

The logo features a green square on the left containing a white graphic of a frog's tail and legs, represented by a series of white dots of varying sizes arranged in a curved path. To the right of the square, the word "LEAPFROG" is written in a bold, green, sans-serif font. Below "LEAPFROG", the words "HOSPITAL" and "SURVEY" are stacked vertically in a bold, grey, sans-serif font.

LEAPFROG
HOSPITAL
SURVEY

2020 LEAPFROG HOSPITAL SURVEY
ORGANIZATIONAL BINDER



TABLE OF CONTENTS

| Section # | Tab # |
|---------------------------------------|-------|
| Overview | 1A |
| Section 1: Basic Hospital Information | 1 |
| Section 2: Medication Safety – CPOE | 2 |
| Section 3: Inpatient Surgery | 3 |
| Section 4: Maternity Care | 4 |
| Section 5: ICU Physician Staffing | 5 |
| Section 6: Patient Safety Practices | 6 |
| Section 7: Managing Serious Errors | 7 |
| Section 8: Medication Safety | 8 |
| Section 9: Pediatric Care | 9 |
| Section 10: Outpatient Procedures | 10 |

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 Healthcare¹. 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 2020 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

[PAGE INTENTIONALLY LEFT BLANK]

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. The report should contain:
 - the units that your hospital reported on and a description of each unit if abbreviations are used
 - the dates for the 3 months that were used to collect this data for your Survey response
 - the orders that were included in the denominator
 - the orders that were included in the numerator
 - credentials of the person entering the order (nurse, physician, etc.)
- 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.

PLACE DOCUMENTATION FOR SECTION 2 AFTER THIS PAGE

[PAGE INTENTIONALLY LEFT BLANK]

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.
- Keep copies of your hospital's privileging processes and appropriateness criteria for each applicable procedure.
- 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 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 3 AFTER THIS PAGE

[PAGE INTENTIONALLY LEFT BLANK]

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

[PAGE INTENTIONALLY LEFT BLANK]

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.
- Make a note of who in your hospital 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 |
|--------------------------|--|--|--------|
| <input type="checkbox"/> | 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 | |
| <input type="checkbox"/> | 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? | <ol style="list-style-type: none"> 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 | |
| <input type="checkbox"/> | <p>Question 4: Are all critical care patients²² in each of these ICUs managed or co-managed²⁴ by one or more physicians certified in critical care medicine²⁵ who meet all of the following criteria:</p> <ul style="list-style-type: none"> • 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 Information²⁷) • supported by an on-site intensivist who establishes and revises the daily care plan for each ICU patient <p><i>If “yes” to question #4, skip question #5 and continue on to question #6. If “no,” continue on to question #5.</i></p> <p><i>If your hospital does not have any tele-intensivist coverage, or meet all three bullets in question #4, select “no” to question #4 and continue on to question #5 to report on on-site intensivist coverage.</i></p> | <p>If telemedicine service is utilized, provide:</p> <ol style="list-style-type: none"> 1) The current service agreement with telemedicine provider, which includes the features outlined in endnote 27; 2) Service agreement with on-site coverage team; 3) 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 | |

| | | | |
|--------------------------|---|--|--|
| <input type="checkbox"/> | <p>Question 5: Are all critical care patients²² in each of these ICUs managed or co-managed²⁴ by one or more physicians certified in critical care medicine²⁵ who meet all of the following criteria:</p> <ul style="list-style-type: none"> • ordinarily present²⁶ on-site in each of these ICUs during daytime hours • for at least 8 hours per day, 7 days per week • providing clinical care exclusively²⁶ in one ICU during these hours | <p>See required documentation for Question 3. Also provide hospital policy that clarifies the clinical care exclusivity for patients in the ICU.</p> | |
| <input type="checkbox"/> | <p>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 analysis²⁸ of notification device response time? (More information on the use of telemedicine to cover calls³⁰)</p> | <p>Quantitative analysis or log showing notification device response times from the latest 3 months prior to Survey submission</p> | |
| <input type="checkbox"/> | <p>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 practitioner³¹, or FCCS-certified nurse or intern “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 analysis²⁸ of notification device response time?</p> | <p>Quantitative analysis or log showing bedside response time from the latest 3 months prior to Survey submission</p> | |

ICU PHYSICIAN STAFFING (continued)

| | SURVEY QUESTION | REQUIRED DOCUMENTATION | SOURCE |
|--------------------------|---|--|--------|
| <input type="checkbox"/> | <p>Question 8: Are all critical care patients²² in each of these ICUs managed or co-managed²⁴ by one or more physicians certified in critical care medicine²⁵ who meet all of the following criteria:</p> <ul style="list-style-type: none"> ordinarily present²⁶ 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 exclusively²⁶ in one ICU during these hours? | <p>See required documentation for Question 3. Also provide hospital policy that clarifies the clinical care exclusivity for patients in the ICU.</p> | |
| <input type="checkbox"/> | <p>Question 9: Are all critical care patients²² in each of these ICUs managed or co-managed²⁴ by one or more physicians certified in critical care medicine²⁵ who meet all of the following criteria:</p> <ul style="list-style-type: none"> 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 Information³²) 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 | <p>See required documentation for Question 3. Also provide written policies and protocols as outlined in the endnotes.</p> | |
| <input type="checkbox"/> | <p>Question 10: Are all critical care patients²² in each of these ICUs managed or co-managed²⁴ by one or more physicians certified in critical care medicine²⁵ who are:</p> <ul style="list-style-type: none"> 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? | <p>See required documentation for Question 3.</p> | |

ICU PHYSICIAN STAFFING (continued)

| | SURVEY QUESTION | REQUIRED DOCUMENTATION | SOURCE |
|--------------------------|--|---|--------|
| <input type="checkbox"/> | <p>Question 11: If not all critical care patients²² are managed or co-managed²⁴ by physicians certified in critical care medicine²⁵, either on-site or via telemedicine²⁷, are some patients managed or co-managed by these physicians?</p> | <p>1) Staffing policies and ICU schedules (with hours indicated) for the latest 3 months prior to Survey submission</p> <p>2) Board certification documentation for each intensivist listed on the schedule</p> | |
| <input type="checkbox"/> | <p>9) Question 12: Does an on-site clinical pharmacist do all of the following:</p> <ul style="list-style-type: none"> • At least 5 days per week, makes daily on-site rounds on all critical care patients²² 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 analysis²⁸ of notification device response time <p>OR</p> <ul style="list-style-type: none"> • Makes daily on-site rounds on all critical care patients²² in each of these ICUs 7 days per week | <p>1) Pharmacist schedule showing ICU rounds from the latest 3 months prior to Survey submission</p> <p>2) Quantitative analysis or log showing notification device response times from the latest 3 months prior to Survey submission, if applicable</p> | |
| <input type="checkbox"/> | <p>Question 13: Does a physician certified in critical care medicine²⁵ lead daily interprofessional rounds on-site on all critical care patients²² in each of these ICUs 7 days per week?</p> | <p>ICU schedules showing interprofessional rounds from the latest 3 months prior to Survey submission</p> | |
| <input type="checkbox"/> | <p>Question 14: When physicians certified in critical care medicine²⁵ are on-site in each of these ICUs, do they have responsibility for all ICU admission and discharge decisions?</p> | <p>ICU admission and discharge policies</p> | |

PLACE DOCUMENTATION FOR SECTION 5 AFTER THIS PAGE

[PAGE INTENTIONALLY LEFT BLANK]

Section 6: Patient Safety 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.
- Make note of who in your hospital 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 stated at the beginning of each question) 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>1.1 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. board (governance) minutes reflect regular communication regarding all three of the following:</p> <ul style="list-style-type: none"> • risks and hazards (as defined by <i>Safe Practice #4, Identification and Mitigation of Risks and Hazards</i>); • culture measurement (as defined by <i>Safe Practice #2, Culture Measurement, Feedback, and Intervention</i>); and, • progress towards resolution of safety and quality problems. (p.75) | <p><i>1) Board 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, hospitals should maintain copies of dated presentations and reports related to these agenda items in order to document adherence to these elements.</i></p> <p><i>2) Chart or description of board structure.</i></p> |
| <input type="checkbox"/> | <p>b. patients 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)</p> | <p><i>Biannual/quarterly meeting notes that reflect patients and/or families of patients participating on the hospital-wide safety and quality committee.</i></p> <p><i>Note: Safety and quality committees should have influence over hospital-wide quality and safety issues, not just a particular department or service line. Meetings should be formal, and minutes should be taken. Hospitals can document adherence to this element by</i></p> |

| | | | |
|--------------------------|--|--|--|
| | | <p><i>maintaining committee rosters and meeting minutes with attendance and participation noted. Patients and/or families of patients should have the opportunity to present or co-present a topic, lead or co-lead a discussion, or co-chair the committee, and this should be noted in the meeting minutes.</i></p> | |
| <input type="checkbox"/> | <p>c. steps have been taken to report ongoing efforts to improve safety and quality in the organization and the results of these efforts to the community.</p> | <p><i>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 hospital 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.</i></p> | |
| <input type="checkbox"/> | <p>d. 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 organization. (p.75)</p> | <p><i>Reports, presentations, meeting minutes, emails or intranet page, with attendance recorded.</i></p> | |

TABLE OF CONTENTS FOR SAFE PRACTICE 1 (continued)

| SURVEY QUESTION | REQUIRED DOCUMENTATION | SOURCE |
|--|---|--------|
| <input type="checkbox"/> 1.2 Within the last 12 months, in regard to holding the board, senior administrative leadership, mid-level management, nursing leadership, 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 entire reporting period, providing oversight and alignment of safe practice activities. (p.76) | <i>Patient safety program that specifically addresses the safe practice activities</i> | |
| <input type="checkbox"/> 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) | <i>1) Documentation of PSO position - highlight information describing the PSO as the primary point of contact of the patient safety program. 2) Provide examples of reports or presentations presented to the board and meeting minutes showing communication with board and senior administrative leadership. 3) Chart or description of board structure.</i> | |
| <input type="checkbox"/> 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) | <i>Performance review templates or compensation incentives for all levels described which includes language related to identifying and reducing unsafe practices</i> | |
| <input type="checkbox"/> d. the interdisciplinary patient safety team communicated regularly with senior administrative leadership regarding all three of the following: <ul style="list-style-type: none"> • progress in meeting safety goals; • provide team training to caregivers; and, • documented these communications in meeting minutes. (pp.76-77) | <i>1) Reports or presentations to management. 2) Meeting notes/minutes with attendance noted. Meeting minutes from more than one meeting should be provided in order to reflect regular communication.</i> | |
| <input type="checkbox"/> e. the facility reported adverse events to external mandatory or voluntary programs. (p.77) | <i>Information indicating external reporting such as report or summary. If no adverse events were identified and the hospital can document that it has policies in place to report such events when they do occur (to a mandatory or voluntary program), the hospital would</i> | |

| | | | |
|--------------------------|--|--|--|
| | | <i>meet the intent of this element. Please see Section 7A Never Events for a list of adverse events and components of a Never Events Policy.</i> | |
| <input type="checkbox"/> | 1.3 Within the last 12 months, in regard to implementation of the patient safety program, the board (governance) and senior administrative leadership have provided resources to cover the implementation as evidenced by: a. dedicated patient safety program budgets that support the program, staffing, and technology investment. (p.77) | <i>Line item budget</i> | |
| <input type="checkbox"/> | 1.4 Within the last 12 months, structures and systems for ensuring that senior administrative leadership is taking direct action has been in place, 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, and reporting to the board (governance). Calendars reflect allocated time. (p.78) | <i>1) CEO and leader schedules showing “walk-arounds”, meeting minutes, etc. 2) Results of implementation of patient safety performance improvement reinforcement.</i> | |
| <input type="checkbox"/> | b. CEO has actively engaged leaders from service lines, midlevel management, nursing leadership, and physician leadership in patient safety improvement actions. (p.79) | <i>Meeting minutes with list of attendees. Hospitals can refer to the American College of Healthcare Executives professional policy statement, which includes examples of how leaders should be engaged in patient safety and quality.</i> | |
| <input type="checkbox"/> | 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) | <i>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.</i> | |

PLACE DOCUMENTATION FOR SAFE PRACTICE 1 AFTER THIS PAGE

[PAGE INTENTIONALLY LEFT BLANK]

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 stated at the beginning of each question) 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>2.1 Within the last 36 months, in regard to Culture Measurement, our organization has done the following:</p> <p>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)</p> <p><i>If item 'a' is not checked, no other items in this Practice 2 may be checked.</i></p> | <p><i>Results from culture of safety survey that show units/departments surveyed; be sure results are dated within past 36 months of submission date. Results should include participation rate.</i></p> | |
| <input type="checkbox"/> | <p>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)</p> | <p><i>Report showing both hospital-wide and unit level results; be sure report is dated</i></p> | |
| <input type="checkbox"/> | <p>c. benchmarked results of the culture survey against external organizations, such as "like" hospitals or other hospitals within the same health system.</p> | <p><i>Benchmark results and list of hospitals in the benchmark group; be sure report is dated</i></p> | |
| <input type="checkbox"/> | <p>d. compared results of the culture survey across roles and staff levels.</p> | <p><i>Culture of safety survey results comparison across roles (job types) and staff levels (hierarchy); be sure report is dated</i></p> | |
| <input type="checkbox"/> | <p>e. <u>service line, midlevel managers, or senior administrative leaders</u> used the results of the culture survey to <u>debrief</u> 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.</p> | <p><i>Meeting notes or presentation lead by local unit/patient safety leaders that reflects semi-structured approach, with attendance reflecting units</i></p> | |

[CONTINUED ON NEXT PAGE]

SAFE PRACTICE 2 (continued)

| | SURVEY QUESTION | REQUIRED DOCUMENTATION | SOURCE |
|--------------------------|--|---|--------|
| <input type="checkbox"/> | 2.2 Within the last 36 months, in regard to accountability for improvements in the measurement of the culture of safety, our organization has done the following: a. shared the results of the culture measurement survey with the board (governance) and senior administrative leadership in a formal report and discussion. (p.88) | <i>Board agenda, minutes, and/or presentation. All documentation should be dated.</i> | |
| <input type="checkbox"/> | b. included in performance evaluation criteria for senior administrative leadership, both the response rates to the survey and the use of the survey results in the improvement efforts. | <i>Performance evaluation of senior administrative leaders that reflects response rates to survey and improvement efforts</i> | |
| <input type="checkbox"/> | 2.3 Within the last 24 months, in regard to the culture of safety measurement, the organization has done the following (or has had the following in place): a. conducted staff education program(s) on methods to improve the culture of safety, tailored to the organization's survey results. | <i>Education session curriculum and sign in sheets.</i> | |
| <input type="checkbox"/> | b. included the costs of annual culture measurement/follow-up activities in the patient safety program budget. | <i>Line item budget or expenses related to culture measurement/follow-up activities</i> | |

[CONTINUED ON NEXT PAGE]

TABLE OF CONTENTS FOR SAFE PRACTICE 2 (continued)

| | SURVEY QUESTION | REQUIRED DOCUMENTATION | SOURCE |
|--------------------------|---|---|--------|
| <input type="checkbox"/> | <p>2.4 Within the last 24 months, in regard to culture measurement, feedback, and interventions, our organization has done the following (or has had the following in place):</p> <p>a. developed or implemented explicit, hospital-wide organizational policies and procedures for regular culture measurement (p.88)</p> | <i>Policies and/or examples of strategies implemented (i.e., meetings, education, events, etc.)</i> | |
| <input type="checkbox"/> | <p>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)</p> | <i>Reports or presentations to departments. Minutes and attendance record from department meetings held by senior administrative leaders.</i> | |
| <input type="checkbox"/> | <p>c. identified performance improvement interventions based on the survey results, which were shared with senior administrative leadership and subsequently measured and monitored. (p.88)</p> | <i>Dashboard of metrics, progress report, etc. showing performance improvement intervention, and meeting minutes showing attendance by senior administrative leadership</i> | |

PLACE DOCUMENTATION FOR SAFE PRACTICE 2 AFTER THIS PAGE

[PAGE INTENTIONALLY LEFT BLANK]

**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 stated at the beginning of each question) 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>9.1 Within the last 12 months, 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):</p> <p>a. held at least one educational meeting for senior administrative leadership, nursing leadership, midlevel management and service line management specifically related to the impact of nursing on patient safety. (p.155)</p> | <p><i>List of meeting attendees (showing senior administrative leadership, nursing leadership, midlevel management and service line management) and a meeting agenda for the educational meeting.</i></p> <p><i>Note: The goal of this element is to educate these specific audiences on topics such as current nurse staffing levels, rates of nursing-sensitive harms (i.e. falls, pressure ulcers), and any links found between nurse staffing (levels or competencies) and patient harms.</i></p> | |
| <input type="checkbox"/> | <p>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)</p> | <p><i>Hospital-wide risk assessment of adverse events</i></p> <p><i>Note: The goal of this element is to understand how nurse staffing, nurse work hours, nursing skill mix, and temporary nurse coverage track with the frequency and severity of adverse events in all units within the hospital. In order for a hospital to be fully aware of the extent that any patient safety issue exists within the organization, a hospital needs to review all adverse events to determine how often they occur and to establish an impact severity scale on the patient (e.g., the NCC MERP Index or other severity indexing tool). Hospitals may find it helpful to use a severity/frequency/risk assessment grid to identify where they need to place a focus on nurse staffing. This element reflects a retrospective</i></p> | |

| | | | |
|--------------------------|---|--|--|
| | | <p><i>review of patient safety events associated with nurse staffing.</i></p> <p><i>This assessment must then be reviewed by senior administrative management and the governance board at least annually to ensure that resources are allocated and performance improvement programs are implemented.</i></p> | |
| <input type="checkbox"/> | c. submitted a report to the board (governance) with recommendations for measurable improvement targets. (p.155) | <p><i>1) Report to board that shows recommendations for measurable improvement targets related to 9.1b.</i></p> <p><i>2) Chart or description of board structure.</i></p> | |
| <input type="checkbox"/> | 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) | <p><i>1) Quarterly unit-specific staffing level analysis</i></p> <p><i>2) Chart or description of board structure.</i></p> <p><i>Note: The goal of this element is to collect and analyze nurse staffing levels on each unit and to use those data for identifying the potential for an adverse event. In each unit, data should include nursing hours per patient day, as defined in the National Quality Forum report, National Voluntary Consensus Standards for Nursing-Sensitive Care: An Initial Performance Measure Set. [NQF, 2004]. This element reflects a prospective review of patient safety events associated with nurse staffing.</i></p> | |
| <input type="checkbox"/> | 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) | <i>Quarterly unit reports, minutes or notes given to senior administrative leadership and board</i> | |
| <input type="checkbox"/> | <p>9.2 Within the last 12 months, 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):</p> <p>a. held nursing leadership directly accountable for improvements in performance through performance reviews or compensation. (p. 155)</p> | <i>Performance reviews or compensation methodology for departmental/clinical leadership</i> | |
| <input type="checkbox"/> | b. included nursing leadership as part of the hospital senior administrative leadership team. (p.155) | <i>Organization chart showing senior administrative leadership team</i> | |

| | | | |
|--------------------------|---|---|--|
| <input type="checkbox"/> | <p>c. reported performance metrics related to this Safe Practice to the board (governance). (p.155)</p> | <p><i>1) Reports, minutes or notes given to board showing performance metrics related to nurse staffing levels</i> <i>2) Chart or description of board structure</i></p> | |
| <input type="checkbox"/> | <p>d. held the board (governance) and senior administrative leadership accountable for the provision of financial resources to ensure adequate nurse staffing levels. (p.155)</p> | <p><i>1) Reports, minutes or notes regarding allocation of financial resources</i> <i>2) Chart or description of board structure</i></p> | |

SAFE PRACTICE 9 (continued)

| SURVEY QUESTION | REQUIRED DOCUMENTATION | SOURCE |
|--|--|--------|
| <input type="checkbox"/> 9.3 Within the last 12 months, 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): 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) | <i>Training tools and attendance records</i> | |
| <input type="checkbox"/> b. allocated protected time for direct care staff and managers to reduce adverse events related to staffing levels or competency issues. | <i>Attendance and indication if compensated time at training events or other methods</i> | |
| <input type="checkbox"/> c. documented expenses incurred during the past year tied to quality improvement efforts around this Safe Practice. | <i>Expenses incurred and summary of how they are tied to quality improvement efforts</i> | |
| <input type="checkbox"/> d. budgeted financial resources for balancing staffing levels and skill levels to improve performance. (p.155) | <i>Line item budget and summary of how items are tied to resources for balancing staffing levels and skills levels</i> | |
| <input type="checkbox"/> e. board (governance) has approved a budget for reaching optimal nurse staffing. | <i>Meeting minutes, notes showing budget approval by governance and summary from 9.3d</i> | |
| <input type="checkbox"/> 9.4 Within the last 12 months, 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 with regular updates): a. implemented a staffing plan, with input from nurses, to ensure that adequate nursing staff-to-patient ratios are achieved. (p.154) | <i>Staffing plan that shows target nursing staff-to-patient ratios</i> <i>“A staffing plan” refers to nursing policies and procedures or a specific process used by the organization to pre-determine appropriate staffing patterns based on usual patient mix and nursing qualifications. A hospital must demonstrate full achievement of its targets.</i> | |
| <input type="checkbox"/> b. developed policies and procedures for effective staffing targets that specify number, competency and skill mix of nursing staff. (p.155) | <i>Staffing plan that shows staffing targets that specify number, competency and skill mix of nursing staff.</i> | |
| <input type="checkbox"/> 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) | <i>Performance improvement program and reports that show regular monitoring of staffing levels</i> | |

PLACE DOCUMENTATION FOR SAFE PRACTICE 9 AFTER THIS PAGE

[PAGE INTENTIONALLY LEFT BLANK]

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 (responses should be based on the practices currently in place at the time you submit this section of the Survey) 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 |
|---|---|--------|
| <i>Training and Education</i> | | |
| <p>1) Do individuals who touch patients or who touch items that will be used by patients³³ in your patient care units receive hand hygiene training from a professional with appropriate training and skills³⁴ at both:</p> <ul style="list-style-type: none"> • the time of onboarding; and • annually thereafter? <p><i>If “no” to question #1, skip questions #2-3 and continue on to question #4.</i></p> | <p><i>1) Hand hygiene educational programming document showing frequency of training (either online or in-person)</i> <i>2) Credentials of hand hygiene trainer</i></p> | |
| <p>2) In order to pass the initial hand hygiene training, do individuals who touch patients or who touch items that will be used by patients³³ in your patient care units need to physically demonstrate proper hand hygiene with soap and water and alcohol-based hand sanitizer?</p> | <p><i>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</i></p> | |
| <p>3) Are all six of the following topics included in your hospital’s initial and annual hand hygiene training?</p> <ul style="list-style-type: none"> • Evidence linking hand hygiene and infection prevention • When individuals who touch patients or who touch items that will be used by patients³³ should perform hand hygiene (e.g., WHO’s 5 Moments for Hand Hygiene, CDC’s Guideline for Hand Hygiene) • How individuals who touch patients or who touch items that will be used by patients³³ 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 • 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 | <p><i>Education session curriculum (either online or in-person) for initial and annual hand hygiene training which includes all six topics</i></p> | |

| | | |
|---|---|--|
| <ul style="list-style-type: none"> The minimum time that should be spent performing hand hygiene with soap and water and alcohol-based hand sanitizer How hand hygiene compliance is monitored | | |
| Infrastructure | | |
| <p>4) Does your hospital have a process in place to ensure that all of the following are done, as necessary, and quarterly audits are conducted on a sample of dispensers in your patient care units to ensure that the process is followed?</p> <ul style="list-style-type: none"> Refill paper towels, soap dispensers, and alcohol-based hand sanitizer dispensers when they are empty or near empty Replace batteries in automated paper towel dispensers, soap dispensers, and alcohol-based hand sanitizer dispensers (if automated dispensers are used in the patient care units) | <p><i>1) Hospital policy & procedure document that outlines policies for refilling paper towels, dispensers, and replacing batteries in automated dispensers</i></p> <p><i>2) Results from a quarterly audit showing that a sample of dispensers were checked to ensure that the following were refilled or replaced:</i></p> <ul style="list-style-type: none"> <i>- paper towels</i> <i>- soap dispensers</i> <i>- alcohol-based hand sanitizer dispensers</i> <i>- batteries in automated paper towel dispensers, soap dispensers, and alcohol-based hand sanitizer dispensers</i> | |
| <p>5) Do all rooms or bed spaces in your patient care units 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 patients³³?</p> | <p><i>Would be verified on-site through demonstration</i></p> | |
| <p>6) Does your hospital 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 in your patient care units at all of the following times:</p> <ul style="list-style-type: none"> upon installation; whenever the brand of product or system changes; and whenever adjustments are made to the dispensers? <p><i>If "no" or "does not apply, wall-mounted dispensers are not used," skip question #7 and continue on to question #8.</i></p> | <p><i>1) Hospital policy & procedure document outlining policies for conducting audits</i></p> <p><i>2) Results from an audit showing that a sample of dispensers were audited</i></p> | |
| <p>7) 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><i>Results from the audit in question #7 showing that the required volume was met (15 or more seconds for hands to dry) on all sampled dispensers</i></p> | |

| Monitoring | | |
|---|--|--|
| <p>8) Does your hospital collect hand hygiene compliance data on at least 200 hand hygiene opportunities, or 1.7% of all possible hand hygiene opportunities, each month in each patient care unit?</p> <p><i>If “yes” to question #8, skip question #9 and continue on to question #10.</i></p> | <p><i>1) Summary of monthly hand hygiene compliance data which shows at least 200 hand hygiene opportunities (or 1.7% of all possible hand hygiene opportunities) were monitored using direct observation and/or electronic compliance monitoring in all patient care units</i></p> <p><i>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 6D FAQs in the hard copy of the Survey)</i></p> | |
| <p>9) Does your hospital collect hand hygiene compliance data on at least 100 hand hygiene opportunities each quarter in each patient care unit?</p> <p><i>If “no” to question #9, skip questions #10-18 and continue on to question #19.</i></p> | <p><i>Summary of quarterly hand hygiene compliance data which shows at least 100 hand hygiene opportunities were monitored using direct observation and/or electronic compliance monitoring in all patient care units</i></p> | |
| <p>10) Does your hospital use hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will be used by patients³³ in your patient care units with feedback on both when they are and are not compliant with performing hand hygiene?</p> | <p><i>List of staff who serve as hand hygiene coaches/observers and the schedules they followed for observing/coaching</i></p> | |
| <p>Monitoring - Direct Monitoring – Electronic Compliance Monitoring System</p> <p><i>If “yes, using only an electronic compliance monitoring system” or “yes, using both an electronic compliance monitoring system and direct observation” to question #8 or question #9, answer questions #11-12.</i></p> | | |
| <p>11) In those patient care units 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"> • The system can identify both opportunities for hand hygiene and that hand hygiene was performed • The hospital itself has validated the accuracy of the data collected by the electronic compliance monitoring system | <p><i>Would be verified on-site through demonstration</i></p> | |
| <p>12) In those patient care units where an electronic compliance monitoring system is used, are direct observations also conducted for coaching and intervention purposes that meet all of the following criteria?</p> | <p><i>1) Example of direct observation template or sheet used by observers/coaches which shows:</i></p> <p><i>- if the observer/coach intervened (observer/coach</i></p> | |

| | | |
|---|--|--|
| <ul style="list-style-type: none"> • Observers immediately intervene prior to any harm occurring to provide non-compliant individuals with immediate feedback • Observations identify both opportunities for hand hygiene and compliance with those opportunities • Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct • Observations within a unit 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 patients³³ on duty for that shift • Observations capture a representative sample of the different roles of individuals who touch patients or who touch items that will be used by patients³³ (e.g., nurses, physicians, techs, environmental services workers) | <p><i>needs to intervene in all cases of noncompliance)</i></p> <ul style="list-style-type: none"> - if a hand hygiene opportunity was observed and if the individual was compliant - the role of the individual being observed - the type hand hygiene opportunity or “moment” being observed - if the individual used proper technique - date of the observation, as well as unit and shift being observed <p><i>2) Report of weekly or monthly direct observation data which shows:</i></p> <ul style="list-style-type: none"> - observations for coaching/intervention purposes were conducted for all patient care units where an electronic compliance monitoring system is used - observations within a unit were conducted weekly or monthly across all shifts and on all days of the week - observations capture a representative sample of the different roles of individuals (e.g., nurses, physicians, techs, environmental services workers) | |
|---|--|--|

Monitoring - Direct Monitoring – Direct Observation

If “yes, using only direct observation” or “yes, using both an electronic compliance monitoring system and direct observation” to question #8 or question #9, answer questions #13-14.

| | | |
|---|---|--|
| <p>13) In those patient care units where an electronic compliance monitoring system is NOT used, do the direct observations meet all of the following criteria?</p> <ul style="list-style-type: none"> • Observations identify both opportunities for hand hygiene and compliance with those opportunities • Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct • Observations within a unit 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 | <p><i>1) Example of direct observation template or sheet used by observers which shows:</i></p> <ul style="list-style-type: none"> - if a hand hygiene opportunity was observed and if the individual was compliant - the role of the individual being observed - the type hand hygiene opportunity or “moment” being observed - if the individual used proper technique - date of the observation, as well as unit and shift being observed | |
|---|---|--|

| | | |
|--|--|--|
| <p>touch items that will be used by patients³³ on duty for that shift</p> <ul style="list-style-type: none"> 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 patients³³ (e.g., nurses, physicians, techs, environmental services workers) | <p><i>2) Report of weekly or monthly direct observation data which shows:</i></p> <ul style="list-style-type: none"> <i>- observations were conducted for all patient care units that do not have an electronic compliance monitoring system</i> <i>- observations within a unit were conducted weekly or monthly across all shifts and on all days of the week</i> <i>- observations capture a representative sample of the different roles of individuals (e.g., nurses, physicians, techs, environmental services workers)</i> | |
| <p>14) Does your hospital have a system in place for both the initial and recurrent training and validation of hand hygiene compliance observers?</p> | <p><i>1) Training schedule for hand hygiene compliance observers which shows initial and recurrent training</i></p> <p><i>2) Results/documentation of regular quality monitoring of hand hygiene compliance observers (e.g., comparing results from simultaneous data collection by someone from Infection Control and a hand hygiene compliance observer)</i></p> | |
| Feedback | | |
| <p>15) Are unit-level hand hygiene compliance data fed back to individuals who touch patients or who touch items that will be used by patients³³ at least monthly for improvement work?</p> | <p><i>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.)</i></p> | |
| <p>16) Are unit-level hand hygiene compliance data used for creating unit-level action plans?</p> | <p><i>Unit-level action plans based on hand hygiene compliance data (hand hygiene compliance data should be highlighted)</i></p> | |
| <p>17) Is regular (at least every 6 months) feedback of hand hygiene compliance data, with demonstration of trends over time, given to:</p> <ul style="list-style-type: none"> senior administrative leadership, physician leadership, and nursing leadership; the board (governance); and the medical executive committee? <p><i>If “no” to question #17, skip question #18 and continue on to question #19.</i></p> | <p><i>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, the board (governance), and medical executive committee (e.g., report, handout, e-mail, etc.)</i></p> | |

| | | |
|---|---|--|
| <p>18) If “yes” to question #17, is senior administrative leadership, physician leadership, and nursing leadership held directly accountable for hand hygiene performance through performance reviews or compensation?</p> | <p><i>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.)</i></p> | |
| <p>Culture</p> | | |
| <p>19) Are patients and visitors invited to remind individuals who touch patients or who touch items that will be used by patients³³ to perform hand hygiene?</p> | <p><i>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</i></p> | |
| <p>20) Have all of the following individuals (or their equivalents) 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 patients³³)?</p> <ul style="list-style-type: none"> • Chief Executive Officer • Chief Medical Officer • Chief Nursing Officer | <p><i>Written or verbal commitments to support hand hygiene improvement dated within the last 12 months from the Chief Executive Officer, Chief Medical Officer, and Chief Nursing Officer (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</i></p> | |
| <p>Additional Questions (Fact Finding Only)</p> | | |
| <p>21) Do all rooms or bed spaces in your patient care units 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 patients³³?</p> | <p><i>Would be verified on-site through demonstration</i></p> | |

PLACE DOCUMENTATION FOR HAND HYGIENE AFTER THIS PAGE

[PAGE INTENTIONALLY LEFT BLANK]

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 hard copy of the Survey 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.
- 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

[PAGE INTENTIONALLY LEFT BLANK]

Section 8: Medication Safety

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- Review the reporting periods for this section.
- Review the questions, reference information and FAQs 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.

SECTION 8B: MEDICATION RECONCILIATION

If your hospital completed the Medication Reconciliation subsection, use the table below to record roles and responsibilities.

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.

| STEP | NAME OF PERSONNEL | TITLE/POSITION |
|---|-------------------|----------------|
| <input type="checkbox"/> Step 1: Identify Patients to Include in the Sample (Survey Coordinator) | | |
| <input type="checkbox"/> Step 2: Interview Patients and Obtain the Gold Standard Medication History (Pharmacist) | | |
| <input type="checkbox"/> Step 3: Complete a Medication Reconciliation Worksheet for each sampled patient (Pharmacist) | | |
| <input type="checkbox"/> Step 4: Compare Gold Standard Medication History to Admission Orders (Pharmacist) | | |
| <input type="checkbox"/> Step 5: Compare Gold Standard Medication History to Discharge Orders (Pharmacist) | | |
| <input type="checkbox"/> Step 6: Sum the number of medications and discrepancies (Survey Coordinator) | | |
| <input type="checkbox"/> Step 7: Contact providers if necessary (Pharmacists) | | |
| <input type="checkbox"/> Step 8: Enter data into Excel Workbook and Online Hospital Survey Tool (Survey Coordinator) | | |
| <input type="checkbox"/> Step 9: Use your hospital's results in quality improvement (Survey Coordinator and Pharmacist) | | |

PLACE DOCUMENTATION FOR SECTION 8 AFTER THIS PAGE

[PAGE INTENTIONALLY LEFT BLANK]

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.

PLACE DOCUMENTATION FOR SECTION 9 AFTER THIS PAGE

[PAGE INTENTIONALLY LEFT BLANK]

Section 10: Outpatient Procedures

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- Review the reporting time periods for this section.
- For Section 10C: Volumes of Procedures be sure to use **only** those CPT codes listed for each procedure in the Library on the [Survey Dashboard](#).
- For Section 10D: Safety of Procedures 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.
- For Section 10E: Medication Safety for Outpatient Procedures 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.
- For Section 10F: Patient Experience (OAS CAHPS) be sure to save a copy of your OAS CAHPS vendor report used to respond to the questions in this section.
- Make note of who in your hospital 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 the same reports next year.
- Be sure to print, date, label, and file any reports, policies/agreements, clinician schedules and certifications that you used for Section 10 in this section of the binder.
- If you submitted any 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.

10A: BASIC OUTPATIENT DEPARTMENT INFORMATION

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.

Transfer Policies and Agreements

| SURVEY QUESTION | REQUIRED DOCUMENTATION | SOURCE |
|---|---|--------|
| <input type="checkbox"/> Question 6: Do your hospital's separate hospital outpatient location(s) have a written transfer agreement ⁵⁰ with a pediatric or general acute care hospital for patients who require a higher level of care? | <i>Written transfer agreement</i> | |
| <input type="checkbox"/> Question 7: Whether or not your surgery center or free-standing hospital outpatient department has a written transfer agreement in place for patients who require a higher level of care, does your surgery center or free-standing hospital outpatient department have a written transfer policy ⁵¹ for emergent transfers, when there is an immediate threat to life or limb, that includes the following components: <ul style="list-style-type: none"> <input type="checkbox"/> Patient is transferred to the nearest hospital <input type="checkbox"/> Receiving facility must have an ED and/or ICU <input type="checkbox"/> Patient must be transferred within an established period of time <input type="checkbox"/> Patient's medication information must be transferred within an established period of time <input type="checkbox"/> None of the above or no written transfer policy | <i>Written transfer policy for emergent transfers that includes details for each of the answer options selected (select all that apply)</i> | |

10B: MEDICAL, SURGICAL, AND CLINICAL STAFF

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 1) dated according to the reporting period for this subsection, 2) labeled, and 3) each page is numbered. Indicate the page number in the source reference.

| SURVEY QUESTION | REQUIRED DOCUMENTATION | SOURCE |
|---|---|--------|
| <input type="checkbox"/> Question 1: Is there an Advanced Cardiovascular Life Support (ACLS) trained clinician ⁵² (regardless of ACLS training), present at all times and immediately available in the facility while an adult patient is recovering? | <p><i>1) Staffing policy that describes minimum staffing requirements;</i> <i>2) Facility staffing schedule (with hours indicated) for the latest 3 months prior to Survey submission;</i> <i>3) ACLS certification documentation for each clinician listed on the schedule</i></p> | |
| <input type="checkbox"/> Question 2: Which of the following medical, surgical, and clinical staff are required to maintain ACLS certification? <ul style="list-style-type: none"> • Anesthesiologists • Certified Registered Nurse Anesthetists (CRNAs) • Physicians • Nurses (RN or MSN) • Physician Assistants (PAs) • Nurse Practitioners (NPs) • Surgical Technicians • First Assists | <p><i>ACLS and PALS Certification Policy or job descriptions</i></p> | |
| <input type="checkbox"/> Question 3: 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 hospital outpatient department? <p><i>Hospital outpatient departments who have a physician or CRNA serving as their ACLS trained clinician in question #2 may respond "yes" to question #3 if the physician/CNRA is present until all adult patients are physically discharged from the hospital outpatient department.</i></p> | <p><i>1) Staffing policy that describes minimum staffing requirements;</i> <i>2) Facility staffing schedule for physicians or CRNAs (with hours indicated) for the latest 3 months prior to Survey submission</i></p> | |

| | | | |
|--------------------------|---|---|--|
| <input type="checkbox"/> | <p>Question 4: Is there a Pediatric Advanced Life Support (PALS) trained clinician⁵², as well as a second clinician⁵³ (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 hospital outpatient department?</p> <p><i>Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on the least intensively staffed location.</i></p> | <p>1) Staffing policy that describes minimum staffing requirements; 2) Facility staffing schedule (with hours indicated) for the latest 3 months prior to Survey submission; 3) PALS certification documentation for each clinician listed on the schedule</p> | |
| <input type="checkbox"/> | <p>Question 5: Which of the following medical, surgical, and clinical staff are required by the hospital to maintain PALS certification?</p> <ul style="list-style-type: none"> • Anesthesiologists • Certified Registered Nurse Anesthetists (CRNAs) • Physicians • Nurses (RN or MSN) • Physician Assistants (PAs) • Nurse Practitioners (NPs) • Surgical Technicians • First Assists | <p>ACLS and PALS Certification Policy or job descriptions</p> | |
| <input type="checkbox"/> | <p>Question 6: 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 hospital outpatient department?</p> <p><i>Hospital outpatient departments who have a physician or CRNA serving as their PALS trained clinician in question #5 may respond “yes” to question #6 if they physician/CRNA is present until all pediatric patients are physically discharged from the hospital outpatient department.</i></p> | <p>1) Staffing policy that describes minimum staffing requirements; 2) Facility staffing schedule for physicians or CRNAs (with hours indicated) for the latest 3 months prior to Survey submission</p> | |
| <input type="checkbox"/> | <p>Question 7: To help ensure that patients are cared for by adequately trained physicians, are those physicians who are authorized to perform procedures at your hospital outpatient department(s) board certified or board eligible?</p> <p><i>Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on all physicians who are authorized to perform the procedures listed in Section 10C at your hospital outpatient departments.</i></p> <ul style="list-style-type: none"> • All are board certified or board eligible (100%) • Most are board certified or board eligible (>=75%) • Some are board certified or board eligible (>=50%) | <p>Board certification, including expiration date, for all physicians performing procedures at facility</p> | |

| | | | |
|--------------------------|---|---|--|
| | <ul style="list-style-type: none"> Few are board certified or board eligible (<50%) None are board certified or board eligible | | |
| <input type="checkbox"/> | <p>Question 8: To help ensure that patients are cared for by adequately trained anesthesiologists and/or certified nurse anesthetists, are those providing anesthesia at your facility board certified or board eligible:</p> <ul style="list-style-type: none"> All are board certified or board eligible (100%) Most are board certified or board eligible (>=50%) Some are board certified or board eligible (<50%) None are board certified or board eligible | <p><i>Board certification, including expiration date, for all anesthesiologists and CRNAs performing procedures at facility</i></p> | |

PATIENT SELECTION AND CONSENT TO TREAT

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 |
|--|---|--------|
| <input type="checkbox"/> <p>Question 7: Do your hospital outpatient department(s) have a standard, written screening protocol to determine whether a patient's procedure can safely be performed on an outpatient basis?</p> <p><i>Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on the location with the fewest processes in place.</i></p> <p>Question 8: Which of the following components are included in your hospital outpatient department(s)' standard, written screening protocol:</p> <ul style="list-style-type: none"> <i>History of difficult intubation</i> <i>Difficult airway/aspiration risk</i> <i>Body Mass Index (BMI)</i> <i>American Society of Anesthesiologists (ASA) Physical Status Classification</i> <i>Recent Medical History (within 30 days of scheduled procedure)</i> <i>Cognitive Assessment</i> | <p><i>Facility's standard, written screening protocol</i></p> | |

| | | | |
|--------------------------|--|---|--|
| | <ul style="list-style-type: none"> • Sleep Apnea Assessment • Availability of transportation following discharge <p>Availability of a caregiver following discharge</p> | | |
| <input type="checkbox"/> | <p>Question 9: Who completes the standard, written screening protocol to determine whether a patient’s procedure can safely be performed on an outpatient basis?</p> <ul style="list-style-type: none"> • Anesthesiologist • Certified Registered Nurse Anesthetist (CRNA) • Physician • Nurse (RN or MSN) • Physician Assistant (PA) • Nurse Practitioner (NP) • Other | <p><i>Policy document outlining the patient screening process</i></p> | |
| <input type="checkbox"/> | <p>Question 10: When patients are identified through your hospital outpatient department(s)’ screening protocol as high-risk, does an anesthesiologist, certified registered nurse anesthetist, or Medical Director complete an additional medical review to determine whether a patient’s procedure can safely be performed on an outpatient basis?</p> | <p><i>Policy document outlining the patient screening process</i></p> | |
| <input type="checkbox"/> | <p>Question 11: To help ensure that patients and their families have adequate time to review and ask questions about written surgical consent materials, it’s our hospital outpatient department(s)’ policy to provide these materials to patients:</p> <p><i>Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on the location with the fewest processes in place.</i></p> <ul style="list-style-type: none"> • At least 3 days prior • 1-3 days prior • Same day • Not at all | <p><i>Policy document describing surgical consent materials (either internal document or created for patient reference)</i></p> | |
| <input type="checkbox"/> | <p>Question 12: To help ensure that patients and their families have adequate time to review and ask questions about written anesthesia consent materials, it’s our hospital outpatient department(s)’ policy to provide these materials to patients:</p> <ul style="list-style-type: none"> • At least 3 days prior • 1-3 days prior • Same day • Not at all | <p><i>Policy document describing surgical consent materials (either internal document or created for patient reference)</i></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 13) 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>Question 14: Do your hospital outpatient department(s) utilize a safe surgery checklist on every patient, every time one of the applicable procedures reported on in Section 10C is performed?</p> <p><i>Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on the location with the fewest processes in place.</i></p> | <i>Policy for surgical procedures or patient preparation</i> | |
| <input type="checkbox"/> | <p>Question 15: Does your safe surgery checklist include all of the following elements before the induction of anesthesia:</p> <ul style="list-style-type: none"> • Patient ID • Confirmation of procedure • Patient consent • Site marked • Anesthesia/medication check • Pulse ox functioning • Allergies assessed • Difficult airway/aspiration risk • Risk of blood loss, if applicable • Availability of devices on-site, if applicable? • | <i>Safe surgery checklist used by facility</i> | |
| <input type="checkbox"/> | <p>Question 16: Who leads the checklist before the induction of anesthesia?</p> <ul style="list-style-type: none"> • <i>Anesthesiologist</i> • <i>Certified Registered Nurse Anesthetist (CRNA)</i> • <i>Physician</i> • <i>Nurse (RN or MSN)</i> • <i>Physician Assistant (PA)</i> • <i>Nurse Practitioner (NP)</i> • <i>Surgical Technician</i> • <i>First Assist</i> | <i>Policy or guidelines for surgery procedures or use of safe surgery checklist, including staff roles</i> | |

| | | | |
|--------------------------|---|---|--|
| <input type="checkbox"/> | <p>Question 17: Does your safe surgery checklist include <u>all</u> of the following elements before the skin incision and/or before the procedure begins:</p> <ul style="list-style-type: none"> • Clinical team introduction • Confirmation of patient name, procedure, and, if applicable, surgical/incision site • Antibiotic prophylaxis, if applicable • Anticipated Critical Events (non-routine steps, length of procedure, blood loss, patient-specific concerns, sterility) • Equipment check/concerns • Essential imaging available • Device representative in the OR, if applicable? | <p><i>Safe surgery checklist used by facility</i></p> | |
| <input type="checkbox"/> | <p>Question 18: Who leads the checklist before the skin incision and/or before the procedure begins?</p> <ul style="list-style-type: none"> • Anesthesiologist • Certified Registered Nurse Anesthetist (CRNA) • Physician • Nurse (RN or MSN) • Physician Assistant (PA) • Nurse Practitioner (NP) • Surgical Technician • First Assist | <p><i>Policy or guidelines for surgery procedures or use of safe surgery checklist, including staff roles</i></p> | |
| <input type="checkbox"/> | <p>Question 19: Does your safe surgery checklist include an assessment, for each patient, of <u>all</u> of the following elements before the patient leaves the operating room:</p> <ul style="list-style-type: none"> • Confirmation of procedure performed • Instrument/supply counts • Specimen labeling, if applicable • Equipment concerns • Patient recovery/management concerns? | <p><i>Safe surgery checklist used by facility</i></p> | |
| <input type="checkbox"/> | <p>Question 20: Who leads the checklist before the patient leaves the operating room and/or procedure room?</p> <ul style="list-style-type: none"> • Anesthesiologist • Certified Registered Nurse Anesthetist (CRNA) • Physician • Nurse (RN or MSN) • Physician Assistant (PA) • Nurse Practitioner (NP) • Surgical Technician • First Assist | <p><i>Policy or guidelines for surgery procedures or use of safe surgery checklist, including staff roles</i></p> | |

PLACE DOCUMENTATION FOR SECTION 10 AFTER THIS PAGE

[PAGE INTENTIONALLY LEFT BLANK]