

Form Approved OMB No. 0935-XXXX Exp. Date XX/XX/20XX

# Hospital Survey on Patient Safety (Version 2.0)

#### **Instructions**

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

- "<u>Patient safety</u>" is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of healthcare delivery.
- A "patient safety event" is defined as any type of healthcare-related error, mistake, or incident, regardless of whether or not it results in patient harm.

This survey is authorized under 42 U.S.C. 299a. This information collection is voluntary and the confidentiality of your responses to this survey is protected by Sections 944(c) and 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 42 U.S.C. 242m(d)]. Information that could identify you will not be disclosed unless you have consented to that disclosure. 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. The data you provide will help AHRQ's mission to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable. 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, 5600 Fishers Lane, Room #07W42, Rockville, MD 20857, or by email to the AHRQ MEPS Project Director at MEPSPROJECTDIRECTOR@ahrq.hhs.gov.

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### **Your Staff Position**

1. What is your position in this hospital?

Select ONE answer.

□6 Resident, Intern □7 Physician, Attending, Hospitalist □20 Ir □20 Ir □21 S □22 T □23 U □23 U □23 U □24 Physical, Occupational, or Speech Therapist □25 Ir □26 Resident, Intern □27 Physician, Attending, Hospitalist □28 Ir □29 Ir □20 Ir □21 S □22 T □23 U □23 U □24 Physical, Occupational, or Speech Therapist □26 Ir □27 Ir □28 Ir □29 Ir □29 Ir □20 Ir □20 Ir □21 S □22 Ir □23 Ir □24 Ir □25 Ir □26 Ir □27 Ir □28 Ir □29 Ir □29 Ir □20 Ir □20 Ir □20 Ir □21 S □22 Ir □23 Ir □24 Ir □25 Ir □26 Ir □27 Ir □27 Ir □28 Ir □29 Ir □29 Ir □20 Ir □20 Ir □21 S □22 Ir □23 Ir □24 Ir □25 Ir □26 Ir □27 Ir □28 Ir □29 Ir □29 Ir □20 Ir □20 Ir □20 Ir □21 S □22 Ir □23 Ir □24 Ir □25 Ir □26 Ir □27 Ir □27 Ir □28 Ir □29 Ir □29 Ir □20 Ir □20 Ir □20 Ir □21 S □22 Ir □23 Ir □23 Ir □24 Ir □25 Ir □26 Ir □27 Ir □27 Ir □28 Ir □29 Ir □29 Ir □20 Ir □20 Ir □20 Ir □20 Ir □21 S □22 Ir □23 Ir □24 Ir □25 Ir □26 Ir □27 Ir □27 Ir □28 Ir □29 Ir □29 Ir □20 Ir □20 Ir □20 Ir □20 Ir □21 S □22 Ir □23 Ir □23 Ir □24 Ir □25 Ir □26 Ir □27 Ir □27 Ir □28 Ir □29 Ir □29 Ir □20 Ir □	acilities ood Services ousekeeping, Environmental Services formation Technology, Health Information ervices, Clinical Informatics				
Your Unit/Work Area					

2. 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 unit or work area in this hospital?

Select ONE answer.

Multiple Units, No specific unit □1 Many different hospital units, No specific unit	Surgical Services □16 Anesthesiology □17 Endoscopy, Colonoscopy	Support Services  129  Admitting/Registrati on
Medical/Surgical Units  □2 Combined  Medical/Surgical Unit  □3 Medical Unit (Non-	□18 Pre Op, Operating Room/Suite, PACU/Post Op, Peri Op	□30 Food Services, Dietary □31 Housekeeping, Environmental
Surgical)	Clinical Services	Services, Facilities

□4 Surgical Unit	□19 Pathology, Lab	□32 Security Services
	□20 Pharmacy	□33 <b>Transport</b>
Patient Care Units	□21 Radiology, Imaging	
□5 Cardiology	□22 Respiratory Therapy	Other
□ <sub>6</sub> Emergency	□23 Social Services, Case	□34 Other, please
Department,	Management, Discharge	specify:
Observation, Short	Planning	
Stay		
□7 Gastroenterology	Administration/	
$\square$ 8 ICU (all adult types)	Management	
□9 Labor & Delivery,	□24 Administration,	
Obstetrics &	Management	
Gynecology	$\square$ 25 Financial Services,	
□10 Oncology,	Billing	
Hematology	$\square$ 26 Human Resources,	
□11 Pediatrics (including	Training	
NICU, PICU)	□27 Information Technology,	
□12 Psychiatry,	Health Information	
Behavioral Health	Management, Clinical	
□13 Pulmonology	Informatics	
□14 Rehabilitation,	□28 Quality, Risk	
Physical Medicine	Management, Patient	
□15 Telemetry	Safety	

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

How much do you agree or disagree with the following statements about your unit/work area?

Th	ink about your unit/work area:	Strongly Disagree	<b>Disagree</b>	Neither Agree nor Disagree	<b>Agree</b>	Strongly Agree	Does Not Apply or Don't Know
1.	In this unit, we work together as an effective team	1	$\square_2$	$\square_3$	$\square_4$	$\square_5$	   □9
2.	In this unit, we have enough staff to handle the workload		$\square_2$	$\square_3$	$\square_4$	$\square_5$	   
3.	Staff in this unit work longer hours than is best for patient care	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$	│ │ <b>□</b> 9
4.	This unit regularly reviews work processes to determine if changes are needed to improve patient safety		$\square_2$	<b>□</b> <sub>3</sub>	$\square_4$	<b>□</b> <sub>5</sub>	     
5.	This unit relies too much on temporary, float, or PRN staff	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$	     <b> </b> 9
6.	In this unit, staff feel like their mistakes are held against them	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$	   
7.	When an event is reported in this unit, it feels like the person is being written up, not the problem		$\square_2$	$\square_3$	<b>□</b> 4	$\square_5$	   
8.	During busy times, staff in this unit help each other	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$	 
9.	There is a problem with disrespectful behavior by those working in this unit	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$	   
10.	When staff make errors, this unit focuses on learning rather than blaming individuals	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$	
11.	The work pace in this unit is so rushed that it negatively affects patient safety	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$	   
12.	In this unit, changes to improve patient safety are evaluated to see how well they worked	$\square_1$	$\square_2$	$\square_3$	<b>□</b> 4	$\square_5$	     □9
13.	In this unit, there is a lack of support for staff involved in patient safety errors	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$	   
14.	This unit lets the same patient safety problems keep happening	$\square_1$	$\square_2$	$\square_3$	$\square_4$	$\square_5$	 

# **SECTION B: Your Supervisor, Manager, or Clinical Leader**

How much do you agree or disagree with the following statements about your immediate supervisor, manager, or clinical leader?

		Strongly Disagree	<b>Disagree</b>	Neither Agree nor Disagree	<b>Agree</b>	Strongly Agree	Does Not Apply or Don't Know
1.	My supervisor, manager, or clinical leader seriously considers staff suggestions for improving patient safety	1	$\square_2$	$\square_3$	$\square_4$	$\square_5$	   
2.	My supervisor, manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts		$\square_2$	$\square_3$	$\square_4$	<b>□</b> 5	   
3.	My supervisor, manager, or clinical leader takes action to address patient safety concerns that are brought to their attention	$\square_1$	$\square_2$	$\square_3$	<b>□</b> 4	<b>□</b> 5	     
	SECTION	C: Con	nmunic	ation			
Hov	v often do the following things happen in yo	ur unit/wo	rk area?	Some-	Most of		Does Not Apply or Don't
Th	ink about your unit/work area:	Never	Rarely	times	the time	<b>Always</b>	Know
	wink about your unit/work area:  We are informed about errors that happen in this unit						Know
	We are informed about errors that happen in			0			Know   [ 
<ol> <li>2.</li> </ol>	We are informed about errors that happen in this unit When errors happen in this unit, we discuss			□ □3	□ □4 —	□ 5 —	Know   [ 
<ol> <li>2.</li> </ol>	We are informed about errors that happen in this unit When errors happen in this unit, we discuss ways to prevent them from happening again In this unit, we are informed about changes			□ 3 3 —	□ 4 □ 4	□ 5 □ 5	Know
<ol> <li>2.</li> <li>3.</li> </ol>	We are informed about errors that happen in this unit When errors happen in this unit, we discuss ways to prevent them from happening again In this unit, we are informed about changes that are made based on event reports In this unit, staff speak up if they see something that may negatively affect patient			□ 3 □ 3 □ 3	□ 4 □ 4	□ 5 □ 5 □ 5	Know
<ol> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> </ol>	We are informed about errors that happen in this unit When errors happen in this unit, we discuss ways to prevent them from happening again In this unit, we are informed about changes that are made based on event reports In this unit, staff speak up if they see something that may negatively affect patient care When staff in this unit see someone with more authority doing something unsafe for			□ 3 □ 3 □ 3 □ 3		□ 5 □ 5 □ 5	Know

#### **SECTION D: Reporting Patient Safety Events Does Not** Apply or Some-Most of Don't the time Always Rarely **Know** Think about your unit/work area: Never times П П П П 1. When a mistake is caught and corrected before reaching the patient, how often is this reported? П $\square_2$ Пз $\prod_{\Delta}$ $\square_5$ 2. When a mistake reaches the patient and could have harmed the patient, but did not, how often is this $\square_2$ $\square_3$ $\square_4$ $\square_5$ reported? ...... $\square_1$ Πg 3. <u>In the past 12 months</u>, how many patient safety events have <u>you</u> reported? □a. None □b. 1 to 2 $\square$ c. 3 to 5 □d. 6 to 10 $\square_{\rm e.}$ 11 or more SECTION E: Patient Safety Rating 1. How would you rate your unit/work area on patient safety? Poor Fair Good Very Good Excellent $\prod_1$ $\prod_{2}$ $\square_3$ **SECTION F: Your Hospital** How much do you agree or disagree with the following statements about your hospital? Does Not Neither Apply or Strongly Don't Agree nor Strongly Disagree Disagree Disagree Agree Agree Know Think about your hospital: The actions of hospital management show $\square_2$ that patient safety is a top priority ...... $\square_1$ $\square_3$ $\square_5$ $\bigsqcup_4$ Hospital management provides adequate $\square_5$ $\square_2$ $\square_3$ $\square_4$ $\square_9$ 3. Hospital management seems interested in patient safety only after an adverse event $\square_2$ $\square_3$ $\square_{4}$ $\square_5$ $\square_9$ happens..... 4. When transferring patients from one unit to another, important information is often left $\square_2$ $\square_3$ $\square_4$ $\square_5$ $\square_9$ out.....

5.	During shift changes, important patient care information is often left out		$\square_2$	$\square_3$	$\square_4$	$\square_5$	$\square_9$
6.	During shift changes, there is adequate time to exchange all key patient care information	🔲 1	$\square_2$	$\square_3$	$\square_4$	$\square_5$	$\square_9$

## Your Unit/Work Area's Processes Around Diagnosis

The following items ask about **your unit/work area's processes around diagnosis**. The processes start when a patient seeks care for a health problem, and include:

- Gathering, integrating, and interpreting information about the patient (e.g., clinical history, physical exam, test and imaging results, referrals),
- o Making an initial diagnosis,
- o Discussing the diagnosis with the patient, and
- o Following the patient and revising the diagnosis over time, as needed.

In this part of the survey, the term "provider" refers to physicians, physician assistants, and nurse practitioners who diagnose, treat patients, and prescribe medications. The term staff refers to all others who work in the

### **SECTION A: Time Availability**

	w much do you agree or disagree with the lowing statements?	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1.	The amount of time that providers have with each patient is long enough to fully evaluate the patient's presenting problem(s)	1	<b></b> 2	<b></b> 3	<b></b> 4	<b></b> 5	<b></b> 9
2.	Providers in this unit have enough time to review the relevant information related to the patient's presenting problem(s)	1	<b></b> 2	<b></b> 3	<b></b> 4	<b></b> 5	<b></b> 9
3.	Providers in this unit finish their patient notes by the end of their regular workday	1	<b></b> 2	<b></b> 3	4	<b></b> 5	<b></b> 9

## **SECTION B: Testing and Referrals**

	ow much do you agree or disagree with the lowing statements?	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1.	This unit is effective at tracking a patient's test results from labs, imaging, and other diagnostic procedures	1	<b></b> 2	<b></b> 3	 4	<b></b> 5	<b></b> 9
2.	When this unit doesn't receive a patient's test results, staff follow up	1	<b></b> 2	<b></b> 3	<b></b> 4	<b></b> 5	<b></b> 9
3.	All test results are communicated to patients, even if the test results are normal	1	<b></b> 2	<b></b> 3	<b></b> 4	<b></b> 5	<b></b> 9
4.	When this hospital makes a high priority referral, we try to have the appointment scheduled before the patient is discharged	1	<b></b> 2	<b></b> 3	<b></b> 4	<b></b> 5	<b></b> 9

## **SECTION C: Provider and Staff Communication Around Diagnosis**

	ow much do you agree or disagree with the llowing statements?	Strongly Disagree	Disagree □	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1.	Providers in this unit encourage staff to share their concerns about a patient's health condition.	 1	<b></b> 2	<b></b> 3	 4	<b></b> 5	<b></b> 9
2.	Providers document differential diagnoses when they have <b>not</b> ruled out other diagnoses	<mark></mark> 1	<b></b> 2	<b></b> 3	<b></b> 4	<b></b> 5	<b></b> 9
3.	When a provider thinks another provider in this unit/hospital/system may have missed a diagnosis, they inform that provider	<b></b> 1	<b></b> 2	<b></b> 3	<b></b> 4	<b></b> 5	<b></b> 9
4.	When a missed, wrong, or delayed diagnosis happens in this unit, we are informed about it	<b>.</b> 1	<b></b> 2	<b></b> 3	<b></b> 4	<b></b> 5	<b></b> 9
5.	Providers in this unit talk directly with specialists/radiologists/pathologists when something needs clarification	1	<b></b> 2	<b></b> 3	<b></b> 4	<b></b> 5	<b></b> 9

# **Background Questions**

1.	How long have you worked in this <u>hospital</u> ?
	<ul> <li>□a. Less than 1 year</li> <li>□b. 1 to 5 years</li> <li>□c. 6 to 10 years</li> <li>□d. 11 or more years</li> </ul>
2.	In this hospital, how long have you worked in your current unit/work area?
	<ul> <li>□a. Less than 1 year</li> <li>□b. 1 to 5 years</li> <li>□c. 6 to 10 years</li> <li>□d. 11 or more years</li> </ul>
3.	Typically, how many hours per week do you work in this <u>hospital</u> ?
	□a. Less than 30 hours per week □b. 30 to 40 hours per week □c. More than 40 hours per week
4.	In your staff position, do you typically have direct interaction or contact with patients?
	$\square_{a.}$ YES, I typically have direct interaction or contact with patients $\square_{b.}$ NO, I typically do NOT have direct interaction or contact with patients
	Your Comments
	Please feel free to provide any comments about how things are done or could be done in your hospital that night affect patient safety.