Medical Respite 2018 CULTURE OF PATIENT SAFETY RESULTS

Composite-level Average Percent Positive Response

IMPORTANT NOTE....
For questions that are positively worded, the participant selected “Strongly Agree” or “Agree”
For questions that are negatively worded, the participant selected “Strongly Disagree” or “Disagree”

The higher the number the better!!
OVERALL PERCEPTIONS OF SAFETY

- Patient safety is never sacrificed to get more work done
- Our procedures and systems are good at preventing errors from happening
- It is just by chance that more serious mistakes don’t happen around here.
- We have patient safety problems on this unit.

SUPERVISOR/MANAGER EXPECTATIONS & ACTIONS PROMOTING SAFETY

- My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.
- My supervisor/manager seriously considers staff suggestions for improving patient safety.
- Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts.
- My supervisor/manager overlooks patient safety problems that happen over and over.
ORGANIZATIONAL LEARNING – CONTINUOUS IMPROVEMENT

We are actively doing things to improve patient safety

Mistakes have led to positive changes here.

After we make changes to improve patient safety, we evaluate their effectiveness.

TEAMWORK WITHIN UNITS

People support one another in this unit

When a lot of work needs to be done quickly, we work together as a team to get the work done.

In this unit, people treat each other with respect.

When one area in this unit gets really busy, others help out.

COMMUNICATION OPENNESS

Staff will freely speak up if they see something that may negatively affect patient care.

Staff feel free to question the decisions or actions of those with more authority.

Staff are afraid to ask questions when something does not seem right.
In this unit, we discuss ways to prevent errors from happening again. We are informed about errors that happen in this unit. We are given feedback about changes put into place based on event reports. In this unit, we discuss ways to prevent errors from happening again.

Staff worry that mistake they make are kept in their personnel file. When an event is reported, it feels like the person is being written up, not the problem. Staff feel like their mistakes are held against them.

We work in "crisis mode" trying to do too much, too quickly. We use more agency/temporary staff than is best for patient care. Staff in this unit work longer hours than is best for patient care. We have enough staff to handle the workload.
HOSPITAL MANAGEMENT SUPPORT FOR PATIENT SAFETY

Hospital management provides a work climate that promotes patient safety.

The actions of hospital management show that patient safety is a top priority.

Hospital management seems interested in patient safety only after an adverse event happens.

TEAMWORK ACROSS HOSPITAL UNITS

There is good cooperation among hospital units that need to work together.

Hospital units work well together to provide the best care for patients.

Hospital units do not coordinate well with each other.

It is often unpleasant to work with staff from other hospital units.

HOSPITAL HANDOFFS & TRANSITIONS

Things "fall between the cracks" when transferring patients from one unit to...

Important patient care information is often lost during shift changes.

Problems often occur in the exchange of information across hospital units.

Shift changes are problematic for patients in this hospital.
Important patient care information is often lost during transitions/shift change

Shift changes/handoffs are problematic for patients in this institution

Problems often occur in the exchange of information across clinic areas or services

Things "fall between the cracks" when transferring patients from one area to another

We discuss ways to prevent errors from happening again

We are informed about errors that happen in this dept/unit

We are given feedback about changes put into place based on event reports

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