LEAPFROG

ASC SURVEY

PATIENT SAFETY AND QUALITY

2024 LEAPFROG ASC SURVEY BINDER

THELEAPFROGGROUP

Giant Leaps for Patient Safety

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Overview

WHAT IS THE PURPOSE OF THIS BINDER?

The Leapfrog ASC Survey Binder is available via PDF for use by all ASCs to collect, organize, and record information during the completion of the 2024 Leapfrog ASC Survey. This document can be printed and placed in a binder. The information is helpful when completing subsequent years' Surveys, in staff and leadership transitions, and as a historical record.

The Binder only includes sections and subsections from the 2024 Leapfrog ASC Survey that are both scored and publicly reported. Sections of the 2024 Leapfrog ASC Survey that are not scored (Section 1A and 3A) are not included in this Binder.

HOW SHOULD WE USE THIS BINDER?

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

Section 1: Patient Rights and Ethics

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting time periods for this section.
- ☐ Make a note of who in your facility provided information or ran reports for you to respond to these questions.
- ☐ Be sure to print, date, label, and file reports that you used for this section in the binder.
- ☐ If you submitted questions on this section to the Leapfrog Help Desk, print copies of your responses (i.e., tickets) and save them in this tab for future reference.

1B: BILLING ETHICS

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

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**Question 1:** What pricing information is displayed on your facility's website for commonly performed procedures?	N/A	
☐	**Question 2:** Webpage URL where payer-specific negotiated charges or cash prices are displayed for consumers:	Webpage URL that displays either negotiated prices or cash prices based on response to question #1.	
☐	**Question 3:** Within 30 days of the final claims adjudication (or within 30 days from date of service for patients without insurance), does your facility 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; 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."*	1. 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.	
☐	**Question 4:** Does your facility give patients instructions for contacting a billing representative: • Who has access to an interpretation service to communicate in the patient's preferred language, and	1. Copy of instructions for contacting a billing representative.	

	• 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 facility policy, and iii. offer a payment plan	2. Policy, procedure, or position description 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 service agreement	
☐	**Question 5:** Does your facility take legal action against patients for late payment or insufficient payment of a medical bill? *This question does not include patients with whom your facility has entered into a written agreement specifying a good faith estimate for a medical service.*	Policy or procedure document that clearly indicates legal action is not taken against patients for late or insufficient payment of a medical bill, unless a pre-existing written agreement specifying a good faith estimate for a medical service is in place. 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 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).	

1C: HEALTH CARE EQUITY

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

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**Question 1:** Which of the following patient self-identified demographic data does your facility collect directly from its patients (or patient's legal guardian) prior to or while registering a patient for a facility visit?	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 facility collects.	
☐	**Question 2:** Does your facility train staff responsible for collecting the self-identified demographic data either in-person or over the phone from its patients (or patient's legal guardian) in question #1 at both: • the time of onboarding, and • annually thereafter?	1. Copy of online or in-person training curriculum. 2. Policy indicating when personnel are required to take the training.	
☐	**Question 3:** Does your facility 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. **Question 4:** By stratifying the quality measure(s) from question #3, has your facility identified any health care disparities among its patients?	Copy of results from measure stratification. 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.	
☐	**Question 5:** In the past 12 months, has your facility 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 facility developed a written action plan that describes how it will address at	Copy of updated policy or procedure or written action plan based on stratified measure results from question #3-4.	

	least one of the health care disparities identified through question #4?		
☐	**Question 6:** Does your facility 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?	Link (URL) to webpage that displays facility 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.	
☐	**Question 7:** Does your facility report out and discuss efforts related to identifying and addressing disparities with your facility's governance and leadership at least annually?	Copy of governance and leadership meeting minutes demonstrating discussion and updates of facility efforts to address disparities, which shows attendance of leadership.	

PLACE DOCUMENTATION FOR SECTION 1 AFTER THIS PAGE

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Section 2: Medical, Surgical, and Clinical Staff

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting period for this section.
- ☐ Review the questions and reference information for this section with anyone who is assisting with the collection of documentation.
- ☐ Include a copy of any reports used to respond to the questions in Section 2.
- ☐ If you submitted questions on this section to the Leapfrog Help Desk, print copies of your responses (i.e., tickets) and save them under this tab for future reference.

MEDICAL, SURGICAL, AND CLINICAL STAFF

The types of documentation you should include in this binder are provided below. Only maintain documentation for those questions in which your facility responds "yes." Note that endnotes refer to the endnotes in the hard copy of the Survey.

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**Question 1:** Is there an Advanced Cardiovascular Life Support (ACLS) trained clinician, as well as a second clinician (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 facility?	Staffing schedule (with hours indicated) for the latest 3 months prior to Survey submission and the ACLS certification documentation for certified staff on the schedule.	
☐	**Question 3:** 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 facility?	Staffing schedule (with hours indicated) for the latest 3 months prior to Survey submission and the PALS certification documentation for certified staff on the schedule.	
☐	**Question 5:** To help ensure that patients are cared for by well-trained physicians and anesthesia providers (e.g., anesthesiologists and certified registered nurse anesthetists), do your medical staff by-laws or facility-wide policies require all physicians and anesthesia providers who have privileges to provide care at your facility to be board certified or board eligible?	Copy of medical staff by-laws or facility policy specifying board certification requirements for physicians and anesthesia providers including CRNA's (if applicable).	

PLACE DOCUMENTATION FOR SECTION 2 AFTER THIS PAGE

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Section 3: Volume and Safety of Procedures

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for this section.
- ☐ For Section 3A: Volume of Procedures and Section 3B: Facility and Surgeon Volume be sure to ***only*** use those CPT codes listed for each procedure in the Library on the Survey Dashboard.
- ☐ Read the questions and FAQs in Section 3D: Informed Consent of the hard copy of the Survey to ensure that you understand the criteria for each question BEFORE you respond to the questions.
- ☐ Make a note of who in your ASC provided information, ran reports, obtained copies of policies or consent forms for you to respond to the questions.
- ☐ If your facility queried (e.g., code or scripts) your claims or other administrative data sets or followed specific protocols to abstract data from clinical records, include a note or copy so that you can create similar reports next year.
- ☐ Be sure to print, date, label, and file reports that you used for this section of the binder.
- ☐ If you submitted questions on this section to the Leapfrog Help Desk, print copies of your responses (i.e., tickets) and save them under this tab for future reference.

3A: VOLUME OF PROCEDURES

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

3B: FACILITY AND SURGEON VOLUME

The types of documentation you should include in this binder are provided below. Ensure that each document is dated according to the reporting period in question #1. Only maintain documentation for those questions in which your facility responds "yes."

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**Question 1:** 12-month or 24-month reporting period used:	N/A	
☐	**Question 2:** Check all procedures that your facility performs: Total Knee Replacement Surgery Total Hip Replacement Surgery Bariatric surgery for weight loss	N/A	
☐	**Question 3:** Total facility volume for each selected procedure during the reporting period:	Use only those CPT and ICD-10 codes listed for each procedure in the Library on the Survey Dashboard. Maintain copies of the reports used to calculate total facility volume.	
☐	**Question 4:** Does your facility's privileging process include the surgeon meeting or exceeding the minimum annual surgeon volume standard listed below?	Copy of privileging process that includes the surgeon meeting or exceeding the minimum surgeon volume standard for each procedure. The surgeon volume standard must be explicitly stated in the document.	

3D: INFORMED CONSENT

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

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**Question 1:** Does your facility have a training program on informed consent that tailors different training topics to different staff roles (including facility leaders, MD/NP/PA, nurses and other clinical staff, administrative staff, and interpreters) and has your facility 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?	1. Slide deck or content from LMS modules used in training 2. Policy indicating when personnel are required to take the training	
☐	**Question 2:** At least once a year, does your facility solicit feedback solicit feedback from patients/legal guardians about your facility'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.*	N/A	
☐	**Question 3:** As part of your facility'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?	A template consent form that includes places to document all the elements outlined in the question.	
☐	**Question 4:** Do ALL applicable consent forms used by your facility 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	A template consent form that includes places to document all the elements outlined in the question.	

	• whether any assistants or trainees will be involved in the procedure, if applicable?		
☐	**Question 5:** Are ALL applicable consent forms used by your facility 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.*	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. 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.	
☐	**Question 6:** Prior to the informed consent discussion, does your facility: • 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 member or caregiver; • use a consent form or notation in the medical record to document whether a qualified medical interpreter was	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	

	used to conduct the informed consent process; and • have the medical interpreter sign the consent form (either in-person, electronically, or by documenting the use of an interpreter in the medical record)?	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	
☐	**Question 7:** As part of the informed consent discussion, do clinicians at your facility 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?	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.	

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

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

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
☐	**Question 2:** Does your facility utilize a safe surgery checklist on every patient every time one of the applicable procedures in Section 3A and 3B (if applicable) is performed?	N/A	
☐	**Question 3: Before the induction of anesthesia,** is a safe surgery checklist that includes all the following elements read aloud in the presence of the anesthesia professional and nursing personnel: • Patient ID • Confirmation of procedure • Patient consent • Site marked, if applicable • Anesthesia/medication check • Allergies assessed • Difficult airway/aspiration risk • Risk of blood loss (only applicable risk of blood loss is >500ml for adults or >7ml/kg for children) • Availability of devices (applicable to endoscopy procedures only)?	Copy of checklist that includes each element in the question and information regarding **when** the checklist was read aloud and **who** was present.	
☐	**Question 4: Before the skin incision and/or before the procedure begins,** is a safe surgery checklist that includes all 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 • Essential imaging available, if applicable	Copy of checklist that includes each element in the question and information regarding **when** the checklist was read aloud and **who** was present.	
☐	**Question 5: Before the patient leaves the operating room and/or procedure room,** is a safe surgery checklist that includes all 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	Copy of checklist that includes each element in the question and information regarding **when** the checklist was read aloud and **who** was present.	

	• Equipment concerns • Patient recovery/management concerns?		
☐	**Question 6:** Did your facility perform an audit (either in-person or via the medical record or other EHR data) on at least 30 cases of patients who underwent a procedure included in Section 3A and 3B, if applicable and measure adherence to the safe surgery checklist?	N/A	
☐	**Question 7:** How many cases were included in the audit from question #6?	N/A	
☐	**Question 8:** Which method was used to perform the audit on at least 30 cases of patients who underwent a procedure in Section 3A and 3B?	N/A	
☐	**Question 9:** Based on your facility's audit (either in-person or via the medical record or other EHR data) on at least 30 cases of patients who underwent an applicable procedure included in Section 3A and 3B, what was your facility's documented rate of adherence to the safe surgery checklist (e.g., what percentage of the sampled cases had all elements in questions #3, #4, and #5 completed)?	**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.	

PLACE DOCUMENTATION FOR SECTION 3 AFTER THIS PAGE

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Section 4: Patient Safety Practices

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

- ☐ Review the reporting periods for this section.
- ☐ Make a note of who in your ASC provided information or ran reports for you to respond to the questions.
- ☐ Be sure to print, date, label, and file reports that you used for this section of the binder.
- ☐ If you submitted questions on this section to the Leapfrog Help Desk, print copies of your responses (i.e., tickets) and save them under this tab for future reference.

4A: MEDICATION SAFETY: MEDICATION AND ALLERGY DOCUMENTATION

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

4B: NHSN OUTPATIENT PROCEDURE COMPONENT MODULE

For the NHSN OPC Module Measures (OPC Annual Facility Survey, SDOM, BRST SSI, HER SSI, KPRO SSI, LAM SSI), print your NHSN reports for the reporting period using the instructions provided on the Join NHSN Group webpage and include them in this binder.

Note that Leapfrog recommends that facilities save copies of the NHSN 2023 Outpatient Procedure Component – Annual Facility Survey and SDOM/SSI Reports on the same day that Leapfrog will be downloading the data from NHSN for all current group members. Download the NHSN Guidance Document on the Join NHSN Group webpage for instructions.

4C: HAND HYGIENE

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

SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
Training and Education		
Question 1: Do individuals who touch patients or who touch items that will be used by patients in your facility receive hand hygiene training from a professional with appropriate training and skills at **both**: • the time of onboarding, and • annually thereafter?	1. Copy of online or in-person training curriculum. 2. Credentials of hand hygiene trainer 3. Policy indicating when personnel are required to take the training	
Question 2: In order to pass the **initial** hand hygiene training, do individuals who touch patients or who touch items that will be used by patients need to physically demonstrate proper hand hygiene with soap and water and alcohol-based hand sanitizer?	Curriculum from an in-person orientation or other in-person session (e.g., occupational health session) which includes physical demonstration of hand hygiene and associated sign in sheets.	
Question 3: Are **all** six of the following topics included in your facility's initial and annual hand hygiene training: • Evidence linking hand hygiene and infection prevention; • When individuals who touch patients or who touch items that will be used by patients should perform hand hygiene (e.g., WHO's 5 Moments for Hand Hygiene, CDC's Guideline for Hand Hygiene); • How individuals who touch patients or who touch items that will be used by patients should clean their hands with alcohol-based hand sanitizer and soap and water as to ensure they cover all surfaces of hands and fingers, including thumbs and fingernails; • When gloves should be used in addition to hand washing (e.g., caring for C. diff. patients) and how hand hygiene should be performed when gloves are used; • The minimum time that should be spent performing hand hygiene with soap and water and alcohol-based hand sanitizer; and • How hand hygiene compliance is monitored?	Copy of online or in-person training curriculum for initial and annual hand hygiene training which includes all **six** topics.	
Infrastructure		

Question 4: Does your facility conduct quarterly audits on a sample of dispensers 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 facility) are replaced?	1. Policy or procedure document that includes all elements outlined in the question. 2. Results from a quarterly audit showing that a sample of dispensers were checked to ensure that the following were refilled or replaced: - paper towels - soap dispensers - alcohol-based hand sanitizer dispensers - batteries in automated paper towel dispensers, soap dispensers, and alcohol-based hand sanitizer dispensers.	
Question 5: Do **all** rooms and bed spaces in your surgical and treatment areas have • an alcohol-based hand sanitizer dispenser located at the entrance to the room or bed space, and • alcohol-based hand sanitizer dispenser(s) located inside the room or bed space that are equally accessible to the location of all patients in the room or bed space?	Would be verified via Leapfrog's on-site verification protocol.	
Question 6: Does your facility conduct audits of the volume of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated) on a sample of dispensers in your facility 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 facility conducted an audit of the volume of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated) on a sample of your facility's existing dispensers if there have been no changes to any dispensers?	1. Policy or procedure document outlining policies for conducting audits. 2. Results from an audit showing that a sample of dispensers were audited.	
Question 7: Do all the audited dispensers deliver, with one activation, 1.0 mL of alcohol-based hand sanitizer OR a volume of alcohol-based sanitizer that covers the hands completely and requires 15 or more seconds for hands to dry (on average)?	Results from the audit in question #6 showing that the required volume was met (1.0 mL of alcohol-based hand sanitizer or a volume that requires 15 or more seconds for hands to dry) on all sampled dispensers.	

Monitoring		
Question 8: Does your facility collect hand hygiene compliance data on at least **200** hand hygiene opportunities, or at least the number of hang hygiene opportunities outlined in Table 1, **each month**?	1. Report showing **summary** counts of monthly opportunities monitored which shows at least 200 hand hygiene opportunities were monitored in the facility (or the number outlined based on the table in the Survey). At a minimum, the report needs to include the month preceding the time of submission of Section 4C Hand Hygiene. The facility should also have a process in place to ensure they can continue to meet the requirement moving forward. 2. For facilities where less than 200 opportunities are being monitored (refer to sample sizes in table in the Survey): - historical data used (e.g., past year, 6 months, 3 months etc.) showing the average number of procedures in a month; and - determined sample size that was used (based on sample sizes in the table in the Survey).	
Question 9: Does your facility collect hand hygiene compliance data on at least **100** hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined in Table 2, **each month**?	1. Report showing **summary** counts of monthly opportunities monitored which shows at least 100 hand hygiene opportunities were monitored in the facility (or the number outlined based on the table in the Survey). At a minimum, the report needs to include the month preceding the time of submission of Section 4C Hand Hygiene. The facility should also have a process in place to ensure they can continue to meet the requirement moving forward. 2. For facilities where less than 200 opportunities are being monitored (refer to sample sizes in table in the Survey):	

	- historical data used (e.g., past year, 6 months, 3 months etc.) showing the average number of procedures in a month; and - determined sample size that was used (based on sample sizes in the table in the Survey).	
Question 10: Does your facility collect hand hygiene compliance data on at least **100** hand hygiene opportunities **each quarter**?	1. Report showing **summary** counts of quarterly opportunities monitored which shows at least 100 hand hygiene opportunities were monitored in the facility. At a minimum, the report needs to include the quarter (or most recent 3 months) preceding the time of submission of Section 4C Hand Hygiene. The facility should also have a process in place to ensure they can continue to meet the requirement moving forward.	
Question 11: Does your facility use hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will be used by patients with feedback on both when they are and are not compliant with performing hand hygiene?	List of staff who serve as hand hygiene coaches/observers and the schedules they followed for observing/coaching.	
Direct Monitoring – Electronic Compliance Monitoring System		
Question 12: In those surgical or treatment areas where an electronic compliance monitoring system is used, does the monitoring system used meet both of the following criteria: • The system can identify both opportunities for hand hygiene and that hand hygiene was performed, and • The facility itself has validated the accuracy of the data collected by the electronic compliance monitoring system?	Would be verified via Leapfrog's on-site verification protocol.	
Question 13: In those surgical or treatment areas where an electronic compliance monitoring system is used, are direct observations also conducted for coaching and intervention purposes that meet all the following criteria: • Observers immediately intervene prior to any harm occurring to provide non-compliant individuals with immediate feedback;	1. Example of direct observation template or sheet (electronic or paper copy) used by observers/coaches which shows: - if the observer/coach intervened (observer/coach needs to intervene in all cases of noncompliance) - the date as well as the start and end time of the	

• Observations identify both opportunities for hand hygiene and compliance with those opportunities; • Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct; • Observations are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch patients or who touch items that will be used by patients on duty for that shift; 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)?	observation session (or the date and shift being observed) - the area where the observation session is being conducted - the role of the individual being observed (e.g., nurse, physician, etc.) - the indication (or moment) for performing hand hygiene that is observed (e.g., before/after touching a patient, before/after a procedure, before/after touching patient surroundings, etc.) - whether hand hygiene was performed or not performed based on the indication noted **and** if the technique was correct. 2. Report showing a **summary** of weekly or monthly direct observation data (or description) which shows: - observations for coaching/intervention purposes were conducted for **all** surgical or treatment areas where an electronic compliance monitoring system is used - observations within a surgical or treatment area were conducted weekly or monthly across all shifts and on all days of the week (i.e., a summary of observation counts by day of week and observation counts by shift for each unit OR a description of how this is accomplished) - observations capture a representative sample of the different roles of individuals, e.g., nurses, physicians, techs, environmental services workers (i.e., a summary of observation counts by role OR a description of how this is accomplished).	
Direct Monitoring- Direct Observation		

Question 14: In those surgical or treatment areas where an electronic compliance monitoring system is NOT used, do the direct observations meet all the following criteria: • Observations identify both opportunities for hand hygiene and compliance with those opportunities; • Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct; • Observations are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch patients or who touch items that will be used by patients20F12 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 21F12 (e.g., nurses, physicians, techs, environmental services workers)?	1. Example of direct observation template or sheet used by observers which shows: - the date as well as the start and end time of the observation session (or the date and shift being observed) - the area where the observation session is being conducted - the role of the individual being observed (e.g., nurse, physician, etc.) - the indication (or moment) for performing hand hygiene that is observed (e.g., before/after touching a patient, before/after a procedure, before/after touching patient surroundings, etc.) - whether hand hygiene was performed or not performed based on the indication noted **and** if the technique was correct. 2. Report showing a **summary** of weekly or monthly direct observation data (or description) which shows: - observations for coaching/intervention purposes were conducted for **all** surgical or treatment areas where an electronic compliance monitoring system is used - observations within a surgical or treatment area were conducted weekly or monthly across all shifts and on all days of the week (i.e., a summary of observation counts by day of week and observation counts by shift for each unit OR a description of how this is accomplished) - observations capture a representative sample of the different roles of individuals, e.g., nurses, physicians, techs, environmental services workers (i.e., a summary of observation counts by role OR a description of how this is accomplished).	

Question 15: Does your facility have a system in place for both the initial and recurrent training and validation of hand hygiene compliance observers?	1. Training schedule for hand hygiene compliance observers which shows initial and recurrent training. 2. Results/documentation of regular quality monitoring of hand hygiene compliance observers (e.g., comparing results from simultaneous data collection by someone from Infection Control and a hand hygiene compliance observer, interactive video assessments, etc.).	
Feedback		
Question 16: Are hand hygiene compliance data fed back to individuals who touch patients or who touch items that will be used by patients at least monthly for improvement work?	Documentation of how hand hygiene compliance data were delivered monthly to individuals who touch patients or who touch items that will be used by patients (e.g., report, handout, e-mail, etc.).	
Question 17: Are hand hygiene compliance data used for creating action plans?	Action plans based on hand hygiene compliance data (hand hygiene compliance data should be highlighted).	
Question 18: Is regular (at least every 6 months) feedback of hand hygiene compliance data, with demonstration of trends over time, given to: • ASC leadership, and • ASC governance?	Documentation of how hand hygiene compliance data, with demonstration of trends over time, were delivered at least every 6 months to ASC leadership and ASC governance (e.g., report, handout, e-mail, etc.).	
Question 19: If "yes" to question #18, is ASC leadership held directly accountable for hand hygiene performance through performance reviews or compensation?	Performance reviews or compensation methodology for ASC leadership which include accountability for hand hygiene performance (e.g., meeting targets for hand hygiene compliance rates, bonuses tied to implementation of technology, etc.).	
Culture		
Question 20: Are patients and visitors invited to remind individuals who touch patients or who touch items that will be used by patients to perform hand hygiene?	Examples or photos of posters, bedside placards, buttons worn by staff, or other materials used to invite patients and visitors to remind individuals to perform hand hygiene.	

Question 21: Has ASC leadership demonstrated a commitment to support hand hygiene improvement in the last year (e.g., a written or verbal commitment delivered to those individuals who touch patients or who touch items that will be used by patients)?	Written or verbal commitments to support hand hygiene improvement dated within the last 12 months from the leadership (e.g., e-mails, videos, minutes or talking points from town hall meetings, public comments to staff, etc.) that are addressed to individuals who touch patients or who touch items that will be used by patients.	

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

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

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
1.1 Within the last 12 months, in regard to raising the awareness of key stakeholders to our facility's efforts to improve patient safety, the following actions related to the identification and mitigation of risks and hazards have been taken:			
☐	a. governance meeting minutes reflect regular communication regarding all three of the following: • risks and hazards (as defined by Safe Practice #4, Identification and Mitigation of Risks and Hazards); • culture measurement (as defined by Safe Practice #2, Culture Measurement, Feedback, and Intervention); and • progress towards resolution of safety and quality problems. (p.75)	Governance meeting minutes, with dates reflecting regular communication about all three topics. The discussion of these items can be a general note in the minutes, without specific details. However, facilities should maintain copies of dated presentations and reports related to these agenda items in order to document adherence to these elements.	
☐	b. steps have been taken to report ongoing efforts to improve safety and quality in the facility and the results of these efforts to the community. (p.75)	1. Report can take the form of a webpage, e-newsletter, mailing, or publicized annual report. 2. Report must include descriptions of BOTH the efforts to improve safety and quality and the measurable results of those efforts. Efforts the facility is taking to improve safety and quality should be related to reducing or preventing patient safety adverse events. Please see Section 4E Never Events for a list of adverse events.	
☐	c. all staff and independent practitioners were made aware of ongoing efforts to reduce risks and	Reports, presentations, meeting minutes, emails, or	

	hazards and to improve patient safety and quality in the facility. (p.75)	intranet page, that clearly demonstrate information regarding ongoing efforts to reduce patient safety risks and hazards and to improve safety and quality have been communicated to all staff and independent practitioners. Efforts the facility is taking to improve safety and quality should be related to reducing or preventing patient safety adverse events. Please see Section 4E Never Events for a list of adverse events.	
1.2 Within the last 12 months, in regard to holding governance and leadership directly accountable for results related to the identification and mitigation of risks and hazards, the facility has done the following:			
☐	a. an integrated patient safety program has been in place for the entire reporting period providing oversight and alignment of safe practice activities. (p.76)	Patient safety program that specifically addresses the safe practice activities.	
☐	b. Risk Manager or Quality Coordinator has been appointed and communicates regularly with governance and leadership; the Risk Manager or Quality Coordinator is the primary point of contact of the integrated patient safety program. (p.76)	1. Copy of Risk Manager or Quality Coordinator position description that includes the responsibilities in the question 2. Examples of reports or presentations presented to governance and meeting minutes showing communication with governance and leadership.	
☐	c. performance has been documented in performance reviews and/or compensation incentives for leadership and ASC-employed caregivers. (p.76)	Performance review templates or compensation incentives for all levels described which includes language related to identifying and reducing unsafe practices.	
	d. the patient safety team, Risk Manager, or Quality Coordinator communicated regularly with leadership regarding both of the following and documented these communications in meeting minutes (pp. 76-77). • progress in meeting safety goals; and • provide team training to caregivers.	1. Reports or presentations to leadership. 2. Meeting notes/minutes with attendance noted. Meeting minutes from more than one meeting should be	

		provided in order to reflect regular communication.	
☐	e. the facility reported adverse events to external mandatory or voluntary programs. (p.77)	Policy on external reporting or evidence that adverse events have been reported to external programs. Please see Section 4E Never Events for a list of adverse events.	
1.3 Within the last 12 months, in regard to implementation of the patient safety program, governance and leadership have provided resources to cover the implementation, as evidenced by:			
☐	a. dedicated patient safety program budgets to support the program, staffing, and technology investment. (p.77)	Line-item budget.	
1.4 Within the last 12 months, structures and systems have been in place to ensure that leadership is taking direct action, as evidenced by:			
☐	a. leadership is personally engaged in reinforcing patient safety improvements (e.g., holding patient safety meetings and reporting to governance). Calendars reflect allocated time. (p.78)	1. Copies of patient safety or governance meeting agendas or minutes that demonstrate facility leadership personally communicated information on patient safety improvements 2. Documented results from implementing patient safety improvement projects	
☐	b. facility has established a structure for input into the patient safety program by licensed independent practitioners and the organized medical staff and physician leadership. Input documented in meeting minutes or materials. (p.79)	Meeting minutes with list of attendees. Input for the patient safety program by licensed independent practitioners and the organized medical staff and physician leadership should be highlighted.	

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

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

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
2.1 Does your facility currently have 20 or more employees?		N/A	
2.2 Within the last 24 months, in regard to culture measurement, our facility has done the following:			
☐	a. Administered one of the following culture of safety surveys to employees: • AHRQ Survey on Patient Safety (SOPS), • Glint Patient Safety Pulse • Press Ganey Safety Culture Survey, or • Safety, Communication, Organizational Reliability, Physician & Employee Burnout and Engagement (SCORE) Survey	Results from culture of safety survey that show patient care or treatment areas surveyed; be sure results are dated within past 24 months of submission date. Results should include participation rate.	
☐	b. benchmarked results of the culture of safety survey against external organizations, such as "like" ASCs or other comparable facilities within the same health system.	Benchmark results and list of facilities in the benchmark group; be sure report is dated.	
☐	c. Risk Manager, Quality Coordinator, or leadership used the results of the culture of safety survey to debrief staff using semi-structured approaches for the debriefings and presenting results in aggregate form to ensure the anonymity of survey respondents.	Meeting notes or presentation lead by local patient safety leaders that reflects semi-structured approach, with attendance reflecting units.	
2.3 Within the last 24 months, in regard to accountability for improvements in culture measurement, our facility has done the following:			
☐	a. shared the results of the culture of safety survey with governance and leadership in a formal report and discussion. (p.88)	Governance and leadership agenda, minutes, and/or presentation. All documentation should be dated.	
☐	b. included in performance evaluation criteria for leadership, both the response rates to the culture of safety survey and the use of the culture of safety survey results in the improvement efforts.	Performance evaluation of leadership that reflects response rates to survey and improvement efforts	

NQF SAFE PRACTICE #2 (continued)

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
2.4 Within the last 12 months, in regard to culture measurement, the facility has done the following (or has had the following in place):			
☐	a. conducted staff education program(s) on methods to improve the culture of safety, tailored to the facility's culture of safety survey results.	Education session curriculum and sign in sheets. Examples of documentation from personnel or administrative records.	
☐	b. included the costs of culture measurement/follow-up activities in the patient safety program budget.	Line-item budget or expenses related to culture measurement/ follow-up activities.	
2.5 Within the last 12 months, in regard to culture measurement, feedback, and interventions, our facility has done the following (or has had the following in place):			
☐	**2.5 Within the last 12 months, in regard to culture measurement, feedback, and interventions, our facility has done the following (or has had the following in place):** a. developed or implemented explicit, facility-wide organizational policies and procedures for regular culture measurement. (p.88)	Policies and/or examples of strategies implemented (i.e., meetings, education, events, etc.).	
☐	b. identified performance improvement interventions based on the culture of safety survey results, which were shared with leadership and subsequently measured and monitored. (p.88)	Dashboard of metrics, progress report, etc. showing performance improvement intervention, and meeting minutes showing attendance by leadership.	
Additional Question (Optional – Fact Finding Only)			
2.6 What was the response rate (i.e., rate of returned surveys) among employees that were administered the culture of safety survey within the past 36 months?		N/A	

4D: NQF SAFE PRACTICE #4: RISKS AND HAZARDS

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

	SURVEY QUESTION	REQUIRED DOCUMENTATION	SOURCE
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; • ASC 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.	List of retrospective sources used to assess risks and hazards.	
☐	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.	Copy of completed FMEA or Probabilistic Risk Assessment dated within the reporting period.	
☐	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.	Copy of risk mitigation plan developed from 4.1a and 4.1b	
☐	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.	Copies of communications sent to board and front-line caregivers that clearly demonstrate the information from 4.1a, 4.1b, and 4.1c was included in the communication.	

	SURVEY QUESTION	REQUIRED DOCUMENTATION	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. incorporation of the identification and mitigation of risks into performance reviews	Performance review templates for facility leadership which includes language related to identifying and mitigating risks.	
4.2 Leadership is accountable for identification of risks and hazards to patients, and mitigation efforts in the past year, as evidenced by:			
☐	a. resourced patient safety program budgets sufficiently to support ongoing risk and hazard assessments and programs for reduction of risk.	Line-item budget or expenses related to risk and hazard assessments and programs to reduce risks and hazards.	

4E: NEVER EVENTS

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

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

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

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

4F: NURSING WORKFORCE: PERCENTAGE OF RNs WHO ARE BSN-PREPARED

Maintain a copy of the report your facility used to respond to questions #1-3 in Section 4F. Facilities selected for Leapfrog's Monthly Documentation Request for this measure will be asked to submit a report that should include the following information:

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

PLACE DOCUMENTATION FOR SECTION 4 AFTER THIS PAGE

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Section 5: Patient Experience (OAS CAHPS)

TIPS/GUIDELINES FOR COLLECTING, ORGANIZING & RECORDING INFORMATION

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

PLACE DOCUMENTATION FOR SECTION 5 AFTER THIS PAGE

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