



## Data Definitions for the Organization/Facility Environmental Site Review (FESR)

### General Directions

1. Answer each item by placing a check in the YES cell if the indicator is satisfied. If item is not satisfied, place a check in the NO cell. If not applicable, place a check in the NA cell.
2. If any required element appears to be absent, please verify with provider **prior** to leaving the office.
3. If you supply facility with required written policies at time of review (i.e., Member Rights and Responsibilities, Complaint/Grievance), please mark appropriate box as YES, and document in the Comments section.
4. **NOTE: FOR CALIFORNIA PROVIDERS, THE ITEMS INDICATED WITH \* AND THE RESPONSE IS "NO" MAY REQUIRE A CORRECTIVE ACTION PLAN FOR PROVIDERS WHETHER OR NOT THEY MEET THE 80% THRESHOLD.**

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Question	To score YES on the review, the following should apply:
1. * Are emergency services available on-site or by referral 24 hours/day, 7 days/week, 365 days/year?	If unable to provide on-site emergent services, is there a clearly identified plan to accommodate member emergencies at all hours?
2. * Are routine appointments available within 7 days?	
3. * Are urgent appointments available within 24 hours?	
4. * Are appointments for life-threatening emergencies available immediately?	Primarily applies to acute care facilities, but others should at least have some procedure for handling such emergencies (911, contact, referrals, etc.)
5. * Are appointments for non-life threatening emergencies seen within 6 hours?	Most critical for inpatient facilities, but all should demonstrate flexibility and responsiveness, and have contingency plans to respond to member needs.
6. * Is the facility in compliance with the Americans with Disabilities Act (ADA) or is working toward compliance where practicable?	<p>If not in compliance, can facility describe how they would accommodate a disabled member?</p> <p>Check that the facility complies with the majority of the following elements:</p> <ul style="list-style-type: none"> <li>• 1 in 25 parking spaces is designated as a reserved handicapped parking space (96 inches wide), curb ramp if curbs exist;</li> <li>• At least one entrance will be handicapped accessible with a ramp, wide enough accessible route, i.e., door (36" wide) to accommodate single wheel chair access;</li> <li>• Door hardware will be easy to grasp requiring only one hand to operate;</li> <li>• If the accessible route has a level change of greater than ½ inch, then the curb ramp, ramp, elevator, or platform lift shall be provided;</li> <li>• If carpet or tile is used on floor surface, then it will be securely attached;</li> <li>• Handrails should be continuous along both sides of the stairs;</li> <li>• All elevator hoistway entrances shall have raised Braille floor designations provided on both jambs;</li> </ul>

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	<ul style="list-style-type: none"> <li>Elevators should be provided with a reopening device that will stop and reopen the door automatically if the door becomes obstructed;</li> <li>There should be tactile, Braille and visual control indicators on each elevator for the control buttons;</li> <li>At least one handicapped accessible bathroom on each floor with a minimum depth of 56 inches, a minimum clear space of 30" X 48" and a grab bar of at least 18 inches in length;</li> <li>Doors to handicapped accessible bathrooms should see out; and</li> <li>At least one phone with TTY capability.</li> </ul>
7. * Does the facility have the ability to assess the waiting time for an evaluation once the member arrives?	Review process with director of facility or other staff member as appropriate.
8. Does the facility have policies and procedures for credentialing or privileging, recredentialing/reappointment?	<p>Check P&amp;P's for a minimum of the following components:</p> <ul style="list-style-type: none"> <li>Each applicant for initial appointment completes an application;</li> <li>Each applicant provides information about voluntary or involuntary termination of professional or medical staff membership or limitation, reduction, or loss of clinical privileges;</li> <li>Reappointment is for a period of no more than 2 years</li> </ul>
9. Does the facility document staff education, training, licensure and experience?	<p>Check P&amp;P's for a minimum of the following components:</p> <ul style="list-style-type: none"> <li>The competence of all personnel and clinical staff is continuously assessed, clinical staff are required to participate in ongoing in-service education sessions and other related training to increase their knowledge, and clinical staff members participate in appropriate education at least annually.</li> <li>Data regarding staff training needs are continuously collected, aggregated, and analyzed for patterns and trends to provide feedback to personnel and clinical staff and to identify and respond to learning needs.</li> <li>Review at least one year of documentation regarding orientation of new employees and in-service training.</li> <li>Review at least two staff files for documentation on education, degree, and licensure.</li> <li>Check in-service schedule and documentation of attendance.</li> </ul>
10. Does the facility retain a copy of license and documentation of experience for each employee?	Review P&P's to determine that this is addressed. Check two files to ensure that the current licensure info is available.
11. Does the facility have a primary source verification process in place to verify licenses of staff members?	Review P&P's or information indicating licenses are verified.
12. Does the facility have a process in place to review Medicare/Medicaid sanctions of staff members?	Review P&P's or information indicating sanction review is completed.



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13. * Does the facility have a process in place to review any state regulated sanction of staff members?	Review P&P's indicating review of state regulated disciplinary actions.
14. Does the facility have a process in place to review any disciplinary actions against staff members?	Review P&P's or information indicating review of disciplinary actions is completed.
15. Does the facility have a quality assurance committee (QAC) that meets on a regular basis?	Check P&P for the following components: <ul style="list-style-type: none"> <li>• A systematic performance improvement process which includes a process to collect data;</li> <li>• Improvement activities include methods for measuring and assessing the effect of the action and implementing effective actions.</li> <li>• Review meeting minutes for the past year to determine that the Committee met a minimum of twice for the year, and that data was reviewed and action taken regarding variances/significant issues.</li> </ul>
16. Does the facility have representation of key disciplines/departments on quality assurance committee (QAC)?	Check P&P to ensure that it requires representation of several disciplines/departments and verify through review of meeting minutes
17. Do formal procedures exist for diagnosis of problems, tracking resolution and monitoring for improvement?	Check P&P. Review meeting minutes for the past year to determine that data was reviewed and action taken regarding variances/significant issues.
18. Is patient satisfaction evaluated and reported on an ongoing basis?	Written or telephonic surveys conducted. Review results at QAC and evaluate need for action.
19. Does the facility have a policy and procedure for evaluating patient complaints?	Check P&P to ensure that the following components are met: <ul style="list-style-type: none"> <li>• There are procedures for registering and managing complaints, including identifying the party receiving complaints;</li> <li>• Aggregating and reporting actions taken on complaints;</li> <li>• Responding in a timely fashion to the member;</li> <li>• Substantively addressing the action taken on the complaint;</li> <li>• Aggregating complaint information and utilizing the data in quality improvement activities;</li> <li>• Protecting the member from any sanctions or penalties from using the complaints process.</li> </ul>
20. Are there policies and procedures for clinical standards of care developed and implemented by the facility?	Check P&P for a systematic process to develop and implement standards related to clinical standards of care, and a method to track adherence to standards.
21. Are there regular meetings with clinical staff and administration to review administrative and clinical policies, procedures and other issues?	Check for meeting minutes a minimum of quarterly.
22. Are there program specific criteria in place for admission, continuing stay and discharge?	Check P&P to review criteria for each contracted program. There should be separate criteria to specifically address substance abuse, eating disorder and child/adolescent treatment.
23. Do programs have defined treatment philosophies and orientations?	Check program description and review criteria for each contracted program. There should be separate philosophies to specifically address substance abuse, eating disorder and child/adolescent treatment.

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24.	Does the staffing ratio follow the facility's policies and procedures and jurisdictional statutes, if any?	Check P&P for defined staffing levels, which take into account the type of unit or program and allow for adjustments based on acuity.
25.	Does a multidisciplinary team provide treatment?	Check P&P for requirement that two or more disciplines are required as part of the treatment team.
26.	Are admission and continued stay criteria consistent with level of care and have a treatment focus?	Check P&P for specific criteria for each program and/or level of care. There should be separate criteria to specifically address substance abuse, eating disorder and child/adolescent treatment.
27.	Is a comprehensive treatment plan completed within appropriate timeframe for level of care?	Check P&P for policies regarding completion of treatment plan. The timeframe for completion should not exceed 5 days. Check (2 or more) files to ensure P&P timeframe was followed.
28.	Does practitioner have opportunity to address clinical modalities specific to clinical needs of individual patients?	Review P&P or form.
29.	Is there active participation by patients in treatment planning when possible?	As evidenced by signature on treatment plan, description of member's stated goals in treatment record.
30.	Is there evidence in treatment records that discharge or long-term care planning starts from day of admission?	Check P&P and sample clinical records (2 or more) to ensure that a preliminary discharge plan was developed on admission.
31.	Does a formal system exist to assure patient follow-through on aftercare arrangements or assertive action taken if patient/guardian fails to follow-up?	Check P&P and sample clinical records (2 or more) to ensure that aftercare plans are documented and reflect that patient was involved in the development of the plan and was informed of the final plan.
32.	Does the organization demonstrate the incorporation of relevant cultural issues into its treatment program?	Check P&P to ensure that patient's cultural issues are assessed at the time of admission and documented, and reasonable accommodations are made to allow for the patient to practice cultural beliefs. Check sample clinical records (2 or more).
33.	Does each program inform members of rights and responsibilities and organizational grievance procedures?	Are policies posted or available to members? (Check at least 2 of the contracted program units.)
34.	Does the organization have a policy and procedure for emergency coverage?	Check P&P for emergency and disaster plans and training to support implementation of such plan when needed.
35.	Are areas where members are seen free from physical furnishings or equipment that represent a risk/safety hazard?	Clinical service areas are suitable to the services provided. Consider for specific populations such as children, high-risk, etc.
36.	Does the facility have a contraband policy and procedure, especially how discoveries of illicit drugs and/or weapons are handled?	Check P&P for frequency of room checks, triggers for room searches, contraband policies.
37.	Do suicide prevention/precaution protocols exist?	Check P&P for varying levels of safety precautions to address suicidality (arms length observation, constant eyesight observation, 15 minute checks, 30-minute checks, etc.).



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38. Does the Psychiatric Residential Treatment Facility (PRTF) treating patients under the age of 21 comply with the CMS (HCFA) guidelines regarding restraint and seclusion? Review attestation letter.	Review attestation letter submitted to CMS (HCFA)
39. Are there clear policies and procedures for the use of seclusion and/or restraint, if utilized?	Check P&P for clinical justification for the use of seclusion and restraint. P&P must address the following components: <ul style="list-style-type: none"> <li>• Every 15 minute observation checks;</li> <li>• Release and range of motion for extremities;</li> <li>• Hydration every two hours;</li> <li>• Toileting every two hours;</li> <li>• Evaluation to reduce or discontinue restraints/seclusion at a minimum of every two hours; and</li> <li>• Documentation of rationale to continue seclusion/restraints.</li> <li>• Requirements exist for the use of the least restrictive alternative. Review all forms use to document seclusion and restraint procedures.</li> </ul>
40. Does staff receive initial and ongoing training in the use of seclusion and restraint, if utilized?	Check P&P and in-service schedule that restraint/seclusion in-services are required for all new staff and all clinical staff at a minimum on an annual basis.
41. Facility program has policy and procedure addressing unrestricted access by patients to other areas without supervision.	Check P&P for patient’s unrestricted access to other areas without supervision.
42. If applicable, facility/program has designated smoking area and facility restricts smoking privileges to certain hours or patients will be supervised during this time. (If non-smoking facility, indicate NA.)	Check to see if facility has designated smoking area or is a smoke-free facility.
43. Are facility and programmatic offices neat, clean and professional?	Program offices are safe and provide a reasonable environment conducive for the delivery of therapeutic services. Check two offices.
44. Does the environment or office site (i.e., magazines, pictures, children, adult, ethnic, etc.) reflect the culture of the members served?	Are magazines pictures in offices representative of the patients being served (i.e., in Florida and New Mexico – Hispanics, etc.)? Are majority of patients children – if so, are there children’s literature, games, etc.?
45. Are files containing any member information maintained in a locked and safe setting?	Examine file system.
46. Are member records kept in individual folder by name or identification number?	Examine file system.
47. Records are available, as appropriate, to other practitioners or staff at the site.	Practitioner makes patient records available as appropriate to other practitioners or staff.
48. Are forms and treatment record methods maintained in a consistent manner with the model treatment record?	Forms and treatment records are consistent with model treatment record.
49. Does the facility record meet professional standards for documentation?	Review record keeping practices and format of record.

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50. * Does the facility/program have a policy addressing confidentiality issues?	Check P&P for the following: A functioning mechanism designed to safeguard records and information identified as sensitive or requiring extraordinary means to preserve patient privacy, and a mechanism designed to safeguard against loss, destruction, and tampering, and from unauthorized access or use.
51. Confidential verbal communication is not audible to unauthorized persons.	Confidential verbal communication between patient and staff members or practitioner is not audible to unauthorized persons.
52. Computer screens with patient information are removed from view. NA if no computer.	Computer screens are not viewable from areas normally occupied by non-employees.
53. Fax forms with patient information are removed from view. NA if no fax.	Fax forms with patient information are not within public view.
54. Mail with patient identifiable information is not visible by unauthorized persons.	Mail with patient identifiable information is not within public view.
55. Other documents with patient identifiable information are not visible by unauthorized persons.	Other documents with patient identifiable information are not within public view.
56. Are there policies and procedures for a UR/UM program?	Check P&P for the following elements: <ul style="list-style-type: none"> <li>• Criteria which defines the information needed to determine the individual's eligibility for entry to the setting or service;</li> <li>• A process which provides for referral, transfer, or discharge of the individual to another level of care, health professional(s), or setting(s) if indicated based upon the member's assessed needs and the organization's capability to provide care.</li> </ul>
57. Is continued treatment review done on a calendar or diagnosis basis?	Check P&P to ensure that the treatment planning process is designed to ensure that care is appropriate to the individual's specific needs and the severity of his/her condition, impairment or disability, and the treatment plan is updated/refined as further clinical information becomes available. Review a sample of clinical records (2 or more).
58. Does the organization have a clearly defined written organizational plan identifying the roles and responsibilities of leadership and the governing body?	Check P&P and/or program description for mission statement that includes scope of activities that address the needs for the population served. The plan includes a description of the resources that are devoted to meeting the organization's objectives.
59. Does the organization have a written staffing plan including number and types of disciplines employed?	Check P&P to determine ratios determined for each unit. Review one month of staff data to assess adherence to policies.
60. Does the organization document staff training and education?	Check P&P, in-service schedule, and documentation of attendance.
61. Are the Accreditation Council on Graduate Medical Education (ACGME) supervisory guidelines (V.B.3) followed by the program?	For review of Psychiatric Residency Training programs.
62. If ACGME has identified supervisory concerns, is there a corrective action plan in place?	Review corrective action plan submitted to ACGME regarding supervision.

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63. Are patients informed of their psychiatrists' status as trainees?	Review P&P, or appropriate documentation, regarding notification of psychiatrist's trainee status to patients in treatment.
64. All medications, including samples, are stored in a safe location that is not accessible to patients.	Medications are in a locked area, away from public access.
65. Does the organization/facility maintain a record of medication samples kept and distributed?	Review medication records maintained by facility/program as applicable.