Hospital Survey on Patient Safety Culture

Feedback Results

{Site}
{City, State}
{Date}

For further information about this feedback report, contact:

Name
Title
Address
Phone
Email

Survey Background

The *Hospital Survey on Patient Safety Culture* was sponsored by the Quality Interagency Coordination Task Force (QuIC), a group established in accordance with a 1998 Presidential directive to ensure that all Federal agencies involved in purchasing, providing, studying, or regulating health care services are working together and toward a common goal of improving quality care. The survey was funded by the Agency for Healthcare Research and Quality (AHRQ).

The development of this safety culture assessment tool included a review of the scientific literature pertaining to safety, error and accidents, as well as error reporting. In addition, hospital employees and managers were interviewed to identify key patient safety and error reporting issues. Other published and unpublished safety culture assessment tools also were examined.

Survey Measures

The Hospital Survey on Patient Safety Culture is designed to measure:

Four overall patient safety outcomes:

1. Overall perceptions of safety
2. Frequency of events reported
3. Number of events reported
4. Overall patient safety grade

The research survey also is intended to measure:

Ten dimensions of culture pertaining to patient safety:

1. Supervisor/manager expectations & actions promoting patient safety
2. Organizational learning – continuous improvement
3. Teamwork within units
4. Communication openness
5. Feedback & communications about error
6. Nonpunitive response to error
7. Staffing
8. Hospital management support for patient safety
9. Teamwork across hospital units
10. Hospital handoffs & transitions

Survey Methodology

In a short paragraph, describe your hospital's sample and data collection methodology, for example:

In Date(s), the *Hospital Survey on Patient Safety Culture* was distributed to a sample of XX (or all) staff at Hospital X. Overall, **XX responses to the survey were received, a(n) XX% response rate**.

To maximize response rates, standard survey procedures were followed:

1. A prenotification letter from the hospital X was distributed, encouraging participation.
2. One week later, the survey was distributed, including a cover letter from the hospital X, a survey, and a postage-paid return envelope.
3. Two weeks after the survey, a reminder postcard was distributed to nonrespondents.
4. Two weeks after the reminder postcard, a second survey was distributed to nonrespondents.
5. Two weeks after the second survey, a final reminder postcard was distributed to nonrespondents.

In this feedback report, the percentages of employee responses to specific survey items are grouped according to the safety culture dimensions being assessed. Some percentages shown in the graphs may not add to exactly 100 percent, due to rounding. Since the total number of respondents was XX, in each graph XX% is approximately equivalent to one person's answer.

Demographic Data about Respondents

1. Primary hospital work area, department or clinical area where respondents spend most of their work time:

- % Many different hospital units / No specific unit
- % Medicine (non-surgical)
- % Surgery
- % Obstetrics
- % Pediatrics
- % Emergency department
- % Intensive care unit (any type)
- % Psychiatry / mental health
- % Rehabilitation
- % Pharmacy
- % Laboratory
- % Radiology
- % Anesthesiology
- % Other
- % (Blank/Missing)

2. Staff position in the hospital:

- % Registered nurse
- % Physician assistant / Nurse practitioner
- % LVN / LPN
- % Patient care assistant / Hospital aide / Care partner
- % Attending / Staff physician
- % Resident physician / Physician in training
- % Pharmacist
- % Dietician
- % Unit assistant / Clerk / Secretary
- % Respiratory therapist
- % Physical, occupational, or speech therapist
- % Technician (e.g., EKG, Lab, Radiology)
- % Administration / Management
- % Other
- % (Blank/Missing)

Demographic Data (continued)

3. Time worked

--in the hospital (hours/week)	% Less than 20 hours	% 20 to 39 hours	% 40 hours or more
--in the hospital (years)	% Less than 1 year	% 1 to 5 years	% 6 to 10 years
	% 11 to 15 years	% 16 to 20 years	% 21 years or more
--in their current hospital work area (years)	% Less than 1 year	% 1 to 5 years	% 6 to 10 years
	% 11 to 15 years	% 16 to 20 years	% 21 years or more
--in their current specialty (years)	% Less than 1 year	% 1 to 5 years	% 6 to 10 years
	% 11 to 15 years	% 16 to 20 years	% 21 years or more

4. Percentage of respondents with direct interaction or contact with patients: %

Main Findings: Strengths

We identify as strengths, those positively worded items which about 75% of respondents endorse by answering “Agree / Strongly agree,” or “Most of the time / Always” (or when about 75% of respondents *disagreed* with negatively worded items).

A number of strengths emerged from the results:

- Most respondents…
- Respondents…

Main Findings: Areas for Improvement

Areas with the potential for improvement were identified as items which about 50% of respondents answered negatively using “Disagree / Strongly disagree” or “Never / Rarely” (or when 50% of respondents *disagreed* with positively worded items).

A number of areas for improvement emerged from the results:

- Most respondents….
- Respondents…..

Overall Perceptions of Safety

Survey Items	% Strongly Disagree/ Disagree	% Neither	% Strongly Agree/ Agree
1. Patient safety is never sacrificed to get more work done. (A15)	5	5	5
2. Our procedures and systems are good at preventing errors from happening. (A18)	5	5	5
R3. It is just by chance that more serious mistakes don't happen around here. (A10)	5	5	5
R4. We have patient safety problems in this unit. (A17)	5	5	5

R Indicates reversed-worded items.
NOTE: The item letter and number in parentheses indicate the item's survey location.

Frequency of Events Reported

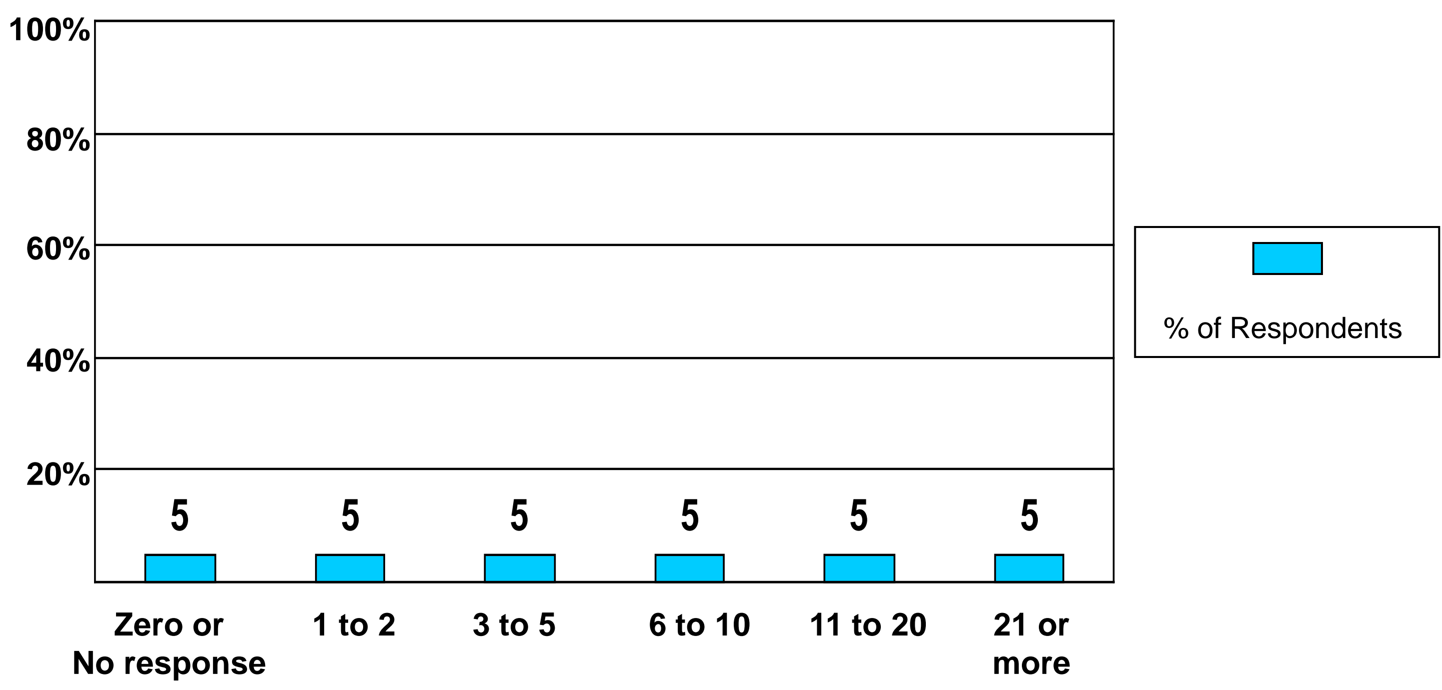
Survey Items	% Never/ Rarely	% Sometimes	% Most of the time/Always
1. When a mistake is made, but is *caught and corrected before affecting the patient*, how often is this reported? (D1)	5	5	5
2. When a mistake is made, but has *no potential to harm the patient*, how often is this reported? (D2)	5	5	5
3. When a mistake is made that *could harm the patient*, but does not, how often is this reported? (D3)	5	5	5

NOTE: The item letter and number in parentheses indicate the item's survey location.

Number of Events Reported

Respondents were asked to indicate the number of events they had reported in the past 12 months.

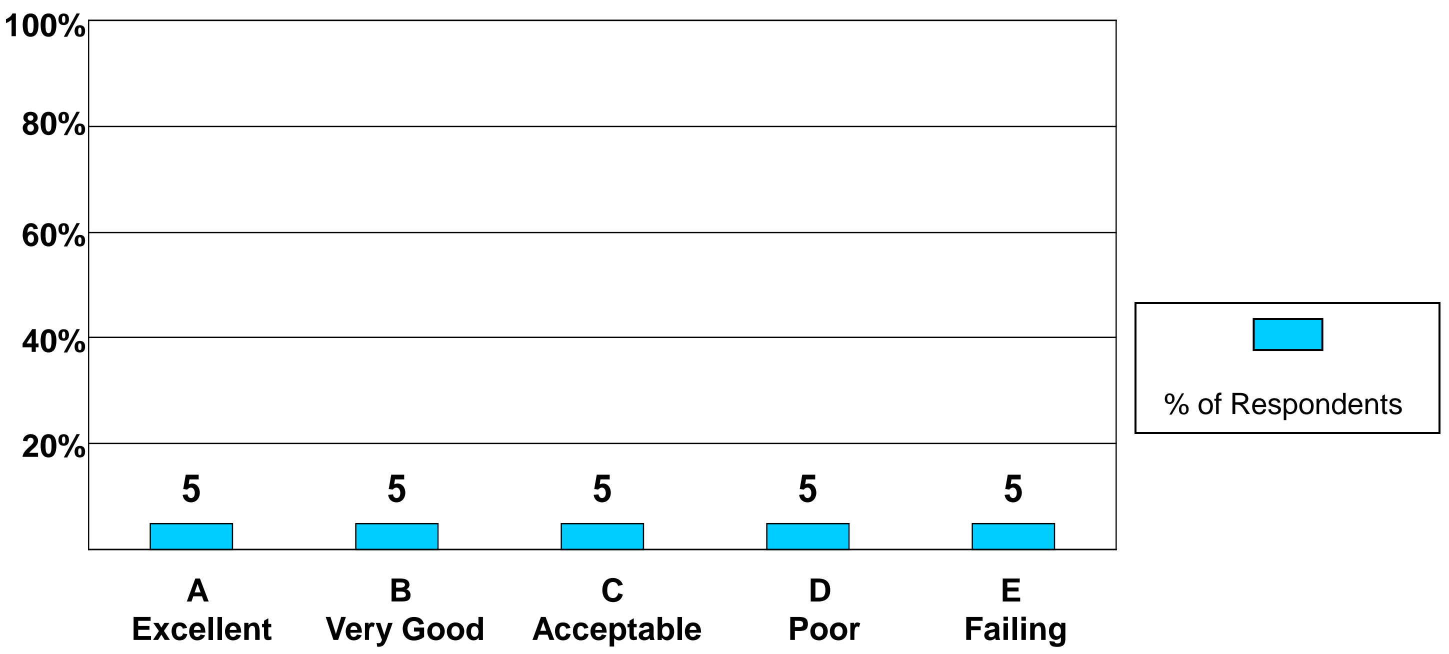
1. In the past 12 months, how many event reports have you filled out and submitted? (Survey item G1)



Overall Patient Safety Grade

Respondents were asked to give their work unit an overall grade on patient safety.

2. Please give your work area/unit in this hospital an overall grade on patient safety.
(Survey item E1)



Supervisor/Manager Expectations & Actions Promoting Patient Safety

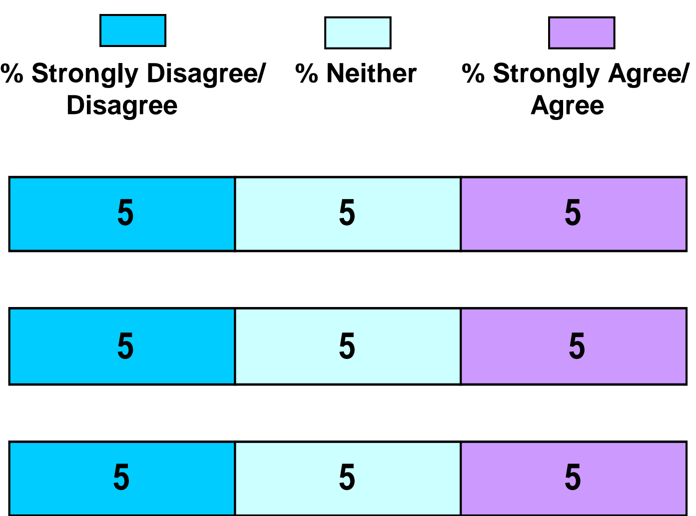
Survey Items	% Strongly Disagree/ Disagree	% Neither	% Strongly Agree/ Agree
1. My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures. (B1)	5	5	5
2. My supervisor/manager seriously considers staff suggestions for improving patient safety. (B2)	5	5	5
[R]3. Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts. (B3)	5	5	5
[R]4. My supervisor/manager overlooks patient safety problems that happen over and over. (B4)	5	5	5

[R] Indicates reversed-worded items.
NOTE: The item letter and number in parentheses indicate the item's survey location.

Organizational Learning—Continuous Improvement

Survey Items

1. We are actively doing things to improve patient safety. (A6)
2. Mistakes have led to positive changes here. (A9)
3. After we make changes to improve patient safety, we evaluate their effectiveness. (A13)



NOTE: The item letter and number in parentheses indicate the item's survey location.

Teamwork Within Units

Survey Items	% Strongly Disagree/ Disagree	% Neither	% Strongly Agree/ Agree
1. People support one another in this unit. (A1)	5	5	5
2. When a lot of work needs to be done quickly, we work together as a team to get the work done. (A3)	5	5	5
3. In this unit, people treat each other with respect. (A4)	5	5	5
4. When one area in this unit gets really busy, others help out. (A11)	5	5	5

NOTE: The item letter and number in parentheses indicate the item's survey location.

Communication Openness

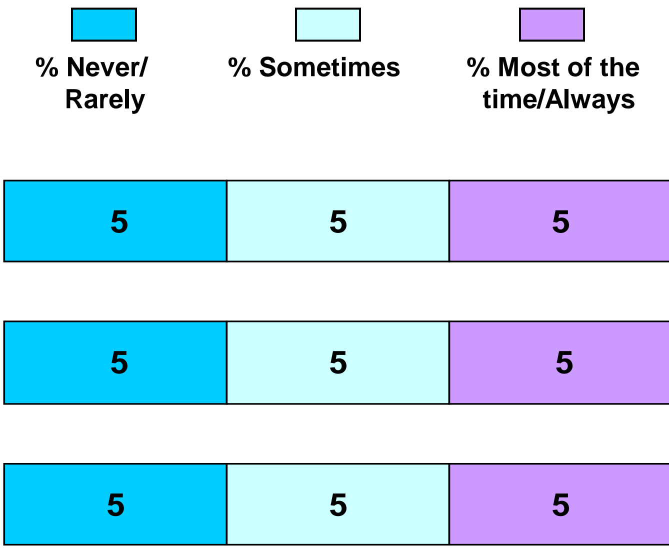
Survey Items	% Never/ Rarely	% Sometimes	% Most of the time/Always
1. Staff will freely speak up if they see something that may negatively affect patient care. (C2)	5	5	5
2. Staff feel free to question the decisions or actions of those with more authority. (C4)	5	5	5
[R]3. Staff are afraid to ask questions when something does not seem right. (C6)	5	5	5

[R] Indicates reversed-worded items.
NOTE: The item letter and number in parentheses indicate the item's survey location.

Feedback and Communication About Error

Survey Items

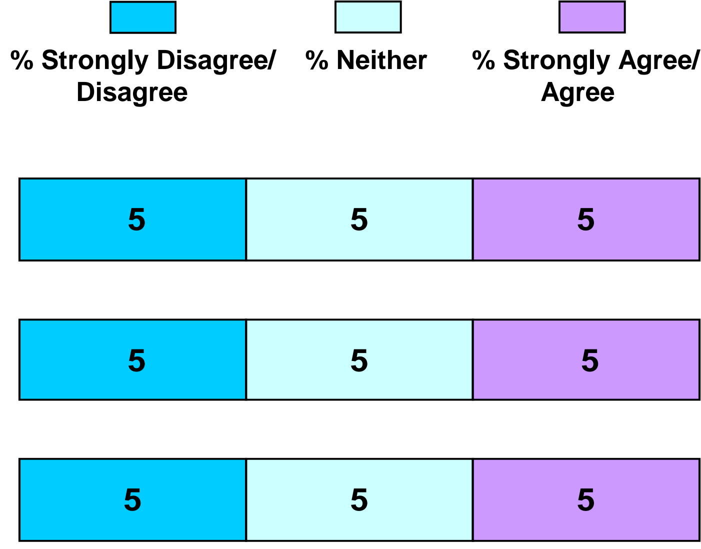
1. We are given feedback about changes put into place based on event reports. (C1)
2. We are informed about errors that happen in this unit. (C3)
3. In this unit, we discuss ways to prevent errors from happening again. (C5)



NOTE: The item letter and number in parentheses indicate the item's survey location.

Nonpunitive Response to Error

Survey Items



R1. Staff feel like their mistakes are held against them. (A8)

R2. When an event is reported, it feels like the person is being written up, not the problem. (A12)

R3. Staff worry that mistakes they make are kept in their personnel file. (A16)

R Indicates reversed-worded items.
NOTE: The item letter and number in parentheses indicate the item's survey location.

Staffing

Survey Items	% Strongly Disagree/ Disagree	% Neither	% Strongly Agree/ Agree
1. We have enough staff to handle the workload. (A2)	5	5	5
R2. Staff in this unit work longer hours than is best for patient care. (A5)	5	5	5
R3. We use more agency/temporary staff than is best for patient care. (A7)	5	5	5
R4. We work in "crisis mode" trying to do too much, too quickly. (A14)	5	5	5

R Indicates reversed-worded items.
NOTE: The item letter and number in parentheses indicate the item's survey location.

Hospital Management Support for Patient Safety

Survey Items	% Strongly Disagree/ Disagree	% Neither	% Strongly Agree/ Agree
1. Hospital management provides a work climate that promotes patient safety. (F1)	5	5	5
2. The actions of hospital management show that patient safety is a top priority. (F8)	5	5	5
[R]3. Hospital management seems interested in patient safety only after an adverse event happens. (F9)	5	5	5

[R] Indicates reversed-worded items.
NOTE: The item letter and number in parentheses indicate the item's survey location.

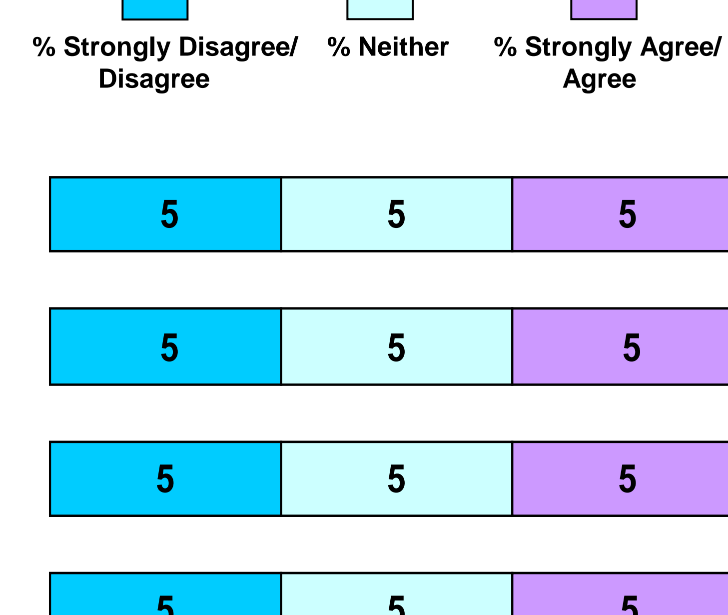
Teamwork Across Hospital Units

Survey Items

1. There is good cooperation among hospital units that need to work together. (F4)
2. Hospital units work well together to provide the best care for patients. (F10)

[R]3. Hospital units do not coordinate well with each other. (F2)

[R]4. It is often unpleasant to work with staff from other hospital units. (F6)



[R] Indicates reversed-worded items.
NOTE: The item letter and number in parentheses indicate the item's survey location.

Hospital Handoffs & Transitions

Survey Items	% Strongly Disagree/ Disagree	% Neither	% Strongly Agree/ Agree
R1. Things “fall between the cracks” when transferring patients from one unit to another. (F3)	5	5	5
R2. Important patient care information is often lost during shift changes. (F5)	5	5	5
R3. Problems often occur in the exchange of information across hospital units. (F7)	5	5	5
R4. Shift changes are problematic for patients in this hospital. (F11)	5	5	5

R Indicates reversed-worded items.
NOTE: The item letter and number in parentheses indicate the item’s survey location.

Staff Comments

(verbatim with spelling and grammar edits)

X% of respondents wrote comments (N = X)

"Section I: Your Comments—Please feel free to write any comments about patient safety, error, or event reporting in your hospital."

Staff Comments Page 1