

## **Hospital and Nursing Home Surveys on Patient Safety Culture**

**HSAG Pressure Ulcer Collaborative  
Learning Session 3  
May 7, 2009**

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## **Hospital Survey Background**

*The development of the Hospital Survey on Patient Safety Culture was sponsored by the Quality Interagency Coordination Task Force (QuIC), a group established in accordance with a 1998 Presidential directive to ensure that all federal agencies involved in purchasing, providing, studying, or regulating health care services are working together toward a common goal of improving quality care. The survey was funded by the Agency for Healthcare Research and Quality (AHRQ).*

*Researchers conducted a review of the scientific literature pertaining to safety, medical error, accidents, error reporting, safety climate/culture, and organizational climate/culture. Researchers also reviewed published and unpublished safety culture surveys, conducted interviews with hospital staff members to identify key patient safety and error reporting issues, and pretested the survey in hospitals across the U.S. This pilot data was analyzed and the survey was revised to retain only the best items and scales.*

Source: <http://www.ahrq.gov/qual/patientsafetyculture/hospcult1.htm> 2

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## 10 Areas of Hospital Patient Safety

### Survey Areas:

1. Supervisor/Manager Expectations and Actions Promoting Safety (4 items)
2. Organizational Learning—Continuous Improvement (3 items)
3. Teamwork Within Units (4 items)
4. Communication Openness (3 items)
5. Feedback and Communication About Error (3 items)
6. Nonpunitive Response to Error (3 items)
7. Staffing (4 items)
8. Hospital Management Support for Patient Safety (3 items)
9. Teamwork Across Hospital Units (4 items)
10. Hospital Handoffs and Transitions (4 items)

### Outcome Variables Included:

1. Overall Perceptions of Safety (4 items)
2. Frequency of Event Reporting (3 items)
3. Patient Safety Grade (of the Hospital Unit) (1 item)
4. Number of Events Reported (1 item)

Source: <http://www.ahrq.gov/qual/patientsafetyculture/hospcult1.htm> 3

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## Nursing Home Survey Background

- Expanded from the AHRQ Hospital Survey on Patient Safety Culture
  - <http://www.ahrq.gov/qual/patientsafetyculture/>
- Specifically designed to measure the culture of resident safety in nursing homes from a staff perspective
  - Assess staff attitudes and beliefs about resident safety
  - Assess many areas similar to the hospital survey, but items are different
- Pilot tested in 2007 in 40 U.S. nursing homes with 3,698 respondents
  - Final survey released on the AHRQ Web site in 2008

Source: *Nursing Home Survey on Patient Safety Culture*, March 2009. Agency for Healthcare Research and Quality, Rockville, MD.  
<http://www.ahrq.gov/qual/patientsafetyculture/nhsurindex.htm>

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## 12 Areas of Resident Safety

### Survey Areas:

1. Teamwork
2. Staffing
3. Compliance With Procedures
4. Training & Skills
5. Nonpunitive Response to Mistakes
6. Handoffs
7. Feedback & Communications About Incidents
8. Communication Openness
9. Supervisor Expectations & Actions Promoting Resident Safety
10. Overall Perceptions of Resident Safety
11. Management Support for Resident Safety
12. Organizational Learning

### Overall Ratings:

1. Overall rating on resident safety
2. Whether staff would tell friends this is a safe nursing home for their family

Source: *Nursing Home Survey on Patient Safety Culture*, March 2009. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/qual/patientsafetyculture/nhsurvindex.htm>

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## Survey Considerations

### Survey Implementation

- How
  - Paper survey
  - SurveyMonkey
- Who
  - What disciplines to target
- When
  - May 2009 rollout
  - Completed surveys due to HSAG by July 31, 2009

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## Survey Process

HSAG will:

- Provide facilities with surveys and informational material.
- Provide facilities with the SurveyMonkey Web site link.
- Receive paper survey results.
- Compile and report back results to facilities no later than January 2010.

*These results represent the facility baseline for remeasurement.*

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*Over 1 million drug-related injuries occur every year in health care settings. The Institute of Medicine estimates that at least a quarter of these injuries are preventable.*

**To find out how to prevent medication errors, go to <http://www.hsag.com/drugsafety/>.**



[www.hsag.com](http://www.hsag.com)

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