LEAPFROG HOSPITAL SURVEY

2021 LEAPFROG HOSPITAL SURVEY BINDER

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Overview

WHAT IS THE PURPOSE OF THIS BINDER?

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 2021 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 Leapfrog's verification protocols.

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).

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.
- ☐ 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.

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.
- ☐ Print, date, label, and file any reports that you used to respond to questions #3-4 in this binder.
- ☐ 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.

SECTION 2: CPOE - IMPLEMENTATION

To prepare for Leapfrog's monthly documentation requests, submit a performance update prior to November 30, or to run the same report next year, note exactly how you calculated the responses to questions #3-4. For each inpatient medication ordered from units that have CPOE, your report should include the following information:

- Date that each medication order was placed
- Patient status (inpatient) or inpatient unit where order was placed
    1. Note which field/column header includes this information and which values in this field/column were included in question #3 (denominator).
- Credentials of each provider who entered the medication order (e.g., RN, MD) into the CPOE system
    1. Note which field/column header includes this information and which values in this field/column were included in question #3 (denominator) and which values were excluded from question #4 (numerator).
    2. If abbreviations are used in your report, include a description of each value.
- Order mode or information that tells you how the order was placed (e.g., paper order, standard/direct CPOE, telephone with readback, verbal order, verbal order with readback, per protocol: cosign required):
    1. Note which field/column header includes this information.
    2. Note which values in this field/column were included in question #4 (numerator) and include a description of each value.
    3. Note which values in this field/column were excluded from question #4 (numerator) and include a description of each value.
- Make a note of how you used the report to determine question #3 (denominator) and question #4 (numerator).

Section 3: Adult and Pediatric Complex Surgery

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for this section.
- ☐ Use ***only*** those ICD-10 procedure and diagnosis codes, as well as CPT Codes (where applicable), listed for each procedure in the hard copy of the Survey.
- ☐ Make a note of who in your hospital provided information or ran reports for you to respond to the questions.
- ☐ If your IT team or data abstractor developed special code, scripts, or parameters to run reports for you, include a note or a copy so that you can run similar reports next year.
- ☐ 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.

SECTION 3A: HOSPITAL AND SURGEON VOLUME

Based on your responses to question #4 in Section 3A, maintain copies of your hospital's privileging processes that includes the surgeon meeting or exceeding the minimum surgeon volume standard for each procedure and appropriateness criteria for each applicable procedure. Highlight or note the relevant information.

SECTION 3B: SURGICAL APPROPRIATENESS

Based on your responses to questions #1 - 6 in Section 3B, maintain copies of meeting minutes, centers of excellence criteria, retrospective reviews of surgical cases, or any other materials that show that there are surgical appropriateness standards of care for each applicable surgery/procedure. Highlight or note the relevant information.

Section 4: Maternity Care

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for this section.
- ☐ 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 a vendor report or California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center report, file a copy of the report in this section of the binder.
- ☐ If Leapfrog is directly obtaining the data from the Vermont Oxford Network for Section 4F High-Risk Deliveries, follow the VON instructions online and save a copy of the report for verification purposes.
- ☐ 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.

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 the collection of data for this section.
- ☐ 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.

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

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**Question 1:** What is the latest 3-month reporting period for which your hospital is submitting responses to this section? 3 months ending:	Dates on documentation for this section should match response for reporting period.	
☐	**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 and indicate which ICU(s) your hospital is reporting on	
☐	**Question 3:** Do physicians certified in critical care medicine[25], when present on-site or via telemedicine, manage or co-manage[24] all critical care patients[22] in these ICUs?	1. ICU staffing schedule (with hours indicated) for the latest 3 months prior to Survey submission showing schedule for on-site intensivists/ teleintensivists 2. Staffing policy regarding patient management or co-management 3. Board certification documentation for each intensivist and/or teleintensivist listed on the schedule. 4. If meeting expanded definition of certified in Critical Care Medicine according to the **first bullet point** in endnote 25: a. List the name of the intensivist from the schedule b. Provide board certification for physician's specialty c. If the intensivist is not on the schedule for at least six weeks during the 3-month reporting period, provide additional schedule showing that at least six weeks of full-time ICU care was completed annually	

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
		5. If meeting expanded definition of certified in Critical Care Medicine according to the **second bullet point** in endnote 25 a. List the name of the intensivist from the schedule b. Provide evidence of completion of fellowship in Critical Care Medicine within the past three years 6. If meeting expanded definition of certified in Critical Care Medicine according to the **third bullet point** in endnote 25: c. List the name of the intensivist from the schedule d. Provide board certification in primary specialty (include name of the certifying board) e. Provide evidence of completion of fellowship in Critical Care Medicine (include name of certifying board) and include date of completion f. If the intensivist is not on the schedule for at least six weeks during the 3-month reporting period, provide an additional schedule showing that at least six weeks of full-time ICU care were completed annually	
☐	**Question 4:** Are all critical care patients[22] in each of these ICUs managed or co-managed[24] by one or more physicians certified in critical care medicine[25] who meet **all** of the following criteria: • ordinarily present[26] **on-site** in each of these ICUs during daytime hours • for at least **8 hours per day, 7 days per week**	1. ICU staffing schedule (with hours indicated) for the latest 3 months prior to Survey submission showing daytime schedule for on-site intensivists	

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
	• providing clinical care exclusively[26] in one ICU during these hours *If "yes" to question #4, skip question #5 and continue on to question #6. If "no," continue on to question #5.*	2. Contract with physician group, if applicable	
☐	**Question 5:** Are all critical care patients[22] in each of these ICUs managed or co-managed[24] by one or more physicians certified in critical care medicine[25] who meet **all** of the following criteria: • present via telemedicine, in combination with on-site intensivist coverage, for a total of **24 hours per day, 7 days per week** • meet all of Leapfrog's ICU requirements for intensivist presence in the ICU via telemedicine (More Information[27]) • supported by an on-site intensivist who establishes and revises the daily care plan for each ICU patient	1. ICU staffing schedule (with hours indicated) for the latest 3 months prior to Survey submission showing schedule for on-site intensivists and teleintensivists 2. The current service agreement with telemedicine provider, which includes the features outlined in endnote 27 (label each item from endnote 27), particularly the: a. Service agreement with on-site coverage team b. Written policies and protocols governing the function of the ICU (including the use of telemedicine) as outlined in the endnote c. Data link reliability reports	
☐	**Question 6:** When the physicians (from question #3) are not present in these ICUs on-site or via telemedicine, do they return more than 95% of calls/pages/texts from these units within five minutes, based on a quantified analysis[28] of notification device response time? (More information on the use of telemedicine to cover calls[30])	Quantitative analysis or log showing notification device response times from the latest 3 months prior to Survey submission. Review endnote 28 in the Survey for an example of how to complete analysis. Note (endnote 30): Hospitals that use telemedicine to cover 'calls' for the on-site intensivist are able to answer "yes" to question #6 if: (1) the telemedicine service meets all ten of the requirements outlined in endnote 27; and (2) the hospital has an 'effector'	

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
		(physician/PA/NP/FCCS certified nurse or intern) on-site during that time period to carry out the tele-intensivist's orders and can reach the ICU patient within 5 minutes, 95% of the time (see question 7).	
☐	**Question 7:** When the physicians (from question #3) are not present on-site in the ICU or not able to physically reach an ICU patient within 5 minutes, can they rely on a physician, physician assistant, nurse practitioner[31], or FCCS-certified nurse 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 analysis[28] of notification device response time?	Quantitative analysis or log showing bedside response time from the latest 3 months prior to Survey submission Review endnote 28 in the Survey for an example of how to complete analysis.	
☐	**Question 8**: Are all critical care patients[22] in each of these ICUs managed or co-managed[24] by one or more physicians certified in critical care medicine[25] who meet **all** of the following criteria: • ordinarily present[26] on-site in each of these units during daytime hours • for at least **8 hours per day, 4 days per week or 4 hours per day, 7 days per week** • providing clinical care exclusively[26] in one ICU during these hours?	1. ICU staffing schedule (with hours indicated) for the latest 3 months prior to Survey submission showing daytime schedule for on-site intensivists 2. Contract with physician group, if applicable	
☐	**Question 9:** Are all critical care patients[22] in each of these ICUs managed or co-managed[24] by one or more physicians certified in critical care medicine[25] who meet **all** of the following criteria: • present via telemedicine for **24 hours per day, 7 days per week** • meet all of Leapfrog's modified ICU requirements for intensivist presence in the ICU via telemedicine (More Information[32]) supported in the establishment and revision of daily care planning for each ICU patient by an on-site intensivist, hospitalist, anesthesiologist, or physician trained in emergency medicine	1. Staffing policy regarding patient management or co-management 2. The current service agreement with telemedicine provider, which includes the features outlined in endnote 32 (label each item from endnote 32), particularly the: a. Service agreement with on-site coverage team b. Written policies and protocols governing the function of the ICU (including the use of telemedicine)	

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
		c. Data link reliability reports	
☐	**Question 10:** Are all critical care patients[22] in each of these ICUs managed or co-managed[24] by one or more physicians certified in critical care medicine[25] who are: on-site at least **4 days per week** to establish or revise daily care plans for each critical care patient in each of these ICUs?	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 showing daytime hours of on-site intensivist 3. Board certification documentation for each intensivist listed on the schedule 4. Contract with physician group, if applicable	
☐	**Question 11:** If not all critical care patients[22] are managed or co-managed[24] by physicians certified in critical care medicine[25], either on-site or via telemedicine[27], are **some patients** managed or co-managed by these physicians?	1. Staffing policies and ICU schedules (with hours indicated) for the latest 3 months prior to Survey submission showing daytime intensivist schedule 2. Board certification documentation for each intensivist or teleintensivist listed on the schedule	
☐	**Question 12:** Does an on-site clinical pharmacist do **all** of the following: • At least 5 days per week, makes daily on-site rounds on all critical care patients[22] in each of these ICUs • On the other 2 days per week, returns more than 95% of calls/pages/texts from these units within 5 minutes, based on a quantified analysis[28] of notification device response time **OR** Makes daily on-site rounds on all critical care patients[22] in each of these ICUs 7 days per week	1. Pharmacist schedule showing ICU rounds from the latest 3 months prior to Survey submission 2. Quantitative analysis or log showing notification device response times from the latest 3 months prior to Survey submission, if applicable Review endnote 28 in the Survey for an example of how to complete analysis.	
☐	**Question 13:** Does a physician certified in critical care medicine[25] lead daily interprofessional rounds on-site on all critical care patients[22] in each of these ICUs 7 days per week?	1. ICU schedules showing interprofessional rounds from the latest 3 months prior to Survey submission	

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**Question 14:** When physicians certified in critical care medicine[25] are on-site in each of these ICUs, do they have responsibility for all ICU admission and discharge decisions?	1. ICU admission and discharge policies	

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.
- ☐ Print, date, label, and file all documentation used in this binder.
- ☐ For long documents, information (e.g., 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.

SECTION 6A: 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
☐	**1.1** Within the last 24 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: a. board (governance) 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. 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. 2. Chart or description of board structure.	
☐	b. patients and/or families of patients are active participants in the hospital-wide safety and quality committee that meets on a regularly scheduled basis (e.g., biannually or quarterly). (p.75)	Biannual/quarterly meeting minutes from **hospital-wide safety and quality committee** that reflect participation of **patients and/or families of patients**, with attendance and participation of patients/family noted. A **safety and quality committee** has influence over hospital-wide quality and safety issues (not just a particular department or service line). Topics covered should be related to broad oversight of hospital-wide patient safety and quality issues and what is being done to effect changes. An example would be tracking and preventing adverse events. **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.	

		Hospitals should identify non-Board members, non-employees to serve on the committee so the participant can represent the views of patients and without conflict.	
☐	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.	Published report for the **entire community** (e.g., 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 the NQF list of adverse events and the results of those efforts would be the measurable outcomes.	
☐	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)	Reports, presentations, meeting minutes, emails, or intranet page. If utilizing an intranet, hospitals must ensure that non-employed practitioners have access to the information.	

SAFE PRACTICE 1 (continued)

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**1.2** Within the last 24 months, in regard to holding the board, senior administrative leadership, midlevel 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)	Description of patient safety program that specifically addresses the safe practice activities. As part of accreditation through The Joint Commission, hospitals are required to meet standard LD.04.04.05, which identifies the elements that must be included in an integrated patient safety program (see pages PS-33 to PS-35 in Patient Safety Systems chapter of the CAMH). Hospitals that are not accredited by The Joint Commission can use these elements as a guide as well.	
☐	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)	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.	
☐	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)	Performance review templates or compensation incentives for board, senior administrative leadership, mid-level management, nursing leadership, physician leadership, and frontline caregivers that includes language related to identifying and reducing unsafe practices.	
☐	d. the interdisciplinary patient safety team communicated regularly with senior administrative leadership regarding **both** of the following and documented these communications in meeting minutes: • progress in meeting safety goals; and • provide team training to caregivers. (pp.76-77)	Two reports or presentations to senior administrative leadership by the **interdisciplinary patient safety team** reflecting regular communication about **team training to caregivers** (showing that it was provided) and progress in meeting safety goals.	

		Interdisciplinary patient safety team: an internal hospital committee that oversees the activities defined in the NQF Safe Practice 1 Practice Element Specifications and develops action plans to create solutions and changes in performance. **Team training to caregivers:** Hospitals can utilize TeamSTEPPS, a comprehensive, evidence-based training program for healthcare professionals. At a minimum, the elements of basic teamwork training should be met as described on page 96 of the Safe Practices for Better Healthcare– 2010 Update.	
☐	e. the hospital 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 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 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.	
☐	**1.3** Within the last 24 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)	Line-item budget or expenses specific to the Safe Practice activities. Categories in the budget do not need to specifically name the Safe Practice if they address the elements.	
☐	**1.4** Within the last 24 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”, and reporting to the board (governance). Calendars reflect allocated time. (p.78)	CEO and leader schedules showing “walk-arounds” or other ways of reinforcing patient safety improvements in various departments in real-time, and board meeting minutes reflecting results of implementation of patient safety performance improvement reinforcement.	

		Example: tracking the number of walk-arounds performed per unit or clinical area for designated time periods as shown in the calendars of the CEO and senior administrative leadership.	
☐	b. CEO has actively engaged leaders from service lines, midlevel management, nursing leadership, and physician leadership in patient safety improvement actions. (p.79)	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.	
☐	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)	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.	

SECTION 6B: 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
☐	**2.1** Within the last 36 months, in regard to culture measurement, our organization has done the following: 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 hospital and include the high patient safety risk units or departments. (p.88) *If item 'a' is not checked, no other items in this Practice #2 may be checked.*	1. Results from culture of safety survey that show units/departments surveyed and that the units/departments surveyed account for at least half of units where patients receive care. Be sure results are dated within past 36 months of submission date. 2. If an Option 3 survey was used that is not on the approved list in the Guidelines for a Culture of Safety Survey, provide documentation to show that the tool has been assessed for validity, consistency, and reliability. 3. A general employee satisfaction survey that has a small component of the survey addressing organizational culture does not qualify. However, an employee engagement survey and a nationally recognized culture of safety survey tool can be conducted at the same time if the culture of safety survey tool is unaltered and administered in its entirety.	
☐	b. portrayed the results of the culture of safety survey in a report, which reflects both hospital-wide and individual unit level results, as applicable. (p.88)	Report showing both hospital-wide and unit level results; be sure report is dated.	
☐	c. benchmarked results of the culture of safety survey against external organizations, such as "like" hospitals or other hospitals within the same health system.	Benchmark results and list of hospitals in the benchmark group with similar demographics; be sure report is dated.	

☐	d. compared results of the culture of safety survey across roles and staff levels.	Culture of safety survey results comparison across roles (job types) and staff levels (hierarchy); be sure report is dated.	
☐	e. service line, midlevel managers, or senior administrative leaders used the results of the culture of safety survey to debrief at the relevant unit level, using semi-structured approaches for the debriefings and presenting results in aggregate form to ensure the anonymity of survey respondents.	Meeting notes or presentation lead by local unit/patient safety leaders, with attendance reflecting units.	

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SAFE PRACTICE 2 (continued)

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**2.2** Within the last 36 months, in regard to accountability for improvements in culture measurement, our organization has done the following: a. shared the results of the culture of safety survey with the board (governance) and senior administrative leadership in a formal report and discussion. (p.88)	Board agenda, minutes, and/or presentation. All documentation should be dated.	
☐	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.	Performance evaluation of senior administrative leaders that reflects response rates to survey and improvement efforts.	
☐	**2.3** Within the last 24 months, in regard to culture 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 culture of safety survey results.	1. Education session curriculum and sign in sheets for all staff levels. 2. If using in-house staff educators to meet the intent, include job description. Highlight text from job description that includes the coordination and delivery of in-service training and educational sessions related to improving the culture of safety based on the organization's culture of safety survey results.	
☐	b. included the costs of annual culture measurement/follow-up activities in the patient safety program budget.	1. Line-item budget or expenses related to culture measurement/follow-up activities. 2. If the budget includes categories that address the Safe Practice but do not specifically name the Safe Practice, then the intent of the element is met.	

[CONTINUED ON NEXT PAGE]

SAFE PRACTICE 2 (continued)

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**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): a. developed or implemented explicit, hospital-wide organizational policies and procedures for regular culture measurement (p.88)	Policies and/or examples of strategies implemented e.g., meetings, education, events, etc.)	
☐	b. disseminated the results of the culture of safety 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)	Reports or presentations to departments. Minutes and attendance records from department meetings held by senior administrative leaders highlighting discussion about survey results and concerns.	
☐	c. identified performance improvement interventions based on the culture of safety survey results, which were shared with senior administrative leadership and subsequently measured and monitored. (p.88)	Dashboard of metrics, progress report, etc. showing performance improvement intervention, and meeting minutes showing attendance by senior administrative leadership.	

SECTION 6C: 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
☐	**9** Is your hospital currently recognized as an American Nurses Credentialing Center (ANCC) Magnet® organization? ☐ Yes ☐ No *If "yes," your hospital will receive full credit for this Safe Practice and no additional boxes need to be checked. If "no," please check all of the boxes that apply.*	Hospitals that are recognized as an American Nurses Credentialing Center (ANCC) Magnet® organization are listed on ANCC's website at https://www.nursingworld.org/organizational-programs/magnet/find-a-magnet-organization/	
☐	**9.1** Within the last 24 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. 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)	1. List of meeting attendees (showing senior administrative leadership, nursing leadership, midlevel management, and service line management) 2. A meeting agenda for the educational meeting that includes topics such as current nurse staffing levels, rates of nursing-sensitive harms (e.g., falls, pressure ulcers), and any links found between nurse staffing (levels or competencies) and patient harms.	
☐	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)	Retrospective hospital-wide (all units) risk assessment of **all** adverse events that includes: - Frequency of adverse events in each unit - Impact severity scale on the patient (e.g., the NCC MERP Index or other severity indexing tool) 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.	
☐	c. submitted a report to the board (governance) with recommendations for measurable improvement targets. (p.155)	1. Report to board that shows recommendations for measurable improvement targets related to 9.1b. 2. Chart or description of board structure.	
☐	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)	Quarterly nurse staffing level analysis for each unit that includes 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].	
☐	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)	Quarterly unit reports from 9.1d presented in minutes or notes given to senior administrative leadership and board that address results of risk assessment from 9.1b.	
☐	**9.2** Within the last 24 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. held nursing leadership directly accountable for improvements in performance through performance reviews or compensation. (p. 155)	Performance reviews or compensation methodology for nursing leadership (e.g., Chief Nursing Officer, Vice President/Assistant Vice President of Nursing, Vice President/Assistant Vice President for Clinical Operations, etc.). Performance review or compensation plan should include specific language about ensuring adequate and competent nursing staff service and nursing leadership at all levels.	
☐	b. included nursing leadership as part of the hospital senior administrative leadership team. (p.155)	Organization chart showing senior administrative leadership team that includes nursing leadership (e.g., Chief Nursing Officer, Vice President/Assistant Vice President of Nursing, Vice President/Assistant Vice President for Clinical Operations, etc.).	
☐	c. reported performance metrics related to this Safe Practice to the board (governance). (p.155)	1. Reports, minutes or notes given to board showing performance metrics related to nurse staffing levels.	

		2. Chart or description of board structure.	
☐	d. held the board (governance) and senior administrative leadership accountable for the provision of financial resources to ensure adequate nurse staffing levels. (p.155)	1. Reports, minutes, or notes regarding allocation of financial resources. 2. Chart or description of board structure.	

SAFE PRACTICE 9 (continued)

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**9.3** Within the last 24 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)	Training tools and attendance records.	
☐	b. allocated protected time for direct care staff and managers to reduce adverse events related to staffing levels or competency issues.	Compensated time allocations where direct care staff and managers were participating in training or education or participating in a quality improvement project aimed at reducing adverse events related to staffing levels or competency issues. Participating in meetings and huddles would not meet the intent of this practice.	
☐	c. documented expenses incurred during the reporting period tied to quality improvement efforts around this Safe Practice.	Expenses incurred and summary of how they are tied to quality improvement efforts.	
☐	d. budgeted financial resources for balancing staffing levels and skill levels to improve performance. (p.155)	Line-item budget and summary of how items are tied to resources for balancing staffing levels and skills levels.	
☐	e. board (governance) has approved a budget for reaching optimal nurse staffing.	Meeting minutes, notes showing budget approval by governance and summary from 9.3d.	
☐	**9.4** Within the last 24 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)	Staffing plan that shows target nursing staff-to-patient ratios. "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.	
☐	b. developed policies and procedures for effective staffing targets that specify number, competency and skill mix of nursing staff. (p.155)	Staffing plan that shows staffing targets that specify number, competency, and skill mix of nursing staff.	

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

SECTION 6D: 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
Training and Education		
1) Do individuals who touch patients or who touch items that will be used by patients[33] in your patient care units receive hand hygiene training from a professional with appropriate training and skills[34] at **both**: • the time of onboarding; and • annually thereafter? *If "no" to question #1, skip questions #2-3 and continue on to question #4.*	1. Hand hygiene educational programming document showing frequency of training (either online or in-person). 2. Credentials of hand hygiene trainer.	
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[33] in your patient care units 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.	
3) Are **all** six of the following topics included in your hospital'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[33] 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[33] 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. difficile* patients) and how hand hygiene should be performed when gloves are used	Education session curriculum (either online or in-person) for initial and annual hand hygiene training which includes all **six** topics.	

SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
• 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		
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? • 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)	1. Hospital 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	
5) Do **all** rooms or bed spaces in your patient care units 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 the location of all patients in the room or bed space?	Would be verified via Leapfrog's virtual verification protocol.	
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: • upon installation; • whenever the brand of product or system changes; and • whenever adjustments are made to the dispensers; OR, Has your hospital 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 hospital's existing dispensers if there have been no recent changes to any dispensers?	1. Hospital policy & procedure document outlining policies for conducting audits 2. Results from an audit showing that a sample of dispensers were audited	

SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
If "no" or "does not apply, wall-mounted dispensers are not used," skip question #7 and continue on to question #8.		
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		
8) Does your hospital collect hand hygiene compliance data on at least 200 hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3, **each <u>month</u> in each patient care unit**? *If "yes" to question #8, skip question #9 and continue on to question #10.*	1. Summary counts of monthly opportunities monitored which shows at least 200 hand hygiene opportunities were monitored in each patient care unit. At a minimum, the report needs to include the month preceding the time of submission of Section 6D Hand Hygiene and needs to list each applicable patient care unit as defined in the <u>Survey</u>. 2. Historical data (e.g., past year, 6 months, 3 months etc.) showing the average daily census, average number of procedures in a month, or average number of emergency department visits in a month and determined sample size for units where less than 200 opportunities are being monitored (refer to sample sizes in Tables 1-3 in the <u>Survey</u>). If using abbreviations, include a description of the unit included.	
9) Does your hospital collect hand hygiene compliance data on at least 100 hand hygiene opportunities **each <u>quarter</u> in each patient care unit**? *If "no" to question #9, skip questions #10-18 and continue on to question #19.*	Summary counts of quarterly opportunities monitored which shows at least 100 hand hygiene opportunities were monitored in each patient care unit. At a minimum, the report needs to include the quarter preceding the time of submission of Section 6D Hand Hygiene and needs to list each applicable patient care unit, as defined in the Survey. If using abbreviations, include a description of the unit included.	
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 patients[33] in your patient care units 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 *If "yes, using an electronic compliance monitoring system throughout all patient care units" or "yes, using an electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units" to question #8 or question #9, answer questions #11-12 based on the units that use an electronic compliance monitoring system.*		
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? • 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	Would be verified via Leapfrog's virtual verification protocol.	
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? • 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 patients[33] 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[33] (e.g., nurses, physicians, techs, environmental services workers)	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 - 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** 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)	
Direct Monitoring – Direct Observation *If "yes, using an electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units" or "yes, using only direct observation" to question #8 or question #9, answer questions #13-14 based on the units that do NOT use an electronic compliance monitoring system.*		
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? • 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 patients[33] 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[33] (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 patient care units 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)	
14) Does your hospital 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).	
	Feedback	
15) Are unit-level hand hygiene compliance data fed back to individuals who touch patients or who touch items that will be used by patients[33] 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.).	
16) Are unit-level hand hygiene compliance data used for creating unit-level action plans?	Unit-level action plans based on hand hygiene compliance data (hand hygiene compliance data should be highlighted).	
17) Is regular (at least every 6 months) feedback of hand hygiene compliance data, with demonstration of trends over time, given to: • senior administrative leadership, physician leadership, and nursing leadership; • the board (governance); and • the medical executive committee? *If "no" to question #17, skip question #18 and continue on to question #19.*	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.).	
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?	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	
19) Are patients and visitors invited to remind individuals who touch patients or who touch items that will be used by patients[33] 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.	
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 patients[33])?	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	

• Chief Executive Officer • Chief Medical Officer • 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	
Additional Questions (Fact Finding Only)		
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 patients[33]?	Would be verified via Leapfrog's virtual verification protocol.	

Section 7: Managing Serious Errors

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for each measure in 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.

SECTION 7A: THE LEAPFROG GROUP "NEVER EVENTS" POLICY STATEMENT

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'.

Review your hospital's Never Event's policy and file it in this binder.

- Ensure that the policy includes all **29 NQF Serious Reportable Events**. Hospitals may not earn credit for any of the 9 questions if they have only implemented a policy that includes the Center for Medicare and Medicaid (CMS) Never Events.

- Circle or highlight the text in the policy that relates to each of the 9 specific Never Events Policy elements (note that endnotes refer to the endnotes in the hard copy of the Survey):
    1. We apologize to the patient[36] and/or family affected by the never event[35].
    2. We report the event to at least one of the following external agencies[37] within 15 business days of becoming aware that the never event[35] has occurred:
        - Joint Commission, as part of its Sentinel Events policy
        - DNV GL Healthcare
        - State reporting program for medical errors
        - Patient Safety Organization (as defined in The Patient Safety and Quality Improvement Act of 2005)
    3. We perform a root cause analysis[38], which at a minimum, includes the elements required by the chosen external reporting agency.
    4. We waive all costs directly related to the never event[35].
    5. We make a copy of this policy available to patients, patients' family members, and payers upon request.
    6. We interview patients and/or families, who are willing and able, to gather evidence for the root cause analysis.
    7. We inform the patient and/or the patient's family of the action(s) that our hospital will take to prevent future recurrences of similar events based on the findings from the root cause analysis.
    8. We have a protocol in place to provide support for caregivers involved in never events[35] and make that protocol known to all caregivers and affiliated clinicians.
    9. We perform an annual review to ensure compliance with each element of Leapfrog's Never Events Policy for each never event[35] that occurred.

SECTION 7B: HEALTHCARE-ASSOCIATED INFECTIONS

For Section 7B: Healthcare-Associated Infections, print copies your NHSN reports for each of the 5 healthcare-associated infection measures (CLABSI, CAUTI, SSI Colon, MRSA, and C. diff) on the same day that Leapfrog downloads your hospital's data and include them in this binder. Find detailed instructions and download dates on Leapfrog's Join NHSN Group webpage.

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.
- ☐ 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 8A: BCMA - UNITS

To prepare for Leapfrog's monthly documentation requests, submit a performance update prior to November 30, or to run the same report next year, note exactly how you arrived at the responses to questions #3-11. Note that endnotes refer to the endnotes in the hard copy of the Survey.

SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
Question 3: Does your hospital operate Intensive Care Units[39] (adult, pediatric, and/or neonatal)? If "no" to question #3, skip questions #4-5 and continue on to question #6. **Question 4:** If "yes," how many of this type of unit are open and staffed in the hospital?	If yes, list all Intensive Care Units (adult, pediatric, and/or neonatal) at your hospital that were open and staffed (question #4) during the reporting period. If abbreviations for units are used, include a description of the unit.	
Question 5: How many of the units in question #4 utilized the BCMA/eMAR system when administering medications at the bedside?	List all Intensive Care Units (adult, pediatric, and/or neonatal) at your hospital that utilized the BCMA/eMAR system when administering medications at the bedside (question #5) during the reporting period.	
Question 6: Does your hospital operate Medical and/or Surgical Units[40] (including telemetry/step-down/progressive units) (adult and/or pediatric)? *If "no" to question #6, skip questions #7-8 and continue on to question #9.* **Question 7:** If "yes," how many of this type of unit were open and staffed in the hospital?	If yes, list all Medical and/or Surgical Units (including telemetry/step-down/progressive units) at your hospital that are open and staffed (question #7) during the reporting period. If abbreviations for units are used, include a description of the unit.	
Question 8: How many of the units in question #7 utilized the BCMA/eMAR system when administering medications at the bedside?	List all Medical and/or Surgical Units (including telemetry/step-down/progressive units) at your hospital that utilized the BCMA/eMAR system when administering medications at the bedside (question #8) during the reporting period.	
Question 9: Does your hospital operate a Labor and Delivery Unit[41]? If "no" to question #9, skip questions #10-11 and continue on to question #12. **Question 10:** If "yes," how many of this type of unit were open and staffed in the hospital?	If yes, list all Labor and Delivery Units at your hospital that are open and staffed (question #10) during the reporting period. If abbreviations for units are used, include a description of the unit.	
Question 11: How many of the units in question #10 utilized the BCMA/eMAR system when administering medications at the bedside?	List all Labor and Delivery Units at your hospital that utilized the BCMA/eMAR system when administering medications at the bedside	

SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
	(question #11) during the reporting period.	

SECTION 8A: BCMA - COMPLIANCE

To prepare for Leapfrog's monthly documentation requests, submit a performance update prior to November 30, or to run the same report next year, note exactly how you calculated the responses to questions #12 and #13. Save the report that includes each scannable medication (medications with a bar code) that was administered to patients in the units from questions #5, #8 and #11 in the Survey during the reporting period. The following information must be included in the report for each scannable medication in questions #12 and #13:

- Date/time the medication was administered
- Information about whether the medication was scanned prior to administration
- Information about whether the patient was scanned prior to administration (remove any PHI)

Make a note of which fields/columns in the report were used to determine the responses to questions #12 and #13.

- Date/time the scannable medication was administered:
  - Note the name of the field/column in the report where this information is included.
- Information about whether the medication was scanned prior to administration:
  - Note the name of the field/column in the report where this information is included.
  - Note the values in this column that were included in question #13 (numerator).
- Information about whether the patient was scanned prior to administration (remove any PHI):
  - Note the name of the field/column in the report where this information is included.
  - Note which values in this column were included in question #13 (numerator).

SECTION 8A: BCMA - DECISION SUPPORT

Would be verified via Leapfrog's virtual verification protocol.

SECTION 8A: BCMA - WORKAROUNDS

Question #	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
15	Which of the following mechanisms does your hospital use to reduce and understand potential BCMA system "workarounds"?		
a)	Has a formal committee that meets routinely to review data reports on BCMA system use	Meeting minutes from last committee meeting	
b)	Has back-up systems for BCMA hardware failures	Would be verified via Leapfrog's virtual verification protocol.	
c)	Has a Help Desk that provides timely responses to urgent BCMA issues in real-time	Would be verified via Leapfrog's virtual verification protocol.	
d)	Conducts real-time observations of users at the unit level using the BCMA system	Would be verified via Leapfrog's virtual verification protocol.	
e)	Engages nursing leadership at the unit level on BCMA use	Meeting minutes from last unit level meetings regarding BCMA use. Highlight related text.	
f)	In the past 12 months used the data and information obtained through items a-e to implement quality improvement projects that have focused on improving the hospital's BCMA performance. -OR- In the past 12 months used the data and information obtained through items a-e to monitor a previously implemented quality improvement project focused on improving the hospital's BCMA performance. *Cannot respond "yes" to this question, unless "yes" to either 15a, b, c, d, or e.*	Quality improvement project from last 12 months prior submission of Section 8A showing the focus on improvement in BCMA performance. Highlight related text.	
g)	In the past 12 months evaluated the results of the quality improvement projects (from f) and demonstrated that these projects have resulted in higher adherence to your hospital's standard medication administration process. -OR- In the past 12 months evaluated the results of the quality improvement projects (from f) and demonstrated continued adherence to your hospital's standard medication administration process. *Cannot respond "yes" to this question, unless "yes" to 15f*	Adherence reports from quality improvement projects from 15f showing higher/continued adherence. Highlight related text.	
h)	Communicated back to end users the resolution of any system deficiencies and/or problems that may have contributed to workarounds. *Cannot respond "yes" to this question, unless "yes" to either 15a, b, c, d, or e.*	Reports or meeting minutes showing communication back to end users. Highlight related text.	

SECTION 8B: MEDICATION RECONCILIATION

Save copies of the Med Rec Worksheets (Word documents) and Med Rec Workbook (Excel document) from the Survey and CPOE Materials webpage for your records.

Use the table below to record the individuals who participated in each data collection step outlined in the Measure Specifications starting on page 214 in the hard copy of the Survey.

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

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.
- ☐ 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 9A: PATIENT EXPERIENCE (CAHPS CHILD HOSPITAL SURVEY)

Save a copy of your vendor report used to respond to questions #1-11 in this section and highlight which responses were used.

SECTION 9B: PEDIATRIC COMPUTED TOMOGRAPHY (CT) RADIATION DOSE

Use the CT Dose Workbook on the Survey and CPOE Materials webpage to enter your hospital's data and save a copy of this workbook for your records. If your hospital is using Dose Monitoring Software or the Leapfrog-specific American College of Radiology Report to report on this measure, save a copy of that report.

If your IT team or data abstractor developed special code, scripts, or parameters to run dose reports for you, include a note or a copy so that you can run similar reports next year.

Section 10: Outpatient Procedures

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting time periods for 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.
- ☐ 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.

SECTION 10A: BASIC OUTPATIENT DEPARTMENT INFORMATION - TRANSFER POLICIES AND AGREEMENTS

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
☐	**Question 6:** Do your surgery center or free-standing hospital outpatient department have a written transfer agreement[52] with a pediatric or general acute care hospital for patients who require a higher level of care? *Hospitals with more than one surgery center or free-standing hospital outpatient department should respond based on the location with the least adherence to the written transfer agreement requirement.*	List of surgery centers or free-standing hospital outpatient departments that share your hospital's CMS Certification Number and a written transfer agreement for each.	

SECTION 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
☐	**Question 1:** Is there an Advanced Cardiovascular Life Support (ACLS) trained clinician[53], as well as a second clinician[53] (regardless of ACLS training), present at all times and immediately available in the building while an adult patient is present in the hospital outpatient department? *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.* *If "no" to question #1, skip question #2 and continue on to question #3.* *If "not applicable; pediatric patients only," skip questions #2-3 and continue on to question #4. The hospital will be scored as "Does Not Apply."*	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 each clinician listed on the schedule.	
☐	**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? *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/CRNA is present until all adult patients are physically discharged from the hospital outpatient department.*	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[53], as well as a second clinician[53] (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? *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.*	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	

	If "no" to question #4, skip question #5 and continue on to question #6. *If "not applicable; adult patients only," skip questions #5-6 and continue on to question #7. The hospital will be scored as "Does Not Apply."*	each clinician listed on the schedule.	
☐	**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? *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 the physician/CRNA is present until all pediatric patients are physically discharged from the hospital outpatient department.*	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.	

SECTION 10C: VOLUMES OF PROCEDURES

Use ***only*** those CPT codes listed for each procedure in the Library on the Survey Dashboard.

SECTION 10D: SAFETY OF PROCEDURES - PATIENT SELECTION AND PATIENT 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.

Keep a copy of the audit or report used to assess types of complications and documented admissions.

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**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? *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*.	Facility's standard, written screening protocol.	
☐	**Question 8:** Which of the following components are included in your hospital outpatient department(s)' standard, written screening protocol: ☐ *History of difficult intubation* ☐ *Difficult airway/aspiration risk* ☐ *Body Mass Index (BMI)* ☐ *American Society of Anesthesiologists (ASA) Physical Status Classification* ☐ *Recent Medical History (within 30 days of scheduled procedure)* ☐ *Cognitive Assessment* ☐ *Sleep Apnea Assessment* ☐ *Availability of transportation following discharge* ☐ *Availability of a caregiver following discharge*	Facility's standard, written screening protocol from Question 7.	
☐	**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?	Policy document outlining the patient screening process.	
☐	**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:	Copy of informed consent policy for procedures.	

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
	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. • *At least 3 days prior* • *1-3 days prior* • *Same day* • *Not at all*		
☐	**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: • At least 3 days prior • 1-3 days prior • Same day • Not at all	Copy of informed consent policy for anesthesia.	

SECTION 10D: SAFETY OF PROCEDURES - 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
☐	**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? *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.* *If "no" to question #14, skip questions #15-20 and continue on to the next subsection. The hospital will be scored as "Limited Achievement."*	Copy of your policy for surgical procedures or patient preparation.	
☐	**Question 15: 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? *If "no" to question #15, skip question #16 and continue on to question #17.*	Copy of checklist; documentation regarding **when** the checklist was read aloud and **who** was present.	
☐	**Question 17: 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	Copy of checklist; documentation regarding **when** the checklist was read aloud and **who** was present.	

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
	• 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? *If "no" to question #17, skip question #18 and continue on to question #19.*		
☐	**Question 19: 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: • Confirmation of procedure performed • Instrument/supply counts • Specimen labeling, if applicable • Equipment concerns • Patient recovery/management concerns? *If "no" to question #19, skip question #20 and continue to the next subsection.*	Copy of checklist; documentation regarding **when** the checklist was read aloud and **who** was present.	

SECTION 10E: MEDICATION SAFETY FOR OUTPATIENT PROCEDURES

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.

SECTION 10F: PATIENT EXPERIENCE (OAS CAHPS)

Save a copy of your OAS CAHPS vendor report used to respond to questions #1-13 in this section.