YORK UNIVERSITÉ UNIVERSITY

2007 MSI Dimensions & Items

F1 – Senior leadership support for safety (valuing safety), 7-items, alpha = 0.88	2007 Q #s
Patient safety decisions are made at the proper level by the most qualified people	1
Good communication flow exists up the chain of command regarding patient safety issues	2
Senior management has a clear picture of the risk associated with patient care	4
Senior management provides a climate that promotes patient safety	7
Senior management considers patient safety when program changes are discussed	12
My organization effectively balances the need for patient safety and the need for productivity	25
I work in an environment where patient safety is a high priority	26

F2 – Supervisory leadership for safety, 7-items, alpha = 0.81	2007 Q #s
My unit takes the time to identify and assess risks to patients	5
My unit does a good job managing risks to ensure patient safety	6
I am rewarded for taking quick action to identify a serious mistake	16
My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	29
My supervisor/manager seriously considers staff suggestions for improving patient safety	30
(*) Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	31*
(*) My supervisor/manager overlooks patient safety problems that happen over and over	32*

F3 – Threats to Safety, 9-items alpha = 0.69	2007 Q #s
(**) I am less effective at work when I am fatigued	11**
(**) Personal problems can adversely affect my performance	13**
(*) Loss of experienced personnel has negatively affected my ability to provide high quality patient care	17*
I have enough time to complete patient care tasks safely	18
(*) 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	20*
I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	21
(*) I have made significant errors in my work that I attribute to my own fatigue	22*
(**) I believe that health care error constitutes a real and significant risk to the patients that we treat	23**
(*) I believe health care errors often go unreported	24*

F4 – Fear of repercussions, 4-items alpha = 0.69	2007 Q #s
(*) Reporting a patient safety problem will result in negative repercussions for the person reporting it	3*
(*) Asking for help is a sign of incompetence	8*
(*) If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	9*
(*) I will suffer negative consequences if I report a patient safety problem	14*

F5 – Learning responses, , 5-items alpha = 0.77	2007 Q #s
Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	41
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	42
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	44
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	45
Changes are made to reduce re-occurrence of major events	46

NOTE: The following 2 dimensions were new on the 2007 MSI,

F6 – Reporting culture	2007 Q #s
I am sure that if I report an incident to our reporting system, it will not be used against me	10
(*) I am not sure about the value of completing incident reports	19*
If I report a patient safety incident, I know that management will act on it	15
Staff are given feedback about changes put into place based on incident reports (modified from AHRQ C1).	27
***Individuals involved in patient safety incidents have a quick and easy way to report what happened	28

F7 – Learning culture	2007 Q #s
On this unit, when an incident occurs, we think about it carefully	33
On this unit, when an incident occurs, we analyze it thoroughly	36
On this unit, after an incident has happened, we think long and hard about how to correct it	38
On this unit, after an incident has happened, we think about how it came about and how to prevent the same mistake in the future	35
On this unit, when people make mistakes, they ask others about how they could have prevented it	34
(*) On this unit, it is difficult to discuss errors (modified from SAQ)	37*

(*) questions are negative in their wording so disagreement is the positive response
** questions are treated as negative for scale calculation but not when reporting % positive
*** wording was changed so subject is PS incidents rather than major events as in previous c34