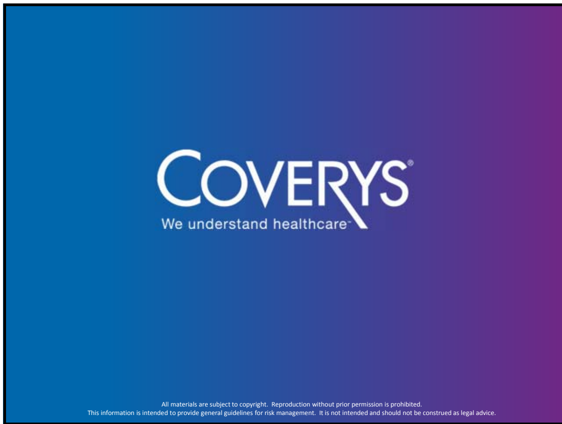
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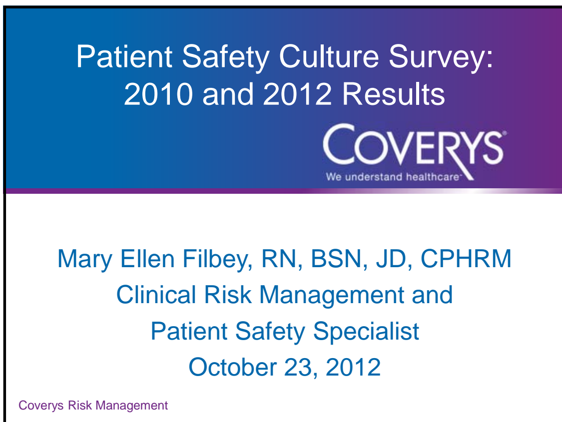
Southern California Patient Safety Collaborative
Track III - Perinatal Safety
Patient Safety First...
a California Partnership for Health
Anthem


Patient Safety Culture Survey:
2010 and 2012 Results
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We understand healthcare
Mary Ellen Filbey, RN, BSN, JD, CPHRM
Clinical Risk Management and
Patient Safety Specialist
October 23, 2012
Coverys Risk Management

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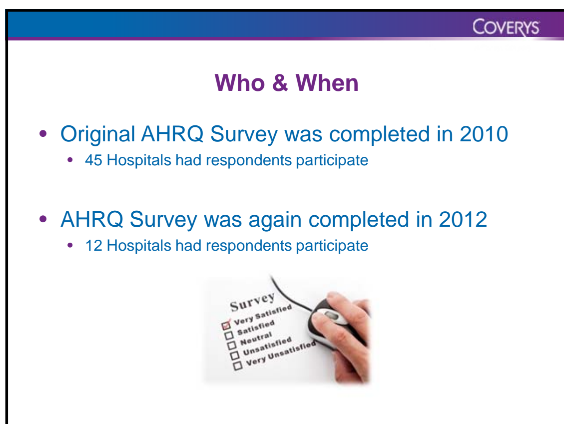
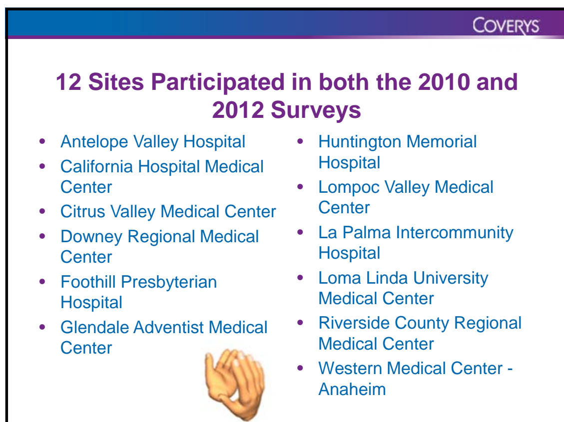
AHRQ survey purpose

- Raise staff awareness about patient safety.
- Assess the current status of the patient safety culture.
- Identify strengths and areas for patient safety culture improvement.
- Examine trends in patient safety culture change over time.
- Evaluate the cultural impact of patient safety initiatives and interventions.

Reference: http://www.ahrq.gov/qual/patientsafetyculture/ accessed February 8, 2012





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Comparing Results 2010 and 2012

- Compare results from the AHRQ survey from 2010 and 2012
  - Using average scores for individual and combined groups of questions for both the 2010 and 2012 responding hospitals
    - 2010 includes 45 sites
    - 2012 includes 12 sites

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Section A

- **Question #1** – People support one another in this unit.
- **Question #3** – When a lot of work needs to be done quickly, we work together as a team to get the work done.
- **Question #4** – In this unit, people treat each other with respect.
- **Question #6** – We are actively doing things to improve patient safety.

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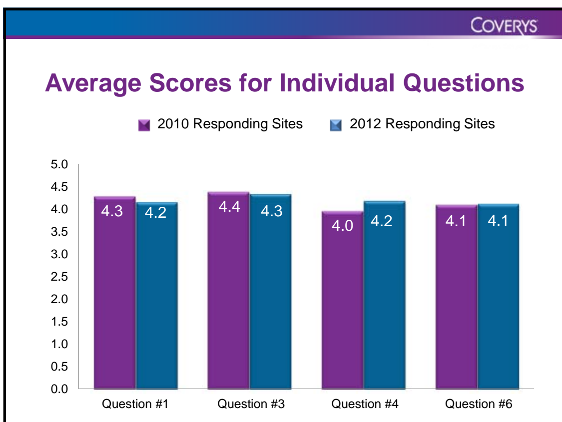
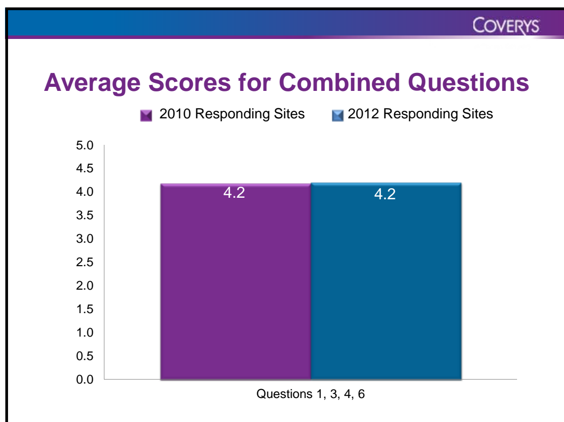
Average Scores for Individual Questions





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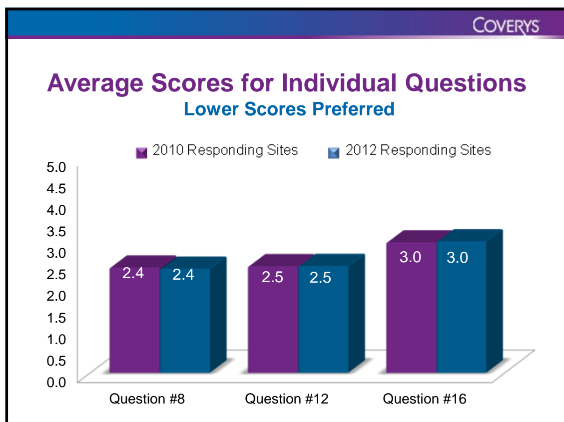
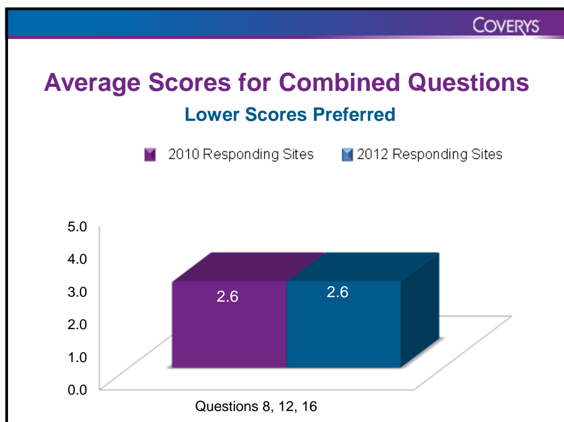
Section A

Lower Scores Preferred

- **Question #8** – Staff feel like their mistakes are held against them.
- **Question #12** – When an event is reported, it feels like the person is being written up, not the problem.
- **Question #16** – Staff worry that mistakes they make are kept in their personnel file.





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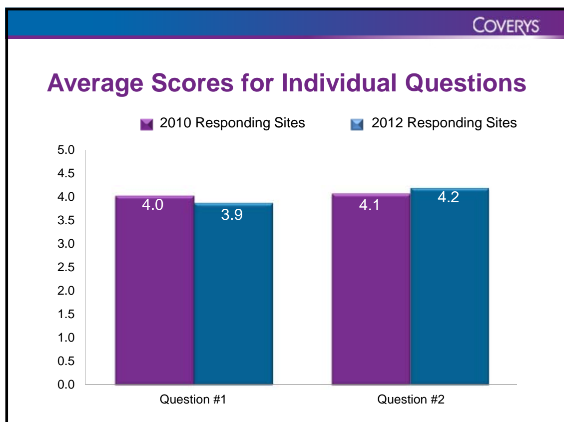
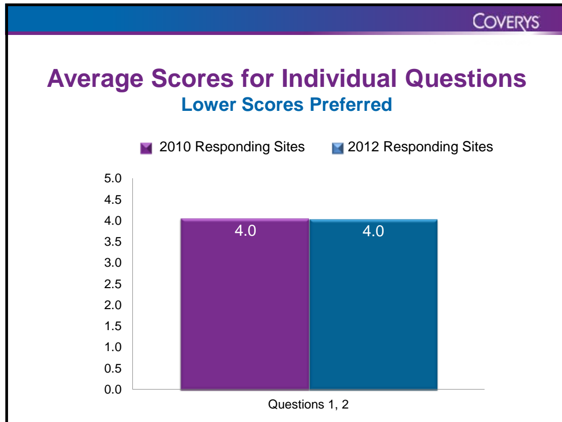
Section B

- **Question #1 –** My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.
- **Question #2 –** My supervisor/manager seriously considers staff suggestions for improving patient safety.





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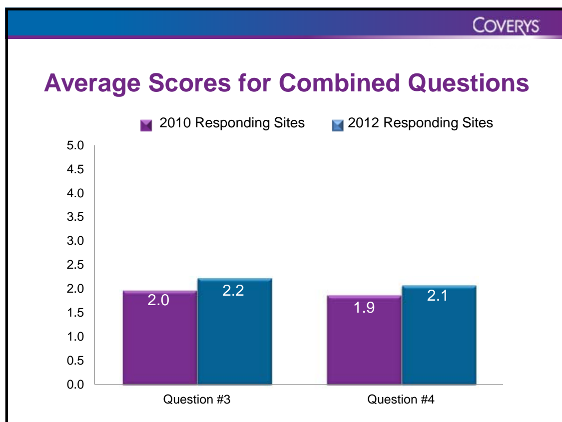
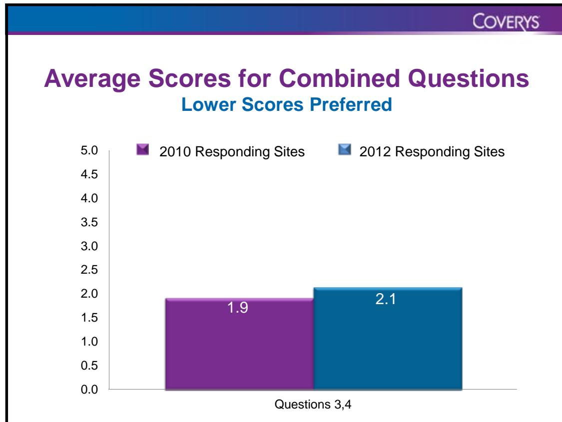
Section B

Lower Scores Preferred

- **Question #3 –** Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts.
- **Question #4 –** My supervisor/manager overlooks patient safety problems that happen over and over.





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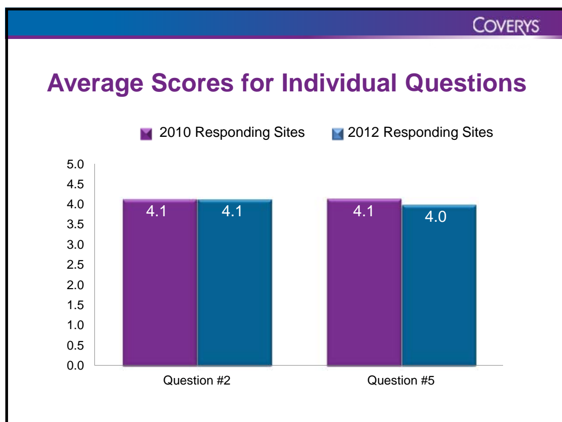
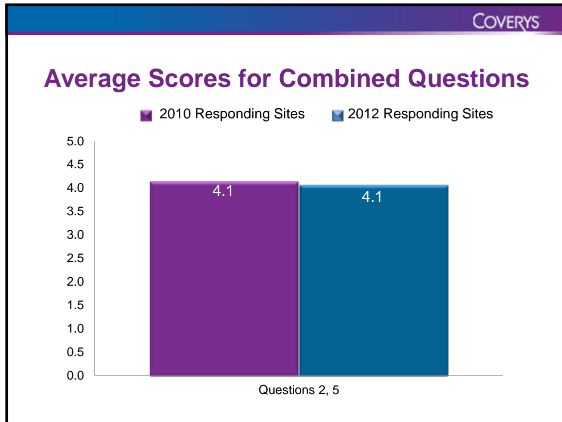
Section C

- **Question #2** – Staff will freely speak up if they see something that may negatively affect patient care.
- **Question #5** - In this unit, we discuss ways to prevent errors from happening again.





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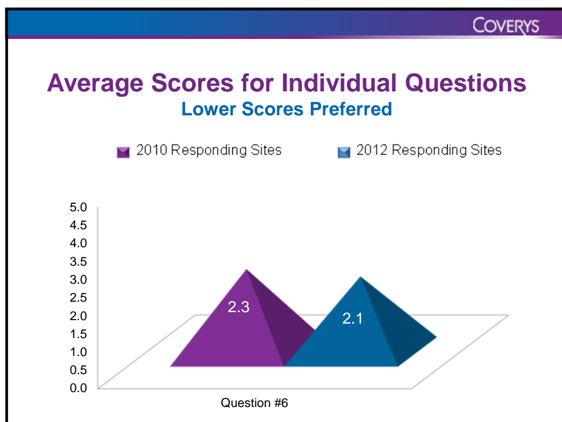
Section C

Lower response preferred

- **Question #6** – Staff are afraid to ask questions when something does not seem right.



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Section D

- **Question #3** – When a mistake is made that could harm the patient, but does not, how often is this reported?

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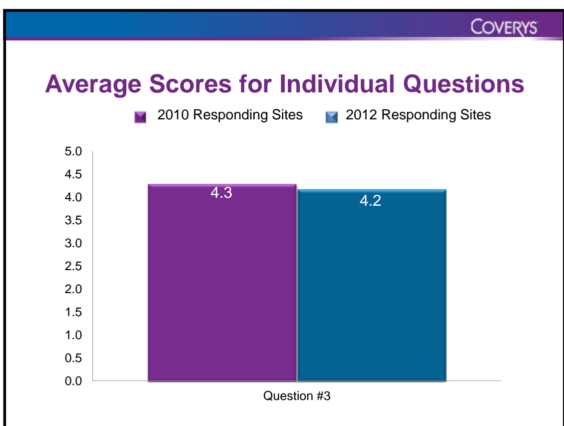

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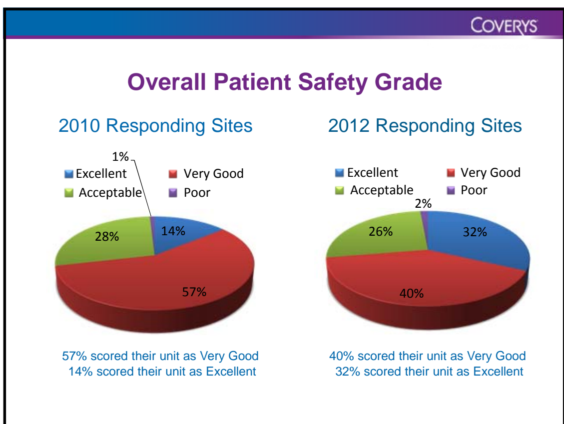

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Section F

- **Question #1** – Hospital management provides a work climate that promotes patient safety.
- **Question #8** – The actions of hospital management show that patient safety is a top priority.

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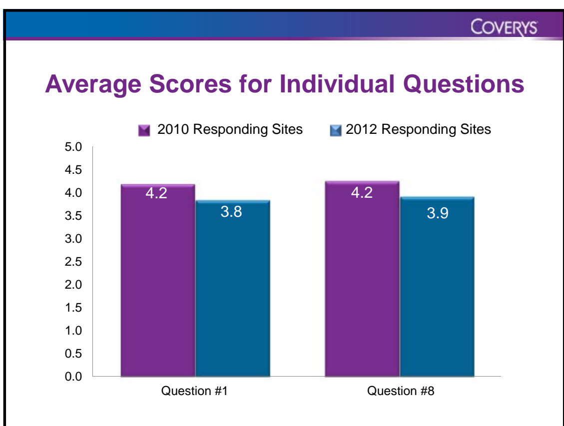
Average Scores for Individual Questions



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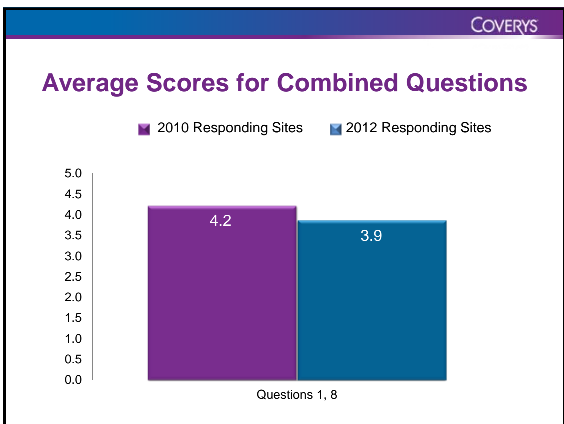
Average Scores for Combined Questions



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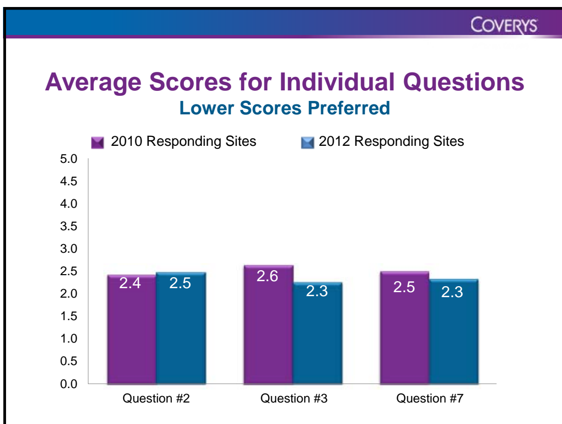
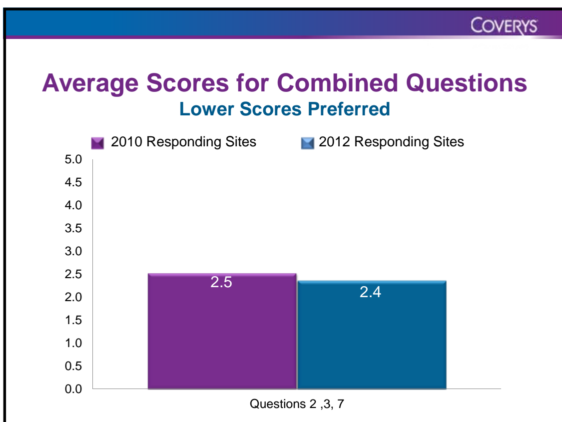
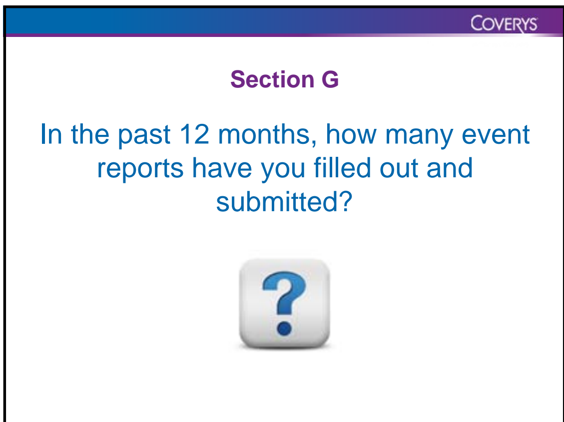
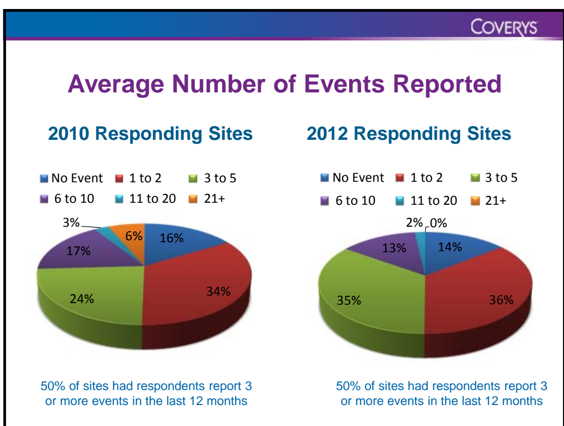
Section F
Lower score preferred

- **Question #2** – Hospital units do not coordinate well with each other.
- **Question #3** – Things "fall between the cracks" when transferring patients from one unit to another.
- **Question #7** – Problems often occur in the exchange of information across hospital units.









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Assessing your Patient Safety Culture-AHRQ Survey

- Why continue to assess your culture?
  - Measure impact of patient safety interventions and obtain staff's perceptions of their unit's culture
- How often?
  - Annually or every 16-18 months

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Action Planning for Improvements

AHRQ proposes seven steps for action planning:

1. Understand your survey results.
2. Communicate and discuss the survey results.
3. Develop focused action plans.
4. Communicate action plans and deliverables.
5. Implement action plans.
6. Track progress and evaluate impact.
7. Share what works.

Source: AHRQ Hospital Survey on patient Safety Culture: 2011 User Comparative Database Report-pg 8.

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"If you want truly to understand something, try to change it."

Kurt Lewin

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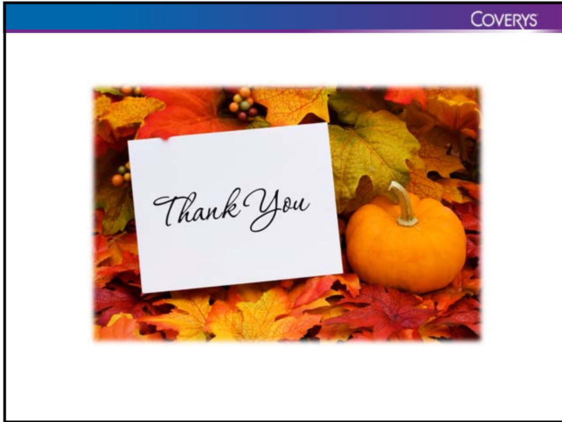
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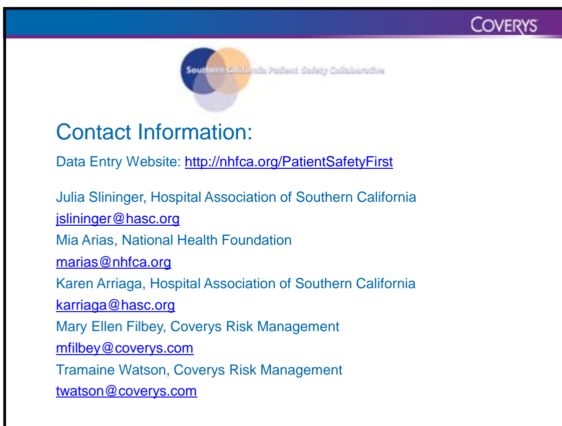
Thank You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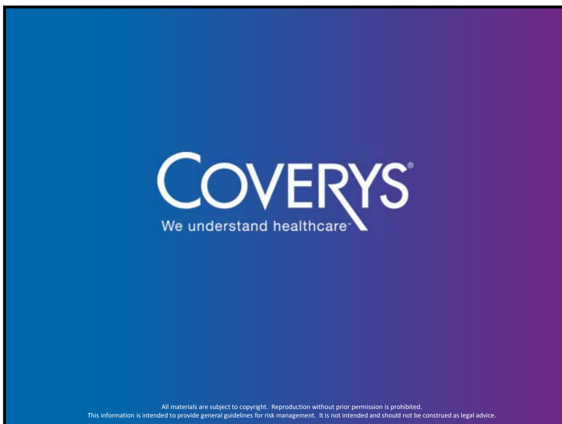
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