Hospital Survey on Patient Safety Culture: 2009 Comparative Database Report

Part II: Appendix A—Overall Results by Hospital Characteristics

> Appendix B—Overall Results by Respondent Characteristics

Part III: Appendix C—Trending Results by Hospital Characteristics

> Appendix D—Trending Results by Respondent Characteristics

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Part II: Appendixes A & B: Overall Results by Hospital and Respondent Characteristics

Appendixes A and B present data tables that show average percent positive scores on the survey composites and items across database hospitals broken down by the following hospital and respondent characteristics:

Appendix A: Overall Results by Hospital Characteristics

- Bed size
- ➢ Teaching status
- Ownership and control
- Geographic region

Appendix B: Overall Results by Respondent Characteristics

- ➢ Work area/unit
- ➢ Staff position
- Interaction with patients

Highlights from these results by hospital and respondent characteristics were presented in the main body of the report, Part I: Comparative Database Report, at the end of Chapter 6 and are also shown on the next two pages. Highlights were based on results for the 12 patient safety culture composites, and on patient safety grade and number of events reported. In the bottom row of the composite-level tables, an overall average across composites is shown as a summary statistic when comparing across breakout categories.

To ensure hospital confidentiality, a rule was established requiring at least 20 hospitals to be in a particular breakout category before data would be displayed by that category. Therefore, in Appendix A two of the standard AHA regions have been combined.

You can compare your hospital's percent positive scores on the patient safety culture composites and items against the averages shown in Appendix A for hospitals with your same bed size, teaching status, ownership and control, and geographic region. You can use a 5 percent difference as a rule of thumb for determining what differences to pay attention to.

To compare your hospital's results against Appendix B, your hospital will have to compute percent positive scores on the safety culture composites and items broken down by Work Area/Unit, staff position, and interaction with patients. You would then compare your hospital's percent positive scores against the averages shown in the tables.

Again, you can use a 5 percent difference as a rule of thumb for determining what differences to pay attention to. *Hospitals that did not ask respondents for their work area/unit, staff position, or about interaction with patients will not be able to make comparisons by these categories, and such hospitals were excluded from the breakout tables in Appendix B. Also, respondents who selected "Many different work areas/No specific work area" (for their work area), "Other" (for their work area or staff position), or did not answer (missing) were not included in the breakout tables in Appendix B.*

Highlights from Appendix A: Overall Results by Hospital Characteristics

Bed Size (Tables A-1, A-3, A-4)

- Smaller hospitals (49 beds or fewer) had the highest average percent positive response on all 12 patient safety culture composites.
- The largest difference by bed size was on *Handoffs & Transitions* where the smallest hospitals (6-24 beds) scored 22 percent higher than large hospitals (400-499 beds) (55 percent compared to 33 percent positive).
- Large hospitals (400-499 beds) scored lowest on the percent of respondents who gave their work area/unit a patient safety grade of "Excellent" or "Very good" (64 percent for 400-499 beds compared to 78 percent for 25-49 beds).
- There were no noticeable differences on number of events reported based on bed size (all differences were 3 percent or less).

Teaching Status, and Ownership and Control (Tables A-5, A-7, A-8)

- Non-teaching hospitals had the highest average percent positive response on *Handoffs & Transitions* (46 percent compared to 41 percent respectively).
- Government-owned hospitals were more positive than non-government on *Handoffs* & *Transitions* (6 percent more positive), and *Staffing* (5 percent more positive).
- There were no noticeable differences on patient safety grade or number of events reported based on teaching status or ownership and control (all differences were 3 percent or less).

Geographic Region (Tables A-9, A-11, A-12)

- East South Central hospitals had the highest average percent positive response across the 12 patient safety culture composites; Pacific hospitals had the lowest.
- The largest difference by region was on *Staffing* and *Handoffs & Transitions* where West North Central hospitals were 10 percent more positive than Mid Atlantic/New England hospitals (for *Staffing*) and Pacific hospitals (for *Handoffs & Transitions*).
- West South Central hospitals scored highest on the percent of respondents who gave their work area/unit a patient safety grade of "Excellent" or "Very good" (77 percent).
- Pacific hospitals had the highest percent of respondents who reported one or more events in the past year (53 percent); the lowest percent of respondents reporting events was in the West South Central region (40 percent).

Highlights from Appendix B: Overall Results by Respondent Characteristics

Work Area/Unit (Tables B-1, B-3, B-4)

- Respondents in *Rehabilitation* had the highest average percent positive response on 8 of the 12 patient safety culture composites.
- The largest difference by work area/unit was on *Nonpunitive Response to Error* (22 percent). On this composite, *Rehabilitation* was 59 percent positive and *Emergency* was 37 percent positive.
- *Rehabilitation* had the highest percent of respondents who gave their work area/unit a patient safety grade of "Excellent" or "Very good" (81 percent); *Emergency* and *Medicine* had the lowest percent (62 percent).
- *ICU (any type)* had the highest percent of respondents reporting one or more events in the past year (66 percent); *Anesthesiology* had the lowest percent of respondents reporting events (43 percent).

Staff Position (Tables B-5, B-7, B-8)

- Respondents in *Administration/Management* had the highest average percent positive response on 11 of the 12 patient safety culture composites.
- The largest difference (26 percent) by staff position was on *Nonpunitive Response to Error; Administration/Management* was 62 percent positive and *Patient Care Assistants Aides/Care Partners* were 36 percent positive.
- *Administration/Management* had the highest percent of respondents who gave their work area/unit a patient safety grade of "Excellent" or "Very good" (82 percent); *Registered Nurse/LVN/LPN* had the lowest percent (66 percent).
- *Pharmacists* had the highest percent of respondents reporting one or more events in the past year (75 percent); *Unit Assistants/Clerks/Secretaries* had the lowest percent reporting events (22 percent).

Interaction With Patients (Tables B-9, B-11, B-12)

- Respondents *with* direct patient interaction were 7 percent more positive on *Handoffs & Transitions* compared to those *without* direct patient interaction (45 percent compared to 38 percent positive).
- Respondents *without* direct patient interaction were 7 percent more positive about *Management Support for Patient Safety* than those *with* direct patient interaction (76 percent compared to 69 percent positive).
- Respondents *without* direct patient interaction had the highest percent of respondents who gave their work area/unit a patient safety grade of "Excellent" or "Very good" (77 percent) compared to those *with* direct patient interaction (72 percent).
- More respondents *with* direct patient interaction reported one or more events in the past year (53 percent) than respondents *without* direct patient interaction (32 percent).

Part III: Appendixes C & D: Trending Results by Hospital and Respondent Characteristics

In Part III of the report, Appendixes C and D show trends over time for the 204 hospitals (of the 622 total database hospitals) that administered the survey and submitted data twice. Average percent positive scores across hospitals from the most recent and previous administrations are shown on the survey composites and items, broken down by the following respondent characteristics:

Appendix C: Trending Results by Hospital Characteristics

- \succ Bed size
- Teaching status
- Ownership and control

Appendix D: Trending Results by Respondent Characteristics

- ➢ Work area/unit
- ➢ Staff position
- Interaction with patients

To ensure hospital confidentiality, a rule was established requiring at least 20 hospitals to be in a particular breakout category before data would be displayed by that category. As a result of not having 20 hospitals in each breakout category, in Appendix C the trending results for the standard AHA regions are not displayed.

Tables 1 and 2 below show examples of the statistics shown in this appendix. The tables show the average percent of respondents who answered positively among the trending hospitals for the hospitals' most recent survey administration (top row) and their previous administration (middle row). The change over time is shown in the bottom row as a negative number if the most recent administration showed a decline, or is shown as a positive number if the most recent administration showed an increase. Changes in scores of 5 percent or greater, whether positive or negative, are bolded.

Table 1: Example of Decrease in Average Score Over Time (Negative Change)

Most Recent	85%
Previous	90%
Change	-5%

Table 2: Example of Increase in Average Score Over Time (Positive Change)

Most Recent	70%
Previous	60%
Change	10%

Highlights of the findings from the breakout tables in these appendixes are provided on the following pages.

Highlights from Appendix C: Trending Results by Hospital Characteristics

Bed Size (Tables C-1, C-3, C-4)

- Hospitals with 100-299 beds had the largest increases in percent positive response over time on 10 of the 12 patient safety culture composites (average increase across the 10 composites was 5 percent).
- Hospitals with 200-299 beds had the greatest average change across the 12 patient safety culture composites (average 5 percent change).
- The largest increase over time was for medium-large hospitals (200-299 beds) on *Teamwork Within Units* and *Organizational Learning—Continuous Improvement*, both increasing 8 percent from the previous administration.
- The largest decrease over time was for large hospitals (500 or more beds) on the *Overall Perceptions of Patient Safety*, decreasing 6 percent from the previous administration.
- Small hospitals (6-24 beds) had the highest increase in percent of respondents who gave their work area/unit a patient safety grade of "Excellent" or "Very good" (a 7 percent increase, from 71 percent in the previous administration to 78 percent in the most recent administration).
- Small hospitals (6-24 beds) also had the highest increase in percent of respondents reporting one or more events in the past year (a 6 percent increase, from 41 percent to 47 percent).

Teaching Status, and Ownership and Control (Tables C-5, C-7, C-8)

- There were no noticeable differences or changes across the patient safety culture composites for teaching versus non-teaching hospitals or government-owned versus non-government hospitals (all changes and differences were 4 percent or less).
- Non-teaching hospitals had a greater increase than teaching hospitals in the percent of respondents who gave their work area/unit a patient safety grade of "Excellent" or "Very good" (a 5 percent increase, from 69 percent to 74 percent).
- Government-owned hospitals had a greater increase than non-government hospitals in the percent of respondents who gave their work area/unit a patient safety grade of "Excellent" or "Very good" (a 6 percent increase, from 69 percent to 75 percent).
- There were no noticeable differences or changes on the percent of respondents who reported one or more events in the past year based on teaching status.
- Government-owned hospitals had a greater increase than non-government hospitals in the percent of respondents who reported one or more events in the past year (a 5 percent increase, from 42 percent to 47 percent).

Highlights from Appendix D: Trending Results by Respondent Characteristics

Work Area/Unit (Tables D-1, D-3, D-4)

- Respondents in *Psych/Mental Health* had the greatest average change in percent positive response across the 12 patient safety culture composites, with an average change of 5 percent.
- Respondents in *Obstetrics* had the largest increases in positive response over time on 5 of the 12 patient safety culture composites (average increase across the 5 composites was 6 percent).
- Respondents in *Anesthesiology* had the largest decreases in positive response over time on 4 of the 12 patient safety culture composites (average decrease across the 4 composites was 5 percent).
- *Medicine* had the largest average percent of respondents who increased over time in giving their work area/unit a patient safety grade of "Excellent" or "Very good" (an 8 percent increase from 56 to 64 percent), followed by *ICU* (7 percent increase), *Surgery* (6 percent increase), and *Lab* (5 percent increase).
- *Lab* had the largest average percent of respondents who increased over time in their reporting of one or more events in the past year (a 7 percent increase: from 48 to 55 percent) followed by *Anesthesiology, Radiology,* and *Rehabilitation* (all increasing by 5 percent); the largest decrease in percent reporting was in *Obstetrics* (a 6 percent decrease from 58 to 52 percent).

Staff Position (Tables D-5, D-7, D-8)

- *Pharmacists* had the largest increases in positive response over time on 4 of the 12 patient safety culture composites (average increase across the 4 composites was 6 percent).
- Admin/Mgmt, RN/LVN/LPN, and Technicians had the largest average percent of respondents who increased over time in giving their work area/unit a patient safety grade of "Excellent" or "Very good" (5 percent increases).
- There were no noticeable differences in the percent of respondents reporting one or more events over time based on staff position (all changes over time were less than +/- 5 percent).

Interaction With Patients (Tables D-9, D-11, D-12)

- There were no noticeable composite differences over time based on respondent interaction with patients (all were increases over time of 4 percent or less).
- There were no noticeable differences in the percent of respondents giving their work unit/area a patient safety grade of "Excellent" or "Very good" or those reporting one or more events over time based on respondent direct patient interaction.

Part II

Appendix A: Overall Results by Hospital Characteristics

Appendix A: Overall Results by Hospital Characteristics

(1) Bed Size

NOTE: The number of hospitals and respondents in each breakout category is shown in each table (e.g., the number of hospitals and respondents by bed size). However, the precise number of hospitals and respondents corresponding to each data cell in a table will vary because hospitals may have omitted a specific survey item and because of individual non-response/missing data.

	Bed Size							
Patient Safety Culture Composites	6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-399 beds	400-499 beds	500+ beds
# Hospitals # Respondents	60 3,703	139 13,426	111 15,766	111 28,539	74 31,990	55 35,153	23 14,636	49 53,249
1. Teamwork Within Units	83%	82%	79%	79%	77%	78%	75%	77%
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	76%	78%	76%	74%	72%	72%	70%	72%
3. Org LearningContinuous Improvement	71%	74%	71%	70%	68%	70%	67%	68%
4. Management Support for Patient Safety	74%	76%	72%	68%	66%	68%	63%	65%
5. Overall Perceptions of Patient Safety	69%	70%	66%	62%	60%	61%	56%	56%
6. Feedback & Communication About Error	64%	65%	63%	62%	61%	63%	59%	60%
7. Communication Openness	64%	63%	62%	61%	61%	61%	58%	60%
8. Frequency of Events Reported	63%	63%	60%	60%	58%	60%	57%	57%
9. Teamwork Across Units	66%	63%	59%	54%	50%	53%	48%	50%
10. Staffing	62%	61%	56%	51%	49%	50%	48%	49%
11. Handoffs & Transitions	55%	50%	47%	41%	36%	40%	33%	38%
12. Nonpunitive Response to Error	48%	48%	45%	43%	41%	40%	38%	38%
Average Across Composites	66%	66%	63%	60%	58%	60%	56%	58%

Table A-1. Composite-level Average Percent Positive Response by Bed Size

		Bed Size								
ltom	Sumay Komo Dy Composito	6-24	25-49	50-99	100-199	200-299	300-399	400-499	500+	
ltem	Survey Items By Composite # Hospitals	beds 60	beds 139	beds 111	beds 111	beds 74	beds 55	beds 23	beds 49	
	# Respondents	3,703	13,426	15,766	28,539	31,990	35,153	14,636		
1.	Teamwork Within Units									
A1	1. People support one another in this unit.	87%	87%	85%	85%	83%	84%	83%	84%	
A3	2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	90%	89%	86%	85%	84%	85%	82%	83%	
A4	3. In this unit, people treat each other with respect.	80%	81%	78%	78%	75%	76%	74%	75%	
A11	 When one area in this unit gets really busy, others help out. 	74%	72%	68%	68%	65%	67%	63%	65%	
2.	Supervisor/Manager Expectations & Actions Promoting Patient Safety									
B1	1. My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures.	71%	73%	72%	72%	71%	71%	69%	71%	
B2	My supv/mgr seriously considers staff suggestions for improving patient safety.	76%	80%	77%	76%	75%	74%	72%	74%	
B3R	3. Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts.	79%	79%	76%	72%	70%	70%	67%	68%	
B4R	 My supv/mgr overlooks patient safety problems that happen over and over. 	77%	80%	78%	76%	74%	74%	71%	74%	
3.	Organizational Learning— Continuous Improvement									
A6	1. We are actively doing things to improve patient safety.	82%	84%	83%	81%	79%	82%	77%	79%	
A9	2. Mistakes have led to positive changes here.	65%	66%	63%	62%	60%	62%	58%	60%	
A13	3. After we make changes to improve patient safety, we evaluate their effectiveness.	66%	71%	68%	67%	66%	67%	64%	65%	

Table A-2. Item-level Average Percent Positive Response by Bed Size (Page 1 of 4)

		Bed Size							
Item	Survey Items By Composite	6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-399 beds	400-499 beds	500+ beds
	# Hospitals # Respondents	60 3,703	139 13,426	111 15,766	111 28,539	74 31,990	55 35, 153	23 14,636	49 53,249
4.	Management Support for Patient Safety								
F1	1. Hospital mgmt provides a work climate that promotes patient safety.	84%	85%	81%	77%	75%	77%	72%	74%
F8	2. The actions of hospital mgmt show that patient safety is a top priority.	75%	76%	73%	70%	69%	71%	65%	67%
F9R	3. Hospital mgmt seems interested in patient safety only after an adverse event happens.	64%	66%	61%	57%	54%	56%	51%	52%
5.	Overall Perceptions of Patient Safety								
A10R	1. It is just by chance that more serious mistakes don't happen around here.	66%	66%	62%	58%	56%	57%	52%	51%
A15	2. Patient safety is never sacrificed to get more work done.	72%	71%	66%	61%	59%	59%	55%	56%
A17R	3. We have patient safety problems in this unit.	69%	69%	64%	60%	58%	57%	53%	50%
A18	4. Our procedures and systems are good at preventing errors from happening.	70%	74%	72%	69%	68%	69%	65%	66%
6.	Feedback and Communication About Error								
C1	1. We are given feedback about changes put into place based on event reports.	52%	54%	52%	53%	53%	56%	52%	54%
C3	2. We are informed about errors that happen in this unit.	68%	67%	65%	63%	61%	63%	59%	61%
C5	3. In this unit, we discuss ways to prevent errors from happening again.	73%	73%	71%	69%	68%	69%	65%	66%

Table A-2. Item-level Average Percent Positive Response by Bed Size (Page 2 of 4)

		Bed Size							
Item	Survey Items By Composite	6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-399 beds	400-499 beds	500+ beds
	# Hospitals # Respondents	60 3,703	139 13,426	111 15,766	111 28,539	74 31,990	55 35, 153	23 14,636	49 53,249
7.	Communication Openness								
C2	1. Staff will freely speak up if they see something that may negatively affect patient care.	78%	77%	76%	76%	74%	75%	71%	73%
C4	2. Staff feel free to question the decisions or actions of those with more authority.	50%	48%	47%	46%	47%	47%	44%	46%
C6R	Staff are afraid to ask questions when something does not seem right.	66%	65%	63%	62%	61%	61%	58%	60%
8.	Frequency of Events Reported								
D1	1. When a mistake is made, but is <u>caught and</u> <u>corrected before affecting the patient</u> , how often is this reported?	54%	53%	52%	51%	51%	53%	50%	50%
D2	2. When a mistake is made, but has <u>no potential</u> to harm the patient, how often is this reported?	58%	58%	55%	55%	54%	55%	53%	52%
D3	3. When a mistake is made that <u>could harm the</u> <u>patient</u> , but does not, how often is this reported?	76%	76%	73%	72%	71%	72%	68%	69%
9.	Teamwork Across Units								
F2R	1. Hospital units do not coordinate well with each other.	54%	50%	47%	42%	37%	41%	34%	37%
F4	2. There is good cooperation among hospital units that need to work together.	68%	64%	60%	55%	51%	54%	49%	50%
F6R	3. It is often unpleasant to work with staff from other hospital units.	65%	64%	60%	56%	52%	55%	50%	52%
F10	4. Hospital units work well together to provide the best care for patients.	77%	73%	69%	64%	60%	63%	58%	59%

Table A-2. Item-level Average Percent Positive Response by Bed Size (Page 3 of 4)

		Bed Size							
Item	Survey Items By Composite	6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-399 beds	400-499 beds	500+ beds
	# Hospitals # Respondents	60 3,703	139 13,426	111 15,766	111 28,539	74 31,990	55 35,153	23 14,636	49 53,249
10.	Staffing								
A2	1. We have enough staff to handle the workload.	63%	62%	56%	49%	48%	47%	46%	46%
A5R	2. Staff in this unit work longer hours than is best for patient care.	58%	57%	53%	48%	48%	47%	46%	47%
A7R	3. We use more agency/temporary staff than is best for patient care.	69%	69%	65%	62%	60%	63%	61%	62%
A14R	4. We work in "crisis mode" trying to do too much, too quickly.	59%	57%	52%	44%	42%	42%	39%	40%
11.	Handoffs & Transitions								
F3R	1. Things "fall between the cracks" when transferring patients from one unit to another.	54%	48%	44%	37%	31%	34%	28%	32%
F5R	2. Important patient care information is often lost during shift changes.	57%	53%	51%	47%	43%	47%	41%	46%
F7R	3. Problems often occur in the exchange of information across hospital units.	52%	48%	44%	39%	34%	37%	31%	35%
F11R	4. Shift changes are problematic for patients in this hospital.	57%	52%	48%	41%	35%	40%	33%	38%
12.	Nonpunitive Response to Error								
A8R	1. Staff feel like their mistakes are held against them.	56%	55%	53%	50%	48%	47%	45%	44%
A12R	2. When an event is reported, it feels like the person is being written up, not the problem.	48%	49%	46%	44%	44%	43%	41%	41%
A16R	3. Staff worry that mistakes they make are kept in their personnel file.	41%	39%	37%	34%	32%	31%	28%	28%

Table A-2. Item-level Average Percent Positive Response by Bed Size (Page 4 of 4)

			Bed Size								
Work Area/Unit Patient Safety Grade		6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-399 beds	400-499 beds	500+ beds		
	# Hospitals # Respondents	60 3,703	139 13,426	111 15,766	111 28,539	74 31,990	55 35,153	23 14,636	49 53,249		
Α	Excellent	26%	27%	25%	24%	23%	24%	21%	22%		
в	Very Good	51%	51%	49%	47%	45%	46%	43%	45%		
С	Acceptable	20%	20%	22%	24%	25%	24%	27%	26%		
D	Poor	3%	2%	4%	5%	5%	5%	7%	6%		
Е	Failing	0%	0%	1%	1%	1%	1%	1%	1%		

Table A-3. Average Percent Distribution of Work Area/Unit Patient Safety Grades by Bed Size

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

		Bed Size									
Number of Events Reported by Respondents	6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-399 beds	400-499 beds	500+ beds			
# Hospitals # Respondents	60 3,703	139 13,426	111 15,766	111 28,539	74 31,990	55 35,153	23 14,636	49 53,249			
No events	50%	52%	53%	53%	51%	53%	53%	53%			
1 to 2 events	29%	28%	28%	27%	27%	28%	27%	28%			
3 to 5 events	14%	12%	12%	13%	13%	12%	12%	13%			
6 to 10 events	4%	4%	5%	4%	5%	4%	4%	4%			
11 to 20 events	2%	2%	2%	2%	2%	1%	2%	1%			
21 event reports or more	1%	1%	1%	1%	1%	1%	1%	1%			

Table A-4. Average Percent Distribution of Number of Events Reports in the Past 12 Months by Bed Size

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Appendix A: Overall Results by Hospital Characteristics

(2) Teaching Status and (3) Ownership and Control

NOTE: The number of hospitals and respondents in each breakout category is shown in each table (e.g., the number of hospitals and respondents by teaching status and ownership and control). However, the precise number of hospitals and respondents corresponding to each data cell in a table will vary because hospitals may have omitted a specific survey item and because of individual non-response/missing data.

	Teachi	ng Status	Ownership	and Control
Patient Safety Culture Composites	Teaching	Non-teaching	Govt	Non-govt
# Hospitals # Respondents	190 94,772	432 101,690	139 20,837	483 175,625
1. Teamwork Within Units	78%	80%	79%	79%
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	73%	75%	76%	74%
3. Org Learning—Continuous Improvement	70%	71%	72%	70%
4. Management Support for Patient Safety	68%	71%	72%	70%
5. Overall Perceptions of Patient Safety	62%	65%	67%	63%
6. Feedback & Communication About Error	61%	63%	63%	62%
7. Communication Openness	60%	63%	63%	62%
8. Frequency of Events Reported	58%	61%	61%	60%
9. Teamwork Across Units	54%	58%	60%	56%
10. Staffing	53%	56%	59%	54%
11. Handoffs & Transitions	41%	46%	49%	43%
12. Nonpunitive Response to Error	42%	45%	45%	43%
Average Across Composites	60%	63%	64%	61%

 Table A-5. Composite-level Average Percent Positive Response by Teaching Status, and Ownership and Control

		Teachi	ng Status	Ownership	and Control
ltem	Survey Items by Composite	Teaching	Non-teaching	Govt	Non-govt
	# Hospitals # Respondents	190 94,772	432 101,690	139 20,837	483 175,625
1.	Teamwork Within Units				
A1	1. People support one another in this unit.	84%	85%	85%	85%
A3	2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	84%	87%	87%	86%
A4	3. In this unit, people treat each other with respect.	77%	78%	77%	78%
A11	4. When one area in this unit gets really busy, others help out.	67%	69%	69%	68%
2.	Supervisor/Manager Expectations & Actions Promoting Patient Safety				
B1	 My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures. 	71%	72%	71%	72%
B2	2. My supv/mgr seriously considers staff suggestions for improving patient safety.	75%	77%	76%	76%
B3R	3. Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts.	72%	75%	77%	73%
B4R	 My supv/mgr overlooks patient safety problems that happen over and over. 	75%	77%	79%	76%
3.	Organizational Learning— Continuous Improvement				
A6	1. We are actively doing things to improve patient safety.	81%	82%	82%	81%
A9	2. Mistakes have led to positive changes here.	61%	63%	65%	62%
A13	3. After we make changes to improve patient safety, we evaluate their effectiveness.	66%	68%	69%	67%

 Table A-6. Item-level Average Percent Positive Response by Teaching Status, and Ownership and Control (Page 1 of 4)

		Teaching Status		Ownership	and Control
Item	Survey Items by Composite	Teaching	Non-teaching	Govt	Non-govt
	# Hospitals	190	432	139	483
	# Respondents	94,772	101,690	20,837	175,625
4.	Management Support for Patient Safety				
F1	 Hospital mgmt provides a work climate that promotes patient safety. 	77%	80%	82%	79%
F8	The actions of hospital mgmt show that patient safety is a top priority.	70%	72%	74%	71%
F9R	3. Hospital mgmt seems interested in patient safety only after an adverse event happens.	57%	60%	61%	59%
5.	Overall Perceptions of Patient Safety				
A10R	 It is just by chance that more serious mistakes don't happen around here. 	58%	61%	62%	59%
A15	2. Patient safety is never sacrificed to get more work done.	61%	65%	69%	63%
A17R	3. We have patient safety problems in this unit.	58%	64%	66%	61%
A18	 Our procedures and systems are good at preventing errors from happening. 	69%	71%	71%	70%
6.	Feedback and Communication About Error				
C1	1. We are given feedback about changes put into place based on event reports.	54%	53%	52%	54%
C3	2. We are informed about errors that happen in this unit.	62%	65%	67%	63%
C5	3. In this unit, we discuss ways to prevent errors from happening again.	69%	71%	71%	70%

Table A-6. Item-level Average Percent Positive Response by Teaching Status, and Ownership and Control (Page 2 of 4)

		Teaching Status		Ownershin	and Control
Item	Survey Items by Composite	Teaching	Non-teaching	Govt	Non-govt
	# Hospitals	190	432	139	483
	# Respondents	94,772	101,690	20,837	175,625
7.	Communication Openness				
C2	1. Staff will freely speak up if they see something that may negatively affect patient care.	74%	77%	76%	76%
C4	2. Staff feel free to question the decisions or actions of those with more authority.	46%	48%	47%	47%
C6R	3. Staff are afraid to ask questions when something does not seem right.	61%	64%	65%	62%
8.	Frequency of Events Reported				
D1	 When a mistake is made, but is <u>caught and</u> <u>corrected before affecting the patient</u>, how often is this reported? 	51%	52%	52%	52%
D2	2. When a mistake is made, but has <u>no potential to</u> <u>harm the patient</u> , how often is this reported?	54%	57%	57%	55%
D3	3. When a mistake is made that <u>could harm the</u> <u>patient</u> , but does not, how often is this reported?	71%	74%	74%	73%
9.	Teamwork Across Units				
F2R	1. Hospital units do not coordinate well with each other.	41%	46%	48%	44%
F4	 There is good cooperation among hospital units that need to work together. 	54%	60%	61%	57%
F6R	3. It is often unpleasant to work with staff from other hospital units.	56%	59%	61%	58%
F10	4. Hospital units work well together to provide the best care for patients.	64%	69%	70%	66%

Table A-6. Item-level Average Percent Positive Response by Teaching Status, and Ownership and Control (Page 3 of 4)

Survey Items by Composite				and Control	
	Teaching	Non-teaching	Govt	Non-govt	
# Hospitals # Respondents	190 94,772	432 101,690	139 20,837	483 175,625	
Staffing					
1. We have enough staff to handle the workload.	51%	55%	59%	52%	
2. Staff in this unit work longer hours than is best for patient care.	49%	53%	55%	51%	
3. We use more agency/temporary staff than is best for patient care.	64%	65%	66%	64%	
4. We work in "crisis mode" trying to do too much, too quickly.	46%	50%	55%	47%	
Handoffs & Transitions					
1. Things "fall between the cracks" when transferring patients from one unit to another.	36%	43%	47%	39%	
2. Important patient care information is often lost during shift changes.	47%	50%	52%	48%	
3. Problems often occur in the exchange of information across hospital units.	38%	43%	46%	40%	
4. Shift changes are problematic for patients in this hospital.	41%	46%	50%	43%	
Nonpunitive Response to Error					
1. Staff feel like their mistakes are held against them.	49%	52%	53%	51%	
2. When an event is reported, it feels like the person is being written up, not the problem.	44%	46%	46%	45%	
3. Staff worry that mistakes they make are kept in their personnel file.	33%	36%	38%	34%	
	# Respondents Staffing 1. We have enough staff to handle the workload. 2. Staff in this unit work longer hours than is best for patient care. 3. We use more agency/temporary staff than is best for patient care. 4. We work in "crisis mode" trying to do too much, too quickly. Handoffs & Transitions 1. Things "fall between the cracks" when transferring patients from one unit to another. 2. Important patient care information is often lost during shift changes. 3. Problems often occur in the exchange of information across hospital units. 4. Shift changes are problematic for patients in this hospital. Nonpunitive Response to Error 1. Staff feel like their mistakes are held against them. 2. When an event is reported, it feels like the person is being written up, not the problem. 3. Staff worry that mistakes they make are kept in	# Respondents94,772Staffing1. We have enough staff to handle the workload.51%2. Staff in this unit work longer hours than is best for patient care.49%3. We use more agency/temporary staff than is best for patient care.64%4. We work in "crisis mode" trying to do too much, too quickly.46%Handoffs & Transitions1. Things "fall between the cracks" when transferring patients from one unit to another.36%2. Important patient care information is often lost during shift changes.47%3. Problems often occur in the exchange of information across hospital units.38%4. Shift changes are problematic for patients in this hospital.41%Nonpunitive Response to Error49%1. Staff feel like their mistakes are held against them.49%2. When an event is reported, it feels like the person is being written up, not the problem.44%3. Staff worry that mistakes they make are kept in23%	# Respondents94,772101,690Staffing	# Respondents94,772101,69020,837Staffing1. We have enough staff to handle the workload.51%55%59%2. Staff in this unit work longer hours than is best for patient care.49%53%55%3. We use more agency/temporary staff than is best for patient care.64%65%66%4. We work in "crisis mode" trying to do too much, too quickly.46%50%55%Handoffs & Transitions1. Things "fall between the cracks" when transferring patients from one unit to another.36%43%47%2. Important patient care information is often lost during shift changes.38%43%46%3. Problems often occur in the exchange of information across hospital units.41%46%50%Nonpunitive Response to Error49%52%53%2. When an event is reported, it feels like the person is being written up, not the problem.44%46%46%3. Staff worry that mistakes they make are kept in22%28%28%	

Table A-6. Item-level Average Percent Positive Response by Teaching Status, and Ownership and Control (Page 4 of 4)

		Teachi	ng Status	Ownership and Control		
Work Area/Unit Patient Safety Grade		Teaching Non-teaching		Govt	Non-govt	
	# Hospitals # Respondents	190 94,772	432 101,690	139 20,837	483 175,625	
Α	Excellent	24%	25%	24%	25%	
в	Very Good	46%	48%	50%	47%	
С	Acceptable	24%	22%	22%	23%	
D	Poor	5%	4%	3%	5%	
Е	Failing	1%	1%	0%	1%	

 Table A-7. Average Percent Distribution of Work Area/Unit Patient Safety Grades by Teaching

 Status, and Ownership and Control

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Table A-8. Average Percent Distribution of Number of Events Reported in the Past 12 Months by	
Teaching Status, and Ownership and Control	

	Teachii	ng Status	Ownership	and Control
Number of Events Reported by Respondents	Teaching	Teaching Non-teaching		Non-govt
# Hospitals # Respondents	190 94,772	432 101,690	139 20,837	483 175,625
No events	53%	52%	52%	52%
1 to 2 events	28%	28%	27%	28%
3 to 5 events	12%	13%	13%	12%
6 to 10 events	4%	5%	5%	4%
11 to 20 events	1%	2%	2%	2%
21 event reports or more	1%	1%	1%	1%

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Appendix A: Overall Results by Hospital Characteristics

(4) Geographic Region

NOTE: The number of hospitals and respondents in each breakout category is shown in each table (e.g., the number of hospitals and respondents by region). However, the precise number of hospitals and respondents corresponding to each data cell in a table will vary because hospitals may have omitted a specific survey item and because of individual non-response/missing data.

	Geographic Region							
Patient Safety Culture Composites	Mid Atlantic/ New England	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific
# Hospitals # Respondents	37 20,546	104 36,825	165 54,909	34 8,978	104 20,986	45 13,242	58 17,264	75 23,712
1. Teamwork Within Units	77%	79%	79%	81%	81%	81%	81%	78%
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	73%	77%	73%	78%	74%	78%	74%	73%
3. Org Learning—Continuous Improvement	70%	73%	69%	74%	71%	74%	70%	68%
4. Management Support for Patient Safety	70%	70%	69%	74%	72%	73%	70%	67%
5. Overall Perceptions of Patient Safety	63%	62%	63%	67%	68%	67%	66%	60%
6. Feedback & Communication About Error	62%	64%	61%	64%	61%	67%	63%	60%
7. Communication Openness	62%	62%	61%	63%	61%	64%	63%	62%
8. Frequency of Events Reported	61%	60%	58%	65%	61%	63%	61%	59%
9. Teamwork Across Units	55%	56%	55%	62%	61%	58%	59%	54%
10. Staffing	50%	53%	54%	54%	60%	55%	55%	52%
11. Handoffs & Transitions	42%	43%	42%	48%	50%	45%	45%	40%
12. Nonpunitive Response to Error	41%	42%	42%	45%	48%	46%	47%	42%
Average Across Composites	61%	62%	61%	65%	64%	64%	63%	60%

Table A-9. Composite-level Average Percent Positive Response by Geographic Region

NOTE: States are categorized into AHA-defined regions as follows:

Mid Atlantic/New England: NY, NJ, PA, ME, NH, VT, MA, RI, CT South Atlantic: DE, MD, DC, VA, WV, NC, SC, GA, FL East North Central: OH, IN, IL, MI, WI East South Central: KY, TN, AL, MS West North Central: MN, IA, MO, ND, SD, NE, KS West South Central: AR, LA, OK, TX Mountain: MT, ID, WY, CO, NM, AZ, UT, NV Pacific: WA, OR, CA, AK, HI

		Geographic Region							
ltem	Survey Items By Composite	Mid Atlantic/ New England	South Atlantic	E. North Central	E. South Central	W. North Central	W. South Central	Mountain	Pacific
	# Hospitals # Respondents	37 20,546	104 36,825	165 54,909	34 8,978	104 20,986	45 13,242	58 17,264	75 23,712
1.	Teamwork Within Units								
A1	1. People support one another in this unit.	84%	84%	85%	87%	86%	87%	86%	85%
A3	2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	84%	85%	86%	88%	88%	87%	86%	84%
A4	3. In this unit, people treat each other with respect.	76%	78%	77%	81%	78%	80%	78%	78%
A11	4. When one area in this unit gets really busy, others help out.	65%	67%	68%	69%	70%	70%	72%	67%
2.	Supervisor/Manager Expectations & Actions Promoting Patient Safety								
B1	 My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures. 	70%	74%	71%	75%	69%	77%	71%	71%
B2	My supv/mgr seriously considers staff suggestions for improving patient safety.	75%	78%	75%	79%	75%	79%	76%	75%
B3R	3. Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts.	72%	75%	72%	76%	76%	77%	76%	72%
B4R	 My supv/mgr overlooks patient safety problems that happen over and over. 	75%	79%	76%	81%	78%	79%	75%	73%
3.	Organizational Learning— Continuous Improvement								
A6	 We are actively doing things to improve patient safety. 	81%	83%	80%	84%	81%	84%	81%	81%
A9	2. Mistakes have led to positive changes here.	60%	64%	61%	64%	64%	66%	63%	61%
A13	After we make changes to improve patient safety, we evaluate their effectiveness.	69%	70%	67%	74%	68%	73%	66%	61%

Table A-10. Item-level Average Percent Positive Response by Geographic Region (Page 1 of 4)

					Geographic	Region			
ltem	Survey Items By Composite	Mid Atlantic/ New England	South Atlantic	E. North Central	E. South Central	W. North Central	W. South Central	Mountain	Pacific
	# Hospitals # Respondents	37 20,546	104 36,825	165 54,909	34 8,978	104 20,986	45 13,2 <i>4</i> 2	58 17,264	75 23,712
4.	Management Support for Patient Safety								
F1	1. Hospital mgmt provides a work climate that promotes patient safety.	78%	79%	79%	83%	82%	80%	80%	77%
F8	The actions of hospital mgmt show that patient safety is a top priority.	72%	72%	71%	76%	72%	75%	72%	69%
F9R	3. Hospital mgmt seems interested in patient safety only after an adverse event happens.	58%	59%	59%	63%	62%	62%	59%	55%
5.	Overall Perceptions of Patient Safety								
A10R	 It is just by chance that more serious mistakes don't happen around here. 	58%	55%	59%	62%	66%	63%	64%	57%
A15	2. Patient safety is never sacrificed to get more work done.	64%	64%	62%	67%	67%	65%	68%	61%
A17R	3. We have patient safety problems in this unit.	58%	58%	62%	66%	68%	66%	66%	57%
A18	 Our procedures and systems are good at preventing errors from happening. 	70%	70%	69%	73%	72%	74%	69%	67%
6.	Feedback and Communication About Error								
C1	1. We are given feedback about changes put into place based on event reports.	54%	55%	53%	54%	50%	58%	53%	52%
C3	2. We are informed about errors that happen in this unit.	64%	67%	63%	67%	63%	70%	65%	60%
C5	In this unit, we discuss ways to prevent errors from happening again.	68%	71%	68%	71%	71%	73%	72%	69%

Table A-10. Item-level Average Percent Positive Response by Geographic Region (Page 2 of 4)

		Geographic Region							
ltem	Survey Items By Composite	Mid Atlantic/ New England	South Atlantic	E. North Central	E. South Central	W. North Central	W. South Central	Mountain	Pacific
	# Hospitals # Respondents	37 20,546	104 36,825	165 54,909	34 8,978	104 20,986	45 13,242	58 17,264	75 23,712
7.	Communication Openness		·						
C2	 Staff will freely speak up if they see something that may negatively affect patient care. 	76%	76%	76%	77%	75%	77%	76%	76%
C4	2. Staff feel free to question the decisions or actions of those with more authority.	48%	48%	46%	47%	45%	51%	49%	48%
C6R	Staff are afraid to ask questions when something does not seem right.	62%	63%	62%	64%	62%	66%	64%	62%
8.	Frequency of Events Reported								
D1	1. When a mistake is made, but is <u>caught and</u> <u>corrected before affecting the patient</u> , how often is this reported?	54%	52%	50%	56%	51%	57%	54%	50%
D2	2. When a mistake is made, but has <u>no</u> <u>potential to harm the patient</u> , how often is this reported?	57%	55%	54%	60%	58%	58%	57%	54%
D3	3. When a mistake is made that <u>could harm</u> <u>the patient</u> , but does not, how often is this reported?	73%	72%	72%	78%	75%	74%	72%	72%
9.	Teamwork Across Units								
F2R	1. Hospital units do not coordinate well with each other.	42%	44%	43%	51%	49%	45%	45%	40%
F4	2. There is good cooperation among hospital units that need to work together.	55%	57%	56%	64%	62%	60%	60%	55%
F6R	3. It is often unpleasant to work with staff from other hospital units.	56%	58%	56%	61%	62%	57%	61%	57%
F10	4. Hospital units work well together to provide the best care for patients.	65%	65%	65%	72%	71%	68%	69%	65%

Table A-10. Item-level Average Percent Positive Response by Geographic Region (Page 3 of 4)

		Geographic Region							
ltem	Survey Items By Composite	Mid Atlantic/ New England	South Atlantic	E. North Central	E. South Central	W. North Central	W. South Central	Mountain	Pacific
	# Hospitals	37	104	165	34	104	45	58	75
	# Respondents	20,546	36,825	54,909	8,978	20,986	13,242	17,264	23,712
10.	Staffing								
A2	 We have enough staff to handle the workload. 	49%	51%	52%	50%	61%	55%	56%	52%
A5R	2. Staff in this unit work longer hours than is best for patient care.	47%	51%	51%	53%	55%	52%	52%	50%
A7R	3. We use more agency/temporary staff than is best for patient care.	61%	64%	67%	65%	69%	64%	61%	58%
A14R	4. We work in "crisis mode" trying to do too much, too quickly.	44%	48%	46%	49%	54%	51%	53%	46%
11.	Handoffs & Transitions								
F3R	1. Things "fall between the cracks" when transferring patients from one unit to another.	37%	40%	38%	47%	47%	43%	41%	36%
F5R	Important patient care information is often lost during shift changes.	50%	48%	48%	53%	54%	49%	50%	45%
F7R	Problems often occur in the exchange of information across hospital units.	40%	40%	40%	46%	46%	43%	43%	39%
F11R	 Shift changes are problematic for patients in this hospital. 	42%	43%	42%	48%	53%	44%	47%	41%
12.	Nonpunitive Response to Error								
A8R	1. Staff feel like their mistakes are held against them.	47%	49%	50%	53%	55%	53%	54%	48%
A12R	2. When an event is reported, it feels like the person is being written up, not the problem.	44%	44%	44%	46%	48%	47%	48%	43%
A16R	Staff worry that mistakes they make are kept in their personnel file.	31%	34%	33%	36%	40%	37%	38%	33%

Table A-10. Item-level Average Percent Positive Response by Geographic Region (Page 4 of 4)

			Geographic Region										
Work Area/Unit Patient Safety Grade		Mid Atlantic/ New England	South Atlantic	E. North Central	E. South Central	W. North Central	W. South Central	Mountain	Pacific				
	# Hospitals # Respondents	37 20,546	104 36,825	165 54,909	34 8,978	104 20,986	45 13,242	58 17,264	75 23,712				
Α	Excellent	25%	23%	24%	27%	24%	30%	27%	24%				
В	Very Good	45%	47%	48%	48%	50%	47%	49%	46%				
С	Acceptable	24%	25%	23%	22%	22%	19%	20%	23%				
D	Poor	4%	5%	5%	3%	3%	4%	4%	6%				
Е	Failing	1%	1%	1%	0%	0%	1%	1%	1%				

Table A-11. Average Percent Distribution of Work Area/Unit Patient Safety Grades by Geographic Region

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Table A-12. Average Percent Distribution	of Number of Events Reported in the Past	12 Months by Geographic Region

		Geographic Region										
Number of Events Reported by Respondents	Mid Atlantic/ New England	South Atlantic	E. North Central	E. South Central	W. North Central	W. South Central	Mountain	Pacific				
# Hospitals # Respondents		104 36,825	165 54,909	34 8,978	104 20,986	45 13,242	58 17,264	75 23,712				
No events	56%	53%	52%	55%	50%	60%	54%	47%				
1 to 2 events	26%	28%	29%	27%	28%	24%	27%	30%				
3 to 5 events	11%	12%	12%	11%	14%	10%	12%	15%				
6 to 10 events	4%	4%	4%	4%	5%	4%	4%	5%				
11 to 20 events	2%	2%	2%	2%	2%	1%	2%	2%				
21 event reports or more	1%	1%	1%	1%	1%	1%	1%	1%				

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Appendix B: Overall Results by Respondent Characteristics

Appendix B: Overall Results by Respondent Characteristics

(1) Work area/Unit

NOTE 1: Hospitals that did not ask respondents to indicate their work area/unit were excluded from these breakout tables. In addition, respondents who selected "Many different work areas/No specific work area," "Other," or did not answer (missing) were not included.

NOTE 2: The number of hospitals and respondents in each work area/unit is shown. The number of hospitals is based on: 1) hospitals that asked respondents to indicate their work area/unit (not all hospitals asked this question), and 2) whether the hospital had at least 1 respondent in a particular work area/unit. However, the precise number of hospitals and respondents corresponding to each data cell in the tables will vary because hospitals may have omitted a specific survey item and because of individual non-response/missing data.

		Work Area/Unit										
Patient Safety Culture Composites	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medicine	Obstet- rics	Pediatrics	Pharmacy	Psych/ Mental Hith	Radi- ology	Rehab- ilitation	Surgery
# Hospitals # Respondents	177 1,184	486 9,703	401 12,040	526 9,273	518 17,143	345 8,088	236 4,534	464 5,226	232 4,298	539 10,528	464 7,429	506 17,393
1. Teamwork Within Units	79%	79%	83%	79%	74%	80%	80%	78%	79%	79%	86%	78%
2. Supv/Mgr Expectations & Actions Promoting Patient Safety	74%	72%	72%	75%	72%	73%	75%	77%	76%	76%	81%	74%
3. Org LearningContinuous Improvement	71%	65%	69%	72%	69%	69%	72%	75%	70%	69%	74%	74%
4. Mgmt Support for Patient Safety	65%	62%	59%	71%	65%	66%	67%	70%	67%	72%	75%	68%
5. Overall Perceptions of Patient Safety	64%	55%	56%	70%	55%	61%	65%	65%	59%	72%	76%	67%
6. Feedback & Communication About Error	64%	56%	56%	65%	57%	60%	61%	67%	66%	63%	70%	64%
7. Communication Openness	66%	61%	61%	63%	56%	63%	63%	70%	63%	64%	72%	64%
8. Frequency of Events Reported	58%	56%	56%	64%	61%	60%	60%	59%	63%	54%	61%	64%
9. Teamwork Across Units	54%	48%	53%	56%	56%	54%	53%	55%	53%	56%	61%	53%
10. Staffing	58%	49%	52%	54%	50%	56%	58%	56%	55%	62%	62%	56%
11. Handoffs & Transitions	41%	48%	47%	37%	47%	53%	46%	32%	39%	41%	40%	40%
12. Nonpunitive Response to Error	44%	37%	39%	43%	39%	42%	41%	56%	46%	46%	59%	45%
Average Across Composites	62%	57%	59%	62%	58%	61%	62%	63%	61%	63%	68%	62%

Table B-1. Composite-level Average Percent Positive Response by Work Area/Unit

		Work Area/Unit											
Item	Survey Items by Composite	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medicine	Obstet- rics	Pedi- atrics	Pharmacy	Psych/ Mental Hlth	Radi- ology	Rehab- ilitation	Surgery
	# Hospitals	177	486	401	526	518	345	236	464	232	539	464	506
	# Respondents	1,184	9,703	12,040	9,273	17,143	8,088	4,534	5,226	4,298	10,528	7,429	17,393
1. A1	Teamwork Within Units 1. People support one another in this unit.	85%	85%	88%	83%	83%	87%	86%	85%	84%	85%	91%	83%
A3	2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	87%	87%	88%	85%	80%	88%	87%	84%	84%	87%	90%	87%
A4	In this unit, people treat each other with respect.	78%	75%	80%	76%	74%	77%	80%	78%	79%	77%	88%	74%
A11	4. When one area in this unit gets really busy, others help out.	65%	70%	74%	70%	61%	68%	67%	67%	70%	66%	76%	65%
2.	Supv/Mgr Expectations & Actions Promoting Patient Safety												
B1	 My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures. 	70%	69%	68%	69%	70%	70%	71%	71%	74%	69%	77%	71%
B2	My supv/mgr seriously considers staff suggestions for improving patient safety.	76%	73%	73%	74%	73%	74%	76%	80%	77%	77%	84%	76%
B3R	 Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts. 	74%	72%	70%	80%	72%	72%	75%	78%	73%	78%	80%	71%
B4R	 My supv/mgr overlooks patient safety problems that happen over and over. 	76%	75%	75%	77%	74%	76%	78%	79%	78%	80%	84%	77%
3.	Organizational Learning— Continuous Improvement												
A6	1. We are actively doing things to improve patient safety.	85%	77%	83%	80%	81%	80%	84%	87%	81%	80%	88%	86%
A9	2. Mistakes have led to positive changes here.	63%	56%	57%	69%	59%	61%	60%	73%	60%	62%	62%	64%
A13	 After we make changes to improve patient safety, we evaluate their effectiveness. 	64%	62%	67%	66%	68%	67%	71%	66%	69%	65%	73%	71%

Table B-2. Item-level Average Percent Positive Response by Work Area/Unit (Page 1 of 4)

		Work Area/Unit											
Item	Survey Items by Composite	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medicine	Obstet- rics	Pedi- atrics	Pharmacy	Psych/ Mental Hith	Radi- ology	Rehab- ilitation	Surgery
	# Hospitals # Respondents	177 1,184	486 9,703	401 12,040	526 9,273	518 17,143	345 8,088	236 4,534	464 5,226	232 4,298	539 10,528	464 7,429	506 17,393
4.	Mgmt Support for Patient Safety												
F1	1. Hospital mgmt provides a work climate that promotes patient safety.	75%	70%	68%	81%	73%	76%	76%	77%	75%	83%	84%	78%
F8	2. The actions of hospital mgmt show that patient safety is a top priority.	67%	63%	61%	73%	67%	68%	68%	71%	68%	74%	77%	69%
F9R	 Hospital mgmt seems interested in patient safety only after an adverse event happens. 	54%	52%	49%	60%	55%	54%	55%	61%	58%	60%	63%	58%
5.	Overall Perceptions of Patient Safety												
A10R	 It is just by chance that more serious mistakes don't happen around here. 	63%	52%	54%	64%	53%	60%	62%	62%	58%	67%	74%	63%
A15	2. Patient safety is never sacrificed to get more work done.	58%	55%	51%	70%	54%	55%	64%	63%	62%	74%	76%	64%
A17R	3. We have patient safety problems in this unit.	64%	51%	55%	70%	50%	60%	62%	62%	50%	72%	74%	66%
A18	4. Our procedures and systems are good at preventing errors from happening.	72%	61%	63%	78%	63%	68%	71%	72%	68%	75%	79%	75%
6.	Feedback and Communication About Error												
C1	1. We are given feedback about changes put into place based on event reports.	55%	48%	47%	52%	50%	53%	52%	53%	59%	51%	61%	53%
C3	We are informed about errors that happen in this unit.	61%	57%	55%	69%	55%	59%	62%	73%	67%	69%	70%	65%
C5	3. In this unit, we discuss ways to prevent errors from happening again.	74%	63%	64%	72%	65%	68%	68%	75%	73%	70%	79%	73%

Table B-2. Item-level Average Percent Positive Response by Work Area/Unit (Page 2 of 4)

		Work Area/Unit											
Item	Survey Items by Composite	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medicine	Obstet- rics	Pedi- atrics	Pharmacy	Psych/ Mental Hith	Radi- ology	Rehab- ilitation	Surgery
	# Hospitals	177	486	401	526	518	345	236	464	232	539	464	506
	# Respondents	1,184	9,703	12,040	9,273	17,143	8,088	4,534	5,226	4,298	10,528	7,429	17,393
7.	Communication Openness												
C2	 Staff will freely speak up if they see something that may negatively affect patient care. 	76%	74%	75%	76%	71%	78%	78%	79%	77%	79%	84%	80%
C4	2. Staff feel free to question the decisions or actions of those with more authority.	53%	48%	44%	47%	40%	48%	49%	58%	50%	47%	57%	48%
C6R	3. Staff are afraid to ask questions when something does not seem right.	68%	63%	63%	66%	56%	63%	63%	72%	63%	67%	73%	63%
8.	Frequency of Events Reported												
D1	1. When a mistake is made, but is <u>caught</u> and corrected before affecting the patient, how often is this reported?	53%	44%	44%	55%	50%	50%	50%	46%	55%	44%	54%	57%
D2	2. When a mistake is made, but has <u>no</u> <u>potential to harm the patient</u> , how often is this reported?	52%	53%	52%	58%	58%	56%	56%	57%	59%	48%	56%	60%
D3	3. When a mistake is made that <u>could harm</u> <u>the patient</u> , but does not, how often is this reported?	70%	71%	71%	80%	74%	74%	74%	75%	74%	69%	73%	75%
9.	Teamwork Across Units												
F2R	1. Hospital units do not coordinate well with each other.	39%	38%	39%	43%	43%	39%	41%	43%	39%	43%	47%	40%
F4	There is good cooperation among hospital units that need to work together.	53%	48%	52%	58%	56%	56%	54%	55%	52%	58%	61%	53%
F6R	It is often unpleasant to work with staff from other hospital units.	58%	51%	60%	56%	60%	57%	56%	58%	60%	56%	65%	55%
F10	 Hospital units work well together to provide the best care for patients. 	64%	57%	60%	66%	64%	65%	62%	65%	61%	66%	70%	62%

Table B-2. Item-level Average Percent Positive Response by Work Area/Unit (Page 3 of 4)

		Work Area/Unit											
ltem	Survey Items by Composite	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medicine	Obstet- rics	Pedi- atrics	Pharmacy	Psych/ Mental Hith	Radi- ology	Rehab- ilitation	Surgery
	# Hospitals	177	486	401	526	518	345	236	464	232	539	464	506
	# Respondents	1,184	9,703	12,040	9,273	17,143	8,088	4,534	5,226	4,298	10,528	7,429	17,393
10. A2	Staffing 1. We have enough staff to handle the workload.	62%	43%	48%	49%	44%	53%	57%	51%	51%	60%	56%	55%
A5R	2. Staff in this unit work longer hours than is best for patient care.	49%	51%	51%	55%	48%	52%	54%	56%	53%	58%	60%	49%
A7R	3. We use more agency/temporary staff than is best for patient care.	68%	63%	64%	66%	64%	73%	73%	69%	67%	73%	70%	70%
A14R	4. We work in "crisis mode" trying to do too much, too quickly.	54%	40%	46%	48%	43%	47%	51%	48%	51%	55%	62%	49%
11.	Handoffs & Transitions												
F3R	1. Things "fall between the cracks" when transferring patients from one unit to another.	39%	46%	37%	29%	42%	44%	41%	26%	33%	40%	38%	40%
F5R	2. Important patient care information is often lost during shift changes.	45%	57%	58%	44%	51%	63%	52%	36%	46%	46%	42%	45%
F7R	3. Problems often occur in the exchange of information across hospital units.	40%	45%	41%	36%	44%	46%	40%	33%	35%	39%	41%	39%
F11R	 Shift changes are problematic for patients in this hospital. 	37%	46%	53%	40%	48%	59%	48%	34%	42%	41%	37%	36%
12.	Nonpunitive Response to Error												
A8R	1. Staff feel like their mistakes are held against them.	54%	45%	47%	51%	46%	49%	50%	63%	52%	52%	65%	51%
A12R	2. When an event is reported, it feels like the person is being written up, not the problem.	42%	38%	41%	44%	42%	44%	45%	57%	51%	46%	59%	47%
A16R	3. Staff worry that mistakes they make are kept in their personnel file.	36%	29%	30%	33%	30%	31%	29%	49%	37%	39%	53%	37%

Table B-2. Item-level Average Percent Positive Response by Work Area/Unit (Page 4 of 4)

	5						Work	Area/Unit					
	ork Area/Unit tient Safety Grade	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medicine	Obstetrics	Pediatrics	Pharmacy	Psych/ Mental Health	Radiology	Rehab- ilitation	Surgery
	# Hospitals	177	486	401	526	518	345	236	464	232	539	464	506
	# Respondents	1,184	9,703	12,040	9,273	17,143	8,088	4,534	5,226	4,298	10,528	7,429	17,393
Α	Excellent	35%	16%	18%	26%	15%	21%	24%	25%	23%	28%	35%	32%
в	Very Good	42%	46%	49%	51%	47%	47%	49%	49%	44%	49%	46%	45%
С	Acceptable	19%	30%	26%	20%	31%	25%	22%	20%	22%	19%	16%	18%
D	Poor	3%	7%	6%	3%	6%	6%	5%	5%	9%	3%	2%	4%
Е	Failing	1%	1%	1%	0%	1%	1%	0%	1%	1%	0%	1%	1%

Table B-3. Average Percent Distribution of Work Area/Unit Patient Safety Grades by Work Area/Unit

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Table B-4. Average Percent Distribution of Number of Events Reported in the Past 12 Months by Work Area/Unit

						Work	Area/Unit					
Number of Events Reported by Respondents	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medicine	Obstetrics	Pediatrics	Pharmacy	Psych/ Mental Health	Radiology	Rehab- ilitation	Surgery
# Hospitals	177	486	401	526	518	345	236	464	232	539	464	506
# Respondents	1,184	9,703	12,040	9,273	17,143	8,088	4,534	5,226	4,298	10,528	7,429	17,393
No events	56%	46%	34%	49%	38%	43%	44%	42%	51%	55%	55%	46%
1 to 2 events	30%	32%	38%	29%	33%	36%	34%	18%	26%	31%	33%	32%
3 to 5 events	7%	13%	20%	12%	20%	15%	16%	15%	14%	10%	8%	14%
6 to 10 events	4%	5%	6%	5%	6%	4%	4%	10%	6%	2%	3%	5%
11 to 20 events	1%	2%	2%	3%	2%	1%	2%	8%	2%	1%	0%	1%
21 event reports or more	1%	2%	0%	3%	1%	0%	0%	8%	1%	0%	0%	1%

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Appendix B: Overall Results by Respondent Characteristics

(2) Staff Position

NOTE 1: Hospitals that did not ask respondents to indicate their staff position were excluded from these breakout tables. In addition, respondents who selected "Other," or did not answer (missing) were not included.

NOTE 2: The number of hospitals and respondents in each staff position is shown. The number of hospitals is based on: 1) hospitals that asked respondents to indicate their staff position (not all hospitals asked this question), and 2) whether the hospital had at least 1 respondent in a particular staff position. However, the precise number of hospitals and respondents corresponding to each data cell in the tables will vary because hospitals may have omitted a specific survey item and because of individual non-response/missing data.

Table B-5. Composite-level Average Percent Positive Response by Staff Position

	Staff Position												
Patient Safety Culture Composites	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharmacist	RN/LVN/LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary				
# Hospitals	581	444	320	530	434	606	549	529	573				
# Respondents	13,750	8,084	1,195	10,386	3,123	66,261	19,230	9,026	11,914				
1. Teamwork Within Units	88%	82%	81%	74%	80%	79%	77%	84%	77%				
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	84%	71%	77%	75%	77%	73%	75%	77%	76%				
3. Org LearningContinuous Improvement	81%	71%	69%	73%	74%	70%	69%	70%	70%				
4. Management Support for Patient Safety	83%	69%	75%	73%	68%	64%	70%	71%	73%				
5. Overall Perceptions of Patient Safety	73%	63%	66%	61%	61%	59%	70%	69%	65%				
6. Feedback & Communication About Error	74%	61%	68%	64%	64%	58%	63%	65%	65%				
7. Communication Openness	75%	63%	65%	57%	71%	61%	62%	67%	60%				
8. Frequency of Events Reported	66%	55%	57%	65%	52%	61%	59%	55%	65%				
9. Teamwork Across Units	63%	59%	61%	59%	55%	54%	54%	61%	57%				
10. Staffing	63%	55%	55%	49%	56%	56%	56%	58%	51%				
11. Handoffs & Transitions	45%	44%	37%	49%	30%	47%	39%	41%	45%				
12. Nonpunitive Response to Error	62%	42%	45%	36%	60%	43%	43%	50%	39%				
Average Across Composites	71%	61%	63%	61%	62%	60%	61%	64%	62%				

						Staff Posit	ion			
ltem	Patient Safety Culture Composites	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	# Hospitals	581	444	320	530	434	606	549	529	573
	# Respondents	13,750	8,084	1,195	10,386	3, 123	66,261	19,230	9,026	11,914
1.	Teamwork Within Units									
A1	1. People support one another in this unit.	93%	88%	86%	80%	87%	86%	83%	89%	82%
A3	2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	93%	87%	86%	80%	85%	86%	85%	87%	83%
A4	3. In this unit, people treat each other with respect.	88%	84%	80%	72%	80%	78%	75%	84%	75%
A11	4. When one area in this unit gets really busy, others help out.	77%	70%	73%	65%	68%	67%	67%	75%	68%
2.	Supv/Mgr Expectations & Actions Promoting Patient Safety									
B1	 My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures. 	82%	69%	78%	73%	70%	70%	68%	74%	74%
B2	My supv/mgr seriously considers staff suggestions for improving patient safety.	87%	75%	81%	76%	79%	75%	75%	81%	76%
B3R	 Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts. 	84%	66%	75%	74%	78%	73%	77%	76%	77%
B4R	 My supv/mgr overlooks patient safety problems that happen over and over. 	85%	72%	76%	76%	79%	76%	78%	78%	77%
3.	Organizational Learning— Continuous Improvement									
A6	1. We are actively doing things to improve patient safety.	88%	79%	81%	85%	86%	83%	80%	83%	81%
A9	2. Mistakes have led to positive changes here.	80%	68%	62%	60%	76%	60%	63%	59%	62%
A13	3. After we make changes to improve patient safety, we evaluate their effectiveness.	76%	66%	64%	73%	61%	68%	65%	68%	68%

Table B-6. Item-level Average Percent Positive Response by Staff Position (Page 1 of 4)

	-	Staff Position										
ltem	Patient Safety Culture Composites	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary		
	# Hospitals	581	444	320	530	434	606	549	529	573		
	# Respondents	13,750	8,084	1,195	10,386	3, 123	66,261	19,230	9,026	11,914		
4.	Mgmt Support for Patient Safety											
F1	1. Hospital mgmt provides a work climate that promotes patient safety.	89%	77%	86%	82%	74%	73%	81%	81%	83%		
F8	The actions of hospital mgmt show that patient safety is a top priority.	84%	71%	78%	77%	69%	65%	72%	71%	75%		
F9R	3. Hospital mgmt seems interested in patient safety only after an adverse event happens.	75%	59%	61%	59%	60%	55%	58%	59%	61%		
5.	Overall Perceptions of Patient Safety											
A10R	1. It is just by chance that more serious mistakes don't happen around here.	72%	62%	58%	51%	61%	59%	64%	67%	56%		
A15	2. Patient safety is never sacrificed to get more work done.	72%	63%	65%	63%	56%	56%	70%	68%	69%		
A17R	3. We have patient safety problems in this unit.	70%	60%	66%	60%	57%	56%	70%	69%	65%		
A18	4. Our procedures and systems are good at preventing errors from happening.	77%	68%	74%	69%	71%	66%	74%	74%	71%		
6.	Feedback and Communication About Error											
C1	1. We are given feedback about changes put into place based on event reports.	64%	54%	60%	55%	51%	51%	51%	56%	55%		
C3	We are informed about errors that happen in this unit.	77%	62%	67%	66%	69%	57%	68%	65%	68%		
C5	3. In this unit, we discuss ways to prevent errors from happening again.	82%	69%	76%	71%	73%	66%	70%	73%	71%		

Table B-6. Item-level Average Percent Positive Response by Staff Position (Page 2 of 4)

	D-0. Rem-level Average Fercent Fositive K	Staff Position										
ltem	Patient Safety Culture Composites	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary		
	# Hospitals	581	444	320	530	434	606	549	529	573		
	# Respondents	13,750	8,084	1,195	10,386	3,123	66,261	19,230	9,026	11,914		
7.	Communication Openness											
C2	 Staff will freely speak up if they see something that may negatively affect patient care. 	83%	72%	76%	74%	79%	75%	77%	80%	76%		
C4	2. Staff feel free to question the decisions or actions of those with more authority.	68%	55%	56%	41%	61%	45%	46%	53%	42%		
C6R	3. Staff are afraid to ask questions when something does not seem right.	74%	63%	62%	57%	74%	62%	64%	69%	61%		
8.	Frequency of Events Reported											
D1	1. When a mistake is made, but is <u>caught</u> and corrected before affecting the patient, how often is this reported?	58%	48%	53%	62%	35%	48%	51%	48%	61%		
D2	2. When a mistake is made, but has <u>no</u> potential to harm the patient, how often is this reported?	62%	50%	50%	61%	50%	59%	52%	49%	60%		
D3	3. When a mistake is made that <u>could</u> <u>harm the patient</u> , but does not, how often is this reported?	78%	69%	69%	74%	72%	76%	74%	67%	75%		
9.	Teamwork Across Units											
F2R	 Hospital units do not coordinate well with each other. 	52%	48%	50%	46%	43%	41%	42%	48%	46%		
F4	2. There is good cooperation among hospital units that need to work together.	65%	60%	62%	60%	55%	55%	56%	62%	58%		
F6R	3. It is often unpleasant to work with staff from other hospital units.	63%	61%	61%	59%	61%	58%	54%	67%	55%		
F10	4. Hospital units work well together to provide the best care for patients.	74%	67%	71%	72%	63%	63%	65%	69%	68%		

Table B-6. Item-level Average Percent Positive Response by Staff Position (Page 3 of 4)

		Staff Position											
ltem	Patient Safety Culture Composites	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary			
	# Hospitals	581	444	320	530	434	606	549	529	573			
	# Respondents	13,750	8,084	1,195	10,386	3,123	66,261	19,230	9,026	11,914			
10.	Staffing												
A2	1. We have enough staff to handle the workload.	67%	57%	57%	44%	49%	52%	53%	53%	49%			
A5R	2. Staff in this unit work longer hours than is best for patient care.	59%	51%	53%	44%	59%	54%	54%	56%	48%			
A7R	3. We use more agency/temporary staff than is best for patient care.	69%	61%	58%	62%	71%	71%	67%	69%	59%			
A14R	4. We work in "crisis mode" trying to do too much, too quickly.	56%	51%	52%	47%	46%	47%	49%	55%	50%			
11.	Handoffs & Transitions												
F3R	1. Things "fall between the cracks" when transferring patients from one unit to another.	41%	43%	32%	46%	25%	43%	34%	36%	44%			
F5R	2. Important patient care information is often lost during shift changes.	49%	46%	40%	57%	33%	53%	45%	44%	51%			
F7R	3. Problems often occur in the exchange of information across hospital units.	44%	44%	39%	43%	31%	44%	37%	42%	43%			
F11R	 Shift changes are problematic for patients in this hospital. 	46%	40%	37%	50%	31%	49%	40%	41%	44%			
12.	Nonpunitive Response to Error												
A8R	1. Staff feel like their mistakes are held against them.	69%	48%	53%	43%	65%	50%	50%	57%	45%			
A12R	2. When an event is reported, it feels like the person is being written up, not the problem.	68%	45%	47%	37%	62%	46%	43%	51%	39%			
A16R	3. Staff worry that mistakes they make are kept in their personnel file.	50%	31%	35%	28%	54%	33%	35%	43%	32%			

Table B-6. Item-level Average Percent Positive Response by Staff Position (Page 4 of 4)

						Staff Posi	tion			
-	rk Area/Unit ient Safety Grade	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharmacist	RN/LVN/LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	# Hospitals	581	444	320	530	434	606	549	529	573
	# Respondents	13,750	8,084	1,195	10,386	3,123	66,261	19,230	9,026	11,914
Α	Excellent	30%	25%	27%	24%	21%	19%	27%	29%	27%
В	Very Good	52%	47%	48%	46%	49%	47%	49%	46%	47%
С	Acceptable	16%	22%	21%	24%	23%	26%	20%	20%	22%
D	Poor	2%	5%	3%	5%	6%	6%	3%	4%	3%
Е	Failing	1%	1%	0%	1%	1%	1%	1%	1%	1%

Table B-7. Average Percent Distribution of Work Area/Unit Patient Safety Grades by Staff Position

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Table B-8. Average Percent Distribution of Number of Events Reported in the Past 12 Months by Staff Position

		Staff Position							
Number of Events Reported by Respondents	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharmacist	RN/LVN/LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
# Hospitals	581	444	320	530	434	606	549	529	573
# Respondents	13,750	8,084	1,195	10,386	3, 123	66,261	19,230	9,026	11,914
No events	45%	59%	75%	75%	25%	29%	57%	59%	77%
1 to 2 events	24%	27%	16%	19%	22%	38%	29%	31%	17%
3 to 5 events	16%	9%	6%	4%	20%	22%	9%	7%	4%
6 to 10 events	8%	3%	2%	1%	13%	7%	3%	2%	1%
11 to 20 events	4%	1%	0%	0%	10%	3%	1%	0%	0%
21 event reports or more	3%	1%	0%	0%	10%	1%	1%	0%	0%

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Appendix B: Overall Results by Respondent Characteristics

(3) Interaction with Patients

NOTE 1: Hospitals that did not ask respondents to indicate their interaction with patients were excluded from these breakout tables. In addition, respondents who did not answer (missing) were not included.

NOTE 2: The number of hospitals and respondents is shown in each table. The number of hospitals is based on: 1) hospitals that asked respondents to indicate their interaction with patients (not all hospitals asked this question), and 2) whether the hospital had at least 1 respondent in the response categories (WITH or WITHOUT direct interaction with patients). However, the precise number of hospitals and respondents corresponding to each data cell in the tables will vary because hospitals may have omitted a specific survey item and because of individual non-response/missing data.

	Interaction v	vith Patients
Patient Safety Culture Composites	WITH direct interaction	WITHOUT direct interaction
# Hospitals # Respondents	614 143,052	596 43,658
1. Teamwork Within Units	79%	81%
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	75%	76%
3. Org LearningContinuous Improvement	71%	72%
4. Management Support for Patient Safety	69%	76%
5. Overall Perceptions of Patient Safety	64%	66%
6. Feedback & Communication About Error	62%	66%
7. Communication Openness	62%	64%
8. Frequency of Events Reported	60%	62%
9. Teamwork Across Units	57%	58%
10. Staffing	56%	53%
11. Handoffs & Transitions	45%	38%
12. Nonpunitive Response to Error	43%	47%
Average Across Composites	62%	63%

Table B-9. Composite-level Average Percent Positive Response by Interaction with Patients

		Interaction w	vith Patients
ltem	Survey Items By Composite	WITH direct interaction	WITHOUT direct interaction
	# Hospitals	614	596
	# Respondents	143,052	43,658
1.	Teamwork Within Units		
A1	1. People support one another in this unit.	85%	86%
A3	2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	86%	87%
A4	3. In this unit, people treat each other with respect.	77%	80%
A11	4. When one area in this unit gets really busy, others help out.	68%	69%
2.	Supervisor/Manager Expectations & Actions Promoting Patient Safety		
B1	1. My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures.	71%	75%
B2	My supv/mgr seriously considers staff suggestions for improving patient safety.	76%	78%
B3R	3. Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts.	74%	76%
B4R	4. My supv/mgr overlooks patient safety problems that happen over and over.	77%	77%
3.	Organizational Learning— Continuous Improvement		
A6	1. We are actively doing things to improve patient safety.	82%	80%
A9	2. Mistakes have led to positive changes here.	62%	69%
A13	3. After we make changes to improve patient safety, we evaluate their effectiveness.	68%	68%

Table B-10. Item-level Average Percent Positive Response by Interaction with Patients (Page 1 of 4)

		Interaction	with Patients
Item	Survey Items By Composite	WITH direct interaction	WITHOUT direct interaction
	# Hospitals # Respondents	614 143,052	596 43,658
4.	Management Support for Patient Safety		
F1	 Hospital mgmt provides a work climate that promotes patient safety. 	78%	85%
F8	2. The actions of hospital mgmt show that patient safety is a top priority.	70%	78%
F9R	3. Hospital mgmt seems interested in patient safety only after an adverse event happens.	58%	66%
5.	Overall Perceptions of Patient Safety		
A10R	1. It is just by chance that more serious mistakes don't happen around here.	60%	61%
A15	2. Patient safety is never sacrificed to get more work done.	64%	66%
A17R	3. We have patient safety problems in this unit.	62%	65%
A18	4. Our procedures and systems are good at preventing errors from happening.	70%	72%
6.	Feedback and Communication About Error		
C1	1. We are given feedback about changes put into place based on event reports.	53%	56%
C3	2. We are informed about errors that happen in this unit.	63%	69%
C5	3. In this unit, we discuss ways to prevent errors from happening again.	70%	74%

Table B-10. Item-level Average Percent Positive Response by Interaction with Patients (Page 2 of 4)

	Interaction v	with Patients
Survey Items By Composite	WITH direct interaction	WITHOUT direct interaction
# Hospitals # Respondents	614 143,052	596 43,658
Communication Openness		
1. Staff will freely speak up if they see something that may negatively affect patient care.	76%	76%
2. Staff feel free to question the decisions or actions of those with more authority.	46%	51%
3. Staff are afraid to ask questions when something does not seem right.	63%	66%
Frequency of Events Reported		
1. When a mistake is made, but is <u>caught and corrected before</u> <u>affecting the patient</u> , how often is this reported?	51%	56%
2. When a mistake is made, but has <u>no potential to harm the patient</u> , how often is this reported?	56%	57%
3. When a mistake is made that <u>could harm the patient</u> , but does not, how often is this reported?	73%	73%
Teamwork Across Units		
1. Hospital units do not coordinate well with each other.	44%	47%
2. There is good cooperation among hospital units that need to work together.	58%	59%
3. It is often unpleasant to work with staff from other hospital units.	59%	57%
4. Hospital units work well together to provide the best care for patients.	66%	70%
	 # Hospitals # Respondents Communication Openness 1. Staff will freely speak up if they see something that may negatively affect patient care. 2. Staff feel free to question the decisions or actions of those with more authority. 3. Staff are afraid to ask questions when something does not seem right. Frequency of Events Reported 1. When a mistake is made, but is <u>caught and corrected before affecting the patient</u>, how often is this reported? 2. When a mistake is made, but has <u>no potential to harm the patient</u>, how often is this reported? 3. When a mistake is made that <u>could harm the patient</u>, but does not, how often is this reported? Teamwork Across Units 1. Hospital units do not coordinate well with each other. 2. There is good cooperation among hospital units that need to work together. 3. It is often unpleasant to work with staff from other hospital units. 4. Hospital units work well together to provide the best care for 	Survey Items By CompositeWITH direct interaction# Hospitals # Respondents614 143,052Communication Openness143,0521. Staff will freely speak up if they see something that may negatively affect patient care.76%2. Staff feel free to question the decisions or actions of those with more authority.46%3. Staff are afraid to ask questions when something does not seem right.63%Frequency of Events Reported51%2. When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?51%3. When a mistake is made, but has no potential to harm the patient, how often is this reported?56%3. When a mistake is made that could harm the patient, but does not, how often is this reported?73%4. Hospital units do not coordinate well with each other.58%3. It is often unpleasant to work with staff from other hospital units.59%4. Hospital units work well together to provide the best care for66%

Table B-10. Item-level Average Percent Positive Response by Interaction with Patients (Page 3 of 4)

		Interaction v	with Patients
Item	Survey Items By Composite	WITH direct interaction	WITHOUT direct interaction
	# Hospitals	614	596
	# Respondents	143,052	43,658
10.	Staffing		
A2	1. We have enough staff to handle the workload.	53%	57%
A5R	2. Staff in this unit work longer hours than is best for patient care.	53%	49%
A7R	3. We use more agency/temporary staff than is best for patient care.	67%	57%
A14R	4. We work in "crisis mode" trying to do too much, too quickly.	49%	48%
11.	Handoffs & Transitions		
F3R	1. Things "fall between the cracks" when transferring patients from one unit to another.	42%	35%
F5R	2. Important patient care information is often lost during shift changes.	51%	43%
F7R	3. Problems often occur in the exchange of information across hospital units.	43%	38%
F11R	4. Shift changes are problematic for patients in this hospital.	46%	39%
12.	Nonpunitive Response to Error		
A8R	1. Staff feel like their mistakes are held against them.	50%	55%
A12R	2. When an event is reported, it feels like the person is being written up, not the problem.	45%	49%
A16R	3. Staff worry that mistakes they make are kept in their personnel file.	35%	38%

Table B-10. Item-level Average Percent Positive Response by Interaction with Patients (Page 4 of 4)

		Interaction v	with Patients
	ork Area/Unit tient Safety Grade	WITH direct interaction	WITHOUT direct interaction
	# Hospitals # Respondents	614 143,052	596 43,658
Α	Excellent	24%	28%
в	Very Good	48%	49%
С	Acceptable	23%	20%
D	Poor	5%	3%
Е	Failing	1%	0%

 Table B-11. Average Percent Distribution of Work Area/Unit Patient Safety

 Grades by Interaction with Patients

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Table B-12. Average Percent Distribution of Number of Events Reported inthe Past 12 Months by Interaction with Patients

	Interaction v	with Patients
Number of Events Reported by Respondents	WITH direct interaction	WITHOUT direct interaction
# Hospitals	614	596
# Respondents	143,052	43,658
No events	48%	68%
1 to 2 events	31%	16%
3 to 5 events	14%	8%
6 to 10 events	5%	4%
11 to 20 events	2%	2%
21 event reports or more	1%	2%

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Part III

Appendix C: Trending Results by Hospital Characteristics

Appendix C: Trending Results by Hospital Characteristics

(1) Bed Size

NOTE: The number of hospitals and respondents in each breakout category is shown in each table (e.g., the number of hospitals and respondents by bed size). However, the precise number of hospitals and respondents corresponding to each data cell in a table will vary because hospitals may have omitted a specific survey item and because of individual non-response/missing data.

					Bed Size			
Patient Safety Culture Composites	Database Year	6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-499 beds	500+ beds
# Hospitals	Both Years	21	42	37	32	22	26	24
# Respondents	Most Recent Previous	1,054 1,362	3,550 3,401	4,360 4,686	8,886 7,573	8,408 8,108	15,678 14,300	27,605 25,891
	Most Recent	83%	83%	78%	79%	77%	78%	76%
1. Teamwork Within Units	Previous	81%	82%	77%	73%	69%	75%	77%
	Change	2%	1%	1%	6%	8%	3%	-1%
2. Supervisor/Manager	Most Recent	76%	80%	74%	75%	73%	72%	72%
Expectations & Actions	Previous	75%	78%	73%	74%	69%	71%	72%
Promoting Patient Safety	Change	1%	2%	1%	1%	4%	71% 1% 70%	0%
	Most Recent	73%	75%	72%	72%	70%	70%	68%
3. Org LearningContinuous Improvement	Previous	71%	74%	69%	65%	62%	67%	69%
	Change	2%	1%	3%	7%	8%	3%	-1%
	Most Recent	77%	77%	70%	71%	66%	67%	64%
4. Management Support for Patient Safety	Previous	76%	77%	68%	65%	61%	66%	65%
	Change	1%	0%	2%	6%	5%	1%	-1%
	Most Recent	74%	72%	65%	64%	61%	61%	52%
5. Overall Perceptions of Patient Safety	Previous	71%	68%	63%	60%	54%	58%	58%
	Change	3%	4%	2%	4%	7%	3%	-6%
	Most Recent	66%	65%	62%	63%	60%	61%	60%
6. Feedback & Communication About Error	Previous	66%	65%	61%	58%	55%	60%	61%
	Change	0%	0%	1%	5%	5%	1%	-1%

 Table C-1. Trending: Composite-level Average Percent Positive Response by Bed Size (Page 1 of 2)

		Bed Size						
Patient Safety Culture Composites	Database Year	6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-499 beds	500+ beds
# Hospitals	Both Years	21	42	37	32	22	26	24
# Respondents	Most Recent Previous	1,054 1,362	3,550 3,401	4,360 4,686	8,886 7,573	8,408 8,108	15,678 14,300	27,605 25,891
	Most Recent	65%	64%	61%	61%	60%	60%	59%
7. Communication Openness	Previous	65%	62%	60%	58%	56%	61%	61%
	Change	0%	2%	1%	3%	4%	-1%	-2%
	Most Recent	64%	65%	60%	63%	59%	60%	57%
8. Frequency of Events Reported	Previous	64%	63%	60%	58%	54%	57%	57%
	Change	0%	2%	0%	5%	5%	3%	0%
	Most Recent	68%	65%	58%	57%	50%	52%	49%
9. Teamwork Across Units	Previous	66%	64%	57%	53%	47%	50%	50%
	Change	2%	1%	1%	4%	3%	2%	-1%
	Most Recent	65%	61%	54%	53%	50%	52%	47%
10. Staffing	Previous	62%	59%	55%	51%	46%	49%	49%
	Change	3%	2%	-1%	2%	4%	3%	-2%
	Most Recent	59%	53%	47%	43%	37%	38%	37%
11. Handoffs & Transitions	Previous	55%	51%	46%	41%	36%	37%	38%
	Change	4%	2%	1%	2%	1%	1%	-1%
	Most Recent	53%	50%	43%	44%	41%	41%	38%
12. Nonpunitive Response to Error	Previous	49%	47%	42%	42%	39%	39%	38%
	Change	4%	3%	1%	2%	2%	2%	0%

 Table C-1. Trending: Composite-level Average Percent Positive Response by Bed Size (Page 2 of 2)

	2. Hending. Rein level Averag		•	,	Ŭ /	Bed Size			
			6-24	25-49	50-99	100-199	200-299	300-499	500+
Item	Survey Items by Composite	Database Year	beds	beds	beds	beds	beds		beds
	# Hospitals	Both Years	21	42	37	32	22	-	24
	# Respondents	Most Recent Previous	1,054 1,362	3,550 3,401	4,360 4,686	8,886 7,573	8,408 8,108		27,605 25,891
1.	Teamwork Within Units	TTevious	1,302	3,401	4,000	7,075	0,100	14,300	20,091
		Most Recent	88%	88%	83%	84%	83%	84%	84%
A1	1. People support one another	Previous	86%	86%	82%	78%	73%		83%
	in this unit.	Change	2%	2%	1%	6%	10%	3%	1%
	2. When a lot of work needs to	Most Recent	91%	90%	84%	84%	85%	84%	82%
A3	be done quickly, we work	Previous	89%	89%	85%	79%	76%	82%	82%
	together as a team to get the work done.	Change	2%	1%	-1%	5%	9%	2%	0%
		Most Recent	80%	82%	75%	77%	76%	76%	75%
A4	3. In this unit, people treat	Previous	80%	80%	76%	72%	68%	74%	75%
	each other with respect.	Change	0%	2%	-1%	5%	8%	74% 2% 67% 64%	0%
	4. When one area in this unit	Most Recent	74%	73%	69%	69%	66%	67%	65%
A11	gets really busy, others help	Previous	70%	71%	67%	64%	59%	64%	66%
	out.	Change	4%	2%	2%	5%	7%	3%	-1%
2.	Supervisor/Manager Expectation	ons & Actions Pr	omoting Pati	ent Safety					
	1. My supv/mgr says a good	Most Recent	71%	76%	70%	72%	72%	70%	72%
B1	word when he/she sees a job done according to established	Previous	69%	74%	69%	67%	65%	67%	71%
	patient safety procedures.	Change	2%	2%	1%	5%	7%	beds 26 15,678 14,300 84% 81% 3% 24% 2% 76% 74% 2% 67% 64% 3%	1%
	2. My supv/mgr seriously	Most Recent	77%	81%	75%	77%	75%	73%	74%
B2	considers staff suggestions for	Previous	77%	80%	75%	71%	67%	71%	75%
	improving patient safety.	Change	0%	1%	0%	6%	8%	2%	-1%
	3. Whenever pressure builds	Most Recent	80%	80%	75%	75%	71%	71%	68%
B3R	up, my supv/mgr wants us to work faster, even if it means	Previous	78%	78%	73%	73%	67%	69%	69%
	taking shortcuts.	Change	2%	2%	2%	2%	4%	2%	-1%
	4. My supv/mgr overlooks	Most Recent	76%	82%	77%	77%	74%	73%	75%
B4R	patient safety problems that	Previous	76%	80%	75%	72%	67%		73%
	happen over and over.	Change	0%	2%	2%	5%	7%	2%	2%

Table C-2. Trending: Item-level Average Percent Positive Response by Bed Size (Page 1 of 6)

			•	y (<u> </u>	Bed Size			
		Database	6-24	25-49	50-99	100-199	200-299	300-499	500+
ltem	Survey Items by Composite	Year	beds	beds	beds	beds	beds	beds	beds
	# Hospitals	Both Years	21	42	37	32	22	26	24
	# Respondents	Most Recent	1,054	3,550	4,360	8,886	8,408	15,678	27,605
•	·	Previous	1,362	3,401	4,686	7,573	8,108	14,300	25,891
3.	Organizational Learning— Co	-							
	1. We are actively doing	Most Recent	83%	86%	83%	83%	81%	81%	79%
A6	things to improve patient	Previous	82%	85%	81%	75%	71%	79%	80%
	safety.	Change	1%	1%	2%	8%	10%	2%	-1%
		Most Recent	67%	68%	63%	65%	61%	62%	60%
A9	 Mistakes have led to positive changes here. 	Previous	64%	67%	61%	59%	53%	59%	61%
	positive changes here.	Change	3%	1%	2%	6%	8%	3%	-1%
	3. After we make changes to improve patient safety, we	Most Recent	69%	73%	69%	70%	67%	67%	65%
A13		Previous	68%	70%	66%	62%	60%	64%	66%
	evaluate their effectiveness.	Change	1%	3%	3%	8%	7%	3%	-1%
4.	Management Support for Patie	ent Safety							
	1. Hospital mgmt provides a	Most Recent	85%	86%	80%	80%	75%	76%	73%
F1	work climate that promotes	Previous	85%	86%	78%	74%	71%	76%	75%
	patient safety.	Change	0%	0%	2%	6%	4%	0%	-2%
	2. The actions of hospital	Most Recent	78%	78%	71%	73%	69%	70%	67%
F8	mgmt show that patient safety	Previous	76%	78%	69%	66%	60%	67%	69%
	is a top priority.	Change	2%	0%	2%	7%	9%	3%	-2%
	3. Hospital mgmt seems	Most Recent	67%	68%	58%	59%	55%	56%	52%
F9R	interested in patient safety only after an adverse event	Previous	66%	66%	57%	55%	51%	54%	52%
	happens.	Change	1%	2%	1%	4%	4%	2%	0%

Table C-2. Trending: Item-level Average Percent Positive Response by Bed Size (Page 2 of 6)

		Г	•	, , , , , , , , , , , , , , , , , , ,	<u> </u>	Bed Size			
		Database	6-24	25-49	50-99	100-199	200-299	300-499	500+
Item	Survey Items by Composite	Year	beds	beds	beds	beds	beds	beds	beds
	# Hospitals	Both Years	21	42	37	32	22	26	24
	# Respondents	Most Recent	1,054	3,550	4,360	8,886	8,408	15,678	27,605
-	Overall Demonstration of Detion	Previous	1,362	3,401	4,686	7,573	8,108	14,300	25,891
5.	Overall Perceptions of Patient			070/	2 4 9 4		= (= = = = (4=07
	1. It is just by chance that	Most Recent	69%	67%	61%	60%	56%	59%	45%
A10R	more serious mistakes don't	Previous	65%	64%	61%	57%	52%	55%	54%
	happen around here.	Change	4%	3%	0%	3%	4%	4%	-9%
	2. Patient safety is never	Most Recent	77%	73%	63%	65%	61%	59%	55%
A15	sacrificed to get more work	Previous	75%	69%	64%	60%	52%	56%	58%
	done.	Change	2%	4%	-1%	5%	9%	3%	-3%
	3. We have patient safety problems in this unit.	Most Recent	74%	70%	63%	62%	57%	58%	44%
A17R		Previous	72%	68%	62%	58%	51%	56%	55%
		Change	2%	2%	1%	4%	6%	2%	-11%
	4. Our procedures and systems are good at preventing errors from	Most Recent	75%	76%	71%	71%	69%	68%	65%
A18		Previous	70%	73%	67%	64%	60%	66%	66%
	happening.	Change	5%	3%	4%	7%	9%	2%	-1%
6.	Feedback and Communication	n About Error							
	1. We are given feedback	Most Recent	52%	53%	52%	54%	53%	54%	54%
C1	about changes put into place	Previous	53%	53%	50%	49%	48%	53%	56%
	based on event reports.	Change	-1%	0%	2%	5%	5%	1%	-2%
		Most Recent	72%	67%	65%	65%	61%	61%	60%
C3	2. We are informed about errors that happen in this unit.	Previous	69%	68%	65%	60%	58%	60%	60%
	enors that happen in this unit.	Change	3%	-1%	0%	5%	3%	1%	0%
	3. In this unit, we discuss	Most Recent	73%	74%	70%	70%	67%	68%	66%
C5	ways to prevent errors from	Previous	75%	74%	69%	64%	60%	67%	68%
	happening again.	Change	-2%	0%	1%	6%	7%	1%	-2%
		,							

Table C-2. Trending: Item-level Average Percent Positive Response by Bed Size (Page 3 of 6)

			•	· · · ·	• <i>i</i>	Bed Size									
			6-24	25-49	50-99	100-199	200-299	300-499	500+						
Item	Survey Items by Composite	Database Year	beds	beds	beds	beds	beds	beds	beds						
	# Hospitals	Both Years	21	42	37	32	22	26	24						
	# Respondents	Most Recent	1,054	3,550	4,360	8,886	8,408	15,678	27,605						
_		Previous	1,362	3,401	4,686	7,573	8,108	14,300	25,891						
7.	Communication Openness														
	 Staff will freely speak up if 	Most Recent	78%	78%	75%	75%	74%	74%	72%						
C2	they see something that may	Previous	80%	76%	75%	70%	68%	74%	74%						
	negatively affect patient care.	Change	-2%	2%	0%	5%	6%	0%	-2%						
	2. Staff feel free to question the	Most Recent	50%	48%	46%	48%	47%	46%	46%						
C4	decisions or actions of those with more authority.	Previous	50%	47%	45%	44%	44%	47%	48%						
		Change	0%	1%	1%	4%	3%	-1%	-2%						
	3. Staff are afraid to ask	Most Recent	67%	66%	61%	62%	59%	61%	59%						
C6R	questions when something does not seem right.	Previous	66%	63%	60%	59%	55%	61%	60%						
		Change	1%	3%	1%	3%	4%	0%	-1%						
8.	Frequency of Events Reported														
	1. When a mistake is made,	Most Recent	55%	56%	51%	55%	52%	53%	51%						
D1	but is <u>caught and corrected</u> before affecting the patient,	Previous	55%	54%	51%	50%	47%	51%	51%						
	how often is this reported?	Change	0%	2%	0%	5%	5%	2%	0%						
	2. When a mistake is made,	Most Recent	61%	61%	56%	59%	55%	55%	53%						
D2	but has <u>no potential to harm</u> the patient, how often is this	Previous	61%	59%	55%	54%	50%	52%	52%						
	reported?	Change	0%	2%	1%	5%	5%	3%	1%						
	3. When a mistake is made	Most Recent	77%	78%	73%	73%	70%	71%	68%						
D3	that <u>could harm the patient</u> , but does not, how often is this	Previous	78%	77%	72%	70%	65%	69%	67%						
	reported?	Change	-1%	1%	1%	3%	5%	2%	1%						

 Table C-2. Trending: Item-level Average Percent Positive Response by Bed Size (Page 4 of 6)

		Bed Size										
		Database	6-24	25-49	50-99	100-199	200-299	300-499	500+			
ltem	Survey Items by Composite	Year	beds	beds	beds	beds	beds	beds	beds			
	# Hospitals	Both Years	21	42	37	32	22	26	24			
	# Respondents	Most Recent	1,054	3,550	4,360	8,886	8,408	15,678	27,605			
		Previous	1,362	3,401	4,686	7,573	8,108	14,300	25,891			
9.	Teamwork Across Units											
	1. Hospital units do not	Most Recent	57%	54%	45%	45%	37%	39%	37%			
F2R	coordinate well with each	Previous	54%	52%	45%	42%	37%	37%	37%			
	other.	Change	3%	2%	0%	3%	0%	2%	0%			
	2. There is good cooperation	Most Recent	71%	67%	59%	59%	51%	53%	50%			
F4	among hospital units that	Previous	68%	67%	60%	53%	47%	50%	51%			
	need to work together.	Change	3%	0%	-1%	6%	4%	3%	-1%			
	3. It is often unpleasant to work with staff from other hospital units.	Most Recent	67%	65%	58%	58%	51%	54%	51%			
F6R		Previous	65%	63%	57%	53%	49%	52%	53%			
		Change	2%	2%	1%	5%	2%	2%	-2%			
	4. Hospital units work well	Most Recent	78%	75%	68%	68%	59%	62%	58%			
F10	together to provide the best	Previous	76%	75%	68%	62%	56%	59%	60%			
	care for patients.	Change	2%	0%	0%	6%	3%	3%	-2%			
10.	Staffing											
		Most Recent	64%	63%	53%	51%	47%	50%	44%			
A2	 We have enough staff to handle the workload. 	Previous	63%	62%	54%	51%	43%	47%	47%			
		Change	1%	1%	-1%	0%	4%	3%	-3%			
	2. Staff in this unit work longer	Most Recent	61%	55%	51%	51%	48%	50%	45%			
A5R	hours than is best for patient	Previous	56%	55%	51%	48%	45%	49%	46%			
	care.	Change	5%	0%	0%	3%	3%	1%	-1%			
	3. We use more	Most Recent	69%	68%	63%	62%	64%	65%	61%			
A7R	agency/temporary staff than is	Previous	69%	64%	65%	59%	55%	60%	60%			
	best for patient care.	Change	0%	4%	-2%	3%	9%	5%	1%			
	4. We work in "crisis mode"	Most Recent	64%	59%	50%	48%	43%	43%	39%			
A14R	trying to do too much, too	Previous	58%	55%	49%	47%	40%	41%	41%			
	quickly.	Change	6%	4%	1%	1%	3%	2%	-2%			

Table C-2. Trending: Item-level Average Percent Positive Response by Bed Size (Page 5 of 6)

						Bed Size			
L		Database	6-24	25-49	50-99	100-199	200-299	300-499	500+
ltem	Survey Items by Composite	Year	beds	beds	beds	beds	beds	beds	beds
	# Hospitals	Both Years	21	42	37	32	22	26	24
	# Respondents	Most Recent Previous	1,054 1,362	3,550 3,401	4,360 4,686	8,886 7,573	8,408 8,108	15,678 14,300	27,605 25,891
11.	Handoffs & Transitions	FIEVIOUS	1,302	3,401	4,000	7,575	0,100	14,300	20,091
	1. Things "fall between the	Most Recent	58%	52%	44%	39%	32%	32%	32%
F3R	cracks" when transferring	Previous	55%	50%	45%	38%	31%	32%	32%
i ort	patients from one unit to another.	Change	3%	2%	-1%	1%	1%	0%	0%
	2. Important patient care	Most Recent	59%	55%	50%	48%	44%	45%	44%
F5R	information is often lost	Previous	56%	55%	50%	45%	41%	44%	46%
	during shift changes.	Change	3%	0%	0%	3%	3%	1%	-2%
	3. Problems often occur in the exchange of information across hospital units.	Most Recent	57%	51%	45%	42%	36%	36%	34%
F7R		Previous	52%	49%	45%	37%	34%	34%	35%
		Change	5%	2%	0%	5%	2%	2%	-1%
	4. Shift changes are problematic for patients in this hospital.	Most Recent	61%	55%	47%	43%	37%	39%	36%
F11R		Previous	58%	52%	44%	43%	37%	38%	38%
		Change	3%	3%	3%	0%	0%	1%	-2%
12.	Nonpunitive Response to Err	or							
	1. Staff feel like their	Most Recent	61%	57%	50%	51%	48%	47%	44%
A8R	mistakes are held against	Previous	58%	55%	49%	49%	45%	45%	44%
	them.	Change	3%	2%	1%	2%	3%	2%	0%
	2. When an event is reported,	Most Recent	53%	51%	44%	46%	43%	43%	41%
A12R	it feels like the person is	Previous	48%	48%	42%	43%	41%	41%	40%
	being written up, not the problem.	Change	5%	3%	2%	3%	2%	2%	1%
	3. Staff worry that mistakes	Most Recent	45%	42%	36%	35%	33%	31%	28%
A16R	they make are kept in their	Previous	41%	38%	35%	35%	30%	30%	28%
	personnel file.	Change	4%	4%	1%	0%	3%	1%	0%

 Table C-2. Trending: Item-level Average Percent Positive Response by Bed Size (Page 6 of 6)

					-	Bed Size			
	k Area/Unit ent Safety Grade	Database Year	6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-499 beds	500+ beds
	# Hospitals	Both Years	21	42	37	32	22	26	24
	# Respondents	Most Recent Previous	1,054 1,362	3,550 3,401	4,360 4,686	8,886 7,573	8,408 8,108	15,678 14,300	27,605 25,891
		Most Recent	28%	28%	22%	27%	25%	24%	21%
Α	Excellent	Previous	25%	25%	20%	24%	20%	22%	21%
		Change	3%	3%	2%	3%	5%	2%	0%
		Most Recent	50%	50%	49%	46%	42%	46%	44%
В	Very Good	Previous	46%	49%	45%	47%	42%	46%	44%
		Change	4%	1%	4%	-1%	0%	0%	0%
		Most Recent	20%	20%	23%	21%	27%	24%	27%
С	Acceptable	Previous	21%	20%	26%	24%	29%	25%	27%
		Change	-1%	0%	-3%	-3%	-2%	-1%	0%
		Most Recent	3%	2%	5%	5%	6%	6%	7%
D	Poor	Previous	6%	4%	8%	4%	7%	6%	6%
		Change	-3%	-2%	-3%	1%	-1%	0%	1%
		Most Recent	0%	0%	1%	1%	1%	1%	1%
Е	Failing	Previous	2%	1%	2%	1%	2%	1%	2%
		Change	-2%	-1%	-1%	0%	-1%	0%	-1%

Table C-3. Trending: Average Percent Distribution of Work Area/Unit Patient Safety Grades by Bed Size

					Bed Size			
Number of Events Reported by Respondents	Database Year	6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-499 beds	500+ beds
# Hospitals	Both Years	21	42	37	32	22	26	24
# Respondents	Most Recent Previous	1,054 1,362	3,550 3,401	4,360 4,686	8,886 7,573	8,408 8,108	15,678 14,300	27,605 25,891
	Most Recent	53%	52%	51%	53%	50%	53%	55%
No events	Previous	60%	53%	55%	55%	50%	53%	53%
	Change	-7%	-1%	-4%	-2%	0%	0%	2%
	Most Recent	26%	28%	29%	27%	28%	28%	28%
1 to 2 events	Previous	22%	27%	26%	25%	27%	27%	27%
	Change	4%	1%	3%	2%	1%	1%	1%
	Most Recent	14%	13%	12%	12%	14%	12%	12%
3 to 5 events	Previous	12%	12%	12%	12%	14%	13%	12%
	Change	2%	1%	0%	0%	0%	-1%	0%
	Most Recent	4%	5%	4%	4%	5%	4%	4%
6 to 10 events	Previous	4%	5%	5%	5%	6%	4%	4%
	Change	0%	0%	-1%	-1%	-1%	0%	0%
	Most Recent	2%	2%	2%	2%	2%	1%	2%
11 to 20 events	Previous	2%	2%	2%	2%	2%	2%	2%
	Change	0%	0%	0%	0%	0%	-1%	0%
	Most Recent	1%	1%	1%	1%	2%	1%	1%
21 event reports or more	Previous	1%	1%	1%	1%	2%	1%	1%
	Change	0%	0%	0%	0%	0%	0%	0%

Table C-4. Trending: Average Percent Distribution of Number of Events Reported in the Past 12 Months by Respondent Bed Size

Appendix C: Trending Results by Hospital Characteristics

(2) Teaching Status and (3) Ownership and Control

NOTE: The number of hospitals and respondents in each breakout category is shown in each table (e.g., the number of hospitals and respondents by teaching status and ownership and control). However, the precise number of hospitals and respondents corresponding to each data cell in a table will vary because hospitals may have omitted a specific survey item and because of individual non-response/missing data.

 Table C-5. Trending: Composite-level Average Percent Positive Response by Hospital Teaching Status, and Ownership and Control (Page 1 of 2)

		Teaching Status		Ownership	and Control
Patient Safety Culture Composites	Database Year	Teaching	Non-teaching	Govt	Non-Govt
# Hospitals	Both Years	59	145	63	141
# Respondents	Most Recent Previous	40,839 38,681	28,702 26,640	10,036 10,007	59,505 55,314
	Most Recent	77%	81%	80%	79%
1. Teamwork Within Units	Previous	73%	78%	79%	76%
	Change	4%	3%	1%	3%
	Most Recent	73%	76%	76%	74%
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	Previous	71%	75%	75%	73%
	Change	2%	1%	1%	1%
	Most Recent	69%	73%	73%	71%
3. Org LearningContinuous Improvement	Previous	66%	70%	71%	67%
	Change	3%	3%	2%	4%
	Most Recent	66%	73%	74%	70%
4. Management Support for Patient Safety	Previous	64%	71%	73%	67%
	Change	2%	2%	1%	3%
	Most Recent	58%	67%	69%	63%
5. Overall Perceptions of Patient Safety	Previous	57%	64%	66%	61%
	Change	1%	3%	3%	2%
	Most Recent	61%	63%	64%	62%
6. Feedback & Communication About Error	Previous	59%	62%	63%	60%
	Change	2%	1%	1%	2%

 Table C-5. Trending: Composite-level Average Percent Positive Response by Hospital Teaching Status, and Ownership and Control (Page 2 of 2)

		Teaching Status		Ownership	and Control
Patient Safety Culture Composites	Database Year	Teaching	Non-teaching	Govt	Non-Govt
# Hospitals	Both Years	59	145	63	141
# Respondents	Most Recent Previous	40,839 38,681	28,702 26,640	10,036 10,007	59,505 55,314
	Most Recent	59%	62%	63%	61%
7. Communication Openness	Previous	58%	61%	61%	60%
	Change	1%	1%	2%	1%
	Most Recent	58%	63%	63%	61%
8. Frequency of Events Reported	Previous	56%	61%	62%	58%
	Change	2%	2%	1%	3%
	Most Recent	51%	61%	62%	56%
9. Teamwork Across Units	Previous	50%	58%	61%	54%
	Change	1%	3%	1%	2%
	Most Recent	50%	57%	59%	54%
10. Staffing	Previous	49%	55%	57%	52%
	Change	1%	2%	2%	2%
	Most Recent	38%	48%	52%	42%
11. Handoffs & Transitions	Previous	39%	46%	49%	42%
	Change	-1%	2%	3%	0%
	Most Recent	40%	47%	47%	43%
12. Nonpunitive Response to Error	Previous	38%	44%	45%	42%
	Change	2%	3%	2%	1%

Table C-6. Trending: Item-level Average Percent Positive Response by Hospital Teaching Status, and Ownership and Control (Page 1 of 6)

			Teaching Status		Ownership	and Control
Item	Survey Items by Composite	Database Year	Teaching	Non-teaching	Govt	Non-Govt
ittem	# Hospitals	Both Years	59	145	<u> </u>	<u>141</u>
	# HOSPILAIS	Most Recent	40,839	28,702	10.036	59,505
	# Respondents	Previous	40,839 38,681	26,640	10,007	55,314
1.	Teamwork Within Units	1101003	30,001	20,040	10,007	00,014
		Most Recent	83%	86%	84%	85%
A1	1. People support one another in this unit.	Previous	78%	83%	84%	81%
,,,,		Change	5%	3%	0%	4%
	2. When a lot of work needs to be done	Most Recent	83%	87%	87%	86%
A3	quickly, we work together as a team to get the work done.	Previous	79%	86%	87%	82%
		Change	4%	1%	0%	4%
	3. In this unit, people treat each other with respect.	Most Recent	75%	78%	77%	78%
A4		Previous	71%	77%	77%	74%
		Change	4%	1%	0%	4%
	4. When one area in this unit gets really	Most Recent	66%	71%	69%	69%
A11	4. When one area in this unit gets really busy, others help out.	Previous	63%	68%	68%	65%
	busy, others help out.	Change	3%	3%	1%	4%
2.	Supervisor/Manager Expectations & Ac	ctions Promoti	ng Patient Safet	у		
	1. My supv/mgr says a good word when	Most Recent	71%	72%	72%	72%
B1	he/she sees a job done according to	Previous	67%	70%	70%	69%
	established patient safety procedures.	Change	4%	2%	2%	3%
		Most Recent	75%	77%	77%	76%
B2	 My supv/mgr seriously considers staff suggestions for improving patient safety. 	Previous	71%	75%	76%	73%
	suggestions for improving patient safety.	Change	4%	2%	1%	3%
	3. Whenever pressure builds up, my	Most Recent	71%	76%	78%	73%
B3R	supv/mgr wants us to work faster, even if it	Previous	70%	75%	76%	72%
	means taking shortcuts.	Change	1%	1%	2%	1%
	4. My supv/mgr overlooks patient safety	Most Recent	75%	78%	79%	76%
B4R	problems that happen over and over.	Previous	71%	76%	77%	73%
		Change	4%	2%	2%	3%

Table C-6. Trending: Item-level Average Percent Positive Response by Hospital Teaching Status, and Ownership and Control (Page 2 of 6)

			Teaching Status		Ownership and Control	
ltem	Survey Items by Composite	Database Year	Teaching	Non-teaching	Govt	Non-Govt
	# Hospitals	Both Years	59	145	63	141
	, # Respondents	Most Recent Previous	40,839 38,681	28,702 26,640	10,036 10,007	59,505 55,314
3.	Organizational Learning— Continuous	Improvement				,
		Most Recent	80%	83%	84%	82%
A6	1. We are actively doing things to improve patient safety.	Previous	77%	81%	83%	78%
		Change	3%	2%	1%	4%
	2. Mistakes have led to positive changes here.	Most Recent	61%	65%	65%	63%
A9		Previous	58%	62%	63%	60%
		Change	3%	3%	2%	3%
	3. After we make changes to improve	Most Recent	66%	70%	71%	68%
A13	patient safety, we evaluate their	Previous	63%	67%	69%	64%
	effectiveness.	Change	3%	3%	2%	4%
4.	Management Support for Patient Safet	у				
		Most Recent	75%	82%	83%	78%
F1	 Hospital mgmt provides a work climate that promotes patient safety. 	Previous	73%	81%	83%	76%
	climate that promotes patient safety.	Change	2%	1%	0%	2%
	2. The actions of beenited memory about	Most Recent	69%	74%	75%	72%
F8	2. The actions of hospital mgmt show that patient safety is a top priority.	Previous	66%	71%	74%	68%
	that patient safety is a top phonty.	Change	3%	3%	1%	4%
	3. Hospital mgmt seems interested in	Most Recent	55%	62%	63%	59%
F9R	patient safety only after an adverse	Previous	53%	60%	61%	56%
	event happens.	Change	2%	2%	2%	3%

Table C-6. Trending: Item-level Average Percent Positive Response by Hospital Teaching Status, and Ownership and Control (Page 3 of 6)

			Teachi	ing Status	Ownership	and Control
Item	Survey Items by Composite	Database Year	Teaching	Non-teaching	Govt	Non-Govt
	# Hospitals	Both Years	59	145	63	141
	# Doopondonto	Most Recent	40,839	28,702	10,036	59,505
	# Respondents	Previous	38,681	26,640	10,007	55,314
5.	Overall Perceptions of Patient Safety					
	1. It is just by chance that more serious	Most Recent	53%	63%	63%	59%
A10R	mistakes don't happen around here.	Previous	54%	61%	60%	58%
	motakeo don't happen dround here.	Change	-1%	2%	3%	1%
	2. Detient exferts is never exertified to	Most Recent	59%	68%	70%	63%
A15	2. Patient safety is never sacrificed to get more work done.	Previous	57%	65%	68%	60%
	get more work done.	Change	2%	3%	2%	3%
	2. We have notiont actaty problems in	Most Recent	52%	66%	68%	59%
A17R	3. We have patient safety problems in this unit.	Previous	54%	63%	65%	59%
		Change	-2%	3%	3%	0%
	4. Our procedures and systems are	Most Recent	67%	73%	73%	70%
A18	good at preventing errors from	Previous	63%	69%	69%	66%
	happening.	Change	4%	4%	4%	4%
6.	Feedback and Communication About E	Error				
	1. We are given feedback about	Most Recent	54%	53%	51%	54%
C1	changes put into place based on event	Previous	52%	52%	51%	52%
	reports.	Change	2%	1%	0%	2%
		Most Recent	61%	66%	68%	63%
C3	2. We are informed about errors that happen in this unit.	Previous	59%	65%	67%	62%
		Change	2%	1%	1%	1%
	2 In this wait, we discuss wows to	Most Recent	68%	71%	72%	70%
C5	3. In this unit, we discuss ways to prevent errors from happening again.	Previous	65%	70%	72%	67%
		Change	3%	1%	0%	3%

Table C-6. Trending: Item-level Average Percent Positive Response by Hospital Teaching Status, and Ownership and Control (Page 4 of 6)

			Teachi	ng Status	Ownership	and Control
ltem	Survey Items by Composite	Database Year	Teaching	Non-teaching	Govt	Non-Govt
	# Hospitals	Both Years	59	145	63	141
	# Respondents	Most Recent Previous	40,839 38,681	28,702 26,640	10,036 10,007	59,505 55,314
7.	Communication Openness					
	1. Staff will freely speak up if they see	Most Recent	73%	76%	75%	75%
C2	something that may negatively affect	Previous	71%	75%	75%	73%
	patient care.	Change	2%	1%	0%	2%
	2. Staff feel free to question the	Most Recent	46%	48%	48%	47%
C4	decisions or actions of those with more	Previous	46%	46%	47%	46%
	authority.	Change	0%	2%	1%	1%
		Most Recent	59%	63%	65%	61%
C6R	3. Staff are afraid to ask questions when something does not seem right.	Previous	58%	62%	63%	60%
	something does not seem right.	Change	1%	1%	2%	1%
8.	Frequency of Events Reported					
	1. When a mistake is made, but is	Most Recent	51%	54%	55%	53%
D1	caught and corrected before affecting	Previous	48%	53%	54%	50%
	the patient, how often is this reported?	Change	3%	1%	1%	3%
	2. When a mistake is made, but has no	Most Recent	54%	59%	60%	56%
D2	potential to harm the patient, how often	Previous	51%	57%	58%	54%
	is this reported?	Change	3%	2%	2%	2%
	3. When a mistake is made that could	Most Recent	70%	75%	75%	73%
D3	harm the patient, but does not, how	Previous	68%	73%	75%	71%
	often is this reported?	Change	2%	2%	0%	2%

Table C-6. Trending: Item-level Average Percent Positive Response by Hospital Teaching Status, and Ownership and Control (Page 5 of 6)

			Teachi	ing Status	Ownership	and Control
Item	Survey Items by Composite	Database Year	Teaching	Non-teaching	Govt	Non-Govt
	# Hospitals	Both Years	59	145	63	141
	# Respondents	Most Recent	40,839	28,702	10,036	59,505
	# Respondents	Previous	38,681	26,640	10,007	55,314
9.	Teamwork Across Units					
	1. Hoopital units do not coordinate wall	Most Recent	38%	49%	50%	44%
F2R	1. Hospital units do not coordinate well with each other.	Previous	39%	46%	49%	42%
		Change	-1%	3%	1%	2%
	2. There is good cooperation among	Most Recent	51%	63%	64%	57%
F4	hospital units that need to work	Previous	50%	60%	63%	55%
	together.	Change	1%	3%	1%	2%
	2 It is often upplessent to work with	Most Recent	53%	61%	61%	57%
F6R	3. It is often unpleasant to work with staff from other hospital units.	Previous	52%	58%	60%	55%
	stan nom other hospital anits.	Change	1%	3%	1%	2%
	4. Hospital units work well together to	Most Recent	61%	71%	72%	66%
F10	provide the best care for patients.	Previous	59%	69%	71%	63%
		Change	2%	2%	1%	3%
10.	Staffing					
	1. We have anough staff to handle the	Most Recent	47%	57%	59%	52%
A2	 We have enough staff to handle the workload. 	Previous	48%	55%	58%	51%
	workioud.	Change	-1%	2%	1%	1%
		Most Recent	47%	54%	55%	51%
A5R	2. Staff in this unit work longer hours than is best for patient care.	Previous	47%	52%	54%	49%
	than is best for patient care.	Change	0%	2%	1%	2%
		Most Recent	62%	66%	64%	65%
A7R	3. We use more agency/temporary staff	Previous	58%	64%	64%	61%
	than is best for patient care.	Change	4%	2%	0%	4%
		Most Recent	43%	53%	57%	47%
A14R	4. We work in "crisis mode" trying to do	Previous	43%	50%	52%	46%
	too much, too quickly.	Change		3%	52 %	40%
		Change	0%	3%	5%	170

Table C-6. Trending: Item-level Average Percent Positive Response by Hospital Teaching Status, and Ownership and Control (Page 6 of 6)

			Teachi	ng Status	Ownershin	and Control
•	• · · • •	Database			•	
Item	Survey Items by Composite	Year	Teaching	Non-teaching	Govt	Non-Govt
	# Hospitals	Both Years	59	145	63	141
	# Respondents	Most Recent	40,839	28,702	10,036	59,505
		Previous	38,681	26,640	10,007	55,314
11.	Handoffs & Transitions					
	1. Things "fall between the cracks"	Most Recent	33%	46%	51%	38%
F3R	when transferring patients from one unit	Previous	34%	44%	49%	38%
	to another.	Change	-1%	2%	2%	0%
	2. Important patient care information in	Most Recent	45%	52%	54%	48%
F5R	2. Important patient care information is often lost during shift changes.	Previous	45%	50%	53%	47%
	onen lost during snint changes.	Change	0%	2%	1%	1%
	3. Problems often occur in the	Most Recent	35%	47%	49%	41%
F7R	exchange of information across hospital	Previous	36%	44%	46%	40%
	units.	Change	-1%	3%	3%	1%
	4. Chift changes are problematic for	Most Recent	38%	49%	53%	43%
F11R	 Shift changes are problematic for patients in this hospital. 	Previous	40%	47%	50%	42%
	patients in this hospital.	Change	-2%	2%	3%	1%
12.	Nonpunitive Response to Error	·				
		Most Recent	46%	54%	54%	50%
A8R	1. Staff feel like their mistakes are held against them.	Previous	44%	52%	53%	48%
	against them.	Change	2%	2%	1%	2%
	2. When an event is reported, it feels	Most Recent	42%	48%	47%	46%
A12R	• •	Previous	41%	45%	45%	43%
	the problem.	Change	1%	3%	2%	3%
		Most Recent	31%	39%	40%	35%
A16R	3. Staff worry that mistakes they make are kept in their personnel file.	Previous	30%	36%	37%	33%
		Change	1%	3%	3%	2%

 Table C-7. Trending: Average Percent Distribution of Work Area/Unit Patient Safety Grades by Hospital Teaching Status, and

 Ownership and Control

			Teachi	ng Status	Ownership	and Control
_	< Area/Unit ent Safety Grade	Database Year	Teaching	Non-teaching	Govt	Non-Govt
	# Hospitals	Both Years	59	145	63	141
	# Respondents	Most Recent Previous	40,839 38,681	28,702 26,640	10,036 10,007	59,505 55,314
		Most Recent	22%	26%	25%	25%
Α	Excellent	Previous	20%	23%	22%	23%
		Change	2%	3%	3%	2%
		Most Recent	44%	48%	50%	46%
В	Very Good	Previous	45%	46%	47%	46%
		Change	-1%	2%	3%	0%
		Most Recent	25%	21%	21%	23%
С	Acceptable	Previous	27%	23%	24%	24%
		Change	-2%	-2%	-3%	-1%
		Most Recent	7%	4%	3%	5%
D	Poor	Previous	7%	6%	6%	6%
		Change	0%	-2%	-3%	-1%
		Most Recent	1%	1%	0%	1%
Е	Failing	Previous	1%	1%	1%	1%
		Change	0%	0%	-1%	0%

 Table C-8. Trending: Average Percent Distribution of Number of Events Reported in the Past 12 Months by Hospital Teaching

 Status, and Ownership and Control

		Teachi	ng Status	Ownership	and Control
Number of Events Reported by Respondents	Database Year	Teaching	Non-teaching	Govt	Non-Govt
# Hospitals	Both Years	59	145	63	141
# Respondents	Most Recent Previous	40,839 38,681	28,702 26,640	10,036 10,007	59,505 55,314
	Most Recent	53%	52%	53%	52%
No events	Previous	52%	55%	58%	52%
	Change	1%	-3%	-5%	0%
	Most Recent	28%	27%	26%	29%
1 to 2 events	Previous	27%	25%	23%	27%
	Change	1%	2%	3%	2%
	Most Recent	12%	13%	13%	12%
3 to 5 events	Previous	13%	12%	12%	13%
	Change	-1%	1%	1%	-1%
	Most Recent	4%	5%	5%	4%
6 to 10 events	Previous	5%	5%	4%	5%
	Change	-1%	0%	1%	-1%
	Most Recent	2%	2%	2%	2%
11 to 20 events	Previous	2%	2%	2%	2%
	Change	0%	0%	0%	0%
	Most Recent	1%	1%	1%	1%
21 events reports or more	Previous	1%	1%	1%	1%
	Change	0%	0%	0%	0%

Appendix D: Trending Results by Respondent Characteristics

Appendix D: Trending Results by Respondent Characteristics

(1) Work Area/Unit

NOTE 1: The number of hospitals and respondents in each breakout category is shown in each table (e.g., the number of hospitals and respondents by work area/unit). However, the precise number of hospitals and respondents corresponding to each data cell in a table will vary because hospitals may have omitted a specific survey item and because of individual non-response/missing data.

NOTE 2: Only hospitals that had at least 1 respondent in the particular work area/unit for both their previous and most recent administrations of the survey are included.

NOTE 3: Respondents who selected "Many different work areas/No specific work area," "Other," or those who did not answer (missing) are not included.

_	-		Work Area/Unit ICU Psych/ Sthe Emer (any Destate Padia Montel Padia Pohab											
Patient Safety Culture Composites	Database Year	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medicine	Obstet- rics	Pedi- atrics	Pharmacy	Psych/ Mental Hith	Radi- ology	Rehab- ilitation	Surgery	
# Hospitals	Both Years	42	146	114	164	171	101	62	135	60	161	139	154	
# Respondents	Most Recent Previous	293 406	3,442 3,120	4,032 3,895	2,926 2,865	7,598 6,220	2,600 1,876	1,356 1,525	1,705 1,560	1,174 1,220	3,275 3,082	2,090 1,941	5,282 5,328	
	Most Recent	83%	79%	82%	79%	75%	81%	77%	78%	77%	79%	86%	79%	
1. Teamwork Within Units	Previous	77%	76%	80%	78%	72%	74%	77%	75%	71%	78%	82%	75%	
	Change	6%	3%	2%	1%	3%	7%	0%	3%	6%	1%	4%	4%	
2. Supv/Mgr Expectations &	Most Recent	75%	71%	70%	75%	72%	74%	78%	76%	77%	77%	83%	74%	
Actions Promoting	Previous	70%	73%	71%	75%	72%	72%	72%	76%	74%	76%	80%	74%	
Patient Safety	Change	5%	-2%	-1%	0%	0%	2%	6%	0%	3%	1%	3%	0%	
3. Org Learning	Most Recent	71%	65%	69%	73%	71%	72%	74%	75%	70%	71%	75%	75%	
Continuous	Previous	71%	63%	68%	69%	67%	68%	65%	74%	66%	67%	71%	71%	
Improvement	Change	0%	2%	1%	4%	4%	4%	9%	1%	4%	4%	4%	4%	
4. Management	Most Recent	64%	63%	59%	72%	65%	69%	66%	69%	65%	74%	74%	69%	
Support for	Previous	70%	60%	59%	71%	63%	64%	65%	68%	61%	70%	74%	67%	
Patient Safety	Change	-6%	3%	0%	1%	2%	5%	1%	1%	4%	4%	0%	2%	
5. Overall	Most Recent	59%	54%	56%	71%	55%	62%	64%	64%	57%	73%	74%	68%	
Perceptions of	Previous	61%	55%	55%	71%	53%	58%	63%	64%	57%	70%	73%	65%	
Patient Safety	Change	-2%	-1%	1%	0%	2%	4%	1%	0%	0%	3%	1%	3%	
6. Feedback &	Most Recent	66%	55%	54%	65%	56%	62%	62%	65%	68%	64%	71%	64%	
Communication About Error	Previous	60%	55%	53%	63%	56%	58%	60%	63%	58%	64%	68%	63%	
	Change	6%	0%	1%	2%	0%	4%	2%	2%	10%	0%	3%	1%	

Table D-1. Trending: Composite-level Average Percent Positive Response by Work Area/Unit (Page 1 of 2)

	•		Work Area/Unit										
Patient Safety Culture Composites	Database Year	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medicine	Obstet- rics	Pedi- atrics	Pharmacy	Psych/ Mental Hith	Radi- ology	Rehab- ilitation	Surgery
# Hospitals	Both Years	42	146	114	164	171	101	62	135	60	161	139	154
# Respondents	Most Recent Previous	293 406	3,442 3,120	4,032 3,895	2,926 2,865	7,598 6,220	2,600 1,876	1,356 1,525	1,705 1,560	1,174 1,220	3,275 3,082	2,090 1,941	5,282 5,328
	Most Recent	62%	60%	61%	62%	55%	63%	64%	69%	66%	63%	71%	64%
7. Communication Openness	Previous	70%	58%	60%	62%	55%	62%	64%	66%	59%	61%	67%	64%
	Change	-8%	2%	1%	0%	0%	1%	0%	3%	7%	2%	4%	0%
8. Frequency of	Most Recent	59%	57%	57%	66%	62%	62%	62%	60%	65%	56%	61%	65%
Events	Previous	45%	57%	57%	64%	59%	58%	57%	57%	57%	52%	62%	62%
Reported	Change	14%	0%	0%	2%	3%	4%	5%	3%	8%	4%	-1%	3%
	Most Recent	50%	47%	52%	57%	56%	54%	53%	53%	51%	57%	60%	53%
9. Teamwork Across Units	Previous	54%	49%	50%	55%	56%	52%	50%	54%	46%	55%	58%	52%
	Change	-4%	-2%	2%	2%	0%	2%	3%	-1%	5%	2%	2%	1%
	Most Recent	53%	47%	54%	54%	51%	58%	60%	54%	53%	64%	61%	55%
10. Staffing	Previous	46%	49%	52%	54%	51%	51%	60%	52%	51%	62%	60%	55%
	Change	7%	-2%	2%	0%	0%	7%	0%	2%	2%	2%	1%	0%
	Most Recent	37%	47%	46%	38%	49%	54%	47%	31%	40%	44%	38%	40%
11. Handoffs & Transitions	Previous	36%	48%	48%	38%	47%	49%	45%	31%	37%	42%	42%	41%
	Change	1%	-1%	-2%	0%	2%	5%	2%	0%	3%	2%	-4%	-1%
12. Nonpunitive	Most Recent	43%	38%	38%	44%	41%	42%	43%	54%	51%	45%	57%	45%
Response to	Previous	39%	35%	38%	43%	40%	37%	46%	52%	39%	44%	56%	46%
Error	Change	4%	3%	0%	1%	1%	5%	-3%	2%	12%	1%	1%	-1%

Table D-1. Trending: Composite-level Average Percent Positive Response by Work Area/Unit (Page 2 of 2)

Work Area/Unit														
ltem	Survey Items by Composite	Database Year	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medi- cine	Obstet- rics	Pedi- atrics	Pharm- acy	Psych/ Mental Hith	Radi- ology	Rehab- ilitation	Surgery
	# Hospitals	Both Years	42	146	114	164	171	101	62	135	60	161	139	154
	# Respondents	Most Recent	293	3,442	4,032	2,926	7,598	2,600	1,356	1,705	1,174	3,275	2,090	5,282
		Previous	406	3,120	3,895	2,865	6,220	1,876	1,525	1,560	1,220	3,082	1,941	5,328
1.	Teamwork Within Units													
		Most Recent	90%	84%	86%	85%	84%	88%	81%	85%	82%	83%	89%	85%
A1	1. People support one another in	Previous	83%	82%	84%	81%	79%	78%	80%	82%	74%	82%	88%	80%
	this unit.	Change	7%	2%	2%	4%	5%	10%	1%	3%	8%	1%	1%	5%
	2. When a lot of work needs to	Most Recent	89%	86%	89%	86%	82%	89%	83%	84%	83%	88%	90%	88%
A3	be done quickly, we work	Previous	79%	83%	87%	84%	80%	84%	82%	80%	77%	88%	85%	84%
	together as a team to get the work done.	Change	10%	3%	2%	2%	2%	5%	1%	4%	6%	0%	5%	4%
		Most Recent	83%	75%	77%	77%	74%	78%	75%	79%	75%	75%	87%	76%
A4	3. In this unit, people treat each	Previous	78%	74%	78%	76%	71%	72%	76%	74%	72%	75%	83%	73%
	other with respect.	Change	5%	1%	-1%	1%	3%	6%	-1%	5%	3%	0%	4%	3%
A 4		Most Recent	70%	69%	75%	71%	61%	68%	67%	65%	68%	68%	77%	66%
A1 1	4. When one area in this unit	Previous	69%	67%	70%	70%	59%	63%	69%	63%	61%	66%	72%	62%
I	gets really busy, others help out.	Change	1%	2%	5%	1%	2%	5%	-2%	2%	7%	2%	5%	4%
2.	Supervisor/Manager Expecta	tions & Action	s Promoti	ng Patie	nt Safety	/								
	1. My supv/mgr says a good	Most Recent	71%	68%	65%	69%	68%	72%	71%	70%	75%	70%	78%	73%
B1	word when he/she sees a job done according to established	Previous	63%	69%	66%	67%	66%	65%	66%	69%	62%	70%	73%	69%
	patient safety procedures.	Change	8%	-1%	-1%	2%	2%	7%	5%	1%	13%	0%	5%	4%
	2. My supv/mgr seriously	Most Recent	77%	73%	72%	74%	73%	75%	81%	77%	77%	77%	84%	77%
B2	considers staff suggestions for	Previous	74%	72%	70%	75%	70%	70%	74%	72%	69%	74%	81%	75%
	improving patient safety.	Change	3%	1%	2%	-1%	3%	5%	7%	5%	8%	3%	3%	2%
	3. Whenever pressure builds up,	Most Recent	71%	70%	70%	80%	72%	73%	79%	79%	76%	79%	82%	71%
B3R	my supv/mgr wants us to work faster, even if it means taking	Previous	68%	73%	69%	78%	72%	72%	73%	78%	77%	76%	79%	72%
	shortcuts.	Change	3%	-3%	1%	2%	0%	1%	6%	1%	-1%	3%	3%	-1%
	4. My supv/mgr overlooks	Most Recent	79%	74%	72%	76%	74%	75%	81%	79%	78%	82%	86%	78%
B4R	patient safety problems that	Previous	71%	72%	71%	74%	74%	71%	67%	77%	72%	77%	79%	75%
	happen over and over.	Change	8%	2%	1%	2%	0%	4%	14%	2%	6%	5%	7%	3%

Table D-2. Trending: Item-level Average Percent Positive Response by Work Area/Unit (Page 1 of 6)

	-	Work Area/Unit												
ltem	Survey Items by Composite	Database Year	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medi- cine	Obstet- rics	Pedi- atrics	Pharm- acy	Psych/ Mental Hlth	Radi- ology	Rehab- ilitation	Surgery
	# Hospitals	Both Years	42	146	114	164	171	101	62	135	60	161	139	154
	# Respondents	Most Recent	293	3,442	4,032	2,926	7,598	2,600	1,356	1,705	1,174	3,275	2,090	5,282
3.	Organizational Learning— C	Previous	406	3,120	3,895	2,865	6,220	1,876	1,525	1,560	1,220	3,082	1,941	5,328
J.	organizational Learning— 0	•	1		- 1-1									
	 We are actively doing 	Most Recent	89%	77%	84%	81%	82%	84%	86%	86%	78%	82%	88%	87%
A6	things to improve patient	Previous	81%	72%	81%	76%	77%	77%	79%	84%	76%	78%	84%	84%
	safety.	Change	8%	5%	3%	5%	5%	7%	7%	2%	2%	4%	4%	3%
		Most Recent	62%	56%	56%	70%	61%	63%	64%	72%	61%	63%	62%	65%
A9	2. Mistakes have led to positive changes here.	Previous	61%	56%	56%	65%	59%	61%	54%	73%	56%	59%	58%	62%
	positive changes here.	Change	1%	0%	0%	5%	2%	2%	10%	-1%	5%	4%	4%	3%
	3. After we make changes to	Most Recent	61%	63%	68%	67%	69%	69%	69%	67%	71%	67%	74%	73%
A13	improve patient safety, we	Previous	71%	60%	66%	64%	63%	65%	63%	67%	65%	63%	71%	68%
	evaluate their effectiveness.	Change	-10%	3%	2%	3%	6%	4%	6%	0%	6%	4%	3%	5%
4.	Management Support for Pa	tient Safety												
	1. Hospital mgmt provides a	Most Recent	73%	71%	68%	82%	74%	77%	77%	76%	72%	84%	81%	79%
F1	work climate that promotes	Previous	81%	71%	68%	81%	73%	74%	76%	74%	69%	81%	83%	76%
	patient safety.	Change	-8%	0%	0%	1%	1%	3%	1%	2%	3%	3%	-2%	3%
	2. The actions of hospital	Most Recent	66%	64%	60%	74%	67%	71%	68%	70%	68%	74%	77%	70%
F8	mgmt show that patient	Previous	70%	59%	59%	73%	63%	65%	61%	71%	62%	70%	75%	68%
	safety is a top priority.	Change	-4%	5%	1%	1%	4%	6%	7%	-1%	6%	4%	2%	2%
	3. Hospital mgmt seems	Most Recent	53%	53%	49%	60%	54%	58%	54%	60%	56%	63%	64%	57%
F9R	interested in patient safety only after an adverse event	Previous	58%	49%	49%	59%	53%	53%	58%	60%	52%	58%	63%	57%
	happens.	Change	-5%	4%	0%	1%	1%	5%	-4%	0%	4%	5%	1%	0%

Table D-2. Trending: Item-level Average Percent Positive Response by Work Area/Unit (Page 2 of 6)

	5	0	Work Area/Unit											
ltem	Survey Items by Composite	Database Year	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medi- cine	Obstet- rics	Pedi- atrics	Pharm- acy	Psych/ Mental Hith	Radi- ology	Rehab- ilitation	Surgery
	# Hospitals	Both Years	42	146	114	164	171	101	62	135	60	161	139	154
	# Respondents	Most Recent Previous	293 406	3,442 3,120	4,032 3,895	2,926 2,865	7,598 6,220	2,600 1,876	1,356 1,525	1,705 1,560	1,174 1.220	3,275 3,082	2,090 1,941	5,282 5,328
5.	Overall Perceptions of Patien			0,120	0,000	_,	0,220	.,	.,020	.,	.,0	0,002	.,	0,020
	1. It is just by chance that	Most Recent	58%	52%	54%	65%	53%	60%	60%	60%	55%	67%	72%	63%
A10R		Previous	61%	52%	55%	65%	54%	56%	64%	62%	57%	63%	70%	60%
	happen around here.	Change	-3%	0%	-1%	0%	-1%	4%	-4%	-2%	-2%	4%	2%	3%
	2. Patient safety is never	Most Recent	52%	55%	54%	73%	55%	59%	62%	65%	61%	76%	75%	66%
A15	sacrificed to get more work	Previous	56%	55%	50%	70%	51%	55%	60%	61%	63%	73%	74%	64%
	done.	Change	-4%	0%	4%	3%	4%	4%	2%	4%	-2%	3%	1%	2%
	2 We have noticet actatic	Most Recent	57%	50%	55%	68%	50%	59%	62%	60%	48%	73%	71%	66%
A17R	3. We have patient safety problems in this unit.	Previous	57%	52%	51%	70%	49%	57%	60%	61%	48%	71%	71%	65%
		Change	0%	-2%	4%	-2%	1%	2%	2%	-1%	0%	2%	0%	1%
	4. Our procedures and	Most Recent	70%	60%	63%	78%	64%	70%	73%	73%	66%	76%	79%	76%
A18	systems are good at preventing errors from	Previous	71%	59%	63%	78%	60%	65%	66%	71%	61%	72%	77%	71%
	happening.	Change	-1%	1%	0%	0%	4%	5%	7%	2%	5%	4%	2%	5%
6.	Feedback and Communication	on About Erro	r											
	1. We are given feedback	Most Recent	59%	47%	45%	52%	49%	56%	54%	50%	59%	52%	61%	54%
C1	about changes put into place	Previous	46%	48%	47%	51%	49%	53%	52%	50%	48%	53%	59%	49%
	based on event reports.	Change	13%	-1%	-2%	1%	0%	3%	2%	0%	11%	-1%	2%	5%
	2. We are informed about	Most Recent	61%	55%	54%	71%	55%	61%	63%	71%	71%	70%	72%	66%
C3	errors that happen in this	Previous	60%	56%	51%	68%	56%	57%	61%	66%	58%	69%	69%	66%
	unit.	Change	1%	-1%	3%	3%	-1%	4%	2%	5%	13%	1%	3%	0%
	3. In this unit, we discuss	Most Recent	78%	62%	63%	73%	65%	69%	68%	73%	73%	70%	80%	74%
C5	ways to prevent errors from	Previous	76%	62%	62%	71%	62%	65%	67%	72%	67%	69%	76%	72%
	happening again.	Change	2%	0%	1%	2%	3%	4%	1%	1%	6%	1%	4%	2%

Table D-2. Trending: Item-level Average Percent Positive Response by Work Area/Unit (Page 3 of 6)

	-	-	Work Area/Unit											
Item	Survey Items by Composite	Database Year	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medi- cine	Obstet- rics	Pedi- atrics	Pharm- acy	Psych/ Mental Hith	Radi- ology	Rehab- ilitation	Surgery
	# Hospitals	Both Years	42	146	114	164	171	101	62	135	60	161	139	154
	# Respondents	Most Recent	293	3,442	4,032	2,926	7,598	2,600	1,356	1,705	1,174	3,275	2,090	5,282
	•	Previous	406	3,120	3,895	2,865	6,220	1,876	1,525	1,560	1,220	3,082	1,941	5,328
7.	Communication Openness													
	1. Staff will freely speak up if	Most Recent	71%	72%	75%	77%	70%	78%	78%	78%	78%	77%	84%	79%
C2	they see something that may negatively affect patient	Previous	81%	70%	70%	74%	69%	75%	74%	77%	70%	74%	81%	78%
	care.	Change	-10%	2%	5%	3%	1%	3%	4%	1%	8%	3%	3%	1%
	2. Staff feel free to question	Most Recent	48%	48%	45%	46%	40%	48%	52%	57%	54%	46%	58%	48%
C4	the decisions or actions of	Previous	58%	45%	48%	45%	40%	49%	52%	52%	49%	47%	53%	50%
	those with more authority.	Change	-10%	3%	-3%	1%	0%	-1%	0%	5%	5%	-1%	5%	-2%
	3. Staff are afraid to ask	Most Recent	68%	61%	61%	64%	55%	64%	62%	71%	67%	66%	70%	64%
C6R	questions when something	Previous	71%	59%	61%	66%	55%	61%	65%	69%	59%	62%	67%	64%
	does not seem right.	Change	-3%	2%	0%	-2%	0%	3%	-3%	2%	8%	4%	3%	0%
8.	Frequency of Events Report	ed												
	1. When a mistake is made,	Most Recent	55%	48%	45%	57%	52%	55%	52%	48%	58%	47%	54%	57%
D1	but is caught and corrected	Previous	33%	45%	46%	55%	50%	46%	46%	46%	50%	44%	56%	53%
	before affecting the patient, how often is this reported?	Change	22%	3%	-1%	2%	2%	9%	6%	2%	8%	3%	-2%	4%
	2. When a mistake is made,	Most Recent	57%	53%	54%	61%	60%	57%	58%	57%	60%	50%	57%	61%
D2	but has no potential to harm	Previous	44%	56%	53%	59%	57%	54%	54%	53%	52%	47%	56%	57%
	the patient, how often is this reported?	Change	13%	-3%	1%	2%	3%	3%	4%	4%	8%	3%	1%	4%
	3. When a mistake is made	Most Recent	65%	71%	70%	80%	75%	74%	75%	75%	77%	70%	73%	77%
D3	that <u>could harm the patient</u> ,	Previous	59%	71%	71%	78%	71%	75%	71%	72%	70%	66%	72%	75%
	but does not, how often is this reported?	Change	6%	0%	-1%	2%	4%	-1%	4%	3%	7%	4%	1%	2%

Table D-2. Trending: Item-level Average Percent Positive Response by Work Area/Unit (Page 4 of 6)

	5	U	Work Area/Unit											
ltem	Survey Items by Composite	Database Year	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medi- cine	Obstet -rics	Pedi- atrics	Pharm- acy	Psych/ Mental Hith	Radi- ology	Rehab- ilitation	Surgery
	# Hospitals	Both Years	42	146	114	164	171	101	62	135	60	161	139	154
	# Respondents	Most Recent	293	3,442	4,032	2,926	7,598	2,600	1,356	1,705	1,174	3,275	2,090	5,282
	-	Previous	406	3,120	3,895	2,865	6,220	1,876	1,525	1,560	1,220	3,082	1,941	5,328
9.	Teamwork Across Units													
	1. Hospital units do not	Most Recent	32%	36%	36%	44%	44%	38%	38%	41%	35%	45%	45%	41%
F2R	coordinate well with each	Previous	39%	41%	37%	43%	44%	38%	41%	42%	31%	43%	46%	39%
	other.	Change	-7%	-5%	-1%	1%	0%	0%	-3%	-1%	4%	2%	-1%	2%
	2. There is good cooperation	Most Recent	50%	47%	51%	60%	57%	57%	56%	52%	50%	59%	61%	55%
F4	among hospital units that	Previous	54%	48%	52%	57%	54%	54%	51%	56%	44%	57%	60%	51%
	need to work together.	Change	-4%	-1%	-1%	3%	3%	3%	5%	-4%	6%	2%	1%	4%
	3. It is often unpleasant to	Most Recent	53%	48%	59%	57%	60%	58%	55%	56%	59%	56%	63%	53%
F6R	work with staff from other	Previous	61%	47%	53%	56%	60%	54%	56%	53%	56%	55%	60%	56%
	hospital units.	Change	-8%	1%	6%	1%	0%	4%	-1%	3%	3%	1%	3%	-3%
	4. Hospital units work well	Most Recent	64%	56%	62%	68%	65%	65%	63%	63%	59%	68%	70%	64%
F10	together to provide the best	Previous	63%	59%	57%	64%	64%	61%	55%	64%	55%	65%	65%	61%
	care for patients.	Change	1%	-3%	5%	4%	1%	4%	8%	-1%	4%	3%	5%	3%
10.	Staffing	•												
		Most Recent	59%	41%	50%	49%	46%	54%	59%	47%	48%	64%	54%	54%
A2	1. We have enough staff to handle the workload.	Previous	49%	44%	49%	54%	46%	43%	53%	48%	45%	60%	54%	53%
	nandie the workload.	Change	10%	-3%	1%	-5%	0%	11%	6%	-1%	3%	4%	0%	1%
	2. Staff in this unit work	Most Recent	38%	50%	54%	53%	49%	53%	54%	54%	49%	61%	59%	48%
A5R	longer hours than is best for	Previous	33%	49%	53%	51%	50%	48%	53%	54%	49%	60%	58%	49%
	patient care.	Change	5%	1%	1%	2%	-1%	5%	1%	0%	0%	1%	1%	-1%
	3. We use more	Most Recent	69%	60%	65%	67%	63%	75%	73%	67%	65%	73%	69%	69%
A7R	agency/temporary staff than	Previous	57%	59%	61%	65%	64%	69%	76%	61%	64%	69%	70%	69%
	is best for patient care.	Change	12%	1%	4%	2%	-1%	6%	-3%	6%	1%	4%	-1%	0%
	4. We work in "crisis mode"	Most Recent	46%	38%	45%	48%	47%	51%	53%	49%	51%	58%	61%	50%
A14R	trying to do too much, too	Previous	44%	43%	46%	46%	44%	44%	56%	45%	44%	59%	59%	50%
	quickly.	Change	2%	-5%	-1%	2%	3%	7%	-3%	4%	7%	-1%	2%	0%

Table D-2. Trending: Item-level Average Percent Positive Response by Work Area/Unit (Page 5 of 6)

			Work Area/Unit											
Item	Survey Items by Composite	Database Year	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medi- cine	Obstet- rics	Pedi- atrics	Pharm- acy	Psych/ Mental Hith	Radi- ology	Rehab- ilitation	Surgery
	# Hospitals	Both Years	42	146	114	164	171	101	62	135	60	161	139	154
	# Respondents	Most Recent	293	3,442	4,032	2,926	7,598	2,600	1,356	1,705	1,174	3,275	2,090	5,282
	•	Previous	406	3,120	3,895	2,865	6,220	1,876	1,525	1,560	1,220	3,082	1,941	5,328
11.	Handoffs & Transitions													
	1. Things "fall between the	Most Recent	35%	44%	35%	31%	46%	46%	43%	26%	36%	43%	36%	39%
F3R	cracks" when transferring patients from one unit to	Previous	34%	48%	38%	29%	44%	43%	37%	24%	26%	42%	39%	40%
	another.	Change	1%	-4%	-3%	2%	2%	3%	6%	2%	10%	1%	-3%	-1%
	2. Important patient care	Most Recent	42%	55%	57%	43%	52%	65%	59%	33%	48%	47%	41%	46%
F5R	information is often lost	Previous	40%	55%	58%	44%	50%	58%	53%	32%	45%	46%	46%	47%
	during shift changes.	Change	2%	0%	-1%	-1%	2%	7%	6%	1%	3%	1%	-5%	-1%
	3. Problems often occur in	Most Recent	37%	44%	39%	38%	46%	47%	39%	31%	34%	43%	39%	40%
F7R	the exchange of information	Previous	37%	45%	39%	36%	43%	40%	42%	30%	34%	38%	42%	40%
	across hospital units.	Change	0%	-1%	0%	2%	3%	7%	-3%	1%	0%	5%	-3%	0%
	4. Shift changes are	Most Recent	36%	44%	53%	41%	52%	61%	46%	34%	41%	42%	37%	37%
F11R	problematic for patients in	Previous	33%	45%	56%	41%	50%	56%	48%	37%	45%	43%	41%	38%
	this hospital.	Change	3%	-1%	-3%	0%	2%	5%	-2%	-3%	-4%	-1%	-4%	-1%
12.	Nonpunitive Response to Er	ror												
	1. Staff feel like their	Most Recent	55%	44%	46%	54%	47%	49%	54%	61%	56%	51%	64%	52%
A8R	mistakes are held against	Previous	48%	41%	45%	51%	47%	44%	57%	59%	46%	50%	63%	52%
	them.	Change	7%	3%	1%	3%	0%	5%	-3%	2%	10%	1%	1%	0%
	2. When an event is	Most Recent	38%	40%	40%	44%	43%	44%	47%	55%	57%	46%	55%	48%
A12R	reported, it feels like the person is being written up,	Previous	44%	37%	40%	43%	42%	38%	45%	52%	41%	45%	55%	49%
	not the problem.	Change	-6%	3%	0%	1%	1%	6%	2%	3%	16%	1%	0%	-1%
	3. Staff worry that mistakes	Most Recent	37%	29%	29%	35%	32%	33%	28%	46%	41%	37%	52%	38%
A16R	they make are kept in their	Previous	25%	27%	30%	34%	31%	30%	34%	44%	31%	36%	49%	36%
	personnel file.	Change	12%	2%	-1%	1%	1%	3%	-6%	2%	10%	1%	3%	2%

Table D-2. Trending: Item-level Average Percent Positive Response by Work Area/Unit (Page 6 of 6)

	-	_						Wo	rk Area/U	nit				
Work Area Patient Sa Grade		Database Year	Anesthe- siology	Emer- gency	ICU	Lab	Medicine	Obstet- rics	Pedi- atrics	Pharmacy	Psych/ Mental Health	Radiology	Rehab- ilitation	Surgery
#	Hospitals	Both Years	42	146	114	164	171	101	62	135	60	161	139	154
# Ros	spondents	Most Recent	293	3,442	4,032	2,926	7,598	2,600	1,356	1,705	1,174	3,275	2,090	5,282
π Λου	spondents	Previous	406	3,120	3,895	2,865	6,220	1,876	1,525	1,560	1,220	3,082	1,941	5,328
		Most Recent	33%	16%	18%	26%	15%	24%	25%	26%	24%	29%	33%	33%
A Excel	llent	Previous	34%	17%	18%	27%	12%	20%	21%	23%	21%	24%	31%	28%
		Change	-1%	-1%	0%	-1%	3%	4%	4%	3%	3%	5%	2%	5%
		Most Recent	40%	44%	50%	52%	49%	45%	45%	46%	39%	48%	47%	45%
B Very	Good	Previous	41%	41%	43%	46%	44%	46%	46%	47%	41%	50%	48%	44%
		Change	-1%	3%	7%	6%	5%	-1%	-1%	-1%	-2%	-2%	-1%	1%
		Most Recent	24%	30%	25%	20%	30%	24%	22%	21%	24%	18%	18%	18%
C Acce	ptable	Previous	18%	29%	28%	21%	33%	26%	26%	22%	26%	20%	17%	20%
		Change	6%	1%	-3%	-1%	-3%	-2%	-4%	-1%	-2%	-2%	1%	-2%
		Most Recent	3%	8%	5%	2%	5%	6%	8%	6%	11%	4%	2%	4%
D Poor		Previous	4%	10%	9%	5%	9%	7%	7%	6%	10%	5%	3%	6%
		Change	-1%	-2%	-4%	-3%	-4%	-1%	1%	0%	1%	-1%	-1%	-2%
		Most Recent	0%	1%	2%	0%	1%	1%	0%	1%	2%	0%	0%	1%
E Failin	ng	Previous	3%	3%	3%	1%	1%	1%	0%	2%	2%	1%	1%	1%
		Change	-3%	-2%	-1%	-1%	0%	0%	0%	-1%	0%	-1%	-1%	0%

Table D-3. Trending: Average Percent Distribution of Work Area/Unit Patient Safety Grades by Work Area/Unit

-	. Average i ere							Area/Unit					
Number of Events Reported by Respondents	Database Year	Anesthe- siology	Emer- gency	ICU	Lab	Medicine	Obstet- rics	Pedi- atrics	Pharm- acy	Psych/ Mental Health	Radiology	Rehab- ilitation	Surgery
# Hospitals	Both Years	42	146	114	164	171	101	62	135	60	161	139	154
# Respondents	Most Recent	293	3,442	4,032	2,926	7,598	2,600	1,356	1,705	1,174	3,275	2,090	5,282
# Respondents	Previous	406	3,120	3,895	2,865	6,220	1,876	1,525	1,560	1,220	3,082	1,941	5,328
	Most Recent	57%	45%	36%	45%	37%	48%	41%	38%	47%	55%	54%	48%
No events	Previous	62%	45%	32%	51%	41%	41%	42%	40%	45%	59%	59%	45%
	Change	-5%	0%	4%	-6%	-4%	7%	-1%	-2%	2%	-4%	-5%	3%
	Most Recent	34%	32%	38%	30%	33%	31%	34%	18%	26%	32%	34%	30%
1 to 2 events	Previous	25%	31%	35%	27%	28%	36%	33%	16%	29%	28%	28%	32%
	Change	9%	1%	3%	3%	5%	-5%	1%	2%	-3%	4%	6%	-2%
	Most Recent	6%	14%	18%	14%	20%	16%	22%	16%	16%	10%	8%	14%
3 to 5 events	Previous	11%	14%	21%	11%	20%	14%	20%	19%	15%	9%	9%	14%
	Change	-5%	0%	-3%	3%	0%	2%	2%	-3%	1%	1%	-1%	0%
	Most Recent	3%	5%	7%	5%	7%	3%	3%	10%	9%	1%	3%	7%
6 to 10 events	Previous	0%	6%	8%	6%	7%	5%	4%	10%	9%	2%	2%	6%
	Change	3%	-1%	-1%	-1%	0%	-2%	-1%	0%	0%	-1%	1%	1%
	Most Recent	0%	2%	1%	3%	2%	2%	1%	8%	2%	1%	0%	1%
11 to 20 events	Previous	1%	3%	3%	2%	3%	3%	1%	6%	1%	1%	1%	2%
	Change	-1%	-1%	-2%	1%	-1%	-1%	0%	2%	1%	0%	-1%	-1%
	Most Recent	0%	2%	1%	3%	1%	0%	1%	11%	1%	1%	0%	0%
21 event reports or more	Previous	1%	1%	1%	2%	2%	0%	0%	9%	1%	0%	0%	1%
	Change	-1%	1%	0%	1%	-1%	0%	1%	2%	0%	1%	0%	-1%

Table D-4. Trending: Average Percent Distribution of Number of Events Reported in the Past 12 Months by Work Area/Unit

Appendix D: Trending Results by Respondent Characteristics

(2) Staff Position

NOTE: The number of hospitals and respondents in each breakout category is shown in each table (e.g., the number of hospitals and respondents by staff position). However, the precise number of hospitals and respondents corresponding to each data cell in a table will vary because hospitals may have omitted a specific survey item and because of individual non-response/missing data.

NOTE 2: Only hospitals that had at least 1 respondent in the particular staff position for both their previous and most recent administrations of the survey are included.

NOTE 3: Respondents who selected "Other" or those who did not answer (missing) are not included.

				,		Staff Positi				
Patient Safety Culture Composites	Database Year	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Diet- ician	Pat Care Asst/Aide/ Care Partner	Pharm- acist	RN/LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Resp, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
# Hospitals	Both Years	187	120	80	158	116	201	165	162	179
# Respondents	Most Recent Previous	4,881 4,608	2,869 2,492	365 371	3,755 3,512	985 909	22,584 20,928	5,948 5,322	2,831 2,675	3,700 3,741
	Most Recent	89%	83%	84%	73%	80%	79%	77%	82%	77%
1. Teamwork Within Units	Previous	84%	81%	81%	69%	73%	78%	73%	81%	76%
	Change	5%	2%	3%	4%	7%	1%	4%	1%	1%
2. Supervisor/Manager	Most Recent	86%	72%	82%	74%	76%	73%	76%	78%	77%
Expectations & Actions	Previous	83%	67%	76%	71%	73%	72%	72%	75%	79%
Promoting Patient Safety	Change	3%	5%	6%	3%	3%	1%	4%	3%	-2%
	Most Recent	84%	72%	72%	72%	72%	71%	70%	71%	71%
3. Org LearningContinuous Improvement	Previous	80%	66%	73%	68%	69%	69%	66%	69%	69%
·	Change	4%	6%	-1%	4%	3%	2%	4%	2%	2%
	Most Recent	83%	69%	75%	74%	67%	64%	72%	71%	76%
4. Management Support for Patient Safety	Previous	80%	65%	74%	69%	64%	63%	70%	67%	73%
	Change	3%	4%	1%	5%	3%	1%	2%	4%	3%
	Most Recent	73%	62%	68%	62%	60%	60%	70%	68%	66%
5. Overall Perceptions of Patient Safety	Previous	70%	60%	66%	59%	58%	57%	68%	67%	67%
	Change	3%	2%	2%	3%	2%	3%	2%	1%	-1%
6 Foodbook 9 Communication	Most Recent	76%	60%	71%	63%	63%	58%	63%	65%	65%
6. Feedback & Communication About Error	Previous	73%	57%	67%	60%	59%	57%	60%	63%	67%
	Change	3%	3%	4%	3%	4%	1%	3%	2%	-2%

Table D-5. Trending: Composite-level Average Percent Positive Response by Staff Position (Page 1 of 2)

						Staff Posit				
Patient Safety Culture Composites	Database Year	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Diet- ician	Pat Care Asst/Aide/ Care Partner	Pharm- acist	RN/LVN/L PN	Technician (EKG, Lab, Radiology)	Therapist (Respir, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
# Hospitals	Both Years	187	120	80	158	116	201	165	162	179
# Respondents	Most Recent Previous	4,881 4,608	2,869 2,492	365 371	3,755 3,512	985 909	22,584 20,928	5,948 5,322	2,831 2,675	3,700 3,741
	Most Recent	76%	64%	64%	55%	69%	60%	61%	66%	60%
7. Communication Openness	Previous	72%	62%	64%	56%	67%	60%	59%	65%	61%
	Change	4%	2%	0%	-1%	2%	0%	2%	1%	-1%
	Most Recent	67%	56%	60%	65%	52%	62%	60%	54%	67%
8. Frequency of Events Reported	Previous	63%	54%	52%	61%	47%	59%	59%	55%	63%
	Change	4%	2%	8%	4%	5%	3%	1%	-1%	4%
	Most Recent	64%	58%	60%	58%	54%	56%	54%	62%	59%
9. Teamwork Across Units	Previous	60%	55%	63%	58%	51%	53%	54%	57%	58%
	Change	4%	3%	-3%	0%	3%	3%	0%	5%	1%
	Most Recent	64%	54%	56%	50%	56%	56%	57%	60%	53%
10. Staffing	Previous	60%	53%	58%	47%	50%	55%	54%	57%	52%
	Change	4%	1%	-2%	3%	6%	1%	3%	3%	1%
	Most Recent	47%	44%	39%	49%	28%	49%	39%	41%	48%
11. Handoffs & Transitions	Previous	46%	40%	42%	49%	28%	47%	39%	40%	46%
	Change	1%	4%	-3%	0%	0%	2%	0%	1%	2%
	Most Recent	63%	40%	47%	37%	60%	44%	42%	52%	39%
12. Nonpunitive Response to Error	Previous	59%	41%	43%	34%	55%	42%	40%	49%	41%
	Change	4%	-1%	4%	3%	5%	2%	2%	3%	-2%

Table D-5. Trending: Composite-level Average Percent Positive Response by Staff Position (Page 2 of 2)

							Staff Posi	tion			
Item	Patient Safety Culture Composites	Database Year	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	# Hospitals	Both Years	187	120	80	158	116	201	165	162	179
	#Respondents	Most Recent Previous	4,881 4,608	2,869 2,492	365 371	3,755 3,512	985 909	22,584 20,928	5,948 5,322	2,831 2,675	3,700 3,741
1.	Teamwork Within Units										·
A1	1. People support one another in this unit.	Most Recent Previous Change	94% 89% 5%	89% 87% 2%	88% 85% 3%	77% 74% 3%	87% 80% 7%	86% 83% 3%	82% 77% 5%	88% 85% 3%	83% 81% 2%
A3	2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	Most Recent Previous Change	94% 90% 4%	86% 86% 0%	88% 85% 3%	78% 77% 1%	84% 80% 4%	87% 85% 2%	85% 82% 3%	85% 85% 0%	84% 82% 2%
A4	3. In this unit, people treat each other with respect.	Most Recent Previous Change	89% 83% 6%	86% 85% 1%	86% 81% 5%	72% 66% 6%	81% 71% 10%	77% 76% 1%	74% 71% 3%	82% 81% 1%	73% 74% -1%
A11	4. When one area in this unit gets really busy, others help out.	Most Recent Previous Change	79% 73% 6%	69% 67% 2%	74% 72% 2%	64% 60% 4%	67% 61% 6%	67% 66% 1%	67% 64% 3%	74% 72% 2%	69% 68% 1%
2.	Supervisor/Manager Expect	ations & Action	s Promoti	ng Patient S	Safety						
B1	 My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures. 	Most Recent Previous Change	84% 78% 6%	71% 60% 11%	81% 78% 3%	72% 68% 4%	70% 65% 5%	69% 68% 1%	70% 66% 4%	76% 70% 6%	74% 72% 2%
B2	2. My supv/mgr seriously considers staff suggestions for improving patient safety.	Most Recent Previous Change	89% 86% 3%	76% 70% 6%	85% 77% 8%	77% 70% 7%	76% 75% 1%	74% 73% 1%	76% 73% 3%	82% 77% 5%	76% 79% -3%
B3R	 Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts. 	Most Recent Previous Change	85% 81% 4%	67% 66% 1%	76% 68% 8%	74% 71% 3%	78% 75% 3%	72% 72% 0%	78% 74% 4%	77% 74% 3%	78% 79% -1%
B4R	4. My supv/mgr overlooks patient safety problems that happen over and over.	Most Recent Previous Change	87% 81% 6%	74% 71% 3%	85% 74% 11%	76% 71% 5%	80% 73% 7%	75% 73% 2%	79% 73% 6%	77% 75% 2%	78% 79% -1%

Table D-6. Trending: Item-level Average Percent Positive Response by Staff Position (Page 1 of 6)

							Staff Pos	ition			
Item	Patient Safety Culture Composites	Database Year	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	# Hospitals	Both Years	187	120	80	158	116	201	165	162	179
	# Respondents	Most Recent Previous	4,881 4,608	2,869 2,492	365 371	3,755 3,512	985 909	22,584 20,928	5,948 5,322	2,831 2,675	3,700 3,741
3.	Organizational Learning— C	Continuous Imp	rovemen	t							
	1. We are actively doing	Most Recent	90%	81%	84%	86%	83%	83%	81%	83%	83%
A6	things to improve patient	Previous	85%	79%	81%	80%	83%	81%	77%	80%	80%
	safety.	Change	5%	2%	3%	6%	0%	2%	4%	3%	3%
		Most Recent	83%	68%	65%	60%	72%	61%	65%	61%	62%
A9	Mistakes have led to positive changes here.	Previous	78%	62%	66%	56%	68%	60%	59%	58%	59%
	positive enanges here.	Change	5%	6%	-1%	4%	4%	1%	6%	3%	3%
	3. After we make changes	Most Recent	79%	65%	68%	71%	61%	70%	66%	68%	70%
A13	to improve patient safety, we evaluate their	Previous	75%	59%	71%	68%	57%	65%	62%	68%	69%
	effectiveness.	Change	4%	6%	-3%	3%	4%	5%	4%	0%	1%
4.	Management Support for Pa	tient Safety									
	1. Hospital mgmt provides a	Most Recent	90%	75%	84%	82%	73%	73%	83%	81%	85%
F1	work climate that promotes	Previous	88%	76%	86%	78%	68%	73%	79%	79%	83%
	patient safety.	Change	2%	-1%	-2%	4%	5%	0%	4%	2%	2%
	2. The actions of hospital	Most Recent	85%	71%	81%	78%	68%	66%	73%	73%	79%
F8	mgmt show that patient	Previous	80%	63%	76%	73%	67%	63%	71%	68%	75%
	safety is a top priority.	Change	5%	8%	5%	5%	1%	3%	2%	5%	4%
	3. Hospital mgmt seems	Most Recent	74%	60%	60%	60%	60%	55%	59%	60%	63%
F9R	interested in patient safety	Previous	72%	56%	59%	56%	58%	54%	58%	54%	62%
	only after an adverse event happens.	Change	2%	4%	1%	4%	2%	1%	1%	6%	1%

Table D-6. Trending: Item-level Average Percent Positive Response by Staff Position (Page 2 of 6)

							Staff Pos	ition			
Item	Patient Safety Culture Composites	Database Year	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	# Hospitals	Both Years	187	120	80	158	116	201	165	162	179
	# Respondents	Most Recent Previous	4,881 4,608	2,869 2,492	365 371	3,755 3,512	985 909	22,584 20,928	5,948 5,322	2,831 2,675	3,700 3,741
5.	Overall Perceptions of Pati	ent Safety									
	1. It is just by chance that	Most Recent	72%	58%	64%	55%	59%	59%	63%	66%	55%
A10R	more serious mistakes	Previous	70%	62%	67%	52%	55%	58%	61%	65%	58%
	don't happen around here.	Change	2%	-4%	-3%	3%	4%	1%	2%	1%	-3%
	2. Patient safety is never	Most Recent	73%	63%	63%	64%	55%	57%	72%	67%	72%
A15	sacrificed to get more work	Previous	69%	59%	63%	62%	53%	54%	68%	68%	70%
	done.	Change	4%	4%	0%	2%	2%	3%	4%	-1%	2%
		Most Recent	68%	59%	66%	59%	55%	57%	69%	65%	64%
A17R	We have patient safety problems in this unit.	Previous	67%	55%	60%	55%	55%	55%	69%	65%	67%
		Change	1%	4%	6%	4%	0%	2%	0%	0%	-3%
	4. Our procedures and	Most Recent	79%	66%	78%	69%	71%	67%	76%	74%	74%
A18	systems are good at	Previous	75%	62%	73%	66%	67%	63%	73%	70%	71%
	preventing errors from happening.	Change	4%	4%	5%	3%	4%	4%	3%	4%	3%
6.	Feedback and Communicat	tion About Erro	or								
	1. We are given feedback	Most Recent	65%	52%	64%	55%	50%	50%	51%	59%	53%
C1	about changes put into	Previous	63%	49%	60%	53%	49%	49%	48%	54%	58%
	place based on event reports.	Change	2%	3%	4%	2%	1%	1%	3%	5%	-5%
	2. We are informed about	Most Recent	78%	59%	69%	65%	67%	57%	68%	65%	69%
C3	errors that happen in this	Previous	74%	57%	65%	64%	60%	57%	66%	62%	69%
	unit.	Change	4%	2%	4%	1%	7%	0%	2%	3%	0%
	3. In this unit, we discuss	Most Recent	85%	69%	80%	69%	71%	66%	69%	73%	73%
C5	ways to prevent errors from	Previous	81%	64%	74%	65%	66%	65%	67%	72%	72%
	happening again.	Change	4%	5%	6%	4%	5%	1%	2%	1%	1%

Table D-6. Trending: Item-level Average Percent Positive Response by Staff Position (Page 3 of 6)

	-	-					Staff Pos	ition			
ltem	Patient Safety Culture Composites	Database Year	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	# Hospitals	Both Years	187	120	80	158	116	201	165	162	179
	# Respondents	Most Recent Previous	4,881 4,608	2,869 2,492	365 371	3,755 3,512	985 909	22,584 20,928	5,948 5,322	2,831 2,675	3,700 3,741
7.	Communication Openness										
	1. Staff will freely speak up	Most Recent	84%	72%	75%	71%	78%	75%	76%	80%	75%
C2	if they see something that may negatively affect	Previous	81%	72%	77%	73%	76%	74%	73%	80%	74%
	patient care.	Change	3%	0%	-2%	-2%	2%	1%	3%	0%	1%
	2. Staff feel free to question	Most Recent	69%	56%	56%	40%	60%	44%	45%	52%	43%
C4	the decisions or actions of	Previous	65%	53%	56%	39%	57%	45%	42%	50%	47%
	those with more authority.	Change	4%	3%	0%	1%	3%	-1%	3%	2%	-4%
	3. Staff are afraid to ask	Most Recent	75%	64%	62%	56%	71%	61%	63%	67%	61%
C6R	questions when something	Previous	70%	61%	58%	55%	69%	61%	61%	65%	61%
	does not seem right.	Change	5%	3%	4%	1%	2%	0%	2%	2%	0%
8.	Frequency of Events Report	ted									
	1. When a mistake is made,	Most Recent	59%	48%	57%	63%	37%	49%	52%	48%	64%
D1	but is <u>caught and corrected</u> before affecting the patient,	Previous	55%	46%	47%	58%	32%	46%	51%	48%	60%
	how often is this reported?	Change	4%	2%	10%	5%	5%	3%	1%	0%	4%
	2. When a mistake is made,	Most Recent	64%	49%	52%	60%	50%	60%	54%	47%	62%
D2	but has <u>no potential to harm</u> the patient, how often is this	Previous	59%	50%	46%	56%	41%	57%	54%	48%	58%
	reported?	Change	5%	-1%	6%	4%	9%	3%	0%	-1%	4%
	3. When a mistake is made	Most Recent	79%	70%	69%	73%	69%	76%	74%	66%	75%
D3	that <u>could harm the patient</u> , but does not, how often is	Previous	75%	65%	64%	69%	67%	75%	71%	68%	72%
	this reported?	Change	4%	5%	5%	4%	2%	1%	3%	-2%	3%

Table D-6. Trending: Item-level Average Percent Positive Response by Staff Position (Page 4 of 6)

							Staff Pos	ition			
ltem	Patient Safety Culture Composites	Database Year	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	# Hospitals	Both Years	187	120	80	158	116	201	165	162	179
	# Respondents	Most Recent Previous	4,881 4,608	2,869 2,492	365 371	3,755 3,512	985 909	22,584 20,928	5,948 5,322	2,831 2,675	3,700 3,741
9.	Teamwork Across Units							·	· · ·		
	1. Hospital units do not	Most Recent	53%	46%	49%	44%	42%	43%	42%	50%	47%
F2R	coordinate well with each	Previous	50%	42%	51%	47%	39%	42%	42%	47%	45%
	other.	Change	3%	4%	-2%	-3%	3%	1%	0%	3%	2%
	2. There is good	Most Recent	66%	57%	61%	60%	53%	56%	56%	64%	61%
F4	cooperation among hospital units that need to work	Previous	61%	55%	64%	60%	53%	54%	56%	58%	60%
	together.	Change	5%	2%	-3%	0%	0%	2%	0%	6%	1%
	3. It is often unpleasant to	Most Recent	63%	61%	61%	57%	57%	59%	53%	65%	56%
F6R	work with staff from other	Previous	59%	59%	65%	58%	55%	57%	53%	59%	56%
	hospital units.	Change	4%	2%	-4%	-1%	2%	2%	0%	6%	0%
	4. Hospital units work well	Most Recent	75%	65%	70%	71%	63%	64%	66%	69%	72%
F10	together to provide the best	Previous	72%	65%	72%	69%	57%	62%	64%	64%	70%
	care for patients.	Change	3%	0%	-2%	2%	6%	2%	2%	5%	2%
10.	Staffing		•								
	1. We have enough staff to	Most Recent	68%	54%	60%	43%	48%	53%	54%	55%	49%
A2	handle the workload.	Previous	67%	53%	63%	42%	44%	52%	53%	52%	48%
		Change	1%	1%	-3%	1%	4%	1%	1%	3%	1%
	2. Staff in this unit work	Most Recent	60%	50%	53%	45%	58%	54%	54%	57%	48%
A5R	longer hours than is best for patient care.	Previous Change	54% 6%	49% 1%	53%	44%	57% 1%	54% 0%	53% 1%	55% 2%	51% -3%
	3. We use more	Most Recent	69%	<u> </u>	0% 55%	<u>1%</u> 61%	<u> </u>	<u> </u>	68%	<u> </u>	<u>-3%</u> 60%
A7R	agency/temporary staff than	Previous	69% 65%	58%	55% 59%	58%	69% 57%	69% 67%	64%	69%	60% 59%
	is best for patient care.	Change	4%	3%	-4%	3%	57% 12%	2%	4%	2%	59% 1%
	4. We work in "crisis mode"	Most Recent	59%	51%	55%	49%	47%	47%	51%	56%	53%
A14R		Previous	54%	53%	54%	44%	43%	47%	47%	54%	51%
	quickly.	Change	5%	-2%	1%	5%	4%	0%	4%	2%	2%

Table D-6. Trending: Item-level Average Percent Positive Response by Staff Position (Page 5 of 6)

							Staff Pos	ition			
ltem	Patient Safety Culture Composites	Database Year	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	# Hospitals	Both Years	187	120	80	158	116	201	165	162	179
	# Respondents	Most Recent Previous	4,881 4,608	2,869 2,492	365 371	3,755 3,512	985 909	22,584 20,928	5,948 5,322	2,831 2,675	3,700 3,741
11.	Handoffs & Transitions										
	1. Things "fall between the	Most Recent	43%	43%	34%	47%	25%	45%	34%	36%	47%
F3R	cracks" when transferring patients from one unit to	Previous	41%	38%	37%	48%	23%	42%	35%	38%	45%
	another.	Change	2%	5%	-3%	-1%	2%	3%	-1%	-2%	2%
	2. Important patient care	Most Recent	50%	47%	44%	55%	30%	55%	44%	44%	53%
F5R	information is often lost	Previous	47%	45%	47%	55%	33%	53%	44%	46%	50%
	during shift changes.	Change	3%	2%	-3%	0%	-3%	2%	0%	-2%	3%
	3. Problems often occur in	Most Recent	46%	43%	41%	43%	27%	46%	38%	43%	46%
F7R	the exchange of	Previous	45%	38%	45%	44%	26%	44%	37%	41%	42%
	information across hospital units.	Change	1%	5%	-4%	-1%	1%	2%	1%	2%	4%
	4. Shift changes are	Most Recent	49%	41%	38%	51%	29%	51%	40%	40%	48%
F11R	problematic for patients in	Previous	49%	37%	43%	48%	30%	49%	41%	38%	47%
	this hospital.	Change	0%	4%	-5%	3%	-1%	2%	-1%	2%	1%
12.	Nonpunitive Response to E	Frror									
	1. Staff feel like their	Most Recent	68%	47%	53%	44%	63%	51%	50%	59%	45%
A8R	mistakes are held against	Previous	65%	49%	50%	41%	58%	49%	46%	58%	50%
	them.	Change	3%	-2%	3%	3%	5%	2%	4%	1%	-5%
	2. When an event is	Most Recent	69%	43%	50%	38%	64%	47%	43%	53%	37%
A12R	reported, it feels like the person is being written up,	Previous	65%	43%	43%	34%	58%	44%	41%	47%	40%
	not the problem.	Change	4%	0%	7%	4%	6%	3%	2%	6%	-3%
	3. Staff worry that mistakes	Most Recent	52%	30%	37%	28%	53%	35%	35%	44%	33%
A16R	they make are kept in their	Previous	47%	31%	38%	26%	47%	33%	33%	41%	32%
	personnel file.	Change	5%	-1%	-1%	2%	6%	2%	2%	3%	1%

Table D-6. Trending: Item-level Average Percent Positive Response by Staff Position (Page 6 of 6)

0	U U	Staff Position								
Work Area/Unit Patient Safety Grade	Database Year	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharmacist	RN/LVN/LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
# Hospitals	Both Years	187	120	80	158	116	201	165	162	179
# Respondents	Most Recent	4,881	2,869	365	3,755	985	22,584	5,948	2,831	3,700
# Nespondents	Previous	4,608	2,492	371	3,512	909	20,928	5,322	2,675	3,741
	Most Recent	32%	24%	27%	24%	24%	20%	26%	28%	28%
A Excellent	Previous	28%	19%	28%	20%	19%	17%	26%	25%	24%
	Change	4%	5%	-1%	4%	5%	3%	0%	3%	4%
	Most Recent	51%	44%	50%	44%	42%	47%	50%	46%	47%
B Very Good	Previous	50%	45%	46%	48%	44%	45%	45%	48%	50%
	Change	1%	-1%	4%	-4%	-2%	2%	5%	-2%	-3%
	Most Recent	15%	26%	21%	24%	24%	26%	21%	21%	21%
C Acceptable	Previous	18%	27%	22%	26%	27%	28%	22%	22%	22%
	Change	-3%	-1%	-1%	-2%	-3%	-2%	-1%	-1%	-1%
	Most Recent	2%	6%	2%	6%	8%	6%	3%	4%	3%
D Poor	Previous	3%	7%	3%	5%	8%	8%	6%	4%	4%
	Change	-1%	-1%	-1%	1%	0%	-2%	-3%	0%	-1%
	Most Recent	0%	0%	0%	2%	1%	1%	0%	1%	1%
E Failing	Previous	1%	2%	1%	1%	2%	2%	1%	1%	1%
	Change	-1%	-2%	-1%	1%	-1%	-1%	-1%	0%	0%

Table D-7. Trending: Average Percent Distribution of Work Area/Unit Patient Safety Grades by Staff Position

-	-					Staff Pos	ition			
Number of Events Reported by Respondents	Database Year	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharmacist	RN/LVN/LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
# Hospitals	Both Years	187	120	80	158	116	201	165	162	179
# Doonondonto	Most Recent	4,881	2,869	365	3,755	985	22,584	5,948	2,831	3,700
# Respondents	Previous	4,608	2,492	371	3,512	909	20,928	5,322	2,675	3,741
	Most Recent	46%	61%	78%	75%	21%	29%	54%	58%	77%
No events	Previous	48%	65%	79%	73%	24%	30%	56%	58%	79%
	Change	-2%	-4%	-1%	2%	-3%	-1%	-2%	0%	-2%
	Most Recent	24%	26%	16%	18%	22%	38%	31%	30%	18%
1 to 2 events	Previous	23%	23%	16%	20%	18%	37%	27%	31%	16%
	Change	1%	3%	0%	-2%	4%	1%	4%	-1%	2%
	Most Recent	15%	8%	3%	5%	20%	21%	11%	8%	4%
3 to 5 events	Previous	15%	7%	4%	5%	21%	21%	11%	8%	3%
	Change	0%	1%	-1%	0%	-1%	0%	0%	0%	1%
	Most Recent	9%	3%	2%	2%	12%	7%	3%	3%	1%
6 to 10 events	Previous	7%	2%	2%	1%	15%	8%	4%	2%	1%
	Change	2%	1%	0%	1%	-3%	-1%	-1%	1%	0%
	Most Recent	4%	0%	1%	0%	13%	3%	1%	1%	0%
11 to 20 events	Previous	5%	2%	0%	0%	10%	3%	2%	0%	0%
	Change	-1%	-2%	1%	0%	3%	0%	-1%	1%	0%
04	Most Recent	3%	2%	0%	0%	12%	1%	1%	1%	0%
21 event reports or more	Previous	2%	1%	0%	0%	13%	1%	1%	0%	0%
	Change	1%	1%	0%	0%	-1%	0%	0%	1%	0%

 Table D-8. Trending: Average Percent Distribution of Number of Events Reported in the Past 12 Months by Staff Position

Appendix D: Trending Results by Respondent Characteristics

(3) Interaction with Patients

NOTE: The number of hospitals and respondents in each breakout category is shown in each table (e.g., the number of hospitals and respondents by interaction with patients). However, the precise number of hospitals and respondents corresponding to each data cell in a table will vary because hospitals may have omitted a specific survey item and because of individual non-response/missing data.

NOTE 2: Only hospitals that had at least 1 respondent in the response categories (WITH or WITHOUT direct interaction with patients) for both their previous and most recent administrations of the survey are included.

NOTE 3: Respondents who did not answer (missing) are not included.

		Interaction v	vith Patients
		WITH	WITHOUT
Patient Safety Culture Composites	Database Year	direct interaction	direct interaction
# Hospitals	Both Years	203	198
# Respondents	Most Recent	48,941	15,100
	Previous	7,300	2,079
	Most Recent	79%	81%
1. Teamwork Within Units	Previous	77%	78%
	Change	2%	3%
	Most Recent	75%	77%
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	Previous	74%	76%
	Change	1%	1%
	Most Recent	72%	73%
3. Org LearningContinuous Improvement	Previous	69%	71%
	Change	3%	2%
	Most Recent	70%	76%
4. Management Support for Patient Safety	Previous	67%	74%
	Change	3%	2%
	Most Recent	65%	66%
5. Overall Perceptions of Patient Safety	Previous	62%	64%
	Change	3%	2%
	Most Recent	62%	67%
6. Feedback & Communication About Error	Previous	60%	65%
	Change	2%	2%

Table D-9. Trending: Composite-level Average Percent Positive Response by Interaction with Patients (Page 1 of 2)

		Interaction with Patients			
		WITH	WITHOUT		
Patient Safety Culture Composites	Database Year	direct interaction	direct interaction		
# Hospitals	Both Years	203	198		
# Respondents	Most Recent	48,941	15,100		
	Previous	7,300	2,079		
	Most Recent	61%	64%		
7. Communication Openness	Previous	60%	63%		
	Change	1%	1%		
	Most Recent	61%	62%		
8. Frequency of Events Reported	Previous	59%	60%		
	Change	2%	2%		
	Most Recent	57%	59%		
9. Teamwork Across Units	Previous	56%	57%		
	Change	1%	2%		
	Most Recent	56%	54%		
10. Staffing	Previous	55%	50%		
	Change	1%	4%		
	Most Recent	47%	40%		
11. Handoffs & Transitions	Previous	46%	38%		
	Change	1%	2%		
	Most Recent	44%	49%		
12. Nonpunitive Response to Error	Previous	42%	45%		
	Change	2%	4%		

Table D-9. Trending: Composite-level Average Percent Positive Response by Interaction with Patients (Page 2 of 2)

	5-10. Trending. Reiniever Average Fercent Fositive Response	-	vith Patients	
			WITH	WITHOUT
ltem	Survey Items By Composite	Database Year	direct interaction	direct interaction
	# Hospitals	Both Years	203	198
	# Respondents	Most Recent Previous	48,941 7,300	15,100 2,079
1.	Teamwork Within Units			
		Most Recent	85%	87%
A1	1. People support one another in this unit.	Previous	82%	83%
		Change	3%	4%
		Most Recent	86%	87%
A3	2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	Previous	84%	84%
	together as a team to get the work done.	Change	2%	3%
		Most Recent	77%	81%
A4	3. In this unit, people treat each other with respect.	Previous	75%	77%
		Change	2%	4%
		Most Recent	69%	71%
A11	4. When one area in this unit gets really busy, others help out.	Previous	66%	67%
		Change	3%	4%
2.	Supervisor/Manager Expectations & Actions Promoting Pati	ent Safety		
		Most Recent	71%	75%
B1	1. My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures.	Previous	69%	72%
	done according to established patient safety procedures.	Change	2%	3%
	2 My annulate considere staff another for	Most Recent	76%	79%
B2	2. My supv/mgr seriously considers staff suggestions for improving patient safety.	Previous	74%	76%
	improving patient safety.	Change	2%	3%
		Most Recent	75%	77%
B3R	3. Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts.	Previous	73%	75%
		Change	2%	2%
	4. My our /por overleake petient affett making that have	Most Recent	77%	78%
B4R	My supv/mgr overlooks patient safety problems that happen over and over.	Previous	75%	74%
		Change	2%	4%

Table D-10. Trending: Item-level Average Percent Positive Response by Interaction with Patients (Page 1 of 6)

		-			
			Interaction v	vith Patients	
			WITH	WITHOUT	
Item	Survey Items By Composite	Database Year	direct interaction	direct interaction	
	# Hospitals	Both Years	203	198	
	# Respondents	Most Recent	48,941	15,100	
	,	Previous	7,300	2,079	
3.	Organizational Learning— Continuous Improvement				
		Most Recent	83%	81%	
A6	1. We are actively doing things to improve patient safety.	Previous	80%	79%	
		Change	3%	2%	
		Most Recent	63%	68%	
A9	2. Mistakes have led to positive changes here.	Previous	60%	67%	
		Change	3%	1%	
		Most Recent	69%	69%	
A13	3. After we make changes to improve patient safety, we evaluate their effectiveness.	Previous	66%	66%	
		Change	3%	3%	
4.	Management Support for Patient Safety				
	4. I have the low most more than a surely alter at a thirty more stars a strike the	Most Recent	79%	85%	
F1	1. Hospital mgmt provides a work climate that promotes patient safety.	Previous	77%	84%	
	Survey.	Change	2%	1%	
		Most Recent	71%	79%	
F8	2. The actions of hospital mgmt show that patient safety is a top priority.	Previous	68%	76%	
	phoney.	Change	3%	3%	
	O the sticle sector is the state is a sticle state of the	Most Recent	59%	66%	
F9R	3. Hospital mgmt seems interested in patient safety only after an adverse event happens.	Previous	57%	63%	
	an auverse event nappens.	Change	2%	3%	

 Table D-10. Trending: Item-level Average Percent Positive Response by Interaction with Patients (Page 2 of 6)

		-			
			Interaction w	vith Patients	
			WITH	WITHOUT	
ltem	Survey Items By Composite	Database Year	direct interaction	direct interaction	
	# Hospitals	Both Years	203	198	
	# Respondents	Most Recent	48,941	15,100	
		Previous	7,300	2,079	
5.	Overall Perceptions of Patient Safety		-		
	1. It is just by shanes that more serious mistokes den't bennen	Most Recent	61%	60%	
A10R	1. It is just by chance that more serious mistakes don't happen around here.	Previous	59%	59%	
		Change	2%	1%	
		Most Recent	65%	68%	
A15	2. Patient safety is never sacrificed to get more work done.	Previous	62%	65%	
		Change	3%	3%	
		Most Recent	62%	64%	
A17R	3. We have patient safety problems in this unit.	Previous	61%	62%	
		Change	1%	2%	
		Most Recent	71%	74%	
A18	4. Our procedures and systems are good at preventing errors from happening.	Previous	67%	69%	
	nom napponing.	Change	4%	5%	
6.	Feedback and Communication About Error				
		Most Recent	52%	56%	
C1	1. We are given feedback about changes put into place based on event reports.	Previous	51%	54%	
		Change	1%	2%	
		Most Recent	63%	70%	
C3	2. We are informed about errors that happen in this unit.	Previous	62%	68%	
		Change	1%	2%	
	3. In this unit, we discuss ways to prevent errors from	Most Recent	70%	75%	
C5	happening again.	Previous	68%	73%	
		Change	2%	2%	

 Table D-10. Trending: Item-level Average Percent Positive Response by Interaction with Patients (Page 3 of 6)

			Interaction v	vith Patients
			WITH	WITHOUT
ltem	Survey Items By Composite	Database Year	direct interaction	direct interaction
	# Hospitals	Both Years	203	198
	# Respondents	Most Recent Previous	48,941 7,300	15,100 2,079
7.	Communication Openness		· · · · · · · · · · · · · · · · · · ·	
	A District the first second	Most Recent	75%	76%
C2	1. Staff will freely speak up if they see something that may negatively affect patient care.	Previous	74%	74%
		Change	1%	2%
	Q. Chaff feel free to superfine the decisions on estimate of these	Most Recent	46%	51%
C4	2. Staff feel free to question the decisions or actions of those with more authority.	Previous	46%	50%
	with more autionty.	Change	0%	1%
	2. Otatt and attraid to ach associate when a second him does not	Most Recent	62%	65%
C6R	3. Staff are afraid to ask questions when something does not seem right.	Previous	61%	63%
	ocon right.	Change	1%	2%
8.	Frequency of Events Reported			
	1 When a mintaly is made, but is caught and corrected before	Most Recent	53%	57%
D1	1. When a mistake is made, but is <u>caught and corrected before</u> <u>affecting the patient</u> , how often is this reported?	Previous	51%	55%
	anoding the patient, now often to this reported.	Change	2%	2%
	• Will be a substated a best been as a startistic been the	Most Recent	57%	56%
D2	2. When a mistake is made, but has <u>no potential to harm the</u> patient, how often is this reported?	Previous	55%	55%
		Change	2%	1%
	3. When a mistake is made that could harm the patient, but	Most Recent	74%	73%
D3	does not, how often is this reported?	Previous	72%	70%
		Change	2%	3%

 Table D-10. Trending: Item-level Average Percent Positive Response by Interaction with Patients (Page 4 of 6)

			Interaction with Patients		
			WITH	WITHOUT	
ltem	Survey Items By Composite	Database Year	direct interaction	direct interaction	
	# Hospitals	Both Years	203	198	
	# Respondents	Most Recent	48,941	15,100	
•	•	Previous	7,300	2,079	
9.	Teamwork Across Units				
		Most Recent	45%	49%	
F2R	1. Hospital units do not coordinate well with each other.	Previous	44%	46%	
		Change	1%	3%	
	2. There is good econoration among boasital units that need to	Most Recent	59%	60%	
F4	2. There is good cooperation among hospital units that need to work together.	Previous	57%	59%	
	work together.	Change	2%	1%	
		Most Recent	59%	58%	
F6R	3. It is often unpleasant to work with staff from other hospital units.	Previous	57%	54%	
	unts.	Change	2%	4%	
		Most Recent	67%	71%	
F10	4. Hospital units work well together to provide the best care for patients.	Previous	65%	68%	
	patients.	Change	2%	3%	
10.	Staffing	-			
		Most Recent	53%	57%	
A2	1. We have enough staff to handle the workload.	Previous	52%	55%	
	-	Change	1%	2%	
		Most Recent	53%	50%	
A5R	2. Staff in this unit work longer hours than is best for patient	Previous	52%	46%	
	care.	Change	1%	4%	
		Most Recent	67%	58%	
A7R	3. We use more agency/temporary staff than is best for patient	Previous	65%	54%	
	care.	Change	2%	4%	
		Most Recent	50%	51%	
A14R	4. We work in "crisis mode" trying to do too much, too quickly.	Previous	49%	45%	
, .		Change	1%	6%	
	item's survey location is shown to the left. An "R" indicates a negatively worde	-			

Table D-10. Trending: Item-level Average Percent Positive Response by Interaction with Patients (Page 5 of 6)

5 5 1				
		Interaction with Patients		
		WITH	WITHOUT	
Survey Items By Composite	Database Year	direct interaction	direct interaction	
# Hospitals	Both Years	203	198	
#Respondents	Most Recent	48,941	15,100	
,	Previous	7,300	2,079	
Handoffs & Transitions				
1 Things "fall between the cracks" when transferring patients	Most Recent	44%	37%	
	Previous	43%	35%	
	Change	1%	2%	
2. Important potient core information is often last during shift	Most Recent	52%	44%	
· · · ·	Previous	51%	41%	
ondinges.	Change	1%	3%	
	Most Recent	44%	41%	
	Previous	43%	36%	
nospital units.	Change	1%	5%	
	Most Recent	47%	40%	
4. Shift changes are problematic for patients in this hospital.	Previous	46%	39%	
	Change	1%	1%	
Nonpunitive Response to Error				
	Most Recent	51%	56%	
1. Staff feel like their mistakes are held against them.	Previous	50%	52%	
	Change	1%	4%	
	Most Recent	46%	51%	
	Previous	43%	48%	
	Change	3%	3%	
	Most Recent	36%	39%	
3. Staff worry that mistakes they make are kept in their personnel file.	Previous	34%	35%	
	 # Hospitals #Respondents Handoffs & Transitions Things "fall between the cracks" when transferring patients from one unit to another. Important patient care information is often lost during shift changes. Problems often occur in the exchange of information across hospital units. Shift changes are problematic for patients in this hospital. Nonpunitive Response to Error Staff feel like their mistakes are held against them. When an event is reported, it feels like the person is being written up, not the problem. 3. Staff worry that mistakes they make are kept in their	# Hospitals Both Years #Respondents Most Recent Previous Handoffs & Transitions Most Recent Previous 1. Things "fall between the cracks" when transferring patients from one unit to another. Most Recent Previous Change 2. Important patient care information is often lost during shift changes. Most Recent Previous Change 3. Problems often occur in the exchange of information across hospital units. Most Recent Previous Change 4. Shift changes are problematic for patients in this hospital. Most Recent Previous Change 1. Staff feel like their mistakes are held against them. Most Recent Previous Change 2. When an event is reported, it feels like the person is being written up, not the problem. Most Recent Previous Change 3. Staff worry that mistakes they make are kept in their Most Recent Previous	Survey Items By CompositeWITH direct interaction# HospitalsBoth Years203#RespondentsMost Recent48,941 PreviousPrevious7,300Handoffs & TransitionsMost Recent44% Previous1. Things "fall between the cracks" when transferring patients from one unit to another.Most Recent44% Previous2. Important patient care information is often lost during shift changes.Most Recent52% Previous3. Problems often occur in the exchange of information across hospital units.Most Recent44% Previous4. Shift changes are problematic for patients in this hospital.Most Recent44% Previous1. Staff feel like their mistakes are held against them.Most Recent51% Previous2. When an event is reported, it feels like the person is being written up, not the problem.Most Recent51% Previous3. Staff worry that mistakes they make are kept in theirMost Recent36% Previous3. Staff worry that mistakes they make are kept in theirMost Recent36%	

Table D-10. Trending: Item-level Average Percent Positive Response by Interaction with Patients (Page 6 of 6)

			Interaction with Patients			
-	rk Area/Unit ient Safety Grade	Database Year	WITH direct interaction	WITHOUT direct interaction		
	# Hospitals	Both Years	203	198		
	# Respondents	Most Recent Previous	48,941 7,300	15,100 2,079		
		Most Recent	24%	29%		
Α	Excellent	Previous	22%	25%		
		Change	2%	4%		
		Most Recent	47%	48%		
в	Very Good	Previous	46%	48%		
		Change	1%	0%		
		Most Recent	23%	20%		
С	Acceptable	Previous	25%	22%		
		Change	-2%	-2%		
		Most Recent	5%	3%		
D	Poor	Previous	6%	4%		
		Change	-1%	-1%		
		Most Recent	1%	1%		
Е	Failing	Previous	1%	1%		
		Change	0%	0%		

 Table D-11. Trending: Average Percent Distribution of Work Area/Unit Patient Safety Grade by

 Interaction with Patients

		Interaction with Patients			
Number of Events Reported by Respondents	Database Year	WITH direct interaction	WITHOUT direct interaction		
# Hospitals	Both Years	203	198		
# Respondents	Most Recent Previous	48,941 7,300	15,100 2,079		
	Most Recent	48%	69%		
No events	Previous	49%	71%		
	Change	-1%	-2%		
	Most Recent	31%	16%		
1 to 2 events	Previous	29%	15%		
	Change	2%	1%		
	Most Recent	14%	7%		
3 to 5 events	Previous	14%	7%		
	Change	0%	0%		
	Most Recent	5%	3%		
6 to 10 events	Previous	5%	4%		
	Change	0%	-1%		
	Most Recent	2%	2%		
11 to 20 events	Previous	2%	2%		
	Change	0%	0%		
	Most Recent	1%	2%		
21 event reports or more	Previous	1%	2%		
	Change	0%	0%		

 Table D-12. Trending: Average Percent Distribution of Number of Events Reported in the Past 12

 Months by Interaction with Patients