



LEAPFROG  
**ASC SURVEY**

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PATIENT SAFETY AND QUALITY

2020 LEAPFROG ASC SURVEY BINDER



THE LEAPFROG GROUP

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# Overview

## WHAT IS THE PURPOSE OF THIS BINDER?

The Leapfrog ASC Survey Binder is available via PDF for use by all ASCs to collect, organize, and record information during the completion of the 2020 Leapfrog ASC 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.

## 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 ASC 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/asc>).

# Section 1: Basic Facility Information

## TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- Review the reporting time periods for this section.
- Make a note of who in your facility provided information or ran reports for you to respond to these questions.
- If your facility queried (e.g., code or scripts) your EHR or followed specific protocols to abstract data from clinical records, include a note or copy so that you can create 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.

## BASIC FACILITY INFORMATION

The types of documentation you should include in this binder are provided below. 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
<input type="checkbox"/>	<b>Question 6:</b> Does your facility have a formal teaching agreement with a training institution (e.g., academic medical center)?	If "yes," your formal teaching agreement	
<input type="checkbox"/>	<b>Question 7:</b> Is your facility nationally accredited by one of the following organizations?	If "yes," your non-expired accreditation certificate or letter	
<input type="checkbox"/>	<b>Question 10:</b> Does your facility have a written transfer agreement with a pediatric or general acute care hospital for patients who require a higher level of care?	If "yes," your written transfer agreement	
<input type="checkbox"/>	<p><b>Question 11:</b> Whether or not your facility has a written transfer agreement in place for patients who require a higher level of care, does your facility have a <u>written transfer policy</u> for emergent transfers, when there is an immediate threat to life or limb, that includes the following components:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Patient is transferred to the nearest hospital</li> <li><input type="checkbox"/> Receiving facility must have an ED and/or ICU</li> <li><input type="checkbox"/> Patient must be transferred within an established period of time</li> <li><input type="checkbox"/> Patient's medication information must be transferred within an established period of time</li> </ul>	Written transfer policy for emergent transfers that includes details for each of the answer options selected (select all that apply)	

PLACE DOCUMENTATION FOR SECTION 1 AFTER THIS PAGE

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## Section 2: Medical, Surgical, and Clinical Staff

### 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 documentation.
- Include a copy of any reports or rosters used to respond to the questions in Section 2.
- 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.

## MEDICAL, SURGICAL, AND CLINICAL STAFF

The types of documentation you should include in this binder are provided below. Ensure that each document is dated (according to the reporting period) 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
<input type="checkbox"/> <b>Question 1:</b> Is there an Advanced Cardiovascular Life Support (ACLS) trained clinician, as well as a second clinician <sup>11</sup> (regardless of ACLS training), present at all times and immediately available in the facility building while an adult patient is present in the facility?	<b>1) Staffing policy that describes minimum staffing requirements;</b> <b>2) Facility staffing schedule (with hours indicated) for the latest 3 months prior to Survey submission;</b> <b>3) ACLS certification documentation for each clinician listed on the schedule</b>	
<input type="checkbox"/> <b>Question 2:</b> Which of the following medical, surgical, and clinical staff are required by the facility to maintain ACLS certification? <ul style="list-style-type: none"> <li>• Anesthesiologists</li> <li>• Certified Registered Nurse Anesthetists (CRNAs)</li> <li>• Physicians</li> <li>• Nurses (RN or MSN)</li> <li>• Physician Assistants (PAs)</li> <li>• Nurse Practitioners (NPs)</li> <li>• Surgical Technicians</li> <li>• First Assists</li> </ul>	<b>ACLS and PALS Certification Policy or job descriptions</b>	
<input type="checkbox"/> <b>Question 3:</b> Is there a physician or CRNA present at all times and immediately available in the building until all adult patients are physically discharged from the facility?	<b>1) Staffing policy that describes minimum staffing requirements;</b> <b>2) Facility staffing schedule for physicians or CRNAs (with hours indicated) for the latest 3 months prior to Survey submission</b>	
<input type="checkbox"/> <b>Question 4:</b> Is there a Pediatric Advanced Life Support (PALS) trained clinician <sup>11</sup> , as well as a second clinician <sup>11</sup> (regardless of PALS training), present at all times and immediately available in the building while a pediatric patient (infant through 12 years) is present in the facility?	<b>1) Staffing policy that describes minimum staffing requirements;</b> <b>2) Facility staffing schedule (with hours indicated) for the latest 3 months prior to Survey submission;</b>	



		<b>3) PALS certification documentation for each clinician listed on the schedule</b>	
<input type="checkbox"/>	<p><b>Question 5:</b> Which of the following medical, surgical, and clinical staff are required by the facility to maintain PALS certification?</p> <ul style="list-style-type: none"> <li>• Anesthesiologists</li> <li>• Certified Registered Nurse Anesthetists (CRNAs)</li> <li>• Physicians</li> <li>• Nurses (RN or MSN)</li> <li>• Physician Assistants (PAs)</li> <li>• Nurse Practitioners (NPs)</li> <li>• Surgical Technicians</li> <li>• First Assists</li> </ul>	<b>ACLS and PALS Certification Policy or job descriptions</b>	
<input type="checkbox"/>	<p><b>Question 6:</b> Is there a physician or CRNA present at all times and immediately available in the building until all pediatric patients (infant through 12 years) are physically discharged from the facility?</p>	<p><b>1) Staffing policy that describes minimum staffing requirements;</b>  <b>2) Facility staffing schedule for physicians or CRNAs (with hours indicated) for the latest 3 months prior to Survey submission</b></p>	
<input type="checkbox"/>	<p><b>Question 7:</b> To help ensure that patients are cared for by adequately trained physicians, are <b>those physicians</b> who are authorized to perform procedures at your facility board certified or board eligible?</p>	<b>Board certification, including expiration date, for all physicians performing procedures at facility</b>	
<input type="checkbox"/>	<p><b>Question 8:</b> To help ensure that patients are cared for by adequately trained anesthesiologists and/or certified registered nurse anesthetists, <b>are those providing anesthesia</b> at your facility board certified or board eligible?</p>	<b>Board certification, including expiration date, for all anesthesiologists and CRNAs performing procedures at facility</b>	

PLACE DOCUMENTATION FOR SECTION 2 AFTER THIS PAGE

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# Section 3: Volume and Safety of Procedures

## TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- Review the reporting periods for this section.
- For Section 3A: Volumes of Procedures be sure to use **only** those CPT codes listed for each procedure in the Library on the [Survey Dashboard](#).
- For Section 3B: Patient Follow-up be sure to keep a copy of the audit or report used to assess types of complications and documented admissions, as well as to calculate rates of complications and admissions.
- Make a note of who in your ASC provided information or ran reports for you to respond to the questions.
- If your facility queried (e.g., code or scripts) your EHR or followed specific protocols to abstract data from clinical records, include a note or copy so that you can create similar reports next year.
- Be sure to print, date, label, and file reports that you used for this section of 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 under this tab for future reference.

## PATIENT SELECTION AND CONSENT TO TREAT

The types of documentation you should include in this binder are provided below. Ensure that each document is dated (according to the reporting period) 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
<input type="checkbox"/>	<p><b>Question 1:</b> Does your facility have a standard, written screening protocol to determine whether a patient's procedure can safely be performed at the facility?</p> <p><b>Question 2:</b> Which of the following components are included in your facility's standard, written screening protocol?</p>	<p>Facility's standard, written screening protocol</p>	
<input type="checkbox"/>	<p><b>Question 3:</b> Who completes the standard, written screening protocol to determine whether a patient's procedure can safely be performed at the facility?</p>	<p><i>No required documentation.</i></p>	
<input type="checkbox"/>	<p><b>Question 4:</b> When patients are identified through your facility's screening protocol as high-risk, does an anesthesiologist, certified registered nurse anesthetist, or Medical Director complete an additional medical review to determine whether the patient's procedure can safely be performed at the facility?</p>	<p>Policy document outlining the patient screening process</p>	
<input type="checkbox"/>	<p><b>Question 5:</b> To help ensure that patients and their families have adequate time to review and ask questions about written surgical consent materials, it's our facility's policy to provide these materials to patients: [At least 3 days prior/ 1-3 days prior/ Same day/ Not at all]</p>	<p>Policy document describing surgical consent materials (either internal document or created for patient reference)</p>	
<input type="checkbox"/>	<p><b>Question 6:</b> To help ensure that patients and their families have adequate time to review and ask questions about written anesthesia consent materials, it's our facility's policy to provide these materials to patients: [At least 3 days prior/ 1-3 days prior/ Same day/ Not at all]</p>	<p>Policy document describing surgical consent materials (either internal document or created for patient reference)</p>	

## SAFE SURGERY CHECKLIST

The types of documentation you should include in this binder are provided below. 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
<input type="checkbox"/>	<b>Question 2:</b> Does your facility utilize a safe surgery checklist on every patient, every time one of the applicable procedures reported on in Section 3A is performed?	Policy for surgical procedures or patient preparation	
	<b>Question 3:</b> Does your safe surgery checklist include all of the following elements before the induction of anesthesia?	Safe surgery checklist used by facility	
<input type="checkbox"/>	<b>Question 4:</b> Who leads the checklist before the induction of anesthesia?	Policy or guidelines for surgery procedures or use of safe surgery checklist, including staff roles	
<input type="checkbox"/>	<b>Question 5:</b> Does your safe surgery checklist include all of the following elements before the skin incision and/or before the procedure begins?	Safe surgery checklist used by facility	
<input type="checkbox"/>	<b>Question 6:</b> Who leads the checklist before the skin incision and/or before the procedure begins?	Policy or guidelines for surgery procedures or use of safe surgery checklist, including staff roles	
<input type="checkbox"/>	<b>Question 7:</b> Does your safe surgery checklist include an assessment, for each patient, of all of the following elements before the patient leaves the operating room and/or procedure room:	Safe surgery checklist used by facility	
<input type="checkbox"/>	<b>Question 8:</b> Who leads the checklist before the patient leaves the operating room and/or procedure room?	Policy or guidelines for surgery procedures or use of safe surgery checklist, including staff roles	

PLACE DOCUMENTATION FOR SECTION 3 AFTER THIS PAGE

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# Section 4: Patient Safety Practices

## TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- Review the reporting periods for this section.
- Make a note of who in your ASC provided information or ran reports for you to respond to the questions.
- For the Medication and Allergy Documentation measure, be sure to use the worksheets and data collection workbook in the “Survey Materials” section of the website. Save copies of these materials for your records.
- For the NHSN OPC Module Measures (OPC Annual Facility Survey, SDOM, BRST SSI, HER SSI, KPRO SSI, LAM SSI), print your NHSN reports for the reporting period using the instructions provided in the [NHSN Instructions webpage](#) and include them in this binder.

Note that Leapfrog recommends that facilities save copies of the NHSN 2019 Outpatient Procedure Component – Annual Facility Survey and SDOM/SSI Reports on the same day that Leapfrog will be downloading the data from NHSN for all current group members.

- For Never Events, facilities 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.
- If your facility queried (e.g., code or scripts) your EHR or followed specific protocols to abstract data from clinical records, include a note or copy so that you can create similar reports next year.
- Be sure to print, date, label, and file reports that you used for this section of 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 under this tab for future reference.

## ANTIMICROBIAL STEWARDSHIP PRACTICES

The types of documentation you should include in this binder are provided below. Ensure that each document is dated (according to the reporting period) 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
<input type="checkbox"/>	<b>Question 9:</b> Does your facility have a formal, written statement of support from leadership that supports efforts to improve antimicrobial use (antimicrobial stewardship)?	Memo or email to all staff; PowerPoint presentation at all staff or board meeting	
<input type="checkbox"/>	<b>Question 10:</b> Does your facility receive any <u>budgeted</u> financial support for antimicrobial stewardship activities (e.g., support for salary, training, or IT support)?	Budget showing support for one or more of these areas	
<input type="checkbox"/>	<b>Question 11:</b> Is there a physician leader responsible for program outcomes of stewardship activities at your facility?	Antimicrobial stewardship program summary document or letter from facility detailing physician roles and responsibilities	
<input type="checkbox"/>	<b>Question 12:</b> Is there a pharmacist leader responsible for working to improve antimicrobial use at your facility?	Antimicrobial stewardship program summary document or letter from facility detailing pharmacist roles and responsibilities	
<input type="checkbox"/>	<b>Question 13:</b> Does your facility have a policy that requires prescribers to document in the medical record or during order entry a dose, duration, and indication for all antimicrobial prescriptions?	Policy document detailing prescribing requirement	
<input type="checkbox"/>	<b>Question 14:</b> Does your stewardship program monitor adherence to the policy (such as by monitoring dose, duration, and indication)?	Policy document detailing monitoring or evaluation	
<input type="checkbox"/>	<b>Question 15:</b> Does your facility have facility-specific treatment recommendations, based on national guidelines and local susceptibility, to assist with antimicrobial selection for common clinical conditions?	Facility's treatment recommendations	
<input type="checkbox"/>	<b>Question 16:</b> Does your stewardship program monitor adherence to facility-specific treatment recommendations?	Policy around monitoring or results of evaluation	
<input type="checkbox"/>	<b>Question 17:</b> Do specified antimicrobial agents need to be approved by a physician or pharmacist prior to dispensing (i.e., pre-authorization) at your facility?	List of antimicrobial agents requiring pre-authorization	



□	<b>Question 18:</b> Does a physician or pharmacist review courses of therapy for specified antimicrobial agents (i.e., prospective audit with feedback) at your facility?	Policy; example of audit with feedback	
□	<b>Question 19:</b> Does your stewardship program provide education to clinicians and other relevant staff members on improving antimicrobial prescribing?	Education materials or schedule of training sessions	

## OPIOID PRESCRIBING

The types of documentation you should include in this binder are provided below. Ensure that each document is dated (according to the reporting period) 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
<input type="checkbox"/>	<b>Question 20:</b> Does your facility ensure, through tracking or as a requirement of privileging, that all licensed prescribers who are authorized to prescribe scheduled drugs are registered for access to your state or regional Prescription Drug Monitoring Program (PDMP)?	Tracking report or privileging policy document detailing registry to state or regional PDMP	
<input type="checkbox"/>	<b>Question 21:</b> Does your facility ensure, through tracking or as a requirement of privileging, that all licensed prescribers who are authorized to prescribe scheduled drugs query and assess the PDMP prior to prescribing an opioid pain medication to a patient?	Tracking report or privileging policy document detailing requirement to query PDMP prior to prescribing opioid medications	
<input type="checkbox"/>	<b>Question 22:</b> Does your facility retain copies of all discharge instructions, including medications prescribed at discharge, for all patients who underwent one or more of the procedures included in Section 3A?	Policy detailing requirement to retain copy of discharge instructions	
<input type="checkbox"/>	<b>Question 23:</b> Do all licensed prescribers, who are authorized to prescribe scheduled drugs, adhere to these national, evidence-based <a href="#">Surgical Opioid Guidelines</a> ?	Policy for prescribers of scheduled drugs that includes the elements outlined in the Guidelines	
<input type="checkbox"/>	<b>Question 24:</b> Does your facility conduct regular retrospective reviews of licensed prescribers to identify the extent to which they adhere to the <a href="#">Surgical Opioid Guidelines</a> ?	Policy or guidelines around retrospective reviews; example review findings	
<input type="checkbox"/>	<b>Question 25:</b> Does your facility have a process in place for communicating with licensed prescribers, as well as leadership, when a licensed prescriber's trend or prescribing pattern suggests challenges to adhering to the Surgical Opioid Guidelines to understand barriers and improve adherence?	Outline or policy of feedback process; may include description of concerning prescribing trends	

## 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 facility responded 'YES'. Ensure that each document is dated (according to the reporting period) and labeled, and that each page is numbered. Indicate the page number in the source reference.

SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
<b>Training and Education</b>		
<p><b>Question 1:</b> Do individuals who touch patients or who touch items<sup>33</sup> that will be used by patients in your facility receive hand hygiene training from a professional with appropriate training and skills<sup>34</sup> at <b>both</b>:</p> <ul style="list-style-type: none"> <li>• the time of onboarding; and</li> <li>• annually thereafter?</li> </ul>	<p>1) Hand hygiene educational programming document showing frequency of training (either online or in-person) 2) Credentials of hand hygiene trainer</p>	
<p><b>Question 2:</b> In order to pass the <b>initial</b> hand hygiene training, do individuals who touch patients or who touch items that will be used by patients<sup>33</sup> need to physically demonstrate proper hand hygiene with soap and water and alcohol-based hand sanitizer?</p>	<p>Curriculum from an in-person orientation or other in-person session (e.g., occupational health session) which includes physical demonstration of hand hygiene and associated sign in sheets</p>	
<p><b>Question 3:</b> Are <b>all</b> six of the following topics included in your facility's initial and annual hand hygiene training?</p> <ul style="list-style-type: none"> <li>• Evidence linking hand hygiene and infection prevention</li> <li>• When individuals who touch patients or who touch items that will be used by patients<sup>33</sup> should perform hand hygiene (e.g., WHO's 5 Moments for Hand Hygiene, CDC's Guideline for Hand Hygiene)</li> <li>• How individuals who touch patients or who touch items that will be used by patients<sup>33</sup> should clean their hands with alcohol-based hand sanitizer and soap and water as to ensure they cover all surfaces of hands and fingers, including thumbs and fingernails</li> <li>• When gloves should be used in addition to hand washing (e.g., caring for <i>C. difficile</i> patients) and how hand hygiene should be performed when gloves are used</li> <li>• The minimum time that should be spent performing hand hygiene with soap and water and alcohol-based hand sanitizer</li> <li>• How hand hygiene compliance is monitored</li> </ul>	<p>Education session curriculum (either online or in-person) for initial and annual hand hygiene training which includes all <b>six</b> topics</p>	
<b>Infrastructure</b>		
<p><b>Question 4:</b> Does your facility have a process in place to ensure that <b>all</b> of the following are done, as necessary, and <u>quarterly audits</u> are conducted on a sample of dispensers to ensure that the process is followed?</p>	<p>1) Facility policy &amp; procedure document that outlines policies for refilling paper towels, dispensers, and replacing</p>	

<ul style="list-style-type: none"> <li>• Refill paper towels, soap dispensers, and alcohol-based hand sanitizer dispensers when they are empty or near empty</li> <li>• Replace batteries in automated paper towel dispensers, soap dispensers, and alcohol-based hand sanitizer dispensers (if automated dispensers are used in the facility)</li> </ul>	<p>batteries in automated dispensers</p> <p>2) Results from a quarterly audit showing that a sample of dispensers were checked to ensure that the following were refilled or replaced:</p> <ul style="list-style-type: none"> <li>- paper towels</li> <li>- soap dispensers</li> <li>- alcohol-based hand sanitizer dispensers</li> <li>- batteries in automated paper towel dispensers, soap dispensers, and alcohol-based hand sanitizer dispensers</li> </ul>	
<p><b>Question 5:</b> Do all rooms or bed spaces in your surgical or treatment areas have an alcohol-based hand sanitizer within 5 steps of the patient's bed that is easily accessible to individuals who touch patients or who touch items that will be used by patients<sup>12</sup>?</p>	<p>Would be verified on-site through demonstration</p>	
<p><b>Question 6:</b> Does your facility conduct audits of the volume of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated) on a sample of dispensers at all of the following times:</p> <ul style="list-style-type: none"> <li>• upon installation;</li> <li>• whenever the brand of product or system changes; and</li> <li>• whenever adjustments are made to the dispensers?</li> </ul>	<p>1) Facility policy &amp; procedure document outlining policies for conducting audits</p> <p>2) Results from an audit showing that a sample of dispensers were audited</p>	
<p><b>Question 7:</b> Do all of the audited dispensers deliver, with one activation, a volume of alcohol-based hand sanitizer that covers the hands completely and requires 15 or more seconds for hands to dry (on average)?</p>	<p>Results from the audit in question #7 showing that the required volume was met (15 or more seconds for hands to dry) on <b>all</b> sampled dispensers</p>	
<b>Monitoring</b>		
<p><b>Question 8:</b> Does your facility collect hand hygiene compliance data on at least 200 hand hygiene opportunities, or 6% of all possible hand hygiene opportunities in the facility, <b>each month</b>?</p>	<p>1) Summary of <b>monthly</b> hand hygiene compliance data which shows at least 200 hand hygiene opportunities (or 6% of all possible hand hygiene opportunities) were monitored using direct observation and/or electronic compliance monitoring in facility</p> <p>2) Unit calculations of hand hygiene opportunities for inpatient, outpatient, and emergency department units where less than 200 opportunities are being monitored (refer to calculations within the Section 4C FAQs in the hard copy of the Survey)</p>	

<p><b>Question 9:</b> Does your facility collect hand hygiene compliance data on at least 200 hand hygiene opportunities each quarter?</p>	<p>Summary of <b>quarterly</b> hand hygiene compliance data which shows at least 100 hand hygiene opportunities were monitored using direct observation and/or electronic compliance monitoring in facility</p>	
<p><b>Question 10:</b> Does your facility use hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will be used by patients<sup>12</sup> with feedback on both when they are and are not compliant with performing hand hygiene?</p>	<p>List of staff who serve as hand hygiene coaches/observers and the schedules they followed for observing/coaching</p>	
<p><b>Direct Monitoring – Electronic Compliance Monitoring System</b></p>		
<p><b>Question 11:</b> In those surgical or treatment areas where an electronic compliance monitoring system is used, does the monitoring system used meet both of the following criteria?</p> <ul style="list-style-type: none"> <li>• The system can identify both opportunities for hand hygiene and that hand hygiene was performed</li> <li>• The facility itself has validated the accuracy of the data collected by the electronic compliance monitoring system</li> </ul>	<p>Would be verified on-site through demonstration</p>	
<p><b>Question 12:</b> In those surgical or treatment areas where an electronic compliance monitoring system is used, are direct observations also conducted for coaching and intervention purposes that meet <b>all</b> of the following criteria?</p> <ul style="list-style-type: none"> <li>• Observers immediately intervene prior to any harm occurring to provide non-compliant individuals with immediate feedback</li> <li>• Observations identify both opportunities for hand hygiene and compliance with those opportunities</li> <li>• Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct</li> <li>• Observations are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch patients or who touch items that will be used by patients <b>Error! Bookmark not defined.</b> on duty for that shift</li> <li>• Observations capture a representative sample of the different roles of individuals who touch patients or who touch items that will be used by patients <b>Error! Bookmark not defined.</b> (e.g., nurses, physicians, techs, environmental services workers)</li> </ul>	<p>1) Example of direct observation template or sheet used by observers/coaches which shows:</p> <ul style="list-style-type: none"> <li>- if the observer/coach intervened (observer/coach needs to intervene in all cases of noncompliance)</li> <li>- if a hand hygiene opportunity was observed and if the individual was compliant</li> <li>- the role of the individual being observed</li> <li>- the type hand hygiene opportunity or “moment” being observed</li> <li>- if the individual used proper technique</li> <li>- date of the observation, as well as unit and shift being observed</li> </ul> <p>2) Report of weekly or monthly direct observation data which shows:</p> <ul style="list-style-type: none"> <li>- observations for coaching/intervention purposes were conducted for <b>all</b> surgical or treatment areas where an electronic compliance monitoring system is used</li> </ul>	

	<ul style="list-style-type: none"> <li>- observations within a surgical or treatment area were conducted weekly or monthly across all shifts and on all days of the week</li> <li>- observations capture a representative sample of the different roles of individuals (e.g., nurses, physicians, techs, environmental services workers)</li> </ul>	
<b>Direct Monitoring- Direct Observation</b>		
<p><b>Question 13:</b> In those surgical or treatment areas where an electronic compliance monitoring system is NOT used, do the direct observations meet <b>all</b> of the following criteria?</p> <ul style="list-style-type: none"> <li>• Observations identify both opportunities for hand hygiene and compliance with those opportunities</li> <li>• Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct</li> <li>• Observations are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch patients or who touch items that will be used by patients <b>Error! Bookmark not defined.</b> on duty for that shift</li> <li>• Observations are conducted to capture a representative sample of the different roles of individuals who touch patients or who touch items that will be used by patients <b>Error! Bookmark not defined.</b> (e.g., nurses, physicians, techs, environmental services workers)</li> </ul>	<p>1) Example of direct observation template or sheet used by observers which shows:</p> <ul style="list-style-type: none"> <li>- if a hand hygiene opportunity was observed and if the individual was compliant</li> <li>- the role of the individual being observed</li> <li>- the type hand hygiene opportunity or “moment” being observed</li> <li>- if the individual used proper technique</li> <li>- date of the observation, as well as unit and shift being observed</li> </ul> <p>2) Report of weekly or monthly direct observation data which shows:</p> <ul style="list-style-type: none"> <li>- observations were conducted for all surgical or treatment areas that do not have an electronic compliance monitoring system</li> <li>- observations within a unit were conducted weekly or monthly across all shifts and on all days of the week</li> <li>- observations capture a representative sample of the different roles of individuals (e.g., nurses, physicians, techs, environmental services workers)</li> </ul>	
<p><b>Question 14:</b> Does your facility have a system in place for both the initial and recurrent training and validation of hand hygiene compliance observers?</p>	<p>1) Training schedule for hand hygiene compliance observers which shows initial and recurrent training</p> <p>2) Results/documentation of regular quality monitoring of hand hygiene compliance</p>	

	observers (e.g., comparing results from simultaneous data collection by someone from Infection Control and a hand hygiene compliance observer)	
<b>Feedback</b>		
<b>Question 15:</b> Are hand hygiene compliance data fed back to individuals who touch patients or who touch items that will be used by patients <sup>12</sup> at least monthly for improvement work?	Documentation of how hand hygiene compliance data were delivered monthly to individuals who touch patients or who touch items that will be used by patients (e.g., report, handout, e-mail, etc.)	
<b>Question 16:</b> Are hand hygiene compliance data used for creating action plans?	Facility action plans based on hand hygiene compliance data (hand hygiene compliance data should be highlighted)	
<b>Question 17:</b> Is regular (at least every 3 months) feedback of hand hygiene compliance data, with demonstration of trends over time, given to: <ul style="list-style-type: none"> <li>• ASC leadership; and</li> <li>• ASC governance?</li> </ul>	Documentation of how hand hygiene compliance data, with demonstration of trends over time, were delivered at least every 6 months to senior administrative leadership, physician leadership, nursing leadership, and governance (e.g., report, handout, e-mail, etc.)	
<b>Question 18:</b> If “yes” to question #17, is ASC leadership held directly accountable for hand hygiene performance through performance reviews or compensation?	Performance reviews or compensation methodology for senior administrative leadership, physician leadership and nursing leadership which include accountability for hand hygiene performance (e.g., meeting targets for hand hygiene compliance rates, bonuses tied to implementation of technology, etc.)	
<b>Culture</b>		
<b>Question 19:</b> Are patients and visitors invited to remind individuals who touch patients or who touch items that will be used by patients <sup>12</sup> to perform hand hygiene?	Examples or photos of posters, bedside placards, buttons worn by staff, or other materials used to invite patients and visitors to remind individuals to perform hand hygiene	
<b>Question 20:</b> Has ASC leadership demonstrated a commitment to support hand hygiene improvement in the last year (e.g., a written or verbal commitment delivered to those individuals who touch patients or who touch items that will be used by patients <sup>12</sup> )?	Written or verbal commitments to support hand hygiene improvement dated within the last 12 months from the leadership (e.g., e-mails, videos, minutes or talking points from town hall meetings, public comments to	

	staff, etc.) that are addressed to individuals who touch patients or who touch items that will be used by patients	
<b>Additional Questions (Fact Finding Only)</b>		
<b>Question 21:</b> Do all rooms or bed spaces in your surgical or treatment areas have a sink for hand washing within 20 feet of the patient's bed that is easily accessible to individuals who touch patients or who touch items that will be used by patients? <b>Error! Bookmark not defined.?</b>	Would be verified on-site through demonstration	



**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 facility responded 'YES'. Ensure that each document is dated (according to the reporting period) and labeled, and that each page is numbered. Indicate the page number in the source reference.

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
<input type="checkbox"/>	<p><b>1.1</b> Within the last 12 months, 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:</p> <p>a. Governance minutes reflect regular communication regarding <b>all</b> three of the following:</p> <ul style="list-style-type: none"> <li>• risks and hazards (as defined by <i>Safe Practice #4, Identification and Mitigation of Risks and Hazards</i>);</li> <li>• culture measurement (as defined by <i>Safe Practice #2, Culture Measurement, Feedback, and Intervention</i>); and,</li> <li>• progress towards resolution of safety and quality problems. (p.75)</li> </ul>	<p>1) Governance meeting minutes, with dates reflecting regular communication about all three topics. The discussion of these items can be a general note in the minutes, without specific details. However, facilities should maintain copies of dated presentations and reports related to these agenda items in order to document adherence to these elements.</p> <p>2) Chart or description of governance structure.</p>	
<input type="checkbox"/>	<p>b. steps have been taken to report to the community of ongoing efforts to improve safety and quality in the facility and the results of these efforts. (p.75)</p>	<p>Published report for the entire community (i.e. webpage, e-newsletter, mailing or annual report) that specifically mentions BOTH the efforts to improve safety and quality and the measurable results of those efforts. Efforts the facility is taking to improve safety and quality should be related to reducing or preventing these adverse events and the results of those efforts would be the measurable outcomes.</p>	

<input type="checkbox"/>	<p>c. all staff and independent practitioners were made aware of ongoing efforts to reduce risks and hazards and to improve patient safety and quality in the facility. (p.75)</p>	<p>Reports, presentations, meeting minutes, emails or intranet page, with attendance recorded.</p>	
<input type="checkbox"/>	<p><b>1.2</b> Within the last 12 months, in regard to holding governance and leadership directly accountable for results related to identifying and reducing unsafe practices, the facility has done the following:</p> <p>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)</p>	<p>Patient safety program that specifically addresses the safe practice activities.</p>	
<input type="checkbox"/>	<p>b. Risk Manager or Quality Coordinator has been appointed and communicates regularly with governance and leadership; the Risk Manager or Quality Coordinator is the primary point of contact of the integrated, patient safety program. (p.76)</p>	<p>1) Documentation of Risk Manager or Quality Coordinator position - highlight information describing the individual as the primary point of contact of the patient safety program. 2) Provide examples of reports or presentations presented to governance and meeting minutes showing communication with governance and leadership. 3) Chart or description of governance structure.</p>	
<input type="checkbox"/>	<p>c. performance has been documented in performance reviews and/or compensation incentives for leadership and ASC-employed caregivers. (p.76)</p>	<p>Performance review templates or compensation incentives for all levels described which includes language related to identifying and reducing unsafe practices</p>	
	<p>d. the patient safety team, Risk Manager, or Quality Coordinator communicated regularly with leadership regarding both of the following:</p> <ul style="list-style-type: none"> <li>• progress in meeting safety goals;</li> <li>• provide team training to caregivers; and, documented these communications in meeting minutes. (pp.76-77)</li> </ul>	<p>1) Reports or presentations to leadership. 2) Meeting notes/minutes with attendance noted. Meeting minutes from more than one meeting should be provided in order to reflect regular communication.</p>	

<input type="checkbox"/>	<p>e. the facility reported adverse events to external mandatory or voluntary programs. (p.77)</p>	<p>Information indicating external reporting such as report or summary. If no adverse events were identified <b>and</b> the facility can document that it has policies in place to report such events when they do occur (to a mandatory or voluntary program), the facility would meet the intent of this element. Please see Section 4E Never Events for a list of adverse events and components of a Never Events Policy.</p>	
<input type="checkbox"/>	<p><b>1.3</b> Within the last 12 months, in regard to implementation of the patient safety program, governance and leadership have provided resources to cover the implementation, and:</p> <p>a. dedicated patient safety program budgets to support the program, staffing, and technology investment. (p.77)</p>	<p>Line item budget</p>	
<input type="checkbox"/>	<p><b>1.4</b> Within the last 12 months, structures and systems have been in place to ensure for assuring that leadership is taking direct and specific actions have been in place for the past 12 months, as evidenced by:</p> <p>a. leadership is personally engaged in reinforcing patient safety improvements (e.g., holding patient safety meetings and reporting to governance). Calendars reflect allocated time. (p.78)</p>	<p>1) Leadership schedules showing “walk-arounds”, meeting minutes, etc. 2) Results of implementation of patient safety performance improvement reinforcement.</p>	
<input type="checkbox"/>	<p>b. facility 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)</p>	<p>Meeting minutes with list of attendees. Input for the patient safety program by licensed independent practitioners and the organized medical staff and physician leadership should be highlighted.</p>	

**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 facility responded ‘YES’. Ensure that each document is dated (according to the reporting period) and labeled, and that each page is numbered. Indicate the page number in the source reference.

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
<input type="checkbox"/>	<p><b>2.2</b> Within the last 36 months, in regard to culture measurement, our facility has done the following:</p> <p>a. the AHRQ Surveys on Patient Safety Culture (SOPS), a nationally recognized tool that has demonstrated validity, consistency, and reliability, was administered to employees.</p> <p><i>If item ‘a’ is not checked, no other items in this Practice 2 may be checked.</i></p>	<p>Results from culture of safety survey that show patient care or treatment areas surveyed; be sure results are dated within past 36 months of submission date. Results should include participation rate.</p>	
<input type="checkbox"/>	<p>b. benchmarked results of the AHRQ SOPS against external organizations, such as “like” ASCs or other comparable facilities within the same health system.</p>	<p>Benchmark results and list of facilities in the benchmark group; be sure report is dated.</p>	
<input type="checkbox"/>	<p>c. Risk Manager, Quality Coordinator, or leadership used the results of the AHRQ SOPS to debrief staff using semi-structured approaches for the debriefings and presenting results in aggregate form to ensure the anonymity of survey respondents.</p>	<p>Meeting notes or presentation lead by local patient safety leaders that reflects semi-structured approach, with attendance reflecting units</p>	
<input type="checkbox"/>	<p><b>2.3</b> Within the last 36 months, in regard to accountability for improvements in culture measurement, our facility has done the following:</p> <p>d. shared the results of AHRQ SOPS with governance and leadership in a formal report and discussion. (p.88)</p>	<p>Governance and leadership agenda, minutes, and/or presentation. All documentation should be dated</p>	
<input type="checkbox"/>	<p>e. included in performance evaluation criteria for leadership, both the response rates to the survey and the use of the survey results in the improvement efforts.</p>	<p>Performance evaluation of leadership that reflects response rates to survey and improvement efforts</p>	

## SAFE PRACTICE 2 (continued)

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
<input type="checkbox"/>	<p><b>2.4</b> Within the last 24 months, in regard to culture measurement, the organization has done the following (or has had the following in place):</p> <p>a. conducted staff education program(s) on methods to improve the culture of safety, tailored to the facility's AHRQ SOPS results.</p>	Education session curriculum and sign in sheets. Examples of documentation from personnel or administrative records.	
<input type="checkbox"/>	<p>b. included the costs of annual culture measurement/follow-up activities in the patient safety program budget.</p>	Line item budget or expenses related to culture measurement/follow-up activities	
<input type="checkbox"/>	<p><b>2.5</b> Within the last 24 months, in regard to culture measurement, feedback, and interventions, our facility has done the following (or has had the following in place):</p> <p>a. developed or implemented explicit, facility-wide organizational policies and procedures for regular culture measurement. (p.88)</p>	Policies and/or examples of strategies implemented (i.e., meetings, education, events, etc.)	
<input type="checkbox"/>	<p>b. identified performance improvement interventions based on the AHRQ SOPS results, which were shared with leadership and subsequently measured and monitored. (p.88)</p>	Dashboard of metrics, progress report, etc. showing performance improvement intervention, and meeting minutes showing attendance by leadership	

PLACE DOCUMENTATION FOR SECTION 4 AFTER THIS PAGE

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# Section 5: Patient Experience (OAS CAHPS)

## 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.
- Be sure to save a copy of your OAS CAHPS 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 facility queried (e.g., code or scripts) your EHR or followed specific protocols to abstract data from clinical records, include a note or copy so that you can create 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.

PLACE DOCUMENTATION FOR SECTION 5 AFTER THIS PAGE

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