2024 LEAPFROG HOSPITAL SURVEY BINDER

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Overview

WHAT IS THE PURPOSE OF THIS BINDER?

The Leapfrog Hospital Survey Binder is available for use by all hospitals to collect, organize, and record information collected while completing the 2024 Leapfrog Hospital Survey. This document can be printed and placed in a binder or stored electronically. 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, including Leapfrog's monthly documentation requests.

The Binder only includes sections and subsections from the 2024 Leapfrog Hospital Survey that are both scored and publicly reported. Sections of the 2024 Leapfrog Hospital Survey that are not scored or publicly reported are not included in this Binder (i.e., Section 2B: EHR Application Information).

HOW SHOULD WE USE THIS BINDER?

This binder is meant to be used as a tool to help collect, organize, and record information that you used to complete your Leapfrog Hospital Survey, so that you can be prepared to respond to Leapfrog's Data Verification messages and requests for documentation. More information about Leapfrog's pre- and post-submission protocols for ensuring data accuracy our available on our website.

Nothing in this 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.

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Section 1: Patient Rights and Ethics

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

☐ Review the reporting period for this section.

☐ Read the questions and FAQs in Section 1B Billing Ethics, Section 1C Health Care Equity, and Section 1D Informed Consent in the hard copy of the Survey to ensure that you understand the criteria for each question before you respond to the questions.

☐ Save any reports that you used for this section in the binder.

☐ Make a note of who in your hospital obtained copies of policies, billing statements, consent forms or reports used to respond to questions.

☐ If you submitted any questions on this section to the Leapfrog Help Desk, save the responses (i.e., tickets) in 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 which your hospital responded "yes" or "only upon request." 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 Source and applicable page number(s) used in the Source column.

Survey Question	Response	Required Documentation	Source

1) Within 30 days of the final claims adjudication (or within 30 days from date of service for patients without insurance), does your hospital provide every patient, either by mail or electronically (via email or the patient portal), 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 performed;
  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, if applicable ;
	○ Yes
	○ No
	○ Only upon request
		1. Hospital policy or procedure outlining the timeframe for providing the billing statement or master itemized bill
		
		2. Copy or sample of billing statement or master itemized bill that includes items a-j.	

Survey Question	Response	Required Documentation	Source
i. Instructions in the patient's preferred language on how to obtain a written translation or oral interpretation of the bill; and j. Notification that physician services will be billed separately, if applicable? *If any one of the elements above are only provided upon request, select "Only upon request." If any one of the elements above are not ever provided, select "No."*			
2) Does your hospital give patients instructions for contacting a billing representative: • Who has access to an interpretation service to communicate in the patient's preferred language, **and** • Who has the authority to do all the following within 10 business days of being contacted by the patient or patient representative: i. initiate an investigation into errors on the bill, ii. offer a price adjustment or debt forgiveness based on hospital policy, and iii. offer a payment plan	○ Yes ○ No	1. Copy of instructions for contacting a billing representative 2. Hospital policy or procedure outlining the scope of the billing representative's responsibilities, including items i-iii 3. Evidence that billing representatives have access to an interpretation service, such as a vendor contract or agreement	
3) Does your hospital take legal action against patients for late payment or insufficient payment of a medical bill? *This question does not include patients with whom your hospital has entered into a written agreement specifying a good faith estimate for a medical service.*	○ Yes ○ No	Policy or procedure document that clearly indicates legal action is not taken against patients for late or insufficient payment of a medical bill, <u>unless a pre-existing written agreement specifying a good faith estimate for a medical service is in place</u>. The definition of legal action, must at a minimum, include 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	

Survey Question	Response	Required Documentation	Source
		transferring a patient's debt to a debt collection agency that will take legal action against the patient. Note that other legal proceedings where patients may be named as defendants for causes other than late or non-payment of a medical bill are not included in this question (e.g., filing a lien after an auto accident, or misappropriation of an insurance reimbursement).	

SECTION 1C: HEALTH CARE EQUITY

The types of documentation you should include in this binder are provided below. Only provide documentation for those questions in 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 Source and applicable page number(s) used in the Source column.

Survey Question	Response	Required Documentation	Source
1) Which of the following **patient self-identified** demographic data does your hospital collect **directly from its patients** (**or patient's legal guardian)** prior to or while registering a patient for a hospital visit? *Select all that apply.* *If "none of the above," skip the remaining questions in Section 1C and continue to the next subsection. The hospital will be scored as "Limited Achievement."*	☐ Race ☐ Ethnicity ☐ Spoken language preferred for healthcare (patient or legal guardian) ☐ Written language preferred for healthcare (patient or legal guardian) ☐ Sexual orientation ☐ Gender identity ☐ None of the above	1. A template registration form or screenshot of patient portal form where demographic information is collected. 2. A copy of a script that clearly demonstrates staff ask patients/legal guardians about the demographic information your hospital collects.	
2) Does your hospital train staff responsible for collecting the self-identified demographic data either in-person or over the phone from patients (or patient's legal guardian) in question #1 at both: • the time of onboarding, and • annually thereafter?	○ Yes ○ No	1. Copy of online or in-person training curriculum. 2. Policy indicating when personnel are required to take the training.	
3) Does your hospital use the patient self-identified demographic data it collects directly from patients (or patient's legal guardian) in question #1 to stratify any quality measure(s) with the aim of identifying health care disparities? *If "no" to question #3, skip questions #4-5 and continue to question #6.* 4) By stratifying the quality measure(s) from question #3, has your hospital identified any health	○ Yes ○ No	Copy of stratified quality measure results. If your submitted stratified Cesarean Birth data in Section 4B, no additional documentation is required for this question. Note: Leapfrog defines health care disparities as differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.	

Survey Question	Response	Required Documentation	Source
care disparities among its patients? *If "no, disparities were not identified" or "inadequate data available to determine if disparities exist" to question #4, skip question #5 and continue to question #6.*	○ Yes, disparities were identified ○ No, disparities were not identified ○ Inadequate data available to determine if disparities exist		
5) In the past 12 months, has your hospital used the data and information obtained through question #4 to update or revise its policies or procedures? OR In the past 12 months, has your hospital developed a written action plan that describes how it will address at least one of the health care disparities identified through question #4?	○ Yes ○ No	Copy of updated policy or procedure or written action plan based on stratified measure results from question #3-4.	
6) Does your hospital share information on its efforts to identify and reduce health care disparities based on *race, ethnicity, spoken language preferred for healthcare (patient or legal guardian), written language preferred for healthcare (patient or legal guardian), sexual orientation, or gender identity* and the impact of those efforts on its public website?	○ Yes ○ No	Link (URL) to webpage that displays hospital efforts to reduce health care disparities and the impact of those efforts. The webpage could include quantitative or qualitative data. It may also include a description of the types of demographic data collected and the analyses performed, which in some cases demonstrated no apparent health care disparities. Please note that the information on your webpage should be easily accessible. If your hospital is part of a health system, you must provide a link to the system webpage from your hospital's individual website.	
7) Does your hospital report out and discuss efforts related to identifying and addressing	○ Yes ○ No	Copy of board meeting minutes demonstrating discussion and updates of hospital efforts to address	

Survey Question	Response	Required Documentation	Source
disparities with the Board at least annually?		disparities, which shows attendance of board.	

SECTION 1D: INFORMED CONSENT

The types of documentation you should include in this binder are provided below. Only provide documentation for those questions in which your hospital responded "yes" or "yes, all forms are written at a 6th grade reading level or lower" or "at least one form is written at a 6th grade reading level or lower" or "No, all applicable forms are written at a 9th grade reading level or lower". 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 Source and applicable page number(s) used in the Source column.

Policies and Training

Survey Question	Response	Required Documentation	Source
1) Does your hospital have a training program on informed consent that tailors different training topics to different staff roles, including hospital leaders, MD/NP/PA, nurses and other clinical staff, administrative staff, and interpreters, and has your hospital made the training: • a required component of onboarding for the appropriate newly hired staff, and • required for the appropriate existing staff who were not previously trained?	○ Yes ○ No	1. Slide deck or content from LMS modules used in training 2. Hospital policy indicating when personnel are required to take the training	
2) At least once a year, does your hospital solicit feedback from patients/legal guardians about your hospital's informed consent process to understand how it can be improved over time? *This question is required but response will not be scored or publicly reported in 2024.*	○ Yes ○ No	N/A (not scored in 2024)	

Content of Informed Consent Forms

Survey Question	Response	Required Documentation	Source
3) As part of your hospital's process for obtaining informed consent, does: • the clinician explain expected difficulties, recovery time, pain management, and restrictions after a procedure that may be experienced by the patient either in the facility or post-discharge, if applicable; • the patient have the opportunity to ask questions; and • the consent form document that these two elements of the process have taken place?	○ Yes ○ No	A template consent form that includes places to document all the elements outlined in the question	
4) Do ALL applicable consent forms used by your hospital include: • the name(s) of the clinician(s) performing the procedure; • whether the clinician is expected to be absent from portions of the procedure (e.g., opening, closing), if applicable; and • whether any assistants or trainees will be involved in the procedure, if applicable?	○ Yes ○ No	A template consent form that includes places to document all the elements outlined in the question	
5) Are ALL applicable consent forms used by your hospital written at a 6th grade reading level or lower? *The procedure name and description, and any words accompanied by a plain language definition can be excluded from the reading level assessment.*	○ Yes, all applicable forms are written at a 6th grade reading level or lower ○ No, but at least one form is written at a 6th grade reading	Copy of consent form(s) for applicable procedures. The results of the reading level assessment, which can be performed in Microsoft Word using the following instructions: (1) on the "File" tab, click the "Options" button; (2) on the "Proofing" tab, under "When correcting spelling and grammar in Word," select the "Show readability statistics" check box. Exit the window.	

Survey Question	Response	Required Documentation	Source
	level or lower o No forms are written at a 6th grade reading level or lower o No, all applicable forms are written at a 9th grade reading level or lower	Then, under the Review tab in your Word document, click the "Editor" button in the far left corner of the ribbon, then click "Insights – Document Stats" on the "Editor" sidebar: Word displays a message box showing you the Flesch-Kincaid readability grade-level: any value less than or equal to 6.9 is considered a "sixth-grade" reading level. Reading level can also be assessed using online tools, such as those provided at Readable.com, provided those tools use either the Flesch-Kincaid or SMOG readability standard to evaluate the readability of written language.	

Process for Gaining Informed Consent

Survey Question	Response	Required Documentation	Source
6) Prior to the informed consent discussion, does your hospital: • ask what the patient/legal guardian's preferred language for medical decision-making is; • where needed, provide the patient/legal guardian access to a qualified medical interpreter, **NOT a family caregiver;** • use a consent form or notation in the medical record to document whether a qualified medical interpreter was used to conduct the informed consent process; and • have the medical interpreter sign the consent form (either in-person,	o Yes o No	1. A template consent form that includes a space for the medical interpreter to sign or a copy/screenshot of an example medical record the use of an interpreter has been clearly documented 2. Copy of policy or other document (such as a registration form or informed consent training curriculum) that clearly demonstrates staff always ask patients/legal guardian's about their preferred language for medical decision-making 3. Evidence that those performing the informed consent have access to qualified medical interpreters or an interpretation service, such as a vendor contract or agreement	

Survey Question	Response	Required Documentation	Source
electronically, or by documenting the use of an interpreter in the medical record)?			
7) As part of the informed consent discussion, do clinicians at your hospital use the "teach back method" with patients/legal guardians where patients/legal guardians are asked to describe in their own words what they understand will be performed, why it will be performed, and what are the primary risks?	o Yes o No	Copy of policy or informed consent training curriculum that clearly demonstrates that clinicians are trained and required to use the teach back method with patients during the informed consent process.	

Section 2: Medication Safety

SECTION 2A: COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE)

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

☐ Review the reporting period for this section.

☐ Review the questions, reference information, endnotes, and FAQs 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.

☐ Save all reports that you used to respond to questions #3-4 and make sure they are dated and labeled.

☐ 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.

☐ If you submitted questions on this section to the Leapfrog Help Desk, save the responses (i.e., tickets) in this tab for future reference.

Maintain a copy of the report your hospital used to respond to questions #3 and #4 in Section 2A. Hospitals selected for Leapfrog's Monthly Documentation Request for this measure will be asked to submit a report that should include the following information:

- A list of all inpatient units at the hospital, including inpatient units that do not have a functioning CPOE system.
- 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).
- Date that each medication order was placed
- Credentials of each provider who entered the medication order (e.g., RN, MD):
    1. Note which field/column header includes this information and which values in this field/column were included and excluded in question #4 (numerator)
    2. If abbreviations are used in your report, include a description of each value.
    3. Make a note of which clinicians are authorized by your state to order medications for patients.
- 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.
- A description of how your hospital used the report to determine the responses to question #3 (denominator) and question #4 (numerator).

SECTION 2C: BAR CODE MEDICATION ADMINISTRATION (BCMA)

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

☐   Review the reporting period for this section.

☐   Review the questions, reference information, endnotes, and FAQs 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 medication administrations should be included in questions #15-16.

☐   Save all reports that you used to respond to questions #15-16.

☐   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.

☐   If you submitted questions on this section to the Leapfrog Help Desk, save the responses (i.e., tickets) in this this tab for future reference.

BCMA - Units

The types of documentation you should include in this binder are provided below.

Hospitals selected for [Leapfrog's Monthly Documentation Request](#) for this measure will be asked to submit documentation that should include the information in the table below. Only maintain documentation for those questions in this subsection 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 Source and applicable page number(s) used in the Source column.

Survey Question	Response	Required Documentation	Source
1) What is the latest 3-month reporting period for which your hospital is submitting responses to questions #2-18? 3-month reporting period ending:	_____ *Format: Month/Year*	Dates on documentation for this section should match response for reporting period.	
2) Does your hospital use a Bar Code Medication Administration (BCMA) system that is linked to the electronic medication administration record (eMAR) when administering medications at the bedside in at least one of the following units: • Intensive Care Units (adult, pediatric, and/or neonatal), • Medical and/or Surgical Units (including telemetry/step-down/progressive units) (adult and/or pediatric), • Labor and Delivery Unit, or • Pre-operative and Post-anesthesia Care Units (adult and/or pediatric)? *If "no" to question #2, skip questions #3-18 and continue to the next subsection. The hospital will be scored as "Limited Achievement."*	○ Yes ○ No	If yes, provide documentation for each unit type as outlined below for questions #3-14.	
3) Does your hospital operate Intensive Care Units (adult, pediatric, and/or neonatal)? *If "no" to question #3, skip questions #4-5 and continue to question #6.*	○ Yes ○ No	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.	
4) If "yes," how many of this type of unit are open and staffed in the hospital?	_____		
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 during the reporting period.	

6) Does your hospital operate <u>Medical and/or Surgical Units (including telemetry/step-down/progressive units)</u> (adult and/or pediatric)? *If "no" to question #6, skip questions #7-8 and continue to question #9.*	○ Yes ○ No	If yes, list all Medical and/or Surgical Units (including telemetry/step-down/progressive units) at your hospital that were open and staffed (question #7) during the reporting period. If abbreviations for units are used, include a description of the unit.	
7) If "yes," how many of this type of unit were open and staffed in the hospital?	_____		
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 during the reporting period.	
9) Does your hospital operate a <u>Labor and Delivery Unit</u>? *If "no" to question #9, skip questions #10-11 and continue to question #12.*	○ Yes ○ No	If yes, list all Labor and Delivery Units at your hospital that were open and staffed (question #10) during the reporting period. If abbreviations for units are used, include a description of the unit.	
10) If "yes," how many of this type of unit were open and staffed in the hospital?	_____		
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 during the reporting period.	
12) Does your hospital operate <u>Pre-operative and Post-anesthesia Care Units</u> (adult and/or pediatric)? *If "no" to question #12, skip questions #13-14 and continue to question #15.*	○ Yes ○ No	If yes, list all Pre-operative and Post-anesthesia Care Units (adult and/or pediatric) at your hospital that were open and staffed (question #13) during the reporting period. If abbreviations for units are used, include a description of the unit.	
13) If "yes," how many of this type of unit are open and staffed in the hospital?	_____		
14) How many of the units in question #12 utilized the BCMA/eMAR system when administering medications at the bedside?	_____	List all Pre-operative and Post-anesthesia Care Units (adult and/or pediatric) at your hospital that utilized the BCMA/eMAR system when administering medications at the bedside during the reporting period.	

The types of documentation you should include in this binder are provided below.

Hospitals selected for Leapfrog's Monthly Documentation Request for this measure will be asked to submit the report used to respond to question #15 and #16. The report should include each scannable medication (medications with a bar code) that was administered to patients in the units reported on in questions #5, #8, #11 and #14 (see previous page).

The report must include the following information for each scannable medication included in questions #15 and #16:

- Date/time the medication was administered
- Patient care unit where 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 #15 and #16.

- o Date/time the scannable medication was administered:
    - Note the name of the field/column in the report where this information is included.
- o Patient care unit where medication was administered:
    - Note the name of the field/column in the report where this information is included.
    - If this is not included in your vendor report, instead describe the parameters that were used to include medication administrations from the applicable patient care units in the report.
- o 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 #16 (numerator).
- o 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 #16 (numerator).

BCMA - Decision Support

Hospitals should review the FAQs in the [hard copy of the Survey](#) related to decision support and ensure the decision support functionality is in place prior to responding to this section of the Survey.

Survey Question		Response	Required Documentation	Source
17) What types of decision support does your hospital's BCMA system provide to users of the system?			See below.	
a)	Wrong patient	o Yes o No	Would be verified via Leapfrog's [on-site verification protocol](#).	
b)	Wrong medication	o Yes o No	Would be verified via Leapfrog's [on-site verification protocol](#).	
c)	Wrong dose	o Yes o No	Would be verified via Leapfrog's [on-site verification protocol](#).	
d)	Wrong time (e.g., early/late warning; warning that medication cannot be administered twice within a given window of time)	o Yes o No	Would be verified via Leapfrog's [on-site verification protocol](#).	
e)	Second nurse check needed	o Yes o No	Would be verified via Leapfrog's [on-site verification protocol](#).l	

BCMA - Workarounds

The types of documentation you should include in this binder are provided below.

Hospitals selected for Leapfrog's Monthly Documentation Request for this measure will be asked to submit documentation that should include the information outlined below. Only maintain documentation for those questions in this subsection 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 Source and applicable page number(s) used in the Source column.

Survey Question	Response	Required Documentation	Source
18) Which of the following mechanisms does your hospital use to reduce and understand potential BCMA system "workarounds"?		See below.	
a) Has a formal committee that meets routinely to review data reports on BCMA system use	o Yes o No	Meeting minutes from last committee meeting	
b) Has back-up systems for BCMA hardware failures	o Yes o No	Would be verified via Leapfrog's on-site verification protocol.	
c) Has a Help Desk that provides timely responses to urgent BCMA issues in real-time	o Yes o No	Would be verified via Leapfrog's on-site verification protocol.	
d) Conducts real-time observations of users at the unit level using the BCMA system	o Yes o No	Would be verified via Leapfrog's on-site verification protocol.	
e) Engages nursing leadership at the unit level on BCMA use	o Yes o No	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	o Yes o No	Quality improvement project from last 12 months prior to the submission of Section 2C showing the focus on improvement in BCMA performance. Highlight related text.	

Survey Question	Response	Required Documentation	Source
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 18d or 18e.*			
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 18f.*	○ Yes ○ No	Adherence reports from quality improvement projects from 18f 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 ○ No	Reports or meeting minutes showing communication back to end users. Highlight related text.	

Survey Question	Response	Required Documentation	Source
"yes" to either 18d or 18e.			

Use the Med Rec Worksheets (Word document) and Med Rec Workbook (Excel document) on the <u>Survey and CPOE Materials</u> webpage to enter your hospital's data and save a copy of BOTH the worksheets and workbook for your records.

Section 3: Adult and Pediatric Complex Surgery

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

☐ Review the reporting periods for this section.

☐ For Section 3A, **only** use 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 and CPT Code Workbook (available via the Online Survey Tool).

☐ For Section 3A, if your hospital participates in the Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database (ACSD) and submitted data for all applicable procedures, include a copy of the report for the most recent 36-month period for which performance reports are available. The report should contain your hospital's Mitral Valve Repair/Replacement Composite Score.

☐ For Section 3A, if your hospital participates in the Society of Thoracic Surgeons (STS) Congenital Heart Surgery Database (CHSD) and submitted data for the Norwood procedure, include a copy of the report for the most recent 48-month period for which performance reports are available.

☐ 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.

☐ Save reports that you used for this section.

☐ If you submitted questions on this section to the Leapfrog Help Desk, save the responses (i.e., tickets) in this tab for future reference.

SECTION 3A: HOSPITAL AND SURGEON VOLUME

Maintain reports used to calculate total volume for each procedure selected in question #2 for the selected reporting period. In addition, based on your responses to question #5 in Section 3A, maintain copies of your hospital's criteria for privileging surgeons that includes the specific procedure (as defined using the ICD-10 and CPT procedure codes) and minimum annual surgeon volume standard for each procedure. Highlight or note the relevant information.

SECTION 3B: SAFE SURGERY CHECKLIST FOR ADULT AND PEDIATRIC COMPLEX SURGERY

The types of documentation you should include in this binder are provided below. <u>Ensure that each document is 1) dated according to the reporting period for this subsection, 2) labeled, and 3) each page is numbered.</u> Indicate the Source and applicable page number(s) used in the Source column.

Survey Question	Response	Required Documentation	Source
1) What is the latest 12-month reporting period for which your hospital is submitting responses to questions #2-9? 12-month reporting period ending:	_____ *Format: Month/Year*	N/A	
2) Does your hospital utilize a safe surgery checklist on <u>every</u> patient <u>every</u> time one of the applicable procedures in Section 3A is performed? *If "no" to question #2, skip the remaining questions in Section 3B and go to the Affirmation of Accuracy. The hospital will be scored as "Limited Achievement."*	o Yes o No	N/A	
3) **Before the induction of anesthesia**, is a safe surgery checklist that includes <u>all</u> the following elements <u>read aloud</u> in the presence of the <u>anesthesia professional and nursing personnel</u>: • Patient ID; • Confirmation of procedure; • Patient consent; • Site marked, if applicable; • Anesthesia/medication check; • Allergies assessed; • Difficult airway/aspiration risk; • Risk of blood loss (only applicable if risk of blood loss is >500ml for adults or > 7ml/kg for children); and • Availability of devices (applicable to endoscopy procedures only)?	o Yes o No	Copy of checklist that includes each element in the question and information regarding **when** the checklist was read aloud and **who** was present.	
4) **Before the skin incision and/or before the procedure begins**, is a safe surgery checklist that includes <u>all</u> the following elements <u>read aloud</u> in the presence of the whole surgical team**:** • Clinical team introduction;	o Yes o No	Copy of checklist that includes each element in the question and information regarding **when** the checklist was read aloud and **who** was present.	

Survey Question	Response	Required Documentation	Source
• Confirmation of patient name, procedure, and, if applicable, surgical/incision site; • Antibiotic prophylaxis, if applicable; • Anticipated Critical Events (i.e., non-routine steps, length of procedure, blood loss, patient-specific concerns, sterility); • Equipment check/concerns; and • Essential imaging available, if applicable?			
5) **Before the patient leaves the operating room and/or procedure room**, is a safe surgery checklist that includes <u>all</u> the following elements <u>read aloud</u> in the presence of the whole surgical team: • Confirmation of procedure performed; • Instrument/supply counts; • Specimen labeling, if applicable; • Equipment concerns; and • Patient recovery/management concerns?	○ Yes ○ No	Copy of checklist that includes each element in the question and information regarding **when** the checklist was read aloud and **who** was present.	
If "no" to question #3, #4, or #5, skip the remaining questions in Section 3B, and go to the Affirmation of Accuracy. The hospital will be scored as "Limited Achievement." *Hospitals performing the audit in Section 3B question #6 and the audit in Section 9D question #6 should audit 15 cases who underwent a procedure included in Section 3A and 15 cases who underwent a procedure included in Section 9C. Hospitals only performing the audit in Section 3B question #6 and not in Section 9D question #6 should audit 30 cases who underwent a procedure included in Section 3A.*			
6) Did your hospital perform an audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 3A and measure adherence to the safe surgery checklist? *Free-standing pediatric hospitals that perform the Norwood Procedure and hospitals that reported a combined total*	○ Yes ○ No	N/A	

Survey Question	Response	Required Documentation	Source
hospital volume of less than the sufficient sample for all the procedures in Section 3A can sample any patients that had a procedure performed under general anesthesia. *If "no" to question #6, skip the remaining questions in Section 3B and go to the Affirmation of Accuracy. The hospital will be scored as "Limited Achievement."*			
7) How many cases were included in the audit from question #6?	_____	N/A	
8) Which method was used to perform the audit on a sufficient sample in question #6?	○ In-person observational audit ○ Retrospective audit of medical records or EHR data ○ Both	N/A	
9) Based on your hospital's audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 3A, what was your hospitals 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)?	○ 90%-100% ○ 75%-89% ○ 50%-74% ○ Less than 50%	**For Observational Audits:** A copy of the checklist or observation sheet used to perform the safe surgery checklist audit. The checklist or observation sheet must clearly document (a) which elements were read aloud, when each element was read aloud, and who was present. Provide **complete** checklists for each sampled patients. **For Retrospective Chart Audits:** Provide screenshots from the medical record or chart that clearly demonstrate (a) which elements were read aloud, when each element was read aloud, and who was present for each sampled patients.	

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.

☐ Review the questions, reference information, endnotes, and FAQs for this section with anyone who is assisting with the collection of data.

☐ 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.

☐ If you used a vendor report or California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center or Michigan Obstetrics Initiative (OBI) 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 4E High-Risk Deliveries, follow the VON instructions online and save a copy of the report for verification purposes.

☐ Save reports that you used for subsections 4A-4E in this binder.

☐ If you submitted questions on this section to the Leapfrog Help Desk, save the responses (i.e., tickets) in this tab for future reference.

Section 5: ICU Physician Staffing

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

☐ Review the reporting period for this section.

☐ Read the questions, endnotes, and FAQs in Section 5 of the hard copy of the Survey with anyone who is going to assist with the collection of data for this section and 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.

☐ Save 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, save the responses (i.e., tickets) in this tab for future reference.

The types of documentation you should include in this binder are provided below.

Hospitals selected for <u>Leapfrog's Monthly Documentation Request</u> for this measure will be asked to submit documentation that should include the information in the table below. Only maintain documentation for those questions in this section for which your hospital responded "yes." <u>Ensure that each document is 1) dated according to the reporting period for this subsection, 2) labeled, and 3) each page is numbered.</u> Indicate the Source and applicable page number(s) used in the Source column.

Survey Question	Response	Required Documentation	Source
1) What is the latest 3-month reporting period for which your hospital is submitting responses to this section? 3 months ending:	_____ *Format: Month/Year*	Dates on documentation for this section should match response for reporting period.	
2) Does your hospital operate any adult or pediatric general medical and/or surgical ICUs or neuro ICUs? *If your hospital has more than one applicable ICU, respond to all questions in this section based on the ICU that has the lowest level of staffing by physicians certified in critical care medicine.* *If your hospital does not operate an applicable ICU but regularly admits critical care patients to non-critical care or mixed acuity units, select "yes" and respond to the remaining questions in Section 5.* *If "no" to question #2, skip the remaining questions in Section 5 and go to the Affirmation of Accuracy. The hospital will be scored as "Does Not Apply."*	○ Yes ○ No	Provide a list and description of all ICUs at your hospital. Include staffing levels of intensivists for each and indicate which ICU your hospital is reporting on. *Hospitals should report on the ICU with the lowest level of staffing by physicians certified in critical care medicine.*	
3) Is the ICU staffed with physicians who are certified in critical care medicine and present on-site or via telemedicine? *If "no" to question #3, skip the remaining questions in Section 5 and go to the Affirmation of Accuracy. This hospital will be scored as "Limited Achievement."*	○ Yes, the ICU is staffed with physicians certified in critical care medicine ○ Yes, the ICU is staffed with	1. ICU staffing schedule (with hours indicated) for the latest 3 months prior to Survey submission showing schedule for on-site intensivists/ tele-intensivists 2. Board certification documentation for each intensivist and/or tele-intensivist listed on the schedule. 3. If meeting expanded definition of certified in	

Survey Question	Response	Required Documentation	Source
	physicians certified in critical care medicine based on Leapfrog's expanded definition ○ No, the ICU is not staffed with any physicians certified in critical care medicine	Critical Care Medicine according to the **first bullet point** in endnote 36: 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 4. If meeting expanded definition of certified in Critical Care Medicine according to the **second bullet point** in endnote 36 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 5. If meeting expanded definition of certified in Critical Care Medicine according to the **third bullet point** in endnote 36: a. List the name of the intensivist from the schedule b. Provide board certification in primary specialty (include name of the certifying board) c. Provide evidence of completion of fellowship in Critical Care Medicine (include name of certifying board) and include date of completion d. If the intensivist is not on the schedule for at least six weeks during the 3-month reporting period, provide an additional	

Survey Question	Response	Required Documentation	Source
		schedule showing that at least six weeks of full-time ICU care were completed annually	
4) Do the physicians who are certified in critical care medicine (whether present on-site or via telemedicine) manage or co-manage all critical care patients in the ICU? *If "no" to question #4, skip questions #5-11 and continue to question #12.*	○ Yes, all patients are managed or co-managed by a physician certified in critical care medicine when the physician is present (on-site or via telemedicine) ○ No, not all patients are managed or co-managed by a physician certified in critical care medicine when the physician is present (on-site or via telemedicine)	Staffing policy regarding patient management or co-management	
*There are currently <u>two different options</u> to achieve Leapfrog's ICU Physician Staffing Standard: on-site intensivist coverage for 8 hours a day/7 days per week or 24/7 tele-intensivist coverage with some daily on-site intensivist coverage. Questions #5 and #6 are meant to differentiate between these two options; however, they are both worth the same credit. Hospitals that have 24/7 **on-site** intensivist coverage, and who meet all the criteria listed, should respond "yes" to question #5.*			

Survey Question	Response	Required Documentation	Source
5) Are all critical care patients in the ICU managed or co-managed by one or more physicians certified in critical care medicine who meet all the following criteria: • ordinarily present on-site in the ICU during daytime hours; • for at least 8 hours per day, 7 days per week; and • providing clinical care exclusively in the ICU during these hours? *If "yes" to question #5, skip question #6 and continue to question #7.*	○ Yes ○ No	ICU staffing schedule (with hours indicated) for the latest 3 months prior to Survey submission showing daytime schedule for on-site intensivists	

6) Are all critical care patients in the ICU managed or co-managed by one or more physicians certified in critical care medicine who meet **all** 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 and
• supported by an on-site intensivist who establishes and revises the daily care plan for each ICU patient?
	○ Yes
	○ No
		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 38 (label each item from endnote 38), 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	

If "no" to question #5 and question #6, skip questions #7-8 and continue to question #9.			

Survey Question	Response	Required Documentation	Source

7) When the physicians (from question #3) are not present in the ICU 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 of notification device response time?	○ Yes
	○ No
	○ Not applicable; intensivists are present on-site 24/7
		Quantitative analysis or log showing notification device response times from the latest 3 months prior to Survey submission. Review endnote 39 in the Survey for an example of how to complete analysis.
		
		For hospitals that use tele-intensivists to cover calls (see endnote 41 in the Survey):
		1. ICU staffing schedule (with hours indicated) for the latest 3 months prior to Survey submission showing schedule for on-site intensivists and tele-intensivists
		
		2. The current service agreement with telemedicine provider, which includes the features outlined in endnote 41 (label each item from endnote 41), 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 endnotes
		   c. Data link reliability reports	

8) 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, or FCCS-certified nurse or intern "effector" 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 of response time of the effector reaching the patient?	○ Yes ○ No ○ Not applicable; intensivists are present on-site 24/7	Quantitative analysis or log showing bedside response time from the last year. Review endnote 39 in the Survey for an example of how to complete analysis.	
If "no" to either question #7 or #8 in this section, continue to questions #9-15. If "yes" or "not applicable; intensivists are present on-site 24/7" to questions #7 and #8, skip the remaining questions in Section 5.			

Survey Question	Response	Required Documentation	Source
9) Are all critical care patients in the ICU managed or co-managed by one or more physicians certified in critical care medicine who meet **all** the following criteria: • ordinarily present on-site in the ICU during daytime hours; • for at least 8 hours per day, 4 days per week or 4 hours per day, 7 days per week; and • providing clinical care exclusively in the ICU during these hours?	○ Yes ○ No	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 schedule for on-site intensivists	

10) Are all critical care patients in the ICU managed or co-managed by one or more physicians certified in critical care medicine who meet all 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; and
• 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?
	○ Yes
	○ No
		1. Staffing policy regarding patient management or co-management
		2. The current service agreement with telemedicine provider, which includes the features outlined in endnote 43 (label each item from endnote 43), 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)
		  c. Data link reliability reports	

11) Are all critical care patients in the ICU managed or co-managed by one or more physicians certified in critical care medicine who are: • on-site at least 4 days per week to establish or revise daily care plans for each critical care patient in the ICU?	○ Yes ○ No	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	
If "yes" to question #9, #10, or #11, skip question #12 and continue to question #13.			

Survey Question	Response	Required Documentation	Source
12) If not all critical care patients are managed or co-managed by physicians certified in critical care medicine, either on-site or via telemedicine, are some critical care patients managed or co-managed by these physicians who are: • ordinarily present on-site in the ICU during daytime hours; • for at least **8 hours per day, 4 days per week or 4 hours per day, 7 days per week**; and • providing clinical care exclusively in the ICU during these hours?	○ Yes ○ No	1. Staffing policy regarding patient management or co-management 2. ICU schedules (with hours indicated) for the latest 3 months prior to Survey submission showing daytime intensivist schedule 3. Board certification documentation for each intensivist or teleintensivist listed on the schedule	
13) Does an on-site clinical pharmacist do all the following: • at least 5 days per week, makes daily on-site rounds on all critical care patients in the ICU; and • on the other 2 days per week, returns more than 95% of calls/pages/texts from the unit within 5 minutes, based on a quantified analysis of notification device response time; **OR** • makes daily on-site rounds on all critical care patients in the ICU 7 days per week?	○ Yes ○ No ○ Clinical pharmacist rounds 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 39 in the Survey for an example of how to complete analysis.	
14) Does a physician certified in critical care medicine lead daily interprofessional rounds on-site on all critical care patients in the ICU 7 days per week?	○ Yes ○ No	ICU schedules showing interprofessional rounds from the latest 3 months prior to Survey submission	
15) Are physicians certified in critical care medicine responsible for all ICU admission and discharge decisions when they are: • present on-site for at least **8 hours per day, 4 days per week or 4 hours per**	○ Yes ○ No	1) ICU staffing schedule (with hours indicated) for the latest 3 months prior to Survey submission 2) ICU admission and discharge policies	

Survey Question	Response	Required Documentation	Source
day, 7 days per week?			

Section 6: Patient Safety Practices

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for this section.

- ☐ Review the instructions for reporting on Section 6 in the hard copy of the Survey.

- ☐ Review the FAQs in Section 6 of the hard copy of the Survey to ensure that you understand the criteria for each question.

- ☐ Save 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, save the responses (i.e., tickets) in this tab for future reference.

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The types of documentation you should include in this binder are provided below.

Page numbers throughout this subsection refer to the NQF Safe Practices for Better Healthcare – 2010 Update report, not this document.

Hospitals selected for Leapfrog's Monthly Documentation Request for this measure will be asked to submit documentation that should include the information in the table below. Only maintain documentation for those safe practice elements where 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 Source and applicable page number(s) used in the Source column.

Survey Question	Response	Required Documentation	Source
1.1 Within the last 12 months, in regard to raising the awareness of key stakeholders to our organization's efforts to improve patient safety, the following actions related to the identification and mitigation of risks 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)	○ Yes ○ No	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)	○ Yes ○ No	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	

Survey Question	Response	Required Documentation	Source
		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.	○ Yes ○ No	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)	○ Yes ○ No	Reports, presentations, meeting minutes, emails, or intranet page. If utilizing an intranet, hospitals must ensure that non-employed practitioners have access to the information.	

Survey Question	Response	Required Documentation	Source
1.2 Within the last 12 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 the identification and mitigation of risks and hazards, 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.03.09.01, which identifies the elements that must be included in an integrated patient safety program (see pages PS-28 to PS-30 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. 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 senior administrative leadership, mid-level management, nursing leadership, physician leadership, and frontline caregivers that includes language related to the identification and	

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Survey Question	Response	Required Documentation	Source
		mitigation of risks and hazards.	
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. **I**nterdisciplinary 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	

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Survey Question	Response	Required Documentation	Source
		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 12 months, in regard to implementation of the patient safety program, the board (governance) and senior administrative leadership have provided resources to cover the implementation as evidenced by:			
a. dedicated patient safety program budgets that support the program, staffing, and technology investment. (p.77)		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 12 months, structures and systems for ensuring that senior administrative leadership is taking direct action has been in place, as evidenced by:			
a. CEO and senior administrative leadership are personally engaged in reinforcing patient safety improvements, e.g., "walk-arounds", 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	

Survey Question	Response	Required Documentation	Source
		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: NQF SAFE PRACTICE #2 – CULTURE MEASUREMENT, FEEDBACK & INTERVENTION

The types of documentation you should include in this binder are provided below.

Page numbers throughout this subsection refer to the NQF Safe Practices for Better Healthcare – 2010 Update report, not this document.

Hospitals selected for Leapfrog's Monthly Documentation Request for this measure will be asked to submit documentation that should include the information in the table below. Only maintain documentation for those safe practice elements where 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	Response	Required Documentation	Source
2.1 Within the last 24 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 "no" to question 2.1a, skip the remaining questions in Section 6B and continue to the next subsection. The hospital will be scored as "Limited Achievement."*	○ Yes ○ No	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 24 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, please contact the Leapfrog Help Desk as a form must be completed in order for the survey to be reviewed by the expert panel. 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.	

Survey Question	Response	Required Documentation	Source
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)	o Yes o No	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.	o Yes o No	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.	o Yes o No	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.	o Yes o No	Meeting notes or presentation lead by local unit/patient safety leaders, with attendance reflecting units.	
2.2 Within the last 24 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)	o Yes o No	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.	o Yes o No	Performance evaluation of senior administrative leaders that reflects response rates to survey and improvement efforts.	
2.3 Within the last 12 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.	o Yes o No	1. Education session curriculum and sign in sheets for all staff levels. 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.	o Yes o No	1. Line-item budget or expenses related to culture measurement/follow-up activities.	

Survey Question	Response	Required Documentation	Source
		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.	
2.4 Within the last 12 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)	○ Yes ○ No	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)	○ Yes ○ No	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)	○ Yes ○ No	Dashboard of metrics, progress report, etc. showing performance improvement intervention, and meeting minutes showing attendance by senior administrative leadership.	

SECTION 6C: NURSING WORKFORCE

Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, and Nursing Skill Mix

Maintain a copy of the report your hospital used to respond to questions #1-14 in Section 6C. Hospitals selected for Leapfrog's Monthly Documentation Request for this measure will be asked to submit a report that should include the following information:

- Nursing database that was used to collect data for the report, if applicable (NDNQI, PatientCareLink or other database)
- Method used to calculate the total number of patient days for each unit type
  - Method options are: midnight census, patient days from actual hours, patient days from multiple census reports, or midnight census and patient days from actual hours for short stay patients)
- Total number of patient days for each month or quarter during the reporting period for each unit type
- Total productive hours worked by employed and contract nursing staff with direct patient care responsibilities (RN, LPN/LVN, and UAP) by each unit type for each month or quarter during the reporting period
- Total number of productive hours worked by RN nursing staff with direct patient care responsibilities by each unit type for each month or quarter during the reporting period

The types of documentation you should include in this binder are provided below.

Hospitals selected for <u>Leapfrog's Monthly Documentation Request</u> for this measure will be asked to submit documentation that should include the information in the table below. Only maintain documentation for those safe practice elements where your hospital responded "yes." <u>Ensure that each document is 1) dated according to the reporting period for this subsection, 2) labeled, and 3) each page is numbered.</u> Indicate the page number in the source reference.

Survey Question	Response	Required Documentation	Source
15) Is your hospital currently recognized as an American Nurses Credentialing Center (ANCC) Magnet® organization or a 2020 or 2024 Pathway to Excellence® organization? ☐ Yes, our hospital is a current American Nurses Credentialing Center (ANCC) Magnet® organization ☐ Yes, our hospital is a 2020 Pathway to Excellence® organization ☐ No *If "yes, our hospital is a current American Nurses Credentialing Center (ANCC) Magnet® organization" or "yes, our hospital is a 2020 Pathway to Excellence® organization," skip question #16, and continue to question #17.* *Pathway to Excellence® hospitals that have not received the 2020 designation must select "no."*	○ Yes, our hospital is a current American Nurses Credentialing Center (ANCC) Magnet® organization ○ Yes, our hospital is a 2020 Pathway to Excellence® organization ○ No	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/ Hospitals that are recognized as a Pathway to Excellence® organization are listed on ANCC's website at https://www.nursingworld.org/organizational-programs/pathway/find-a-pathway-organization/	
16) Within the last 12 months, to ensure adequate and competent nursing staff service and nursing leadership at all levels, our organization has:			
a. held nursing leadership directly accountable for improvements in performance through performance reviews or compensation.	○ Yes ○ No	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.	○ Yes ○ No	Organization chart showing senior administrative leadership team that includes nursing	

Survey Question	Response	Required Documentation	Source
		leadership (e.g., Chief Nursing Officer, Vice President/Assistant Vice President of Nursing, Vice President/Assistant Vice President for Clinical Operations, etc.).	
c. held the board (governance) and senior administrative leadership accountable for the provision of financial resources to ensure adequate nurse staffing levels.	○ Yes ○ No	1. Reports, minutes, or notes regarding allocation of financial resources. 2. Chart or description of board structure.	
d. budgeted financial resources for balancing staffing levels and skill levels to improve performance.	○ Yes ○ No	Line-item budget and summary of how items are tied to resources for balancing staffing levels and skills levels.	
e. developed a staffing plan, with input from nurses, to ensure that adequate nursing staff-to-patient ratios are achieved.	○ Yes ○ No	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.	

Nursing Workforce - Percentage of RNs who are BSN-Prepared

Maintain a copy of the report your hospital used to respond to questions #17-19 in Section 6C. Hospitals selected for Leapfrog's Monthly Documentation Request for this measure will be asked to submit a report that should include the following information:

- Unit type and description
- Total number of employed RN nursing staff at the hospital with direct patient care responsibilities during the reporting period

Total number of employed RN nursing staff at the hospital with direct patient care responsibilities who have a BSN degree or higher (e.g., MSN, DNP, PhD)

SECTION 6D: HAND HYGIENE

The types of documentation you should include in this binder are provided below.

Hospitals selected for Leapfrog's Monthly Documentation Request for this measure will be asked to submit documentation that should include the information in the table below. Only maintain documentation for those questions in this subsection 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 Source and applicable page number(s) used in the Source column.

Training and Education

Survey Question	Response	Required Documentation	Source
1) Do individuals who touch patients or who touch items that will be used by patients in your patient care units receive hand hygiene training from a professional with appropriate training and skills at **both:** • the time of onboarding, and • annually thereafter? *If "no" to question #1, skip questions #2-3 and continue to question #4.*	o Yes o No	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 in your patient care units need to physically demonstrate proper hand hygiene with soap and water and alcohol-based hand sanitizer?	o Yes o No	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 or description of computer-based assessment used for physical demonstration and report showing completion for new individuals.	
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 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	o Yes o No	Education session curriculum (either online or in-person) for initial and annual hand hygiene training which includes all **six** topics.	

Survey Question	Response	Required Documentation	Source
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; and • How hand hygiene compliance is monitored?			

Infrastructure

Survey Question	Response	Required Documentation	Source
4) Does your hospital conduct quarterly audits on a sample of dispensers in your patient care units to ensure all the following: • Paper towels, soap dispensers, and alcohol-based hand sanitizer dispensers are refilled when they are empty or near empty; and • Batteries in automated paper towel dispensers, soap dispensers, and alcohol-based hand sanitizer dispensers (if automated dispensers are used in the patient care units) are replaced?	○ Yes ○ No	1. Hospital policy or 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 and 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?	○ Yes ○ No	Would be verified via Leapfrog's on-site verification protocol.	

Survey Question	Response	Required Documentation	Source
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** 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 <u>existing</u> dispensers if there have been no changes to any dispensers? *If "no" or "does not apply, wall-mounted dispensers, not used," skip question #7 and continue to question #8.*	○ Yes ○ No ○ Does not apply, wall-mounted dispensers are not used	1. Hospital policy or procedure document outlining policies for conducting audits 2. Results from an audit showing that a sample of dispensers were audited	
7) Do all the audited dispensers deliver, with one activation, 1.0 mL of alcohol-based hand sanitizer OR a volume of alcohol-based hand sanitizer that covers the hands completely and requires 15 or more seconds for hands to dry (on average)?	○ Yes ○ No	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

Survey Question	Response	Required Documentation	Source
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 questions #9-10 and continue to question #11.*	○ Yes, using an electronic compliance monitoring system throughout all patient care units ○ Yes, using an electronic compliance monitoring system throughout some patient care units	1. Report showing **summary** counts of monthly opportunities monitored which shows at least 200 hand hygiene opportunities were monitored in each patient care unit (or the number outlined based on the unit	

Survey Question	Response	Required Documentation	Source
	and only direct observation in all other patient care units o Yes, using only direct observation throughout all patient care units o No	type in Tables 1-3 in the Survey). 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 Survey. The hospital must also have a process in place to ensure they can continue to meet the requirement moving forward. 2. List and description of the units included in the report (including any descriptions for any units using abbreviations) 3. For units where less than 200 opportunities are being monitored (refer to sample sizes in Tables 1-3 in the Survey): - historical data used (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 that was used (based	

Survey Question	Response	Required Documentation	Source
		on sample sizes in Tables 1-3 in the Survey)	
9) Does your hospital collect hand hygiene compliance data on at least **100 hand hygiene opportunities**, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6, **each <u>month</u> in each patient care unit**? *If "yes" to question #9, skip question #10 and continue to question #11.*	o Yes, using an electronic compliance monitoring system throughout all patient care units o Yes, using an electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units o Yes, using only direct observation throughout all patient care units o No	1. Report showing **summary** counts of monthly 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 month preceding the time of submission of Section 6D Hand Hygiene and needs to list each applicable patient care unit as defined in the Survey. The hospital must also have a process in place to ensure they can continue to meet the requirement moving forward. 2. List and description of the units included in the report (including any descriptions for any units using abbreviations) 3. For units where less than 100 opportunities are being monitored (refer to sample sizes in Tables 4-6 in the <u>Survey</u>):	

Survey Question	Response	Required Documentation	Source
		- historical data used (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 that was used (based on sample sizes in Tables 4-6 in the Survey)	
10) 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 #10, skip questions #11-19 and continue to question #20.*	○ Yes, using an electronic compliance monitoring system throughout all patient care units ○ Yes, using an electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units ○ Yes, using only direct observation throughout all patient care units ○ No	1. Report showing **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 (or most recent 3 months) preceding the time of submission of Section 6D Hand Hygiene and needs to list each applicable patient care unit, as defined in the Survey. The hospital must also have a process in place to ensure they can continue to meet the requirement moving forward.	

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Survey Question	Response	Required Documentation	Source
		2. List and description of the units included in the report (including any descriptions for any units using abbreviations)	
11) 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 in your patient care units with feedback on both when they are and are not compliant with performing hand hygiene?	○ Yes ○ No	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, question #9, or question #10, answer questions #12-13 based on the units that use an electronic compliance monitoring system.

Survey Question	Response	Required Documentation	Source
12) 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, and • The hospital itself has validated the accuracy of the data collected by the electronic compliance monitoring system?	○ Yes ○ No	Would be verified via Leapfrog's on-site verification protocol.	

Survey Question	Response	Required Documentation	Source
13) 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** 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 on duty for that shift; and • 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)?	○ Yes ○ No	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 observation session (or the date and shift being observed) - the unit 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:	

Survey Question	Response	Required Documentation	Source
		- 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 (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

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, question #9, or question #10 answer questions #14-15 based on the units that do NOT use an electronic compliance monitoring system.

Survey Question	Response	Required Documentation	Source
14) In those patient care units where an electronic compliance monitoring system is NOT used, do the direct observations meet **all** 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 on duty for that shift; and • 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)?	o Yes o No	1. Example of direct observation template or sheet (electronic or paper copy 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 unit 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 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 (i.e., a summary of	

Survey Question	Response	Required Documentation	Source
		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)	
15) Does your hospital have a system in place for both the initial and recurrent training and validation of hand hygiene compliance observers?	o Yes o No	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 trained in infection control and a hand hygiene compliance observer, interactive video assessments).	

Feedback

Survey Question	Response	Required Documentation	Source
16) Are unit-level 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?	o Yes o No	Documentation of how unit-level hand hygiene compliance data were delivered monthly to individuals who	

Survey Question	Response	Required Documentation	Source
		touch patients or who touch items that will be used by patients (e.g., report, handout, e-mail, etc.).	
17) Are unit-level hand hygiene compliance data used for creating unit-level action plans?	○ Yes ○ No	Unit-level action plans based on hand hygiene compliance data (hand hygiene compliance data should be highlighted).	
18) 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 #18, skip question #19 and continue to question #20.*	○ Yes ○ No	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.).	
19) If "yes" to question #18, is senior administrative leadership, physician leadership, and nursing leadership held directly accountable for hand hygiene performance through performance reviews or compensation?	○ Yes ○ No	Performance reviews or compensation methodology for senior administrative leadership, physician leadership and nursing leadership which include accountability	

Survey Question	Response	Required Documentation	Source
		for hand hygiene performance (e.g., meeting targets for hand hygiene compliance rates, bonuses tied to implementation of technology, etc.).	

Culture

Survey Response	Response	Required Documentation	Source
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?	o Yes o No	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.	

21) Have **all** 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):
    • Chief Executive Officer,
    • Chief Medical Officer, and
    • Chief Nursing Officer?
	o Yes
	o No
		Written or verbal commitments to support hand hygiene improvement dated within the last 12 months from the Chief Executive Officer, Chief Medical Officer, and Chief Nursing Officer (e.g., e-mails, videos, minutes or talking points from town hall meetings, public comments to staff, etc.) that are addressed	

Survey Response	Response	Required Documentation	Source
		to individuals who touch patients or who touch items that will be used by patients.	

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

☐ Review the reporting periods for each measure in this section.

☐ Review the questions, endnotes, and FAQs for this section with anyone who is assisting with the collection of data.

☐ If you submitted any questions on this section to the Leapfrog Help Desk, save the responses (i.e., tickets) in this tab for future reference.

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The types of documentation you should include in this binder are provided below.

Hospitals selected for Leapfrog's Monthly Documentation Request for this measure will be asked to submit documentation that should include the information below. Only maintain documentation for those questions in this subsection for which your hospital responded "yes." Note that endnotes should be reviewed in the hard copy of the Survey.

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

- o 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.

- o 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 and/or family affected by the never event.
  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:
     - 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, 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.
  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 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 that occurred.

SECTION 7B: HEALTHCARE-ASSOCIATED INFECTIONS

For Section 7B: Healthcare-Associated Infections, save your NHSN IPPS reports for each of the 5 healthcare-associated infection measures (CLABSI, CAUTI, MRSA, C. diff, and SSI Colon) on the same day that Leapfrog downloads your hospital's data and include them in this binder. Save your hospital's 2023 NHSN Patient Safety Component – Annual Hospital Survey as well, since Leapfrog obtains teaching status from this survey. Find detailed instructions and download dates on Leapfrog's Join NHSN Group webpage.

Section 8: Pediatric Care

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

☐ Review the reporting periods for this section.

☐ Review the questions, reference information, endnotes, and FAQs for this section with anyone who is assisting with the collection of data.

☐ If you submitted any questions on this section to the Leapfrog Help Desk, save the responses (i.e., tickets) in this tab for future reference.

SECTION 8A: PATIENT EXPERIENCE (CAHPS CHILD HOSPITAL SURVEY)

Save a copy of your vendor report used to respond to questions #1-12 in this section and highlight which responses were used.

SECTION 8B: PEDIATRIC COMPUTED TOMOGRAPHY (CT) RADIATION DOSE

If your hospital is reporting on this measure using a vendor report (such as an American College of Radiology Report to report) or a Dose Monitoring Software report, save a copy of that report. If your hospital is using manual data collection to report on this measure, you must use the CT Dose Workbook (Excel) 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 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 9: 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.

☐   Save any reports, policies/agreements, clinician schedules and certifications that you used for Section 9 in this section of the binder.

☐   If you submitted any questions on this section to the Leapfrog Help Desk, save the responses (i.e., tickets) in this tab for future reference.

SECTION 9B: 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 Source and applicable page number(s) used in the Source column.

Survey Question	Response	Required Documentation	Source
1) Is there an Advanced Cardiovascular Life Support (ACLS) trained clinician, as well as a second clinician (regardless of ACLS training), present at all times and immediately available in the building while an adult patient (13 years and older) 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.* *Hospitals should report on all hospital outpatient departments or areas of the hospital that perform the outpatient procedures listed in Section 9C and that share the hospital's license or CCN.* *Hospitals that did not perform any applicable procedures on patients 13 years and older during the reporting period should select "not applicable; pediatric patients only." The hospital will be scored as "Does Not Apply."*	o Yes o No o Not applicable; pediatric patients only	Hospital 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	
2) Is there a Pediatric Advanced Life Support (PALS) trained clinician, as well as a second clinician (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.*	o Yes o No o Not applicable; adult patients only	Hospital 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	

Survey Question	Response	Required Documentation	Source
Hospitals should report on all hospital outpatient departments or areas of the hospital that perform the outpatient procedures listed in Section 9C and that share the hospital's license or CCN. *Hospitals that did not perform any applicable procedures on pediatric patients (infant through 12 years) during the reporting period, regardless of the presence of clinicians trained in PALS, should select "not applicable; adult patients only." The hospital will be scored as "Does Not Apply."*			

SECTION 9C: VOLUMES OF PROCEDURES

Use *only* those CPT codes listed for each procedure in the CPT Code Workbook available via the Survey Dashboard. Maintain copies of the reports your hospital used to report on the volume of adult and pediatric procedures during the reporting period.

SECTION 9D: SAFETY OF PROCEDURES - 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 1) dated according to the reporting period for this subsection, 2) labeled, and 3) each page is numbered. Indicate the Source and applicable page number(s) used in the Source column.

Survey Question	Response	Required Documentation	Source
1) What is the latest 12-month reporting period for which your hospital is submitting responses to questions #1-9? 12-month reporting period ending:	_____ *Format: Month/Year*	N/A	
2) Does your hospital utilize a safe surgery checklist on <u>every</u> patient, <u>every</u> time one of the applicable procedures in Section 9C 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 #2, skip the remaining questions in Section 9D and go to the next subsection. The hospital will be scored as "Limited Achievement."*	○ Yes ○ No	N/A	
3) **Before the induction of anesthesia**, is a safe surgery checklist that includes <u>all</u> the following elements <u>read aloud</u> in the presence of the <u>anesthesia professional and nursing personnel</u>: • Patient ID; • Confirmation of procedure; • Patient consent; • Site marked, if applicable; • Anesthesia/medication check; • Allergies assessed; • Difficult airway/aspiration risk; • Risk of blood loss (only applicable if risk of blood loss is >500ml for adults or > 7ml/kg for children); and • Availability of devices (applicable to endoscopy procedures only)?	○ Yes ○ No	Copy of checklist that includes each element in the question and information regarding **when** the checklist was read aloud and **who** was present.	

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Survey Question	Response	Required Documentation	Source
4) **Before the skin incision and/or before the procedure begins**, is a safe surgery checklist that includes all 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 (i.e., non-routine steps, length of procedure, blood loss, patient-specific concerns, sterility); • Equipment check/concerns; and • Essential imaging available, if applicable?	○ Yes ○ No	Copy of checklist that includes each element in the question and information regarding **when** the checklist was read aloud and **who** was present.	
5) **Before the patient leaves the operating room and/or procedure room**, is a safe surgery checklist that includes all the following elements read aloud in the presence of the whole surgical team: • Confirmation of procedure performed; • Instrument/supply counts, if applicable; • Specimen labeling, if applicable; • Equipment concerns; and • Patient recovery/management concerns?	○ Yes ○ No	Copy of checklist that includes each element in the question and information regarding **when** the checklist was read aloud and **who** was present.	

If "no" to question #3, #4, or #5, skip the remaining questions in Section 9D, and go to the next subsection. The hospital will be scored as "Limited Achievement."

Hospitals performing the audit in Section 3B question #6 and the audit in Section 9D question #6 should audit 15 cases who underwent a procedure included in Section 3A and 15 cases who underwent a procedure included in Section 9C. Hospitals only performing the audit in Section 9D question #6 and not in Section 3B question #6 should audit 30 cases who underwent a procedure included in Section 9C.

Survey Question	Response	Required Documentation	Source
6) Did your hospital perform an audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 9C and measure adherence to the safe surgery checklist? *Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should select at least one case from each location.* *If "no" to question #6, skip the remaining questions in Section 9D, and continue to the next subsection. The hospital will be scored as "Limited Achievement."*	○ Yes ○ No	N/A	

Survey Question	Response	Required Documentation	Source
7) How many cases were included in the audit from question #6?	_____	N/A	
8) Which method was used to perform the audit on a sufficient sample in question #6?	o In-person observational audit o Retrospective audit of medical records or EHR data o Both	N/A	
9) Based on your hospital's audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 9C, what was your hospitals 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)?	o 90%-100% o 75%-89% o 50-74% o Less than 50%	**For Observational Audits:** Copy of the checklist or observation sheet used to perform the safe surgery checklist audit. The checklist or observation sheet must clearly document (a) which elements were read aloud, when each element was read aloud, and who was present. Copy of **complete** checklists for each sampled patient. **For Retrospective Chart Audits:** Copy of screenshots from the medical record or chart that clearly demonstrates (a) which elements were read aloud, when each element was read aloud, and who was present for each sampled patient.	

SECTION 9E: MEDICATION SAFETY FOR OUTPATIENT PROCEDURES

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

SECTION 9F: PATIENT EXPERIENCE (OAS CAHPS)

Save a copy of your OAS CAHPS vendor report used to respond to questions #1-10 in this section.