules/rules/193.php for rules pertaining to SDOs. **The above section is not applicable to CSHCN Case Management contractors, WIC contractors, and agencies in which all staff function within their scope of practice.**
III. Quality Management	
1. The agency has a written and implemented internal Quality Management (QM) Plan used to evaluate all services, processes and operations within the agency that includes:	**For DSHS contractors who subcontract for services, the contractor documents how it is monitoring the operations of the subcontractor.**
a. QM Committee.	The QM program describes that the QM Committee: 1. Consists of key leadership of the organization, including the Executive Director/Chief Executive Officer (CEO) and the Medical Director, where applicable 2. Meets at least quarterly, or more often as needed 3. Provides for an oversight process of sub-contractors for the services provided with DSHS funds. 4. Evaluates the QM Plan and process annually The QM Program and committee minutes are reviewed to determine compliance with this criterion. Documentation of results, actions taken and follow-up to assure appropriate improvements have been made are reflected in reports to the QM Committee or in committee meeting minutes. **For CSHCN Case Management and Specialty Service Contractors, the Committee will consist of appropriate staff or staff and consultants (physicians and nurses not required for case management contractors). For WIC only contractors, the Committee will consist of appropriate staff and the administrators.**
b. Evaluation of administrative policies and procedures and review of facilities.	The reviewer verifies that the QM Plan describes the evaluation of administrative policies and reviewing of facilities. The plan includes: 1. The frequency of the reviews 2. The individuals who will be responsible for conducting evaluation/ reviews 3. The procedure to be used (i.e., tools), as applicable 4. The actions to be taken based on the results

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	Documentation of results, actions taken and follow-up to assure appropriate improvements have been made are reflected in reports to the QM Committee or in committee meeting minutes. **For WIC Contractors, WIC State Policy QA:01.0 shall be implemented.**
c. Evaluation of eligibility and billing functions.	The reviewer verifies that the QM Plan describes how the agency evaluates program eligibility to ensure it is being determined and documented correctly and that the documentation supports the billing. The plan includes: 1. The frequency of the reviews 2. The number of records to be reviewed 3. The individuals who will be responsible for conducting ongoing record reviews (an agency utilizes the supervisory staff or a peer group for this activity) 4. The procedure to be used (i.e., tools) 5. The actions to be taken based on the results Reports to the QM Committee or committee meeting minutes document results of the evaluation, actions taken and follow-up to assure that appropriate changes are effective. **For WIC contractors, WIC State Policy QA:01.0 shall be implemented. The annual evaluation should include all areas of the Quality Assurance Tools (Core and WIC Tools) that are applicable to WIC services.**
d. Ongoing clinical record reviews to assure conformity to standards.	The reviewer verifies that the QM Plan describes how the agency's ongoing record reviews are conducted to assure conformity to standards, complete and clear documentation, accurate assessment of findings, appropriate plan of care based on findings, appropriate follow-up/reassessment, and appropriate education based on client needs. The plan includes: 1. The frequency of the reviews (at a minimum, records are reviewed twice yearly). The agency can conduct record reviews more frequently, but conducting record reviews annually is not acceptable 2. The number of records to be reviewed 3. The individuals who will be responsible for conducting ongoing record reviews (an agency utilizes the supervisory staff or a peer group for this activity) 4. The procedure to be used (i.e., tools) 5. The actions to be taken based on the results Record reviews must be documented. **For WIC Contractors, WIC State Policy QA:01.0 shall be implemented. WIC record reviews should**

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	include eligible, ineligible, midpoint, non-contract formula, employee with relatives on WIC, enhanced breastfeeding packages, healthcare referral, record availability, date of first visit, and child abuse.
e. A system to evaluate clients with designated adverse outcomes, which includes documentation of actions taken, reporting and follow-up.	The reviewer verifies that the QM Plan includes a system to identify and evaluate records of clients with designated adverse outcomes. The Plan identifies: 1. The procedures for documenting and reporting an adverse outcome 2. Actions to be taken 3. The follow-up that will be done Records of clients, who have had unfavorable outcomes due to services provided, are available to reviewers. Examples of adverse outcomes include a child who receives an immunization and has a reaction; a pregnant woman attending the agency clinic who delivers a fetal demise; etc. Documentation of results, actions taken and follow-up to assure appropriate improvements have been made are reflected in reports to the QM Committee or in committee meeting minutes. This process is important for the agency's own risk management. **For CSHCN contractors, examples of situations leading to adverse outcomes include: a child has no support during a significant transition; a family is dropped without completion of service plan activities; or no primary case manager is clearly identified when several case managers are involved. This is not applicable for WIC contractors.**
f. Client satisfaction surveys are conducted and the findings are used to improve client services.	The reviewer verifies that the QM Plan describes the process for conducting client satisfaction surveys, The plan includes: 1. The frequency of the reviews (client satisfaction surveys are conducted annually, at a minimum). 2. The individuals who will be responsible 3. The procedure to be used (i.e., survey) 4. The actions to be taken based on the results Documentation of results, actions taken for improving services and follow-up are reflected in reports to the QM Committee or in committee meeting minutes.

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IV. Facility	**This section should be completed for all sites visited where client services are provided. Contractors should review sub-contractors sites to assure compliance, and reports should be available to the reviewer (as assigned on the agenda or by the team leader on-site).**
1. The agency has written and implemented policies which address:	
a. Handling, storage and disposal of hazardous, chemical and infectious waste and medications.	The reviewer verifies that the agency has a policy and procedure for handling, storing and disposing of hazardous, chemical and infectious waste, e.g., syringes/needles and medications. The agency has a method to store and secure items such as clean syringes/needles and medications. If the agency has an emergency box, there is a process for keeping the medications current. Any observation of policy violations or unsafe practices is noted as a finding.
b. An orientation and education program for personnel who manage or have contact with hazardous materials and waste.	The reviewer verifies that the agency has a policy and procedure describing its orientation and education program for personnel who manage, or have contact with, hazardous materials and waste; and supporting documentation reflects compliance.
c. Maintenance of fire-safety equipment and facility evacuation plan.	The reviewer verifies that the agency has a written plan that includes safety inspections, fire drills (if appropriate) and emergency evacuation procedures, including the frequency of these activities. The plan identifies how the agency establishes and maintains a fire-safe environment, to include inspecting, testing and maintaining fire equipment. Fire extinguisher inspection tags are current and fire extinguishers are strategically located throughout the facility according to the agency safety plan.
d. Maintenance, testing and inspection of medical equipment.	The reviewer verifies that the agency has a policy that addresses the maintenance, testing, and inspection of medical equipment (e.g. audiometer, autoclave, glucometer, oxygen tank, microscope, hemacue) according to manufacturer's instructions, to ensure proper working order and calibration of the equipment. The policy and any documentation of implementation are reviewed.
Other pertinent information as noted by reviewer.	