Hospital Survey on Patient Safety Culture: 2008 Comparative Database Report

Part II: Appendix A—Overall Results by Hospital Characteristics

Appendix B—Overall Results by Respondent Characteristics

Part III: Appendix C—Trending Results by Respondent Characteristics

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Appendixes A & B: Overall Results by Hospital and Respondent Characteristics

Appendixes A and B present data tables that show average percent positive scores on the survey composites and items across database hospitals broken down by the following hospital and respondent characteristics:

Appendix A: Results by Hospital Characteristics

- \succ 1-Bed size
- ➢ 2-Teaching status
- ➢ 3-Ownership and control
- ➢ 4-Geographic region

Appendix B: Results by Respondent Characteristics

- ➤ 1-Work area/unit
- 2-Staff position
- ➤ 3-Interaction with patients

Highlights from these results by hospital and respondent characteristics were presented in the main body of the report, Part I: Comparative Database Report, at the end of Chapter 6 and are also shown on the next two pages. Highlights were based on results for the 12 patient safety culture composites, and on patient safety grade and number of events reported. In the bottom row of the composite-level tables, an overall average across composites is shown as a summary statistic when comparing across breakout categories.

To ensure hospital confidentiality, a rule was established requiring at least 20 hospitals to be in a particular breakout category before data would be displayed by that category. Therefore, in Appendix A some of the standard AHA bed size categories and regions have been combined.

You can compare your hospital's percent positive scores on the patient safety culture composites and items against the averages shown in Appendix A for hospitals with your same bed size, teaching status, ownership and control, and geographic region. You can use a 5 percent difference as a rule of thumb for determining what differences to pay attention to.

To compare your hospital's results against Appendix B, your hospital will have to compute percent positive scores on the safety culture composites and items broken down by respondent work area/unit, staff position, and interaction with patients. You would then compare your hospital's percent positive scores against the averages shown in the tables.

Again, you can use a 5 percent difference as a rule of thumb for determining what differences to pay attention to. *Hospitals that did not ask respondents for their work area/unit, staff position, or about interaction with patients will not be able to make comparisons by these categories, and such hospitals were excluded from the breakout tables in Appendix B. Also, respondents who selected "Many different work areas/No specific work area" (for their work area), "Other" (for their work area or staff position), or did not answer (missing) were not included in the breakout tables in Appendix B.*

Highlights from Appendix A: Overall Results by Hospital Characteristics

Bed Size (Tables A-1, A-3, A-4)

- Smaller hospitals (49 beds or fewer) had the highest average positive response on all 12 patient safety culture composites.
- The largest difference by bed size was on *Handoffs & Transitions* where the smallest hospitals (6-24 beds) scored 21 percent higher than the largest hospitals (400+ beds) (56 percent compared to 35 percent positive).
- The smallest difference by bed size was 6 percent on *Feedback & Communication About Error*.
- Large hospitals (400+ beds) scored lowest on the percent of respondents who gave their work area/unit a patient safety grade of "Excellent" or "Very good" (64 percent for 400+ beds compared to 78 percent for 25-49 beds).
- There were no noticeable differences on number of events reported based on bed size (all differences were 3 percent or less).

Teaching Status, and Ownership and Control (Tables A-5, A-7, A-8)

- There were no noticeable differences on the composites between the teaching and non-teaching hospitals (differences were 4 percent or less).
- Government-owned hospitals were more positive than non-government owned hospitals on *Handoffs & Transitions* (7 percent more positive), *Staffing* (5 percent more positive), and *Teamwork Across Units* (5 percent more positive).
- There were no noticeable differences on patient safety grade based on teaching status or ownership and control (all differences were 2 percent or less).
- There were no noticeable differences on number of events reported based on teaching status or ownership and control (all differences were 1 percent or less).

<u>Region</u> (Tables A-9, A-11, A-12)

- East South Central and West North Central hospitals scored highest across the 12 patient safety culture composites; Mid-Atlantic/New England, East North Central, and Pacific hospitals scored lowest.
- The largest difference by region was on *Staffing* where West North Central hospitals were 13 percent more positive than Mid Atlantic/New England hospitals (62 percent compared to 49 percent positive).
- Hospitals in the Mid Atlantic/New England and Pacific regions scored lowest on the percent of respondents who gave their work area/unit a patient safety grade of "Excellent" or "Very good" (69 percent for these regions).
- Hospitals in the Pacific region had the highest percent of respondents who reported one or more events in the past year (53 percent); the lowest percent of respondents reporting events was 40 percent in the West South Central region.

Highlights from Appendix B: Overall Results by Respondent Characteristics

Respondent Work Area/Unit (Tables B-1, B-3, B-4)

- Respondents in *Rehabilitation* had the highest average positive response on 9 of the 12 patient safety culture composites.
- The largest difference by work area/unit was on *Overall Perceptions of Patient Safety* (21 percent) (*Rehabilitation* was 76 percent positive; *ICU (any type)* and *Medicine* were 55 percent positive).
- *Rehabilitation* had the highest percent of respondents who gave their work area/unit a patient safety grade of "Excellent" or "Very good" (82 percent); *Emergency* and *Medicine* had the lowest percent (62 percent).
- *ICU (any type)* had the highest percent of respondents reporting one or more events in the past year (68 percent); *Anesthesiology* and *Rehabilitation* had the lowest percent of respondents reporting events (43 percent).

Respondent Staff Position (Tables B-5, B-7, B-8)

- Respondents in *Administration/Management* had the highest average positive response on 11 of the 12 patient safety culture composites.
- The largest difference (27 percent) by staff position was on *Nonpunitive Response to Error; Administration/Management* was 62 percent positive and *Patient Care Assistants Aides/Care Partners* were 35 percent positive.
- Administration/Management had the highest percent of respondents who gave their work area/unit a patient safety grade of "Excellent" or "Very good" (82 percent); *Registered Nurse/LVN/LPN* had the lowest percent (67 percent).
- *Pharmacists* had the highest percent of respondents reporting one or more events in the past year (78 percent); *Unit Assistants/Clerks/Secretaries* had the lowest percent reporting events (23 percent).

Respondent Interaction With Patients (Tables B-9, B-11, B-12)

- Respondents *with* direct patient interaction were 7 percent more positive on *Handoffs & Transitions* compared to those *without* direct patient interaction (46 percent compared to 39 percent positive).
- Respondents *without* direct patient interaction were 7 percent more positive about *Management Support for Patient Safety* than those *with* direct patient interaction (76 percent compared to 69 percent positive).
- Respondents *without* direct patient interaction had the highest percent of respondents who gave their work area/unit a patient safety grade of "Excellent" or "Very good" (76 percent) compared to those *with* direct patient interaction (71 percent).
- More respondents *with* direct patient interaction reported one or more events in the past year (53 percent) than respondents those *without* direct patient interaction (32 percent).

Appendix C: Trending Results by Respondent Characteristics

Part III of the report, Appendix C, shows trends over time for the 98 hospitals (of the 519 total database hospitals) that administered the survey and submitted data twice. Average percent positive scores across hospitals from the most recent and previous administrations are shown on the survey composites and items, broken down by the following respondent characteristics:

Appendix C: Trending Results by Respondent Characteristics

- ➢ 1-Work area/unit
- ➢ 2-Staff position
- ➢ 3-Interaction with patients

Tables 1 and 2 below show examples of the statistics shown in this appendix. The tables show the average percent of respondents who answered positively among the trending hospitals for the hospitals' most recent survey administration (top row) and their previous administration (middle row). The change over time is shown in the bottom row as a negative number if the most recent administration showed a decline, or is shown as a positive number if the most recent administration showed an increase. Changes in scores of 5 percent or greater, whether positive or negative, are bolded.

Table 1: Example of Decrease in Average Score Over Time (Negative Change)

Most Recent	85%
Previous	90%
Change	-5%

Table 2: Example of Increase in Average Score Over Time (Positive Change)

Most Recent	70%
Previous	60%
Change	10%

Highlights of the findings from the breakout tables in this appendix are provided on the following page.

Highlights from Appendix C: Trending Results by Respondent Characteristics

Respondent Work Area/Unit (Tables C-1, C-3, C-4)

- Respondents in *Pediatrics* had the largest increases in positive response over time on 9 of the 12 patient safety culture composites (average increase across the 9 composites was 11 percent).
- Respondents in *Anesthesiology* had the largest decreases in positive response over time on 7 of the 12 patient safety culture composites (average decrease across the 7 composites was 13 percent).
- *Pediatrics* had the largest average percent of respondents who increased over time in giving their work area/unit a patient safety grade of "Excellent" or "Very good" (a 21 percent increase--from 60 to 81 percent); *Anesthesiology* had the largest decrease over time (a 7 percent decrease--from 89 to 82 percent).
- *Anesthesiology* had the largest average percent of respondents who increased over time in their reporting of one or more events in the past year (a 13 percent increase: from 35 to 48 percent); the largest decrease in percent reporting was in *Obstetrics* (an 11 percent decrease from 65 to 54 percent).

Respondent Staff Position (Tables C-5, C-7, C-8)

- *Dieticians* had the largest decreases in positive response over time on 7 of the 12 patient safety culture composites (average decrease across the 7 composites was 8 percent).
- *Pharmacists* had the largest average percent of respondents who increased over time in giving their work area/unit a patient safety grade of "Excellent" or "Very good" (a 15 percent increase--from 67 to 82 percent); *Dieticians* had the largest decrease over time (a 9 percent decrease--from 83 to 74 percent).
- *Pharmacists* had the largest average percent of respondents who increased over time in their reporting of one or more events in the past year (a 12 percent increase from 69 to 81 percent); the largest decrease in percent reporting was with *Therapists (Respiratory, Physical, Occupational, Speech)* (a 5 percent decrease from 43 to 38 percent).

Respondent Interaction With Patients (Tables C-9, C-11, C-12)

- There were no noticeable composite differences over time based on respondent interaction with patients (all were increases over time of 3 percent or less).
- There were no noticeable differences in patient safety grade over time based on respondent direct patient interaction (difference was 1 percent; a 7 percent increase for respondents *with* direct interaction and a 6 percent increase for respondents *without* direct interaction).
- There were no noticeable differences in the number of events reported over time based on respondent interaction with patients (difference was 3 percent; a 5 percent increase for respondents *with* direct interaction and a 2 percent increase for respondents *without* direct interaction).

Appendix A: Overall Results by Hospital Characteristics

Appendix A: Overall Results by Hospital Characteristics

(1) Bed Size

NOTE: The number of hospitals and respondents in each breakout category is shown in each table (e.g., the number of hospitals and respondents by bed size, teaching status, region, etc.). However, the precise number of hospitals and respondents corresponding to each data cell in a table will vary because hospitals may have omitted a specific survey item and because of individual non-response/missing data.

	Bed Size						
Patient Safety Culture Composites	6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-399 beds	400 or more beds
# Hospitals # Respondents	58 3,601	131 12,421	98 14,243	86 22,092	57 27,730	42 27,568	47 52,521
1. Teamwork Within Units	83%	82%	79%	76%	74%	76%	75%
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	76%	78%	75%	74%	71%	72%	70%
3. Management Support for Patient Safety	75%	76%	71%	67%	65%	66%	62%
4. Org LearningContinuous Improvement	71%	74%	71%	68%	67%	68%	66%
5. Overall Perceptions of Patient Safety	69%	70%	66%	61%	59%	59%	56%
6. Feedback & Communication About Error	65%	65%	62%	60%	60%	60%	59%
7. Communication Openness	66%	64%	62%	60%	59%	60%	60%
8. Frequency of Events Reported	64%	62%	60%	59%	57%	59%	54%
9. Teamwork Across Units	66%	63%	59%	54%	50%	52%	47%
10. Staffing	63%	61%	56%	50%	48%	49%	48%
11. Handoffs & Transitions	56%	50%	46%	40%	37%	39%	35%
12. Nonpunitive Response to Error	48%	48%	44%	42%	40%	40%	37%
Average Across Composites	67%	66%	63%	59%	57%	58%	56%

Table A-1. Composite-level Average Percent Positive Response by Hospital Bed Size

		Bed Size						
Item	Survey Items By Composite	6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-399 beds	400 or more beds
	# Hospitals # Respondents	58 3,601	131 12,421	98 14,243	86 22,092	57 27,730	42 27,568	47 52,521
1.	Teamwork Within Units							
A1	1. People support one another in this unit.	87%	87%	85%	82%	80%	82%	81%
A3	2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	90%	89%	86%	82%	81%	84%	81%
A4	3. In this unit, people treat each other with respect.	80%	80%	78%	75%	73%	75%	73%
A11	4. When one area in this unit gets really busy, others help out.	73%	71%	68%	66%	64%	66%	63%
2.	Supervisor/Manager Expectations & Actions Promoting Patient Safety							
B1	1. My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures.	72%	73%	71%	70%	68%	69%	68%
B2	My supv/mgr seriously considers staff suggestions for improving patient safety.	77%	80%	76%	74%	72%	72%	72%
B3R	3. Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts.	79%	79%	76%	72%	69%	70%	67%
B4R	 My supv/mgr overlooks patient safety problems that happen over and over. 	77%	80%	78%	75%	71%	73%	71%
3.	Management Support for Patient Safety							
F1	1. Hospital mgmt provides a work climate that promotes patient safety.	84%	85%	81%	76%	74%	76%	72%
F8	2. The actions of hospital mgmt show that patient safety is a top priority.	75%	77%	72%	68%	67%	68%	65%
F9R	3. Hospital mgmt seems interested in patient safety only after an adverse event happens.	64%	66%	60%	56%	54%	55%	50%

Table A-2. Item-level Average Percent Positive Response by Hospital Bed Size (Page 1 of 4)

					Bed Siz	e		
ltem	Survey Items By Composite	6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-399 beds	400 or more beds
	# Hospitals # Respondents	58 3,601	131 12,421	98 14,243	86 22,092	57 27,730	42 27,568	47 52,521
4.	Organizational Learning— Continuous Improvement							
A6	 We are actively doing things to improve patient safety. 	83%	84%	82%	78%	77%	79%	77%
A9	2. Mistakes have led to positive changes here.	65%	67%	63%	60%	58%	60%	58%
A13	3. After we make changes to improve patient safety, we evaluate their effectiveness.		71%	68%	65%	65%	64%	62%
5.	Overall Perceptions of Patient Safety							
A10R	1. It is just by chance that more serious mistakes don't happen around here.	66%	66%	61%	57%	55%	57%	53%
A15	2. Patient safety is never sacrificed to get more work done.	72%	71%	66%	60%	58%	57%	55%
A17R	3. We have patient safety problems in this unit.	69%	69%	64%	59%	56%	56%	52%
A18	4. Our procedures and systems are good at preventing errors from happening.	70%	74%	71%	67%	65%	67%	64%
6.	Feedback and Communication About Error							
C1	1. We are given feedback about changes put into place based on event reports.	52%	54%	51%	51%	52%	53%	53%
C3	2. We are informed about errors that happen in this unit.	68%	67%	65%	61%	61%	61%	59%
C5	3. In this unit, we discuss ways to prevent errors from happening again.	74%	74%	70%	68%	66%	66%	65%

Table A-2. Item-level Average Percent Positive Response by Hospital Bed Size (Page 2 of 4)

					Bed Siz	e		
ltem	Survey Items By Composite	6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-399 beds	400 or more beds
	# Hospitals # Respondents	58 3,601	131 12,421	98 14,243	86 22,092	57 27,730	42 27,568	47 52,521
7.	Communication Openness							
C2	1. Staff will freely speak up if they see something that may negatively affect patient care.	79%	77%	76%	74%	72%	74%	72%
C4	2. Staff feel free to question the decisions or actions of those with more authority.	51%	48%	47%	45%	46%	46%	46%
C6R	 Staff are afraid to ask questions when something does not seem right. 		66%	62%	61%	58%	61%	60%
8.	Frequency of Events Reported							
D1	1. When a mistake is made, but is <u>caught and</u> <u>corrected before affecting the patient</u> , how often is this reported?	54%	53%	51%	50%	49%	51%	47%
D2	2. When a mistake is made, but has <u>no potential</u> to harm the patient, how often is this reported?	60%	58%	55%	55%	52%	54%	50%
D3	3. When a mistake is made that <u>could harm the</u> <u>patient</u> , but does not, how often is this reported?	77%	76%	73%	71%	69%	71%	67%
9.	Teamwork Across Units							
F2R	1. Hospital units do not coordinate well with each other.	55%	51%	47%	42%	38%	40%	34%
F4	2. There is good cooperation among hospital units that need to work together.	69%	64%	60%	54%	50%	53%	47%
F6R	3. It is often unpleasant to work with staff from other hospital units.	65%	64%	59%	55%	52%	54%	51%
F10	4. Hospital units work well together to provide the best care for patients.	77%	73%	69%	63%	59%	62%	56%

Table A-2. Item-level Average Percent Positive Response by Hospital Bed Size (Page 3 of 4)

		Bed Size						
Item	Survey Items By Composite	6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-399 beds	400 or more beds
	# Hospitals # Respondents	58 3,601	131 12,421	98 14,243	86 22,092	57 27,730	42 27,568	47 52,521
10.	Staffing							
A2	1. We have enough staff to handle the workload.	64%	62%	56%	48%	46%	46%	45%
A5R	2. Staff in this unit work longer hours than is best for patient care.	58%	57%	53%	47%	48%	48%	48%
A7R	3. We use more agency/temporary staff than is best for patient care.		68%	64%	60%	58%	61%	61%
A14R	 4. We work in "crisis mode" trying to do too much, too quickly. 		57%	52%	43%	41%	42%	40%
11.	Handoffs & Transitions							
F3R	1. Things "fall between the cracks" when transferring patients from one unit to another.	55%	48%	44%	36%	33%	33%	29%
F5R	2. Important patient care information is often lost during shift changes.	57%	52%	50%	45%	44%	46%	44%
F7R	3. Problems often occur in the exchange of information across hospital units.	54%	48%	43%	38%	35%	36%	32%
F11R	4. Shift changes are problematic for patients in this hospital.	57%	51%	47%	41%	38%	40%	36%
12.	Nonpunitive Response to Error							
A8R	1. Staff feel like their mistakes are held against them.	55%	55%	52%	49%	46%	47%	44%
A12R	2. When an event is reported, it feels like the person is being written up, not the problem.	48%	48%	45%	43%	42%	42%	39%
A16R	3. Staff worry that mistakes they make are kept in their personnel file.	41%	39%	36%	34%	31%	31%	28%

Table A-2. Item-level Average Percent Positive Response by Hospital Bed Size (Page 4 of 4)

		Bed Size						
	ork Area/Unit tient Safety Grade	6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-399 beds	400 or more beds
	# Hospitals # Respondents	58 3,601	131 12,421	98 14,243	86 22,092	57 27,730	42 27,568	47 52,521
Α	Excellent	26%	27%	24%	23%	22%	23%	20%
в	Very Good	50%	51%	49%	48%	45%	46%	44%
С	Acceptable	20%	20%	22%	24%	26%	24%	28%
D	Poor	3%	2%	4%	5%	6%	5%	7%
Е	Failing	0%	0%	1%	1%	1%	1%	2%

Table A-3. Percent of Respondents Giving Their Work Area/Unit a Patient Safety Grade by Hospital Bed Size

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

	Bed Size							
Number of Events Reported by Respondents	6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-399 beds	400 or more beds	
# Hospitals # Respondents	58 3,601	131 12,421	98 14,243	86 22,092	57 27,730	42 27,568	47 52,521	
No events	50%	52%	52%	53%	52%	51%	52%	
1 to 2 events	28%	29%	27%	27%	27%	28%	29%	
3 to 5 events	14%	12%	12%	13%	13%	13%	13%	
6 to 10 events	5%	4%	5%	5%	5%	5%	4%	
11 to 20 events	2%	2%	2%	2%	2%	2%	1%	
21 event reports or more	1%	1%	1%	1%	1%	1%	1%	

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Appendix A: Overall Results by Hospital Characteristics

(2) Teaching Status and (3) Ownership and Control

NOTE: The number of hospitals and respondents in each breakout category is shown in each table (e.g., the number of hospitals and respondents by bed size, teaching status, region, etc.). However, the precise number of hospitals and respondents corresponding to each data cell in a table will vary because hospitals may have omitted a specific survey item and because of individual non-response/missing data.

	Teachi	ng Status	Ownership	and Control
Patient Safety Culture Composites	Teaching	Non-teaching	Govt	Non-govt
# Hospitals # Respondents	135 70,495	384 89,681	127 17,482	392 142,694
1. Teamwork Within Units	77%	79%	80%	78%
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	73%	75%	76%	74%
3. Management Support for Patient Safety	68%	71%	73%	69%
4. Org Learning—Continuous Improvement	69%	70%	72%	69%
5. Overall Perceptions of Patient Safety	62%	65%	67%	63%
6. Feedback & Communication About Error	61%	62%	63%	62%
7. Communication Openness	60%	62%	63%	61%
8. Frequency of Events Reported	58%	60%	61%	59%
9. Teamwork Across Units	54%	58%	61%	56%
10. Staffing	53%	55%	59%	54%
11. Handoffs & Transitions	42%	46%	50%	43%
12. Nonpunitive Response to Error	42%	44%	45%	43%
Average Across Composites	60%	62%	64%	61%

 Table A-5. Composite-level Average Percent Positive Response by Hospital Teaching Status, and Ownership and Control

		Teachi	ing Status	Ownership	and Control
Item	Survey Items by Composite	Teaching	Non-teaching	Govt	Non-govt
	# Hospitals # Respondents	135 70,495	384 89,681	127 17,482	392 142,694
1.	Teamwork Within Units				
A1	1. People support one another in this unit.	84%	84%	85%	84%
A3	When a lot of work needs to be done quickly, we work together as a team to get the work done.	84%	86%	87%	85%
A4	3. In this unit, people treat each other with respect.	76%	77%	77%	77%
A11	4. When one area in this unit gets really busy, others help out.	66%	68%	69%	67%
2.	Supervisor/Manager Expectations & Actions Promoting Patient Safety				
B1	1. My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures.	69%	71%	71%	71%
B2	2. My supv/mgr seriously considers staff suggestions for improving patient safety.	75%	76%	76%	75%
B3R	Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts.	72%	75%	77%	73%
B4R	 My supv/mgr overlooks patient safety problems that happen over and over. 	75%	76%	78%	75%
3.	Management Support for Patient Safety				
F1	1. Hospital mgmt provides a work climate that promotes patient safety.	78%	80%	83%	78%
F8	The actions of hospital mgmt show that patient safety is a top priority.	70%	72%	74%	70%
F9R	Hospital mgmt seems interested in patient safety only after an adverse event happens.	58%	60%	61%	59%

 Table A-6. Item-level Average Percent Positive Response by Hospital Teaching Status, and Ownership and Control (Page 1 of 4)

		Teachi	ng Status	Ownership	and Control
Item	Survey Items by Composite	Teaching	Non-teaching	Govt	Non-govt
	# Hospitals # Respondents	135 70,495	384 89,681	127 17,482	392 1 <i>4</i> 2,694
4.	Organizational Learning— Continuous Improvement				
A6	 We are actively doing things to improve patient safety. 	81%	81%	82%	81%
A9	2. Mistakes have led to positive changes here.	61%	63%	65%	62%
A13	3. After we make changes to improve patient safety, we evaluate their effectiveness.	66%	67%	68%	66%
5.	Overall Perceptions of Patient Safety				
A10R	 It is just by chance that more serious mistakes don't happen around here. 	59%	61%	62%	60%
A15	2. Patient safety is never sacrificed to get more work done.	61%	65%	69%	63%
A17R	3. We have patient safety problems in this unit.	60%	63%	66%	61%
A18	 Our procedures and systems are good at preventing errors from happening. 	69%	69%	70%	69%
6.	Feedback and Communication About Error				
C1	 We are given feedback about changes put into place based on event reports. 	53%	52%	51%	53%
C3	2. We are informed about errors that happen in this unit.	62%	65%	66%	63%
C5	3. In this unit, we discuss ways to prevent errors from happening again.	68%	70%	72%	69%

 Table A-6. Item-level Average Percent Positive Response by Hospital Teaching Status, and Ownership and Control (Page 2 of 4)

		Teaching Status		Ownership	and Control
Item	Survey Items by Composite	Teaching	Non-teaching	Govt	Non-govt
	# Hospitals	135	384	127	392
	# Respondents	70,495	89,681	17,482	142,694
7.	Communication Openness				
C2	1. Staff will freely speak up if they see something that may negatively affect patient care.	74%	76%	76%	75%
C4	2. Staff feel free to question the decisions or actions of those with more authority.	46%	48%	47%	47%
C6R	3. Staff are afraid to ask questions when something does not seem right.	61%	63%	65%	62%
8.	Frequency of Events Reported				
D1	1. When a mistake is made, but is <u>caught and</u> <u>corrected before affecting the patient</u> , how often is this reported?	50%	52%	51%	51%
D2	2. When a mistake is made, but has <u>no potential to</u> <u>harm the patient</u> , how often is this reported?	53%	56%	56%	55%
D3	3. When a mistake is made that <u>could harm the</u> <u>patient</u> , but does not, how often is this reported?	70%	74%	74%	72%
9.	Teamwork Across Units				
F2R	1. Hospital units do not coordinate well with each other.	41%	46%	48%	44%
F4	There is good cooperation among hospital units that need to work together.	54%	60%	63%	57%
F6R	3. It is often unpleasant to work with staff from other hospital units.	57%	59%	61%	57%
F10	4. Hospital units work well together to provide the best care for patients.	64%	68%	71%	66%

Table A-6. Item-level Average Percent Positive Response by Hospital Teaching Status, and Ownership and Control (Page 3 of 4)

		Teachi	ng Status	Ownership	and Control
Item	Survey Items by Composite	Teaching	Non-teaching	Govt	Non-govt
	# Hospitals # Respondents	135 70,495	384 89,681	127 17,482	392 142,694
10.	Staffing				
A2	1. We have enough staff to handle the workload.	52%	55%	61%	52%
A5R	2. Staff in this unit work longer hours than is best for patient care.	51%	52%	55%	51%
A7R	3. We use more agency/temporary staff than is best for patient care.	64%	64%	65%	63%
A14R	4. We work in "crisis mode" trying to do too much, too quickly.	48%	50%	56%	47%
11.	Handoffs & Transitions				
F3R	1. Things "fall between the cracks" when transferring patients from one unit to another.	37%	43%	48%	39%
F5R	 Important patient care information is often lost during shift changes. 	48%	50%	53%	48%
F7R	Problems often occur in the exchange of information across hospital units.	39%	43%	47%	41%
F11R	 Shift changes are problematic for patients in this hospital. 	43%	47%	51%	44%
12.	Nonpunitive Response to Error				
A8R	1. Staff feel like their mistakes are held against them.	49%	52%	52%	51%
A12R	2. When an event is reported, it feels like the person is being written up, not the problem.	44%	45%	45%	45%
A16R	3. Staff worry that mistakes they make are kept in their personnel file.	34%	36%	38%	35%

 Table A-6. Item-level Average Percent Positive Response by Hospital Teaching Status, and Ownership and Control (Page 4 of 4)

		Teachii	ng Status	Ownership	and Control
	ork Area/Unit tient Safety Grade	Teaching	Non-teaching	Govt	Non-govt
	# Hospitals	135	384	127	392
	# Respondents	70,495	89,681	17,482	142,694
Α	Excellent	23%	24%	23%	24%
В	Very Good	47%	49%	50%	48%
С	Acceptable	24%	22%	23%	23%
D	Poor	5%	4%	3%	4%
Е	Failing	1%	1%	0%	1%

Table A-7. Percent of Respondents Giving Their Work Area/Unit a Patient Safety Grade by Teaching Status, and Ownership and Control

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Table A-8. Percent of Respondents Reporting Events in the Past 12 Months by Teaching Status, and Ownership and Control

	Teachi	ng Status	Ownership	and Control
Number of Events Reported by Respondents	Teaching	Non-teaching	Govt	Non-govt
# Hospitals # Respondents	135 70,495	384 89,681	127 17,482	392 142,694
No events	53%	52%	52%	52%
1 to 2 events	28%	28%	27%	28%
3 to 5 events	12%	13%	13%	13%
6 to 10 events	4%	5%	5%	5%
11 to 20 events	1%	2%	2%	2%
21 event reports or more	1%	1%	1%	1%

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Appendix A: Overall Results by Hospital Characteristics

(4) Geographic Region

NOTE: The number of hospitals and respondents in each breakout category is shown in each table (e.g., the number of hospitals and respondents by bed size, teaching status, region, etc.). However, the precise number of hospitals and respondents corresponding to each data cell in a table will vary because hospitals may have omitted a specific survey item and because of individual non-response/missing data.

				Regio	on			
Patient Safety Culture Composites	Mid Atlantic/ New England	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific
# Hospitals # Respondents	32 17,875	89 29,200	113 40,643	29 7,350	92 19,255	37 11,121	57 13,301	70 21,431
1. Teamwork Within Units	76%	78%	76%	81%	81%	81%	80%	79%
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	71%	76%	73%	78%	75%	78%	74%	73%
3. Management Support for Patient Safety	68%	71%	67%	74%	74%	73%	70%	67%
4. Org Learning—Continuous Improvement	68%	72%	66%	75%	72%	74%	70%	67%
5. Overall Perceptions of Patient Safety	61%	63%	61%	67%	69%	67%	66%	60%
6. Feedback & Communication About Error	62%	64%	59%	66%	62%	66%	64%	60%
7. Communication Openness	61%	62%	60%	63%	61%	64%	64%	62%
8. Frequency of Events Reported	60%	59%	56%	65%	63%	63%	60%	58%
9. Teamwork Across Units	54%	56%	55%	63%	62%	57%	58%	54%
10. Staffing	49%	54%	54%	54%	62%	56%	54%	52%
11. Handoffs & Transitions	42%	44%	43%	48%	51%	44%	45%	40%
12. Nonpunitive Response to Error	40%	42%	41%	45%	49%	45%	46%	41%
Average Across Composites	59%	62%	59%	65%	65%	64%	63%	59%

Table A-9. Composite-level Average Percent Positive Response by Hospital Geographic Region

NOTE: States are categorized into AHA-defined regions as follows:

Mid Atlantic/New England: NY, NJ, PA, ME, NH, VT, MA, RI, CT South Atlantic: DE, MD, DC, VA, WV, NC, SC, GA, FL East North Central: OH, IN, IL, MI, WI East South Central: KY, TN, AL, MS West North Central: MN, IA, MO, ND, SD, NE, KS West South Central: AR, LA, OK, TX Mountain: MT, ID, WY, CO, NM, AZ, UT, NV Pacific: WA, OR, CA, AK, HI

					Regio	on			
ltem	Survey Items By Composite	Mid Atlantic/ New England	South Atlantic	E. North Central	E. South Central	W. North Central	W. South Central	Mountain	Pacific
	# Hospitals # Respondents	32 17,875	89 29,200	113 40,643	29 7,350	92 19,255	37 11,121	57 13,301	70 21,431
1.	Teamwork Within Units	11,010	20,200	40,040	7,000	10,200	11,121	10,001	21,401
A1	1. People support one another in this unit.	82%	83%	81%	86%	86%	87%	86%	85%
A3	2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	83%	85%	82%	89%	88%	88%	87%	84%
A4	3. In this unit, people treat each other with respect.	75%	77%	74%	81%	79%	80%	78%	78%
A11	4. When one area in this unit gets really busy, others help out.	63%	67%	66%	70%	70%	71%	70%	67%
2.	Supervisor/Manager Expectations & Actions Promoting Patient Safety								
B1	 My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures. 	69%	73%	67%	76%	69%	76%	72%	71%
B2	My supv/mgr seriously considers staff suggestions for improving patient safety.	74%	77%	72%	79%	76%	79%	76%	76%
B3 R	3. Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts.	70%	76%	73%	77%	77%	76%	75%	72%
B4 R	My supv/mgr overlooks patient safety problems that happen over and over.	72%	79%	73%	80%	79%	80%	74%	73%
3.	Management Support for Patient Safety								
F1	1. Hospital mgmt provides a work climate that promotes patient safety.	76%	80%	77%	84%	83%	81%	80%	77%
F8	The actions of hospital mgmt show that patient safety is a top priority.	70%	72%	68%	77%	74%	75%	72%	69%
F9 R	3. Hospital mgmt seems interested in patient safety only after an adverse event happens.	57%	59%	58%	63%	64%	63%	59%	55%

Table A-10. Item-level Average Percent Positive Response by Hospital Geographic Region (Page 1 of 4)

					Regio	on			
ltem	Survey Items By Composite	Mid Atlantic/ New England	South Atlantic	E. North Central	E. South Central	W. North Central	W. South Central	Mountain	Pacific
	# Hospitals # Respondents	32 17,875	89 29,200	113 40,643	29 7,350	92 19,255	37 11,121	57 13,301	70 21,431
4.	Organizational Learning— Continuous Improvement								
A6	 We are actively doing things to improve patient safety. 	80%	83%	77%	85%	83%	84%	81%	81%
A9	2. Mistakes have led to positive changes here.	58%	64%	58%	66%	65%	66%	64%	61%
A13	3. After we make changes to improve patient safety, we evaluate their effectiveness.	67%	70%	63%	74%	69%	72%	66%	60%
5.	Overall Perceptions of Patient Safety								
A10 R	 It is just by chance that more serious mistakes don't happen around here. 	56%	57%	58%	61%	67%	63%	63%	57%
A15	Patient safety is never sacrificed to get more work done.	63%	65%	61%	68%	68%	66%	66%	61%
A17 R	We have patient safety problems in this unit.	57%	60%	60%	65%	69%	67%	66%	57%
A18	 Our procedures and systems are good at preventing errors from happening. 	68%	69%	66%	74%	72%	74%	69%	66%
6.	Feedback and Communication About Error								
C1	 We are given feedback about changes put into place based on event reports. 	53%	54%	51%	55%	50%	56%	53%	52%
C3	2. We are informed about errors that happen in this unit.	64%	66%	61%	71%	64%	69%	65%	60%
C5	In this unit, we discuss ways to prevent errors from happening again.	68%	71%	65%	73%	71%	73%	73%	69%

Table A-10. Item-level Average Percent Positive Response by Hospital Geographic Region (Page 2 of 4)

	_				Regio				
Item	Survey Items By Composite	Mid Atlantic/ New England	South Atlantic	E. North Central	E. South Central	W. North Central	W. South Central	Mountain	Pacific
	# Hospitals # Respondents	32 17,875	89 29,200	113 40,643	29 7,350	92 19,255	37 11,121	57 13,301	70 21,431
7.	Communication Openness								
C2	 Staff will freely speak up if they see something that may negatively affect patient care. 	75%	75%	74%	77%	76%	77%	77%	76%
C4	2. Staff feel free to question the decisions or actions of those with more authority.	48%	47%	45%	49%	46%	49%	50%	49%
C6 R	Staff are afraid to ask questions when something does not seem right.	60%	63%	60%	64%	63%	66%	64%	63%
8.	Frequency of Events Reported								
D1	1. When a mistake is made, but is <u>caught and</u> <u>corrected before affecting the patient</u> , how often is this reported?	53%	51%	47%	57%	53%	56%	52%	49%
D2	2. When a mistake is made, but has <u>no</u> potential to harm the patient, how often is this reported?	56%	55%	51%	60%	59%	58%	56%	54%
D3	3. When a mistake is made that <u>could harm</u> <u>the patient</u> , but does not, how often is this reported?	72%	72%	70%	78%	77%	75%	72%	72%
9.	Teamwork Across Units								
F2 R	1. Hospital units do not coordinate well with each other.	43%	44%	44%	51%	50%	45%	45%	40%
F4	2. There is good cooperation among hospital units that need to work together.	54%	58%	56%	65%	63%	60%	60%	55%
F6 R	3. It is often unpleasant to work with staff from other hospital units.	55%	58%	56%	61%	63%	57%	59%	57%
F10	4. Hospital units work well together to provide the best care for patients.	64%	66%	64%	73%	73%	68%	68%	65%

Table A-10. Item-level Average Percent Positive Response by Hospital Geographic Region (Page 3 of 4)

					Regio	on			
ltem	Survey Items By Composite	Mid Atlantic/ New England	South Atlantic	E. North Central	E. South Central	W. North Central	W. South Central	Mountain	Pacific
	# Hospitals	32	89	113	29	92	37	57	70
	# Respondents	17,875	29,200	40,643	7,350	19,255	11,121	13,301	21,431
10.	Staffing								
A2	 We have enough staff to handle the workload. 	46%	52%	52%	51%	63%	55%	55%	52%
A5 R	2. Staff in this unit work longer hours than is best for patient care.	45%	51%	52%	52%	57%	53%	51%	51%
A7 R	3. We use more agency/temporary staff than is best for patient care.	59%	63%	64%	63%	71%	64%	60%	59%
A14 R	4. We work in "crisis mode" trying to do too much, too quickly.	44%	49%	46%	49%	57%	52%	52%	46%
11.	Handoffs & Transitions								
F3 R	1. Things "fall between the cracks" when transferring patients from one unit to another.	38%	41%	39%	46%	49%	43%	41%	36%
F5 R	Important patient care information is often lost during shift changes.	48%	49%	48%	52%	54%	48%	49%	45%
F7 R	Problems often occur in the exchange of information across hospital units.	40%	41%	40%	47%	48%	42%	43%	39%
F11 R	 Shift changes are problematic for patients in this hospital. 	42%	44%	44%	47%	54%	44%	46%	42%
12.	Nonpunitive Response to Error								
A8 R	1. Staff feel like their mistakes are held against them.	47%	49%	49%	53%	56%	53%	54%	48%
A12 R	2. When an event is reported, it feels like the person is being written up, not the problem.	43%	43%	42%	46%	49%	46%	48%	42%
A16 R	Staff worry that mistakes they make are kept in their personnel file.	31%	33%	33%	36%	42%	37%	38%	33%

Table A-10. Item-level Average Percent Positive Response by Hospital Geographic Region (Page 4 of 4)

			Region												
Work Area/Unit Patient Safety Grade		Mid Atlantic/ New England	South Atlantic	E. North Central	E. South Central	W. North Central	W. South Central	Mountain	Pacific						
	# Hospitals # Respondents	32 17,875	89 29,200	113 40,643	29 7,350	92 19,255	37 11,121	57 13,301	70 21,431						
Α	Excellent	24%	22%	21%	27%	24%	30%	27%	23%						
в	Very Good	45%	48%	50%	48%	51%	48%	47%	46%						
С	Acceptable	25%	25%	24%	22%	21%	19%	21%	24%						
D	Poor	5%	4%	5%	3%	3%	3%	4%	6%						
Е	Failing	1%	1%	1%	0%	0%	1%	1%	1%						

Table A-11. Percent of Respondents Giving Their Work Area/Unit a Patient Safety Grade by Hospital Geographic Region

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Table A-12. Percent of Respondents Reporting Events in the Past 12 Months by Hospital Geographic Region

Number of Events Reported by Respondents	Mid Atlantic/ New England	South Atlantic	E. North Central	E. South Central	W. North Central	W. South Central	Mountain	Pacific
# Hospitals # Respondents	32 17,875	89 29,200	113 40,643	29 7,350	92 19,255	37 11,121	57 13,301	70 21,431
No events	56%	53%	51%	57%	50%	60%	53%	46%
1 to 2 events	26%	28%	29%	26%	28%	24%	27%	30%
3 to 5 events	12%	12%	13%	10%	14%	10%	12%	15%
6 to 10 events	4%	4%	4%	4%	6%	4%	5%	5%
11 to 20 events	2%	2%	2%	2%	2%	1%	2%	2%
21 event reports or more	1%	1%	1%	1%	1%	1%	1%	1%

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Appendix B: Overall Results by Respondent Characteristics

Appendix B: Overall Results by Respondent Characteristics

(1) Work area/Unit

NOTE 1: Hospitals that did not ask respondents to indicate their work area/unit were excluded from these breakout tables. In addition, respondents who selected "Many different work areas/No specific work area," "Other," or did not answer (missing) were not included.

NOTE 2: The number of hospitals and respondents in each work area/unit is shown. The number of hospitals is based on: 1) hospitals that asked respondents to indicate their work area/unit (not all hospitals asked this question), and 2) whether the hospital had at least 1 respondent in a particular work area/unit. However, the precise number of hospitals and respondents corresponding to each data cell in the tables will vary because hospitals may have omitted a specific survey item and because of individual non-response/missing data.

		Work Area/Unit												
Patient Safety Culture Composites	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medicine	Obste- trics	Pediatrics	Pharmacy	Psych/ Mental Hith	Radi- ology	Rehab- ilitation	Surgery		
# Hospitals # Respondents	135 1,115	405 7,846	313 9,845	443 7,740	433 13,228	269 5,800	183 4,044	375 4,159	174 3,308	449 8,439	385 5,708	417 14,327		
1. Teamwork Within Units	78%	79%	81%	79%	74%	79%	79%	78%	78%	79%	86%	77%		
2. Supv/Mgr Expectations & Actions Promoting Patient Safety	71%	73%	70%	76%	73%	73%	74%	77%	76%	77%	81%	75%		
3. Mgmt Support for Patient Safety	67%	62%	59%	72%	65%	65%	66%	71%	67%	72%	74%	69%		
4. Org LearningContinuous Improvement	71%	65%	68%	71%	69%	68%	70%	76%	69%	69%	74%	74%		
5. Overall Perceptions of Patient Safety	64%	56%	55%	71%	55%	60%	65%	66%	60%	72%	76%	68%		
6. Feedback & Communication About Error	61%	56%	55%	64%	56%	60%	61%	67%	63%	65%	70%	65%		
7. Communication Openness	68%	61%	60%	64%	56%	63%	63%	70%	63%	65%	71%	65%		
8. Frequency of Events Reported	53%	56%	56%	64%	61%	60%	59%	61%	62%	53%	60%	64%		
9. Teamwork Across Units	53%	50%	52%	57%	56%	53%	53%	56%	53%	56%	60%	52%		
10. Staffing	56%	51%	52%	55%	51%	54%	60%	56%	55%	62%	62%	57%		
11. Handoffs & Transitions	37%	50%	48%	38%	47%	51%	45%	32%	40%	42%	41%	40%		
12. Nonpunitive Response to Error	43%	38%	39%	44%	40%	41%	41%	56%	44%	47%	58%	47%		
Average Across Composites	60%	58%	58%	63%	59%	61%	61%	64%	61%	63%	68%	63%		

Table B-1. Composite-level Average Percent Positive Response by Respondent Work Area/Unit

		Work Area/Unit												
ltem	Survey Items by Composite	Anesthe- siology	Emer- gency	ICU	Lab	Medicine	Obstet- rics	Pedi- atrics	Pharmacy	Psych/ Mental Hith	Radi- ology	Rehab- ilitation	Surgery	
	# Hospitals	135	405	313	443	433	269	183	375	174	449	385	417	
	# Respondents	1,115	7,846	9,845	7,740	13,228	5,800	4,044	4,159	3,308	8,439	5,708	14,327	
1.	Teamwork Within Units													
A1	 People support one another in this unit. 	82%	85%	86%	83%	81%	85%	84%	84%	82%	85%	91%	82%	
A3	2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	88%	86%	87%	85%	80%	88%	86%	84%	84%	87%	90%	86%	
A4	In this unit, people treat each other with respect.	80%	76%	78%	77%	73%	77%	79%	78%	78%	77%	87%	74%	
A11	4. When one area in this unit gets really busy, others help out.	63%	70%	72%	71%	59%	67%	67%	68%	68%	67%	77%	65%	
2.	Supv/Mgr Expectations & Actions Promoting Patient Safety													
B1	 My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures. 	65%	68%	66%	69%	69%	69%	68%	71%	71%	70%	76%	72%	
B2	My supv/mgr seriously considers staff suggestions for improving patient safety.	72%	73%	70%	74%	72%	74%	75%	78%	76%	78%	84%	76%	
B3 R	 Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts. 	71%	73%	69%	80%	73%	72%	74%	79%	75%	79%	81%	72%	
B4 R	 My supv/mgr overlooks patient safety problems that happen over and over. 	74%	75%	73%	77%	75%	74%	75%	79%	78%	80%	83%	77%	
3.	Mgmt Support for Patient Safety													
F1	1. Hospital mgmt provides a work climate that promotes patient safety.	75%	71%	68%	81%	74%	76%	76%	78%	74%	83%	84%	78%	
F8	The actions of hospital mgmt show that patient safety is a top priority.	68%	62%	59%	74%	66%	66%	66%	72%	68%	74%	76%	69%	
F9 R	 Hospital mgmt seems interested in patient safety only after an adverse event happens. 	57%	52%	49%	61%	55%	52%	55%	62%	58%	61%	63%	59%	

Table B-2. Item-level Average Percent Positive Response by Respondent Work Area/Unit (Page 1 of 4)

	-	Work Area/Unit											
ltem	Survey Items by Composite	Anesthe- siology	Emer- gency	ICU	Lab	Medicine	Obstet- rics	Pedi- atrics	Pharmacy	Psych/ Mental Hlth	Radi- ology	Rehab- ilitation	Surgery
	# Hospitals	135	405	313	443	433	269	183	375	174	449	385	417
4.	# Respondents Organizational Learning— Continuous Improvement	1,115	7,846	9,845	7,740	13,228	5,800	4,044	4,159	3,308	8,439	5,708	14,327
A6	1. We are actively doing things to improve patient safety.	82%	77%	82%	79%	80%	78%	83%	86%	81%	80%	87%	86%
A9	2. Mistakes have led to positive changes here.	63%	56%	55%	68%	60%	60%	58%	74%	58%	63%	61%	63%
A13	 After we make changes to improve patient safety, we evaluate their effectiveness. 	66%	62%	65%	66%	67%	66%	68%	68%	68%	64%	72%	71%
5.	Overall Perceptions of Patient Safety												
A10 R	 It is just by chance that more serious mistakes don't happen around here. 	63%	53%	53%	65%	53%	59%	62%	64%	60%	67%	74%	64%
A15	Patient safety is never sacrificed to get more work done.	59%	56%	50%	70%	54%	55%	63%	64%	64%	74%	76%	65%
A17 R	3. We have patient safety problems in this unit.	64%	52%	55%	72%	51%	59%	65%	64%	50%	73%	75%	68%
A18	 Our procedures and systems are good at preventing errors from happening. 	71%	61%	62%	78%	61%	67%	71%	73%	67%	74%	78%	74%
6.	Feedback and Communication About Error												
C1	 We are given feedback about changes put into place based on event reports. 	50%	48%	46%	51%	49%	53%	51%	53%	55%	53%	62%	53%
C3	We are informed about errors that happen in this unit.	61%	57%	54%	70%	54%	60%	63%	72%	62%	71%	71%	67%
C5	3. In this unit, we discuss ways to prevent errors from happening again.	72%	64%	63%	72%	64%	69%	67%	75%	71%	71%	78%	74%

Table B-2. Item-level Average Percent Positive Response by Respondent Work Area/Unit (Page 2 of 4)

		Work Area/Unit Psych/											
Item	Survey Items by Composite	Anesthe- siology	Emer- gency	ICU	Lab	Medicine	Obstet- rics	Pedi- atrics	Pharmacy	Psych/ Mental Hlth	Radi- ology	Rehab- ilitation	Surgery
	# Hospitals	135	405	313	443	433	269	183	375	174	449	385	417
	# Respondents	1,115	7,846	9,845	7,740	13,228	5,800	4,044	4,159	3,308	8,439	5,708	14,327
7.	Communication Openness												
C2	 Staff will freely speak up if they see something that may negatively affect patient care. 	78%	73%	74%	77%	72%	78%	78%	78%	76%	80%	83%	80%
C4	2. Staff feel free to question the decisions or actions of those with more authority.	55%	47%	45%	48%	40%	48%	48%	59%	50%	49%	57%	50%
C6 R	3. Staff are afraid to ask questions when something does not seem right.	69%	63%	61%	67%	56%	63%	62%	73%	64%	68%	72%	65%
8.	Frequency of Events Reported												
D1	1. When a mistake is made, but is <u>caught</u> and corrected before affecting the patient, how often is this reported?	44%	44%	43%	54%	49%	49%	49%	48%	54%	44%	53%	56%
D2	2. When a mistake is made, but has <u>no</u> <u>potential to harm the patient</u> , how often is this reported?	47%	54%	52%	58%	59%	56%	56%	58%	57%	47%	55%	60%
D3	3. When a mistake is made that <u>could harm</u> <u>the patient</u> , but does not, how often is this reported?	67%	72%	72%	80%	74%	75%	72%	77%	73%	69%	71%	75%
9.	Teamwork Across Units												
F2 R	1. Hospital units do not coordinate well with each other.	39%	40%	39%	45%	44%	38%	41%	44%	39%	44%	47%	40%
F4	2. There is good cooperation among hospital units that need to work together.	52%	50%	53%	60%	56%	55%	54%	57%	52%	58%	61%	52%
F6 R	3. It is often unpleasant to work with staff from other hospital units.	58%	51%	57%	56%	61%	55%	56%	59%	59%	57%	64%	55%
F10	4. Hospital units work well together to provide the best care for patients.	62%	59%	59%	67%	64%	63%	62%	66%	61%	67%	69%	62%

Table B-2. Item-level Average Percent Positive Response by Respondent Work Area/Unit (Page 3 of 4)

			Work Area/Unit Psych/										
Item	Survey Items by Composite	Anesthe- siology	Emer- gency	ICU	Lab	Medicine	Obstet- rics	Pedi- atrics	Pharmacy	Psych/ Mental Hith	Radi- ology	Rehab- ilitation	Surgery
	# Hospitals	135	405	313	443	433	269	183	375	174	449	385	417
	# Respondents	1,115	7,846	9,845	7,740	13,228	5,800	4,044	4,159	3,308	8,439	5,708	14,327
10.	Staffing												
A2	 We have enough staff to handle the workload. 	60%	44%	48%	51%	46%	49%	58%	53%	49%	60%	57%	56%
A5 R	2. Staff in this unit work longer hours than is best for patient care.	47%	51%	52%	54%	49%	51%	56%	57%	52%	59%	60%	51%
A7 R	3. We use more agency/temporary staff than is best for patient care.	62%	64%	63%	66%	64%	71%	73%	67%	68%	71%	69%	70%
A14 R	4. We work in "crisis mode" trying to do too much, too quickly.	52%	43%	46%	49%	44%	44%	55%	48%	49%	57%	62%	52%
11.	Handoffs & Transitions												
F3 R	 Things "fall between the cracks" when transferring patients from one unit to another. 	35%	47%	38%	29%	43%	43%	40%	26%	32%	42%	40%	41%
F5 R	Important patient care information is often lost during shift changes.	43%	57%	58%	44%	51%	60%	53%	34%	46%	46%	45%	45%
F7 R	3. Problems often occur in the exchange of information across hospital units.	36%	47%	42%	37%	45%	43%	42%	32%	37%	39%	42%	39%
F11 R	 Shift changes are problematic for patients in this hospital. 	34%	47%	55%	41%	49%	57%	46%	35%	44%	42%	39%	37%
12.	Nonpunitive Response to Error												
A8 R	1. Staff feel like their mistakes are held against them.	54%	45%	47%	53%	46%	49%	50%	62%	50%	54%	65%	53%
A12 R	 When an event is reported, it feels like the person is being written up, not the problem. 	42%	38%	39%	44%	42%	42%	43%	57%	49%	46%	57%	49%
A16 R	3. Staff worry that mistakes they make are kept in their personnel file.	32%	29%	29%	36%	32%	32%	32%	50%	33%	41%	52%	38%

Table B-2. Item-level Average Percent Positive Response by Respondent Work Area/Unit (Page 4 of 4)

		-						-	-				
							Work	Area/Unit					
	rk Area/Unit ient Safety Grade	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medicine	Obstetrics	Pediatrics	Pharmacy	Psych/ Mental Health	Radiology	Rehab- ilitation	Surgery
	# Hospitals	135	405	313	443	433	269	183	375	174	449	385	417
	# Respondents	1,115	7,846	9,845	7,740	13,228	5,800	4,044	4,159	3,308	8,439	5,708	14,327
Α	Excellent	35%	16%	18%	27%	14%	20%	23%	24%	23%	28%	35%	32%
В	Very Good	42%	46%	47%	51%	48%	50%	49%	50%	46%	50%	47%	45%
С	Acceptable	19%	30%	27%	19%	30%	24%	22%	19%	24%	19%	15%	18%
D	Poor	2%	7%	6%	3%	6%	5%	5%	5%	7%	3%	2%	4%
Е	Failing	2%	1%	1%	0%	1%	1%	1%	1%	1%	0%	1%	1%

Table B-3. Percent of Respondents Giving Their Work Area/Unit a Patient Safety Grade by Respondent Work Area/Unit

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Table B-4. Percent of Respondents Reporting Events in the Past 12 Months by Respondent Work Area/Unit

						Work	Area/Unit					
Number of Events Reported by Respondents	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medicine	Obstetrics	Pediatrics	Pharmacy	Psych/ Mental Health	Radiology	Rehab- ilitation	Surgery
# Hospitals	135	405	313	443	433	269	183	375	174	449	385	417
# Respondents	1,115	7,846	9,845	7,740	13,228	5,800	4,044	4,159	3,308	8,439	5,708	14,327
No events	57%	45%	32%	48%	38%	42%	46%	40%	49%	54%	56%	46%
1 to 2 events	29%	32%	37%	29%	32%	38%	34%	18%	28%	32%	32%	32%
3 to 5 events	8%	14%	23%	12%	20%	14%	16%	16%	13%	11%	8%	15%
6 to 10 events	4%	6%	6%	6%	7%	4%	3%	11%	7%	2%	2%	5%
11 to 20 events	1%	3%	2%	2%	3%	1%	1%	7%	2%	1%	1%	1%
21 event reports or more	1%	1%	0%	2%	1%	0%	0%	8%	1%	0%	0%	1%

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Appendix B: Overall Results by Respondent Characteristics

(2) Staff Position

NOTE 1: Hospitals that did not ask respondents to indicate their staff position were excluded from these breakout tables. In addition, respondents who selected "Other," or did not answer (missing) were not included.

NOTE 2: The number of hospitals and respondents in each staff position is shown. The number of hospitals is based on: 1) hospitals that asked respondents to indicate their staff position (not all hospitals asked this question), and 2) whether the hospital had at least 1 respondent in a particular staff position. However, the precise number of hospitals and respondents corresponding to each data cell in the tables will vary because hospitals may have omitted a specific survey item and because of individual non-response/missing data.

		•	· · ·		Staff Pos	ition			
Patient Safety Culture Composites	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharmacist	RN/LVN/LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
# Hospitals	487	346	265	438	345	510	458	433	479
# Respondents	10,955	7,345	1,046	8,663	2,387	55,119	16,173	7,258	9,864
1. Teamwork Within Units	86%	82%	79%	73%	79%	79%	77%	84%	76%
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	84%	70%	76%	74%	75%	74%	75%	77%	76%
3. Management Support for Patient Safety	82%	69%	74%	72%	67%	64%	70%	70%	73%
4. Org LearningContinuous Improvement	80%	70%	69%	72%	73%	70%	68%	70%	69%
5. Overall Perceptions of Patient Safety	72%	62%	64%	60%	62%	59%	70%	70%	66%
6. Feedback & Communication About Error	73%	61%	66%	63%	63%	58%	64%	65%	64%
7. Communication Openness	74%	64%	63%	58%	71%	61%	63%	68%	59%
8. Frequency of Events Reported	65%	55%	55%	65%	53%	61%	58%	54%	63%
9. Teamwork Across Units	63%	59%	60%	59%	56%	55%	55%	62%	56%
10. Staffing	62%	55%	55%	49%	55%	57%	56%	58%	52%
11. Handoffs & Transitions	45%	43%	37%	49%	29%	48%	40%	42%	45%
12. Nonpunitive Response to Error	62%	42%	44%	35%	59%	43%	43%	50%	40%
Average Across Composites	71%	61%	62%	61%	62%	61%	62%	64%	62%

						Staff Positi	on			
ltem	Patient Safety Culture Composites	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respir, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	# Hospitals	487	346	265	438	345	510	458	433	479
	# Respondents	10,955	7,345	1,046	8,663	2,387	55,119	16,173	7,258	9,864
1.	Teamwork Within Units									
A1	1. People support one another in this unit.	92%	88%	84%	78%	85%	85%	82%	89%	81%
A3	2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	92%	87%	84%	80%	84%	86%	84%	87%	82%
A4	3. In this unit, people treat each other with respect.	86%	85%	77%	70%	79%	77%	75%	84%	74%
A11	 When one area in this unit gets really busy, others help out. 	76%	69%	71%	64%	67%	66%	67%	75%	67%
2.	Supv/Mgr Expectations & Actions Promoting Patient Safety									
B1	 My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures. 	80%	65%	76%	72%	68%	69%	68%	73%	73%
B2	My supv/mgr seriously considers staff suggestions for improving patient safety.	86%	74%	78%	75%	77%	74%	75%	80%	75%
B3 R	 Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts. 	83%	66%	73%	74%	77%	73%	77%	75%	78%
B4 R	 My supv/mgr overlooks patient safety problems that happen over and over. 	84%	72%	73%	74%	77%	76%	77%	77%	78%
3.	Mgmt Support for Patient Safety									
F1	1. Hospital mgmt provides a work climate that promotes patient safety.	89%	78%	84%	81%	73%	73%	81%	82%	83%
F8	2. The actions of hospital mgmt show that patient safety is a top priority.	83%	70%	78%	77%	68%	64%	72%	70%	75%
F9 R	3. Hospital mgmt seems interested in patient safety only after an adverse event happens.	75%	60%	60%	59%	60%	55%	59%	58%	60%

Table B-6. Item-level Average Percent Positive Response by Respondent Staff Position (Page 1 of 4)

	-		•		•	Staff Positi	on			
ltem	Patient Safety Culture Composites	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respir, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	# Hospitals	487	346	265	438	345	510	458	433	479
	# Respondents	10,955	7,345	1,046	8,663	2,387	55,119	16,173	7,258	9,864
4.	Organizational Learning— Continuous Improvement									
A6	1. We are actively doing things to improve patient safety.	87%	79%	81%	84%	85%	82%	79%	83%	80%
A9	2. Mistakes have led to positive changes here.	79%	67%	63%	59%	74%	60%	62%	58%	61%
A13	 After we make changes to improve patient safety, we evaluate their effectiveness. 	75%	65%	64%	72%	61%	67%	64%	68%	66%
5.	Overall Perceptions of Patient Safety									
A10 R	1. It is just by chance that more serious mistakes don't happen around here.	72%	62%	57%	52%	62%	59%	64%	67%	58%
A15	2. Patient safety is never sacrificed to get more work done.	72%	61%	64%	64%	58%	57%	70%	70%	70%
A17 R	3. We have patient safety problems in this unit.	69%	59%	63%	59%	58%	57%	71%	69%	66%
A18	4. Our procedures and systems are good at preventing errors from happening.	76%	67%	73%	67%	69%	65%	73%	74%	70%
6.	Feedback and Communication About Error									
C1	1. We are given feedback about changes put into place based on event reports.	63%	53%	58%	55%	50%	50%	51%	55%	54%
C3	2. We are informed about errors that happen in this unit.	76%	62%	66%	66%	67%	57%	69%	65%	68%
C5	3. In this unit, we discuss ways to prevent errors from happening again.	82%	68%	75%	70%	72%	66%	71%	73%	70%

Table B-6. Item-level Average Percent Positive Response by Respondent Staff Position (Page 2 of 4)

						Staff Positi	on			
ltem	Patient Safety Culture Composites	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respir, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	# Hospitals	487	346	265	438	345	510	458	433	479
	# Respondents	10,955	7,345	1,046	8,663	2,387	55,119	16,173	7,258	9,864
7.	Communication Openness									
C2	1. Staff will freely speak up if they see something that may negatively affect patient care.	83%	73%	75%	76%	77%	75%	77%	81%	75%
C4	2. Staff feel free to question the decisions or actions of those with more authority.	67%	56%	53%	41%	61%	45%	46%	53%	42%
C6 R	3. Staff are afraid to ask questions when something does not seem right.	73%	63%	62%	57%	73%	62%	65%	69%	60%
8.	Frequency of Events Reported									
D1	1. When a mistake is made, but is <u>caught</u> and corrected before affecting the patient, how often is this reported?	57%	47%	49%	61%	36%	48%	49%	46%	59%
D2	2. When a mistake is made, but has <u>no</u> potential to harm the patient, how often is this reported?	60%	49%	48%	60%	50%	59%	51%	47%	58%
D3	3. When a mistake is made that <u>could</u> <u>harm the patient</u> , but does not, how often is this reported?	77%	68%	68%	73%	73%	76%	73%	67%	74%
9.	Teamwork Across Units									
F2 R	1. Hospital units do not coordinate well with each other.	51%	48%	51%	47%	42%	42%	42%	50%	45%
F4	2. There is good cooperation among hospital units that need to work together.	65%	60%	59%	60%	56%	55%	57%	62%	57%
F6 R	3. It is often unpleasant to work with staff from other hospital units.	63%	61%	60%	59%	61%	59%	55%	65%	55%
F10	4. Hospital units work well together to provide the best care for patients.	74%	67%	70%	71%	62%	63%	65%	69%	68%

Table B-6. Item-level Average Percent Positive Response by Respondent Staff Position (Page 3 of 4)

		-	-		•	Staff Posit	ion			
ltem	Patient Safety Culture Composites	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respir, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	# Hospitals	487	346	265	438	345	510	458	433	479
	# Respondents	10,955	7,345	1,046	8,663	2,387	55,119	16,173	7,258	9,864
10.	Staffing									
A2	 We have enough staff to handle the workload. 	67%	56%	58%	45%	49%	53%	54%	53%	50%
A5 R	2. Staff in this unit work longer hours than is best for patient care.	59%	51%	54%	45%	59%	55%	54%	56%	50%
A7 R	3. We use more agency/temporary staff than is best for patient care.	68%	60%	57%	61%	67%	70%	66%	69%	58%
A14 R	4. We work in "crisis mode" trying to do too much, too quickly.	55%	53%	52%	47%	46%	48%	50%	55%	51%
11.	Handoffs & Transitions									
F3 R	1. Things "fall between the cracks" when transferring patients from one unit to another.	41%	43%	32%	45%	25%	44%	36%	39%	44%
F5 R	2. Important patient care information is often lost during shift changes.	48%	46%	41%	57%	31%	53%	45%	46%	51%
F7 R	3. Problems often occur in the exchange of information across hospital units.	44%	44%	37%	43%	31%	45%	39%	43%	42%
F11 R	4. Shift changes are problematic for patients in this hospital.	47%	40%	38%	51%	31%	50%	41%	41%	45%
12.	Nonpunitive Response to Error									
A8 R	1. Staff feel like their mistakes are held against them.	68%	48%	51%	42%	63%	50%	50%	57%	47%
A12 R	2. When an event is reported, it feels like the person is being written up, not the problem.	67%	45%	46%	36%	60%	45%	42%	50%	40%
A16 R	3. Staff worry that mistakes they make are kept in their personnel file.	50%	33%	35%	27%	54%	34%	36%	43%	32%

Table B-6. Item-level Average Percent Positive Response by Respondent Staff Position (Page 4 of 4)

						Staff Posi	tion			
-	rk Area/Unit ient Safety Grade	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharmacist	RN/LVN/LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	# Hospitals	487	346	265	438	345	510	458	433	479
	# Respondents	10,955	7,345	1,046	8,663	2,387	55,119	16,173	7,258	9,864
Α	Excellent	29%	23%	25%	23%	20%	19%	27%	29%	26%
В	Very Good	53%	49%	48%	47%	50%	48%	49%	47%	48%
С	Acceptable	16%	22%	23%	24%	22%	26%	19%	20%	22%
D	Poor	2%	5%	4%	4%	6%	6%	3%	3%	3%
Е	Failing	1%	1%	1%	1%	1%	1%	1%	1%	1%

Table B-7. Percent of Respondents Giving Their Work Area/Unit a Patient Safety Grade by Respondent Staff Position

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Table B-8. Percent of Respondents Reporting Events in the Past 12 Months by Respondent Staff Position

					Staff Pos	ition			
Number of Events Reported by Respondents	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharmacist	RN/LVN/LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
# Hospitals	487	346	265	438	345	510	458	433	479
# Respondents	10,955	7,345	1,046	8,663	2,387	55,119	16,173	7,258	9,864
No events	45%	59%	73%	74%	22%	28%	57%	59%	76%
1 to 2 events	24%	26%	17%	20%	21%	38%	29%	31%	18%
3 to 5 events	15%	9%	7%	5%	21%	22%	9%	7%	4%
6 to 10 events	9%	4%	3%	1%	15%	8%	3%	2%	1%
11 to 20 events	4%	2%	0%	0%	10%	3%	1%	0%	0%
21 event reports or more	2%	1%	0%	0%	11%	1%	1%	0%	0%

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Appendix B: Overall Results by Respondent Characteristics

(3) Interaction With Patients

NOTE 1: Hospitals that did not ask respondents to indicate their interaction with patients were excluded from these breakout tables. In addition, respondents who did not answer (missing) were not included.

NOTE 2: The number of hospitals and respondents is shown in each table. The number of hospitals is based on: 1) hospitals that asked respondents to indicate their interaction with patients (not all hospitals asked this question), and 2) whether the hospital had at least 1 respondent in the response categories (WITH or WITHOUT direct interaction with patients). However, the precise number of hospitals and respondents corresponding to each data cell in the tables will vary because hospitals may have omitted a specific survey item and because of individual non-response/missing data.

	Respondent Interaction with Patients							
Patient Safety Culture Composites	WITH direct interaction	WITHOUT direct interaction						
# Hospitals # Respondents	512 115,426	495 35, 122						
1. Teamwork Within Units	79%	79%						
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	75%	76%						
3. Management Support for Patient Safety	69%	76%						
4. Org LearningContinuous Improvement	70%	71%						
5. Overall Perceptions of Patient Safety	64%	66%						
6. Feedback & Communication About Error	62%	66%						
7. Communication Openness	62%	64%						
8. Frequency of Events Reported	60%	61%						
9. Teamwork Across Units	57%	58%						
10. Staffing	56%	52%						
11. Handoffs & Transitions	46%	39%						
12. Nonpunitive Response to Error	44%	47%						
Average Across Composites	62%	63%						

 Table B-9. Composite-level Average Percent Positive Response by Respondent Interaction with Patients

		Respondent Interaction with Patient					
		WITH	WITHOUT				
Item	Survey Items By Composite	direct interaction	direct interaction				
	# Hospitals	512	495				
	# Respondents	115,426	35, 122				
1.	Teamwork Within Units						
A1	1. People support one another in this unit.	84%	85%				
A3	2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	85%	86%				
A4	3. In this unit, people treat each other with respect.	77%	79%				
A11	4. When one area in this unit gets really busy, others help out.	68%	69%				
2.	Supervisor/Manager Expectations & Actions Promoting Patient Safety						
B1	 My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures. 	70%	74%				
B2	My supv/mgr seriously considers staff suggestions for improving patient safety.	76%	77%				
B3R	Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts.	75%	75%				
B4R	4. My supv/mgr overlooks patient safety problems that happen over and over.	77%	76%				
3.	Management Support for Patient Safety						
F1	1. Hospital mgmt provides a work climate that promotes patient safety.	78%	85%				
F8	2. The actions of hospital mgmt show that patient safety is a top priority.	70%	78%				
F9R	3. Hospital mgmt seems interested in patient safety only after an adverse event happens.	58%	66%				

 Table B-10. Item-level Average Percent Positive Response by Respondent Interaction with Patients (Page 1 of 4)

		Respondent Interaction with Patien					
Item	Survey Items By Composite	WITH direct interaction	WITHOUT direct interaction				
	# Hospitals	512	495				
	# Respondents	115,426	35, 122				
4.	Organizational Learning— Continuous Improvement						
A6	1. We are actively doing things to improve patient safety.	82%	79%				
A9	2. Mistakes have led to positive changes here.	61%	68%				
A13	3. After we make changes to improve patient safety, we evaluate their effectiveness.	68%	67%				
5.	Overall Perceptions of Patient Safety						
A10R	1. It is just by chance that more serious mistakes don't happen around here.	61%	61%				
A15	2. Patient safety is never sacrificed to get more work done.	64%	66%				
A17R	3. We have patient safety problems in this unit.	63%	65%				
A18	4. Our procedures and systems are good at preventing errors from happening.	69%	71%				
6.	Feedback and Communication About Error						
C1	1. We are given feedback about changes put into place based on event reports.	52%	55%				
C3	2. We are informed about errors that happen in this unit.	63%	69%				
C5	In this unit, we discuss ways to prevent errors from happening again.	69%	73%				

Table B-10. Item-level Average Percent Positive Response by Respondent Interaction with Patients (Page 2 of 4)

		Respondent Interaction with Patients					
Item	Survey Items By Composite	WITH direct interaction	WITHOUT direct interaction				
	# Hospitals	512	495				
	# Respondents	115,426	35, 122				
7.	Communication Openness						
C2	 Staff will freely speak up if they see something that may negatively affect patient care. 	76%	75%				
C4	2. Staff feel free to question the decisions or actions of those with more authority.	47%	51%				
C6R	3. Staff are afraid to ask questions when something does not seem right.	63%	65%				
8.	Frequency of Events Reported						
D1	1. When a mistake is made, but is <u>caught and corrected before</u> <u>affecting the patient</u> , how often is this reported?	50%	55%				
D2	2. When a mistake is made, but has <u>no potential to harm the patient</u> , how often is this reported?	56%	56%				
D3	3. When a mistake is made that <u>could harm the patient</u> , but does not, how often is this reported?	73%	72%				
9.	Teamwork Across Units						
F2R	1. Hospital units do not coordinate well with each other.	45%	47%				
F4	2. There is good cooperation among hospital units that need to work together.	58%	59%				
F6R	3. It is often unpleasant to work with staff from other hospital units.	59%	56%				
F10	4. Hospital units work well together to provide the best care for patients.	67%	70%				

 Table B-10. Item-level Average Percent Positive Response by Respondent Interaction with Patients (Page 3 of 4)

		Respondent Interaction with Patient					
ltem	Survey Items By Composite	WITH direct interaction	WITHOUT direct interaction				
	# Hospitals	512	495				
	# Respondents	115,426	35, 122				
10.	Staffing						
A2	1. We have enough staff to handle the workload.	54%	57%				
A5R	2. Staff in this unit work longer hours than is best for patient care.	53%	49%				
A7R	3. We use more agency/temporary staff than is best for patient care.	66%	56%				
A14R	4. We work in "crisis mode" trying to do too much, too quickly.	50%	47%				
11.	Handoffs & Transitions						
F3R	1. Things "fall between the cracks" when transferring patients from one unit to another.	43%	35%				
F5R	2. Important patient care information is often lost during shift changes.	51%	42%				
F7R	3. Problems often occur in the exchange of information across hospital units.	44%	37%				
F11R	4. Shift changes are problematic for patients in this hospital.	47%	39%				
12.	Nonpunitive Response to Error						
A8R	1. Staff feel like their mistakes are held against them.	51%	55%				
A12R	2. When an event is reported, it feels like the person is being written up, not the problem.	45%	48%				
A16R	3. Staff worry that mistakes they make are kept in their personnel file.	35%	38%				

 Table B-10. Item-level Average Percent Positive Response by Respondent Interaction with Patients (Page 4 of 4)

		Respondent Intera	ction with Patients
	ork Area/Unit tient Safety Grade	WITH direct interaction	WITHOUT direct interaction
	# Hospitals	512	495
	# Respondents	115,426	35, 122
Α	Excellent	23%	27%
В	Very Good	48%	49%
С	Acceptable	23%	21%
D	Poor	5%	2%
Е	Failing	1%	1%

Table B-11. Percent of Respondents Giving Their Work Area/Unit a Patient Safety Grade by Respondent Interaction With Patients

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

	Respondent Intera	ction with Patients
Number of Events Reported by Respondents	WITH direct interaction	WITHOUT direct interaction
# Hospitals	512	495
# Respondents	115,426	35, 122
No events	47%	68%
1 to 2 events	31%	17%
3 to 5 events	14%	7%
6 to 10 events	5%	4%
11 to 20 events	2%	2%
21 event reports or more	1%	2%

Note: Average percent totals in the table may not sum to exactly 100% due to rounding of decimals.

Appendix C: Trending Results by Respondent Characteristics

Appendix C: Trending Results by

(1) Work Area/Unit

NOTE: The number of hospitals and respondents in each breakout category is shown in each table (e.g., the number of hospitals and respondents by work area/unit). However, the precise number of hospitals and respondents corresponding to each data cell in a table will vary because hospitals may have omitted a specific survey item and because of individual non-response/missing data.

NOTE 2: Only hospitals that had at least 1 respondent in the particular work area/unit for both their previous and most recent administrations of the survey are included.

NOTE 3: Respondents who selected "Many different work areas/No specific work area," "Other," or those who did not answer (missing) are not included.

	•			•		•	Work A	Area/Unit	•				
Patient Safety Culture Composites	Database Year	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medicine	Obstet- rics	Pedi- atrics	Pharmacy	Psych/ Mental Hith	Radi- ology	Rehab- ilitation	Surgery
No. of Hospitals	Both Years	10	68	39	83	84	37	21	61	20	80	66	72
No. of Respondents	Most Recent Previous	170 85	1,035 903	1,315 988	1,102 890	2,702 2,048	586 551	497 456	617 487	504 467	1,066 810	546 650	1,984 1,635
	Most Recent	85%	84%	78%	81%	76%	81%	84%	82%	78%	80%	89%	81%
1. Teamwork Within Units	Previous	91%	81%	83%	80%	74%	77%	75%	85%	77%	81%	86%	80%
	Change	-6%	3%	-5%	1%	2%	4%	9%	-3%	1%	-1%	3%	1%
2. Supv/Mgr	Most Recent	69%	75%	66%	74%	74%	77%	77%	81%	76%	78%	85%	80%
Expectations & Actions Promoting	Previous	88%	73%	74%	75%	70%	78%	68%	81%	77%	74%	82%	76%
Patient Safety	Change	-19%	2%	-8%	-1%	4%	-1%	9%	0%	-1%	4%	3%	4%
	Most Recent	64%	68%	57%	73%	69%	71%	71%	74%	62%	76%	74%	74%
3. Mgmt Support for Patient Safety	Previous	82%	63%	58%	73%	64%	70%	63%	74%	68%	73%	77%	72%
	Change	-18%	5%	-1%	0%	5%	1%	8%	0%	-6%	3%	-3%	2%
4. Org Learning	Most Recent	72%	68%	69%	73%	72%	72%	80%	83%	71%	74%	76%	81%
Continuous	Previous	85%	65%	73%	67%	66%	75%	67%	83%	74%	70%	77%	76%
Improvement	Change	-13 %	3%	-4%	6%	6%	-3%	13%	0%	-3%	4%	-1%	5%
5. Overall	Most Recent	63%	60%	58%	74%	59%	68%	76%	74%	62%	77%	79%	76%
Perceptions of	Previous	72%	58%	58%	74%	54%	62%	60%	73%	62%	74%	79%	72%
Patient Safety	Change	-9%	2%	0%	0%	5%	6%	16%	1%	0%	3%	0%	4%
6. Feedback &	Most Recent	61%	56%	54%	65%	57%	67%	69%	69%	65%	67%	74%	72%
Communication	Previous	56%	55%	54%	65%	55%	64%	59%	72%	59%	65%	72%	65%
About Error	Change	5%	1%	0%	0%	2%	3%	10%	-3%	6%	2%	2%	7%

Table C-1. Trending: Composite-level Percent Positive Response by Respondent Work Area/Unit (Page 1 of 2)

-	composite iev	Work Area/Unit												
Patient Safety Culture Composites	Database Year	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medicine	Obstet- rics	Pedi- atrics	Pharmacy	Psych/ Mental Hith	Radi- ology	Rehab- ilitation	Surgery	
No. of Hospitals	Both Years	10	68	39	83	84	37	21	61	20	80	66	72	
No. of Respondents	Most Recent Previous	170 85	1,035 903	1,315 988	1,102 890	2,702 2,048	586 551	497 456	617 487	504 467	1,066 810	546 650	1,984 1,635	
	Most Recent	54%	61%	57%	65%	57%	68%	74%	74%	68%	66%	73%	70%	
7. Communication Openness	Previous	74%	58%	60%	63%	52%	68%	61%	72%	59%	61%	72%	69%	
	Change	-20%	3%	-3%	2%	5%	0%	13%	2%	9%	5%	1%	1%	
0. England and of	Most Recent	54%	61%	57%	60%	67%	65%	59%	69%	63%	57%	61%	69%	
8. Frequency of Events Reported	Previous	47%	61%	63%	58%	61%	65%	64%	66%	63%	52%	64%	63%	
	Change	7%	0%	-6%	2%	6%	0%	-5%	3%	0%	5%	-3%	6%	
	Most Recent	56%	56%	50%	61%	61%	55%	60%	59%	54%	63%	61%	58%	
9. Teamwork Across Units	Previous	56%	57%	48%	58%	58%	58%	48%	59%	48%	61%	62%	58%	
	Change	0%	-1%	2%	3%	3%	-3%	12%	0%	6%	2%	-1%	0%	
	Most Recent	55%	53%	54%	58%	52%	60%	66%	60%	48%	68%	64%	62%	
10. Staffing	Previous	62%	53%	54%	59%	54%	56%	56%	60%	56%	67%	66%	61%	
	Change	-7%	0%	0%	-1%	-2%	4%	10%	0%	-8%	1%	-2%	1%	
	Most Recent	24%	54%	46%	41%	54%	57%	44%	32%	34%	50%	44%	46%	
11. Handoffs & Transitions	Previous	32%	55%	46%	42%	51%	53%	43%	38%	31%	48%	45%	45%	
	Change	-8%	-1%	0%	-1%	3%	4%	1%	-6%	3%	2%	-1%	1%	
	Most Recent	40%	39%	40%	47%	42%	44%	38%	60%	48%	48%	58%	54%	
12. Nonpunitive Response to Error	Previous	38%	35%	43%	45%	36%	39%	41%	61%	43%	46%	62%	50%	
-	Change	2%	4%	-3%	2%	6%	5%	-3%	-1%	5%	2%	-4%	4%	

Table C-1. Trending: Composite-level Percent Positive Response by Respondent Work Area/Unit (Page 2 of 2)

			Work Area/Unit											
ltem	Survey Items by Composite	Database Year	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medi- cine	Obste- trics	Pedi- atrics	Pharm- acy	Psych/ Mental Hlth	Radi- ology	Rehab- ilitation	Surgery
	No. of Hospitals	Both Years	10	68	39	83	84	37	21	61	20	80	66	72
	No. of Respondents	Most Recent Previous	170 85	1,035 903	1,315 988	1,102 890	2,702 2,048	586 551	497 456	617 487	504 467	1,066 810	546 650	1,984 1,635
1.	Teamwork Within Units	Flevious	00	905	900	090	2,040	551	430	407	407	010	0.00	1,035
••		Most Recent	88%	89%	83%	85%	84%	86%	87%	87%	84%	85%	91%	86%
A1	1. People support one another	Previous	96%	84%	88%	81%	81%	81%	79%	92%	83%	83%	91 <i>%</i> 93%	84%
	in this unit.	Change	-8%	5%	-5%	4%	3%	5%	8%	-5%	1%	2%	-2%	2%
	2. When a lot of work needs to	Most Recent										89%		
	be done quickly, we work		99%	91%	92%	87%	84%	90%	92%	89%	85%		94%	89%
A3	together as a team to get the	Previous	90%	89%	94%	87%	84%	87%	79%	90%	80%	91%	89%	89%
	work done.	Change	9%	2%	-2%	0%	0%	3%	13%	-1%	5%	-2%	5%	0%
		Most Recent	98%	80%	73%	80%	76%	80%	82%	85%	80%	75%	90%	81%
A4	3. In this unit, people treat each other with respect.	Previous	94%	77%	84%	77%	71%	75%	74%	86%	77%	78%	87%	79%
		Change	4%	3%	-11%	3%	5%	5%	8%	-1%	3%	-3%	3%	2%
	4. When one area in this unit	Most Recent	54%	74%	66%	74%	59%	68%	73%	70%	65%	71%	82%	68%
A11	gets really busy, others help	Previous	81%	73%	67%	73%	61%	63%	69%	72%	68%	73%	75%	69%
	out.	Change	-27%	1%	-1%	1%	-2%	5%	4%	-2%	-3%	-2%	7%	-1%
2.	Supv/Mgr Expectations & A	ctions Promoti	ing Patien	t Safety										
	1. My supv/mgr says a good	Most Recent	60%	68%	59%	67%	68%	76%	67%	73%	75%	69%	80%	78%
B1	word when he/she sees a job	Previous	81%	69%	72%	64%	63%	74%	60%	75%	70%	69%	75%	70%
	done according to established patient safety procedures.	Change	-21%	-1%	-13%	3%	5%	2%	7%	-2%	5%	0%	5%	8%
	2. My supv/mgr seriously	Most Recent	71%	75%	65%	73%	73%	75%	80%	82%	75%	78%	87%	80%
B2	considers staff suggestions for	Previous	88%	72%	77%	79%	69%	79%	72%	80%	81%	73%	87%	78%
	improving patient safety.	Change	-17%	3%	-12%	-6%	4%	-4%	8%	2%	-6%	5%	0%	2%
	3. Whenever pressure builds	Most Recent	67%	77%	72%	80%	77%	77%	80%	83%	78%	81%	85%	76%
B3 R	up, my supv/mgr wants us to work faster, even if it means	Previous	89%	76%	71%	81%	72%	78%	69%	84%	79%	76%	79%	77%
	taking shortcuts.	Change	-22%	1%	1%	-1%	5%	-1%	11%	-1%	-1%	5%	6%	-1%
	4. My supv/mgr overlooks	Most Recent	79%	79%	70%	77%	77%	79%	81%	87%	78%	84%	87%	83%
B4 B	patient safety problems that	Previous	90%	75%	76%	75%	75%	81%	72%	83%	79%	76%	86%	79%
R	happen over and over.	Change	-11%	4%	-6%	2%	2%	-2%	9%	4%	-1%	8%	1%	4%

Table C-2. Trending: Item-level Percent Positive Response by Respondent Work Area/Unit (Page 1 of 6)

]	Work Area/Unit											
ltem	Survey Items by Composite	Database Year	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medi- cine	Obste- trics	Pedi- atrics	Pharm- acy	Psych/ Mental Hith	Radi- ology	Rehab- ilitation	Surgery
	No. of Hospitals	Both Years	10	68	39	83	84	37	21	61	20	80	66	72
	No. of Respondents	Most Recent Previous	170 85	1,035 903	1,315 988	1,102 890	2,702 2,048	586 551	497 456	617 487	504 467	1,066 810	546 650	1,984 1,635
3.	Management Support for Pa	tient Safety												
	1. Hospital mgmt provides a	Most Recent	67%	76%	64%	84%	78%	81%	86%	81%	68%	87%	82%	84%
F1	work climate that promotes	Previous	89%	75%	68%	83%	75%	81%	74%	80%	77%	86%	88%	81%
	patient safety.	Change	-22%	1%	-4%	1%	3%	0%	12%	1%	-9%	1%	-6%	3%
	2. The actions of hospital	Most Recent	71%	70%	57%	74%	71%	72%	68%	74%	67%	76%	75%	75%
F8	mgmt show that patient safety is a top priority.	Previous	83%	63%	58%	74%	65%	71%	62%	76%	71%	73%	78%	74%
		Change	-12%	7%	-1%	0%	6%	1%	6%	-2%	-4%	3%	-3%	1%
	3. Hospital mgmt seems interested in patient safety only after an adverse event happens.	Most Recent	54%	58%	49%	60%	58%	60%	59%	67%	52%	67%	64%	64%
F9 R		Previous	75%	53%	48%	61%	52%	59%	53%	66%	55%	61%	67%	60%
ĸ		Change	-21%	5%	1%	-1%	6%	1%	6%	1%	-3%	6%	-3%	4%
4.	Organizational Learning-	– Continuous	Improvem	nent										
	1. We are actively doing	Most Recent	84%	79%	85%	79%	83%	83%	91%	91%	81%	84%	90%	92%
A6	things to improve patient	Previous	89%	76%	86%	77%	78%	81%	82%	93%	85%	81%	88%	88%
	safety.	Change	-5%	3%	-1%	2%	5%	2%	9%	-2%	-4%	3%	2%	4%
	2 Mistokas boya ladita	Most Recent	60%	60%	55%	70%	64%	64%	74%	79%	60%	68%	63%	69%
A9	Mistakes have led to positive changes here.	Previous	78%	57%	60%	64%	57%	70%	58%	79%	65%	61%	66%	68%
		Change	-18%	3%	-5%	6%	7%	-6%	16%	0%	-5%	7%	-3%	1%
	3. After we make changes to	Most Recent	75%	66%	66%	69%	69%	68%	75%	80%	72%	70%	76%	83%
A13	improve patient safety, we	Previous	87%	63%	73%	61%	63%	72%	61%	78%	71%	68%	77%	72%
	evaluate their effectiveness.	Change	-12%	3%	-7%	8%	6%	-4%	14%	2%	1%	2%	-1%	11%

Table C-2. Trending: Item-level Percent Positive Response by Respondent Work Area/Unit (Page 2 of 6)

	C-2. Trending. Rem-level Ferc]		· · · · · · · ·		-			Area/Uni	t				
ltem	Survey Items by Composite	Database Year	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medi- cine	Obste- trics	Pedi- atrics	Pharm- acy	Psych/ Mental Hith	Radi- ology	Rehab- ilitation	Surgery
	No. of Hospitals	Both Years	10	68	39	83	84	37	21	61	20	80	66	72
	No. of Respondents	Most Recent Previous	170 85	1,035 903	1,315 988	1,102 890	2,702 2,048	586 551	497 456	617 487	504 467	1,066 810	546 650	1,984 1,635
5.	Overall Perceptions of Patien	nt Safety												
	1. It is just by chance that	Most Recent	66%	56%	57%	70%	56%	67%	73%	68%	61%	74%	78%	72%
A10 R	more serious mistakes don't	Previous	77%	56%	61%	68%	56%	57%	66%	70%	60%	66%	75%	67%
IX .	happen around here.	Change	-11%	0%	-4%	2%	0%	10%	7%	-2%	1%	8%	3%	5%
	2. Patient safety is never	Most Recent	46%	63%	50%	75%	58%	63%	67%	72%	71%	78%	78%	75%
A15	sacrificed to get more work	Previous	65%	58%	50%	74%	55%	57%	56%	71%	69%	81%	79%	71%
	done.	Change	-19%	5%	0%	1%	3%	6%	11%	1%	2%	-3%	-1%	4%
A 4 7	2 Ma have notions actably	Most Recent	70%	57%	60%	74%	57%	67%	83%	72%	53%	78%	78%	75%
A17 R	We have patient safety problems in this unit.	Previous	65%	57%	55%	73%	49%	63%	54%	69%	48%	75%	79%	73%
IX .		Change	5%	0%	5%	1%	8%	4%	29%	3%	5%	3%	-1%	2%
	4. Our procedures and	Most Recent	69%	64%	65%	78%	65%	74%	82%	83%	63%	79%	82%	83%
A18	systems are good at preventing errors from	Previous	83%	62%	68%	81%	57%	70%	62%	82%	71%	75%	85%	80%
	happening.	Change	-14%	2%	-3%	-3%	8%	4%	20%	1%	-8%	4%	-3%	3%
6.	Feedback and Communication	on About Erroi	•											
	1. We are given feedback	Most Recent	49%	47%	40%	47%	44%	60%	64%	52%	54%	53%	62%	60%
C1	about changes put into place	Previous	29%	47%	46%	51%	47%	58%	48%	55%	55%	53%	58%	48%
	based on event reports.	Change	20%	0%	-6%	-4%	-3%	2%	16%	-3%	-1%	0%	4%	12%
	2. We are informed about	Most Recent	63%	56%	60%	75%	57%	68%	67%	77%	66%	75%	78%	74%
C3	errors that happen in this	Previous	51%	57%	54%	70%	59%	67%	61%	78%	53%	72%	76%	72%
	unit.	Change	12%	-1%	6%	5%	-2%	1%	6%	-1%	13%	3%	2%	2%
	3. In this unit, we discuss	Most Recent	71%	65%	60%	72%	67%	73%	76%	80%	75%	72%	81%	81%
C5	ways to prevent errors from	Previous	87%	61%	62%	73%	59%	69%	69%	82%	69%	71%	81%	76%
	happening again.	Change	-16%	4%	-2%	-1%	8%	4%	7%	-2%	6%	1%	0%	5%

Table C-2. Trending: Item-level Percent Positive Response by Respondent Work Area/Unit (Page 3 of 6)

	C-2. Trending. Rein-level Ferc]		<u>., , , , , , , , , , , , , , , , , , , </u>					Area/Unit	t				
ltem	Survey Items by Composite	Database Year	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medi- cine	Obste- trics	Pedi- atrics	Pharm- acy	Psych/ Mental Hith	Radi- ology	Rehab- ilitation	Surgery
	No. of Hospitals	Both Years	10	68	39	83	84	37	21	61	20	80	66	72
	No. of Respondents	Most Recent Previous	170 85	1,035 903	1,315 988	1,102 890	2,702 2,048	586 551	497 456	617 487	504 467	1,066 810	546 650	1,984 1,635
7.	Communication Openness													
	1. Staff will freely speak up if they see something that may	Most Recent	64%	74%	72%	79%	73%	83%	87%	82%	79%	80%	88%	84%
C2	negatively affect patient	Previous	85%	70%	70%	73%	66%	81%	71%	86%	76%	76%	86%	83%
	care.	Change	-21%	4%	2%	6%	7%	2%	16%	-4%	3%	4%	2%	1%
	2. Staff feel free to question	Most Recent	47%	47%	41%	47%	42%	56%	60%	64%	54%	48%	60%	57%
C4	the decisions or actions of	Previous	58%	45%	46%	44%	35%	56%	48%	53%	42%	45%	56%	54%
	those with more authority.	Change	-11%	2%	-5%	3%	7%	0%	12%	11%	12%	3%	4%	3%
00	3. Staff are afraid to ask	Most Recent	53%	62%	58%	69%	56%	65%	76%	76%	71%	69%	72%	70%
C6 R	questions when something	Previous	78%	58%	65%	71%	55%	68%	64%	77%	59%	62%	74%	69%
	does not seem right.	Change	-25%	4%	-7%	-2%	1%	-3%	12%	-1%	12%	7%	-2%	1%
8.	Frequency of Events Report	ed												
	1. When a mistake is made,	Most Recent	45%	50%	44%	48%	56%	60%	50%	55%	58%	47%	54%	58%
D1	but is <u>caught and corrected</u> before affecting the patient,	Previous	48%	47%	50%	47%	49%	50%	53%	54%	61%	44%	57%	52%
	how often is this reported?	Change	-3%	3%	-6%	1%	7%	10%	-3%	1%	-3%	3%	-3%	6%
	2. When a mistake is made,	Most Recent	56%	58%	57%	54%	66%	57%	56%	68%	56%	51%	57%	66%
D2	but has <u>no potential to harm</u> the patient, how often is this	Previous	42%	62%	64%	50%	60%	63%	60%	63%	56%	43%	58%	59%
	reported?	Change	14%	-4%	-7%	4%	6%	-6%	-4%	5%	0%	8%	-1%	7%
	3. When a mistake is made	Most Recent	61%	75%	71%	78%	80%	78%	69%	85%	74%	73%	71%	82%
D3	that <u>could harm the patient</u> , but does not, how often is	Previous	52%	74%	75%	77%	74%	81%	80%	80%	73%	67%	76%	80%
	this reported?	Change	9%	1%	-4%	1%	6%	-3%	-11%	5%	1%	6%	-5%	2%

Table C-2. Trending: Item-level Percent Positive Response by Respondent Work Area/Unit (Page 4 of 6)

	C-2. Trending. Rem-level Ferc			<u>., , , , , , , , , , , , , , , , , , , </u>					Area/Uni	t				
ltem	Survey Items by Composite	Database Year	Anesthe- siology	Emer- gency	ICU (any type)	Lab	Medi- cine	Obste- trics	Pedi- atrics	Pharm- acy	Psych/ Mental HIth	Radi- ology	Rehab- ilitation	Surgery
	No. of Hospitals	Both Years	10	68	39	83	84	37	21	61	20	80	66	72
	No. of Respondents	Most Recent Previous	170 85	1,035 903	1,315 988	1,102 890	2,702 2,048	586 551	497 456	617 487	504 467	1,066 810	546 650	1,984 1,635
9.	Teamwork Across Units						_,					010		.,
50	1. Hospital units do not	Most Recent	30%	43%	34%	48%	47%	41%	41%	47%	34%	51%	48%	47%
F2 R	coordinate well with each	Previous	34%	47%	36%	44%	45%	45%	36%	48%	33%	48%	50%	41%
ĸ	other.	Change	-4%	-4%	-2%	4%	2%	-4%	5%	-1%	1%	3%	-2%	6%
	2. There is good cooperation	Most Recent	69%	59%	50%	65%	62%	57%	64%	58%	54%	65%	66%	59%
F4	among hospital units that	Previous	52%	57%	52%	59%	58%	58%	49%	61%	47%	63%	65%	59%
	need to work together.	Change	17%	2%	-2%	6%	4%	-1%	15%	-3%	7%	2%	1%	0%
F6	3. It is often unpleasant to	Most Recent	55%	54%	56%	61%	65%	59%	60%	60%	61%	62%	61%	57%
го R	work with staff from other	Previous	80%	55%	47%	60%	61%	62%	51%	57%	57%	62%	62%	61%
IX I	hospital units.	Change	-25%	-1%	9%	1%	4%	-3%	9%	3%	4%	0%	-1%	-4%
	4. Hospital units work well	Most Recent	71%	67%	61%	72%	70%	64%	74%	69%	68%	74%	69%	69%
F10	together to provide the best	Previous	61%	69%	58%	69%	68%	65%	57%	70%	54%	71%	71%	70%
	care for patients.	Change	10%	-2%	3%	3%	2%	-1%	17%	-1%	14%	3%	-2%	-1%
10.	Staffing													
	1. We have enough staff to	Most Recent	69%	45%	52%	55%	48%	54%	69%	58%	41%	66%	57%	59%
A2	handle the workload.	Previous	58%	46%	50%	61%	47%	50%	49%	58%	54%	66%	58%	61%
	hanalo no nonaoadi	Change	11%	-1%	2%	-6%	1%	4%	20%	0%	-13%	0%	-1%	-2%
A5	2. Staff in this unit work	Most Recent	33%	54%	54%	52%	47%	54%	57%	58%	43%	67%	60%	56%
R	longer hours than is best for	Previous	45%	53%	57%	57%	52%	49%	52%	58%	53%	64%	63%	56%
IX .	patient care.	Change	-12%	1%	-3%	-5%	-5%	5%	5%	0%	-10%	3%	-3%	0%
A7	3. We use more	Most Recent	80%	65%	62%	72%	61%	81%	81%	68%	61%	72%	73%	71%
R	agency/temporary staff than	Previous	75%	65%	63%	69%	69%	75%	72%	68%	66%	74%	73%	72%
	is best for patient care.	Change	5%	0%	-1%	3%	-8%	6%	9%	0%	-5%	-2%	0%	-1%
A14	4. We work in "crisis mode"	Most Recent	38%	48%	47%	53%	51%	50%	57%	57%	48%	66%	65%	62%
R	trying to do too much, too	Previous	56%	46%	48%	51%	48%	52%	51%	55%	53%	63%	68%	54%
••	quickly.	Change	-18%	2%	-1%	2%	3%	-2%	6%	2%	-5%	3%	-3%	8%

Table C-2. Trending: Item-level Percent Positive Response by Respondent Work Area/Unit (Page 5 of 6)

	_	Γ	•	<u>, ,</u>		-		(Page 6 Work	Area/Un	it				
ltem	Survey Items by Composite No. of Hospitals	Database Year Both Years	Anesthe- siology 10	Emer- gency 68	ICU (any type) 39	Lab 83	Medi- cine 84	Obste- trics 37	Pedi- atrics 21	Pharm- acy <i>61</i>	Psych/ Mental Hith 20	Radi- ology 80	Rehab- ilitation 66	Surgery 72
	No. of Respondents	Most Recent Previous	170 85	1,035 903	1,315 988	1,102 890	2,702 2,048	586 551	497 456	617 487	504 467	1,066 810	546 650	1,984 1,635
11.	Handoffs & Transitions													
	1. Things "fall between the	Most Recent	18%	52%	39%	36%	54%	47%	38%	29%	28%	48%	43%	49%
F3 R	cracks" when transferring patients from one unit to	Previous	28%	57%	36%	36%	51%	43%	35%	33%	23%	47%	41%	46%
ĸ	another.	Change	-10%	-5%	3%	0%	3%	4%	3%	-4%	5%	1%	2%	3%
	2. Important patient care	Most Recent	29%	60%	54%	40%	53%	65%	60%	32%	42%	54%	48%	47%
F5 R	information is often lost	Previous	32%	59%	63%	47%	53%	64%	51%	37%	42%	52%	47%	48%
ĸ	during shift changes.	Change	-3%	1%	-9%	-7%	0%	1%	9%	-5%	0%	2%	1%	-1%
	3. Problems often occur in	Most Recent	18%	54%	40%	40%	50%	50%	39%	33%	33%	48%	44%	46%
F7	the exchange of information	Previous	45%	53%	36%	38%	44%	43%	40%	38%	28%	43%	48%	45%
R	across hospital units.	Change	-27%	1%	4%	2%	6%	7%	-1%	-5%	5%	5%	-4%	1%
- 44	4. Shift changes are	Most Recent	30%	51%	50%	45%	58%	64%	40%	35%	31%	50%	40%	42%
F11 R	problematic for patients in	Previous	23%	50%	50%	47%	56%	63%	46%	41%	33%	50%	42%	40%
IX .	this hospital.	Change	7%	1%	0%	-2%	2%	1%	-6%	-6%	-2%	0%	-2%	2%
12.	Nonpunitive Response to Er	ror												
	1. Staff feel like their	Most Recent	55%	48%	49%	57%	48%	51%	51%	68%	48%	53%	63%	63%
A8 R	mistakes are held against	Previous	58%	41%	47%	53%	45%	46%	50%	70%	50%	54%	69%	56%
IX .	them.	Change	-3%	7%	2%	4%	3%	5%	1%	-2%	-2%	-1%	-6%	7%
	2. When an event is	Most Recent	36%	43%	37%	44%	43%	44%	38%	59%	53%	47%	55%	55%
A12	reported, it feels like the person is being written up,	Previous	42%	36%	45%	43%	38%	38%	42%	61%	42%	47%	58%	50%
R	not the problem.	Change	-6%	7%	-8%	1%	5%	6%	-4%	-2%	11%	0%	-3%	5%
A4C	3. Staff worry that mistakes	Most Recent	29%	29%	33%	40%	36%	38%	24%	54%	42%	44%	55%	43%
A16 R	they make are kept in their	Previous	14%	28%	37%	40%	26%	33%	30%	51%	37%	38%	58%	43%
13	personnel file.	Change	15%	1%	-4%	0%	10%	5%	-6%	3%	5%	6%	-3%	0%

Table C-2. Trending: Item-level Percent Positive Response by Respondent Work Area/Unit (Page 6 of 6)

							Wo	ork Area/U	nit				
	Database Year	Anesthe- siology	Emer- gency	ICU	Lab	Medicine	Obstet- rics	Pedi- atrics	Pharmacy	Psych/ Mental Health	Radiology	Rehab- ilitation	Surgery
No. of Hospitals	Both Years	10	68	39	83	84	37	21	61	20	80	66	72
No. of Respondents	Most Recent	170	1,035	1,315	1,102	2,702	586	497	617	504	1,066	546	1,984
	Previous	85	903	988	890	2,048	551	456	487	467	810	650	1,635
Patient Safety Grade						Average F	Percent of F	Responder	nts within Hos	pitals			
	Most Recent	26%	17%	18%	25%	13%	27%	28%	27%	22%	28%	37%	38%
A Excellent	Previous	32%	15%	14%	26%	10%	24%	19%	23%	17%	21%	31%	32%
	Change	-6%	2%	4%	-1%	3%	3%	9%	4%	5%	7%	6%	6%
	Most Recent	56%	48%	51%	53%	56%	47%	53%	55%	42%	50%	48%	46%
B Very Good	Previous	57%	43%	43%	48%	44%	39%	41%	51%	36%	53%	47%	45%
	Change	-1%	5%	8%	5%	12%	8%	12%	4%	6%	-3%	1%	1%
	Most Recent	17%	30%	23%	19%	27%	19%	14%	14%	25%	18%	13%	12%
C Acceptable	Previous	6%	28%	24%	20%	37%	27%	34%	19%	26%	20%	16%	15%
	Change	11%	2%	-1%	-1%	-10%	-8%	-20%	-5%	-1%	-2%	-3%	-3%
	Most Recent	1%	5%	5%	3%	4%	7%	5%	4%	10%	3%	1%	3%
D Poor	Previous	4%	11%	14%	6%	9%	10%	6%	6%	17%	5%	4%	7%
	Change	-3%	-6%	-9%	-3%	-5%	-3%	-1%	-2%	-7%	-2%	-3%	-4%
	Most Recent	0%	0%	4%	0%	0%	1%	0%	0%	2%	0%	0%	0%
E Failing	Previous	0%	2%	4%	1%	1%	0%	0%	2%	4%	0%	1%	1%
	Change	0%	-2%	0%	-1%	-1%	1%	0%	-2%	-2%	0%	-1%	-1%

Table C-3. Trending: Average Distribution of Work Area/Unit Patient Safety Grade by Respondent Work Area/Unit

-	-							k Area/Unit	•				
	Database Year	Anesthe- siology	Emer- gency	ICU	Lab	Medicine	Obstet- rics	Pedi- atrics	Pharm- acy	Psych/ Mental Health	Radiology	Rehab- ilitation	Surgery
No. of Hospitals	Both Years	10	68	39	83	84	37	21	61	20	80	66	72
No. of Respondents	Most Recent Previous	170 85	1,035 903	1,315 988	1,102 890	2,702 2,048	586 551	497 456	617 487	504 467	1,066 810	546 650	1,984 1,635
Number of Events Reported						Average P	ercent of Re	espondents	s within Hos	pitals			
	Most Recent	52%	39%	32%	50%	35%	47%	50%	41%	54%	56%	57%	51%
No events	Previous	65%	42%	29%	63%	38%	35%	44%	43%	47%	66%	66%	46%
	Change	-13%	-3%	3%	-13%	-3%	12%	6%	-2%	7%	-10%	-9%	5%
	Most Recent	45%	33%	41%	31%	33%	33%	32%	17%	19%	31%	32%	29%
1 to 2 events	Previous	31%	31%	35%	25%	29%	38%	36%	14%	30%	24%	25%	37%
	Change	14%	2%	6%	6%	4%	-5%	-4%	3%	-11%	7%	7%	-8%
	Most Recent	3%	17%	16%	12%	19%	15%	16%	13%	11%	13%	7%	14%
3 to 5 events	Previous	3%	18%	23%	8%	22%	16%	15%	13%	18%	7%	7%	13%
	Change	0%	-1%	-7%	4%	-3%	-1%	1%	0%	-7%	6%	0%	1%
	Most Recent	0%	6%	8%	4%	9%	4%	1%	9%	11%	1%	3%	5%
6 to 10 events	Previous	1%	6%	9%	3%	7%	8%	4%	10%	4%	2%	1%	3%
	Change	-1%	0%	-1%	1%	2%	-4%	-3%	-1%	7%	-1%	2%	2%
	Most Recent	0%	3%	2%	1%	3%	2%	0%	9%	3%	0%	0%	1%
11 to 20 events	Previous	0%	2%	5%	1%	3%	3%	0%	7%	1%	1%	0%	2%
	Change	0%	1%	-3%	0%	0%	-1%	0%	2%	2%	-1%	0%	-1%
04	Most Recent	0%	1%	1%	1%	1%	0%	0%	12%	2%	0%	0%	0%
21 event reports or more	Previous	0%	1%	0%	0%	2%	0%	0%	13%	0%	0%	0%	0%
	Change	0%	0%	1%	1%	-1%	0%	0%	-1%	2%	0%	0%	0%

Table C-4. Trending: Average Distribution of Number of Events Reported in the Past 12 Months by Respondent Work Area/Unit

Appendix C: Trending Results by

(2) Staff Position

NOTE: The number of hospitals and respondents in each breakout category is shown in each table (e.g., the number of hospitals and respondents by staff position). However, the precise number of hospitals and respondents corresponding to each data cell in a table will vary because hospitals may have omitted a specific survey item and because of individual non-response/missing data.

NOTE 2: Only hospitals that had at least 1 respondent in the particular staff position for both their previous and most recent administrations of the survey are included.

NOTE 3: Respondents who selected "Other" or those who did not answer (missing) are not included.

Table C-5. Trending. Composite-lev	g.		<u></u>		•	Staff Posi				
Patient Safety Culture Composites	Database Year	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Diet- ician	Pat Care Asst/Aide/ Care Partner	Pharm- acist	RN/LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Resp, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
No. of Hospitals	Both Years	92	53	27	58	41	98	70	66	89
No. of Respondents	Most Recent Previous	1,201 1,046	1,656 1,118	117 83	1,160 1,062	297 235	7,452 6,560	2,113 1,513	891 814	1,270 1,105
	Most Recent	89%	84%	85%	75%	85%	79%	79%	84%	78%
1. Teamwork Within Units	Previous	84%	81%	88%	73%	83%	79%	77%	83%	80%
	Change	5%	3%	-3%	2%	2%	0%	2%	1%	-2%
2. Supervisor/Manager	Most Recent	85%	73%	83%	75%	80%	74%	78%	79%	76%
Expectations & Actions	Previous	81%	68%	76%	74%	79%	73%	76%	79%	81%
Promoting Patient Safety	Change	4%	5%	7%	1%	1%	1%	2%	0%	-5%
	Most Recent	85%	74%	71%	76%	74%	67%	75%	71%	77%
3. Management Support for Patient Safety	Previous	82%	68%	73%	69%	73%	67%	73%	71%	77%
	Change	3%	6%	-2%	7%	1%	0%	2%	0%	0%
	Most Recent	85%	75%	76%	78%	81%	72%	73%	72%	70%
4. Org LearningContinuous Improvement	Previous	81%	72%	81%	70%	78%	71%	69%	74%	73%
	Change	4%	3%	-5%	8%	3%	1%	4%	-2%	-3%
	Most Recent	74%	65%	68%	65%	73%	64%	75%	74%	70%
5. Overall Perceptions of Patient Safety	Previous	72%	63%	76%	59%	67%	61%	72%	71%	71%
C alloly	Change	2%	2%	-8%	6%	6%	3%	3%	3%	-1%
	Most Recent	76%	63%	71%	64%	70%	58%	65%	67%	63%
6. Feedback & Communication About Error	Previous	72%	56%	77%	58%	66%	59%	63%	68%	69%
	Change	4%	7%	-6%	6%	4%	-1%	2%	-1%	-6%

Table C-5. Trending: Composite-level Average Percent Positive Response by Respondent Staff Position (Page 1 of 2)

Table C-5. Trending. Composite-le				,	•	Staff Posi		<u> </u>		
Patient Safety Culture Composites	Database Year	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Diet- ician	Pat Care Asst/Aide/ Care Partner	Pharm- acist	RN/LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respir, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
No. of Hospitals	Both Years	92	53	27	58	41	98	70	66	89
No. of Respondents	Most Recent Previous	1,201 1,046	1,656 1,118	117 83	1,160 1,062	297 235	7,452 6,560	2,113 1,513	891 814	1,270 1,105
	Most Recent	76%	69%	63%	56%	76%	61%	63%	69%	58%
7. Communication Openness	Previous	71%	59%	71%	53%	71%	61%	61%	67%	61%
	Change	5%	10%	-8%	3%	5%	0%	2%	2%	-3%
	Most Recent	67%	63%	65%	66%	65%	66%	61%	53%	65%
8. Frequency of Events Reported	Previous	64%	62%	60%	59%	50%	62%	60%	58%	67%
	Change	3%	1%	5%	7%	15%	4%	1%	-5%	-2%
	Most Recent	67%	64%	61%	61%	64%	59%	59%	65%	61%
9. Teamwork Across Units	Previous	63%	62%	70%	63%	56%	57%	58%	61%	65%
	Change	4%	2%	-9%	-2%	8%	2%	1%	4%	-4%
	Most Recent	65%	62%	60%	47%	59%	58%	60%	62%	52%
10. Staffing	Previous	61%	63%	70%	47%	57%	59%	59%	62%	57%
	Change	4%	-1%	-10%	0%	2%	-1%	1%	0%	-5%
	Most Recent	51%	53%	43%	47%	33%	53%	42%	45%	52%
11. Handoffs & Transitions	Previous	50%	48%	52%	50%	36%	50%	42%	42%	52%
	Change	1%	5%	-9%	-3%	-3%	3%	0%	3%	0%
	Most Recent	65%	41%	50%	37%	70%	45%	44%	56%	41%
12. Nonpunitive Response to Error	Previous	61%	42%	55%	32%	68%	45%	42%	52%	44%
	Change	4%	-1%	-5%	5%	2%	0%	2%	4%	-3%

Table C-5. Trending: Composite-level Average Percent Positive Response by Respondent Staff Position (Page 2 of 2)

							Staff Pos	ition			
ltem	Patient Safety Culture Composites	Database Year	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	No. of Hospitals	Both Years	92	53	27	58	41	98	70	66	89
	No. of Deenendente	Most Recent	1,201	1,656	117	1,160	297	7,452	2,113	891	1,270
	No. of Respondents	Previous	1,046	1,118	83	1,062	235	6,560	1,513	814	1,105
1.	Teamwork Within Units										
	1 Deeple support one enother	Most Recent	94%	92%	86%	79%	89%	85%	84%	90%	83%
A1	 People support one another in this unit. 	Previous	90%	83%	87%	77%	91%	85%	79%	86%	85%
		Change	4%	9%	-1%	2%	-2%	0%	5%	4%	-2%
	2. When a lot of work needs to	Most Recent	93%	90%	93%	84%	90%	88%	86%	86%	84%
A3	be done quickly, we work	Previous	90%	83%	94%	82%	90%	87%	87%	88%	87%
	together as a team to get the work done.	Change	3%	7%	-1%	2%	0%	1%	-1%	-2%	-3%
		Most Recent	89%	88%	82%	74%	89%	77%	76%	85%	73%
A4	3. In this unit, people treat each	Previous	84%	83%	86%	69%	78%	77%	75%	83%	77%
	other with respect.	Change	5%	5%	-4%	5%	11%	0%	1%	2%	-4%
	4. When one area in this unit	Most Recent	79%	69%	78%	65%	71%	67%	70%	76%	70%
A11	gets really busy, others help	Previous	73%	73%	85%	64%	72%	67%	69%	73%	72%
	out.	Change	6%	-4%	-7%	1%	-1%	0%	1%	3%	-2%
2.	Supv/Mgr Expectations & A	ctions Promoti	ng Patier	nt Safety							
	1. My supv/mgr says a good	Most Recent	82%	66%	84%	74%	69%	69%	70%	77%	73%
B1	word when he/she sees a job	Previous	75%	59%	78%	69%	72%	68%	68%	72%	76%
	done according to established patient safety procedures.	Change	7%	7%	6%	5%	-3%	1%	2%	5%	-3%
	2. My supv/mgr seriously	Most Recent	87%	74%	86%	78%	80%	74%	76%	82%	73%
B2	considers staff suggestions for	Previous	86%	68%	77%	70%	85%	75%	79%	84%	83%
	improving patient safety.	Change	1%	6%	9%	8%	-5%	-1%	-3%	-2%	-10%
	3. Whenever pressure builds	Most Recent	85%	75%	77%	73%	86%	75%	83%	80%	79%
B3	up, my supv/mgr wants us to	Previous	81%	70%	67%	76%	79%	74%	80%	80%	81%
R	work faster, even if it means taking shortcuts.	Change	4%	5%	10%	-3%	7%	1%	3%	0%	-2%
	4. My supv/mgr overlooks	Most Recent	85%	76%	86%	75%	86%	76%	83%	75%	80%
B4	patient safety problems that	Previous	81%	72%	83%	80%	78%	75%	78%	81%	84%
R	happen over and over.	Change	4%	4%	3%	-5%	8%	1%	5%	-6%	-4%

Table C-6. Trending: Item-level Percent Positive Response by Respondent Staff Position (Page 1 of 6)

							Staff Pos	ition			
ltem	Patient Safety Culture Composites	Database Year	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	No. of Hospitals	Both Years	92	53	27	58	41	98	70	66	89
	No. of Respondents	Most Recent Previous	1,201 1,046	1,656 1,118	117 83	1,160 1,062	297 235	7,452 6,560	2,113 1,513	891 814	1,270 1,105
3.	Management Support for Pa	tient Safety									
	1. Hospital mgmt provides a	Most Recent	91%	79%	79%	84%	78%	76%	85%	84%	87%
F1	work climate that promotes	Previous	91%	80%	86%	80%	75%	77%	84%	84%	87%
	patient safety.	Change	0%	-1%	-7%	4%	3%	-1%	1%	0%	0%
	2. The actions of hospital	Most Recent	87%	76%	81%	82%	76%	68%	77%	69%	79%
F8	mgmt show that patient	Previous	82%	63%	73%	74%	75%	67%	76%	73%	77%
	safety is a top priority.	Change	5%	13%	8%	8%	1%	1%	1%	-4%	2%
	3. Hospital mgmt seems	Most Recent	76%	67%	54%	63%	70%	57%	64%	58%	63%
F9 R	interested in patient safety only after an adverse event	Previous	74%	60%	61%	54%	67%	57%	59%	58%	66%
ĸ	happens.	Change	2%	7%	-7%	9%	3%	0%	5%	0%	-3%
4.	Organizational Learning— C	Continuous Imp	rovemen	t							
	1. We are actively doing	Most Recent	90%	84%	82%	90%	89%	85%	82%	87%	81%
A6	things to improve patient	Previous	86%	82%	80%	79%	91%	83%	78%	83%	83%
	safety.	Change	4%	2%	2%	11%	-2%	2%	4%	4%	-2%
		Most Recent	83%	74%	71%	67%	76%	62%	67%	60%	62%
A9	Mistakes have led to positive changes here.	Previous	81%	65%	81%	59%	77%	63%	61%	63%	60%
	positive originges riere.	Change	2%	9%	-10%	8%	-1%	-1%	6%	-3%	2%
	3. After we make changes	Most Recent	81%	69%	74%	77%	77%	70%	70%	68%	68%
A13	to improve patient safety,	Previous	76%	69%	79%	73%	66%	68%	67%	73%	75%
	we evaluate their effectiveness.	Change	5%	0%	-5%	4%	11%	2%	3%	-5%	-7%

Table C-6. Trending: Item-level Percent Positive Response by Respondent Staff Position (Page 2 of 6)

						Staff Pos	ition			
Patient Safety Culture Composites	Database Year	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
No. of Hospitals	Both Years	92	53	27	58	41	98	70	66	89
No. of Respondents	Most Recent Previous	1,201 1,046	1,656 1,118	117 83	1,160 1,062	297 235	7,452 6,560	2,113 1,513	891 814	1,270 1,105
Overall Perceptions of Patient	ent Safety									
1. It is just by chance that	Most Recent	75%	60%	60%	59%	68%	62%	70%	71%	61%
more serious mistakes	Previous	71%	67%	81%	49%	66%	60%	61%	70%	63%
don't happen around here.	Change	4%	-7%	-21%	10%	2%	2%	9%	1%	-2%
2. Patient safety is never	Most Recent	75%	70%	63%	68%	70%	62%	74%	73%	75%
sacrificed to get more work	Previous	70%	65%	76%	67%	62%	58%	74%	68%	75%
done.	Change	5%	5%	-13%	1%	8%	4%	0%	5%	0%
	Most Recent	68%	62%	69%	60%	70%	62%	76%	72%	69%
	Previous	69%	58%	73%	53%	62%	60%	73%	71%	71%
	Change	-1%	4%	-4%	7%	8%	2%	3%	1%	-2%
4. Our procedures and	Most Recent	77%	69%	81%	71%	83%	68%	78%	78%	77%
	Previous	77%	62%	76%	70%	78%	65%	80%	76%	75%
happening.	Change	0%	7%	5%	1%	5%	3%	-2%	2%	2%
Feedback and Communicat	ion About Erro	r								
1. We are given feedback	Most Recent	61%	53%	62%	57%	57%	48%	50%	56%	49%
3 1	Previous	58%	48%	70%	52%	51%	49%	50%	57%	58%
reports.	Change	3%	5%	-8%	5%	6%	-1%	0%	-1%	-9%
2 We are informed about	Most Recent	79%	60%	74%	66%	74%	59%	73%	69%	69%
errors that happen in this	Previous	76%	57%	75%	62%	72%	60%	70%	72%	72%
unit.	Change	3%	3%	-1%	4%	2%	-1%	3%	-3%	-3%
3. In this unit, we discuss	Most Recent	87%	75%	78%	68%	79%	68%	72%	75%	71%
ways to prevent errors from	Previous	81%	63%	86%	62%	75%	66%	71%	76%	76%
happening again.	Change	6%	12%	-8%	6%	4%	2%	1%	-1%	-5%
	CompositesNo. of HospitalsNo. of RespondentsOverall Perceptions of Patie1. It is just by chance that more serious mistakes don't happen around here.2. Patient safety is never sacrificed to get more work done.3. We have patient safety problems in this unit.4. Our procedures and systems are good at preventing errors from happening.Feedback and Communicat 1. We are given feedback about changes put into place based on event reports.2. We are informed about errors that happen in this unit.3. In this unit, we discuss ways to prevent errors from	CompositesDatabase YearNo. of HospitalsBoth YearsNo. of RespondentsMost Recent PreviousOverall Perceptions of Patient Safety1. It is just by chance that more serious mistakes don't happen around here.Most Recent Previous Change2. Patient safety is never sacrificed to get more work done.Most Recent Previous Change3. We have patient safety problems in this unit.Most Recent Previous Change4. Our procedures and systems are good at preventing errors from happening.Most Recent Previous ChangeFeedback and Communication About Errot Neased on event reports.Most Recent Previous Change2. We are informed about errors that happen in this unit.Most Recent Previous Change3. In this unit, we discuss ways to prevent errors from previous changeMost Recent Previous Change3. In this unit, we discuss ways to prevent errors from previousMost Recent Previous Change3. In this unit, we discuss ways to prevent errors from previousMost Recent 	CompositesDatabase YearMgmtNo. of HospitalsBoth Years92No. of RespondentsMost Recent1,201Previous1,046Overall Perceptions of Patient Safety1,046Overall Perceptions of Patient Safety71%1. It is just by chance that more serious mistakes don't happen around here.Most Recent75%2. Patient safety is never sacrificed to get more work done.Most Recent75%3. We have patient safety problems in this unit.Most Recent68%4. 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We have patient safety problems in this unit.</td><td>Patient Safety Cuture Composites Database Year Both Years Admin/ Mgmt Patient PA or NP PA or NP Patient Dietician Patient Patient Patient SatV/kide/ Cast Therapist (KG, Lab, Patient Therapist (KG, KG, KG, KG, KG, KG, KG, KG, KG, KG,</td></td>	Patient Safety Culture CompositesDatabase Year MgmtPhysician/ Resident/ PA or NPPhysician/ Resident/ PA or NPDietician DieticianNo. of HospitalsBoth Years925327No. of RespondentsMost Recent Previous1,2011,656117No. of RespondentsMost Recent Previous1,0461,11883Overall Perceptions of PatientSafety1,0461,11883Overall Perceptions of Patient SafetyMost Recent75%60%60%1. It is just by chance that more serious mistakes don't happen around here.Most Recent75%70%63%2. Patient safety is never sacrificed to get more work done.Most Recent75%70%63%3. We have patient safety problems in this unit.Most Recent68%62%69%4. 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Patient safety is never sacrificed to get more work done.Most Recent75%70%63%68%3. We have patient safety problems in this unit.Most Recent77%69%81%71%9. Our procedures and systems are good at preventing errors from happening.Most Recent77%69%81%71%Previous77%62%76%70%52%1%Previous77%62%76%70%52%Previous77%63%62%57%5%9. We are given feedback about changes put into place based on event reports.Most Recent71%53%62%5%9. We are informed about errors that happen in this unit.Most Recent79%60%74%66%9. We are informed about errors tha	Patient Safety Culture CompositesDatabase Year Database YearAttending/ MgmtPat Care Asst/Aide/ PA or NPPat Care Asst/Aide/ DieticianPat Care Asst/Aide/ PattnerNo. of HospitalsBoth Years9253275841No. of HospitalsMost Recent1,2011,6561171,160297Previous1,0461,118831,062235Overall Perceptions of Patient Safety </td <td>Patient Safety Culture Composites Database Year Attending/ Mgmt Pat Care Physician/ Mgmt Pat Care Phast(Alde/ Care Pharma- cist RN/ LVN/ LPN No. of Hospitals Both Years 92 53 27 58 41 98 No. of Hospitals Both Years 92 53 27 58 41 98 No. of Respondents Most Recent Previous 1,046 1,118 83 1,062 235 6,560 Overall Perceptions of Patient Safety 1 1.1 is just by chance that more serious mistakes Most Recent 75% 60% 60% 59% 68% 62% 2. Patient safety is never sacrificed to get more work done. Most Recent 75% 70% 63% 68% 70% 62% 58% 3. We have patient safety problems in this unit. 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Table C-6. Trending: Item-level Percent Positive Response by Respondent Staff Position (Page 3 of 6)

			•	• •		•	Staff Pos	•			
ltem	Patient Safety Culture Composites	Database Year	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	No. of Hospitals	Both Years	92	53	27	58	41	98	70	66	89
	No. of Respondents	Most Recent Previous	1,201 1,046	1,656 1,118	117 83	1,160 1,062	297 235	7,452 6,560	2,113 1,513	891 814	1,270 1,105
7.	Communication Openness										
	1. Staff will freely speak up	Most Recent	85%	76%	76%	72%	80%	75%	78%	81%	73%
C2	if they see something that may negatively affect	Previous	80%	70%	88%	71%	83%	75%	75%	81%	74%
	patient care.	Change	5%	6%	-12%	1%	-3%	0%	3%	0%	-1%
	2. Staff feel free to question	Most Recent	67%	62%	47%	41%	71%	44%	46%	55%	42%
C4	the decisions or actions of	Previous	61%	47%	70%	36%	56%	46%	41%	50%	45%
	those with more authority.	Change	6%	15%	-23%	5%	15%	-2%	5%	5%	-3%
C6	3. Staff are afraid to ask	Most Recent	76%	70%	64%	56%	78%	62%	65%	70%	60%
R R	questions when something	Previous	70%	58%	55%	53%	74%	62%	66%	70%	65%
	does not seem right.	Change	6%	12%	9%	3%	4%	0%	-1%	0%	-5%
8.	Frequency of Events Report	ted									
	1. When a mistake is made,	Most Recent	58%	54%	59%	61%	52%	52%	51%	46%	62%
D1	but is <u>caught and corrected</u> before affecting the patient,	Previous	56%	54%	55%	56%	37%	48%	50%	49%	63%
	how often is this reported?	Change	2%	0%	4%	5%	15%	4%	1%	-3%	-1%
	2. When a mistake is made,	Most Recent	64%	57%	59%	62%	63%	65%	54%	46%	60%
D2	but has <u>no potential to harm</u>	Previous	60%	57%	55%	54%	47%	59%	55%	54%	62%
	the patient, how often is this reported?	Change	4%	0%	4%	8%	16%	6%	-1%	-8%	-2%
	3. When a mistake is made	Most Recent	78%	78%	77%	75%	78%	80%	77%	66%	73%
D3	that <u>could harm the patient</u> ,	Previous	76%	73%	71%	66%	67%	78%	76%	71%	76%
	but does not, how often is this reported?	Change	2%	5%	6%	9%	11%	2%	1%	-5%	-3%

Table C-6. Trending: Item-level Percent Positive Response by Respondent Staff Position (Page 4 of 6)

							Staff Pos	ition			
ltem	Patient Safety Culture Composites	Database Year	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	No. of Hospitals	Both Years	92	53	27	58	41	98	70	66	89
	No. of Respondents	Most Recent Previous	1,201 1,0 4 6	1,656 1,118	117 83	1,160 1,062	297 235	7,452 6,560	2,113 1,513	891 814	1,270 1,105
9.	Teamwork Across Units										
F2 R	1. Hospital units do not coordinate well with each other.	Most Recent Previous	54% 51%	51% 46%	54% 53%	44% 51%	50% 44%	48% 44%	48% 45%	57% 46%	48% 52%
	2. There is good	Change	3%	5%	1%	-7%	6%	4%	3%	11%	-4%
F4	cooperation among hospital units that need to work	Most Recent Previous	69% 65%	65% 65%	58% 71%	64% 64%	62% 59%	62% 58%	61% 60%	67% 65%	63% 67%
	together.	Change	4%	0%	-13%	0%	3%	4%	1%	2%	-4%
F6 R	3. It is often unpleasant to work with staff from other hospital units.	Most Recent Previous	66% 60%	71% 65%	60% 76%	61% 63%	69% 58%	61% 59%	59% 59%	63% 63%	58% 62%
		Change	6%	6%	-16%	-2%	11%	2%	0%	0%	-4%
F10	 Hospital units work well together to provide the best care for patients. 	Most Recent Previous Change	78% 75% 3%	68% 70% -2%	71% 78% -7%	73% 73% 0%	74% 62% 12%	68% 67% 1%	70% 69% 1%	69% 69% 0%	76% 79% -3%
10.	Staffing	<u> </u>	- / -	_/•				.,.			- / -
A2	1. We have enough staff to handle the workload.	Most Recent Previous Change	69% 68% 1%	64% 67% -3%	66% 73% -7%	42% 43% -1%	50% 53% -3%	54% 54% 0%	59% 59% 0%	54% 57% -3%	48% 51% -3%
A5 R	2. Staff in this unit work longer hours than is best for patient care.	Most Recent Previous Change	61% 55% 6%	56% 58% -2%	63% 59% 4%	43% 43% 0%	63% 61% 2%	56% 58% -2%	57% 58% -1%	58% 58% 0%	51% 57% -6%
A7 R	3. We use more agency/temporary staff than is best for patient care.	Most Recent Previous Change	68% 68% 0%	65% 71% -6%	53% 76% -23%	54% 58% -4%	67% 57% 10%	70% 70% 0%	68% 68% 0%	75% 73% 2%	57% 65% -8%
A14 R	4. We work in "crisis mode" trying to do too much, too quickly.	Most Recent Previous Change	62% 56% 6%	63% 56% 7%	56% 70% -14%	48% 42% 6%	58% 57% 1%	53% 52% 1%	57% 50% 7%	59% 58% 1%	54% 57% -3%

Table C-6. Trending: Item-level Percent Positive Response by Respondent Staff Position (Page 5 of 6)

			Staff Position								
ltem	Patient Safety Culture Composites	Database Year	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	No. of Hospitals	Both Years	92	53	27	58	41	98	70	66	89
	No. of Respondents	Most Recent Previous	1,201 1,046	1,656 1,118	117 83	1,160 1,062	297 235	7,452 6,560	2,113 1,513	891 814	1,270 1,105
11.	Handoffs & Transitions										
	1. Things "fall between the	Most Recent	47%	55%	41%	45%	34%	50%	36%	44%	51%
F3	cracks" when transferring	Previous	46%	45%	52%	51%	33%	46%	38%	37%	53%
R	patients from one unit to another.	Change	1%	10%	-11%	-6%	1%	4%	-2%	7%	-2%
Fr	2. Important patient care	Most Recent	53%	53%	50%	54%	30%	57%	46%	48%	56%
F5 R	information is often lost during shift changes.	Previous	51%	49%	48%	58%	41%	55%	45%	49%	53%
N		Change	2%	4%	2%	-4%	-11%	2%	1%	-1%	3%
	3. Problems often occur in the exchange of information across hospital units.	Most Recent	49%	57%	38%	40%	34%	50%	43%	48%	49%
F7		Previous	49%	49%	59%	44%	34%	45%	37%	44%	48%
R		Change	0%	8%	-21%	-4%	0%	5%	6%	4%	1%
	4. Shift changes are	Most Recent	53%	46%	43%	49%	35%	55%	43%	41%	53%
F11 R	problematic for patients in	Previous	53%	47%	56%	49%	35%	51%	46%	39%	53%
ĸ	this hospital.	Change	0%	-1%	-13%	0%	0%	4%	-3%	2%	0%
12.	Nonpunitive Response to E	rror									
A8	1. Staff feel like their	Most Recent	70%	53%	54%	43%	75%	52%	52%	64%	47%
Að R	mistakes are held against	Previous	67%	53%	59%	42%	72%	52%	49%	61%	55%
IX .	them.	Change	3%	0%	-5%	1%	3%	0%	3%	3%	-8%
	2. When an event is	Most Recent	70%	42%	60%	38%	70%	47%	42%	55%	39%
A12 R	reported, it feels like the	Previous	65%	42%	57%	29%	72%	45%	40%	49%	41%
ĸ	person is being written up, not the problem.	Change	5%	0%	3%	9%	-2%	2%	2%	6%	-2%
	3. Staff worry that mistakes	Most Recent	55%	28%	36%	30%	66%	37%	40%	50%	37%
A16 R	they make are kept in their	Previous	51%	31%	54%	26%	61%	36%	38%	45%	36%
N	personnel file.	Change	4%	-3%	-18%	4%	5%	1%	2%	5%	1%

Table C-6. Trending: Item-level Percent Positive Response by Respondent Staff Position (Page 6 of 6)

		J				,	Staff Posi	tion			
		Database Year	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharmacist	RN/LVN/LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	No. of Hospitals	Both Years	92	53	27	58	41	98	70	66	89
No	o. of Respondents	Most Recent Previous	1,201 1,046	1,656 1,118	117 83	1,160 1,062	297 235	7,452 6,560	2,113 1,513	891 814	1,270 1,105
	tient Safety ade				Ave	rage Percer	nt of Respon	dents within F	lospitals		
		Most Recent	30%	25%	22%	21%	30%	20%	28%	26%	27%
Α	Excellent	Previous	23%	18%	42%	19%	19%	16%	24%	26%	20%
		Change	7%	7%	-20%	2%	11%	4%	4%	0%	7%
		Most Recent	54%	45%	52%	48%	52%	50%	52%	51%	49%
в	Very Good	Previous	48%	47%	41%	49%	48%	45%	46%	48%	54%
		Change	6%	-2%	11%	-1%	4%	5%	6%	3%	-5%
		Most Recent	14%	24%	21%	24%	14%	24%	17%	18%	21%
С	Acceptable	Previous	22%	26%	17%	26%	24%	27%	22%	19%	19%
		Change	-8%	-2%	4%	-2%	-10%	-3%	-5%	-1%	2%
		Most Recent	1%	6%	5%	5%	4%	5%	2%	3%	2%
D	Poor	Previous	5%	7%	0%	6%	8%	9%	7%	7%	5%
		Change	-4%	-1%	5%	-1%	-4%	-4%	-5%	-4%	-3%
		Most Recent	0%	0%	0%	2%	0%	1%	1%	1%	1%
Е	Failing	Previous	1%	2%	0%	1%	1%	2%	0%	1%	2%
		Change	-1%	-2%	0%	1%	-1%	-1%	1%	0%	-1%

Table C-7. Trending: Average Distribution of Work Area/Unit Patient Safety Grade by Respondent Staff Position

	-					Staff Pos	ition			
	Database Year	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharmacist	RN/LVN/LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
No. of Hospitals	Both Years	92	53	27	58	41	98	70	66	89
No. of Respondents	Most Recent Previous	1,201 1,046	1,656 1,118	117 83	1,160 1,062	297 235	7,452 6,560	2,113 1,513	891 814	1,270 1,105
Number of Events Reported				l	Average Perc	ent of Respon	dents within He	ospitals		
	Most Recent	47%	65%	71%	75%	19%	28%	55%	63%	77%
No events	Previous	50%	69%	69%	70%	31%	30%	55%	57%	81%
	Change	-3%	-4%	2%	5%	-12%	-2%	0%	6%	-4%
	Most Recent	24%	25%	21%	17%	23%	36%	31%	26%	18%
1 to 2 events	Previous	23%	21%	18%	23%	13%	36%	29%	33%	15%
	Change	1%	4%	3%	-6%	10%	0%	2%	-7%	3%
	Most Recent	13%	6%	4%	7%	16%	22%	11%	8%	4%
3 to 5 events	Previous	15%	4%	6%	6%	15%	22%	11%	8%	3%
	Change	-2%	2%	-2%	1%	1%	0%	0%	0%	1%
	Most Recent	11%	3%	4%	1%	13%	9%	2%	2%	1%
6 to 10 events	Previous	5%	1%	4%	1%	13%	7%	3%	2%	1%
	Change	6%	2%	0%	0%	0%	2%	-1%	0%	0%
	Most Recent	3%	0%	0%	0%	16%	5%	1%	1%	0%
11 to 20 events	Previous	5%	3%	0%	0%	14%	4%	1%	0%	0%
	Change	-2%	-3%	0%	0%	2%	1%	0%	1%	0%
21 avant ranarta	Most Recent	2%	0%	0%	0%	13%	1%	1%	1%	0%
21 event reports or more	Previous	2%	2%	4%	0%	14%	1%	0%	0%	0%
	Change	0%	-2%	-4%	0%	-1%	0%	1%	1%	0%

Table C-8. Trending: Average Distribution of Number of Events Reported in the Past 12 Months by Respondent Staff Position

Appendix C: Trending Results by

(3) Interaction with Patients

NOTE: The number of hospitals and respondents in each breakout category is shown in each table (e.g., the number of hospitals and respondents by interaction with patients). However, the precise number of hospitals and respondents corresponding to each data cell in a table will vary because hospitals may have omitted a specific survey item and because of individual non-response/missing data.

NOTE 2: Only hospitals that had at least 1 respondent in the response categories (WITH or WITHOUT direct interaction with patients) for both their previous and most recent administrations of the survey are included.

NOTE 3: Respondents who did not answer (missing) are not included.

		Respondent Interaction with Patients		
Patient Safety Culture Composites	Database Year	WITH direct interaction	WITHOUT direct interaction	
No. of Hospitals	Both Years	97	92	
No. of Respondents	Most Recent Previous	13,063 12,254	3,179 2,933	
	Most Recent	80%	82%	
1. Teamwork Within Units	Previous	78%	81%	
	Change	2%	1%	
	Most Recent	76%	76%	
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	Previous	74%	76%	
	Change	2%	0%	
	Most Recent	72%	78%	
3. Management Support for Patient Safety	Previous	71%	77%	
	Change	1%	1%	
	Most Recent	74%	74%	
4. Org LearningContinuous Improvement	Previous	71%	73%	
	Change	3%	1%	
	Most Recent	68%	69%	
5. Overall Perceptions of Patient Safety	Previous	65%	66%	
	Change	3%	3%	
	Most Recent	63%	67%	
6. Feedback & Communication About Error	Previous	61%	66%	
	Change	2%	1%	

 Table C-9. Trending: Composite-level Average Percent Positive Response by Respondent Interaction with Patients (Page 1 of 2)

		Respondent Interaction with Patients		
		WITH	WITHOUT	
Patient Safety Culture Composites	Database Year	direct interaction	direct interaction	
No. of Hospitals	Both Years	97	92	
No. of Respondents	Most Recent Previous	13,063	<i>3,179</i>	
		12,254	2,933	
	Most Recent	63%	64%	
7. Communication Openness	Previous	60%	64%	
	Change	3%	0%	
	Most Recent	63%	62%	
8. Frequency of Events Reported	Previous	61%	60%	
	Change	2%	2%	
	Most Recent	61%	62%	
9. Teamwork Across Units	Previous	60%	60%	
	Change	1%	2%	
	Most Recent	58%	56%	
10. Staffing	Previous	58%	53%	
	Change	0%	3%	
	Most Recent	51%	43%	
11. Handoffs & Transitions	Previous	49%	41%	
	Change	2%	2%	
	Most Recent	46%	51%	
12. Nonpunitive Response to Error	Previous	44%	48%	
	Change	2%	3%	

 Table C-9. Trending: Composite-level Average Percent Positive Response by Respondent Interaction with Patients (Page 2 of 2)

	To. Trending. Reinfever Average Feldent Fostive Response R		Respondent Interaction with Patie			
			WITH	WITHOUT		
ltem	Survey Items By Composite	Database Year	direct interaction	direct interaction		
	No. of Hospitals	Both Years	97	92		
	No. of Respondents	Most Recent Previous	13,063 12,254	3,179 2,933		
1.	Teamwork Within Units					
		Most Recent	85%	87%		
A1	1. People support one another in this unit.	Previous	83%	86%		
		Change	2%	1%		
	• When a later found and to be done with the second	Most Recent	87%	87%		
A3	2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	Previous	87%	88%		
	together as a team to get the work done.	Change	0%	-1%		
		Most Recent	78%	81%		
A4	3. In this unit, people treat each other with respect.	Previous	76%	80%		
		Change	2%	1%		
		Most Recent	69%	71%		
A11	4. When one area in this unit gets really busy, others help out.	Previous	68%	69%		
		Change	1%	2%		
2.	Supervisor/Manager Expectations & Actions Promoting Pati	ent Safety				
	1 New supplyment as a good word when he/she same a jak	Most Recent	71%	74%		
B1	1. My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures.	Previous	69%	72%		
	done according to established patient safety procedures.	Change	2%	2%		
	2 My annulation conjugate considere staff another for	Most Recent	76%	78%		
B2	2. My supv/mgr seriously considers staff suggestions for improving patient safety.	Previous	75%	78%		
	improving patient safety.	Change	1%	0%		
Do		Most Recent	78%	76%		
	3. Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts.	Previous	76%	76%		
IX I	המונה, ביכו זו זו ווכמוז נמוווץ אוטונטנס.	Change	2%	0%		
		Most Recent	78%	77%		
	My supv/mgr overlooks patient safety problems that happen over and over.	Previous	77%	77%		
B1 B2 B3 R B4 R		Change	1%	0%		
-	$(1, \dots, 2, \dots, \dots, n) = 1, \dots, \dots, 1, \dots, \dots, 1, \dots, 1, \dots, 1, \dots, \dots, 1, \dots, \dots, 1, \dots, \dots, \dots, 1, \dots, \dots,$			<u> </u>		

Table C-10. Trending: Item-level Average Percent Positive Response by Respondent Interaction with Patients (Page 1 of 6)

		• •				
			Respondent Intera	ction with Patients		
			WITH	WITHOUT		
ltem	Survey Items By Composite	Database Year	direct interaction	direct interaction		
	No. of Hospitals	Both Years	97	92		
	No. of Respondents	Most Recent	13,063	3,179		
		Previous	12,254	2,933		
3.	Management Support for Patient Safety					
	1. Hospital mgmt provides a work climate that promotes patient	Most Recent	82%	87%		
F1	safety.	Previous	81%	88%		
	Saroty.	Change	1%	-1%		
	2. The extinue of been itely ment about that patient extent is a ten	Most Recent	74%	80%		
F8	2. The actions of hospital mgmt show that patient safety is a top priority.	Previous	71%	78%		
	phoney.	Change	3%	2%		
50	 Hospital mgmt seems interested in patient safety only after an adverse event happens. 	Most Recent	61%	67%		
F9 R		Previous	60%	65%		
IX.		Change	1%	2%		
4.	Organizational Learning— Continuous Improvement					
		Most Recent	84%	81%		
A6	1. We are actively doing things to improve patient safety.	Previous	82%	81%		
		Change	2%	0%		
		Most Recent	65%	69%		
A9	2. Mistakes have led to positive changes here.	Previous	62%	69%		
		Change	3%	0%		
		Most Recent	71%	71%		
A13	3. After we make changes to improve patient safety, we evaluate their effectiveness.	Previous	69%	69%		
		Change	2%	2%		

 Table C-10. Trending: Item-level Average Percent Positive Response by Respondent Interaction with Patients (Page 2 of 6)

			Respondent Intera	ction with Patients
			WITH	WITHOUT
ltem	Survey Items By Composite	Database Year	direct interaction	direct interaction
	No. of Hospitals	Both Years	97	92
	No. of Respondents	Most Recent	13,063	3,179
		Previous	12,254	2,933
5.	Overall Perceptions of Patient Safety		-	
A 1 O	1. It is just by shapped that more parious mistakes den't bappen	Most Recent	64%	64%
A10 R	1. It is just by chance that more serious mistakes don't happen around here.	Previous	61%	62%
IX.		Change	3%	2%
		Most Recent	69%	70%
A15	2. Patient safety is never sacrificed to get more work done.	Previous	66%	67%
		Change	3%	3%
A17 R		Most Recent	67%	69%
	3. We have patient safety problems in this unit.	Previous	65%	65%
n		Change	direct interaction 97 13,063 12,254 64% 61% 3% 69% 66% 3% 66% 3%	4%
		Most Recent	73%	73%
A18	4. Our procedures and systems are good at preventing errors from happening.	Previous	69%	72%
	nom nappening.	Change	4%	1%
6.	Feedback and Communication About Error			
		Most Recent	51%	53%
C1	 We are given feedback about changes put into place based on event reports. 	Previous	50%	54%
		Change	1%	-1%
		Most Recent	66%	72%
C3	2. We are informed about errors that happen in this unit.	Previous	65%	70%
		Change	1%	2%
	2. In this unit, we discuss would be prevent errors from	Most Recent	71%	76%
C5	In this unit, we discuss ways to prevent errors from happening again.	Previous	69%	76%
	паррепшу адаш.	Change	2%	0%

 Table C-10. Trending: Item-level Average Percent Positive Response by Respondent Interaction with Patients (Page 3 of 6)

		• •		
			Respondent Intera	ction with Patients
			WITH	WITHOUT
Item	Survey Items By Composite	Database Year	direct interaction	direct interaction
	No. of Hospitals	Both Years	97	92
	No. of Respondents	Most Recent Previous	13,063 12,254	3,179 2,933
7.	Communication Openness			,
	4. Ctoff will freely encode up if they are compating that may	Most Recent	76%	76%
C2	1. Staff will freely speak up if they see something that may negatively affect patient care.	Previous	75%	78%
	negatively aneor patient ouro.	Change	1%	-2%
C4	2. Staff fool from to question the desicions or actions of those	Most Recent	47%	51%
	2. Staff feel free to question the decisions or actions of those with more authority.	Previous	45%	49%
	with more autionty.	Change	2%	2%
<u> </u>	3. Staff are afraid to ask questions when something does not seem right.	Most Recent	64%	66%
C6 R		Previous	62%	66%
IX .	eeen ng.m	Change	2%	0%
8.	Frequency of Events Reported			
	1 When a mintake is made, but is sought and corrected before	Most Recent	53%	57%
D1		Previous	52%	53%
		Previous Change ncy of Events Reported a mistake is made, but is caught and corrected before the patient, how often is this reported? Most Recent Previous Change	1%	4%
	2. When a mintake is made, but has no natential to have the	Most Recent	60%	55%
D2		Previous	57%	56%
	2. When a mistake is made, but has no potential to harm the batient, how often is this reported?Previous57%Change3%	3%	-1%	
	3. When a mistake is made that could harm the patient, but	Most Recent	76%	73%
D3	does not, how often is this reported?	Previous	75%	71%
		Change	1%	2%

 Table C-10. Trending: Item-level Average Percent Positive Response by Respondent Interaction with Patients (Page 4 of 6)

			Respondent Interaction with Patients			
			WITH	WITHOUT		
Item	Survey Items By Composite	Database Year	direct interaction	direct interaction		
	No. of Hospitals	Both Years	-	92		
	No. of Respondents	Most Recent Previous	13,063 12,254	3,179 2,933		
9.	Teamwork Across Units					
50		Most Recent	49%	52%		
	1. Hospital units do not coordinate well with each other.	Previous	47%	48%		
IX .		Change	WITH direct interaction 97 13,063 12,254 49% 47% 2% 64% 62% 2% 61% 60% 1% 71% 70% 1% 56% 0% 55% 56% 1% 67% 68% -1% 55% 55% 55% 55% 55% 55% 55% 55% 55% 55%	4%		
		Most Recent	64%	61%		
F4	2. There is good cooperation among hospital units that need to work together.	Previous	62%	62%		
	work together.	Change	2%	-1%		
F2 R F4 F6 R F10 10. A2	Only in the second se	Most Recent	61%	60%		
	3. It is often unpleasant to work with staff from other hospital units.	Previous	60%	57%		
IX.		Change	1%	3%		
	4. Llognitel units work well to get her to provide the heat each for	Most Recent	71%	73%		
F10	4. Hospital units work well together to provide the best care for patients.	Previous	70%	72%		
		Change	WITH direct interaction 97 13,063 12,254 49% 47% 2% 64% 62% 2% 61% 60% 1% 71% 70% 1% 0% 56% 0% 55% 56% -1% 67% 68% -1% 55%	1%		
10.	Staffing					
		Most Recent	56%	60%		
A2	1. We have enough staff to handle the workload.	Previous	56%	59%		
		Change	0%	1%		
<u>۸</u> ۳	0. Otaff in this writewark low new house there is heart for a stight	Most Recent	55%	50%		
	2. Staff in this unit work longer hours than is best for patient care.	Previous	56%	47%		
IX I		Change	-1%	3%		
۸ <i>¬</i>	2. We use more energy themperery staff then is heat for a stight	Most Recent	67%	57%		
A7 R	3. We use more agency/temporary staff than is best for patient care.	Previous	68%	56%		
13	ouro.	Change	-1%	1%		
		Most Recent	55%	55%		
A14 R	4. We work in "crisis mode" trying to do too much, too quickly.	Previous	53%	50%		
IX .		Change	2%	5%		

 Table C-10. Trending: Item-level Average Percent Positive Response by Respondent Interaction with Patients (Page 5 of 6)

		Respondent Interac	tion with Patients		
		WITH	WITHOUT		
Survey Items By Composite	Database Year	direct interaction	direct interaction		
No. of Hospitals	Both Years	97	92		
No. of Respondents	Most Recent		3,179		
	Previous	12,254	2,933		
Handoffs & Transitions					
1 Things "foll between the gracks" when transferring patients	Most Recent	49%	40%		
с	Previous	48%	40%		
	Change	1%	0%		
2. Important patient care information is often last during shift	Most Recent	54%	46%		
	Previous	53%	43%		
changes.	Change	1%	3%		
	Most Recent	49%	43%		
	Previous	46%	39%		
nospital units.	Change	WITH direct interaction 97 13,063 12,254 49% 48% 1% 54% 53% 1% 49%	4%		
	Most Recent	52%	44%		
4. Shift changes are problematic for patients in this hospital.	Previous	50%	43%		
	Change	2%	1%		
Nonpunitive Response to Error					
	Most Recent	53%	60%		
1. Staff feel like their mistakes are held against them.	Previous	53%	56%		
	Change	0%	4%		
	Most Recent	47%	52%		
	Previous	43%	51%		
	Change	4%	1%		
	Most Recent	39%	42%		
	Previous	37%	38%		
	Change		4%		
	No. of Hospitals No. of Respondents Handoffs & Transitions 1. Things "fall between the cracks" when transferring patients from one unit to another. 2. Important patient care information is often lost during shift changes. 3. Problems often occur in the exchange of information across hospital units. 4. Shift changes are problematic for patients in this hospital. Nonpunitive Response to Error	No. of Hospitals Both Years No. of Respondents Most Recent Previous Handoffs & Transitions Most Recent Previous 1. Things "fall between the cracks" when transferring patients from one unit to another. Most Recent Previous Change 2. Important patient care information is often lost during shift changes. Most Recent Previous Change 3. Problems often occur in the exchange of information across hospital units. Most Recent Previous Change 4. Shift changes are problematic for patients in this hospital. Most Recent Previous Change 1. Staff feel like their mistakes are held against them. Most Recent Previous Change 2. When an event is reported, it feels like the person is being written up, not the problem. Most Recent Previous Change 3. Staff worry that mistakes they make are kept in their Most Recent Previous Change	Survey Items By CompositeDatabase Yeardirect interactionNo. of HospitalsBoth Years97No. of RespondentsMost Recent13,063Previous12,254Handoffs & TransitionsMost Recent49%1. Things "fall between the cracks" when transferring patients from one unit to another.Most Recent49%2. Important patient care information is often lost during shift changes.Most Recent54%3. Problems often occur in the exchange of information across hospital units.Most Recent49%4. Shift changes are problematic for patients in this hospital.Most Recent49%1. Staff feel like their mistakes are held against them.Most Recent53%2. When an event is reported, it feels like the person is being written up, not the problem.Most Recent53%3. Staff worry that mistakes they make are kept in theirMost Recent53%3. Staff worry that mistakes they make are kept in theirMost Recent53%3. Staff worry that mistakes they make are kept in theirMost Recent53%3. Staff worry that mistakes they make are kept in theirMost Recent39%3. Staff worry that mistakes they make are kept in theirMost Recent39%		

 Table C-10. Trending: Item-level Average Percent Positive Response by Respondent Interaction with Patients (Page 6 of 6)

			Respondent Interaction with Patients	
		Database Year	WITH direct interaction	WITHOUT direct interaction
	No. of Hospitals	Both Years	97	92
	No. of Respondents	Most Recent Previous	13,063 12,254	3,179 2,933
Patient Safety Grade			Average Percent of Respondents within Hospitals	
		Most Recent	24%	27%
Α	Excellent	Previous	21%	23%
		Change	3%	4%
		Most Recent	50%	50%
в	Very Good	Previous	46%	48%
		Change	4%	2%
		Most Recent	21%	21%
С	Acceptable	Previous	24%	22%
		Change	-3%	-1%
		Most Recent	4%	2%
D	Poor	Previous	7%	5%
		Change	-3%	-3%
		Most Recent	1%	1%
Е	Failing	Previous	2%	1%
		Change	-1%	0%

 Table C-11. Trending: Average Distribution of Work Area/Unit Patient Safety Grade by Respondent Interaction

		Respondent Interaction with Patients	
	Database Year	WITH direct interaction	WITHOUT direct interaction
No. of Hospitals	Both Years	97	92
No. of Respondents	Most Recent Previous	13,063 12,254	3,179 2,933
Number of Events Reported		Average Percent of Respondents within Hospitals	
	Most Recent	48%	70%
No events	Previous	51%	72%
	Change	-3%	-2%
	Most Recent	30%	17%
1 to 2 events	Previous	27%	16%
	Change	3%	1%
	Most Recent	14%	6%
3 to 5 events	Previous	14%	6%
	Change	0%	0%
	Most Recent	5%	3%
6 to 10 events	Previous	4%	3%
	Change	1%	0%
	Most Recent	3%	2%
11 to 20 events	Previous	2%	1%
	Change	1%	1%
	Most Recent	1%	2%
21 event reports or more	Previous	1%	2%
	Change	0%	0%

 Table C-12. Trending: Average Distribution of Number of Events Reported in the Past 12 Months by Respondent Interaction With Patients