Patient Safety Culture in Healthcare Organizations Survey

Instructions:
1. Think of unit as the area where you do most of your work—whether that is a patient care unit / ward, clinic, dept., the community, EMS, etc.. Think of the patient as the client, resident, etc., depending where your work.
2. The survey is seeking your perceptions and opinions of these safety issues. Indicate the extent to which you agree or disagree with each of the following statements. If you are unsure whether you agree or disagree, mark "neutral". If the question does not apply to your role or your work setting, mark "not applicable".

***Patient Safety*:** Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care.

		strongly disagree	disagree	neutral	agree	strongly agree	not applicable
1.	Patient safety decisions are made at the proper level by the most qualified people	❍	❍	❍	❍	❍	❍
2.	Good communication flow exists up the chain of command regarding patient safety issues	❍	❍	❍	❍	❍	❍
3.	Reporting a patient safety problem will result in negative repercussions for the person reporting it	❍	❍	❍	❍	❍	❍
4.	Senior management has a clear picture of the risk associated with patient care	❍	❍	❍	❍	❍	❍
5.	My unit takes the time to identify and assess risks to patients	❍	❍	❍	❍	❍	❍
6.	My unit does a good job managing risks to ensure patient safety	❍	❍	❍	❍	❍	❍
7.	Senior management provides a climate that promotes patient safety	❍	❍	❍	❍	❍	❍
8.	Asking for help is a sign of incompetence	❍	❍	❍	❍	❍	❍
9.	If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	❍	❍	❍	❍	❍	❍
10.	I am sure that if I report an incident to our reporting system, it will not be used against me	❍	❍	❍	❍	❍	❍
11.	I am less effective at work when I am fatigued	❍	❍	❍	❍	❍	❍
12.	Senior management considers patient safety when program changes are discussed	❍	❍	❍	❍	❍	❍
13.	Personal problems can adversely affect my performance	❍	❍	❍	❍	❍	❍
14.	I will suffer negative consequences if I report a patient safety problem	❍	❍	❍	❍	❍	❍
15.	If I report a patient safety incident, I know that management will act on it	❍	❍	❍	❍	❍	❍
16.	I am rewarded for taking quick action to identify a serious mistake	❍	❍	❍	❍	❍	❍
17.	Loss of experienced personnel has negatively affected my ability to provide high quality patient care	❍	❍	❍	❍	❍	❍
18.	I have enough time to complete patient care tasks safely	❍	❍	❍	❍	❍	❍
19.	I am not sure about the value of completing incident reports	❍	❍	❍	❍	❍	❍
20.	In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time	❍	❍	❍	❍	❍	❍
21.	I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	❍	❍	❍	❍	❍	❍
22.	I have made significant errors in my work that I attribute to my own fatigue	❍	❍	❍	❍	❍	❍
23.	I believe that health care error constitutes a real and significant risk to the patients that we treat	❍	❍	❍	❍	❍	❍
24.	I believe health care errors often go unreported	❍	❍	❍	❍	❍	❍
25.	My organization effectively balances the need for patient safety and the need for productivity	❍	❍	❍	❍	❍	❍
26.	I work in an environment where patient safety is a high priority	❍	❍	❍	❍	❍	❍
27.	Staff are given feedback about changes put into place based on incident reports	❍	❍	❍	❍	❍	❍
28.	Individuals involved in patient safety incidents have a quick and easy way to report what happened	❍	❍	❍	❍	❍	❍
29.	My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	❍	❍	❍	❍	❍	❍
30.	My supervisor/manager seriously considers staff suggestions for improving patient safety	❍	❍	❍	❍	❍	❍
31.	Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	❍	❍	❍	❍	❍	❍
32.	My supervisor/manager overlooks patient safety problems that happen over and over	❍	❍	❍	❍	❍	❍

	strongly disagree	disagree	neutral	agree	strongly agree	not applicable
33. On this unit, when an incident occurs, we think about it carefully	❍	❍	❍	❍	❍	❍
34. On this unit, when people make mistakes, they ask others about how they could have prevented it	❍	❍	❍	❍	❍	❍
35. On this unit, after an incident has occurred, we think about how it came about and how to prevent the same mistake in the future	❍	❍	❍	❍	❍	❍
36. On this unit, when an incident occurs, we analyze it thoroughly	❍	❍	❍	❍	❍	❍
37. On this unit, it is difficult to discuss errors	❍	❍	❍	❍	❍	❍
38. On this unit, after an incident has occurred, we think long and hard about how to correct it	❍	❍	❍	❍	❍	❍

B. These questions are about your perceptions of overall patient safety

	A - Excellent	B - Very Good	C - Acceptable	D - Poor	F - Failing
39. Please give your unit an overall grade on patient safety	❍	❍	❍	❍	❍
40. Please give the organization an overall grade on patient safety	❍	❍	❍	❍	❍

C. These questions are about what happens after a Major Event

***Major Events*:** Incidents causing fairly serious harm to patients that result from the delivery of health care.

	strongly disagree	disagree	neutral	agree	strongly agree	not applicable
41. Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	❍	❍	❍	❍	❍	❍
42. A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers.	❍	❍	❍	❍	❍	❍
43. Discussion around major events focuses mainly on system-related issues, rather than focusing on the individual(s) most responsible for the event	❍	❍	❍	❍	❍	❍
44. The patient and family are invited to be *directly* involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events	❍	❍	❍	❍	❍	❍
45. Things that are learned from major events are communicated to staff on our unit using *more than* one method (e.g. communication book, in-services, unit rounds, emails) and / or at *several* times so all staff hear about it	❍	❍	❍	❍	❍	❍
46. Changes are made to reduce re-occurrence of major events	❍	❍	❍	❍	❍	❍

D. Finally, please help us by providing the following information:

Setting where <u>most</u> of your work time is spent:
- ❍ Acute in-patient
- ❍ Long term /continuing care
- ❍ Community
- ❍ Different settings/ no specific setting

Sector where <u>most</u> of your work time is spent:
- ❍ General adult
- ❍ Paediatric
- ❍ Mental health
- ❍ Chronic care
- ❍ Other:_____

Age:
- ❍ <=30
- ❍ 31-40
- ❍ 41-50
- ❍ 51-60
- ❍ >60

Time in organization:
- ❍ < 1 yr
- ❍ 1-2 yrs
- ❍ 3-5 yrs
- ❍ 6-10 yrs
- ❍ > 10 yrs

Gender:
- ❍ Female
- ❍ Male

Your role:
- ❍ RN / R/LPN
- ❍ MD
- ❍ EMS
- ❍ Allied health
- ❍ Healthcare Aide
- ❍ Clinical educator
- ❍ Clinical care manager
- ❍ Technician (lab, radiology, etc.)
- ❍ Unit clerk / clinic reception
- ❍ Support services (food services, housekeeping, maintenance)
- ❍ Other:_____

YORK UNIVERSITÉ UNIVERSITY

Thank you for taking the time to complete this survey
Please return in the enclosed postage-paid envelope

Adapted with permission from:
CHP PCOR STANFORD
PSCI Patient Safety Center of Inquiry