LEAPFROG HOSPITAL SURVEY

2019 LEAPFROG HOSPITAL SURVEY BINDER

THE LEAPFROG GROUP

DHG | healthcare

TABLE OF CONTENTS

Overview

WHAT IS THE PURPOSE OF THIS BINDER?

The Leapfrog Hospital Survey Binder was originally designed for those hospitals that have been selected for Leapfrog's annual On-Site Data Verification Program administered by DHG Healthcare[1]. Prior to an on-site verification visit from DHG Healthcare, a customized binder is sent to the hospitals for the collection and organization of information (i.e., reports, documentation, notes, etc.) that were used to complete the Leapfrog Hospital Survey. DHG Healthcare uses the information in the Hospital Binder during the scheduled visit to verify the hospital's Leapfrog Hospital Survey responses.

The Leapfrog Hospital Survey Binder is available via PDF for use by all hospitals to collect, organize, and record information during the completion of the 2019 Leapfrog Hospital Survey. This document can be printed and placed in a binder. The information is helpful when completing subsequent years' Surveys, in staff and leadership transitions, and as a historical record. The use of the binder also acquaints hospitals with the elements of the On-Site Data Verification Program.

For those sections that have been selected for On-Site Data Verification, DHG Healthcare would include a **pre-visit documentation request** within that section to ensure that a hospital collects, organizes, and records the information that will be reviewed during the scheduled on-site visit. For the purposes of making this binder useful and informational to all hospitals, we have removed those pages in this document.

HOW SHOULD WE USE THIS BINDER?

This binder is meant to be used as a tool to help you collect, organize, and record information that you used to complete your Leapfrog Hospital Survey. Nothing in the binder is meant to replace or substitute the information that Leapfrog provides in the hard copy of the Survey or reference materials available on the Leapfrog website (http://www.leapfroggroup.org/hospital).

[1] DHG Healthcare is the national healthcare practice of Dixon Hughes Goodman LLP.

Section 1: Basic Hospital Information

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting time periods for this section.
- ☐ Make a note of who in your hospital provided information or ran reports for you to respond to these questions.
- ☐ If your IT team or data abstractor developed special code, scripts, or parameters to run any reports for you, include a note or a copy so that you can run similar reports next year.
- ☐ Be sure to print, date, label, and file reports that you used for this section in the binder.
- ☐ If you submitted questions on this section to the Leapfrog Help Desk, print copies of your responses (i.e., tickets) and save them in this tab for future reference.

PLACE DOCUMENTATION FOR SECTION 1 AFTER THIS PAGE

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Section 2: Medication Safety - CPOE

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for this section.
- ☐ Review the questions and reference information for this section with anyone who is assisting with the collection of data.
- ☐ Review the measure specifications in Section 2 of the hard copy of the Survey to ensure that you understand which orders should be included in Questions 3-4.
- ☐ Be sure to print, date, label, and file reports that you used to respond to Questions 3-4 in this binder. Include a copy of the report.
- ☐ Include a copy of any special code, scripts, or parameters that your IT team or data abstractor developed so that you can run similar reports next year. Make a note of who in your hospital ran these reports.
- ☐ If you submitted questions on this section to the Leapfrog Help Desk, print copies of your responses (i.e., tickets) and save them under this tab for future reference.

CPOE EVALUATION TOOL PERSONNEL ROSTER

If your hospital completed the CPOE Evaluation Tool, use the roster below to record roles and responsibilities.

	TEST STEP	PERSONNEL INVOLVED	TITLE/POSITION
☐	Set-up test patients		
☐	Entered lab results		
☐	Entered patient profiles, allergy, and assessment (i.e., diagnosis) information		
☐	Entered test orders and recorded advice/information (must be a provider licensed to prescribe/order medications)		
☐	Completed and submitted online answer sheet		

PLACE DOCUMENTATION FOR SECTION 2 AFTER THIS PAGE

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Section 3: Inpatient Surgery

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for this section.
- ☐ Be sure to use ***only*** those ICD-10 procedure and diagnosis codes listed for each procedure in the hard copy of the Survey.
- ☐ Make a note of who in your hospital provided information or ran reports for you to respond to the questions.
- ☐ If your IT team or data abstractor developed special code, scripts, or parameters to run reports for you, include a note or a copy so that you can run similar reports next year.
- ☐ Be sure to print, date, label, and file reports that you used for this section of the binder.
- ☐ If you submittedquestions on this section to the Leapfrog Help Desk, print copies of your responses (i.e., tickets) and save them under this tab for future reference.

PLACE DOCUMENTATION FOR SECTION 3 AFTER THIS PAGE

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Section 4: Maternity Care

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for this section.
- ☐ Be sure to carefully review the measures specifications in this section. Several measures include ***multiple*** inclusion and exclusion criteria.
- ☐ Note the data sources that you used to identify cases for inclusion and exclusion in each measure (i.e., birth records, billing data, etc.) so that you can easily access the same sources next year.
- ☐ If others are helping you collect and/or abstract these data from paper or electronic sources, take a note of who they are and make sure they have copies of the questions and measure specifications before they begin.
- ☐ If your IT team or data abstractor developed special code, scripts, or parameters to run reports for you, include a note or a copy so that you can run the similar reports next year.
- ☐ If you used an ORYX vendor report, Vermont Oxford Network report, or California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center report, file a copy of the report in this section of the binder.
- ☐ Be sure to print, date, label, and file reports that you used for subsections 4A-4F in this binder, including the parameters/queries used to pull the reports.
- ☐ If you submitted questions on this section to the Leapfrog Help Desk, print copies of your responses (i.e., tickets) and save them under this tab for future reference.

PLACE DOCUMENTATION FOR SECTION 4 AFTER THIS PAGE

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Section 5: ICU Physician Staffing

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for this section.
- ☐ Read the questions, endnotes and FAQs in Section 5 of the hard copy of the Survey to ensure that you understand the criteria for each question BEFORE you respond to the questions.
- ☐ If you have more than one type of ICU, you should be reporting on that ICU with the ***least intense*** staffing level, as compared to the most intense staffing level.
- ☐ Review the questions and reference information for this section with anyone who is going to assist with this collection of data for this section.
- ☐ Be sure to print, date, label, and file any reports that you used for this section in the binder.
- ☐ Take note of who in your hospitals ran reports, helped you complete the physician staffing roster, or obtained copies of policies, schedules, or reports used to respond to questions.
- ☐ If you submitted any questions on this section to the Leapfrog Help Desk, print copies of your responses (i.e., tickets) and save them under this tab for future reference.

ICU PHYSICIAN STAFFING

The types of documentation you should include in this binder are provided below. Only provide documentation for those questions in this section for which your hospital responded 'YES'. Ensure that each document is dated (according to the reporting period in Question 1) and labeled, and that each page is numbered. Indicate the page number in the source reference. Note that endnotes refer to the endnotes in the hard copy of the Survey.

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**Question 2:** Does your hospital operate any adult or pediatric general medical and/or surgical ICUs or neuro ICUs[23]?	Provide a list and description of all ICUs at your hospital	
☐	**Question 3:** Do physicians certified in critical care medicine[25], when present on-site or via telemedicine, manage or co-manage[24] all critical care patients[22] in these ICUs?	**1)** Staffing policy regarding patient management or co-management; **2)** ICU staffing schedule (with hours indicated) for the latest 3 months prior to Survey submission; **3)** Board certification documentation for each intensivist listed on the schedule; **4)** contract with physician group, if applicable	
☐	**Question 4:** Are all critical care patients[22] in each of these ICUs managed or co-managed[24] by one or more physicians certified in critical care medicine[25] who meet **all** of the following criteria: • present via telemedicine, in combination with on-site intensivist coverage, for a total of **24 hours per day, 7 days per week** • meet all of Leapfrog's ICU requirements for intensivist presence in the ICU via telemedicine (More Information[27]) • supported by an on-site intensivist who establishes and revises the daily care plan for each ICU patient	If telemedicine service is utilized, provide: **1)** a copy of the current service agreement with tele-medicine provider, which includes the features outlined in endnote 27; **2)** service agreement with on-site coverage team; **3)** copies of the written policies and protocols governing the function of the ICU (including the use of telemedicine) as outlined in the endnotes **4)** data link reliability reports	

☐	**Question 5:** Are all critical care patients in each of these ICUs managed or co-managed by one or more physicians certified in critical care medicine who meet **all** of the following criteria: • ordinarily present on-site in each of these ICUs during daytime hours • for at least **8 hours per day, 7 days per week** • providing clinical care exclusively in one ICU during these hours	See required documentation for Question 3. Also provide hospital policy that clarifies the clinical care exclusivity for patients in the ICU.	
☐	**Question 6:** When the physicians (from question #3) are not present in these ICUs on-site or via telemedicine, do they return more than 95% of calls/pages/texts from these units within five minutes, based on a quantified analysis[26] of notification device response time? (More information on the use of telemedicine to cover calls)	Copy of quantitative analysis or log showing notification device response times from the latest 3 months prior to Survey submission	
☐	**Question 7:** When the physicians (from question #3) are not present on-site in the ICU or not able to physically reach an ICU patient within 5 minutes, can they rely on a physician, physician assistant, nurse practitioner[31], or FCCS-certified nurse "effector"[29] who is in the hospital and able to reach these ICU patients within five minutes in more than 95% of the cases, based on a quantified analysis[28] of notification device response time?	Copy of quantitative analysis or log showing bedside response time from the latest 3 months prior to Survey submission	

ICU PHYSICIAN STAFFING (continued)

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**Question 8**: Are all critical care patients[22] in each of these ICUs managed or co-managed[24] by one or more physicians certified in critical care medicine[25] who meet **all** of the following criteria: • ordinarily present[26] on-site in each of these units during daytime hours • for at least **8 hours per day, 4 days per week or 4 hours per day, 7 days per week** • providing clinical care exclusively[26] in one ICU during these hours?	See required documentation for Question 3. Also provide hospital policy that clarifies the clinical care exclusivity for patients in the ICU.	
☐	**Question 9:** Are all critical care patients[22] in each of these ICUs managed or co-managed[24] by one or more physicians certified in critical care medicine[25] who meet **all** of the following criteria: • present via telemedicine for **24 hours per day, 7 days per week** • meet all of Leapfrog's modified ICU requirements for intensivist presence in the ICU via telemedicine (More Information[32]) • supported in the establishment and revision of daily care planning for each ICU patient by an on-site intensivist, hospitalist, anesthesiologist, or physician trained in emergency medicine	See required documentation for Question 3. Also provide written policies and protocols as outlined in the endnotes.	
☐	**Question 10:** Are all critical care patients[22] in each of these ICUs managed or co-managed[24] by one or more physicians certified in critical care medicine[25] who are: • on-site at least **4 days per week** to establish or revise daily care plans for each critical care patient in each of these ICUs?	See required documentation for Question 3.	

ICU PHYSICIAN STAFFING (continued)

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**Question 11:** If not all critical care patients[22] are managed or co-managed[24] by physicians certified in critical care medicine[25], either on-site or via telemedicine[Error! Bookmark not defined.], are **some patients** managed or co-managed by these physicians?	1) Staffing policies and ICU schedules (with hours indicated) for the latest 3 months prior to Survey submission 2) Board certification documentation for each intensivist listed on the schedule	
☐	**Question 12:** Does an on-site clinical pharmacist do **all** of the following: • At least 5 days per week, makes daily rounds on all critical care patients**Error! Bookmark not defined.** in each of these ICUs • On the other 2 days per week, returns more than 95% of calls/pages/texts from these units within 5 minutes, based on a quantified analysis**Error! Bookmark not defined.** of notification device response time **OR** Makes daily rounds on all critical care patients in each of these ICUs 7 days per week	1) Pharmacist schedule showing ICU rounds from the latest 3 months prior to Survey submission 2) Copy of quantitative analysis or log showing notification device response times from the latest 3 months prior to Survey submission, if applicable	
☐	**Question 13:** Does a physician certified in critical care medicine[Error! Bookmark not defined.] lead daily interprofessional rounds on-site on all critical care patients[Error! Bookmark not defined.] in each of these ICUs 7 days per week?	ICU schedules showing interprofessional rounds from the latest 3 months prior to Survey submission	
☐	**Question 14:** When physicians certified in critical care medicine**Error! Bookmark not defined.** are on-site in each of these ICUs, do they have responsibility for all ICU admission and discharge decisions?	ICU admission and discharge policies	

PLACE DOCUMENTATION FOR SECTION 5 AFTER THIS PAGE

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Section 6: NQF Safe Practices

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for each safe practice.
- ☐ Review the instructions for reporting on Section 6 in the hard copy of the Survey.
- ☐ Review the practice-specific FAQs in Section 6 of the hard copy of the Survey to ensure that you understand the criteria for each question.
- ☐ Be sure to print, date, label, and file all documentation used in this binder.
- ☐ For long documents, information (such as dates, attendees, content, etc.) specific to each practice and element should be highlighted or circled. Page numbers should be listed in the "Source" column.
- ☐ Take note of who in your hospitals helped you complete each safe practice.
- ☐ If you submitted any questions on this section to the Leapfrog Help Desk, print copies of your responses (i.e., tickets) and save them under this tab for future reference.

SAFE PRACTICE 1:
CULTURE OF SAFETY LEADERSHIP STRUCTURES & SYSTEMS

The types of documentation you should include in this binder are provided below. Only provide documentation for those questions in this section for which your hospital responded 'YES'. Ensure that each document is dated (according to the reporting period in Question 1) and labeled, and that each page is numbered. Indicate the page number in the source reference.

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**1.1** In regard to raising the awareness of key stakeholders to our organization's efforts to improve patient safety, the following actions related to identification and mitigation of risk and hazards have been taken: a. board (governance) minutes for the past 12 months reflect regular communication regarding all three of the following: • risks and hazards (as defined by *Safe Practice #4, Identification and Mitigation of Risks and Hazards)*; • culture measurement (as defined by *Safe Practice #2, Culture Measurement*, *Feedback, and Intervention*); and, • progress towards resolution of safety and quality problems. (p.75)	*Copy of report; be sure report is dated*	
☐	b. patients (who are not employed by the organization) and family of patients are active participants in safety and quality committees that meet on a regularly scheduled basis (e.g., biannually or quarterly). (p.75)	*Meeting notes reflecting appropriate attendance*	
☐	c. steps have been taken to report to the community in the last 12 months of ongoing efforts to improve safety and quality in the organization and the results of these efforts.	*Published a report for the community that specifically mentions BOTH the efforts to improve safety and quality and the results of those efforts.*	
☐	d. all staff and independent practitioners were made aware in the past 12 months of ongoing efforts to reduce risks and hazards and to improve patient safety and quality in the organization.	*Examples of reports or presentations or meeting minutes*	

TABLE OF CONTENTS FOR SAFE PRACTICE 1 (continued)

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**1.2** In regard to holding the Board, senior management, mid-level management, physician leadership, and frontline caregivers directly accountable for results related to identifying and reducing unsafe practices, the organization has done the following: a. an integrated patient safety program has been in place for at least the past 12 months providing oversight and alignment of safe practice activities. (p.76)	*Copy of the patient safety program that specifically addresses the safe practice activities*	
☐	b. a Patient Safety Officer (PSO) has been appointed and communicates regularly with the Board (governance) and senior administrative leadership; the PSO is the primary point of contact of the integrated, patient safety program. (p.76)	*Documentation of PSO position, examples of reports or presentations presented to Governance*	
☐	c. performance has been documented in performance reviews and/or compensation incentives for all levels of hospital management and hospital-employed caregivers noted above. (p.76)	*Copy performance review templates or compensation incentives for all levels described*	
☐	d. the interdisciplinary patient safety team communicated regularly with senior administrative leadership regarding all three of the following: • root cause analyses (as defined by *Safe Practice #4, Culture Measurement, Feedback & Intervention*); • progress in meeting safety goals; • provide team training to caregivers; and, documented these communications in meeting minutes. (pp.76-77)	*Examples of reports or presentations presented to management. Meeting notes/minutes with attendance noted. Meeting minutes from more than one meeting should be provided in order to reflect regular communication.*	
☐	e. the facility reported adverse events to external mandatory or voluntary programs. (p.77)	*Information indicating external reporting such as report or summary*	

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TABLE OF CONTENTS FOR SAFE PRACTICE 1 (continued)

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**1.3** In regard to implementation of the patient safety program, the Board (governance) and senior administrative leadership have provided resources to cover the implementation during the last 12 months, and: a. dedicated patient safety program budgets support the program, staffing, and technology investment. (p.77)	*Copy of line item budget*	
☐	**1.4** Structures and systems for assuring that leadership is taking direct and specific actions have been in place for the past 12 months, as evidenced by: a. CEO and senior administrative leadership are personally engaged in reinforcing patient safety improvements, e.g., "walk-arounds", holding patient safety meetings, reporting to the Board (governance). Calendars reflect allocated time. (p.78)	*Copy of CEO and leaders schedules showing "walk-arounds", copy of meeting minutes*	
☐	b. CEO has actively engaged leaders from service lines, midlevel management, clinical leadership, and physician leadership in patient safety improvement actions. (p.79)	*Copy of meeting minutes including attendees*	
☐	c. hospital has established a structure for input into the patient safety program by licensed independent practitioners and the organized medical staff and physician leadership. Input documented in meeting minutes or materials. (p.79)	*Copy of meeting minutes including attendees*	

PLACE DOCUMENTATION FOR SAFE PRACTICE 1 AFTER THIS PAGE

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SAFE PRACTICE 2:
CULTURE MEASUREMENT, FEEDBACK & INTERVENTION

The types of documentation you should include in this binder are provided below. Only provide documentation for those questions in this section for which your hospital responded 'YES'. Ensure that each document is dated (according to the reporting period in Question 1) and labeled, and that each page is numbered. Indicate the page number in the source reference.

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**2.1** In regard to Culture Measurement, our organization has done the following within the last 24 months: a. conducted a culture of safety survey of our employees using a nationally recognized tool that has demonstrated validity, consistency and reliability. The units surveyed account for at least 50% of the aggregated care delivered to patients within the facility, and includes the high patient safety risk units or departments.(p.88) *If item 'a' is not checked, no other items in this Practice 2 may be checked.*	*Results from culture of safety survey that show units/departments surveyed; be sure results are dated within past 24 months of submission date. Results should include participation rate.*	
☐	b. portrayed the results of the culture survey in a report, which reflects both hospital-wide and individual unit level results, as applicable. (p.88)	*Copy of report showing both hospital-wide and unit level results; be sure report is dated*	
☐	c. benchmarked results of the culture survey against external organizations, such as "like" hospitals or other hospitals within the same health system.	*Copy of report; list of hospitals in the benchmark group; be sure report is dated*	
☐	d. compared results of the culture survey across roles and staff levels.	*Copy of culture of safety survey results comparison across roles and staff levels; be sure report is dated*	
☐	e. Service line, midlevel managers, or senior administrative leaders used the results of the culture survey to debrief at the relevant unit level, using semi-structured approaches for the debriefings and presenting results in aggregate form to ensure the anonymity of survey respondents..	*Copy of meeting notes or presentation lead by local unit/patient safety leaders that reflects semi-structured approach, with attendance reflecting units*	

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SAFE PRACTICE 2 (continued)

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**2.2** In regard to accountability for improvements in the measurement of the culture of safety, our organization has done the following within the last 24 months: a. involved senior administrative leadership in the identification and selection of sampled units; and, in the selection of an appropriate tool for measuring the culture of safety. (p.88)	*Meeting notes with attendance reflecting senior administrator participated in selecting units and tool*	
☐	b. shared the results of the culture measurement survey with the Board (governance) and senior administrative leadership in a formal report and discussion. (p.88)	*Board agenda, minutes, and/or presentation. All documentation should be dated.*	
☐	c. included in performance evaluation criteria for senior administrative leadership included both response rates to the survey **and** the use of survey results in improvement efforts.	*Copy of performance evaluation of senior administrative leaders that reflects response rates to survey and improvement efforts*	
☐	**2.3** In regard to the culture of safety measurement, the organization has done the following (or has had the following in place) within the last 12 months: a. conducted staff education program(s) on methods to improve the culture of safety, tailored to the organization's survey results.	*Education session curriculum and sign in sheets. Examples of documentation from personnel or administrative records.*	
☐	b. included the costs of annual culture measurement/follow-up activities in the patient safety program budget.	*Copy of line item budget or expenses related to culture measurement/follow-up activities*	

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TABLE OF CONTENTS FOR SAFE PRACTICE 2 (continued)

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**2.4** In regard to culture measurement, feedback, and interventions, our organization has done the following or has had the following in place within the last 12 months: a. developed or implemented explicit, hospital-wide organizational policies and procedures for regular culture measurement (p.88)	*Copy of policies and/or examples of strategies implemented (i.e., meetings, education, events, etc.)*	
☐	b. disseminated the results of the survey widely across the institution, and senior administrative leadership held follow-up meetings with the sampled units to discuss the unit's results and concerns. (p. 88)	*Examples of reports or presentations to departments. Minutes and attendance record from department meetings held by senior administrative leaders.*	
☐	c. identified performance improvement interventions based on the survey results, which were shared with senior administrative leadership and subsequently measured and monitored. (p.88)	*Copy of dashboard of metrics, progress report, etc. showing performance improvement intervention, and meeting minutes showing attendance by senior administrative leadership*	

PLACE DOCUMENTATION FOR SAFE PRACTICE 2 AFTER THIS PAGE

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SAFE PRACTICE 4: RISKS & HAZARDS

The types of documentation you should include in this binder are provided below. Only provide documentation for those questions in this section for which your hospital responded 'YES'. Ensure that each document is dated (according to the reporting period in Question 1) and labeled, and that each page is numbered. Indicate the page number in the source reference.

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**4.1** Within the last 12 months our organization has done the following: a. assessed risks and hazards to patients by reviewing multiple retrospective sources, such as: • serious reportable events; • sentinel event reporting; • adverse event reporting; • root cause analyses; • independent comparative mortality and morbidity information with the hospital's performance; • patient safety indicators; • trigger tools; • hospital accreditation surveys; • risk management and filed litigation; • anonymous internal complaints, including complaints of abusive and disruptive caregiver behavior; and, • complaints filed with state/federal authorities; and based on those findings, documented recommendations for improvement. (p.105)	*Copy of information used in assessment including examples of event reporting, root cause analysis or other activities. A copy of the recommendations for improvement.*	
☐	b. assessed risks and hazards to patients using prospective identification methods: Failure Modes and Effects Analysis (FMEA) and/or Probabilistic Risk Assessment, and has documented recommendations for improvement. (p.106)	*Copy of identification tools for prospective identification*	
☐	c. combined results of (a) and (b) above to develop their risk profile, and used that profile to identify priorities and develop risk mitigation plans. (p.107)	*Copy of risk mitigation plan.*	
☐	d. shared results from the two assessments, noted in (a), (b), and the risk mitigation plan noted in (c) above widely across the organization, from the Board (governance) to frontline caregivers. (p.107) *This item may not be checked unless all items 4.1a, b, c are checked.*	*Copy of materials used to share results including presentations, postings or other information*	

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SAFE PRACTICE 4 (continued)

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**4.2** Leadership is accountable for identification of risks and hazards to patients, and mitigation efforts in the past year, as evidenced by: a. approval of an action plan by the CEO and the Board (governance) for undertaking the assessments of risk, hazards and for the mitigation of risk for patients. (p.106)	*Copy of approved action plan and/or meeting minutes or notes describing the approval by the CEO and governance*	
☐	b. incorporation of the identification and mitigation of risks to patients into performance reviews for ALL leadership and the Patient Safety Officer as identified in the approved action plan **OR** outlined financial incentives for ALL leadership and the Patient Safety Officer for identifying and mitigating risks to patients as identified in the approved action plan. ***This item may not be checked unless 4.2a is checked.***	*Copy of performance reviews or financial incentive plan that includes language from the approved action plan*	
☐	**4.3** In regard to developing the ability to appropriately assess risk and hazards to patients, the organization has done the following or had in place during the last 12 months: a. resourced patient safety program budgets sufficiently to support ongoing risk and hazard assessments and programs for reduction of risk.	*Copy of patient safety program budgets reflecting the support of these ongoing assessments/ programs*	
☐	b. provided managers at all levels with training on the prospective identification tools for monitoring risk in their areas. Training was documented. (pp.107-108)	*Copy of training tools used and attendance records showing managers at all levels*	
☐	**4.4** Structures and systems for assuring that direct and specific actions have taken place to mitigate risks to patients for the past 12 months, include: a. provided risk identification training to midlevel management and frontline caregivers in high risk patient safety units such as: emergency department, labor and delivery, ICUs, and operating rooms.	*Copy of training tools and attendance records showing high risk patient safety units units*	
☐	b. established or already had in place a structure, developed by the CEO and senior administrative leadership, for gathering all information related to risks, hazards and mitigation efforts within the organization with input from all levels of staff within the organization and from patients and their families. (p.110)	*Description of structure showing input from all levels of staff and from patients*	

☐	c. evidence of high-performance or actions taken for the following four patient safety risk areas: falls, malnutrition, aspiration, and workforce fatigue (p.108)	*Copy of reports showing incidence/trends in these risk areas*	

PLACE DOCUMENTATION FOR SAFE PRACTICE 4 AFTER THIS PAGE

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SAFE PRACTICE 9:
NURSING WORKFORCE

The types of documentation you should include in this binder are provided below. Only provide documentation for those questions in this section for which your hospital responded 'YES'. Ensure that each document is dated (according to the reporting period in Question 1) and labeled, and that each page is numbered. Indicate the page number in the source reference.

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**9.1** In regard to ensuring adequate and competent nursing staff service and nursing leadership at all levels, our organization has done the following or has had the following in place within the last 12 months: a. held at least one educational meeting for senior administrative leadership, clinical leadership, midlevel management and service line management specifically related to the impact of nursing on patient safety. (p.155)	*Copy of training tools and attendance records showing clinicians, senior management, mid-level management, and line management*	
☐	b. performed a risk assessment that includes a hospital-wide evaluation of the frequency and severity of adverse events that can be related to nurse staffing. (p.155)	*Copy of hospital-wide risk assessment of adverse events*	
☐	c. submitted a report to the board (governance) with recommendations for measurable improvement targets. (p.155)	*Copy of report to governance*	
☐	d. collected and analyzed data of actual unit-specific nurse staffing levels on a quarterly basis to identify and address potential patient safety-related staffing issues. (p.155)	*Copy of quarterly unit-specific staffing level analysis*	
☐	e. provided unit-specific reports of potential patient safety-related staffing issues to senior nursing leadership, senior administrative leadership and the board (governance) at least quarterly. (p.155)	*Copy of quarterly unit reports, minutes or notes given to senior administrative leadership and governance*	
☐	**9.2** In regard to ensuring adequate and competent nursing staff service and nursing leadership at all levels, our organization has done the following or has had the following in place within the last 12 months: a. held departmental/clinical leadership directly accountable for improvements in performance through performance reviews or compensation.	*Copy of performance reviews or compensation methodology for departmental/clinical leadership*	
☐	b. included senior nursing leadership as part of the hospital senior administrative leadership team. (p.155)	*Copy of organization chart*	
☐	c. reported performance metrics related to this Safe Practice to the board (governance). (p.155	*Copy of reports, minutes or notes given to Board showing performance metrics related to*	

		nurse staffing levels	
☐	d. held the Board (governance) and senior administrative leadership accountable for the provision of financial resources to ensure adequate nurse staffing levels. (p.155)	*Copy of reports, minutes or notes regarding allocation of financial resources*	

SAFE PRACTICE 9 (continued)

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**9.3** In regard to ensuring adequate and competent nursing staff service and nursing leadership at all levels, our organization has done the following or has had the following in place within the last 12 months: a. conducted staff education on maintaining and improving competencies specific to assigned job duties related to the safety of the patient, with attendance documented. (p.155)	*Copy of training tools and attendance records*	
☐	b. allocated protected time for direct care staff and managers to reduce adverse events related to staffing levels or competency issues.	*Copy of attendance and indication if compensated time at training events or other methods*	
☐	c. documented expenses incurred during the past year tied to quality improvement efforts around this Safe Practice.	*Copy of expenses incurred and summary of how they are tied to quality improvement efforts*	
☐	d. budgeted financial resources for balancing staffing levels and skill levels to improve performance. (p.155)	*Copy of line item budget and summary of how items are tied to resources for balancing staffing levels and skills levels*	
☐	e. governance has approved a budget for reaching optimal nurse staffing.	*Meeting minutes, notes showing budget approval by governance and summary from 9.3d*	
☐	**9.4** In regard to ensuring adequate and competent nursing staff service and nursing leadership at all levels, our organization has done the following within the last 12 months or has had the following in place during the last 12 months and updates are made regularly: a. implemented a staffing plan, with input from nurses, to ensure that adequate nursing staff-to-patient ratios are achieved. (p.154)	*Copy of staffing plan that shows target nursing staff-to-patient ratios*	
☐	b. developed policies and procedures for effective staffing targets that specify number, competency and skill mix of nursing staff. (p.155)	*Copy of a staffing plan that shows staffing targets that specify number, competency and skill mix of nursing staff.*	

☐	c. implemented a performance improvement program that minimizes the risk to patients from less than optimal staffing levels. (p.155) OR monitored a previously implemented hospital-wide performance improvement program that measures, and demonstrates full achievement of, the impact of this specific Safe Practice. (p.155)	*Copy of performance improvement program and reports that show regular monitoring of staffing levels*	

PLACE DOCUMENTATION FOR SAFE PRACTICE 9 AFTER THIS PAGE

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SAFE PRACTICE 19: HAND HYGIENE

The types of documentation you should include in this binder are provided below. Only provide documentation for those questions in this section for which your hospital responded 'YES'. Ensure that each document is dated (according to the reporting period in Question 1) and labeled, and that each page is numbered. Indicate the page number in the source reference.

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**19.1** In regard to preventing hospital-acquired infections related to inadequate hand hygiene, our organization has done the following or has had the following in place within the last 12 months: a. conducted a hospital-wide evaluation of the potential impact of improvements in hand hygiene on the frequency and severity of hospital-acquired infections in our patient population.	*Copy of evaluation*	
☐	b. submitted a report to the Board (governance) with recommendations for measurable improvement targets.	*Board meeting minutes where report was presented and a dated copy of the presentation/report.*	
☐	**19.2** In regard to preventing hospital-acquired infections related to inadequate hand hygiene, our organization has done the following or has had the following in place within the last 12 months: a. held clinical leadership directly accountable for this patient safety area through performance reviews or compensation.	*Copy of performance review templates or compensation methodology for all clinical leadership. Reviews/methodology must contain specific language related to preventing hospital-acquired infections related to inadequate hand hygiene.*	
☐	b. held senior administrative leadership directly accountable for performance in this patient safety area through performance reviews or compensation.	*Copy of performance review templates or compensation methodology for administrative leadership. Reviews/method*	

		ology must contain specific language related to preventing hospital-acquired infections related to inadequate hand hygiene.	
☐	c. held the patient safety officer directly accountable for improvements in performance through performance reviews or compensation.	*Copy of performance review templates or compensation methodology for the PSO. Reviews/methodology must contain specific language related to preventing hospital-acquired infections related to inadequate hand hygiene.*	
☐	d. reported to the board (governance) the results of the measurable improvement targets.	*Board meeting minutes where report was presented and a dated copy of the presentation/report.*	

[CONTINUED ON NEXT PAGE]

SAFE PRACTICE 19 (continued)

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**19.3** In regard to preventing hospital-acquired infections related to inadequate hand hygiene, our organization has done the following or has had the following in place within the last 12 months: a. conducted staff education/knowledge transfer and skill development programs, with attendance documented. (p.251)	*Copy of training tools and attendance records*	
☐	b. documented expenditures on staff education related to this Safe Practice in the previous year.	*Copy of expenditures*	
☐	**19.4** In regard to preventing hospital-acquired infections related to inadequate hand hygiene, our organization has done the following within the last 12 months or has had the following in place during the last 12 months and updates are made regularly: a. developed and implemented explicit policies and procedures across the entire organization to prevent hospital-acquired infections due to inadequate hand hygiene including CDC guidelines with category IA, IB, or IC evidence. (p.250)	*Copy of policies and procedures and implementation method*	
☐	b. implemented a formal performance improvement program addressing hospital-acquired infections focused on hand hygiene compliance, with regular performance measurement and tracking improvement (pp.250-251) OR monitored a previously implemented hospital-wide performance improvement program that measures, and demonstrates full achievement of, the impact of this specific Safe Practice. (pp.250-251)	*Copy of performance improvement plan or monitoring information*	

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Hand Hygiene Practices

This section is **optional** in 2019. Responses will not be scored or publicly reported.

In the first year of reporting, Leapfrog does not want to be overly prescriptive by specifying the documentation required to demonstrate adherence to each question. We instead ask hospitals to submit examples of documentation and feedback to our Help Desk so we can develop FAQs and guidelines for the 2020 Leapfrog Hospital Survey. Hospitals are still expected to be able to demonstrate adherence to the practices they select either through documentation or eventually via on-site data verification.

Section 7: Managing Serious Errors

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for each measure in this section.
- ☐ For Never Events, hospitals may not earn credit for this question if they have only implemented a policy that includes the Center for Medicare and Medicaid (CMS) Never Events. Policy must include all **29 NQF Serious Reportable Events** AND include all 9 of Leapfrog's policy principles. Review your policy and file it in this binder.
- ☐ For the 5 healthcare-associated infection measures (CLABSI, CAUTI, SSI Colon, MRSA, and C. diff), print your NHSN reports for the reporting period using the instructions provided in the NHSN Instructions webpage and include them in this binder. For the Antibiotic Stewardship Practices, print your responses to the Antibiotic Stewards Practices section of the 2018 Patient Safety Component – Annual Hospital Survey using the instructions provided in the hard copy of the Survey and include a copy in this binder.

  Note that Leapfrog recommends that hospitals save copies of the NHSN 2018 Patient Safety Component – Annual Hospital Survey and CMS IQR Reports on the same day that Leapfrog will be downloading the data from NHSN for all current group members.
- ☐ Be sure to print, date, label, and file all documentation used to respond to this section.
- ☐ If you submitted any questions on this section to the Leapfrog Help Desk, print copies of your responses (i.e., tickets) and save them under this tab for future reference.

PLACE DOCUMENTATION FOR SECTION 7 AFTER THIS PAGE

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Section 8: Medication Safety

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for this section.
- ☐ Review the questions and reference information for this section with anyone who is going to help you collect this data.
- ☐ For the medication reconciliation measure, be sure to use the worksheets and data collection workbook in the "Survey and CPOE Materials" section of the website. Save copies of these materials for your records.
- ☐ Be sure to print, date, label, and file reports and meeting minutes that you used to respond to the questions in this section in this binder.
- ☐ If your IT team or data abstractor developed special code, scripts, or parameters to run any reports for you, include a note or a copy so that you can run similar reports next year.
- ☐ If you submitted any questions on this section to the Leapfrog Help Desk, print copies of your response (i.e., tickets) and save them under this tab for future reference.

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Section 9: Pediatric Care

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for this section.
- ☐ Review the questions and reference information for this section with anyone who is going to help you collect this data.
- ☐ For the CT Radiation Dose measure, be sure to use the worksheet in the "Survey and CPOE Materials" section of the website. Save a copy of this workbook for your records. As a reminder, hospitals have the option of using Dose Monitoring Software or the Leapfrog-specific ACR Report to report on this measure. Refer to the measure specifications in the hard copy of the Survey for detailed instructions.
- ☐ For the CAHPS Child Hospital Survey, be sure to save a copy of your vendor report used to respond to the questions in this section.
- ☐ Be sure to print, date, label, and file any report that you used to respond to the questions in this section.
- ☐ If your IT team or data abstractor developed special code, scripts, or parameters to run any reports for you, include a note or a copy so that you can run similar reports next year.
- ☐ If you submitted any questions on this section to the Leapfrog Help Desk, print copies of your response (i.e., tickets) and save them under this tab for future reference.

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Section 10: Outpatient Procedures

This section is **optional** in 2019. Responses will not be scored or publicly reported.

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