LEAPFROG

ASC SURVEY

PATIENT SAFETY AND QUALITY

2022 LEAPFROG ASC SURVEY BINDER

THELEAPFROGGROUP

Giant Leaps for Patient Safety

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Overview

WHAT IS THE PURPOSE OF THIS BINDER?

The Leapfrog ASC Survey Binder is available via PDF for use by all ASCs to collect, organize, and record information during the completion of the 2022 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.

1B: BILLING ETHICS

The types of documentation you should include in this binder are provided below. Only maintain documentation for those questions in which your facility responds "yes."

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**Question 1:** What pricing information is displayed on your facility's website for commonly performed procedures?	N/A	
☐	**Question 2:** Webpage URL where payer-specific negotiated charges or cash prices are displayed for consumers:	Webpage URL that displays either negotiated prices or cash prices based on response to question #1.	
☐	**Question 3:** Within 30 days of the final claims adjudication, does your facility provide every patient with a billing statement and/or master itemized bill for facility services that includes ALL the following? a. Name and address of the facility where billed services occurred b. Date(s) of service c. An individual line item for each service or bundle of services performed d. Description of services billed that accompanies each line item or bundle of services e. Amount of any principal, interest, or fees (e.g., late or processing fees), if applicable f. Amount of any adjustments to the bill (e.g., health plan payment or discounts), if applicable g. Amount of any payments already received (from the patient or any other party), if applicable h. Instructions on how to apply for financial assistance i. Instructions on how to obtain a copy of the bill in the patient's primary language j. Notification that physician services will be billed separately, if applicable	1. Facility policy or procedure outlining the timeframe for providing the billing statement or master itemized bill. 2. Copy of billing statement or master itemized bill that includes items a-j.	
	Question 4: Does your facility give patients instructions for contacting a billing representative who has the authority to do the following within 5 business days of being contacted by the patient or patient representative? a. Initiate an investigation into errors on a bill b. Review, negotiate and offer a price adjustment or debt forgiveness based on facility policy c. Establish a payment plan	1. Copy of instructions for contacting a billing representative. 2. Facility policy or procedure outlining the scope of the billing representative's responsibilities, including items a-c.	

	Question 5: Does your facility take legal action against patients for late payment or insufficient payment of a medical bill? *Patients with whom your facility has entered into a written agreement specifying a set price (not a range or estimate) for a medical service are not included in this question.*	Facility policy or procedure document that clearly indicates that the facility does not take legal action against patients for late or insufficient payment of a medical bill, unless a pre-existing written agreement specifying a set price for a medical service is in place. The definition of legal action must include at least all of the following: a lawsuit, wage garnishment, filing to take a patient's money out of their tax return, seizing or placing a lien on a patient's personal property, and selling or transferring a patient's debt to a debt collection agency that will take legal action against the patient.	

PLACE DOCUMENTATION FOR SECTION 1 AFTER THIS PAGE

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Section 2: Medical, Surgical, and Clinical Staff

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting period 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 building while an adult patient is present in the facility?	Facility staffing schedule (with hours indicated) for the latest 3 months prior to Survey submission and the ACLS certification documentation for certified staff on the schedule.	
☐	**Question 2:** 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?	Facility staffing schedule for physicians or CRNAs (with hours indicated) for the latest 3 months prior to Survey submission.	
☐	**Question 3:** Is there a Pediatric Advanced Life Support (PALS) trained clinician[10], as well as a second clinician[10](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?	Facility staffing schedule (with hours indicated) for the latest 3 months prior to Survey submission and the PALS certification documentation for certified staff on the schedule.	
☐	**Question 4:** 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?	Facility staffing schedule for physicians or CRNAs (with hours indicated) for the latest 3 months prior to Survey submission.	
☐	**Question 5:** To help ensure that patients are cared for by adequately trained physicians, are **those physicians** who are authorized to perform procedures at your facility board certified or board eligible?	Board certification documentation, including expiration date, for all physicians performing procedures at facility.	
☐	**Question 6:** 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 documentation, including expiration date, for all anesthesiologists and	

		CRNAs performing procedures at facility.	

PLACE DOCUMENTATION FOR SECTION 2 AFTER THIS PAGE

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Section 3: Volume and Safety of Procedures

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for this section.
- ☐ For Section 3A: Volume of Procedures and Section 3B: Facility and Surgeon Volume 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.

3A: VOLUME OF PROCEDURES

Use ***only*** those CPT codes listed for each procedure in the Library on the Survey Dashboard. Maintain copies of the reports your facility is using to report on the volume of adult and pediatric procedures during the reporting period.

3B: FACILITY AND SURGEON VOLUME

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.

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**Question 1:** 12-month or 24-month reporting time period used:	N/A	
☐	**Question 2:** Check all procedures that your facility performs: Total Knee Replacement Surgery Total Hip Replacement Surgery	N/A	
☐	**Question 3:** Total facility volume for each selected procedure during the reporting period:	Use only those CPT codes listed for each procedure in the Library on the Survey Dashboard. Maintain copies of the reports used to calculate total facility volume.	
☐	**Question 4:** Does your facility's privileging process include the surgeon meeting or exceeding the minimum annual surgeon volume standard listed below?	Copy of your facility's privileging process that includes the surgeon meeting or exceeding the minimum surgeon volume standard for each procedure.	

3E: SAFE SURGERY CHECKLIST FOR ADULT AND PEDIATRIC OUTPATIENT PROCEDURES

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.

	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 and 3B (if applicable) is performed?	N/A	
☐	**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 • Allergies assessed • Difficult airway/aspiration risk • Risk of blood loss, if applicable • Availability of devices on-site, if applicable?	Copy of checklist including information regarding **when** the checklist was read aloud and **who** was present.	
☐	**Question 4: 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	Copy of checklist including information regarding **when** the checklist was read aloud and **who** was present.	
☐	**Question 5: 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?	Copy of checklist including information regarding **when** the checklist was read aloud and **who** was present.	

☐	**Question 6:** Did your facility perform an audit (either in-person or via the medical record or other EHR data) on at least 15 cases of patients who underwent a procedure included in Section 3A and 3B, if applicable and measure adherence to the safe surgery checklist?	Copy of the completed Safe Surgery Checklist Workbook (available on the Survey Materials webpage).	
☐	**Question 7:** Based on your facility's audit (either in-person or via the medical record or other EHR data) on at least 15 cases of patients who underwent an applicable procedure included in Section 3A and 3B, what was your facility's documented rate of adherence to the safe surgery checklist (e.g., what percentage of the sampled cases had all elements in questions #3, #4, and #5 completed)?	Copy of the completed Safe Surgery Checklist Workbook (available on the Survey Materials webpage).	

PLACE DOCUMENTATION FOR SECTION 3 AFTER THIS PAGE

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Section 4: Patient Safety Practices

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for this section.
- ☐ Make a note of who in your ASC provided information or ran reports for you to respond to the questions.
- ☐ Be sure to print, date, label, and file reports that you used for this section of the binder.
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4A: MEDICATION SAFETY: MEDICATION AND ALLERGY DOCUMENTATION

Use the Medical Safety Documentation Workbook on the Survey Materials webpage to enter your data and save a copy of the workbook for your records.

4B: NHSN OUTPATIENT PROCEDURE COMPONENT MODULE

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 2021 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. Download the NHSN Guidance Document on the Join NHSN Group webpage for instructions.

4C: 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.

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 above 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 the location of all patients in the room or bed space?	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 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 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 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, 1.0 mL of alcohol-based hand sanitizer OR a volume of alcohol-based 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 (1.0 mL of alcohol-based hand sanitizer or a volume that requires 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. Report showing **summary** counts of monthly opportunities monitored which shows at least 200 hand hygiene opportunities were monitored in the facility (or the number outlined based on the table in the Survey). At a minimum, the report needs to include the month preceding the time of submission of Section 4C Hand Hygiene. The facility should also have a process in place to ensure they can continue to meet the requirement moving forward. 2. For facilities where less than 200 opportunities are being monitored (refer to sample sizes in table in the Survey): - historical data used (e.g., past year, 6 months, 3 months etc.) showing the average number of procedures in a month; and - determined sample size that was used (based on sample sizes in the table in the Survey).	
Question 9: Does your facility collect hand hygiene compliance data on at least **100** hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined in Table 2, **each month**?	1. Report showing **summary** counts of monthly opportunities monitored which shows at least 100 hand hygiene opportunities were monitored in the facility (or the number outlined based on the table in the Survey). At a minimum, the report needs to include the month preceding the time of submission of Section 4C Hand Hygiene. The facility should also have a process in place to ensure they can continue to meet the requirement moving forward. 2. For facilities where less than 200 opportunities are being	

	monitored (refer to sample sizes in table in the Survey): - historical data used (e.g., past year, 6 months, 3 months etc.) showing the average number of procedures in a month; and - determined sample size that was used (based on sample sizes in the table in the Survey).	
Question 10: Does your facility collect hand hygiene compliance data on at least **100** hand hygiene opportunities **each quarter**?	1. Report showing **summary** counts of quarterly opportunities monitored which shows at least 100 hand hygiene opportunities were monitored in the facility. At a minimum, the report needs to include the quarter (or most recent 3 months) preceding the time of submission of Section 4C Hand Hygiene. The facility should also have a process in place to ensure they can continue to meet the requirement moving forward.	
Question 11: 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 12: 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 13: 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	1) Example of direct observation template or sheet (electronic or paper copy) used by observers/coaches which shows: - if the observer/coach intervened (observer/coach needs to intervene in all cases of noncompliance) - the date as well as the start and end time of the	

• 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 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)	observation session (or the date and shift being observed) - the area where the observation session is being conducted - the role of the individual being observed (e.g., nurse, physician, etc.) - the indication (or moment) for performing hand hygiene that is observed (e.g., before/after touching a patient, before/after a procedure, before/after touching patient surroundings, etc.) - whether hand hygiene was performed or not performed based on the indication noted **and** if the technique was correct. 2) Report showing a **summary** of weekly or monthly direct observation data (or description) 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 (i.e., a summary of observation counts by day of week and observation counts by shift for each unit OR a description of how this is accomplished) - observations capture a representative sample of the different roles of individuals, e.g., nurses, physicians, techs, environmental services workers (i.e., a summary of observation counts by role OR a description of how this is accomplished).	
Direct Monitoring- Direct Observation		

Question 14: 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: - the date as well as the start and end time of the observation session (or the date and shift being observed) - the area where the observation session is being conducted - the role of the individual being observed (e.g., nurse, physician, etc.) - the indication (or moment) for performing hand hygiene that is observed (e.g., before/after touching a patient, before/after a procedure, before/after touching patient surroundings, etc.) - whether hand hygiene was performed or not performed based on the indication noted **and** if the technique was correct. 2) Report showing a **summary** of weekly or monthly direct observation data (or description) 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 (i.e., a summary of observation counts by day of week and observation counts by shift for each unit OR a description of how this is accomplished) - observations capture a representative sample of the different roles of individuals, e.g., nurses, physicians, techs, environmental services workers (i.e., a summary of observation counts by role OR a description of how this is accomplished).	

Question 15: 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 16: 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 17: 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 18: 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 ASC leadership and ASC governance (e.g., report, handout, e-mail, etc.).	
Question 19: If "yes" to question #18, is ASC leadership held directly accountable for hand hygiene performance through performance reviews or compensation?	Performance reviews or compensation methodology for ASC 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 20: 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 21: 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 22: 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?	N/A	

4D: NQF SAFE PRACTICE 1:
CULTURE OF SAFETY LEADERSHIP STRUCTURES & SYSTEMS

The types of documentation you should include in this binder are provided below. Only maintain documentation for those safe practice elements that your facility checked the box for. Ensure that each document is dated according to the reporting period.

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**1.1 Within the last 12 months, in regard to raising the awareness of key stakeholders to our facility's efforts to improve patient safety, the following actions related to the identification and mitigation of risks 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 12 months, in regard to holding governance and leadership directly accountable for results related to the identification and**	Patient safety program that specifically addresses the safe practice activities.	

	mitigation of risks and hazards, 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)		
☐	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 (pp. 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 12 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 12 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.	

4D: NQF SAFE PRACTICE 2:
CULTURE MEASUREMENT, FEEDBACK & INTERVENTION

The types of documentation you should include in this binder are provided below. Only maintain documentation for those safe practice elements that your facility checked the box for. Ensure that each document is dated according to the reporting period.

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**2.1** Does your facility currently have 20 or more employees?		
☐	**2.2 Within the last 24 months, in regard to culture measurement, our facility has done the following:** a. Administered one of the following 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 34 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 24 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 culture of safety survey and the use of the culture of safety 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 12 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 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 12 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?	N/A	

4E: NEVER EVENTS POLICY

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 the policy includes all **25 NQF Serious Reportable Events**. ASCs may not earn credit for any of the 9 questions if their policy does not include all 25 NQF Serious Reportable Events.

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**Question 1:** We apologize to the patient and/or family affected by the never event.	Copy of policy with relevant language highlighted.	
☐	**Question 2:** We report the event to at least one of the following external agencies within 15 business days of becoming aware that the never event has occurred: • State reporting program for medical errors • Patient Safety Organization (as defined in The Patient Safety and Quality Improvement Act of 2005) • Accreditation Organizations (i.e., TJC, AAAHC, AAAASF, HFAP, etc.)	Copy of policy with relevant language highlighted.	
☐	**Question 3:** We perform a root cause analysis which at a minimum, includes the elements required by the chosen external reporting agency.	Copy of policy with relevant language highlighted.	
☐	**Question 4:** We waive all costs directly related to the never event.	Copy of policy with relevant language highlighted.	
☐	**Question 5:** We make a copy of this policy available to patients, patients' family members, and payers upon request.	Copy of policy with relevant language highlighted.	
☐	**Question 6:** We interview patients and/or families who are willing and able, to gather evidence for the root cause analysis.	Copy of policy with relevant language highlighted.	
☐	**Question 7:** We inform the patient and/or the patient's family of the action(s) that our facility will take to prevent future recurrences of similar events based on the findings from the root cause analysis.	Copy of policy with relevant language highlighted.	
☐	**Question 8:** We have a protocol in place to provide support for caregivers involved in never events and make that protocol known to all caregivers and affiliated clinicians.	Copy of policy with relevant language highlighted.	

☐	**Question 9:** We perform an annual review to ensure compliance with each element of Leapfrog's Never Events Policy for each never event14 that occurred.	Copy of policy with relevant language highlighted.	

PLACE DOCUMENTATION FOR SECTION 4 AFTER THIS PAGE

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Section 5: Patient Experience (OAS CAHPS)

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for this section.
- ☐ Review the questions and reference information for this section with anyone who is going to help you collect this data.
- ☐ Be sure to save a copy of your OAS CAHPS vendor report used to respond to the questions in this section.
- ☐ If you submitted any questions on this section to the Leapfrog Help Desk, print copies of your response (i.e., tickets) and save them under this tab for future reference.

PLACE DOCUMENTATION FOR SECTION 5 AFTER THIS PAGE

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