Form Approved
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PSIC Participant Web-based Questionnaire

Introduction

Thank you for accessing this questionnaire. This questionnaire is intended to obtain your perceptions of the Agency for Healthcare Research and Quality's/VA's Patient Safety Improvement Corps (PSIC) Training Program. As part of this questionnaire, you are being asked to assess the usefulness of the training program and the concepts, tools, information, techniques, and resources that made up the PSIC course content. You are also being asked to indicate how you have used this material in your current or previous role, whether at your organization or while supporting other organizations. Please answer each question as candidly as possible. Your responses will be used to help AHRQ identify the most useful aspects of the PSIC program. Further, your responses will be used to help AHRQ identify additional support for individuals such as yourselves as you work towards improving patient safety.

Please note that if you do not wish to answer a specific question, you can skip it. You are, however, encouraged to respond to all questions. Please note that all of your information will remain confidential and that all information provided to AHRQ as a result of this questionnaire will be reported at the aggregate level to ensure your confidentiality.

Should you have any questions or comments about this questionnaire or the PSIC evaluation project, please do not hesitate to contact Dr. Laura Steighner of the American Institutes for Research (AIR) at 202-403-5064 or lsteighner@air.org. Dr. Steighner is the project director for the PSIC evaluation contract, which AHRQ awarded to AIR in September 2007.

If you have concerns or questions about your rights as a participant, contact AIR's Institutional Review Board (which is responsible for the protection of project participants) at IRB@air.org toll free at 1-800-634-0797 or c/o IRB, 1000 Thomas Jefferson Street, NW, Washington, DC 20007.

Instructions

Please carefully read each question on this questionnaire. There are six primary sections:

1) PSIC Participant Characteristics
2) Transfer of Training to the Workplace
3) Post-PSIC Activities
4) Facilitators and Barriers to Use of PSIC in the Workplace
5) Outcomes of PSIC Participation
6) Use of Other AHRQ Tools and Resources

Note that the response scale for each question will vary from section to section. For example, in the Post-PSIC Activities section, you will be asked to respond to a given statement using a response scale wherein 1=Disagree, 2 = Neutral, and 3= Agree. By contrast, in the Transfer of Training section, you will be asked to indicate how often you have used a PSIC tool using a response scale ranging from 1=Rarely to 4=Very Often. Please read each question carefully, and make sure that your selected response is what you intended.

PSIC Participant Characteristics

In this section, you are being asked to provide information about yourself, your organization, and your participation in the PSIC program. Please answer candidly and note that your personal information will not be provided to any entity. All information will be reported to AHRQ on an aggregate level.

1. When did you participate in the PSIC training? [Select one]
    a. 2003-2004
    b. 2004-2005
    c. 2005-2006
    d. 2007-2008

2. Which of the following best characterizes the organization in which you currently work? [Select one]
    a. State health department
    b. Hospital or health care system (excluding critical access hospitals)
    c. Quality Improvement Organization (QIO)
    d. Hospital association
    e. Patient safety center/commission
    f. Long term care facility, assisted living facility, or home health agency
    g. Critical access hospital
    h. Regional or state-based healthcare professional association or institution
    i. Other: [Fill in the blank]____

3. In what state is your organization located? [Provide drop-down menu of states]

4. What is the name of your employer facility/organization? [Fill in the blank]_________

5. If your facility is part of a larger healthcare system, what is the name of that larger healthcare system? [Fill in the blank]____
____

6. What is your current job title? [Fill in the blank]_______________________________

7. How long have you served in your current patient safety role (at your current organization)? [Select one]
    a. I do not have a patient safety role.
    b. 0-1 years
    c. 2-5 years
    d. 6-10 years
    e. 11 or more years

8. How long have you served in any patient safety role (at your current organization)? [Select one]
   a. I have never had a patient safety role.
   b. 0-1 years
   c. 2-5 years
   d. 6-10 years
   e. 11 or more years

9. Have you changed jobs since participating in the PSIC program? [Select one]
   a. Yes
   b. No

10. If yes to #9, are you still with the same organization? [Select one]
   a. Yes
   b. No

11. If yes to #9, are you still in a patient safety role? [Select one]
   a. Yes
   b. No

12. Since the PSIC training, how have you used the concepts, tools, information, techniques, and resources you learned? [Check all that apply]
   a. I have used the PSIC concepts, tools, information, techniques, and resources **on my job** without a formal implementation program (e.g., I have applied PSIC tools to patient safety problems at my organization).
   b. I have created new patient safety processes **in my organization** based upon the PSIC concepts, tools, information, and techniques.
   c. I have trained others **in my organization** on any or all of the PSIC concepts, tools, information, and techniques.
   d. I have trained others **outside my organization** on any or all of the PSIC concepts, tools, information, and techniques.
   e. I have facilitated the use of PSIC concepts, tools, information, techniques, and resources by others **in my organization** by providing guidance, observing their use, and answering questions when possible.
   f. I have facilitated the use of PSIC concepts, tools, information, techniques, and resources by others **outside my organization** by providing guidance, observing their use, and answering questions when possible.
   g. I have used the PSIC concepts, tools, information, techniques, and resources to inform, institute, or modify **State-level** regulations and/or policies.
   h. Other: [Fill in the blank]____

Transfer of Training to the Workplace

In this section, you are being asked to assess the ease with which you were able to transfer the PSIC concepts, tools, information, techniques, and resources into the workplace. These questions focus on the extent to which the PSIC concepts, tools, information, techniques, and resources "fit" your needs in conducting your post-PSIC patient safety activities.

Statements	**1 Disagree**	**2 Neutral**	**3 Agree**
1. The PSIC course content met *my patient safety needs* and helped me fulfill my patient safety role(s) and responsibilities			
2. The PSIC course content matched the patient safety needs of *my organization*			
3. The PSIC course content matched the needs of the patient safety efforts being conducted in the *organizations with which I worked* **(For QIOs and State Health Departments only)**			

Post-PSIC Activities

In this section, you are being asked to report on the patient safety activities in which you have engaged since your participation in the PSIC program. Specifically, you are being asked to consider how you have used or disseminated your knowledge about PSIC concepts, tools, information, techniques, and resources since participating in the PSIC program. You are asked to consider the following questions in the section:

For each of the PSIC concepts, tools, information, techniques, and resources listed below, please answer the following questions.

1. After completing the PSIC training, have you used the concepts, tools, information, techniques, and resources in your patient safety role?

2. After completing the PSIC training, how useful were the concepts, tools, information, techniques, and resources in your professional/work environment?

3. After completing the PSIC training, how often have you used the concepts, tools, information, techniques, and resources in your professional/work environment?

4. After completing the PSIC training, to what extent have the concepts, tools, information, techniques, and resources been incorporated into patient safety initiatives in your organization or in organizations in which you have provided education or technical support?

PSIC Concept, Tool, Information, Technique, or Resource	1. Have you used it? [FILTER]	2. How useful is it?	3. How often have you used it?	4. To what extent has it been incorporated?
a. Introduction to Patient Safety	1 – Yes 2 – No 3 – Don't Know	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don't know
b. Safety Assessment Code (SAC) Matrix	1 – Yes 2 – No 3 – Don't Know	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don't know
c. Human Factors Engineering and Patient Safety	1 – Yes 2 – No 3 – Don't Know	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don't know
d. RCA Process & Methods	1 – Yes 2 – No 3 – Don't Know	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don't know
e. Root Causes: Five Rules of Causation (the laminated flip book)	1 – Yes 2 – No 3 – Don't Know	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don't know
f. Cause and Effect Diagramming	1 – Yes 2 – No 3 – Don't Know	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don't know

PSIC Concept, Tool, Information, Technique, or Resource	1. Have you used it? [FILTER]	2. How useful is it?	3. How often have you used it?	4. To what extent has it been incorporated?
g. TeamSTEPPS™ Master Trainer Workshop	1 – Yes 2 – No 3 – Don’t Know 4 – Was not included in my training	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don’t know
h. Healthcare Failure Modes and Effects Analysis (HFMEA)	1 – Yes 2 – No 3 – Don’t Know	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don’t know
i. Heuristic (Expert) Evaluation Technique	1 – Yes 2 – No 3 – Don’t Know	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don’t know
j. Evaluation of Patient Safety Programs	1 – Yes 2 – No 3 – Don’t Know	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don’t know
k. Probabilistic Risk Assessment	1 – Yes 2 – No 3 – Don’t Know	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don’t know
l. Usability Testing Technique	1 – Yes 2 – No 3 – Don’t Know	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don’t know

PSIC Concept, Tool, Information, Technique, or Resource	1. Have you used it? [FILTER]	2. How useful is it?	3. How often have you used it?	4. To what extent has it been incorporated?
m. AHRQ Patient Safety Network (AHRQ PSNet)	1 – Yes 2 – No 3 – Don't Know	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don't know
n. AHRQ Web M&M	1 – Yes 2 – No 3 – Don't Know	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don't know
o. High Alert Medications	1 – Yes 2 – No 3 – Don't Know	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don't know
p. AHRQ Patient Safety Indicators	1 – Yes 2 – No 3 – Don't Know	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don't know
q. AHRQ Hospital Survey on Patient Safety Culture (HSOPS Survey)	1 – Yes 2 – No 3 – Don't Know	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don't know
r. Patient Safety Assessment Tool (PSAT)	1 – Yes 2 – No 3 – Don't Know 4 – Was not included in my training	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don't know

PSIC Concept, Tool, Information, Technique, or Resource	1. Have you used it? [FILTER]	2. How useful is it?	3. How often have you used it?	4. To what extent has it been incorporated?
s. Mistake-Proofing: The Design of Healthcare Processes	1 – Yes 2 – No 3 – Don’t Know 4 – Was not included in my training	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don’t know
t. Just Culture	1 – Yes 2 – No 3 – Don’t Know 4 – Was not included in my training	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don’t know
u. Medical and Legal Issues	1 – Yes 2 – No 3 – Don’t Know 4 – Was not included in my training	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don’t know
v. Business Case for Patient Safety	1 – Yes 2 – No 3 – Don’t Know	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don’t know
w. Leading Change	1 – Yes 2 – No 3 – Don’t Know	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don’t know

PSIC Concept, Tool, Information, Technique, or Resource	1. Have you used it? [FILTER]	2. How useful is it?	3. How often have you used it?	4. To what extent has it been incorporated?
x. Designing for Safety	1 – Yes 2 – No 3 – Don't Know 4 – Was not included in my training	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don't know
y. High Reliability Organizations (HROs)	1 – Yes 2 – No 3 – Don't Know 4 – Was not included in my training	3 = Very useful 2 = Somewhat useful 1 = Not at all useful	4 = Very often 3 = Occasionally 2 = Infrequently 1 = Rarely	4 = Fully incorporated 3 = Partially incorporated 2 = Not incorporated yet 1 = Don't know

5. Which of the following patient safety activities have you conducted or contributed to since participating in the PSIC program? **For each activity you have conducted, please indicate how effective these activities were in promoting patient safety in your organization or organizations that you have educated and supported.**

As a result of PSIC training, I and/or my organization:	Conducted activity? [Filter]	If yes, how effective was this activity in promoting patient safety?
a. Defined new or revised existing policies, standards, or processes at the State level	1 – Yes 2 – No 3 – Not applicable	1 – Not at all effective 2 – Somewhat effective 3 – Very effective
b. Defined new or revised existing policies, standards, or processes at the hospital or health care system level	1 – Yes 2 – No 3 – Not applicable	1 – Not at all effective 2 – Somewhat effective 3 – Very effective
c. Implemented new patient safety processes	1 – Yes 2 – No 3 – Not applicable	1 – Not at all effective 2 – Somewhat effective 3 – Very effective
d. Trained others on developing or implementing patient safety processes	1 – Yes 2 – No 3 – Not applicable	1 – Not at all effective 2 – Somewhat effective 3 – Very effective
e. Strengthened existing relationships with hospitals in your state about patient safety **(NOTE: for QIOs and State Health Departments only)**	1 – Yes 2 – No 3 – Not applicable	1 – Not at all effective 2 – Somewhat effective 3 – Very effective
f. Established new or strengthened existing relationships with the State health department about patient safety **(NOTE: for QIOs and State Health Departments only)**	1 – Yes 2 – No 3 – Not applicable	1 – Not at all effective 2 – Somewhat effective 3 – Very effective
g. Established new or strengthened existing relationships with QIO(s) about patient safety **(NOTE: This question for Hospital/Providers or Regulators only)**	1 – Yes 2 – No 3 – Not applicable	1 – Not at all effective 2 – Somewhat effective 3 – Very effective
h. Created a new or expanded an existing coalition representing patient safety stakeholders	1 – Yes 2 – No 3 – Not applicable	1 – Not at all effective 2 – Somewhat effective 3 – Very effective
i. Created or modified a patient safety/medical error event reporting system	1 – Yes 2 – No 3 – Not applicable	1 – Not at all effective 2 – Somewhat effective 3 – Very effective
j. Sought assistance from QIO regarding patient safety activities **(NOTE: This question for Hospital/Providers only)**	1 – Yes 2 – No 3 – Not applicable	1 – Not at all effective 2 – Somewhat effective 3 – Very effective

6. Since you attended the PSIC training, approximately how many persons have you trained on any of the PSIC concepts, tools, information, techniques, and resources in your organization or other organizations? [Select one]
   1 = None
   2 = 1-49
   3 = 50-99
   4 = 100-149
   5 = 150-199
   6 = 200 or more

7. If responded 2 – 6 on #3: What were the reasons that these individuals were trained? [Check all that apply]
   a. To support health systems in enhancing patient safety initiatives
   b. To support health systems in addressing a patient safety problem or need
   c. To educate others, within or outside my organization, about new patient safety initiatives, policies, or processes in my organization
   d. To educate others, within or outside my organization, about tools that can be used to address safety issues
   e. To provide information to others, within or outside my organization, to support regulatory oversight and support of hospitals/health systems
   f. Other: [Fill in the blank]____

Facilitators and Barriers to Use of PSIC Concepts, Tools, Information, Techniques, and Resources in the Workplace

In this section, you are being asked to identify any factors (organizational or otherwise) you have encountered that facilitated the use of PSIC concepts, tools, information, techniques, and resources on the job. Similarly, you are asked to identify any barriers you have encountered when trying to use or support others in the use of PSIC concepts, tools, information, and techniques. These barriers can be organizationally- or individually-based and impede the use of PSIC concepts, tools, information, techniques, and resources.

1. Which of the following factors have **helped** you implement the PSIC concepts, tools, information, techniques, and/or resources in your organization or in organizations that you have supported? [Check all that apply]

    - **Ample time or resources** made available to support the use of PSIC concepts, tools, information, techniques, and resources
    - **Consistent information sharing** between people within the organization to support the use of PSIC concepts, tools, information, techniques, and resources
    - **Upper management support** for using PSIC concepts, tools, information, techniques, and resources
    - **Staff willingness** to use PSIC concepts, tools, information, techniques, and resources
    - **Unease with current practice** leading to perceptions that use of PSIC concepts, tools, information, techniques, and resources will be effective in improving patient safety
    - **Effective communication of information** resulting in better understanding regarding the use of PSIC concepts, tools, information, techniques, and resources
    - **Ample coordination and follow-up with co-workers** to ensure the proper use of PSIC concepts, tools, information, techniques, and resources
    - **Organizational priorities** that draw attention to the use of PSIC concepts, tools, information, techniques, and resources
    - **Work sharing or shifting of staff responsibilities** to support the implementation of PSIC concepts, tools, information, techniques, and resources

2. What other factors have helped you implement PSIC concepts, tools, information, techniques, and/or resources since attending training? Please list all major factors that you have experienced.

3. Which of the following **barriers** have you encountered when implementing the PSIC concepts, tools, information, techniques, and resources in your organization or in organizations that you have supported? [Check all that apply]

    - **Lack of time or resources** made available to support the use of PSIC concepts, tools, information, techniques, and resources
    - **Lack of information sharing** between people within the organization to support the use of PSIC concepts, tools, information, techniques, and resources

- **Upper management resistance** to the use of PSIC concepts, tools, information, techniques, and resources
- **Staff resistance** to using the PSIC concepts, tools, information, techniques, and resources
- **Comfort with the status quo** leading to perceptions that the use of PSIC concepts, tools, information, techniques, and resources will be ineffective or are unnecessary in improving patient safety
- **Conflicting information** resulting in confusion about the use of PSIC concepts, tools, information, techniques, and resources
- **Lack of coordination and follow-up with co-workers** to ensure the proper use of PSIC concepts, tools, information, techniques, and resources
- **Distractions or different organizational priorities** that draw attention away from the use of PSIC concepts, tools, information, techniques, and resources
- **Reported staff fatigue or work overload** leading to inability or resistance to learning about and using PSIC concepts, tools, information, techniques, and resources

4. Please identify any other barriers to the implementation of PSIC concepts, tools, information, techniques, and resources you have encountered since attending training.

Outcomes of PSIC Participation

In this section, you are being asked to assess what patient safety changes have occurred in your organization or organizations you support as a result of your participation in PSIC and your post-PSIC activities. These outcomes of your participation in PSIC and post-PSIC activities can range from increased awareness to changes in processes or policies. Consider all potential outcomes of your participation and post-training activities.

1. As a result of participating in the PSIC program and your post-PSIC patient safety activities, how have the following aspects changed at your organization?

As a result of participating in PSIC training and my post-PSIC patient safety activities, I have noticed that in my organization …	**1 Disagree**	**2 Neutral**	**3 Agree**	**Does Not Apply**
a. There is an increased level of awareness of the importance of patient safety among non-clinicians (e.g., administrators, managers) within my organization				
b. There is an increased level of awareness of the importance of patient safety among clinicians (e.g., nurses, physicians) in my organization				
c. Better patient safety interventions have been *identified* than before my participation				
d. More effective patient safety interventions have been *applied* in my organization than before our participation.				
e. There are more effective communications about patient safety among staff and management *within* my organization				
f. There are more effective communications about patient safety *with other organizations who support patient safety improvement initiatives*				
g. There are more staff trained on patient safety, as a result of PSIC, *within my organization*				
h. There is increased use of a patient safety or medical error event reporting system **For hospitals/providers only**				
i. There have been improvements in the quality of the process to review or analyze patient safety events and medical errors **For hospitals/providers only**				
j. There is increased sharing of patient safety and medical error event data with				

As a result of participating in PSIC training and my post-PSIC patient safety activities, I have noticed that in my organization …	**1 Disagree**	**2 Neutral**	**3 Agree**	**Does Not Apply**
hospital staff **For hospitals/providers only**				

2. **FOR HOSPITALS/PROVIDERS ONLY:** As a result of participating in the PSIC program and your post-PSIC patient safety activities, how have the following aspects changed at your organization?

As a result of participating in the PSIC program and my post-PSIC patient safety activities, I have noticed that in my organization, …	**1 Disagree**	**2 Neutral**	**3 Agree**	**Don’t Know**
a. It is now easier to address the Joint Commission’s patient safety requirements				
b. After we implement interventions or make changes to improve patient safety, we evaluate the effectiveness and sustainability of those interventions/changes				
c. Staff feel their mistakes are held against them				
d. Staff worry that mistakes they make are kept in their personnel file				
e. Management provides a work environment that promotes patient safety				
f. Management’s actions show that patient safety is a top priority				
g. Management seems to show interest in patient safety only after a medical error or patient safety event occurs				
h. Staff feel free to and will freely speak up if they see something that may negatively affect patient care				
i. Staff feel free to question the decisions or actions of those with more authority when they are concerned that the decisions or actions may negatively affect patient care				
j. Staff are afraid to ask questions when something does not seem right from a patient safety perspective				

FOR STATE HEALTH DEPARTMENT ONLY: Since participating in the PSIC program and your post-training activities, how have the following aspects changed at the organizations you oversee?

Since participating in the PSIC program and my post-PSIC patient safety activities, I have noticed that …	**1 Disagree**	**2 Neutral**	**3 Agree**	**Don't Know**
a. Healthcare providers at organizations that I oversee are actively doing things to improve patient safety				
b. When an medical error or patient safety event is reported at these organizations, it feels like the person is being written up, not the problem				
c. Management at these organizations provides a work environment that promotes patient safety				
d. The actions of management at these organizations show that patient safety is a top priority				
e. Management at these organizations seems to show interest in patient safety only after a medical error or patient safety event occurs				
f. Positive changes in the organizational culture resulting from medical error or patient safety events made at the organizations I oversee have occurred				

FOR FACILITATORS ONLY: Since participating in the PSIC program and your post-training activities, how have the following aspects changed at the organizations you support?

Since participating in the PSIC program and my post-PSIC patient safety activities, I have noticed that...	1 Disagree	2 Neutral	3 Agree	Don't Know
a. Healthcare providers at organizations that I support are actively doing things to improve patient safety				
b. Positive changes in the organizational culture resulting from medical error or patient safety events made at the organizations I support have occurred				
c. After implementing interventions or making changes to improve patient safety, the organizations I support evaluate the effectiveness and sustainability of the interventions/changes				
d. Staff at these organizations feel their mistakes are held against them				
e. Staff at these organizations worry that mistakes they make are kept in their personnel file				
f. Staff at these organizations feel free to and will freely speak up if they see something that may negatively affect patient care				
g. Staff at these organizations feel free to question the decisions or actions of those with more authority when they are concerned that the decisions or actions may negatively affect patient care				
h. Staff at these organizations are afraid to ask questions when something does not seem right from a patient safety perspective				

3. What other outcomes can you attribute to your participation in PSIC and your post-PSIC patient safety activities? Please identify any patient safety initiatives occurring in your organization or state that can be attributed to participation in the PSIC program.

Additional Information about Other AHRQ Tools and Resources

In this section, you are being asked to assess the usefulness of other AHRQ patient safety-related tools or resources that you have used. You will be provided with a series of drop down lists of available AHRQ tools and resources. Only select those you have used. Once selected, please indicate how useful these tools or resources have been in supporting your patient safety activities or initiatives.

1. Consider the following AHRQ tools and techniques and answer the associated questions.

    a. Have you used this tool or technique in your patient safety role? [Select all that apply]

    b. How useful was the tool or technique for your needs? [For each tool/resource selected]

AHRQ Tools/Resources **[Select all that apply]**	**Description**	**Usefulness** **(If tool/resource selected)**
Brochures/Pamphlets		
Be Prepared for Medical Appointments	X number of questions you should ask your practitioner prior to medical appointments.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Check Your Medicines: Tips for Taking Medicines Safely	Use this checklist to help avoid medication errors. Simple checks could save your life!	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
How to Create a Pill Card	This guide was designed to help users create an easy-to-use "pill card" for patients, parents, or anyone who has a hard time keeping track of their medicines. Step-by-step instructions, sample clip art, and suggestions for design and use will help to customize a reminder card.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable

AHRQ Tools/Resources [Select all that apply]	Description	Usefulness (If tool/resource selected)
DVDs		
Patient Safety Improvement Corps Training DVD	Developed by the Agency for Healthcare Research and Quality (AHRQ) and the Department of Veterans Affairs National Center for Patient Safety, a new DVD presents a self-paced, modular approach to training individuals involved in patient safety activities at the institutional level.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Problems and Prevention: Chest Tube Insertion (DVD)	The 11-minute DVD, funded by the AHRQ, uses video excerpts of 50 actual chest tube insertion procedures to illustrate problems that can occur.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Transforming Hospitals: Designing for Safety and Quality	This DVD from the AHRQ reviews the case for evidence-based hospital design and how it increases patient and staff satisfaction and safety, quality of care, and employee retention, and results in a positive return on investment	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Fact Sheets		
10 Patient Safety Tips for Hospitals	10 practical tips for putting patient safety research into practice in hospitals.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
20 Tips to Help Prevent Medical Errors in Children	This fact sheet is intended to help parents avoid medical errors in their children.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
20 Tips to Help Prevent Medical Errors: Patient Fact Sheet	This fact sheet tells what you can do to help prevent medical errors.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable

AHRQ Tools/Resources [Select all that apply]	Description	Usefulness (If tool/resource selected)
30 Safe Practices for Better Health Care: Fact Sheet	30 safe practices that evidence shows can work to reduce or prevent adverse events and medical errors, produced by NQF with support from AHRQ.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Five Steps to Safer Health Care	Five hints on what you can do to get safer health care.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Reducing Medical Errors in Health Care: Fact Sheet	This fact sheet provides information on the impact of systems errors on medical error.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Ways You Can Help Your Family Prevent Medical Errors!	The tips here show what you can do to help keep you and your family safe. These tips are based on studies by many medical researchers.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Publications/Reports		
Advances in Patient Safety: From Research to Implementation	The 140 articles in the 4-volume set cover a wide range of research paradigms, clinical settings, and patient populations. Where the research is complete, the findings are presented; where the research is still in process, the articles report on its progress. In addition to articles with a research and methodological focus, the compendium includes articles that address implementation issues or present useful tools and products that can be used to improve patient safety.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable

AHRQ Tools/Resources [Select all that apply]	**Description**	**Usefulness (If tool/resource selected)**
AHRQ's Patient Safety Initiative: Building Foundations, Reducing Risk: Interim Reports & Publications to the Senate Committee on Appropriations	As a result of its hearings, the Senate Committee on Appropriations directed the Agency for Healthcare Research and Quality (AHRQ) to lead the national effort to combat medical errors and improve patient safety. This Reports & Publications provides the requested Interim Reports & Publications to the Committee and is a status update on AHRQ's entire Patient Safety Initiative.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Becoming a High Reliability Organization: Operational Advice for Hospital Leaders	This document presents the thoughts, successes, and failures of hospital leaders who have used concepts of high reliability to make patient care better.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Closing the Quality Gap: Prevention of Healthcare-Associated Infections	The report describes the effects of quality improvement strategies on promoting adherence to interventions for prevention of selected (surgical site infections (SSI), central line-associated bloodstream infections (CLABSI), ventilator-associated pneumonia (VAP), and catheter-associated urinary tract infections (CAUTI)) healthcare-associated infections (HAIs), and on HAI rates.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
High Reliability Organization (HRO) Strategy	To help create organizations that experience fewer than expected medical errors—high reliability organizations—the Agency for Healthcare Research and Quality (AHRQ) is establishing a learning network with leaders dedicated to improving patient safety. The learning network is designed to support patient safety leaders by providing them with a forum for sharing their experiences, learning about promising practices, and identifying ways to implement research findings and promising practices.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Hospital Survey on Patient Safety (HSOPS) Comparative Database Reports & Publications	Provide comparative data for organizations employing the HSOPS Culture Survey for 2007 and 2008.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable

AHRQ Tools/Resources [Select all that apply]	**Description**	**Usefulness (If tool/resource selected)**
Improving Warfarin Management	This project applied ISO 9001 principles to establish a virtual anticoagulation clinic for two hospitals and two physician practices and resulted in the development of a model for developing safe care delivery systems.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Making Health Care Safer: A Critical Analysis of Patient Safety Practices: Summary, Evidence Reports & Publications	A review of relevant scientific literature on assigned clinical topics and the level of evidence associated.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Mistake-Proofing the Design of Health Care Processes	The document is a synthesis of practical examples from the real world of health care on the use of process or design features to prevent medical errors or the negative impact of errors. It contains over 150 examples of mistake-proofing that can be applied in health care—and in many cases relatively inexpensively.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Patient Safety E-newsletter	The AHRQ Patient Safety E-Newsletter is issued periodically and summarizes important patient safety news and information from the Agency.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Patient Safety Research Highlights: Program Brief	This program brief provides highlights on patient safety research supported by the AHRQ.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
The Effect of Health Care Working Conditions on Patient Safety	The purpose of this Reports & Publications is to compile and summarize existing evidence on the aspects of the working environment that impact patient safety. Five categories of working conditions were evaluated: workforce staffing, workflow design, personal/social issues, physical environment, and organizational factors.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable

AHRQ Tools/Resources [Select all that apply]	Description	Usefulness (If tool/resource selected)
Websites		
Patient Safety Organizations: Web Site	This website provide links to an overview of the Patient Safety and Quality Improvement Act of 2005, explains the rule-making processes, and provides space for the public to comment on the Act.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Toolkits		
Implementing Reduced Work Hours to Improve Patient Safety	Tools. This project implements evidence-based work schedules to help reduce work hours for extended shifts for residents to reduce errors from sleep and fatigue and also from a lack of continuity of care. Toolkit resources include: Read-to-implement carcadian-based work schedules, and evidence-based guidelines for successful shift changes and safe handovers.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Improving Hospital Discharge Through Medication Reconciliation and Education	Tools. This project implements a "discharge bundle" consisting of medication reconciliation, patient-centered hospital discharge education, and post discharge continuity checks. This intervention improves the safety of patient discharges from the hospital by increasing patients' understanding of their illness and treatment and fostering continuity of care.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Improving Medication Adherence	The project implements a multi-modal patient medication education intervention to improve safety hospital-wide by involving clinicians and patients during the hospital stay. Drawing on health behavior change theory, the intervention focuses on reducing 30-day hospital readmissions and on improving patient satisfaction and medication adherence. The toolkit promotes a generalizable and sustainable education program with tools and resources that promote structured medication education, administrative support and staff training, and established quality improvement techniques.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable

AHRQ Tools/Resources [Select all that apply]	**Description**	**Usefulness (If tool/resource selected)**
Improving Medication Safety in Clinics for Patients 55 and Older	This project improves the safety of care and care processes in outpatient settings through a partnership model involving patients, health care providers, and the community. The project implements a patient safety partnership council that includes both providers and patients and uses focus groups, interviews, and other tools to facilitate patient-centered care, including medication safety for elderly patients.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Improving Patient Flow in the ED	This toolkit contains the necessary resources for improves the safety of care for patients in the emergency department (ED) by reducing the time patients wait to be seen and by expediting admission to the most appropriate hospital unit.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Improving Patient Safety Through Enhanced Provider Communication	This project focuses on improving the safety and effectiveness of communication between providers and among teams. A standardized situational briefing model is used as a guide to facilitate timely communication about changes in patient status on need. The model is also used to implement daily patient-centered rounds by multi-disciplinary teams and to conduct team huddles each shift to discuss patient care plans. In addition, the project uses other communication tools designed to help clinicians and health care professionals implement effective teamwork and communication strategies in their practice settings to improve patient safety.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable

AHRQ Tools/Resources [Select all that apply]	**Description**	**Usefulness (If tool/resource selected)**
Interactive Venous Thromboembolism Safety Toolkit for Providers and Patients	This project implements a "discharge bundle" consisting of medication reconciliation, patient-centered hospital discharge education, and post discharge continuity checks. This intervention improves the safety of patient discharges from the hospital by increasing patients' understanding of their illness and treatment and fostering continuity of care.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Is Our Pharmacy Meeting Patients' Needs?	This pharmacy health literacy tool was designed to capture perspectives of three critical audiences-objective auditors, pharmacy staff, and patients. The three parts of the assessment are complementary and designed to form a comprehensive assessment. Although the assessment was designed to be used in outpatient pharmacies of large, urban, public hospitals that primarily serve a minority population, it can be adapted for use in other pharmacy and non-pharmacy environments.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Multidisciplinary Training for Medication Reconciliation	This project implements a single, shared, updated and reconciled medication and allergy list for patients across the continuum of inpatient and outpatient care. A central component of this intervention is the development of objective criteria for use in the hospital inpatient, primary care, or home health outpatient settings to trigger pharmacist review and involvement in taking the patient's medication history.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable

AHRQ Tools/Resources [Select all that apply]	Description	Usefulness (If tool/resource selected)
Overcoming Barriers to Error Reports & Publicationsing in Small, Rural Hospitals	This project provides tools to improve patient safety by engineering a culture of safety in small rural hospitals. These tools include resources for small rural hospitals to conduct and interpret the AHRQ Hospital Survey on Patient Safety Culture. Another aspect is creating an infrastructure for Reports & Publications, collecting, and analyzing data about voluntarily Reports & Publications medication errors.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Reducing Central Line Bloodstream Infections and Ventilator-Associated Pneumonia	This project couples two interventions to improve critical care—reduction of catheter-related blood stream infections and ventilator-associated pneumonia. The project used a randomized controlled trial to compare the effectiveness of various strategies for implementing an improvement initiative.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Reducing Discrepancies in Medication Orders	This project implements a training intervention to improve medication history interviewing skills and offers a guide to creating a single medication history list within the medical record. The training focuses on identifying patient risk factors frequently responsible for inaccurate medication reconciliation, including limited English proficiency and low health literacy, complex medication histories, or impaired cognitive status. The toolkit contains resources for both health care professionals and patients.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Strategies to Improve Communication Between Pharmacy Staff and Patients	This training program is designed to introduce pharmacists to the problem of low health literacy in patient populations and to identify the implications of this problem for the delivery of health care services. The program also explains techniques that pharmacy staff members can use to improve communication with patients who may have limited health literacy skills.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable

AHRQ Tools/Resources [Select all that apply]	Description	Usefulness (If tool/resource selected)
Testing the Re-engineered Hospital Discharge	This project re-engineered the process of discharging patients from a hospital back into the community to make the process safer. The discharge workflow was redesigned using a set of 10 discrete, mutually reinforcing components that aim to reduce post-discharge adverse events and subsequent re-hospitalizations. Two features of the re-engineered process are a discharge advocate who works with patients throughout the process, and the real time production of a simple, easy to understand discharge plan.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
The Emergency Department (ED) Pharmacist as a Safety Measure	This project focuses on improving medication safety by implementing an emergency department pharmacist program. A toolkit facilitates the implementation of similar programs into other hospital emergency departments.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable
Toolkit for Redesign in Health Care: Final Reports & Publications	This toolkit presents strategies for comprehensively redesigning and transforming processes of care in a hospital. It includes a discussion of the forces that compel health care systems to embark on redesign or system transformation; a series of steps to be taken in planning for such as redesign or system transformation; and strategies for translating information gathered into proposed projects for implementation.	3 = Very useful 2 = Somewhat useful 1 = Not at all useful 0 = Not applicable

2. AHRQ is interested in understanding what other tools or resources you need to carry out your patient safety responsibilities so that they can better support you and your patient safety efforts. In this section, please identify what your pressing resource- or tool-based needs are for carrying out your patient safety activities and meeting your patient safety responsibilities. In other words, what resources or tools do you need to help you improve patient safety or support patient safety initiatives?