SOPS® Hospital Survey Items and Composite

Version: 1.0
Language: English

Note

- For more information on getting started, selecting a sample, determining data collection methods, establishing data collection procedures, conducting a Web-based survey, and preparing and analyzing data, and producing reports, please see the **Survey User's Guide.**
- To view the formatted questionnaire, see the **Hospital Survey**.
- To participate in the AHRQ Hospital Survey on Patient Safety Culture Comparative Database, the survey must have been administered in its entirety without significant modifications or deletions:
  - o No changes to any of the survey item text and response options.
  - o No reordering of survey items.
  - o Questions added only at the end of the survey after Section G, before the demographic questions in Section H.

For assistance with this survey, please contact the SOPS Help Line at 1-888-324-9749 or SafetyCultureSurveys@westat.com.

Surveys on Patient Safety Culture™

Hospital Survey on Patient Safety Culture: Items and Composites

In this document, the items in the Hospital Survey on Patient Safety Culture are grouped according to the safety culture composites they are intended to measure. The item's survey location is shown to the left of each item. Negatively worded items are indicated.

1. Teamwork Within Units

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

A1. People support one another in this unit.
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.
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.
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)
B4. My supervisor/manager overlooks patient safety problems that happen over and over. (negatively worded)

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.

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)

[1] Adapted from Zohar (2000). A group-level model of safety climate: Testing the effect of group climate on microaccidents in manufacturing jobs. Journal of Applied Psychology, (85) 4, 587-596.

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

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.
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)
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.
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.
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)

8. Frequency of Events Reported

(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?

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.
A5. Staff in this unit work longer hours than is best for patient care. (negatively worded)
A7. We use more agency/temporary staff than is best for patient care. (negatively worded)
A14. We work in "crisis mode" trying to do too much, too quickly. (negatively worded)

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

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)
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)

12. Nonpunitive Response to Error

(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)
A16. Staff worry that mistakes they make are kept in their personnel file. (negatively worded)

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.

Number of Events Reported

(No event reports, 1 to 2 event reports, 3 to 5 event report, 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.