Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture

Background and Information for Translators

September 2009

Purpose and Use of This Document

In this document, we provide information about the AHRQ *Hospital Survey on Patient Safety Culture* to help translation team members develop a translation that conveys the same meaning as the original U.S. English version.

First, we present background information about the survey, including its purpose and intended target population. Next, we group the survey items according to the patient safety culture dimensions they assess and provide more information about the intended meaning of the items.

Background on the Survey

Recognizing the need for a tool to assess the culture of patient safety in health care organizations, the Agency for Healthcare Research and Quality (AHRQ) developed the *Hospital Survey on Patient Safety Culture,* which was released in November 2004.

What is "patient safety culture"? Patient safety is a critical component of health care quality. As health care organizations continually strive to improve, there is a growing recognition of the importance of establishing a culture of safety. Achieving a culture of safety requires an understanding of the values, beliefs, and norms about what is important in an organization and what attitudes and behaviors related to patient safety are expected and appropriate. A definition of safety culture is provided below.

Safety Culture Definition

The safety culture of an organization is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management. Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.

Organising for Safety: Third Report of the ACSNI (Advisory Committee on the Safety of Nuclear Installations) Study Group on Human Factors. Health and Safety Commission (of Great Britain). Sudbury, England: HSE Books, 1993.

What title should I use on the survey? In the U.S. we recommend using the title "Hospital Survey on Patient Safety" and *not* including the word "Culture." The reason is that in the U.S. some respondents do not know what patient safety culture means - they tend to confuse the word "culture" with ethnicity and race. If you think respondents in your country understand the term "patient safety culture," you may leave the word "culture" in the title.

How can the survey be used? The hospital survey can be used as an intervention to raise staff awareness about patient safety issues, as a diagnostic tool to assess the status of patient safety culture in a hospital, to identify patient safety culture strengths and areas for improvement, to evaluate the impact of patient safety improvement initiatives, to examine trends in patient safety culture change over time, and to facilitate comparisons with other hospitals on patient safety culture.

Who should complete the survey? The *Hospital Survey on Patient Safety Culture* examines patient safety culture from a hospital staff perspective. The survey can be completed by all types of hospital staff—from housekeeping and security to nurses and physicians. The survey is best suited for the following, however:

- Hospital staff who have direct contact or interaction with patients (clinical staff, such as nurses, or nonclinical staff, such as unit clerks);

- Hospital staff who may not have direct contact or interaction with patients but whose work directly affects patient care (staff in units such as pharmacy, laboratory/pathology);

- Hospital-employed physicians who spend most of their work hours in the hospital (emergency department physicians, hospitalists, pathologists); and

- Hospital supervisors, managers, and administrators.

The overall goal is to administer the survey to staff who know the hospital's culture well enough to be a good informant on the culture.

Can the work area or staff position categories be modified? Hospitals can modify or customize the work areas/departments and staff position titles as needed since hospitals usually use different terms to refer to their departments and job titles. Customizing these categories will allow hospitals to analyze their data by these specific categories and will provide feedback results that are meaningful to their hospitals. However, to enable comparisons across hospitals within a larger health system, all hospitals within a system should use the same work areas and staff position categories.

Does the hospital survey focus on hospital units or on the hospital overall? The survey focuses mostly on patient safety culture at the unit level, because staff will be most familiar with patient safety culture at this level. There also is a section in the survey that asks about the hospital as a whole. A small hospital that does not have differentiated units may want to consider modifying some of the instructions and/or items in the survey from a focus on the "unit" to a focus on the hospital as a whole. Also, the term "unit" may be replaced by an equivalent term, such as "department," if it suits the hospital (just be sure to make this replacement everywhere it applies in the survey, including instructions and section titles).

How was the survey tested? The draft survey was pretested during cognitive interviews with hospital staff to ensure that items were easy to understand and relevant to patient safety in a hospital setting. The items were revised as appropriate, and the survey was then pilot tested with more than 1,400 hospital employees from 21 hospitals across the United States. Exploratory and confirmatory factor analyses were conducted to examine the factor structure of the survey, and the survey was revised so that the final items and dimensions have sound psychometric properties. The final survey contains 42 items measuring 12 dimensions. The survey also includes questions asking for an overall rating on patient safety and the number of events reported in the past 12 months, background questions, and a comments section.

How can I get a copy of the survey? The survey is available on the AHRQ Web site, along with a User's Guide and an Items and Dimensions document, which groups the survey items according to the dimensions they are intended to measure: http://www.ahrq.gov/qual/patientsafetyculture/hospsurvindex.htm

AHRQ Hospital Survey on Patient Safety Culture:
More Information About the Items

In this document, the items in the *Hospital Survey on Patient Safety Culture* are grouped according to the patient safety culture dimensions they are intended to measure. The item's survey location is shown to the left of each item. For some items, more information (appears in italic font) is provided to help translators convey the correct meaning of the items.

1. Teamwork Within Units

(Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree)

A1. People support one another in this unit. *(More about this item: All staff help one another as needed.)*

A3. When a lot of work needs to be done quickly, we work together as a team to get the work done.

A4. In this unit, people treat each other with respect. *(More about this item: "People" means all staff, including doctors, treat all other staff with respect.)*

A11. When one area in this unit gets really busy, others help out.

2. Supervisor/Manager Expectations & Actions Promoting Patient Safety[1]

(Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree)

B1. My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures. *(More about this item: "Says a good word" means "praises staff.")*

B2. My supervisor/manager seriously considers staff suggestions for improving patient safety.

B3. Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts. (negatively worded) *(More about this item:"Taking shortcuts" means not following all the standard procedures to get work done faster. The item states that the supervisor encourages staff to not follow all procedures when there is a lot of work to be done. "Shortcuts" also implies that this is not good, not safe for patients.)*

B4. My supervisor/manager overlooks patient safety problems that happen over and over. (negatively worded) *(More about this item: "Overlooks" means "ignores" or "does not pay attention to"; "over and over" means "again and again" or "repeatedly.")*

3. Organizational Learning⎯Continuous Improvement

(Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree)

A6. We are actively doing things to improve patient safety.

A9. Mistakes have led to positive changes here.

A13. After we make changes to improve patient safety, we evaluate their effectiveness. *(More about this item: Hospital managers/administrators compare patient safety before and after changes are made to see if the changes actually lead to improvements in patient safety.)*

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[1] Adapted from Zohar. A group-level model of safety climate: Testing the effect of group climate on microaccidents in manufacturing jobs. Journal of Applied Psychology 2000;85:587-96.

4. Management Support for Patient Safety

(Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree)

> F1. Hospital management provides a work climate that promotes patient safety.
>
> F8. The actions of hospital management show that patient safety is a top priority.
>
> F9. Hospital management seems interested in patient safety only after an adverse event happens. (negatively worded) *(More about this item: Hospital managers do not usually show interest in patient safety—they show interest in patient safety only when there is an adverse event.)*

5. Overall Perceptions of Patient Safety

(Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree)

> A15. Patient safety is never sacrificed to get more work done. *(More about this item: Patient safety is more important than the amount of work done—it implies that patient safety will come first and that procedures will be followed to ensure patient safety, even if it means less work is accomplished or it takes longer to do something safely.)*
>
> A18. Our procedures and systems are good at preventing errors from happening.
>
> A10. It is just by chance that more serious mistakes don't happen around here. (negatively worded) *(More about this item: It is because of good luck or good fortune that more mistakes do not happen. In other words, the reason mistakes do not happen more often is good luck, NOT because procedures or systems are safe.)*
>
> A17. We have patient safety problems in this unit. (negatively worded)

6. Feedback & Communication About Error

(Never, Rarely, Sometimes, Most of the time, Always)

> C1. We are given feedback about changes put into place based on event reports. *(More about this item: Management/supervisors tell staff about changes implemented to improve patient safety that were implemented as a result of information that came from event reports.)*
>
> C3. We are informed about errors that happen in this unit.
>
> C5. In this unit, we discuss ways to prevent errors from happening again.

7. Communication Openness

(Never, Rarely, Sometimes, Most of the time, Always)

> C2. Staff will freely speak up if they see something that may negatively affect patient care. *(More about this item: "Speak up" means to notify someone in authority about the problem.)*
>
> C4. Staff feel free to question the decisions or actions of those with more authority.
>
> C6. Staff are afraid to ask questions when something does not seem right. (negatively worded) *(More about this item: Staff fear reprisals/retaliation or think they will get in trouble if they ask questions about something they think might be a problem.)*

8. Frequency of Events Reported *(More about this item: Refers to reports made to someone in authority or reports submitted through the hospital's event reporting system; the items are NOT about disclosure or reporting of errors to patients.)*

(Never, Rarely, Sometimes, Most of the time, Always)

- D1.   When a mistake is made, but is *caught and corrected before affecting the patient*, how often is this reported?
- D2.   When a mistake is made, but has *no potential to harm the patient*, how often is this reported?
- D3.   When a mistake is made that *could harm the patient*, but does not, how often is this reported? *(More about this item: The difference between this item and D1 is that the mistake occurs in D3 – it is not corrected in D3. Although the mistake actually occurs, there is no harm to the patient, but there could have been harm to the patient.)*

9. Teamwork Across Units

(Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree)

- F4.   There is good cooperation among hospital units that need to work together.
- F10. Hospital units work well together to provide the best care for patients.
- F2.   Hospital units do not coordinate well with each other. (negatively worded)
- F6.   It is often unpleasant to work with staff from other hospital units. (negatively worded)

10. Staffing

(Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree)

- A2.   We have enough staff to handle the workload. *(More about this item: "To handle the workload" means "to do all the work.")*
- A5.   Staff in this unit work longer hours than is best for patient care. (negatively worded) *(More about this item: Staff work too many hours, which is not good for patient care.)*
- A7.   We use more agency/temporary staff than is best for patient care. (negatively worded) [*More about this item: We use more temporary staff (contract staff or nonpermanent staff) than we should, which is not good for patient care.*]
- A14. We work in "crisis mode" trying to do too much, too quickly. (negatively worded) *(More about this item: We work in a hurry, trying to do too much, too quickly.)*

11. Handoffs & Transitions

(Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree)

- F3.   Things "fall between the cracks" when transferring patients from one unit to another. (negatively worded) *(More about this item: Information gets lost or is not communicated when transferring patients.)*
- F5.   Important patient care information is often lost during shift changes. (negatively worded)
- F7.   Problems often occur in the exchange of information across hospital units. (negatively worded)

F11. Shift changes are problematic for patients in this hospital. (negatively worded) *(More about this item: Shift changes cause problems for patients in this hospital—problems happen because staff are so busy arriving and leaving that patients' needs are not met during the shift changes or information about patients is not shared with staff on the new shift.)*

12. Nonpunitive Response to Errors *(More about this dimension: In a nonpunitive environment, when a mistake happens, those in authority look at all factors that contributed to the mistake, including the organization's systems, practices, and procedures. They do not first conclude the staff member is at fault.)*

(Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree)

A8. Staff feel like their mistakes are held against them. (negatively worded)

A12. When an event is reported, it feels like the person is being written up, not the problem. (negatively worded) *(More about this item: When an event is reported, it feels like the person is the focus of blame and gets in trouble instead of focusing on the causes or solutions to the problem.)*

A16. Staff worry that mistakes they make are kept in their personnel file. (negatively worded) *(More about this item: Staff worry that their mistakes are being documented, are kept in their personnel files, and will be used to judge their work performance poorly.)*

Patient Safety Grade

(Excellent, Very Good, Acceptable, Poor, Failing)

E1. Please give your work area/unit in this hospital an overall grade on patient safety. *(More about this item: A "grade" is a rating given to assess work performance. The term "rating" can be used instead of "grade.")*

Number of Events Reported

(No event reports, 1 to 2 event reports, 3 to 5 event reports, 6 to 10 event reports, 11 to 20 event reports, 21 event reports or more)

G1. In the past 12 months, how many event reports have you filled out and submitted?

Note: Negatively worded questions should be reverse coded when calculating percent "positive" response, means, and composites.