**Attachment C**

**Draft HSOPS 2.0**

**Cognitive Interview Guide**

**March 20, 2015**

**Draft Hospital Survey on Patient Safety 2.0**

**Round 1 Telephone Cognitive Interviews: Introduction and Oral Consent**

Respondent ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Respondent Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Interview: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time of Interview: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tape Recorded? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Introduction and Consent**

Hello, my name is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I have [a/two] colleague(s) with me here – [NAME(S)]. We work for Westat, a private research company in Rockville, Maryland. Thank you for taking the time to complete the survey and talk with us.

Westat is developing a patient safety survey for the Agency for Healthcare Research and Quality, Department of Health and Human Services. You recently completed a set of draft items for this survey.

I am talking with you today to find out how the survey items worked for you – for example, were the questions easy to understand and answer? Were any of the words vague or confusing? I am interested in what you think about the questions, and I will be asking you what the questions mean to you. There are no right or wrong comments.

This is a research project and your participation is voluntary. You may skip any question you do not want to answer and you may stop the interview at any point. I expect the interview to take about 1½ hours. We take many steps to keep your comments and survey responses private. I will discuss your responses only with other project team members. We will not include your name or your hospital’s name in any written findings reports.

I will be happy to answer any questions you may have about this task. If you have any questions about your rights as a research participant, you may contact Westat’s Human Subjects Protections office. Would you like that phone number? (IF YES: Please call 1-888-920-7631 and leave a message with your full name, the name of the research study that you are calling about, and a phone number beginning with the area code. Someone will return your call as soon as possible).

Because I want to pay close attention to what you say, I would like to tape record our interview so that I can listen to it later to see if I missed anything. Is that okay?

**TURN ON THE RECORDER**: I need to ask your permission again so that it is recorded: Today is mo/day/year at [time]. Do you agree to participate in this interview and to have it audio recorded?]

I will review the definitions on the first page, then ask a few general questions about the survey items, and then address specific survey items. Your comments will help in identifying possible problems. Please share your thoughts and don’t hesitate to bring up problems, suggest changes, or say which items you prefer – the whole purpose of this pretest is to improve the items and use the best ones in the survey.

Do you have a copy of your survey? Good. Before we start, do you have any questions? Okay, let’s begin.

|  |
| --- |
| **Hospital Survey on Patient Safety 2.0**  Form Approved OMB No. 0935-XXXX Exp. Date XX/XX/20XX |
| **Instructions** |

**This survey asks for your opinions about patient safety issues, medical error, and event reporting in your hospital. It will take about 10 to 15 minutes to complete. If a question does not apply to you or your hospital or you don’t know the answer, please check “Does Not Apply or Don’t Know.”**

|  |
| --- |
| * *An* ***“event”*** *is defined as any type of error, mistake, incident, accident, or deviation that either led to patient harm or could have.* * ***“Patient safety”*** *is defined as the avoidance and prevention of patient injuries or adverse events that result from the processes of health care delivery.* |

**Did you read the definitions in the shaded box? Were they familiar to you? Do you have any suggestions for improving them?**

**SECTION A: Your Work Area/Unit**

**Think of your “unit” as the work area, department, or clinical area of the hospital where you spend *most* of your work time. What is your primary work area or unit in this hospital?**

**Select ONE answer.**

|  |  |  |
| --- | --- | --- |
| * a. Many different hospital units/No specific unit   **Patient Care Units**   * b. Combined Medical/Surgical Unit * c. Medical Unit (Non- Surgical) * d. Surgical Unit * e. Emergency Department * f. Pediatrics (including NICU/PICU) * g. ICU (adult, various types) * h. Labor & Delivery, Obstetrics & Gynecology * i. Oncology/Hematology * j. Psychiatry, Behavioral   Health   * k. Rehabilitation, Physical Medicine   Public reporting burden for this collection of information is estimated to average 15 minutes per response, the estimated time required to complete the survey. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-XXXX) AHRQ, 540 Gaither Road, Room # 5036, Rockville, MD 20850. | **Surgery**   * l. Anesthesiology * m. Surgical Services (Pre Op, Operating Room/Suite, Post Op, Peri Op)   **Clinical Services**   * n. Pathology/Lab * o. Pharmacy * p. Radiology/Imaging * q. Respiratory Therapy   **Management/Administration**   * r. Information Technology, Health Information Management, Clinical Informatics * s. Management, Administration,   Quality, Risk Management,  Patient Safety, Human  Resources, Training | **Support Services**   * t. Environmental Services, Housekeeping * u. Facilities * v. Food Service, Dietary * w. Patient Financial Services, Billing, Admitting * x. Security Services * y. Transport   **Other**   * z. Other, please specify: |

1. **Teamwork Within Units**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements about your unit?** | **Strongly Disagree** ⯆ | **Disagree** ⯆ | **Neither**  **Agree nor Disagree ⯆** | **Agree** ⯆ | **Strongly Agree** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. People support one another in this unit………... | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |
| 1. In this unit, we treat each other with respect. | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

Before we talk about each individual question, do you have any general comments to make about the survey items overall or any ones in specific?

The questions in this first section ask about your unit. Can you describe the “unit” you were thinking about?

(Are the people you work with in the unit usually the same, or do they differ from day to day?)

[PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

Q1 You answered \_\_\_\_\_\_\_\_\_ to question 1 – can you say why you chose that answer?

Who were the “people” you were thinking of when you answered?

Who was included in the “this unit”?

What does it mean to “support” each other?

Can you give some examples?

Q2. Who are the “we” and “each other” you were thinking of?

What does it mean to “treat each other with respect?”

For question 2, you answered \_\_\_\_, Can you say more about that?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. **Teamwork Within Units** | | | | | | |
| **How much do you agree or disagree with the following statements about your unit?** | **Strongly Disagree** ⯆ | **Disagree** ⯆ | **Neither**  **Agree nor Disagree ⯆** | **Agree** ⯆ | **Strongly Agree** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. In this unit, when someone gets really busy, others help out | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |
| 1. In this unit, we work together as an effective team | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

[PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

Q3. For question 3, you answered \_\_\_\_, Can you say more about that?

Who is the “someone” you were thinking about when you answered question 3?

What about doctors?

Can you give an example for why you answered \_\_\_\_\_\_\_\_\_.

Q4. What it means to “work together as an effective team”?

You answered \_\_\_\_. Can you say more about that?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. **Teamwork Within Units** | | | | | | |
| **How much do you agree or disagree with the following statements about your unit?** | **Strongly Disagree** ⯆ | **Disagree** ⯆ | **Neither**  **Agree nor Disagree ⯆** | **Agree** ⯆ | **Strongly Agree** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. We clearly understand the roles and responsibilities of the people we work with in this unit | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |
| 1. In this unit, disrespectful or intimidating behavior by those working here is tolerated | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

[PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

Q5. You answered \_\_\_\_. Can you say more about that?

What does it means to “clearly understand roles and responsibilities”?

Can you give an example?)

What “people” were you thinking about when you answered?

Q6. You answered \_\_\_\_to qx. 6. Can you say more about that?

When you see “disrespectful or intimidating behavior” what does that mean to you?

Can you give some examples?

What does it mean that this behavior is “tolerated”?

Is tolerated a word that you use or do you use some other word?

IF APPROPRIATE: How do you talk about these things when they happen?

1. **Communication Openness**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How often do the following things happen in your unit?** | **Never** ⯆ | **Rarely** ⯆ | **Some-times  ⯆** | **Most of the time** ⯆ | **Always** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. We feel comfortable asking questions when something doesn’t seem right | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |
| 1. We are asked for our opinions about ways to improve patient safety. | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

**2. Communication Openness**

[PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

What unit were you thinking about when you answered the questions in this section?

Q1 Can you say in your own words what Q1 is asking?

(Who were you thinking of when you answered? [Who is the “we”?])

(What does it mean to feel comfortable asking questions?)

What does it mean when “something doesn’t seem right”? – **MEDICAL ISSUE OR PATIENT SAFETY ISSUE?**

Can you give some examples of things that have not “seemed right”?

You answered \_\_\_\_. Can you say more about that?

Q2. You answered \_\_\_\_\_ to qx 2. Can you say more about that?

Who is the “we” you were thinking about when you answered?

Can you give some examples of “opinions about ways to improve patient safety”?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How often do the following things happen in your unit?** | **Never** ⯆ | **Rarely** ⯆ | **Some-times  ⯆** | **Most of the time** ⯆ | **Always** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. Our ideas and suggestions are valued | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |
| 1. When we see someone with more authority doing something unsafe for patients, we speak up | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

[PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

Q3. You answered \_\_\_\_\_\_\_\_\_ to question 3 -- can you say more about that?

Can you give some examples of “ideas and suggestions being valued”?

Q4 You answered \_\_\_\_\_\_ to question 4 – can you say more about that?

Who was the “someone with more authority” that you answered for?

Can you give some examples of “someone with more authority”?

What did you think of when you read “doing something unsafe for patients”?

Can you give some examples of “someone with more authority doing something unsafe for patients”?

What does it mean to “speak up”?

Can you give some examples of “speaking up”?

1. **Communication Openness**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How often do the following things happen in your unit?** | **Never** ⯆ | **Rarely** ⯆ | **Some-times  ⯆** | **Most of the time** ⯆ | **Always** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. When we see staff doing something unsafe for patients, we speak up | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

[PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

Q5. Who were you thinking about when you answered question 5? (Who are “we” and who are the “staff”?)

Who were the “staff” you were thinking about when you answered? Can you give some examples?

[MAKE SURE DOC’S ARE NOT INCLUDED IN THE ANSWER.]

What kinds of things did you think of when you read “Doing something unsafe”?

What does it mean to “speak up?

Who do staff “speak up” to?

(You answered \_\_\_\_. Can you say more about that?)

1. **Communication About Error**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How often do the following things happen in your work area/unit?** | **Never** ⯆ | **Rarely** ⯆ | **Some-times  ⯆** | **Most of the time** ⯆ | **Always** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. We are informed about errors that happen in this unit. | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |
| 1. We are informed about errors that happen outside of this unit | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

[PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

Let’s go on to section 3. What unit were you thinking of when you answered these questions?

Q1 For question 1, you answered \_\_\_\_. Can you say more about that?

Who informs whom? [FIND OUT WHAT DIRECTION THE INFORMATION MOVES IN]

(What types of errors were you thinking of when you answered?)

(How are you informed about errors that happen on your unit?)

[ERRORS DON’T HAVE TO BE PATIENT SAFETY TO QUALIFY HERE.]

Q2. How did you arrive at your answer for qx. 2?

What does it mean to “be informed about errors that happen outside of this unit”?

[NOTE WHETHER “OUTSIDE OF UNIT” MEANS ANOTHER UNIT IN THIS HOSPITAL OR ANOTHER HOSPITAL OR FROM THE RESEARCH LITERATURE.]

Which unit were you thinking of when you answered?

**3. Communication About Error**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How often do the following things happen in your work area/unit?** | **Never** ⯆ | **Rarely** ⯆ | **Some-times  ⯆** | **Most of the time** ⯆ | **Always** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. We discuss errors that happen in this unit | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |
| 1. When errors happen, we discuss ways to prevent them from happening again | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

[PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

Q3. What kind of errors were you thinking of when you answered?

Can you give some examples of how errors are discussed?

Is “error” a word that you use or do you use some other word?

Q4. How did you choose your answer of \_\_\_\_\_?

(IF NOT NEVER): What discussions were you thinking of? (Were they formal or informal? Who leads them? Who participates)?

This question asks about “errors” – when you read “errors” what do you think of?

Is an “error” something different from a “mistake” or is it the same thing as a mistake?

What about incidents? Events?

Can you give some examples of discussions that would prevent errors from happening again?

**3. Communication About Error**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How often do the following things happen in your work area/unit?** | **Never** ⯆ | **Rarely** ⯆ | **Some-times  ⯆** | **Most of the time** ⯆ | **Always** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. In this unit, we are given feedback on what is done after we report events. | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

[PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

Q5. How did you choose your answer of \_\_\_\_\_?

What kind of “feedback” were you thinking of?

Can you give some examples?

Who is the “we” you were thinking of when you answered?

The question asks about “after we report events” -- what does that mean to you?

Can you give some examples of what happens “after you report events”?

**4. Staffing, Work Pressure, and Pace**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How often do the following things happen in your work area/unit?** | **Never** ⯆ | **Rarely** ⯆ | **Some-times  ⯆** | **Most of the time** ⯆ | **Always** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. We have enough staff to handle the workload. | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |
| 1. We have enough time to do our jobs thoroughly | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

[PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

What unit were you thinking of when you answered the questions in this section?

Q1 Can you say in your own words what Q1 is asking?

What does it mean to “have enough staff to handle the workload”?

You answered \_\_\_\_. Can you say more about that?

(Who is the “we” you were thinking about when you answered this question?)

Q2. You answered \_\_\_\_\_\_\_\_\_\_to question 2. Can you say more about that?

What does it mean to “have enough time to do your job thoroughly”?

1. **Staffing, Work Pressure, and Pace**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How often do the following things happen in your work area/unit?** | **Never** ⯆ | **Rarely** ⯆ | **Some-times  ⯆** | **Most of the time** ⯆ | **Always** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. We feel rushed—trying to do too much too quickly | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

[PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

Q3. Can you say more about your answer \_\_\_\_\_\_\_?

What does it mean to “feel rushed”?

Do you think about “rushed” as “trying to do too much too quickly” or do you think about it in some other way?

Does feeling “rushed” affect or not affect patient safety?

Was this question difficult or easy to answer?

Does this question feel relevant? Some people say that people who work in hospitals are “rushed” all the time.

Can you say more about that?

1. **Response to Error**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How often do the following things happen in your work area/unit?** | **Never** ⯆ | **Rarely** ⯆ | **Some-times  ⯆** | **Most of the time** ⯆ | **Always** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. We look at more than staff actions to understand why errors happen. | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |
| 1. Learning, rather than blame, is emphasized when staff make errors | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

Q1. You answered \_\_\_\_ to question 1 – can you say more about that?

Who is the “we” you thought of when answering?

The question asks “we look at more than staff actions” – what kinds of things did you think of as “more than staff actions”?

Do you think it is important to look at more than staff actions? (Why?)

Can you give some examples?

What kind of errors were you thinking about when you answered?

Who were you thinking as the person who makes the “errors?

Can you give some examples of these “errors”?

Q2. You answered \_\_\_\_ to question 2 – can you say more about that?

(Who emphasizes learning rather than blame and how do they do so?)

(How is learning emphasized?)

(Can you give some examples of staff making errors?)

**5. Response to Error**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How often do the following things happen in your work area/unit?** | **Never** ⯆ | **Rarely** ⯆ | **Some-times  ⯆** | **Most of the time** ⯆ | **Always** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. We try to understand the factors that lead to patient safety errors | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |
| 1. Staff are treated fairly when they make errors. | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

Q3. You answered \_\_\_\_. Can you say more about that?

What does it mean to “try to understand the factors that lead to patient safety errors”?

Can you give an example of the errors you were thinking about when you answered?

Who were you thinking about as “trying to understand” when you answered?

MAKE SURE YOU CAPTURE THE LEVEL OF THE HOSPITAL – UNIT OR HOSPITAL LEVEL.

Q4. You answered \_\_\_\_\_\_ to Question 4 – can you say more about that?

What “staff” were you thinking of when you answered?

What errors were you thinking about?

What does it mean to be “treated fairly” when you’ve made an error?

**5. Response to Error**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How often do the following things happen in your work area/unit?** | **Never** ⯆ | **Rarely** ⯆ | **Some-times  ⯆** | **Most of the time** ⯆ | **Always** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. We review our policies and procedures to see if they contribute to errors. | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

Q5. You answered \_\_\_\_\_\_\_; can you say more about what you were thinking about when you answered?

Who is the “we” you were thinking about when you answered?

Is this something you do or have seen done or is this not what you have done or seen done?

What policies and procedures were you thinking about when you answered?

Can you talk about what kind of errors you think the question is referring to?

1. **Organizational Learning – Continuous Improvement**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements about your unit?** | **Strongly Disagree** ⯆ | **Disagree** ⯆ | **Neither**  **Agree nor Disagree ⯆** | **Agree** ⯆ | **Strongly Agree** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. In this unit, we actively look for ways to improve patient safety | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |
| 1. Mistakes lead to improvements in patient safety in this unit | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

[PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

Let’s look now at section 6. What “unit” were you thinking of when you answered these questions?

Q1 You answered \_\_\_\_\_ to question 1. Can you say more about that?

What does it mean to “actively look for ways to improve patient safety”?

Can you give some examples?

Q2 For question 2, you answered \_\_\_\_. Can you say more about that?

What “mistakes” were you thinking about when you answered?

MISTAKES MADE ON YOUR UNIT; IN YOUR HOSPITAL; AT SOME OTHER HOSPITAL; IN THE LITERATURE?

Are these mistakes that you have personally experienced or observed, or some other mistakes?

You answered \_\_\_\_\_. Please say more about that.

Can you give an example?

**6. Organizational Learning – Continuous Improvement**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements about your unit?** | **Strongly Disagree** ⯆ | **Disagree** ⯆ | **Neither**  **Agree nor Disagree ⯆** | **Agree** ⯆ | **Strongly Agree** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. Our processes are good at preventing errors from happening. | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |
| 1. We make improvements when someone points out patient safety problems in this unit. | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

[PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

Q3 You answered \_\_\_\_\_\_ for qx. 3. Can you say more about how you arrived at that answer?

What “processes” were you thinking of when you answered?

Can you walk us through how these process are good at preventing errors?

Q4. You answered \_\_\_\_\_ to question 4 – how did you arrive at this answer?

Can you describe some examples that help us to understand your answer?

What kind of improvements were you thinking about?

**6. Organizational Learning – Continuous Improvement**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements about your unit?** | **Strongly Disagree** ⯆ | **Disagree** ⯆ | **Neither**  **Agree nor Disagree ⯆** | **Agree** ⯆ | **Strongly Agree** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. After we make changes to improve patient safety in this unit, we check to see if the changes worked. | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

[PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

Q5 You answered \_\_\_\_. Can you say more about that?

Can you give an example of a change your unit has made to improve patient safety?

IF A/MOTT: Who checked to see if the changes worked and how did they do that?

IF N/D/Neither: Can you say more about your answer?

1. **Staff Training and Skills**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements about your work area/ unit?** | **Strongly Disagree** ⯆ | **Disagree** ⯆ | **Neither**  **Agree nor Disagree ⯆** | **Agree** ⯆ | **Strongly Agree** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. Staff who are new to this unit receive adequate orientation. | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |
| 1. Staff get thorough on-the-job training in this unit | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

Q1. You answered \_\_\_\_\_\_ to question 1 – can you say more about that?

When the question asks about “adequate orientation” what do you think of?

Q2. You answered \_\_\_\_\_\_ to question 2 – can you say more about that?

What “staff” were you thinking about when you answered the question?

What does “thorough” mean in this question?

Can you gives some examples of “thorough on the job training”?

Who is responsible for providing the “on-the-job training”?

Can you give some examples?

1. **Staff Training and Skills**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements about your work area/ unit?** | **Strongly Disagree** ⯆ | **Disagree** ⯆ | **Neither**  **Agree nor Disagree ⯆** | **Agree** ⯆ | **Strongly Agree** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. Staff feel pressured to do tasks they haven’t been trained to do (negatively worded). | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |
| 1. Staff in this unit have the skills they need to do their jobs well | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

Q3. What made you answer \_\_\_\_\_\_ to question 3?

What does it mean that “staff feel pressed to do tasks they haven’t been trained to do”?

Can you give some examples?

Q4. What does it mean to “have the skills” needed to do the job well?

Can you give some examples?

1. **Staff Training and Skills**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements about your work area/ unit?** | **Strongly Disagree** ⯆ | **Disagree** ⯆ | **Neither**  **Agree nor Disagree ⯆** | **Agree** ⯆ | **Strongly Agree** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. Staff receive adequate training on patient safety | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

Q5. You answered \_\_\_\_ to question 5 – can you say more about that?

Who do you think of when you see the word “staff “?

What does “adequate training on patient safety” mean in this question?

The training that you were thinking about when you answered, is that on-going or only at particular point or time?

1. **Supervisor, Manager, or Clinical Leader Support for Patient Safety**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements about your supervisor, manager, or clinical leader?**  **My supervisor, manager, or clinical leader…** | **Strongly Disagree** ⯆ | **Disagree** ⯆ | **Neither**  **Agree nor Disagree ⯆** | **Agree** ⯆ | **Strongly Agree** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. Encourages everyone to suggest ways to improve patient safety. | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 | 🞏9 |
| 2. Makes sure everyone follows patient safety rules and procedures | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 | 🞏9 |

[PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

Now let’s look at Topic 8.

For this set of questions, who was the supervisor or manager that you answered for?

*(Trying to ascertain if they can pick one person to respond about or if there are multiple people they are thinking of)*

Q1 You answered \_\_\_\_\_ to question 1 – can you say more about that?

Who is “everyone”? Does it include doctors? Patients?

What does “encourages” mean here?

What does it mean to “suggest ways to improve patient safety”?

Q2 You answered \_\_\_\_\_\_ to question 2 – can you say more about that?

When the question asks about “everyone,” who do you think of?

What does it mean to “follow patient safety rules and procedures”?

Who did you think about as the person who “makes sure” when you answered the question?

How do they “make sure”?

Can you think of any specific “rules and procedures”?

1. **Supervisor, Manager, or Clinical Leader Support for Patient Safety**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements about your supervisor, manager, or clinical leader?**  **My supervisor, manager, or clinical leader…** | **Strongly Disagree** ⯆ | **Disagree** ⯆ | **Neither**  **Agree nor Disagree ⯆** | **Agree** ⯆ | **Strongly Agree** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 3. Pays attention to patient safety problems | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 | 🞏9 |
| 4. Takes action to address patient safety problems that are brought to his or her attention | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 | 🞏9 |

[PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

Q3. What does it mean to “pay attention to patient safety problems”?

Who were you thinking of when you answered this question?

Q4. You answered \_\_\_\_\_\_\_\_\_ to question 4 – can you say more about that?

What does it mean to “take action” to address patient safety problems”

Can you give some examples?

Can you give some examples of how things are brought to his/her attention?

1. **Supervisor, Manager, or Clinical Leader Support for Patient Safety**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements about your supervisor, manager, or clinical leader?**  **My supervisor, manager, or clinical leader…** | **Strongly Disagree** ⯆ | **Disagree** ⯆ | **Neither**  **Agree nor Disagree ⯆** | **Agree** ⯆ | **Strongly Agree** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 5. Works with individuals to change their behavior when they take shortcuts that put patient safety at risk. | 🞎1 | 🞎2 | 🞏3 | 🞎4 | 🞏5 | 🞏9 |

Q5. Can you say in your own words what Question 5 is asking?

Can you give some examples of how this plays out where you work?

What does it mean to work with them to change their behavior?

Are there times when your supervisor/manager does work with people to change their behavior? If Yes – can you talk about what led them to work with them?

What situations were you thinking of when you answered?

1. **Frequency of Events Reported**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Never** ⯆ | **Rarely** ⯆ | **Some-times  ⯆** | **Most of the time** ⯆ | **Always** ⯆ | | **Does Not Apply or Don’t Know**  ⯆ |
| 1. When a mistake is made that **could harm the patient, but does not,** how often do you report it?.. | 🞎1 | 🞎2 | 🞎3 | 🞎4 | | 🞎5 | 🞎9 |

PROBES:

In your own words, what is the question asking?

Can you provide some examples of this type of mistake?

How did you arrive at your answer?

What kind of “reporting” were you thinking of when you answered this question?

(If DNA/DK please probe as to why)

**10. Work Area/Unit Patient Safety Rating**

Please give your work area/unit in this hospital an overall rating on patient safety.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Poor**  **▼** | **Fair**  **▼** | **Good**  **▼** | **Very good**  **▼** | **Excellent**  **▼** |
| 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 |

10. You answered \_\_\_\_\_\_\_\_. Can you say more about what made you choose that answer?

Can you give us some examples of what you are saying?

1. **Teamwork Across Units & Handoffs**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How often do the following things happen in your hospital?** | **Never** ⯆ | **Rarely** ⯆ | **Some-times  ⯆** | **Most of the time** ⯆ | **Always** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. There is good cooperation among hospital units that need to work together | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |
| 1. Different hospital units work well together to provide the best care for patients | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

[PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

Q1 asks about hospital units that need to work together. What hospital units were you thinking of when you answered?

(Can you give some examples of “good cooperation”?

You answered \_\_\_\_. Can you say more about that?

Q2 What does it mean to “work together to provide the best care for patients”?

How do hospital units work well together to provide the best care?

Can you give some examples?

**11. Teamwork Across Units & Handoffs**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How often do the following things happen in your hospital?** | **Never** ⯆ | **Rarely** ⯆ | **Some-times  ⯆** | **Most of the time** ⯆ | **Always** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. Problems occur in the exchange of information across hospital units | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |
| 1. Important patient care information is clearly communicated across units | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

Q3. You answered \_\_\_\_\_. What made you choose that answer?

What kinds of problems were you thinking of when you answered?

What type of information where you thinking about when you answered?

Can you give some examples?

Q4. Can you say in your own words what Question 4 is asking?

(What is “important patient care information”?)

(What does it mean to be “clearly communicated”?)

(What ”units” were you thinking about?)

You answered \_\_\_\_. Can you say more about that?

**11. Teamwork Across Units & Handoffs**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How often do the following things happen in your hospital?** | **Never** ⯆ | **Rarely** ⯆ | **Some-times  ⯆** | **Most of the time** ⯆ | **Always** ⯆ | **Does Not Apply or Don’t Know**  ⯆ |
| 1. All key patient care information is communicated during shift changes | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |
| 1. Patient needs are met during shift changes | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

Q5. You answered \_\_\_\_\_\_\_\_. Can you tell us how you arrived at your answer?

What does it mean to “communicate all key patient care information”?

When you read “shift change” in the question, what did you think of?

Q6. What does it mean to “meet patient needs during shift changes”?

What were you thinking of when you read “shift change”?

Can you give some examples?

1. **Hospital Leadership Support for Patient Safety**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements about your hospital leadership?** | **Strongly disagree** ⯆ | **Disagree** ⯆ | **Neither**  **agree nor disagree ⯆** | **Agree** ⯆ | **Strongly agree** ⯆ | **Does not apply or Don’t know**  ⯆ |
| 1. The actions of hospital leadership show that patient safety is a top priority. | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |
| 1. Hospital leadership communicates that patient safety is everyone’s responsibility. | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

[PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

Let’s turn to Topic 12. In this section, when you read the words “hospital leadership,” whom were you thinking of?

Do you include department managers as “Hospital Leadership”?

Was that true for all the questions, or were you thinking of different people some of the time?

Q1 For question 1, you answered \_\_\_\_. Can you say more about that?

(What kinds of actions were you thinking of? Can you give an example?)

Q2 For question 2, you said \_\_\_\_. Can you say more about that?

(What are some examples of how such messages are sent?)

(What does it mean that it is everyone’s job to look for ways to improve patient safety?)

**12. Hospital Leadership Support for Patient Safety**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements about your hospital leadership?** | **Strongly disagree** ⯆ | **Disagree** ⯆ | **Neither**  **agree nor disagree ⯆** | **Agree** ⯆ | **Strongly agree** ⯆ | **Does not apply or Don’t know**  ⯆ |
| 1. Hospital leadership seems interested in patient safety only after a serious error happens | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |
| 1. Hospital leadership provides adequate resources to improve patient safety | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

[PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

Q3. You answered \_\_\_\_\_\_\_\_ for qx. 3. Can you say more about how you arrived at your answer?

When you answered, who were the “hospital leadership” you were thinking of?

When you read “serious error” what did you think of?

Q4 You answered \_\_\_\_. Can you say more about that?

What kinds of “resources” were you thinking of? Can you give some examples? NOTE IF R SAYS “TIME” IS A RESOURCE

When you saw “resources to improve patient safety,” what did you think of?

Can you give some examples of resources that would improve patient safety?

What does “adequate” mean in this question?

**12. Hospital Leadership Support for Patient Safety**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements about your hospital leadership?** | **Strongly disagree** ⯆ | **Disagree** ⯆ | **Neither**  **agree nor disagree ⯆** | **Agree** ⯆ | **Strongly agree** ⯆ | **Does not apply or Don’t know**  ⯆ |
| 1. Hospital leadership encourages us to tell them about our patient safety concerns | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎9 |

[PROBE ON ALL NEUTRAL OR DON’T KNOW RESPONSES.]

Q5 You answered \_\_\_\_\_\_\_\_\_\_\_\_\_\_. Can you tell us how you arrived at your answer?

Can you give some examples of how hospital leadership “encourages” you to tell them about patient safety concerns?

What kind of “patient safety” concerns were you thinking of when you answered the question?

1. **Recommend**

**Would you recommend this hospital to your friends and family?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Definitely no**  **▼** | **Probably no**  **▼** | **Probably yes**  **▼** | **Definitely yes**  **▼** |
| 🞎1 | 🞎2 | 🞎3 | 🞎4 |

|  |  |  |
| --- | --- | --- |
| 13. You answered \_\_\_\_\_\_\_\_\_ to question 13. Can you say what made you choose that answer?  What would make you chose a “Definitely Yes”? |  |  |
|  |  |  |

1. **Reporting**
2. In the past 12 months, did you formally report any events?

|  |  |
| --- | --- |
| **No ⯆** | **Yes ⯆** |
| 🞎1 | 🞎2 |

PROBE: Please say more about your answer.

What does it mean to “formally report” an event?

How did you report them? (to whom or to an error reporting system)

About how many reports have you made in the past 12 months?

**15. Background Questions**

1. **What is your position in this hospital? Check the ONE category that best applies to your job.**

**Department Managers, Senior Leaders**

* a. Manager, Department Manager
* b. Senior Leader, Executive**,** C-Suite

**Medical Staff**

* g. Physician Assistant
* h. Graduate Medical Trainee: Fellow, Resident,

Intern

* i. Staff Physician, Attending

**Nursing Staff**

* c. Advanced PracticeNurse(NP, CRNA,

CNS, CNM)

* d. Licensed Vocational Nurse (LVN), Licensed

Practical Nurse (LPN)

* e. Patient Care, Nursing Assistant
* f. Registered Nurse (RN)

**Other Clinical Staff**

* j. Clinical Psychologist, Social Worker
* k. Dietician
* l. Pharmacist
* m. Pharmacy Technician
* n. Physical, Occupational, or Speech Therapist
* o. Respiratory Therapist
* p. Technologist, Technician (e.g. EKG, Lab, Radiology)

**Support Staff**

* q. Unit Clerk, Secretary, Receptionist, Office Staff
* r. Environmental Services, Housekeeping Staff
* s. Facilities Staff
* t. Food Services, Dietary Staff
* u. Information Technology Staff, Health Information  
   Services
* v. Security
* w. Transporter

**Other**

* x. Other, please specify:

**PROBE:** How easy or difficult was it to find your staff position? (IF DIFFICULT: What made it difficult?)

In “h”, what does “graduate medical trainee” mean to you?

Can you give some examples of a graduate medical trainee?

**15. Background Questions (cont.)**

**2. How long have you worked in this hospital?**

* a. Less than 1 year
* b. 1 to 5 years
* c. 6 to 10 years
* d. 11 to 15 years
* e. 16 to 20 years
* f. 21 years or more

**3. How long have you worked in your current hospital work area/unit?**

* a. Less than 1 year
* b. 1 to 5 years
* c. 6 to 10 years
* d. 11 to 15 years
* e. 16 to 20 years
* f. 21 years or more

1. **Typically, how many hours per week do you work in this hospital?**

* a. 1 to 20 hours per week
* b. 21 to 40 hours per week
* c. 41 to 50 hours per week
* d. 51 to 60 hours per week
* e. 61 or more hours per week

1. **In your position, do you typically have direct interaction or contact with patients? Check ONE answer.**

* a. YES, I typically have direct interaction or contact with patients.
* b. NO, I typically do NOT have direct interaction or contact with patients.

**PROBE: Do you have any comments about the rest of the background questions?**

1. **Your Comments**

**Please feel free to write any comments about how things are done or could be done in your hospital that might affect patient safety.**

|  |
| --- |
|  |

**Thank you for completing this survey.**

**Closing Probes**

(For Rs who did not select DK/DNA): Now I have a general question about the response scales. I noticed you didn’t select Does Not Apply or Don’t Know - the response option in the last column. Did you notice it?

[Note to interviewer: If you know R has worked in other hospitals or other units in the hospital: Would you have answered any differently for any other hospitals or units you have worked in?]

That’s all of my specific questions. Our goal is to shorten this series of questions. In your opinion, which of the questions were the hardest for you to understand or answer? (Why?)

Thanks. Do you have any additional comments?

Thank you very much for participating in this pretest. Your comments have been helpful.

**TURN OFF RECORDER**

To show our appreciation for your time and help, we will send you a check for [$75/$125/$200]. Please [confirm/tell me] your mailing address [DOCUMENT ON NEXT PAGE]:

**Mailing address:**

(Say we will send by FedEx but they do not have to be there to sign for it.) Note: We have to submit info to accounting by COB Monday or Thursday for Tuesday and Friday processing - let person know approximately when to expect check.

**Immediately after the interview,** notify Vicki that the interview has been completed and provide her with the following:

Participant ID#:

First and last name of the participant:

Participant’s gender:

Indicate if the participant is a physician:

Mailing address:

Phone number (for FedEx form):

Incentive amount:

Name of lead interviewer:

**NOTE: After Vicki has the new address, remove this page from the Interview Guide and shred it**.