

MSI Patient Safety Culture in Healthcare Organizations Survey

Instructions:

- ▶ The survey is seeking your perceptions and opinions of these patient 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, please mark “not applicable”.

What do we mean by:

- ▶ **Unit:** Think of unit as the area where you spend *most* of your work or provide *most* of your clinical services —whether that is a patient care unit / ward, clinic, department., the community, EMS, etc.
- ▶ **Supervisor manager:** Think of the person to whom you directly report.
- ▶ **Patient Safety:** Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care.
- ▶ **Serious Errors:** During healthcare delivery many small mistakes occur. The majority of these have minimal consequences for staff and patients. However, there are also more serious errors which cause harm, disability and /or longer hospital stays. Serious errors are those that harm the patient or have the potential to cause harm.

A. In your staff position, do you typically have direct interaction or contact with patients?

- YES, I typically have direct interaction or contact with patients.
- NO, I typically do NOT have direct interaction or contact with patients → *THANK YOU, please return the survey without completing any additional questions.*

B. In what setting do you spend most of your work time:

- Acute in-patient
- Long term/continuing care
- Ambulatory clinic
- Community
- Many different settings/no specific setting

C. What is your primary work area? Select ONE answer.

- Many different hospital units/no specific unit
- Medicine (non-surgical)
- Surgery
- Obstetrics
- Pediatrics
- Emergency department
- Intensive care unit (any type)
- Psychiatry/mental health
- Rehabilitation
- Chronic care
- Pharmacy
- Laboratory
- Radiology
- Anesthesiology
- Other

D. Indicate the extent to which you agree or disagree with each of the following statements.

	strongly disagree	disagree	neutral	agree	strongly agree	not applicable
1. Patient safety decisions are made at the proper level by the most qualified people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Good communication flow exists up the chain of command regarding patient safety issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. If I make a serious error I worry that I will face disciplinary action from the college	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Senior management has a clear picture of the risk associated with patient care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Senior management provides a climate that promotes patient safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. When an incident is reported, it seems like the person is being written up, not the problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I would feel ashamed if I made a serious error and my co-workers heard about it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. There is no point in talking about a patient safety problem because nothing usually gets done about it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Senior management considers patient safety when program changes are discussed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. My co-workers will think I am incompetent if they know I've made a serious error	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. If I make a serious error my manager will think I am incompetent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. On my unit, staff who report a <i>co-worker's</i> error are labelled as 'not being a team player'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. I am rewarded for taking quick action to identify a serious error	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. My co-workers would support me if they learned of a serious error I made	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. On this unit it is difficult to speak up if you feel there is a problem related to patient safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. My co-workers will lose respect for me if they know I've made a serious error	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. If I report a patient safety incident, someone usually follows up to get more information from me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	strongly disagree	disagree	neutral	agree	strongly agree	not applicable
18. Making a serious error may cause a staff member to lose his/her job.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. On this unit it is difficult to question the decisions or actions of those with more authority	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. If I point out a potentially serious patient safety incident, management will look into it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. Others make you feel like a bit of a failure when you make a error	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. My organization effectively balances the need for patient safety and the need for productivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. I work in an environment where patient safety is a high priority	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. Staff are usually given feedback about changes put into place based on incident reports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. If I make a serious error I worry that I will face disciplinary action from management	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. Making a serious error would limit my career opportunities around here	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. If I made a serious error my manager would be supportive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. Individuals involved in patient safety incidents have a quick and easy way to report what happened	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. My supervisor/manager seriously considers staff suggestions for improving patient safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31. Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32. My supervisor/manager overlooks patient safety problems that happen over and over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. On this unit, when a serious error occurs, we think about it carefully	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34. On this unit, when people make a serious error, they ask others about how they could have prevented it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35. On this unit, after a serious error has occurred, we think about how it came about and how to prevent the same mistake in the future	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36. On this unit, when a serious error occurs, we analyze it thoroughly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
37. On this unit, it is difficult to discuss errors	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
38. On this unit, after a serious error has occurred, we think long and hard about how to correct it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
40. Please give the organization an overall grade on patient safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Finally, please help us to analyze these survey data by providing the following information:

Select ONE answer that best describes your role:

- | | | | |
|---------------------------------------------|---------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------|
| <input type="radio"/> RN | <input type="radio"/> Pharmacist | <input type="radio"/> Technician (e.g., EKG, Lab, Radiology) | <input type="radio"/> Attending/Staff Physician |
| <input type="radio"/> RPN / LPN | <input type="radio"/> Dietician | <input type="radio"/> Unit Assistant/Clerk/Secretary | <input type="radio"/> Resident Physician/Physician in Training |
| <input type="radio"/> Clinical educator | <input type="radio"/> PT, OT, or Speech Therapist | <input type="radio"/> Health care aide | <input type="radio"/> EMS staff |
| <input type="radio"/> Clinical care manager | <input type="radio"/> Respiratory Therapist | <input type="radio"/> Administration/Management | <input type="radio"/> Other: _____ |

Time in your current profession:

- < 1 yr
- 1-5 yrs
- 6-10 yrs
- 11-20 yrs
- > 20 yrs

Time in this organization:

- < 1 yr
- 1-5 yrs
- 6-10 yrs
- 11-20 yrs
- > 20 yrs

Age:

- ≤ 30
- 31-40
- 41-50
- 51-60
- > 60

Gender:

- Female
- Male

Mother tongue (1st language learned):

- English
- Not English