2016 LEAPFROG HOSPITAL SURVEY ORGANIZATIONAL BINDER

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Overview

WHAT IS THE PURPOSE OF THIS BINDER?

The Leapfrog Hospital Survey Binder was originally designed for those hospitals that have been selected for Leapfrog's On-Site Data Verification Program administered by DHG Healthcare. Those hospitals are mailed a binder to collect and organize the information (e.g., reports, documentation, notes, etc.) they used to complete their Leapfrog Hospital Survey ***AND*** at the same time they are preparing for their verification. DHG uses the information in the binder during the scheduled visit to verify a hospital's Leapfrog Hospital Survey responses.

However, the Leapfrog Hospital Survey Binder document (PDF) is available for use by all hospitals to collect, organize, and record information during the completion of the 2016 Leapfrog Hospital Survey. The document, which is divided up into 10 tabs (or sections), one for each section of the survey, can be printed and placed in a binder. The information is helpful when completing subsequent year's surveys, in staff and leadership transitions, and as a historical record. The use of the binder also acquaints hospitals with the elements of the On-Site Data Verification Program.

For those sections that have been selected for On-Site Data Verification, DHG would include a **pre-visit documentation request** within that section to ensure that a hospital collects, organizes, and records the information that will be reviewed during the scheduled on-site visit. For the purposes of making this binder useful and informational to all hospitals, we have removed those pages in this document.

HOW SHOULD WE USE THIS BINDER?

This binder is meant to be used as a tool to help you collect, organize, and record information that you used to complete your Leapfrog Hospital Survey. Nothing in the binder is meant to replace or substitute the information that Leapfrog provides in the hard copy of the survey or reference materials available on the Leapfrog website (http://leapfroggroup.org/survey).

Section 1 – Basic Hospital Information

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

☐ Review the reporting time periods for this section.

☐ Take note of who in your hospitals ran reports for you to respond to these questions.

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

☐ Be sure to print, date, label, and file any reports that you used for Section 1 in this section of the binder.

☐ If you submitted any questions on this section to the Leapfrog Hospital Survey Help Desk, print copies of your responses (i.e., tickets) and save them in this tab for future reference.

PLACE DOCUMENTATION FOR SECTION 1 AFTER THIS PAGE

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Section 2 – Computerized Physician Order Entry (CPOE)

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for this section.
- ☐ Review the questions and reference information for this section with anyone who is going to help you collect this data. If there are questions, contact the Leapfrog Hospital Survey Help Desk before you start collecting this data.
- ☐ Review the FAQs in Section 2 of the hard copy of the survey to ensure that you understand which orders should be included in Questions 3-4. If you have questions, contact the Leapfrog Hospital Survey Help Desk.
- ☐ Be sure to print, date, label, and file any reports that you used to respond to Questions 3-4 in this binder. (i.e. Meaningful use reports, pharmacy reports, etc.)
- ☐ Take note of who in your hospitals ran reports for you to respond to Questions 3-4, you may want to ask them again next year.
- ☐ 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.
- ☐ If you submitted any questions on this section to the Leapfrog Hospital Survey Help Desk, print copies of your responses (i.e., tickets) and save them under this tab for future reference.

CPOE EVALUATION TOOL PERSONNEL ROSTER

If your hospital completed the CPOE Evaluation Tool, use the roster below to record roles and responsibilities.

	TEST STEP	PERSONNEL INVOLVED
☐	Admitted/registered test patients	
☐	Entered lab results	
☐	Entered patient profiles, allergy, and assessment (i.e., diagnosis) information	
☐	Entered medication orders and recorded advice/information (must be a provider licensed to prescribe/order medications)	
☐	Completed and submitted electronic answer sheet	

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Section 3 – Evidence-Based Hospital Referral (High-Risk Surgical Procedures)

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

☐ Review the reporting periods for this section.

☐ Be sure to use ***only*** those ICD-9 codes listed for each procedure in the hard copy of the survey.

☐ If you used an STS or regional registry report in Section 3A AVR, file a copy of the report in this binder.

☐ Make note of who in your hospitals ran reports for you to respond to the questions in this section.

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

☐ Be sure to print, date, label, and file any other reports that you used for in responding to questions in this section.

☐ If you submitted any questions on this section to the Leapfrog Hospital Survey Help Desk, print copies of your responses (i.e., tickets) and save them under this tab for future reference.

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Section 4 – Maternity Care

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for this section.
- ☐ Be sure to carefully review the measures specifications in this section. Several measures include ***multiple*** inclusion and exclusion criteria. If you have any questions, please contact the Leapfrog Hospital Survey Help Desk.
- ☐ Take note of the data sources that you used to identify cases for inclusion and exclusion in each measure (i.e., birth records, billing data, etc.) so that you can easily access the same sources next year.
- ☐ If someone else is helping you collect and/or abstract these data from paper or electronic sources, take note of who they are and make sure they have copies of the questions and measure specifications before they begin.
- ☐ If your IT team or data abstractor developed special code, scripts, or parameters to run any reports for you, include a note or a copy so that you can run the same reports next year.
- ☐ If you used an ORYX vendor report or Vermont Oxford Network report, file a copy of the report in this section of your binder.
- ☐ Be sure to print, date, label, and file any reports that you used for subsections 4A-4F in this binder, including the parameters/queries used to pull said reports.
- ☐ If you submitted any questions on this section to the Leapfrog Hospital Survey Help Desk, print copies of your responses (i.e., tickets) and save them under this tab for future reference.

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Section 5 – ICU Physician Staffing

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

☐ Review the reporting periods for this section.

☐ Read the questions and ***endnotes*** carefully 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, NOT the most intense staffing level.

☐ Review the questions and reference information for this section with anyone who is going to help you collect this data. If you have any questions, contact the Leapfrog Hospital Survey Help Desk.

☐ Review the FAQs in Section 5 of the hard copy of the survey to ensure that you understand the criteria for each question. If you have questions, contact the Leapfrog Hospital Survey Help Desk.

☐ Be sure to print, date, label, and file any reports that you used to respond to Questions 2-14 in this binder.

☐ Take note of who in your hospitals ran reports, helped you complete the physician staffing roster, or obtained copies of policies, schedules, reports, or budgets used to respond to Questions 2-14, you may want to include them in the survey process again next year.

☐ If you submitted any questions on this section to the Leapfrog Hospital Survey Help Desk, print copies of your responses (i.e., tickets) and save them under this tab for future reference.

TABLE OF CONTENTS FOR ICU PHYSICIAN STAFFING DOCUMENTATION

Examples of the types of documentation you may want to include in this binder. Only provide documentation for those questions in this section for which your hospital responded 'YES'. Please ensure that each document is dated and labeled, and that each page is numbered.

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**Question 3:** Are **all** patients in these ICUs managed or co-managed by one or more physicians who are certified in critical care medicine?	*Staffing policy regarding patient management or co-management*	
☐	**Question 4:** Is one or more of these physicians **ordinarily present** in each of these ICUs during daytime hours **for at least 8 hours per day, 7 days per week,** and do they provide clinical care **exclusively** in one ICU during these hours?	*ICU staffing schedule for the past 3 months*	
☐	**Question 5:** When these physicians are not present in these ICUs on-site or via telemedicine, do they return more than 95% of calls/pages from these units within five minutes, based on a quantified analysis of notification device response time?	*Copy of quantitative analysis or log*	
☐	**Question 6:** When these physicians are not present on-site in the ICU or not able to reach an ICU patient within 5 minutes, can they rely on a physician, physician assistant, nurse practitioner, or FCCS-certified nurse "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 notification device response time?	*Copy of quantitative analysis or log*	

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TABLE OF CONTENTS FOR ICU PHYSICIAN STAFFING (continued)

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**Question 7**: Are all patients in these ICUs managed or co-managed by one or more physicians certified in critical care medicine who meet all of the following criteria: • ordinarily present on-site in these units; • 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 one ICU during these hours?	*Staffing policies and ICU schedules for the past 3 months; contract with physician group*	
☐	**Question 8:** Are all patients in these ICUs managed or co-managed by one or more physicians certified in critical care medicine who meet all three of the following criteria: • present via telemedicine for 24 hours per day, 7 days per week; • meet modified Leapfrog 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?	*Staffing policies and ICU schedules for the past 3 months; contract with physician group providing tele-medicine service*	
☐	**Question 9:** Are all patients in these ICUs 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 ICU patient?	*Staffing policies and ICU schedules for the past 3 months*	

TABLE OF CONTENTS FOR ICU PHYSICIAN STAFFING (continued

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**Question 10:** If not all patients are managed or co-managed by physicians certified in critical care medicine, either on-site or via telemedicine, are some patients managed by these physicians?	*See examples above*	
☐	**Question 11:** Does your hospital have a board-approved budget that is adequate to fully meet Leapfrog's ICU Physician Staffing standard?	*Copy of line item budget*	
☐	**Question 12:** Does an on-site clinical pharmacist make daily rounds on patients in these ICUs 7 days per week?	*Pharmacist schedule*	
☐	**Question 13:** Does a physician certified in critical care medicine lead daily multi-disciplinary rounds onsite on all patients in these ICUs 7 days per week?	*ICU schedules*	
☐	**Question 14:** When certified physicians are on-site in these ICUs, do they have responsibility for all ICU admission and discharge decisions?	*Hospital policies*	

PLACE DOCUMENTATION FOR SECTION 5 AFTER THIS PAGE

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Section 6 – NQF Safe Practices

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for each safe practice.
- ☐ Review the tips for reporting on Section 6 in the hard copy of the survey.
- ☐ Review the practice-specific FAQs in Section 6 of the hard copy of the survey to ensure that you understand the criteria for each question. If you have questions, contact the Leapfrog Hospital Survey Help Desk.
- ☐ Be sure to print, date, label, and file all documentation used to respond to this section in this binder.
- ☐ Documents can be highlighted and information specific to the practice and specific question should be highlighted or circled such as dates, attendees, content, etc.
- ☐ Take note of who in your hospitals helped you complete each safe practice, you may want to include them in the survey process again next year.
- ☐ If you submitted any questions on this section to the Leapfrog Hospital Survey Help Desk, print copies of your responses (i.e., tickets) and save them under this tab for future reference.

TABLE OF CONTENTS FOR SAFE PRACTICE 1: CULTURE OF SAFETY LEADERSHIP STRUCTURES & SYSTEMS DOCUMENTATION

Examples of the types of documentation you may want to include in this binder. Only provide documentation for those questions in this section for which your hospital responded 'YES'.

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**1.1** In regard to raising the awareness of key stakeholders to our organization's efforts to improve patient safety, the following actions related to identification and mitigation of risk and hazards have been taken: a. Board (governance) minutes for the past 12 months 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)	*Copy of report; be sure report is dated*	
☐	b. Patients (who are not employed by the organization) and family of patients are active participants in safety and quality committees that meet on a regularly scheduled basis (e.g. biannually or quarterly). (p.75)	*Meeting notes reflecting attendance*	
☐	c. steps have been taken to report to the community in the last 12 months of ongoing efforts to improve safety and quality in the organization and the results of these efforts. (p.75)	*Published reports for the community that specifically mention quality and safety*	
☐	d. all staff and independent practitioners were made aware in the past 12 months of ongoing efforts to reduce risks and hazards and to improve patient safety and quality in the organization. (p.75)	*Examples of reports or presentations or meeting minutes showing attendance*	

Questions about the survey:
Contact Leapfrog at https://leapfroghospitalsurvey.zendesk.com

TABLE OF CONTENTS FOR SAFE PRACTICE 1 (continued)

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**1.2** In regard to holding the Board, senior management, mid-level management, physician leadership, and frontline caregivers directly accountable for results related to identifying and reducing unsafe practices, the organization has done the following: a. an integrated, patient safety program has been in place for at least the past 12 months providing oversight and alignment of safe practice activities. (p.76)	*Copy of the patient safety program that specifically addresses the safe practice activities*	
☐	b. a patient safety officer (PSO) has been appointed and communicates regularly with the Board (governance) and senior administrative leadership; the PSO is the primary point of contact of the integrated, patient safety program. (p.76)	*Documentation of PSO position, examples of reports or presentations presented to Governance*	
☐	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)	*Copy performance review templates or compensation incentives for all levels described*	
☐	d. the interdisciplinary patient safety team communicated regularly with management regarding all three of the following: • root cause analyses (as defined by *Safe Practice #4, Culture Measurement, Feedback & Intervention*); • progress in meeting safety goals; and, • providing team training to caregivers (as defined by *Safe Practice #3, Teamwork Training & Skill Building*); and, documented these communications in meeting minutes. (pp.76-77)	*Examples of reports or presentations presented to management. Meeting notes with attendance noted*	
☐	e. the facility reported adverse events to external mandatory or voluntary programs. (p.77)	*Information indicating external reporting such as report or summary*	

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TABLE OF CONTENTS FOR SAFE PRACTICE 1 (continued)

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**1.3** In regard to implementation of the patient safety program, the Board (governance) and senior administrative leaders have provided resources to cover the implementation during the last 12 months, and: a. dedicated patient safety program budgets support the program, staffing, and technology investment. (p.77)	*Copy of line item budget*	
☐	**1.4** Structures and systems for assuring that leadership is taking direct and specific actions have been in place for the past 12 months, as evidenced by: a. CEO and senior administrative leaders are personally engaged in reinforcing patient safety improvements, e.g., “walk-arounds”, holding patient safety meetings, reporting to the Board (governance). Calendars reflect allocated time. (p.78)	*Copy of CEO and leaders schedules showing “walk-arounds”, copy of meeting minutes*	
☐	b. CEO has actively engaged unit, service-line, departmental and mid-level management leaders in patient safety improvement actions. (p.79)	*Copy of meeting minutes including attendees*	
☐	c. hospital has established a structure for input into the patient safety program by licensed independent practitioners and the organized medical staff and medical leadership. Input documented in meeting minutes or materials. (p.79)	*Copy of meeting minutes including attendees*	

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TABLE OF CONTENTS FOR SAFE PRACTICE 2: CULTURE MEASUREMENT, FEEDBACK & INTERVENTION DOCUMENTATION

Examples of the types of documentation you may want to include in this binder. Only provide documentation for those questions in this section for which your hospital responded 'YES'.

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**2.1** In regard to Culture Measurement, our organization has done the following within the last 24 months: a. conducted a culture of safety survey of our employees using a nationally recognized tool that has demonstrated validity, consistency and reliability. The units surveyed account for at least 50% of the aggregated care delivered to patients within the facility, and includes the high patient safety risk units or departments.(p.88) *If item 'a' is not checked, no other items in this Practice 2 may be checked.*	*Results from culture of safety survey; be sure results are dated within past 24 months of submission date. Results should include participation rate*	
☐	b. portrayed the results of the culture survey in a report, which reflects both hospital-wide and individual unit level results, as applicable. (p.88)	*Copy of report; be sure report is dated*	
☐	c. benchmarked results of the culture survey against external organizations, such as "like" hospitals or other hospitals within the same health system.	*Copy of report; be sure report is dated*	
☐	d. compared results of the culture survey across internal work groups, roles, and staff levels.	*Copy of culture of safety survey results comparison; be sure report is dated*	
☐	e. used results of the culture 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.	*Copy of meeting notes or presentation, with attendance reflecting units*	

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TABLE OF CONTENTS FOR SAFE PRACTICE 2 (continued)

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**2.2** In regard to accountability for improvements in the measurement of the culture of safety, our organization has done the following within the last 24 months: a. involved senior administrative leadership in the identification and selection of sampled units; and, in the selection of an appropriate tool for measuring the culture of safety. (p.88)	*Meeting notes with attendance reflecting senior administrator participated in selecting units*	
☐	b. shared the results of the culture measurement survey with the Board (governance) and senior administrative leadership in a formal report and discussion. (p.88)	*Board agenda, minutes, and/or presentation. All documentation should be dated*	
☐	c. performance evaluation criteria for senior administrative leaders included both response rates to the survey and the use of survey results in improvement efforts.	*Copy of performance evaluation of senior administrative leaders*	
☐	**2.3** In regard to the culture of safety measurement, the organization has done the following (or has had the following in place) within the last 12 months: a. conducted staff education program(s) on methods to improve the culture of safety, tailored to the organization's survey results. (p.89)	*Education session curriculum and sign in sheets. Examples of documentation from personnel or administrative records*	
☐	b. included the costs of annual culture measurement/follow-up activities in the patient safety program budget. (p.88)	*Copy of line item budget*	

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TABLE OF CONTENTS FOR SAFE PRACTICE 2 (continued)

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**2.4** In regard to culture measurement, feedback, and interventions, our organization has done the following or has had the following in place within the last 12 months: a. developed or implemented explicit, hospital-wide organizational policies and procedures for regular culture measurement (p.88) OR implemented strategies for improving culture based on survey results. (p.88)	*Copy of policies and/or examples of strategies implemented (i.e., meetings, education, events, etc.)*	
☐	b. disseminated the results of the survey widely across the institution, with follow-up meetings held by senior administrative leadership with the sampled units. (p.88)	*Examples of reports or presentations presented to departments. Meeting notes with attendance noted of meetings held by senior administrative leaders.*	
☐	c. identified performance improvement interventions based on the survey results, which were shared with senior administrative leadership and subsequently measured and monitored. (p.88)	*Copy of dashboard of metrics, progress report, etc.*	

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TABLE OF CONTENTS FOR SAFE PRACTICE 3: TEAMWORK TRAINING & SKILL BUILDING DOCUMENTATION

Examples of the types of documentation you may want to include in this binder. Only provide documentation for those questions in this section for which your hospital responded 'YES'.

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**3.1** In regard to teamwork training and skill building, our organization has done the following within the last 12 months: a. conducted a literature review of teamwork training in healthcare or other settings and have identified best practices. (p.101) **OR** conducted a review of available teamwork training programs in progressive organizations to identify best practices. (p.99)	*Copy of literature review or documentation of teamwork training programs explored*	
☐	b. conducted an assessment of high-risk areas, in terms of patient safety, by an interdisciplinary patient safety team to determine specific processes (e.g. communication, collaboration, etc.) and those involved in those processes in need of teamwork improvement. The results of the assessment were shared to senior administrative leadership. (p.97)	*Copy of assessment and copy of presentation or meeting minutes for senior administrative leadership*	
☐	c. shared results of the assessment (from 3.1b) that determined specific processes and those involved in those processes in need of teamwork improvement with senior management, mid-level management and physician leadership. (pp.97-98)	*Copy of meeting minutes showing discussion of requirements including attendance*	
☐	d. informed senior management, mid-level management and physician leadership that to meet the need, internal resources and possible resources from progressive organizations have been identified.	*Copy of assessment and copy of any associated training materials utilized*	
	e. assessed the organizational need for rapid response systems and any associated training. (p.97)	*Copy of needs assessment*	

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TABLE OF CONTENTS FOR SAFE PRACTICE 3 (continued)

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**3.2** In regard to leadership being held accountable for the demonstration of teamwork skills in the organization, our organization has done the following within the last 12 months: a. determined, through a literature review or an assessment, a set of targeted units or service lines for detailed teamwork training and effective teamwork skill building. These units/lines were identified by the CEO to the Board (governance), senior managers, and medical staff. (p.97)	*Copy of literature review with specific mention of units or service lines. Meeting minutes or notes from CEO presentations to Board, senior managers and medical staff*	
☐	b. provided basic teamwork training to the Board (governance), senior managers, medical staff, mid-level management, and frontline nurses on communication hand-offs and team failures leading to patient harm. Training was documented in personnel or administrative records. (p.96)	*Copy of teamwork training materials. Teamwork training subject matter includes: sources of communication failures, hand-offs, and team failures that lead to patient harm. Participation should be documented.*	
☐	**3.3** In regard to effective teamwork training and skill building, our organization has done the following within the last 12 months: a. resourced patient safety program budgets to support the assessment of need and team training activities.	*Copy of budgets referenced*	
☐	b. provided clinical staff and licensed independent practitioners in the hospital-targeted units detailed teamwork training and skill building. Participation was documented. (p.96)	*Copy of training materials and training attendance records*	
☐	**3.4** Effective team-centered interventions were either in place or were initiated in the past 12 months, as evidenced by: a. notation in board minutes documenting that the performance improvement targets in identified units were being addressed. (p.97)	*Copy of board minutes documenting the performance improvement*	
☐	b. evaluation or documentation of unit or service line results for teams that had received the detailed team training intervention during the past 12 months. (pp.97-98)	*Copy of evaluation or documentation of results*	

PLACE DOCUMENTATION FOR SAFE PRACTICE 3 AFTER THIS PAGE

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TABLE OF CONTENTS FOR SAFE PRACTICE 4: RISKS & HAZARDS DOCUMENTATION

Examples of the types of documentation you may want to include in this binder. Only provide documentation for those questions in this section for which your hospital responded 'YES'.

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**4.1** Within the last 12 months our organization has done the following: a. assessed risks and hazards to patients by reviewing multiple retrospective sources, such as: • serious and sentinel event reporting; • root cause analyses for adverse events; • independent comparative mortality and morbidity information with the hospital's performance; • patient safety indicators; • trigger tools; • hospital accreditation surveys; • risk management and filed litigation; • anonymous internal complaints, including complaints of abusive and disruptive caregiver behavior; and • complaints filed with state/federal authorities; and based on those findings, documented recommendations for improvement. (p.105)	*Copy of information used in assessment including examples of event reporting, root cause analysis or other activities. A copy of the recommendations for improvement*	
☐	b. assessed risks and hazards to patients using prospective identification methods: Failure Modes and Effects Analysis (FMEA) and/or Probabilistic Risk Assessment, and has documented recommendations for improvement. (p.106)	*Copy of identification tools for prospective identification*	
☐	c. combined results of (a) and (b) above to develop their risk profile, and used that profile to identify priorities and develop risk mitigation plans. (p.107)	*Copy of the documented recommendations*	
☐	d. shared results from the two assessments, noted in (a), (b), and the risk mitigation plan noted in (c) above widely across the organization, from the Board (governance) to front-line caregivers. (p.107) *This item may not be checked unless all items 4.1a, b, c are checked.*	*Copy of materials used to share results including presentations, postings or other information*	

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TABLE OF CONTENTS FOR SAFE PRACTICE 4 (continued)

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**4.2** Leadership is accountable for identification of risks and hazards to patients, and mitigation efforts in the past year, as evidenced by: a. approval of an action plan by the CEO and the Board (governance) for undertaking the assessments of risk, hazards and for the mitigation of risk for patients. (p.106)	*Copy of approved action plan and/or meeting minutes or notes describing the approval by the CEO and governance*	
☐	b. incorporation of the identification and mitigation of risks into performance reviews OR outlined financial incentives for leadership and the Patient Safety Officer for identifying and mitigating risks to patients as identified in the approved action plan.	*Copy of performance reviews or financial incentive plan demonstrating this information*	
☐	**4.3** In regard to developing the ability to appropriately assess risk and hazards to patients, the organization has done the following or had in place during the last 12 months: a. resourced patient safety program budgets sufficiently to support ongoing risk and hazard assessments and programs for reduction of risk.	*Copy of resourced budgets*	
☐	b. provided managers at all levels with training on the prospective identification tools for monitoring risk in their areas. Training was documented. (pp.107-108)	*Copy of training tools used in training and attendance records*	
☐	c. senior managers have received training in the integration of risk and hazard information across the organization. Training was documented. (pp. 107-108)	*Copy of training tools and attendance record*	
☐	**4.4** Structures and systems for assuring that direct and specific actions have taken place to mitigate risks to patients for the past 12 months, include: a. provided risk identification training to the management and staff in high risk patient safety units such as: emergency department, labor and delivery, ICUs, and operating rooms. (p.106)	*Copy of training tools and attendance records*	
☐	b. established or already had in place a structure, developed by the CEO and senior leadership, for gathering all information related to risks, hazards and mitigation efforts within the organization with input from all levels of staff within the organization and from patients and their families. (p.110)	*Description of structure and description of development*	
☐	c. evidence of high-performance or actions taken for the following four patient safety risk areas: falls, malnutrition, aspiration, and workforce fatigue (p.108)	*Copy of reports showing incidence/trends in these risk areas*	

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TABLE OF CONTENTS FOR SAFE PRACTICE 9: NURSING WORKFORCE DOCUMENTATION

Examples of the types of documentation you may want to include in this binder. Only provide documentation for those questions in this section for which your hospital responded 'YES'.

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**9.1** In regard to ensuring adequate and competent nursing staff service and nursing leadership at all levels, our organization has done the following or has had the following in place within the last 12 months: a. held at least one educational meeting for clinicians, senior management, mid-level management, and line management specifically related to the areas of patient safety and adequate nurse staffing effectiveness. (p.155)	*Copy of training tools and attendance records*	
☐	b. performed a risk assessment that includes an evaluation of the frequency and severity of adverse events that can be related to nurse staffing. (p.155)	*Copy of risk assessment*	
☐	c. submitted a report to the Board (governance) with recommendations for measurable improvement targets. (p.155)	*Copy of report to governance*	
☐	d. collected and analyzed data of actual unit-specific nurse staffing levels on a quarterly basis to identify and address potential patient safety-related staffing issues. (p.155)	*Copy of staffing level analysis*	
☐	e. provided unit-specific reports of potential patient safety-related staffing issues to senior administrative leadership and the Board (governance) at least quarterly. (p.155)	*Copy of reports, minutes or notes given to senior administrative leadership and governance*	
☐	**9.2** In regard to ensuring adequate and competent nursing staff service and nursing leadership at all levels, our organization has done the following or has had the following in place within the last 12 months: a. held departmental/clinical leadership directly accountable for improvements in performance through performance reviews or compensation. (p.155)	*Copy of performance reviews or compensation methodology*	
☐	b. included senior nursing leadership as part of the hospital senior management team. (p.155)	*Copy of organization chart*	
☐	c. reported performance metrics related to this Safe Practice to the Board (governance). (p.155	*Copy of reports, minutes or notes given to governance*	
☐	d. held the Board (governance) and senior administrative leadership accountable for the provision of financial resources to ensure adequate nurse staffing levels. (p.155)	*Copy of reports, minutes or notes regarding allocation of financial resources*	

TABLE OF CONTENTS FOR SAFE PRACTICE 9 (continued)

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**9.3** In regard to ensuring adequate and competent nursing staff service and nursing leadership at all levels, our organization has done the following or has had the following in place within the last 12 months: a. conducted staff education on maintaining and improving competencies specific to assigned job duties related to the safety of the patient, with attendance documented. (p.155)	*Copy of training tools and attendance records*	
☐	b. allocated protected time for direct care staff and managers to reduce adverse events related to staffing levels or competency issues.	*Copy of attendance and indication if compensated time at training events or other methods*	
☐	c. documented expenses incurred during the past year tied to quality improvement efforts around this Safe Practice.	*Copy of expenses incurred*	
☐	d. budgeted financial resources for balancing staffing levels and skill levels to improve performance. (p.155)	*Copy of line item budget*	
☐	e. governance has approved a budget for reaching optimal nurse staffing. (p.155)	*Meeting minutes, notes showing budget approval by governance*	
☐	**9.4** In regard to ensuring adequate and competent nursing staff service and nursing leadership at all levels, our organization has done the following within the last 12 months or has had the following in place during the last 12 months and updates are made regularly: a. implemented a staffing plan, with input from nurses, to ensure that adequate nursing staff-to-patient ratios are achieved. (p.154)	*Copy of policies and procedures and implementation information*	
☐	b. developed policies and procedures for effective staffing targets that specify number, competency and skill mix of nursing staff. (p.155)	*Copy of policies and procedures*	
☐	c. implemented a performance improvement project that minimizes the risk to patients from less than optimal staffing levels. (p.155) OR monitored a previously implemented hospital-wide performance improvement program that measures, and demonstrates full achievement of, the impact of this specific Safe Practice. (p.155)	*Copy of performance improvement plan*	

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TABLE OF CONTENTS FOR SAFE PRACTICE 17: MEDICATION RECONCILIATION DOCUMENTATION

Examples of the types of documentation you may want to include in this binder. Only provide documentation for those questions in this section for which your hospital responded 'YES'.

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**17.1** In regard to adverse drug events and the medication reconciliation process, our organization has done the following or has had the following in place within the last 12 months: a. completed a review of the literature and identified specific, evidence-based best practices for process redesign. (pp.225-228)	*Copy of literature review*	
☐	b. conducted a hospital-wide evaluation of the frequency and severity of adverse drug events associated with medication reconciliation in our patient population.	*Copy of evaluation*	
☐	c. submitted a report to the Board (governance) with recommendations for measurable improvement targets. (p.224)	*Copy of meeting minutes, notes or presentation to governance*	
☐	**17.2** In regard to adverse drug events and the medication reconciliation process, our organization has done the following or has had the following in place within the last 12 months: a. held senior administrative leadership directly accountable for performance in this patient safety area through performance reviews or compensation.	*Copy of performance reviews or compensation methodology*	
☐	b. held the patient safety officer directly accountable for improvements in performance through performance reviews or compensation.	*Copy of performance reviews or compensation methodology*	
☐	c. reported to the Board (governance) the results of the measurable improvement targets. (p.224)	*Copy of meeting minutes, notes or presentation to governance*	

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TABLE OF CONTENTS FOR SAFE PRACTICE 17 (continued)

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**17.3** In regard to adverse drug events and the medication reconciliation process, our organization has done the following or has had the following in place within the last 12 months: a. conducted staff education/ knowledge transfer and skill development programs, with attendance documented. (p.221)	*Copy of training tools and attendance records*	
☐	b. conducted an education program for all newly hired clinicians on the importance of medication reconciliation, with attendance documented. (p.219)	*Copy of training tools and attendance records*	
☐	c. allocated protected time for direct care staff and managers, and dedicated budget resources for best practices development for the organization's medication reconciliation system. (p.222)	*Copy of line item budget*	
☐	**17.4** In regard to the medication reconciliation process, our organization has done the following within the last 12 months or has had the following in place during the last 12 months and updates are made regularly: a. developed and implemented explicit policies and procedures across the entire organization regarding medication reconciliation.	*Copy of policies and implementation methods*	
☐	b. implemented a formal performance improvement program addressing the impact of this specific Safe Practice OR monitored a previously implemented hospital-wide performance improvement program that measures, and demonstrates full achievement of, the impact of this specific Safe Practice.	*Copy of performance improvement plan or monitoring information*	
☐	c. implemented standardized processes to obtain and document a complete list of each patient's current medications at the beginning of each episode of care. (p.219)	*Copy or screenshot of the process for current medication documentation at beginning of the episode*	
☐	d. implemented standardized processes to ensure that a complete list of the patient's medications is communicated to the next provider of service, including the documentation of communication between providers. (p.220)	*Copy or screenshot of the process*	
☐	e. implemented standardized processes to provide the patient, and family/caregiver as needed, a current list and explanation of the patient's reconciled medications upon the patient leaving the organization's care. (p.220)	*Copy or screenshot of the process*	
☐	f. have reconciled medications for patients whose care setting, or level of care has changed, or has had a change in health status. (p.220)	*Copy or screenshot of process*	

Questions about the survey:
Contact Leapfrog at https://leapfroghospitalsurvey.zendesk.com

LEAPFROG HOSPITAL SURVEY

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TABLE OF CONTENTS FOR SAFE PRACTICE 19: HAND HYGIENE DOCUMENTATION

Please complete the Table of Contents below. Only provide documentation for those questions in this section for which your hospital responded 'YES'

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**19.1** In regard to preventing hospital-acquired infections related to inadequate hand hygiene, our organization has done the following or has had the following in place within the last 12 months: a. conducted a hospital-wide evaluation of the potential impact of improvements in hand hygiene on the frequency and severity of hospital-acquired infections in our patient population. (p.250)	*Copy of evaluation*	
☐	b. submitted a report to the Board (governance) with recommendations for measurable improvement targets.	*Copy of meeting minutes, notes or presentation to governance*	
☐	**19.2** In regard to preventing hospital-acquired infections related to inadequate hand hygiene, our organization has done the following or has had the following in place within the last 12 months: a. held clinical leadership directly accountable for this patient safety area through performance reviews or compensation.	*Copy of performance reviews or compensation methodology*	
☐	b. held senior administrative leadership directly accountable for performance in this patient safety area through performance reviews or compensation.	*Copy of performance reviews or compensation methodology*	
☐	c. held the patient safety officer directly accountable for improvements in performance through performance reviews or compensation.	*Copy of performance reviews or compensation methodology*	
☐	d. reported to the Board (governance) the results of the measurable improvement targets.	*Copy of meeting minutes, notes or presentation to governance*	

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TABLE OF CONTENTS FOR SAFE PRACTICE 19 (continued)

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**19.3** In regard to preventing hospital-acquired infections related to inadequate hand hygiene, our organization has done the following or has had the following in place within the last 12 months: a. conducted staff education/knowledge transfer and skill development programs, with attendance documented. (p.251)	*Copy of training tools and attendance records*	
☐	b. documented expenditures on staff education related to this Safe Practice in the previous year.	*Copy of expenditures*	
☐	**19.4** In regard to preventing hospital-acquired infections related to inadequate hand hygiene, our organization has done the following within the last 12 months or has had the following in place during the last 12 months and updates are made regularly: a. developed and implemented explicit policies and procedures across the entire organization to prevent hospital-acquired infections due to inadequate hand hygiene including CDC guidelines with category IA, IB, or IC evidence. (p.250)	*Copy of policies and procedures and implementation method*	
☐	b. implemented a formal performance improvement program addressing hospital-acquired infections focused on hand hygiene compliance, with regular performance measurement and tracking improvement (pp.250-251) OR monitored a previously implemented hospital-wide performance improvement program that measures, and demonstrates full achievement of, the impact of this specific Safe Practice. (pp.250-251)	*Copy of performance improvement plan or monitoring information*	

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TABLE OF CONTENTS FOR SAFE PRACTICE 23: PREVENTION OF VENTILATOR ASSOCIATED COMPLICATIONS DOCUMENTATION

Please complete the Table of Contents below. Only provide documentation for those questions in this section for which your hospital responded 'YES'

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**23.1** In regard to complications associated with ventilator use, our organization has done the following or has had the following in place within the last 12 months: a. conducted an evaluation of the frequency and severity of ventilator-associated complications, specifically ventilator associated pneumonia, venous thromboembolism, peptic ulcer disease, dental complications, and pressure ulcers in our patient population and communicated findings to senior administrative and clinical leadership. (p.290)	*Copy of evaluation and minutes, notes or presentation to senior administrative and clinical leadership*	
☐	b. submitted a report to the Board (governance) with recommendations for measurable improvement targets.	*Copy of report to the Board*	
☐	**23.2** In regard to complications associated with ventilator use, our organization has done the following or has had the following in place within the last 12 months: a. held senior administrative leadership and clinical leadership directly accountable for improvements in performance through performance reviews or compensation.	*Copy of performance reviews or compensation methodology*	
☐	b. held the patient safety officer directly accountable for improvements in performance through performance reviews or compensation.	*Copy of performance reviews or compensation methodology*	
☐	c. reported to the Board (governance) the results of the measurable improvement targets.	*Copy of meeting minutes, notes or presentation*	

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TABLE OF CONTENTS FOR SAFE PRACTICE 23 (continued)

	REQUIRED DOCUMENTATION	EXAMPLE(S)	SOURCE
☐	**23.3** In regard to complications associated with ventilator use, our organization has done the following or has had the following in place within the last 12 months: a. conducted a staff education/ knowledge transfer and skill development programs on best practices and strategies to reduce complications with attendance documented.	*Copy of training tools and attendance records*	
☐	b. documented or can document expenses incurred during the past year tied to this Safe Practice. (p.293)	*Copy of expenses referenced*	
☐	c. allocated compensated caregiver staff time and dedicated line item budget resources for best practices development for the organization's prevention of ventilator associated complications.	*Copy of information showing time and budget allocation*	
☐	**23.4** In regard to complications associated with ventilator use, our organization has done the following within the last 12 months or has had the following in place during the last 12 months and updates are made regularly: a. documented evidence that all ventilated patients are included in an appropriate adult or pediatric specific bundle or prevention plan that is clearly documented in the medical record. (p.293)	*Documentation supporting the prevention plan or bundle from the medical record*	
☐	b. implemented explicit organizational policies for the disinfection, sterilization, and maintenance of respiratory equipment that are aligned with evidenced based guidelines. (p.290)	*Copy of policies and procedures and implementation information*	
☐	c. documented evidence that all ventilated patients and/or their families have been educated on prevention measures involved in the care of the ventilated patient. (p.292)	*Copy of training tools*	
☐	d. implemented a formal performance improvement program with regular performance measurement and tracking improvement addressing ventilator associated complication prevention and compliance with prevention strategies (p.293) OR monitored a previously implemented hospital-wide performance improvement program that measures, and demonstrates full achievement of the impact of this specific Safe Practice. (p.293)	*Copy of tracking tool or information showing monitoring and achievement of this specific safe practice*	

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Section 7 – Managing Serious Errors

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for each measure in this section.
- ☐ For Never Events, hospitals may not earn credit for this question if they have only implemented a policy that includes the Center for Medicare and Medicaid (CMS) Never Events. Policy must include all **29 NQF Serious Reportable Events** AND include all 5 of Leapfrog's policy principles. Review your policy and file it in this binder.
- ☐ For the 5 infection measures (CLABSI, CAUTI, SSI Colon, MRSA, and C. Diff) print off your NHSN report for the reporting period and file it in this binder.
- ☐ Take note of who in your hospitals ran reports for you to respond to the measures in this section, particularly the hospital-acquired pressure ulcer and injury measures as custom reports may be required.
- ☐ If you used a previously submitted CDC/NHSN Annual Patient Safety Survey to respond to the questions in Section 7E Antibiotic Stewardship Practices, include a copy in this binder.
- ☐ If your IT team or data abstractor developed special code, scripts, or parameters to run any reports for you, include a note or a copy so that you can run the same reports next year.
- ☐ Be sure to print, date, label, and file all documentation used to respond to this section in this binder.
- ☐ If you submitted any questions on this section to the Leapfrog Hospital Survey Help Desk, print copies of your responses (i.e., tickets) and save them under this tab for future reference.

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Section 8 – Bar Code Medication Administration (BCMA)

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for this section.
- ☐ Review the questions and reference information for this section with anyone who is going to help you collect this data. If there are questions, contact the Leapfrog Hospital Survey Help Desk before you start collecting this data.
- ☐ Be sure to print, date, label, and file any report that you used to respond to the questions in this Section in this binder.
- ☐ If your IT team or data abstractor developed special code, scripts, or parameters to run any reports for you, include a note or a copy so that you can run the same reports next year.
- ☐ If you submitted any questions on this section to the Leapfrog Hospital Survey Help Desk, print copies of your response (i.e., tickets) and save them under this tab for future reference.

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Section 9 – Readmission for Common Acute Conditions & Procedures

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

N/A

This section of the survey is pre-populated with CMS data based on the hospital's responses to Section 9A.