Public Comment from Jean Public:

Comment received by AHRQ September 5, 2009:

> **From:** jean public [mailto:usacitizen1@live.com]
> **Sent:** Saturday, September 05, 2009 7:35 AM
> **To:** Lefkowitz, Doris C. (AHRQ); americanvoices@mail.house.gov; info@taxpayer.net
> **Subject:** FW: duplicative surveys - the taxpayers should be paying for only one survey that bothers hospitals AND COSTS TAXPAYERS - instead there are multiples by different agencies
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> public comment on federal register
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> taxpayers have been funding this "survey" since 2003 - 6 years.it is clear this information is available for action to be taken. i can see that no action has resulted. therefore, it is clear the survey is not needed to be done every year espexially. every 5 years should be often enough. why are we doing surveys if they dontinitiate action? ahrq specializes in surveys that go nowhere and result in absolutely no help to americans. this spending is wasteful.jean public 15 elm st florham park nj 07932

AHRQ's Response to Jean Public:

Hospitals interested in assessing staff views of patient safety culture voluntarily administer the Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture (Hospital SOPS) to their staff at their own expense; AHRQ does not use government funds to administer the survey in hospitals.

AHRQ established the *Hospital Survey on Patient Safety Culture Comparative Database* in response to requests from hospitals interested in comparing their results to other hospitals to assist them in their patient safety improvement efforts. An annual Hospital SOPS Comparative Database Report is made available in the public domain on the AHRQ web site at http://www.ahrq.gov/qual/hospsurvey09/ or can be requested in hard copy for free through AHRQ's publications clearinghouse (AHRQ publication number 09-0030).

Hospitals use the Hospital SOPS Survey, Comparative Database Reports and Individual Hospital Survey Feedback Reports for a number of purposes, to:

- Raise staff awareness about patient safety.
- Diagnose and assess the current status of patient safety culture in their hospital.
- Identify strengths and areas for patient safety culture improvement.
- Examine trends in patient safety culture change over time.
- Evaluate the cultural impact of patient safety initiatives and interventions.
- Facilitate meeting Joint Commission hospital accreditation standards in Leadership that require a regular assessment of hospital patient safety culture.
- Compare patient safety culture survey results with other hospitals in their efforts to improve patient safety and quality.

The *Hospital Survey on Patient Safety Culture 2009 Comparative Database Report* summarizes results from data that were voluntarily submitted to AHRQ from 622 hospitals covering 196,462 hospital staff respondents. In addition, the 2009 report includes a chapter on trending that presents results showing change over time for 204 hospitals that administered the survey and submitted data more than once. Some highlights about patient safety culture improvement and actions taken by the trending hospitals are summarized below.

- For the 204 hospitals with trending data, the average change in percent positive scores between administrations on the patient safety culture composites was a slight increase of 2 percentage points (ranging from 1 to 3 percentage points change).

- In 37 percent of trending hospitals, an increase was seen of 5 percentage points or more on *Overall Perceptions of Patient Safety*.

Table 7-10 (from page 71 of the 2009 Comparative Database Report) shows the percentages of trending hospitals that reported they had implemented various types of actions. The action most frequently taken was implementing the Situation-BackgroundAssessment-Recommendation (SBAR) technique (95 hospitals, or 58 percent). About 10 percent (17 hospitals) indicated they had developed action plans but had not implemented them yet.

Table 7-10. Types of Patient Safety Actions Taken by the 2009 Trending Hospitals

Type of Action Taken	2009 Trending Hospitals*	
	Number	Percent
Implemented SBAR Communication (Situation-Background-Assessment-Recommendation)	95	58%
Made changes to policies/procedures	92	56%
Implemented patient safety walkarounds	84	51%
Conducted training	81	49%
Improved compliance with Joint Commission National Patient Safety Goals	65	39%
Conducted chart audits	63	38%
Improved fall prevention program	62	38%
Took other action	59	36%
Conducted root cause analysis	58	35%
Improved error reporting system	54	33%
Purchased new hospital equipment	52	32%
Held education/patient safety fair for staff	48	29%
Formed a committee	42	25%
Conducted followup interviews/focus groups	29	18%
Implemented patient safety bulletin board/suggestion box/hotline	24	15%
Implemented “Ticket to Ride” communication tool to reduce handoff risk	19	12%
Developed action plans but have not implemented them yet	17	10%
Implemented patient safety briefings	16	10%
Implemented TeamSTEPPS	8	5%

Most of the trending hospitals providing information on improvement efforts (151 hospitals, or 92 percent) indicated they had implemented more than one action. Hospitals described the types of "other" actions implemented, such as:

- Patient Safety Champion/Representative programs;
- Color-coded wristbands;
- Hand hygiene programs;
- Electronic medical records; and
- Medication error reduction strategies.

While these database results are not statistically representative of the entire population of hospitals in the U.S. as a whole, the AHRQ Hospital SOPS Comparative Database is the largest central repository of publicly available patient safety culture survey data. In addition, researchers are now conducting analyses demonstrating linkages between positive patient safety culture survey scores, better patient outcomes, fewer adverse events, and higher patient satisfaction with hospital care. These initiatives are perceived to be of value to hospitals and health systems and ultimately to be of value toward improving the quality and safety of care provided to patients.