



Surveys on Patient Safety Culture®

Findings From the 2024 Hospital 2.0 Database



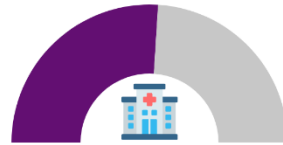
445

Participating Hospitals



284,036

Provider and Staff Respondents



52%

Average Response Rate Across Hospitals

Highest Scoring Composite Measures



Teamwork

81%

of respondents reported that staff work together as an effective team, help each other during busy times, and are respectful.



Supervisor, Manager, or Clinical Leader Support for Patient Safety

80%

of respondents reported that supervisors, managers, or clinical leaders consider staff suggestions for improving patient safety, do not encourage taking shortcuts, and take action to address patient safety concerns.

Lowest Scoring Composite Measures



Response to Error

64%

of respondents reported that staff are treated fairly when they make mistakes and there is a focus on learning from mistakes and supporting staff involved in errors.



Staffing and Work Pace

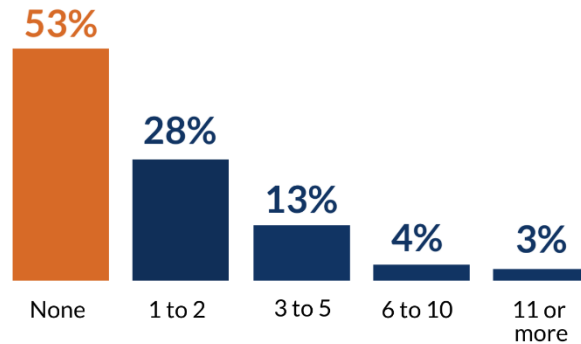
55%

of respondents reported there are enough staff to handle the workload, staff work appropriate hours and do not feel rushed, and there is an appropriate reliance on temporary, float, or PRN staff.

Note: Composite measures are composed of two to four survey items that assess the same area of patient safety culture.

Number of Events Reported

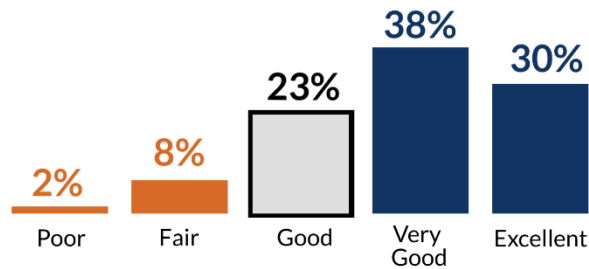
47% of respondents reported at least one patient safety event in the last 12 months.



Note: Chart totals may not add to 100% due to rounding.

Overall Rating on Patient Safety

68% of respondents rated their hospital as Excellent or Very Good.



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Database Results from 2021 to 2024

Communication About Error

had the largest average percent positive increase of 4 percentage points from 2021 to 2024

71% ↑ **75%**

Staffing and Work Pace

had the largest average percent positive decrease of 3 percentage points from 2021 to 2024

58% ↓ **55%**

What's Next? Action planning for patient safety improvement

The *Action Planning Tool for the AHRQ Surveys on Patient Safety Culture* provides step-by-step guidance on how to develop an action plan to improve patient safety culture, available at www.ahrq.gov/sops/resources/planning-tool.

To view the full report: <https://www.ahrq.gov/sops/databases/hospital>

For more information on SOPS Hospital Database submission: <https://www.ahrq.gov/sops/databases/hospital/databases/submission>