LEAPFROG

ASC SURVEY

PATIENT SAFETY AND QUALITY

2021 LEAPFROG ASC SURVEY BINDER

THELEAPFROGGROUP

TABLE OF CONTENTS

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 2021 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.
- ☐ 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
☐	**Question 6:** Does your facility have a formal teaching agreement with a training institution (e.g., academic medical center)?	Copy of teaching agreement	
☐	**Question 9:** Is your facility nationally accredited by one of the following organizations?	Copy of current accreditation certificate or letter	
☐	**Question 10:** 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?	Copy of transfer agreement	

PLACE DOCUMENTATION FOR SECTION 1 AFTER THIS PAGE

[PAGE INTENTIONALLY LEFT BLANK]

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 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
☐	**Question 1:** Is there an Advanced Cardiovascular Life Support (ACLS) trained clinician, as well as a second clinician[10] (regardless of ACLS training), present at all times and immediately available in the facility building while an adult patient is present in the facility?	***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)*** *ACLS certification documentation for certified staff*	
☐	**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 facility?	***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*	
☐	**Question 4:** Is there a Pediatric Advanced Life Support (PALS) trained clinician[10], as well as a second clinician[11](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?	***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 certified staff*	
☐	**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 facility?	***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*	
☐	**Question 7:** To help ensure that patients are cared for by adequately trained physicians, are **those**	*Board certification, including expiration date, for all physicians*	

	physicians who are authorized to perform procedures at your facility board certified or board eligible?	*performing procedures at facility*	
☐	**Question 8:** To help ensure that patients are cared for by adequately trained anesthesiologists and/or certified registered nurse anesthetists, **are those providing anesthesia** at your facility board certified or board eligible?	*Board certification, including expiration date, for all anesthesiologists and CRNAs performing procedures at facility*	

PLACE DOCUMENTATION FOR SECTION 2 AFTER THIS PAGE

[PAGE INTENTIONALLY LEFT BLANK]

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 ***only*** use those CPT codes listed for each procedure in the Library on the Survey Dashboard.
- ☐ 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 claims or other administrative data sets 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
☐	**Question 1:** Does your facility have a standard, written screening protocol to determine whether a patient's procedure can safely be performed at the facility? **Question 2:** Which of the following components are included in your facility's standard, written screening protocol?	Facility's standard, written screening protocol	
☐	**Question 5:** 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*]	Copy of informed consent policy for procedures	
☐	**Question 6:** 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*]	Copy of informed consent policy for anesthesia	

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
☐	**Question 2:** 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?	Copy of your policy for surgical procedures or patient preparation	
	Question 3: Before the induction of anesthesia, is a safe surgery checklist that includes all of the following elements read aloud in the presence of the anesthesia professional and nursing personnel: • Patient ID • Confirmation of procedure • Patient consent • Site marked, if applicable • 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?	Copy of checklist; documentation regarding **when** the checklist was read aloud and **who** was present	
☐	**Question 5: Before the skin incision and/or before the procedure begins, is a** safe surgery checklist that includes all of the following elements read aloud in the presence of the whole surgical team**:** • 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, if applicable • Device representative in the OR, if applicable?	Copy of checklist; documentation regarding **when** the checklist was read aloud and **who** was present	
☐	**Question 7: Before the patient leaves the operating room and/or procedure room,** is a safe surgery checklist that includes all of the following elements read aloud in the presence of the whole surgical team**:**	Copy of checklist; documentation regarding **when** the checklist was read	

	• Confirmation of procedure performed • Instrument/supply counts • Specimen labeling, if applicable • Equipment concerns • Patient recovery/management concerns?	aloud and **who** was present	

PLACE DOCUMENTATION FOR SECTION 3 AFTER THIS PAGE

[PAGE INTENTIONALLY LEFT BLANK]

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 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 on the Join NHSN Group webpage and include them in this binder.

  Note that Leapfrog recommends that facilities save copies of the NHSN 2020 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 **25 NQF Serious Reportable Events** AND include all 9 of Leapfrog's policy principles. Review your policy and file it in this binder.
- ☐ 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.

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
Training and Education		
Question 1: Do individuals who touch patients or who touch items that will be used by patients in your facility receive hand hygiene training from a professional with appropriate training and skills at **both**: • the time of onboarding; and • annually thereafter?	1. Hand hygiene educational programming document showing frequency of training (either online or in-person). 2. Credentials of hand hygiene trainer.	
Question 2: In order to pass the **initial** hand hygiene training, do individuals who touch patients or who touch items that will be used by patients need to physically demonstrate proper hand hygiene with soap and water and alcohol-based hand sanitizer?	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.	
Question 3: Are **all** six of the following topics included in your facility's initial and annual hand hygiene training? • Evidence linking hand hygiene and infection prevention • When individuals who touch patients or who touch items that will be used by patients 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 patients 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 *C. diff.* patients) and how hand hygiene should be performed when gloves are used • 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	Education session curriculum (either online or in-person) for initial and annual hand hygiene training which includes all **six** topics	

Infrastructure		
Question 4: Does your facility 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 to ensure that the process is followed? • 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 facility)	1) Facility policy & procedure document that outlines policies for refilling paper towels, dispensers, and replacing batteries in automated dispensers 2) Results from a quarterly audit showing that a sample of dispensers were checked to ensure that the following were refilled or replaced: - paper towels - soap dispensers - alcohol-based hand sanitizer dispensers - batteries in automated paper towel dispensers, soap dispensers, and alcohol-based hand sanitizer dispensers	
Question 5: Do **all** rooms and bed spaces in your surgical and treatment areas have • an alcohol-based hand sanitizer dispenser located at the entrance to the room or bed space; and • alcohol-based hand sanitizer dispenser(s) located inside the room or bed space that are equally accessible to all patients?	Would be verified via Leapfrog's virtual verification protocol.	
Question 6: 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 in your patient care unit at **all** of the following times: • upon installation; • whenever the brand of product or system changes; and • whenever adjustments are made to the dispensers; *OR* Has your facility conducted an audit 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 your facility's existing dispensers *if there have been no recent changes to any dispensers?*	1) Facility policy & procedure document outlining policies for conducting audits 2) Results from an audit showing that a sample of dispensers were audited	
Question 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)?	Results from the audit in question #6 showing that the required volume was met (15 or more seconds for hands to dry) on **all** sampled dispensers	

Monitoring		
Question 8: Does your facility collect hand hygiene compliance data on at least 200 hand hygiene opportunities, or at least the number of hang hygiene opportunities outlined in Table 1, **each month**?	1. Summary counts of monthly opportunities monitored which shows at least 200 hand hygiene opportunities were monitored in the facility. At a minimum, the report needs to include the month preceding the time of submission of Section 4C Hand Hygiene. 2. Historical data (e.g., past year, 6 months, 3 months etc.) showing average number of procedures in a month used to determine sample size if 200 opportunities are not being monitored (refer to sample sizes in table in the Survey).	
Question 9: Does your facility collect hand hygiene compliance data on at least 100 hand hygiene opportunities **each quarter**?	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 facility	
Question 10: 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 with feedback on both when they are and are not compliant with performing hand hygiene?	List of staff who serve as hand hygiene coaches/observers and the schedules they followed for observing/coaching	
Direct Monitoring – Electronic Compliance Monitoring System		
Question 11: 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? • The system can identify both opportunities for hand hygiene and that hand hygiene was performed • The facility itself has validated the accuracy of the data collected by the electronic compliance monitoring system	Would be verified via Leapfrog's virtual verification protocol.	
Question 12: 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 **all** of the following criteria? • 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	1) Example of direct observation template or sheet used by observers/coaches which shows: - if the observer/coach intervened (observer/coach needs to intervene in all cases of noncompliance) - if a hand hygiene opportunity was observed and if the individual was compliant - the role of the individual being observed	

• Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct • 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 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 patients (e.g., nurses, physicians, techs, environmental services workers)	- 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 2) Report of weekly or monthly direct observation data which shows: - observations for coaching/intervention purposes were conducted for **all** surgical or treatment areas where an electronic compliance monitoring system is used - observations within a surgical or treatment area 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)	
Direct Monitoring- Direct Observation		
Question 13: In those surgical or treatment areas where an electronic compliance monitoring system is NOT used, do the direct observations meet **all** of the following criteria? • 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 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 on duty for that shift • 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 (e.g., nurses, physicians, techs, environmental services workers)	1) Example of direct observation template or sheet used by observers which shows: - 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 2) Report of weekly or monthly direct observation data which shows: - observations were conducted for all surgical or treatment areas that do not have an	

	electronic compliance monitoring system - 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)	
Question 14: Does your facility have a system in place for both the initial and recurrent training and validation of hand hygiene compliance observers?	1) Training schedule for hand hygiene compliance observers which shows initial and recurrent training 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, interactive video assessments, etc.)	
Feedback		
Question 15: Are hand hygiene compliance data fed back to individuals who touch patients or who touch items that will be used by patients 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.)	
Question 16: 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)	
Question 17: Is regular (at least every 6 months) feedback of hand hygiene compliance data, with demonstration of trends over time, given to: • ASC leadership; and • ASC governance?	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.)	
Question 18: 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.)	
Culture		
Question 19: Are patients and visitors invited to remind individuals who touch patients or who touch items that will be used by patients 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	
Question 20: 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)?	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	
Additional Questions (Fact Finding Only)		
Question 21: Do **all** rooms and bed spaces in your surgical and 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?	Would be verified via Leapfrog's virtual verification protocol.	

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
☐	**1.1 Within the last 24 months, in regard to raising the awareness of key stakeholders to our facility's efforts to improve patient safety, the following actions related to identification and mitigation of risk and hazards have been taken:** a. Governance meeting minutes reflect regular communication regarding **all** three of the following: • risks and hazards (as defined by *Safe Practice 4, Identification and Mitigation of Risks and Hazards)*; • culture measurement (as defined by *Safe Practice #2, Culture Measurement*, *Feedback, and Intervention*); and, • progress towards resolution of safety and quality problems. (p.75)	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. 2) Chart or description of governance structure.	
☐	b. steps have been taken to report ongoing efforts to improve safety and quality in the facility and the results of these efforts to the community. (p.75)	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.	

☐	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)	Reports, presentations, meeting minutes, emails or intranet page, with attendance recorded.	
☐	**1.2 Within the last 24 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:** a. an integrated patient safety program has been in place for the entire reporting period providing oversight and alignment of safe practice activities. (p.76)	Patient safety program that specifically addresses the safe practice activities.	
☐	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)	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.	
☐	c. performance has been documented in performance reviews and/or compensation incentives for leadership and ASC-employed caregivers. (p.76)	Performance review templates or compensation incentives for all levels described which includes language related to identifying and reducing unsafe practices	
	d. the patient safety team, Risk Manager, or Quality Coordinator communicated regularly with leadership regarding both of the following and documented these communications in meeting minutes (p. 76-77). • progress in meeting safety goals; and • provide team training to caregivers.	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.	

☐	e. the facility reported adverse events to external mandatory or voluntary programs. (p.77)	Information indicating external reporting such as report or summary. If no adverse events were identified **and** 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.	
☐	**1.3 Within the last 24 months, in regard to implementation of the patient safety program, governance and leadership have provided resources to cover the implementation, as evidenced by:** a. dedicated patient safety program budgets to support the program, staffing, and technology investment. (p.77)	Line item budget	
☐	**1.4 Within the last 24 months, structures and systems have been in place to ensure that leadership is taking direct action, as evidenced by:** 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)	1) Leadership schedules showing "walk-arounds", meeting minutes, etc. 2) Results of implementation of patient safety performance improvement reinforcement.	
☐	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)	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.	

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
☐	**2.1** Does your facility currently have 20 or more employees?		
☐	**2.2 Within the last 36 months, in regard to culture measurement, our facility has done the following:** a. Administered one of the follow culture of safety surveys to employees: • AHRQ Survey on Patient Safety (SOPS), • Glint Patient Safety Pulse, or • Press Ganey Safety Culture Survey	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.	
☐	b. benchmarked results of the culture of safety survey against external organizations, such as "like" ASCs or other comparable facilities within the same health system.	Benchmark results and list of facilities in the benchmark group; be sure report is dated.	
☐	c. Risk Manager, Quality Coordinator, or leadership used the results of the culture of safety survey to debrief staff using semi-structured approaches for the debriefings and presenting results in aggregate form to ensure the anonymity of survey respondents.	Meeting notes or presentation lead by local patient safety leaders that reflects semi-structured approach, with attendance reflecting units	
☐	**2.3 Within the last 36 months, in regard to accountability for improvements in culture measurement, our facility has done the following:** a. shared the results of the culture of safety survey with governance and leadership in a formal report and discussion. (p.88)	Governance and leadership agenda, minutes, and/or presentation. All documentation should be dated	
☐	b. 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.	Performance evaluation of leadership that reflects response rates to survey and improvement efforts	

SAFE PRACTICE 2 (continued)

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**2.4 Within the last 24 months, in regard to culture measurement, the facility 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 facility's culture of safety survey results.	Education session curriculum and sign in sheets. Examples of documentation from personnel or administrative records.	
☐	b. included the costs of annual culture measurement/follow-up activities in the patient safety program budget.	Line item budget or expenses related to culture measurement/ follow-up activities	
☐	**2.5 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):** a. developed or implemented explicit, facility-wide organizational policies and procedures for regular culture measurement. (p.88)	Policies and/or examples of strategies implemented (i.e., meetings, education, events, etc.)	
☐	b. identified performance improvement interventions based on the culture of safety survey results, which were shared with leadership and subsequently measured and monitored. (p.88)	Dashboard of metrics, progress report, etc. showing performance improvement intervention, and meeting minutes showing attendance by leadership	
	Additional Question (Fact Finding Only)		
	2.7 What was the response rate (i.e., rate of returned surveys) among employees that were administered the culture of safety survey within the past 36 months:		

PLACE DOCUMENTATION FOR SECTION 4 AFTER THIS PAGE

[PAGE INTENTIONALLY LEFT BLANK]

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.
- ☐ 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

[PAGE INTENTIONALLY LEFT BLANK]