Attachment B-4

Survey on Patient Safety (SOPS)

Final Report on Feedback from Users of SOPS Databases

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Table of Contents

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All hospitals in the United States that administer the *Hospital Survey on Patient Safety Culture (HSOPS)* are eligible to submit their collected HSOPS data to the HSOPS data submission Web site (a secure password-protected extranet Web site where hospitals can upload their data). This Web site is sponsored and funded by the Agency for Healthcare Research and Quality (AHRQ) and managed by Westat. Each submitter receives a customized individual hospital report comparing its hospital's data with the overall database results. If a hospital has submitted data in more than 1 year to the HSOPS Comparative Database, the report includes 2-year trend comparisons of its hospital results and the overall database results. Appendixes to the report include breakouts of individual hospital and comparative data by various hospital characteristics (e.g., bed size category, teaching status, and geographic region). These data allow hospitals to compare themselves with other hospitals sharing similar characteristics.

In addition to the individual hospital reports, Westat prepares an annual HSOPS Comparative Database Report, which provides more information about the characteristics of the hospitals submitting data to the database. The first two Comparative Database reports were issued in 2007 and 2008. The third report is under way. Published reports are available at the AHRQ Web site (www.ahrq.gov/qual/hospculture).

To allow Westat to monitor and assess its performance in meeting the needs of database submitters and report users and to identify ways to improve its technical assistance as well as AHRQ-sponsored patient safety products, SOPS project team members conducted telephone interviews with staff, such as patient safety officers, quality improvement directors, chief executive officer, data support specialists, and survey coordinators, from nine hospitals that had submitted data to the HSOPS data submission Web site. The interviews addressed user experiences with HSOPS products and the HSOPS data submission Web site. In addition, users were asked about their hospitals' administration of the survey and their reactions to and use of the survey results to promote a patient safety culture and safe patient care practices.

In the remainder of this report, we describe the following:

- Methods used to select and recruit hospitals and conduct the interviews
- Characteristics of the nine participating hospitals
- Survey administration experiences, lessons learned, and advice from the participants for other hospitals considering use of the HSOPS
- Comments and suggestions regarding the HSOPS hospital registration and data submission processes
- Comments on the design and content of the 2008 HSOPS Overall Comparative Database Report and the individual hospital reports
- Dissemination of HSOPS survey results within the hospitals

- Reactions within the hospitals to their HSOPS results
- Comments regarding notable changes in results in hospitals with trend data
- Setting of expectations and development of action plans within the hospitals
- Actions taken to promote a patient safety culture and safe patient care practices
- Recommendations for improving HSOPS products and technical assistance to HSOPS users

1. Methods for Selecting and Recruiting Hospitals and Conducting the User Feedback Interviews

1.1 Selection Criteria

An effort was made to select hospitals meeting the following criteria:

- Hospitals that had submitted data more than once to the HSOP data submission Web site
- Hospitals that were recent first-time submitters in 2008 and had not yet received a customized, individual hospital report

In addition, selected hospitals were roughly representative of overall database submitters with respect to bed-size category, teaching status, ownership and control, geographic region, and system versus stand-alone status. Also, some of the selected hospitals had conducted a census of staff (all staff), whereas others administered the survey only to a subset of hospital staff.

1.2 Recruitment

Westat sent emails to selected HSOPS Comparative Database hospital contacts asking if they would be willing to participate in an interview. Interviews were scheduled with nine hospitals saying yes, and a general list of interview topics and a copy of the hospital's most recent individual hospital report was sent prior to the interview. For the most part, recruited hospitals met the selection criteria goals (see Table 1 on the next page).

1.3 Interviews

The interviews were conducted over the telephone. Participants were told of their rights as voluntary participants in the interview and were asked for their consent to have the interview tape recorded as a backup to notetaking. All participants agreed. Interviewers used a prepared interview protocol or guide to conduct the interviews, which lasted from about 45 minutes to an hour.

Table 1. Characteristics of Participating Hospitals

	Type of Organization	Bed Size	Region	Teaching Status	Ownership	Staff Sampled	Years Submitted
1.	Stand-alone hospital	Fewer than 50 beds	Central	Non-teaching	Non-government, not-for-profit	All staff	2006, 2007, 2008
2.	Stand-alone critical care hospital	100-199 beds	Central	Non-teaching	Government, non-federal	All staff	2006, 2007, 2008
3.	Hospital within larger system	100-199 beds	Central	Non-teaching	Non-government, not-for-profit	Sample of all staff	2008
4.	Hospital within larger system	100-199 beds	Midwest	Non-teaching	Non-government, not-for-profit	All staff	2008
5.	Stand-alone pedatric hospital	200-299 beds	West	Teaching	Non-government, not-for-profit	Selected staff only	2007, 2008
6.	County Department of Health Services (two hospitals)	200-299 beds; 500 or more beds	West	Teaching	Government, non-federal	Selected departments/units only	2006, 2008
7.	Stand-alone hospital	400-499 beds	Midwest	Teaching	Non-government, not-for-profit	All staff	2007, 2008
8.	University hospital	500 or more beds	Mid-Atlantic	Teaching	Investor-owned (for profit)	Selected departments/units only	2008
9.	Hospital within larger system	500 or more beds	Southeast	Non-teaching	Non-government, not-for-profit	All staff	2006, 2007, 2008

2. Interview Findings

2.1 Survey Administration

When asked about changes they have made or lessons learned in their HSOPS survey administration process, participants made the following comments about their experiences:

- No participants mentioned they had changed survey mode from previous to current administrations, although some are thinking of switching from paper to web. Three participants said they have continued to use the same mode in all three of their administrations of the HSOPS: two have used paper surveys only, and the other has only used a Web survey, with extensive access to the survey on hospital computers and home computers (technical assistance is available on request). Another hospital that uses a Web survey said it is crucial to have the survey accessible on each desktop computer or to have a designated room for the survey.
- In one hospital, to improve response rates, they changed from putting the surveys in payroll envelopes to delivering them directly to managers to distribute.
- At least two of the hospitals extended their data collection period to improve response rates.
- Two hospitals learned lessons about timing survey administration—one administered it during union negotiations (the interview participant thought that because of contentious negotiations staff tended to be somewhat negative when they completed the survey), and another administered it while it was implementing computerized physician order entry (the participant speculated that staff were too busy and consequently their response rate suffered).
- Most hospitals use flyers and reminders to promote the survey (e.g., email reminders to managers to promote the survey in staff meetings, screen saver messages to compete the survey, in-person reminders to staff, particularly staff in small hospitals).
- One system that surveyed multiple hospitals learned that it is crucial to modify the form so that it is possible to identify which site a respondent is from.
- Some hospitals used incentives and others did not, although one participant said their hospital might use incentives next year to promote survey response.

In addition to sharing comments about their own experiences, participants said they would give the following advice to other hospitals that are considering using the HSOPS:

- Evaluate why your hospital wants to participate and what they expect to get from the results.
- The survey itself promotes patient safety because it makes staff aware of patient safety issues.

- It is a useful tool for getting baseline measurements, identifying issues, tracking progress, and comparing your hospital's patient safety culture results with other hospitals' results.
- It is an important tool not only as a way to gather information but because it says to all employees: "Whether you touch the patient or not, you may have some knowledge or you may have made some observation or you may know something that makes this a safer hospital, so you input matters."
- Be sure to get a good representative sampling of staff, including physicians; do not survey just one department.
- If a system wants to use a Web survey and has not done so before, it should consider using a Web survey with only one of its hospitals the first year to learn about glitches in the process.
- Also, systems need to have a point of contact at each hospital and should hold unit managers accountable for response rates in their units.
- If a paper survey is being used and your hospital is large or your system is administering the survey to more than one hospital, consider using scanning software (despite the initial high cost) to avoid the time and resource constraints of manually entering data.
- Be sure to disseminate your survey results and undertake real, actionable steps to improve patient safety culture. Staff need to know their participation in the survey was worthwhile.
- Use a vendor if you do not have in-house data analysts.
- To keep staff comfortable about taking the survey, keep the survey anonymous and have sealed boxes throughout the hospital for returning completed paper surveys.
- Do not modify the survey because it is a validated tool.

2.2 Database Registration and Data Submission Processes

All interview participants who logged on to the HSOPS data submission Web site to register their hospitals said their most recent experiences in registering were positive.

Examples of participant comments on the registration process:

- **Logging on** - Those who recalled receiving the email with instructions for logging on to the Comparative Database Web site said the instructions were clear and easy to follow.
- **Data submission Web site organization** - The data submission Web site was well organized, straightforward, and easy to navigate and use.
- **Entering information about their hospitals** - No problems or issues were reported. Two participants commented that they had noticed recent improvements that facilitated the registration/data submission processes.

- **Submitting their questionnaire -** Submitting a copy of their questionnaire was easy. They either uploaded a PDF version of their own survey file or they opted to upload the PDF survey file on the AHRQ Web site.

- **Receiving/submitting a copy of the Data Use Agreement (DUA) -** They either received the DUA by email from Westat or downloaded it from the AHRQ Web site—found it easy to download. One participant said, "I actually liked that it was all in a row—this is what you do—the steps—and it was right there and I could just grab it."

  No one commented that there were problems in getting the DUA signed. Several participants commented that it was reviewed by their legal departments. One participant had difficulty in faxing the signed DUA to Westat. Finally, she scanned it and emailed it. Another participant mentioned that it would be nice to have the option for electronically signing the DUA (as noted, they can scan signatures and email the documents—perhaps this option should be explicitly offered in the instructions). A third participant said instructions should be clearer that hospitals can return the signed DUA at any point after registering—they do not have to wait until they are ready to submit their data.

Participants also reported positive experiences in submitting their data files. Some of the participants providing information on data submission were vendor organizations or Quality Improvement Organizations (QIO) employed by hospitals to help them with data collection and/or analysis and reporting of results.

Examples of participant comments on the submission process:

- **Formatting and uploading data files -** Most participants said they had no difficulty with their latest submissions—said the instructions about formatting the data were clear and easy to follow and they did not need to call Westat for technical assistance. Some participants mentioned they had had problems with earlier submissions before Westat updated its data submission process, but resolved them easily with technical assistance from Westat, and one participant said that this last year it was "a breeze."

- **Problems –** A few participants commented on problems with the data submission process:

  - One participant could not remember the password to log on to the data submission Web site and called Westat for assistance. Also, this participant said she had to make two separate data files because she was not allowed to keep her headers showing question numbers. In addition, she called Westat for technical assistance because she did not recall seeing any instructions about removing headers or comments from the data file. She would like to be able to submit the survey data as written (with comments and headers with item numbers)—she was afraid she would lose data by removing cells.

  - One participant said that although the new Web site is much improved, hospital staff were confused by the instructions to attach data to a specific hospital because they were a stand-alone hospital, not part of a system.

- Another participant said that changes in the data format instructions caused some problems—she had to go through line by line to find out where things were not matching up. She said the error messages should be more specific or easier to understand (e.g., "too many columns") if possible. She was able to resolve her problems with technical assistance from Westat.

- **Closing comments -** Several participants said future changes in the Web site should be minimized—they are now familiar with the current processes and that familiarity makes it easy to register their hospitals and submit their data.

2.3 Comments About the Overall Comparative Database Report

Participants in six of the nine selected hospitals reviewed the Overall Comparative Database Report, and two others glanced at electronic versions of it. Generally, they thought it was not difficult to understand. One participant said that "it was not easy but not difficult because there are really good explanations…and once I read the instructions and the explanations, I understood how to interpret the data in the report." A few participants said they shared the report with relevant hospital committees. One participant said the percentile information was useful, and they used this information in feedback to staff. Another participant, however, did not find the percentile tables useful. A few participants did not find the report very useful or had some problems with, or suggestions for, specific sections:

- Two participants thought it was too long ("typical government report"; "I was almost overwhelmed"). One wondered if it could be simplified, and the other did not find it effective because it contained nothing specific to his hospital ("More excited to know, 'How am I doing?'").

- Several participants said it was a bit difficult to either understand results for the negatively worded questions or explain them to others in the hospital, or both. One participant suggested making all questions in the survey positively worded.

- One participant suggested reporting on the percentages of *Strongly agree* and *Strongly disagree* responses.

- One participant found the Table of Contents difficult to navigate and said an index would be useful.

- One participant said people in their hospital prefer bar charts to tables of data. This person also reiterated the request for pie charts with respondent data, and suggested that results be reported separately for hospitals that administer the survey to all staff versus hospitals that administer the survey to subsets of staff only (as documented in Table 2-4)—suspects the latter group would have higher scores.

- One participant reiterated the request that results be tailored to pediatric hospitals.

2.4 Comments About the Individual Hospital Report

Participants for five of the nine selected hospitals said they had downloaded and reviewed the individual comparative database report prepared by Westat for their hospitals. Participants like the report—one said, "I don't know of any way that we could do a survey of similar or better value…of getting the value of what you get here." Another participant said, "I think this report is beautifully done…there is a format for just about any group—macro and micro views of the results. They're attractive. You can pull out the graphs…and tables and put them in PowerPoint presentations—a nicely done product."

Participants' initial comments about the **usefulness of the report:**

- **Bar charts with comparative results** - Participants like the comparative results in the bar charts because they are clear and easy to understand ("I'm a picture person") and can be easily imported into presentations of results. The bar charts are particularly important for Board and senior executive presentations—generally, those audiences want to see how they compare on the composite percent positive scores with other hospitals in their system and/or with other hospitals overall and they like to see results presented graphically ("Hospital leaders mostly want macro data—the big picture.")

- **Individual item data and trend data** - Those receiving trend data also said the data are very useful in tracking their progress—identifying improvements, declines, or no change ("Report shows that what they are doing is validated."). Many of the participants (who often had responsibility for patient safety and/or quality improvement performance in their hospitals) said they focused primarily on their own hospital data rather than on comparative data with other hospitals. They wanted to know how their own hospital was doing over time. These data were also incorporated into presentations for senior leadership or for department managers, or both.

- **Use of the data** - Participants consider the survey results to be actionable. Most use the composite bar chart results and the individual item results to identify areas needing improvement, to set priorities, and to develop action plans. Hospitals with trend data rely on changes in the results over time as well to monitor progress and refine action plans. Some participants find it useful to use the appendix data, particularly the breakouts by work area, staff position, bed size, and teaching status, to drill down further into the data. Their hospitals may share those more detailed data with particular department managers only or they may use them to develop department-specific action plans.

- **Supplementary data sources** - A couple of participants said they had analyzed their survey data themselves (or received a report from a vendor or hospital system headquarters) prior to receiving their individual hospital report from Westat and thus focused primarily on the comparative results in the Westat report. Several participants mentioned that their HSOPS results tended to reinforce anecdotal reports and other sources of patient safety information in their hospitals, such as audit data and employee satisfaction surveys.

Respondents were all pleased with the contents of their reports and the ease of incorporating the different parts of the report into presentations for different audiences. Several of them made some suggestions for report changes or additions:

- Two participants said they would like a shorter time lag between submission of their data to the database and receipt of their report. In one of these two cases, the hospital was not using the Excel tool (a Microsoft Excel file with macros that enable hospitals to enter survey data and automatically generate charts of the results) or a vendor to prepare its own reports of findings. The participant said she was not really familiar with the Excel tool. Another participant said they also do not use the Excel tool.
- One participant said he would like to see the percent negative scores so that they can be separated from the percent neutral scores.
- Another participant would like to see the results tailored to pediatric hospitals—said it is hard for them to make comparisons with other hospitals because they do not have adult patients.
- One participant would like trend data for more than 2 years.
- Another participant said it would be nice to see pie charts showing respondent demographics.

2.5 Dissemination of the HSOPS Survey Results Within Hospitals

Dissemination of the survey results varied to some extent among the nine recruited hospitals. The following conclusions apply generally:

- Aggregate composite findings and comparisons with overall database results are presented to senior executive leaders (at the system and hospital levels); in addition, they are often, but not always, presented to Boards of Directors. One of the CEO participants said his Board Chairman is very focused on quality and patient safety and wants to know where they are exposed regarding patient safety and what they are doing about it. The Board Chairman instructed the CEO to make his survey report to the Board "succinct but thorough" and to answer the questions, "Are we providing good care and are we safe?"
- The aggregate composite results, as well as more detailed item results and breakouts by hospital or respondent characteristics are presented to various patient safety/quality improvement committees and planning groups and to managers and department directors (in one instance, the more detailed information is provided only to senior executive leaders). In some cases, more detailed data are shared only with directors of departments experiencing low scores on a composite or on individual items.
- Managers and department directors then share results with staff – usually during staff meetings. One participant at the system level said the administrators in each hospital in the system are responsible for disseminating results, but she is not sure results were shared with individual staff members.

- Results are usually shared with physicians either directly in medical staff meetings or indirectly through physician leaders who are members of patient safety or quality improvement committees or administrative councils (several participants said they have not yet shared the data with medical staff but plan to do so). However, most participants said physicians are not strongly engaged with the survey or the survey results. One participant said physicians consider the results "fluff." Another participant, though, noted that even though many of their physicians are not engaged with the survey, in the past 5 months more physicians are completing the simplified event reporting form that the hospital developed after reviewing the survey findings.

Other reported dissemination activities included the following:

- A few hospitals present the results to staff during annual educational fairs or in staff newsletters.
- In addition to its regular presentations of survey results, one hospital makes all the report data available online to all staff, but does not think many of them review it online.
- One participant has heard of a worksheet developed by the Sexton group (Safety Attitudes Questionnaire—SAQ) for managers to use as a tool to elicit discussion about areas of patient safety culture strength and area needing improvement and thinks this would be a good tool to use.

2.6 Reactions to Results

All participants who reviewed their survey results (either from their own analyses or from the Westat report, or both) said they thought the results reflected their hospitals' patient safety culture at the time of the survey(s) and confirmed what they already thought (several were not surprised that they had relatively low scores on Nonpunitive Response to Error and Handoffs & Transitions or that they had relatively high scores on Teamwork within Units). A few participants, however, did describe surprises in their data**:**

- One participant said they had a lower-than-expected percent positive score on Staffing and attributed that finding to staff frustration associated with a recent facility move. To reduce the level of frustration, they focused on explaining to staff why things were temporarily the way they were.
- Another participant said the results for Nonpunitive Reponse to Error and Handoffs & Transitions were counter to his and other managers' expectations. They could not explain the results.
- Another participant said they were surprised by their low score on Communication Openness but acknowledged they still had room for improvement in that area.

2.7 Hospitals With Trend Data – Comments on Changes in Results

Participants from three of the hospitals with trend data described notable changes (or lack of change) and offered possible explanations for those results:

- One participant said they saw continuous improvement regarding organizational learning, event reporting, and nonpunitive culture. She attributed the improvement to several factors:
    - Simply administering the survey raises staff awareness of patient safety issues and motivates them to think about it.
    - Management continually stresses to staff that the hospital is working on patient safety.
    - Prior to the followup survey in 2007, they formed a task force comprising nearly every department manager to redesign their hospital's event reporting form (made it simpler and easier to use). They also added optional telephone and electronic reporting.
    - She now sends thank you notes to nurses who report their own errors (that's hard for nurses to do).
    - Department managers are expected to investigate and follow up on reported events; this helps staff to understand that their reports are followed up without repercussions for them. Currently, they do not have a form for notifying event reporters what happened as a result of their reports—someone usually just talks to them about what was done.
- Another participant noted that they focus on the composites with the three lowest percent positive scores. Those three composites have been consistent for the past 3 years (Handoffs & Transitions, Supervisor/Manager Expectations and Actions Promoting Patient Safety, and Nonpunitive Response to Error). She commented on each of these composites:
    - She suggested that scores may not have shown expected improvement for Handoffs & Transitions (H&T) simply because their intensive focus on it may have raised staff awareness of the issues and the continued need for improvement. She said despite the low score for H&T, she believes they are making progress because they have implemented H&T changes across all hospital units with a hand in patient care (including transitions within the hospital and between the hospital and other external entities).
    - She said that managers and supervisors did not really sit up and take notice of the HSOPS results until the hospital experienced a preventable death in 2007. Then the demand for accountability came from the very top, with a new focus on process changes. Leaders were told that "this is your area and you are accountable." She expects better survey results in the future on this composite.
    - Regarding nonpunitive culture, they have not seen much progress—she said they seem to be spending too long talking about it without doing anything definitive.

- A third participant said his hospital has improved in many areas but their scores also declined for two composites. He attributes the improvement to their focus on promoting good communication from top leadership through managers to staff. Managers discuss patient safety topics they consider important and in need of attention (including survey results) during their monthly meetings and the need to reinforce desirable behaviors. The hospital, however, does not develop action plans. As noted earlier, he and other managers were unable to explain the decline in scores for Nonpunitive Response to Error and Handoffs & Transitions. If these areas continue to be problematic, they will look at what they can do differently.

2.8 Setting of Expectations and Development of Action Plans

Hospital actions plans often originate with the committees, councils, or patient safety/quality improvement officials charged with ensuring that safe and high-quality patient care practices are in place. These committee members and officials review the HSOPS survey data and other hospital information and propose goals, priorities, and initiatives to Board members and senior executives in the hospital or at system headquarters. Two participants said their Boards set strong expectations, but Board members seem to be less involved in other hospitals.

One hospital follows a policy that it will focus on the three HSOPS composite areas with the lowest percent positive scores. Another participant said that his hospital is already performing quite well and that instead of developing action plans, they focus on strong communication throughout the hospital at all levels about patient safety issues and monitoring of staff behaviors.

2.9 Other Actions Taken by Hospitals to Promote Patient Safety Culture or Practice Improvements

Interview participants reported other followup initiatives in response to the survey results and other hospital information on patient safety:

- The patient safety committee defined expectations for handoffs and transitions.
- Hospital leaders attend to Joint Commission indicators (e.g., colored armbands).
- One hospital developed an education program on falls, implemented TeamSTEPPS training for direct caregivers, and developed (but have not implemented since the departure of the former quality director) an action plan in response to HSOPS results for specific patient safety culture composites. The action plan includes the following activities:
    - Overall Perceptions of Safety: Communicate safety as a priority to all departments and management. Made a New Year's resolution for patient safety.
    - Frequency of Events Reported: Increase from 69 percent to 90 percent; increase reporting and usage of hotline through newsletters and staff education.
    - Supervisor/Manager Expectations: Share management commitment to patient safety with staff.

- Organizational Learning and Continuous Improvement: Report results to nurses, staff, and physicians.
- Feedback and Communication about Error: Include something about patient safety in each weekly newsletter. Send out study results to directors and ask them for feedback at staff meetings. Ask staff how they would prevent errors and send information back to management.

- One hospital began focusing on Nonpunitive Response to Error and Frequency of Events Reported; also, it has tried to increase resources needed by staff to prevent errors.
- Another hospital had David Marks conduct intensive training on how the hospital can change its culture to a "Just Culture" by improving accountability and taking a systems approach to responding to errors. They also became founding members of the California Patient Safety Action Coalition in January 2008. This coalition of health care leaders spreads the concept and practice of a "Just Culture" in which people are comfortable with reporting errors and evaluating them on a systems level.
- One hospital is focusing on using safety data to improve patient safety practices in operating rooms and emergency departments. Hospitalwide, they are integrating basic safety training for all associates (includes a 2-hour mandatory program covering why errors occur and strategies to prevent errors—they began doing this before the survey). Also, they are working with nurses to ensure handoff reports are comprehensive, and they are aggressively conducting root cause analyses and apparent cause analyses of incidents (these analyses have led to training initiatives on intravenous medication administration and monitoring of their procedures).
- Immediately after the survey, one hospital identified problems with its incident reporting system through discussions with staff. With help from its IT department, it changed its reporting system hospitalwide. This hospital also worked on communication about errors and communication openness in the ICU. Using the the model developed by Peter Provonost at Johns Hopkins, they developed a Comprehensive Unit-Based Safety Plan. Also, a physician championed the use of a To Do List for ICU rounding. They are currently in the process of changing policies about discussion of errors as a result of VP safety rounds implemented shortly after the survey.

2.10 Observed Improvements in Patient Safety Culture and Practices

Some observed improvements have already been described in this report. Generally, all participants identified a range of improvements in patient safety culture and practices that are at least partly attributable to the survey and its results. Some of these improvements are evident hospitalwide, while others have been observed in particular departments:

- The survey has contributed to a stronger awareness among staff of patient safety as a concept and is leading to more openness and willingness to talk about patient safety issues.

- Staff reports of errors have increased in hospitals that simplified their forms and offered alternative anonymous reporting methods.
- Hospitals working on Handoffs & Transitions have seen improvement with clinical staff, but one is focusing now on increasing improvement with nonclinical transportation personnel (they are training them on what to watch for while a patient is in transit—things to look for, when they might need to call for help).
- In one hospital, outcome results show considerable improvement in patient safety in the obstetrics and operating room units.
- Slowly, survey results indicate increased positive perceptions that senior leaders are taking steps to improve patient safety.
- Another participant said a Vice President conducting safety rounds reported that the respiratory department has been proactively promoting patient safety initiatives, as has the intensive care unit with respect to self-excavation, sedation, and other issues.

3. Recommendations

Overall, the interview participants commented positively about the HSOPS hospital registration and data submission processes and Web site, the HSOPS Overall Comparative Database Report, and the individual hospital reports. But there were some comments and suggestions that Westat can follow up on to improve HSOPS products and its technical assistance to HSOPS users. Potential improvements are presented below.

Registration and Submission Processes/Comparison Database Web Site

1. In the instructions for the Data Use Agreement (DUA), clarify that signed copies of the DUA may be submitted to Westat at any time after the hospital enters its registration information at the HSOPS data submission Web site—hospitals do not have to wait until they actually submit their data files.
2. Instruct hospitals that they can email DUAs containing scanned signatures.
3. Clarify instructions about attaching data to a specific hospital so that stand-alone hospitals do not get confused when they read the instructions.
4. Review error messages associated with data file format instructions to see if they can be simplified for persons with nontechnical backgrounds.
5. When something is new or changed in the registration or submission processes, highlight the fact that it is new or revised so that resubmitters will not be confused.

Comparative Database Reports

1. Include a graphical example in the database reports (and the Excel tool) to demonstrate how to interpret and report negatively worded questions.
2. Consider reporting overall percent negative scores, so that users can distinguish between negative and neutral scores.
3. Consider using graphs when reporting trend data.
4. Consider using pie charts to present respondent characteristics.
5. Improve navigation in the Table of Contents of the electronic version of the Overall Comparative Database Report and consider adding an index to that report.
6. Investigate the feasibility of additional breakouts in the appendixes (e.g., by hospitals that administered the survey to all staff, only to clinical staff, or only to a specific department or departments).

Technical Assistance

1. More effectively advertise the Excel tool to HSOPS users and potential users and highlight the availability of free technical assistance in using the tool.

2. Continue to develop resource lists and other tools that are designed to assist hospitals in developing initiatives to improve their performance on specific HSOPS composites and patient safety practices in general.