# Final Results from the Hospital Survey on Patient Safety Culture
## Hospital Name

**Survey Period: December 2008**

**DEFINITIONS**

**Positive:** Percent of responses that were rated a 4 or 5 (Agree / Strongly agree or Most of the Time / Always) for positively worded questions, or a 1 or 2 (Disagree / Strongly Disagree or Rarely / Never) for reverse worded questions.

**Negative:** Percent of responses that were rated a 1 or 2 (Disagree / Strongly Disagree or Rarely / Never ) for positively worded questions, or a 4 or 5 (Agree / Strongly agree or Most of the Time / Always) for reverse worded

**National Database:** Contains data from 519 hospitals (160,176 staff) who voluntarily reported results from the Hospital Survey on Patient Safety Culture to AHRQ's National Comparative Database in 2008 (http://www.ahrq.gov/qual/hospsurvey08/hospdbpurp.htm)

*Response Rate =_____ Returned/______Distributed = ___%*

| | Positive Responses | | |
|---|---|---|---|
| | Hospital | 2008 National Database | |
| | DATE | Percentiles | |
| | N= | 10th | 90th |
| **Overall Perceptions of Safety** | | | |
| 1. Patient safety is never sacrificed to get more work done. (A15) | | 50% | 80% |
| 2. Our procedures and systems are good at preventing errors from happening. (A18) | | 58% | 81% |
| R3. It is just by chance that more serious mistakes don't happen around here. (A10) | | 47% | 74% |
| R4. We have patient safety problems in this department. (A17) | | 48% | 77% |
| **COMPOSITE Overall Perceptions of Safety** | | 52% | 77% |
| **Frequency of Events Reported** | | | |
| 1. When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported? (D1) | | 39% | 63% |
| 2. When a mistake is made, but has no potential to harm the patient, how often is this reported? (D2) | | 43% | 68% |
| 3. When a mistake is made that could harm the patient, but does not, how often is this reported? (D3) | | 63% | 83% |
| **COMPOSITE Frequency of Events Reported** | | 50% | 71% |
| **Supervisor/Manager Expectations & Actions Promoting Patient Safety** | | | |
| 1. My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures. (B1) | | 60% | 81% |
| 2. My supervisor/manager seriously considers staff suggestions for improving patient safety. (B2) | | 65% | 86% |
| R3. Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts. (B3) | | 64% | 85% |
| R4. My supervisor/manager overlooks patient safety problems that happen over and over. (B4) | | 67% | 86% |
| **COMPOSITE Supervisor/Manager Expectations & Actions Promoting Patient Safety** | | 66% | 83% |

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| **Organizational Learning—Continuous Improvement** | | | |
| 1. We are actively doing things to improve patient safety. (A6) | | 72% | 91% |
| 2. Mistakes have led to positive changes here. (A9) | | 52% | 74% |
| 3. After we make changes to improve patient safety, we evaluate their effectiveness. (A13) | | 54% | 79% |
| **COMPOSITE Organizational Learning—Continuous Improvement** | | 61% | 80% |
| **Teamwork Within Departments** | | | |
| 1. People support one another in this department. (A1) | | 76% | 93% |
| 2. When a lot of work needs to be done quickly, we work together as a team to get the work done. (A3) | | 78% | 93% |
| 3. In this department, people treat each other with respect. (A4) | | 67% | 87% |
| 4. When one area in this department gets really busy, others help out. (A11) | | 57% | 79% |
| **COMPOSITE Teamwork Within Departments** | | 71% | 87% |
| **Communication Openness** | | | |
| 1. Staff will freely speak up if they see something that may negatively affect patient care. (C2) | | 67% | 85% |
| 2. Staff feel free to question the decisions or actions of those with more authority. (C4) | | 37% | 58% |
| R3. Staff are afraid to ask questions when something does not seem right. (C6) | | 53% | 73% |
| **COMPOSITE Communication Openness** | | 54% | 71% |
| **Feedback and Communication About Error** | | | |
| 1. We are given feedback about changes put into place based on event reports. (C1) | | 39% | 64% |
| 2. We are informed about errors that happen in this department. (C3) | | 53% | 77% |
| 3. In this department, we discuss ways to prevent errors from happening again. (C5) | | 59% | 82% |
| **COMPOSITE Feedback and Communication About Error** | | 52% | 74% |
| **Nonpunitive Response to Error** | | | |
| R1. Staff feel like their mistakes are held against them. (A8) | | 39% | 64% |
| R2. When an event is reported, it feels like the person is being written up, not the problem. (A12) | | 33% | 57% |
| R3. Staff worry that mistakes they make are kept in their personnel file. (A16) | | 24% | 49% |
| **COMPOSITE Nonpunitive Response to Error** | | 32% | 56% |

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| **Staffing** | | | |
| 1. We have enough staff to handle the workload. (A2) | | 36% | 75% |
| R2. Staff in this department work longer hours than is best for patient care. (A5) | | 40% | 65% |
| R3. We use more agency/temporary staff than is best for patient care. (A7) | | 47% | 79% |
| R4. We work in “crisis mode” trying to do too much, too quickly. (A14) | | 33% | 67% |
| **COMPOSITE Staffing** | | 42% | 70% |
| **Hospital Management Support for Patient Safety** | | | |
| 1. Hospital management provides a work climate that promotes patient safety. (F1) | | 67% | 92% |
| 2. The actions of hospital management show that patient safety is a top priority. (F8) | | 57% | 85% |
| R3. Hospital management seems interested in patient safety only after an adverse event happens. (F9) | | 44% | 76% |
| **COMPOSITE Hospital Management Support for Patient Safety** | | 57% | 84% |
| **Teamwork Across Hospital Departments** | | | |
| 1. There is good cooperation among hospital departments that need to work together. (F4) | | 42% | 76% |
| 2. Hospital departments work well together to provide the best care for patients. (F10) | | 52% | 83% |
| R3. Hospital departments do not coordinate well with each other. (F2) | | 29% | 63% |
| R4. It is often unpleasant to work with staff from other hospital departments. (F6) | | 46% | 73% |
| **COMPOSITE Teamwork Across Hospital Departments** | | 44% | 72% |
| **Hospital Handoffs & Transitions** | | | |
| R1. Things “fall between the cracks” when transferring patients from one department to another. (F3) | | 25% | 61% |
| R2. Important patient care information is often lost during shift changes. (F5) | | 36% | 64% |
| R3. Problems often occur in the exchange of information across hospital departments. (F7) | | 29% | 60% |
| R4. Shift changes are problematic for patients in this hospital. (F11) | | 30% | 64% |
| **COMPOSITE Hospital Handoffs & Transitions** | | 31% | 61% |