This report has been customized and prepared specifically for:

CPS 2016 Database

Rollup

HOSPITAL PATIENT SAFETY CULTURE FEEDBACK REPORT

SURVEY PERIOD

01/01/2016 to 12/31/2016

This safety culture survey is administered by the Center for Patient Safety

www.centerforpatientsafety.org | 888.935.8272

This report is provided confidentially by Center for Patient Safety to the specified Facility for internal safety improvement purposes.

TABLE OF CONTENTS

DASHBOARD

SAFETY GRADE

SURVEY RESPONDENT DEMOGRAPHICS

TOP PRIORITIES BY DIMENSION

RESULTS BY DIMENSION

TOP PRIORITIES BY QUESTION

RESULTS BY QUESTION

ACTUAL RESPONSES BY QUESTION

COMMENTS

RECOMMENDATIONS

ADDITIONAL INFORMATION

This report is provided confidentially by Center for Patient Safety to the specified Facility for internal safety improvement purposes.

RESULT HIGHLIGHTS

- CPS 2016 Database - Rollup had 14765 respondents respondents
- The majority of staff responding to this survey gave a patient safety grade of B
- This report utilizes the most recent compare databases for percentile rankings
- 7 dimensions (out of 12 total) are equal to or higher than the 50th AHRQ Percentile
- 0 dimensions (out of 12 total) are equal to or higher than the 90th AHRQ Percentile
- 23 questions (out of 40 total) are equal to or higher than the 50th AHRQ Percentile
- 1 question (out of 40 total) is equal to or higher than the 90th AHRQ Percentile

For more highlights, view the Dashboard on page 5.

TIPS FOR REVIEWING THIS REPORT...
Once you've explored your dashboard and the rest of the report, set aside time to fully review the information contained in each section. Consider starting at the back of the report, then work your way forward.

Consider starting at the back of the report:
1. Review the Comments. Read the valuable feedback provided by your survey respondents.
2. Review the Details by Question. This includes details for each question's results. Look at the graphs on the right-hand side - more red indicates poor scores; more green indicates more positive results. Questions require at least 5 responses to maintain anonymity.
3. Review the Results by Question. This section includes the positive percent response desired and includes up to two years of previous survey results. Trends are provided if historical data is available.
4. Review the Priorities by Question. Questions are sorted from lowest-performing to highest-performing. The lowest scoring questions are considered your "top priorities".
5. Review the Results by Dimension. Questions are rolled up into respective categories, or dimensions. Trends are provided if historical data is available.
6. Review the Priorities by Dimension. Your results are displayed compared to available benchmarks and compare groups.
7. Review the Demographics. Consider the summary of those taking your survey. Were any areas not represented as well as others?
8. Review the Dashboard. Use this as a snapshot to present to executive leaders, employees, or others as a high-level overview of your current culture's strengths and opportunities.

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HOSPITAL CULTURE OF SAFETY

SURVEY RESULTS FOR CPS 2016 DATABASE

Rollup

DASHBOARD

Survey period: 01/01/16 to 12/31/16

2016 survey respondents: 14765

WEAKNESSES - TOP PRIORITIES

These are the dimensional areas (and specific questions) that staff have indicated as current weaknesses.

BY DIMENSION			2016			
			Positive	AHRQ Percentile	AHRQ 50th Percentile	AHRQ 90th Percentile
Handoffs & Transitions			42.6%	25th	*46.3%*	*62.5%*
Non- punitive Response to Error			50.4%	75th	*45.0%*	*56.7%*
Staffing			54.0%	50th	*53.5%*	*67.8%*

BY QUESTION			2016			
*Things "fall between the cracks" when transferring patients from one unit to another.			35.6%	25th	*41.0%*	*58.0%*
*Staff worry that mistakes they make are kept in their personnel file.			42.1%	75th	*36.0%*	*48.0%*
*Problems often occur in the exchange of information across hospital units.			42.1%	25th	*45.0%*	*61.0%*

STRENGTHS

These are the dimensional areas (and specific questions) that staff have indicated as current strengths.

BY DIMENSION			2016			
			Positive	AHRQ Percentile	AHRQ 50th Percentile	AHRQ 90th Percentile
Teamwork Within Units			84.2%	50th	*82.0%*	*88.3%*
Suprvsr/ Manager Expectations & Actions Promoting Patient Safety			78.6%	50th	*78.5%*	*87.3%*
Org Learning— Continuous Improvement			72.7%	50th	*68.3%*	*78.8%*

BY QUESTION			2016			
People support one another in this unit.			90.2%	50th	*88.0%*	*93.0%*
When a lot of work needs to be done quickly, we work together as a team to get the work done.			88.9%	50th	*87.0%*	*93.0%*
We are actively doing things to improve patient safety.			83.6%	90th	*71.9%*	*82.3%*

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HOSPITAL CULTURE OF SAFETY

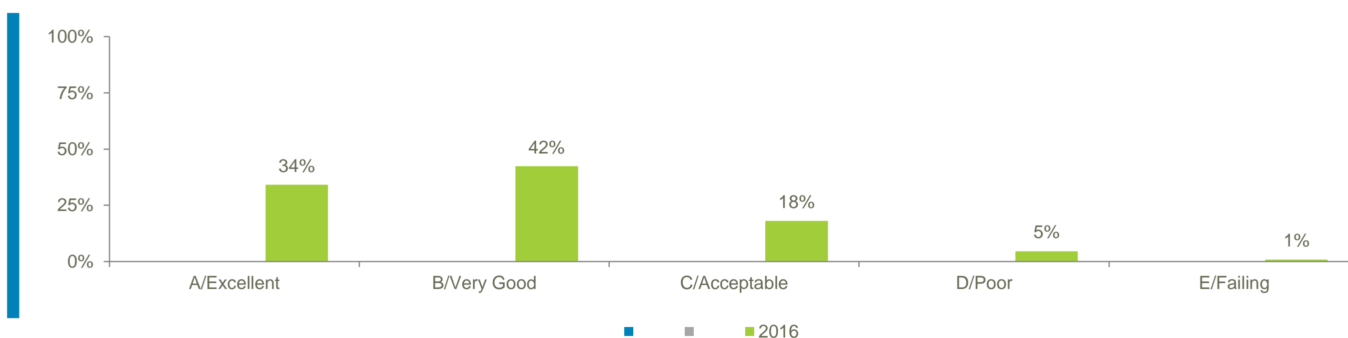
SURVEY RESULTS FOR CPS 2016 DATABASE

Rollup

DEMOGRAPHICS

PATIENT SAFETY GRADE

	2016			
	Average Percent	AHRQ Percentile	AHRQ 50th Percentile	AHRQ 90th Percentile
A/Excellent	76.5%	25th	*77.0%*	*88.0%*
B/Very Good				
C/Acceptable	18.0%			
D/Poor	4.6%			
E/Failing	0.9%			



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HOSPITAL CULTURE OF SAFETY

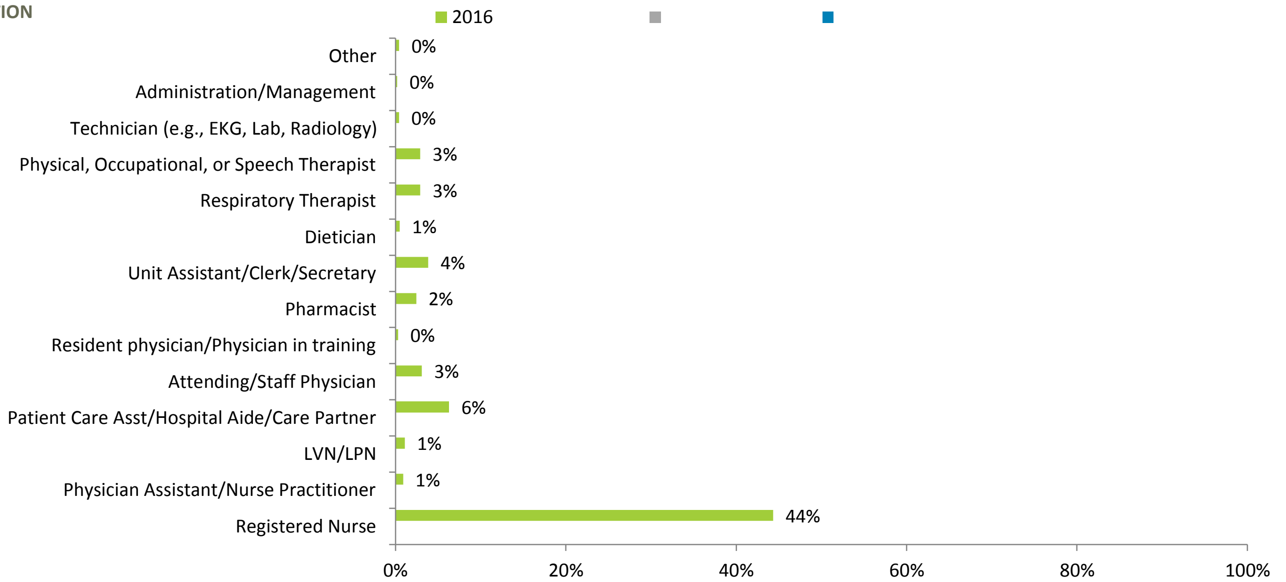
SURVEY RESULTS FOR CPS 2016 DATABASE

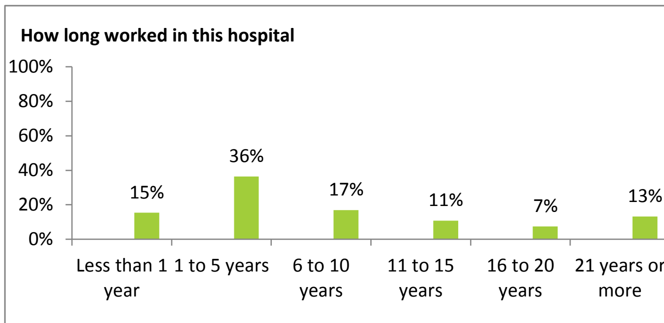
Rollup

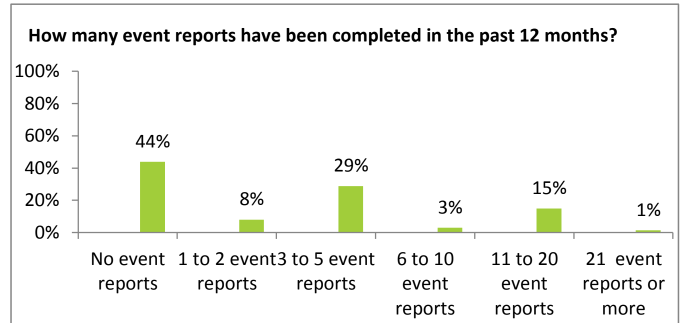
DEMOGRAPHICS

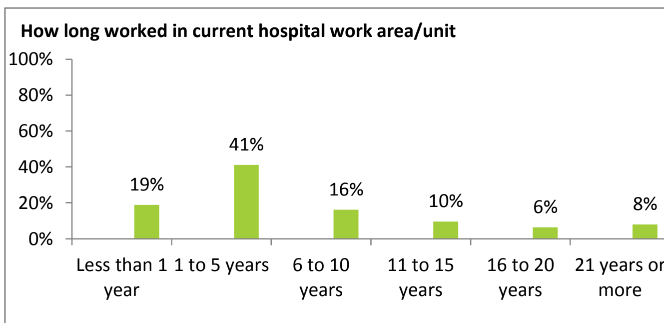
SURVEY RESPONDENT DEMOGRAPHICS

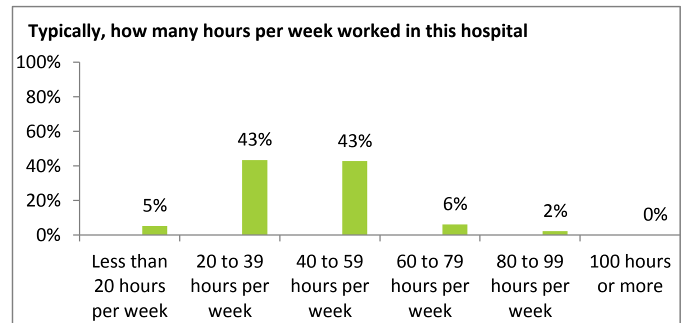
BY POSITION

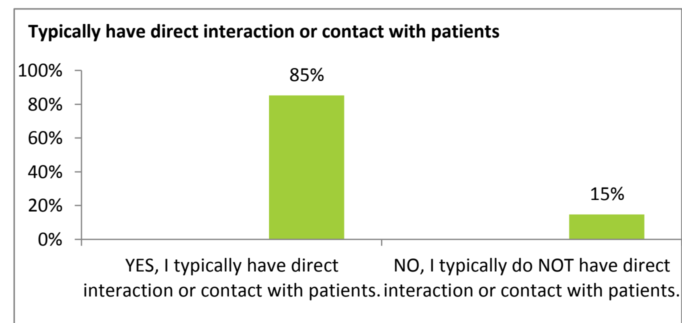












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HOSPITAL CULTURE OF SAFETY

SURVEY RESULTS FOR CPS 2016 DATABASE

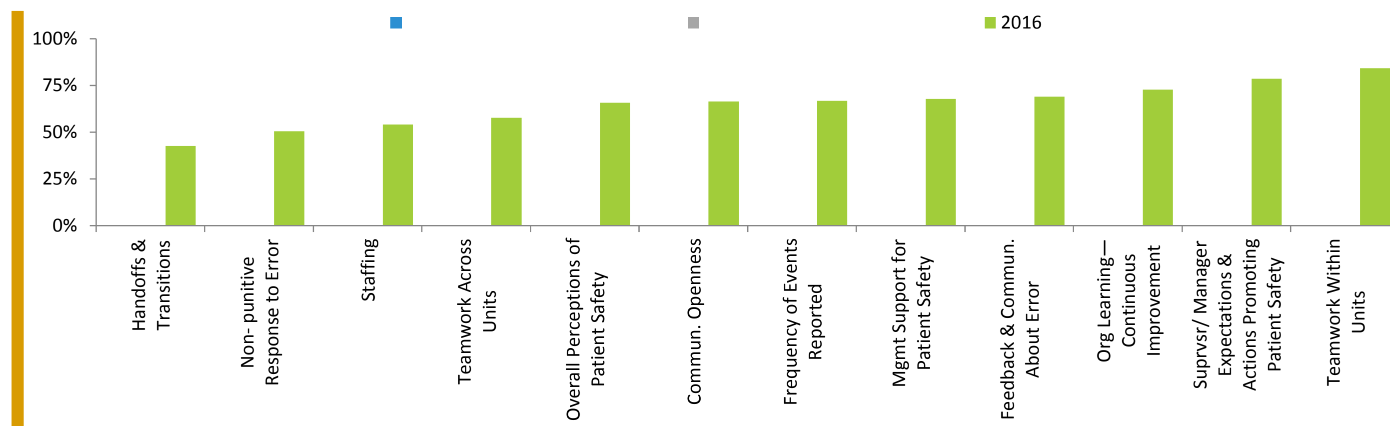
Rollup

TOP PRIORITIES BY DIMENSION

Listed in order of lowest positive score to highest positive score

Dimensions with positive scores in green are the areas in which your facility is successful. Top priorities for the period are those with positive scores noted in red (lowest scoring). Some shifts in priorities can occur over time. Dimensions in red for the current period should be the first addressed. A period change of 5% or greater is statistically significant.

DIMENSION	Priority			2016				Period to Period Trend
				Positive	AHRQ Percentile	AHRQ 50th Percentile	AHRQ 90th Percentile	
Handoffs & Transitions	1st			**42.6%**	*25th*	*46%*	*63%*	
Non- punitive Response to Error	2nd			**50.4%**	*75th*	*45%*	*57%*	
Staffing	3rd			**54.0%**	*50th*	*54%*	*68%*	
Teamwork Across Units	4th			57.6%	*25th*	*61%*	*74%*	
Overall Perceptions of Patient Safety	5th			65.7%	*25th*	*66%*	*79%*	
Commun. Openness	6th			66.3%	*50th*	*64%*	*73%*	
Frequency of Events Reported	7th			66.7%	*25th*	*67%*	*77%*	
Mgmt Support for Patient Safety	8th			67.8%	*25th*	*73%*	*84%*	
Feedback & Commun. About Error	9th			69.0%	*50th*	*69%*	*78%*	
Org Learning— Continuous Improvement	10th			**72.7%**	*50th*	*68%*	*79%*	
Suprvsr/ Manager Expectations & Actions Promoting Patient Safety	11th			**78.6%**	*50th*	*79%*	*87%*	
Teamwork Within Units	12th			**84.2%**	*50th*	*82%*	*88%*	



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HOSPITAL CULTURE OF SAFETY

SURVEY RESULTS FOR CPS 2016 DATABASE

Rollup

RESULTS BY DIMENSION

DIMENSION	Responses (2016)	Missing	Negative	Neutral	Positive	Period to Period Trend	Distribution Negative Neutral Positive
Teamwork Within Units	14349.0	416.0	7.6%	8.2%	84.2%		
Suprvsr/ Manager Expectations & Actions Promoting Patient Safety	13958.3	806.8	9.1%	12.3%	78.6%		
Org Learning— Continuous Improvement	14203.0	562.0	7.7%	19.6%	72.7%		
Mgmt Support for Patient Safety	13471.7	1293.3	16.1%	16.1%	67.8%		
Overall Perceptions of Patient Safety	14238.0	527.0	16.9%	17.4%	65.7%		
Feedback & Commun. About Error	13906.7	858.3	8.7%	22.3%	69.0%		
Frequency of Events Reported	13360.7	1404.3	10.4%	22.9%	66.7%		
Commun. Openness	13944.7	820.3	11.3%	22.4%	66.3%		
Teamwork Across Units	13355.3	1409.8	17.5%	24.9%	57.6%		
Staffing	14191.8	573.3	25.4%	20.6%	54.0%		
Handoffs & Transitions	13133.5	1631.5	25.4%	31.9%	42.6%		
Non- punitive Response to Error	14211.7	553.3	22.6%	27.0%	50.4%		

NOTE:

· Addressing more than one or two dimensions at a time can be overwhelming. Start with low-hanging fruit in the form of the lowest scoring questions (see Dashboard), then tackle one dimension at a time. Some dimensions may have similar underlying themes and could be addressed simultaneously. For example, the dimensions "Nonpunitive Response to Error" and "Frequency of Events Reported" both link to a just culture that supports open communication and supports the reporting of errors. Review the recommendations provided for you at the end of this report.

· Areas in which dimensional positive scores are greater than 80% are considered to have a "consensus of excellence". The number of positive responses for these areas represent breadth and depth of a safety culture. It reflects staff awareness and consistency in the methods and processes for ensuring safe and high-quality patient care.

· Areas in which dimensional positive scores are lower than 60% require intervention. The number of low-scoring dimensions may point to a lack of consistent beliefs about the culture of the organization. Policies and processes regarding safe and high-quality patient care may not be embedded in the organization.

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SURVEY RESULTS FOR CPS 2016 DATABASE

Rollup

TOP PRIORITIES BY QUESTION

Listed in order of lowest positive score to highest positive score

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* Question is reverse-worded

DIMENSION	QUESTION	Priority			2016				Period to Period Trend
					Positive	AHRQ Percentile	AHRQ 50th Percentile	AHRQ 90th Percentile	
Handoffs & Transitions	*Things "fall between the cracks" when transferring patients from one unit to another.	1st			35.6%	25th	41%	58%	
Non- punitive Response to Error	*Staff worry that mistakes they make are kept in their personnel file.	2nd			42.1%	75th	36%	48%	
Handoffs & Transitions	*Problems often occur in the exchange of information across hospital units.	3rd			42.1%	25th	45%	61%	
Handoffs & Transitions	*Shift changes are problematic for patients in this hospital.	4th			43.4%	25th	46%	64%	
Teamwork Across Units	*Hospital units do not coordinate well with each other.	5th			44.5%	25th	48%	63%	
Staffing	*We work in "crisis mode" trying to do too much, too quickly.	6th			48.9%	50th	48%	64%	
Handoffs & Transitions	*Important patient care information is often lost during shift changes.	7th			49.3%	25th	53%	67%	
Staffing	*Staff in this unit work longer hours than is best for patient care.	8th			50.6%	50th	50%	63%	
Staffing	We have enough staff to handle the workload.	9th			51.8%	50th	51%	67%	
Non- punitive Response to Error	*When an event is reported, it feels like the person is being written up, not the problem.	10th			52.7%	50th	48%	59%	
Commun. Openness	Staff feel free to question the decisions or actions of those with more authority.	11th			52.8%	50th	48%	59%	
Mgmt Support for Patient Safety	*Hospital mgmt seems interested in patient safety only after an adverse event happens.	12th			54.1%	25th	60%	74%	
Non- punitive Response to Error	*Staff feel like their mistakes are held against them.	13th			56.3%	75th	51%	63%	
Teamwork Across Units	There is good cooperation among hospital units that need to work together.	14th			58.3%	25th	62%	75%	
Overall Perceptions of Patient Safety	Patient safety is never sacrificed to get more work done.	15th			59.8%	25th	64%	76%	
Teamwork Across Units	*It is often unpleasant to work with staff from other hospital units.	16th			60.2%	25th	63%	74%	
Feedback & Commun. About Error	We are given feedback about changes put into place based on event reports.	17th			61.3%	50th	61%	73%	
Frequency of Events Reported	When a mistake is made, but has no potential to harm the patient, how often is this reported?	18th			62.0%	25th	63%	74%	
Frequency of Events Reported	When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?	19th			62.2%	50th	62%	73%	
Overall Perceptions of Patient Safety	*It is just by chance that more serious mistakes don't happen around here.	20th			64.2%	50th	62%	75%	
Staffing	*We use more agency/temporary staff than is best for patient care.	21st			64.6%	25th	65%	77%	

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Rollup

TOP PRIORITIES BY QUESTION

Listed in order of lowest positive score to highest positive score

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* Question is reverse-worded

DIMENSION	QUESTION	Priority			2016				Period to Period Trend
					Positive	AHRQ Percentile	AHRQ 50th Percentile	AHRQ 90th Percentile	
Overall Perceptions of Patient Safety	*We have patient safety problems in this unit.	22nd			64.7%	25th	65%	79%	
Org Learning—Continuous Improvement	Mistakes have led to positive changes here.	23rd			64.9%	50th	63%	73%	
Teamwork Across Units	Hospital units work well together to provide the best care for patients.	24th			67.5%	25th	72%	84%	
Commun. Openness	*Staff are afraid to ask questions when something does not seem right.	25th			68.5%	50th	66%	74%	
Org Learning—Continuous Improvement	After we make changes to improve patient safety, we evaluate their effectiveness.	26th			69.7%	25th	70%	81%	
Feedback & Commun. About Error	We are informed about errors that happen in this unit.	27th			69.8%	50th	69%	78%	
Mgmt Support for Patient Safety	The actions of hospital mgmt show that patient safety is a top priority.	28th			71.3%	25th	76%	87%	
Overall Perceptions of Patient Safety	Our procedures and systems are good at preventing errors from happening.	29th			74.3%	50th	74%	84%	
Teamwork Within Units	When one area in this unit gets really busy, others help out.	30th			74.5%	50th	72%	79%	
Frequency of Events Reported	When a mistake is made that could harm the patient, but does not, how often is this reported?	31st			75.7%	50th	75%	83%	
Feedback & Commun. About Error	In this unit, we discuss ways to prevent errors from happening again.	32nd			75.9%	25th	76%	84%	
Suprvsr/ Manager Expectations & Actions Promoting Patient Safety	*Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts.	33rd			76.8%	25th	77%	87%	
Commun. Openness	Staff will freely speak up if they see something that may negatively affect patient care.	34th			77.8%	25th	78%	86%	
Mgmt Support for Patient Safety	Hospital mgmt provides a work climate that promotes patient safety.	35th			78.0%	25th	82%	91%	
Suprvsr/ Manager Expectations & Actions Promoting Patient Safety	My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures.	36th			78.2%	50th	78%	87%	
Suprvsr/ Manager Expectations & Actions Promoting Patient Safety	*My supv/mgr overlooks patient safety problems that happen over and over.	37th			79.1%	50th	79%	87%	
Suprvsr/ Manager Expectations & Actions Promoting Patient Safety	My supv/mgr seriously considers staff suggestions for improving patient safety.	38th			**80.3%**	50th	80%	88%	
Teamwork Within Units	In this unit, people treat each other with respect.	39th			**83.2%**	50th	81%	88%	
Org Learning—Continuous Improvement	We are actively doing things to improve patient safety.	40th			**83.6%**	90th	72%	82%	
Teamwork Within Units	When a lot of work needs to be done quickly, we work together as a team to get the work done.	41st			**88.9%**	50th	87%	93%	
Teamwork Within Units	People support one another in this unit.	42nd			**90.2%**	50th	88%	93%	

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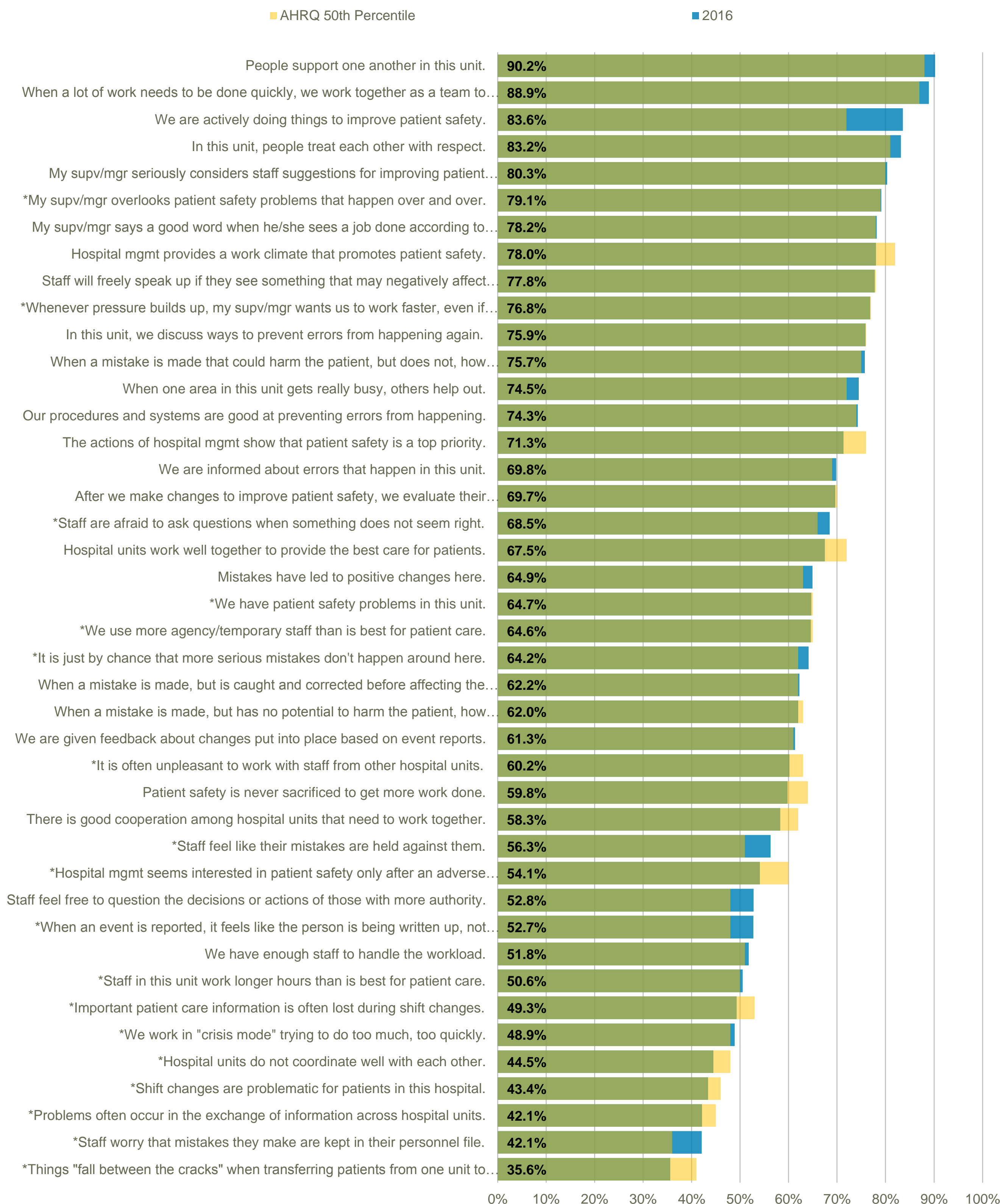
HOSPITAL CULTURE OF SAFETY

SURVEY RESULTS FOR CPS 2016 DATABASE

Rollup

GRAPH: TOP PRIORITIES BY QUESTION



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HOSPITAL CULTURE OF SAFETY

SURVEY RESULTS FOR CPS 2016 DATABASE

Rollup

RESULTS BY QUESTION

Priority rankings are indicated before each question for the most recent survey period.
* Question is reverse-worded

Dimension	Rank	Question											2016 Responses	2016 Missing	2016 Negative	2016 Neutral	2016 Positive	Period to Period Trend
Teamwork Within Units	42nd	People support one another in this unit.											14408	357	5.0%	4.8%	90.2%	
Teamwork Within Units	41st	When a lot of work needs to be done quickly, we work together as a team to get the work done.											14373	392	4.7%	6.3%	88.9%	
Teamwork Within Units	39th	In this unit, people treat each other with respect.											14380	385	7.6%	9.2%	83.2%	
Teamwork Within Units	30th	When one area in this unit gets really busy, others help out.											14235	530	13.0%	12.5%	74.5%	
Suprvsr/ Manager Expectations & Actions Promoting Patient Safety	36th	My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures.											13986	779	9.7%	12.1%	78.2%	
Suprvsr/ Manager Expectations & Actions Promoting Patient Safety	38th	My supv/mgr seriously considers staff suggestions for improving patient safety.											13949	816	7.8%	11.8%	80.3%	
Suprvsr/ Manager Expectations & Actions Promoting Patient Safety	33rd	*Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts.											13962	803	8.6%	14.6%	76.8%	
Suprvsr/ Manager Expectations & Actions Promoting Patient Safety	37th	*My supv/mgr overlooks patient safety problems that happen over and over.											13936	829	10.2%	10.6%	79.1%	
Org Learning—Continuous Improvement	40th	We are actively doing things to improve patient safety.											14247	518	5.2%	11.2%	83.6%	
Org Learning—Continuous Improvement	23rd	Mistakes have led to positive changes here.											14169	596	8.3%	26.8%	64.9%	
Org Learning—Continuous Improvement	26th	After we make changes to improve patient safety, we evaluate their effectiveness.											14193	572	9.5%	20.8%	69.7%	
Mgmt Support for Patient Safety	35th	Hospital mgmt provides a work climate that promotes patient safety.											13543	1222	10.3%	11.7%	78.0%	
Mgmt Support for Patient Safety	28th	The actions of hospital mgmt show that patient safety is a top priority.											13451	1314	11.4%	17.2%	71.3%	
Mgmt Support for Patient Safety	12th	*Hospital mgmt seems interested in patient safety only after an adverse event happens.											13421	1344	26.6%	19.3%	54.1%	
Overall Perceptions of Patient Safety	20th	*It is just by chance that more serious mistakes don't happen around here.											14210	555	17.4%	18.5%	64.2%	
Overall Perceptions of Patient Safety	15th	Patient safety is never sacrificed to get more work done.											14232	533	23.3%	16.9%	59.8%	
Overall Perceptions of Patient Safety	22nd	*We have patient safety problems in this unit.											14233	532	18.0%	17.4%	64.7%	
Overall Perceptions of Patient Safety	29th	Our procedures and systems are good at preventing errors from happening.											14277	488	8.9%	16.8%	74.3%	
Feedback & Commun. About Error	17th	We are given feedback about changes put into place based on event reports.											13897	868	11.8%	26.9%	61.3%	
Feedback & Commun. About Error	27th	We are informed about errors that happen in this unit.											13876	889	8.3%	21.9%	69.8%	
Feedback & Commun. About Error	32nd	In this unit, we discuss ways to prevent errors from happening again.											13947	818	6.0%	18.1%	75.9%	

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RESULTS BY QUESTION

Priority rankings are indicated before each question for the most recent survey period.
* Question is reverse-worded

Dimension	Rank	Question	2016 Responses	2016 Missing	2016 Negative	2016 Neutral	2016 Positive	Period to Period Trend
Frequency of Events Reported	19th	When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?	13402	1363	12.0%	25.8%	62.2%	
	18th	When a mistake is made, but has no potential to harm the patient, how often is this reported?	13347	1418	12.9%	25.1%	62.0%	
	31st	When a mistake is made that could harm the patient, but does not, how often is this reported?	13333	1432	6.4%	17.9%	75.7%	
Commun. Openness	34th	Staff will freely speak up if they see something that may negatively affect patient care.	13958	807	5.3%	17.0%	77.8%	
	11th	Staff feel free to question the decisions or actions of those with more authority.	13926	839	18.9%	28.3%	52.8%	
	25th	*Staff are afraid to ask questions when something does not seem right.	13950	815	9.8%	21.7%	68.5%	
Teamwork Across Units	5th	*Hospital units do not coordinate well with each other.	13397	1368	29.9%	25.6%	44.5%	
	14th	There is good cooperation among hospital units that need to work together.	13375	1390	15.8%	25.9%	58.3%	
	16th	*It is often unpleasant to work with staff from other hospital units.	13287	1478	15.2%	24.6%	60.2%	
	24th	Hospital units work well together to provide the best care for patients.	13362	1403	9.1%	23.4%	67.5%	
Staffing	9th	We have enough staff to handle the workload.	14342	423	35.1%	13.1%	51.8%	
	8th	*Staff in this unit work longer hours than is best for patient care.	14147	618	24.4%	25.0%	50.6%	
	21st	*We use more agency/temporary staff than is best for patient care.	14020	745	12.6%	22.8%	64.6%	
	6th	*We work in "crisis mode" trying to do too much, too quickly.	14258	507	29.5%	21.6%	48.9%	
Handoffs & Transitions	1st	*Things "fall between the cracks" when transferring patients from one unit to another.	13176	1589	33.4%	31.0%	35.6%	
	7th	*Important patient care information is often lost during shift changes.	13110	1655	20.9%	29.8%	49.3%	
	3rd	*Problems often occur in the exchange of information across hospital units.	13144	1621	25.0%	32.9%	42.1%	
	4th	*Shift changes are problematic for patients in this hospital.	13104	1661	22.5%	34.1%	43.4%	
Non- punitive Response to Error	13th	*Staff feel like their mistakes are held against them.	14271	494	19.9%	23.8%	56.3%	
	10th	*When an event is reported, it feels like the person is being written up, not the problem.	14201	564	20.1%	27.2%	52.7%	
	2nd	*Staff worry that mistakes they make are kept in their personnel file.	14163	602	27.9%	30.0%	42.1%	

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HOSPITAL CULTURE OF SAFETY

SURVEY RESULTS FOR CPS 2016 DATABASE

Rollup

ACTUAL RESPONSES BY QUESTION

Grey-shaded boxes and percentages in **bold** indicate positive response desired
Priority rankings are indicated before each question for the most recent survey period
* Question is reverse-worded

Dimension	Rank	Question	2016 Responses	Missing	Strongly Disagree/ Never	Disagree/ Rarely	Neither/ Some-times	Agree/ Most of the time	Strongly Agree/ Always	Distribution Negative Neutral Positive
Teamwork Within Units	42nd	People support one another in this unit.	14408	357	1.1%	3.9%	4.8%	**48.2%**	**42.0%**	
	41st	When a lot of work needs to be done quickly, we work together as a team to get the work done.	14373	392	0.9%	3.8%	6.3%	**48.7%**	**40.2%**	
	39th	In this unit, people treat each other with respect.	14380	385	1.7%	5.9%	9.2%	**51.2%**	**32.0%**	
	30th	When one area in this unit gets really busy, others help out.	14235	530	2.6%	10.3%	12.5%	**51.3%**	**23.2%**	
Suprvsr/ Manager Expectations & Actions Promoting Patient Safety	36th	My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures.	13986	779	2.6%	7.1%	12.1%	**45.6%**	**32.6%**	
	38th	My supv/mgr seriously considers staff suggestions for improving patient safety.	13949	816	2.4%	5.4%	11.8%	**46.7%**	**33.6%**	
	33rd	*Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts.	13962	803	**30.2%**	**46.6%**	14.6%	6.4%	2.1%	
	37th	*My supv/mgr overlooks patient safety problems that happen over and over.	13936	829	**39.6%**	**39.5%**	10.6%	7.1%	3.1%	
Org Learning— Continuous Improvement	40th	We are actively doing things to improve patient safety.	14247	518	1.1%	4.1%	11.2%	**53.4%**	**30.1%**	
	23rd	Mistakes have led to positive changes here.	14169	596	1.9%	6.4%	26.8%	**52.1%**	**12.8%**	
	26th	After we make changes to improve patient safety, we evaluate their effectiveness.	14193	572	1.7%	7.8%	20.8%	**54.2%**	**15.5%**	
Mgmt Support for Patient Safety	35th	Hospital mgmt provides a work climate that promotes patient safety.	13543	1222	2.3%	8.0%	11.7%	**52.8%**	**25.2%**	
	28th	The actions of hospital mgmt show that patient safety is a top priority.	13451	1314	3.0%	8.4%	17.2%	**45.3%**	**26.0%**	
	12th	*Hospital mgmt seems interested in patient safety only after an adverse event happens.	13421	1344	**15.5%**	**38.6%**	19.3%	19.6%	7.0%	
Overall Perceptions of Patient Safety	20th	*It is just by chance that more serious mistakes don't happen around here.	14210	555	**24.1%**	**40.0%**	18.5%	13.0%	4.4%	
	15th	Patient safety is never sacrificed to get more work done.	14232	533	4.5%	18.8%	16.9%	**38.2%**	**21.6%**	
	22nd	*We have patient safety problems in this unit.	14233	532	**23.0%**	**41.6%**	17.4%	14.0%	4.0%	
	29th	Our procedures and systems are good at preventing errors from happening.	14277	488	2.2%	6.6%	16.8%	**56.3%**	**18.0%**	
Feedback & Commun. About Error	17th	We are given feedback about changes put into place based on event reports.	13897	868	2.4%	9.4%	26.9%	**37.8%**	**23.6%**	
	27th	We are informed about errors that happen in this unit.	13876	889	1.3%	6.9%	21.9%	**37.8%**	**32.0%**	
	32nd	In this unit, we discuss ways to prevent errors from happening again.	13947	818	1.2%	4.8%	18.1%	**38.9%**	**36.9%**	

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HOSPITAL CULTURE OF SAFETY

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Dimension	Rank	Question	Responses (2016)	Missing	Strongly Disagree/ Never	Disagree/ Rarely	Neither/ Some-times	Agree/ Most of the time	Strongly Agree/ Always	Distribution (Negative / Neutral / Positive)
Frequency of Events Reported	19th	When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?	13402	1363	1.8%	10.2%	25.8%	**35.0%**	**27.2%**	
	18th	When a mistake is made, but has no potential to harm the patient, how often is this reported?	13347	1418	1.9%	11.0%	25.1%	**33.6%**	**28.4%**	
	31st	When a mistake is made that could harm the patient, but does not, how often is this reported?	13333	1432	1.2%	5.2%	17.9%	**35.8%**	**40.0%**	
Commun. Openness	34th	Staff will freely speak up if they see something that may negatively affect patient care.	13958	807	1.0%	4.3%	17.0%	**42.1%**	**35.7%**	
	11th	Staff feel free to question the decisions or actions of those with more authority.	13926	839	4.6%	14.3%	28.3%	**33.6%**	**19.1%**	
	25th	*Staff are afraid to ask questions when something does not seem right.	13950	815	**26.4%**	**42.1%**	21.7%	7.2%	2.6%	
Teamwork Across Units	5th	*Hospital units do not coordinate well with each other.	13397	1368	**8.8%**	**35.7%**	25.6%	23.9%	5.9%	
	14th	There is good cooperation among hospital units that need to work together.	13375	1390	2.5%	13.4%	25.9%	**48.1%**	**10.2%**	
	16th	*It is often unpleasant to work with staff from other hospital units.	13287	1478	**14.2%**	**46.0%**	24.6%	12.7%	2.5%	
	24th	Hospital units work well together to provide the best care for patients.	13362	1403	1.4%	7.7%	23.4%	**49.9%**	**17.6%**	
Staffing	9th	We have enough staff to handle the workload.	14342	423	9.5%	25.6%	13.1%	**38.4%**	**13.4%**	
	8th	*Staff in this unit work longer hours than is best for patient care.	14147	618	**12.4%**	**38.1%**	25.0%	17.2%	7.2%	
	21st	*We use more agency/temporary staff than is best for patient care.	14020	745	**33.1%**	**31.5%**	22.8%	9.0%	3.6%	
	6th	*We work in "crisis mode" trying to do too much, too quickly.	14258	507	**12.2%**	**36.7%**	21.6%	22.3%	7.2%	
Handoffs & Transitions	1st	*Things "fall between the cracks" when transferring patients from one unit to another.	13176	1589	**7.2%**	**28.4%**	31.0%	27.6%	5.8%	
	7th	*Important patient care information is often lost during shift changes.	13110	1655	**10.8%**	**38.5%**	29.8%	18.0%	2.9%	
	3rd	*Problems often occur in the exchange of information across hospital units.	13144	1621	**8.2%**	**33.9%**	32.9%	22.6%	2.4%	
	4th	*Shift changes are problematic for patients in this hospital.	13104	1661	**10.2%**	**33.2%**	34.1%	18.5%	4.0%	
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