

Perceptions of Patient Safety Culture in Four Manitoba Healthcare Organizations

Final Report
February 2008

Report prepared for the Manitoba Institute for Patient Safety (MIPS)

Prepared by:

Liane R. Ginsburg
MOHLTC Career Scientist
Associate Professor
School of Health Policy & Management
York University
lgins@yorku.ca

Executive Summary

In fall 2007 the Manitoba Institute for Patient Safety (MIPS) arranged to conduct a survey of patient safety culture in four health regions in Manitoba. A survey (MSI-2007) of patient safety culture in Healthcare Organizations was sent to all direct care providers, clinical care managers, support staff and non-direct care managers in all sectors including pre-hospital care, acute care, long term care, community care, and mental health in these four organizations. Staff in administrative departments were excluded as the survey instrument is not relevant to this group.

The survey included items in seven areas: (1) organizational leadership for safety; (2) unit leadership for safety; (3) perceived state of safety; (4) shame and repercussions of reporting; (5) safety learning behaviours (6) reporting culture; and (7) learning culture. Of 3,157 eligible surveys that were sent out, 1144 were returned for a response rate of 36%. Response rates ranged from 25% to 44% across the four organizations.

Data gathered through this initiative can be used to drive change initiatives in several ways: (1) looking at high and low performance on individual survey items, (2) focusing on questions that reflect areas that are the most important to staff, (3) using the data to stimulate discussion of safety culture through the organization.

Results

When data are rolled up to the organization level, we are seeing some organizations performing better than others on certain dimensions of patient safety culture. Results also differed by staff group. The main differences that are seen are that care aides have higher perceptions of safety culture than most other staff groups on the organizational leadership, reporting, and state of safety dimensions. Similarly, clinical care managers also have higher perceptions of organizational leadership, reporting, and shame and repercussions dimensions than most of their counterparts in clinical care. Some sector differences are also evident across several dimensions. Staff in long term care settings tend to score higher than staff in acute, mental health and out-patient clinic settings. It is; however, unclear whether higher scores in LTC are attributable to the setting itself or to the higher proportion of care aides in this setting.

Data on the proportion of positive responses to individual questions on the survey are also presented for facilities, reporting groups defined by each organization, and units, provided they met the minimum number of respondent criteria. It is often these more detailed data that can best help drive specific change and improvement efforts. Although some of the facilities, reporting groups and units scored significantly higher than others on most or all questions, suggesting some clear high performers, the same groups of questions seem to receive higher and lower proportions of positive responses across the dataset. The following three areas achieve the highest proportion of positive responses across all organizations (note that question numbers used throughout this report are the question numbers that appeared on the **2007** MSI survey):

Q8. Asking for help is a sign of incompetence	88.2 % disagree
Q9. If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	92.1 % disagree
Q11. I am less effective at work when I am fatigued	83.6% agree

In terms of identifying opportunities for improvement, it may be useful to consider the 9 areas where fewer than 45% positive responses were achieved:

q24. I believe health care errors often go unreported	16.2% disagree
q16. I am rewarded for taking quick action to identify a serious mistake	22.8% agree
q17. Loss of experienced personnel has negatively affected my ability to provide high quality patient care	31.8% disagree
q21. I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	36% agree
q27. Staff are given feedback about changes put into place based on incident reports	37% agree
q44 The patient and family are invited to be directly involved in the entire process of understanding: what happened following a major event and generating solutions for reducing	37.3% agree
q4. Senior management has a clear picture of the risk associated with patient care	43.4% agree
q20. In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time	44.9% disagree
q38. On this unit, after an incident has occurred, we think long and hard about how to correct it	44.9% agree

Relative to other dimensions, organizations tend to receive a higher proportion of positive responses to questions about shame and repercussions and fewer positive responses to questions about the perceived state of safety in their organization. A similar level of responses is received regarding how safety is prioritized in the unit/organization and the learning and reporting dimensions.

Prioritizing areas for change and improvement can also be achieved by considering an item's performance (percentage of positive responses) along with an item's importance (measured using an item's correlation with the overall patient safety rating). This approach helps organizations focus attention on areas where performance is lowest among those that are felt by staff to be the most critical for overall safety. Nine items were identified using this approach:

q7. Senior management provides a climate that promotes patient safety
q46. Changes are made to reduce re-occurrence of major events
q2. Good communication flow exists up the chain of command regarding patient safety issues
q36. On this unit, when an incident occurs, we analyze it thoroughly
q45. Things that are learned from major events are communicated to staff on our unit using more than one method (communication book, in-services, unit rounds, emails) and / or at <i>several</i> times so all staff hear about it
q33. On this unit, when an incident occurs, we think about it carefully
q15. If I report a patient safety incident, I know that management will act on it
q4. Senior management has a clear picture of the risk associated with patient care
q25. My organization effectively balances the need for patient safety and the need for productivity

Perceptions of Patient Safety Culture in Six Canadian Healthcare Organizations

In fall 2007 the Manitoba Institute for Patient Safety (MIPS) arranged to conduct a survey of patient safety culture in four health regions in Manitoba. Questionnaire data was collected from staff to help examine patient safety culture in these organizations. This report provides a summary of the data collected as part of this initiative. Data presented in the main body of this report are considered to be the most useful for directing safety initiatives in the healthcare organizations in this report. Data presented in appendices are provided to meet organizations' wishes for more detailed organization-specific data. However, caution should be used in interpreting the data presented in the organization-specific private appendices given the small numbers for many of the groups reported there.

1. Background

A variety of instruments have been used to measure patient safety culture in healthcare organizations. In 2002 an instrument initially developed by a group of researchers at Stanford (Singer, Gaba, et al., 2003) was modified by a group of Canadian researchers and used in a study that examined the effects of a patient safety educational intervention on nurse leader perceptions of patient safety culture (Ginsburg, Norton, Casebeer, & Lewis, 2005). Since that time, the Stanford Instrument (MSI) has been used in other Canadian settings, most notably by the Manitoba Institute for Patient Safety (MIPS) who implemented the MSI-v2005 in four Manitoba health regions in 2005. In 2006 the instrument underwent further testing as part of a study funded by the Canadian Patient Safety Institute.

2. Survey Procedures

The author of this report (Ginsburg) worked through MIPS with each of the four participating organizations to guide them in identifying all staff members in the organization whose role linked them with patient care (either directly or indirectly) and to identify a number of reporting groups for which survey data would be meaningful. Through this process, staff in each organization (with the exception of staff in administrative departments) were identified to receive the MSI-v2007 Patient Safety Culture Survey. Staff were surveyed in the Fall of 2007. A two-stage mailing approach was used whereby all identified staff received a survey in the mail. Some organizations sent surveys through internal region mail while others mailed to staff home addresses. The survey included an option to return the questionnaire by mail or to complete and return it on-line using a secure pass code. A second survey was sent to all non-responders approximately six weeks later. Survey data collection and data entry were carried out by Agili-T Health Solutions Inc. Data files, stripped of individual identifiers, were provided to Liane Ginsburg for analysis and reporting.

3. Subjects

The approach just described led to the collection of data from direct care providers, clinical care managers, direct (e.g. unit clerk) and non-direct care support staff (e.g. maintenance staff) and non-direct care managers (e.g. food services supervisor). Data were collected from staff in all sectors including acute care, long term care, community care, and mental health. While previous Manitoba samples have included a sizeable group of staff in the pre-hospital care setting, there were fewer than 10 subjects in the four organizations participating in this initiative.

4. Questionnaire

Staff were mailed the MSI-v2007, a 52-item patient safety culture questionnaire (adapted from Singer, Gaba et al., 2003 and Ginsburg et al., 2005). The survey included items designed to measure seven dimensions: (1) organizational leadership for safety; (2) unit leadership for safety; (3) perceived state of safety; (4) shame and repercussions of reporting; (5) safety learning behaviours (6) reporting culture; and (7) learning culture. Variations of the first four dimensions were previously found to be valid, reliable, and meaningful¹. All of the dimensions reported here were subjected to reliability analysis yielding acceptable results. Questions in all seven dimensions were answered using a five-point agree-disagree Likert type scale. All of these items had a “not applicable” option. Box 1 shows the items in each of the seven dimensions.

The questionnaire also contained two items adapted from the AHRQ survey designed to provide an overall assessment of patient safety culture at the unit and organizational level. These two questions were answered using an A (excellent) through F (failing) rating scale. The questionnaire can be found in Appendix 1.

5. Response Rates

A total of 3449 questionnaires were sent out. 292 were returned as undeliverable and 1144 completed questionnaires were returned for a response rate of 36.2% across all four organizations. Table 1 shows response rates by organization, staff category, and sector. For the organizational response rates, the number of surveys mailed out / returned and the proportion of respondents is not shown to protect the identity of the four organizations whose data are presented in this report. Nurses, allied health professionals and care aides comprise nearly 75% of the respondent group.

Table 1 – Response Rates by Organization, Staff Group and Sector

	# returned/ # sent out (eligible)	Response Rate	Proportion of total respondents
Across Full Sample	1144/3157	36.2%	
By Organization			
Organization 1		32.6%	
Organization 2		43.9%	
Organization 3		38.4%	
Organization 4		25.0%	
By Staff Category			
Nurses	401/991	40.5%	35.1
Care aides	201/752	26.7%	17.6
Allied & technicians	229/425	53.9%	20.0
Clinical care managers	68/105	64.8%	5.9
Support staff	174/624	27.9%	15.2
Physicians	34/194	17.5%	3.0
Other ²	37/66	56.1%	3.2

¹ The psychometric properties of dimensions 1, 3, and 4 were reported previously for nurses in clinical leadership roles (Ginsburg et al., 2005). Dimension 2, unit leadership for safety, was adapted from the Supervisory leadership dimension on the Agency for Healthcare Research and Quality’s Hospital Survey on Patient Safety Culture (AHRQ, 2005). Items in the fifth dimension, safety behaviours, emerged from patient safety research the author is engaged in. Items in the 6th dimension reflect the key elements of a reporting culture which include trust, feedback, and ease of reporting. Dimension 7 is adapted from Hofmann and Mark’s (2006) work on learning culture.

² “Other” staff refers to staff roles relevant to patient safety that do not fit into the previous categories (eg. Safety

	# returned/ # sent out (eligible)	Response Rate	Proportion of total respondents
Across Full Sample	1144/3157	36.2%	
By Sector			
Acute inpatients	792/2117	37.4%	69.2
Mental health (acute & community)	34/75	45.3%	3.0
Long term care	212/632	33.5%	18.5
Out-patient clinics	61/143	42.7%	5.3
Community - general	30/119	25.2%	2.6
Other / multiple settings	15/71	21.1%	1.3

6. Ways of Using Patient Safety Culture Data to Drive Change and Improvement

Survey items reflect perceptions of the importance of patient safety on the unit and in the organization (F1 and F2 items), perceptions of how safety failures are reported and handled (F4 and F6 items), attitudes and knowledge and perceptions of the state of patient safety in the organization (F3), and safety learning culture and behaviours (F5 and F7). There are many ways to consider and approach data such as these when it comes to driving change.

- (1) *Looking at high and low performance on individual survey items.* It is reasonable and may be important to examine items where a fairly low proportion of staff give positive responses while at the same time celebrating those areas where an organization achieves a very high percentage of positive responses (e.g where over 70 or 80% of staff agree or strongly agree with various individual survey items).
- (2) *Focusing on questions that reflect areas that are the most important to staff.* Simple correlations between individual survey items and overall ratings of patient safety can be used to help prioritize which items make the most important contributions to overall safety ratings from staff members' perspectives. Combining this knowledge with knowledge from (1) above can help organizations focus in on areas that are particularly important and are achieving fewer positive responses.
- (3) *Benchmarking - Looking for high performing groups.* Looking to other groups for which similar data are available can, in theory, provide useful learning opportunities. While it may be of interest to see how other similar organizations perform using the same instrument, there is as much diversity within the kind of large multi-site organizations we studied as there is between them. Accordingly, it is likely more valuable to consider how specific sites or units *within* a health organization perform. There were 34 sites in this dataset with respondent groups large enough to permit meaningful comparisons (34 sites had >30 respondents).
- (4) *Using data to guide discussion of safety culture in different parts of an organization.* An organization's survey results can be used alongside qualitative typologies or frameworks that group units or organizations into different culture types. Survey data can be used by individuals and teams to locate their unit or organization on this kind of framework. Use of frameworks in this way can promote open discussion and raise awareness about patient safety, highlight differences in perceptions between staff, stimulate discussion regarding strengths and weaknesses of patient safety culture, and identify opportunities for improvement.

officers, quality and risk staff, director level positions, etc)

7. Data Analysis & Reporting

In keeping with the above suggestions for how to use these data to foster change and improvement, data are reported in several ways.

7.1. *Comparing Mean Dimension Scores by Organization, Staff Group and Sector.*

First, data are presented for groups of questions that were used to measure each of the seven dimensions of patient safety culture covered by the survey noted above: (1) organizational leadership for safety; (2) unit leadership for safety; (3) perceived state of safety; (4) shame and repercussions of reporting; (5) safety learning behaviours; (6) reporting culture; and (7) learning culture (see Box 1 for questions in each dimension). Mean scores on each of these dimensions of patient safety culture are presented by organization, and by staff group and sector (for all four organizations combined). Respondents had to answer more than half of the questions in a dimension in order for a dimension score to be calculated. These high level data are designed to show broad differences across these groups. The 95% confidence interval (CI) of the mean is provided to help make it clear when differences between groups should be considered *statistically* significant. If the lower and upper bounds of the 95% CI for two groups overlap, then differences between the groups are NOT statistically significant³. These data are presented in tables 3, 4 and 5 and some discussion is provided indicating which differences are statistically significant as well as what level of difference should be considered clinically meaningful⁴. Organization-specific data by staff group and sector are not contained in this main report but can be found in your organization's private appendix.

7.2. *Data for Individual Survey Questions.*

More detailed data are shown by reporting the percentage of positive responses for each of the individual questions that make up the seven dimensions. The percentage of positive responses includes the percentage of respondents who *agreed* or *strongly agreed* with positively worded questions, and the percentage who *disagreed* or *strongly disagree* with negatively worded items. These data on individual questions are provided for all **facilities** that had > 30 responders, for all **reporting groups** (that were defined by each organization) that had > 20 responders, and for all **units** that had > 20 responders. Consistent with the suggestions above, organizations are encouraged to look at and learn from their own high and low performing questions. They can also look at their own lower-performing areas where others performed very well as these (a) provide an indication of minimally achievable levels of performance, and (b) provide potential opportunities for networking, data sharing and learning. MIPS would be happy to facilitate this networking process by brokering contacts between sites wishing to share current practice in these areas. Data on individual survey questions for each organization are provided in Appendix 2.

³ A Confidence Interval of the mean reflects the fact that mean scores are actually estimates of the mean (E.g the mean will vary from sample to sample of respondents with these 6 organizations). Instead of a single estimate for the mean, a confidence interval generates a lower and upper limit for the mean. The interval estimate gives an indication of how much uncertainty there is in the estimate of the true mean. The narrower the interval, the more precise the estimate. The smaller the size of the respondent group, the larger the confidence interval.

⁴ Effect sizes are used to comment on how clinically meaningful differences between groups are. See note 6.

Box 1– Survey Items in Each of the Seven Dimensions

F1 – Organizational leadership for safety

Senior management provides a climate that promotes patient safety

Patient safety decisions are made at the proper level by the most qualified people

Good communication flow exists up the chain of command regarding patient safety issues

Senior management has a clear picture of the risk associated with patient care

My organization effectively balances the need for patient safety and the need for productivity

Senior management considers patient safety when program changes are discussed

I work in an environment where patient safety is a high priority

F2 – Unit leadership for safety

My supervisor says a good word when he/she sees a job according to established patient safety procedures

My supervisor seriously considers staff suggestions for improving patient safety

Whenever pressure builds up, my supervisor wants us to work faster, even if it means taking shortcuts (% disagree)

My supervisor overlooks patient safety problems that happen over and over (%disagree)

My unit takes the time to identify and assess risks to patients

My unit does a good job managing risks to ensure patient safety

I am rewarded for taking quick action to identify a serious mistake

F3 – Perceived state of safety

Loss of experienced personnel has negatively affected my ability to provide high quality patient care (%disagree)

I have enough time to complete patient care tasks safely

In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time

I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care

I have made significant errors in my work that I attribute to my own fatigue

I believe that health care error constitutes a real and significant risk to the patients that we treat

I believe that health care errors often go unreported

I am less effective at work when I am fatigued

Personal problems can adversely affect my performance

F4 – Shame and repercussions of reporting

Reporting a patient safety problem will result in negative repercussions for the person reporting it

Asking for help is a sign of incompetence

If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it

I will suffer negative consequences if I report a patient safety problem

F5^{new} – Safety learning behaviours

Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions

A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers

The patient and family are invited to be *directly* involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events

Things that are learned from major events are communicated to staff on our unit using *more than* one method (e.g. communication books, in-services, unit rounds, emails) and/or at *several* times so all staff hear about it

Changes are made to reduce re-occurrence of major events

F6 – Reporting culture

I am sure that if I report an incident to our reporting system, it will not be used against me

I am not sure about the value of completing incident reports

If I report a patient safety incident, I know that management will act on it

Staff are given feedback about changes put into place based on incident reports (modified from AHRQ C1).

Individuals involved in patient safety incidents have a quick and easy way to report what happened

F7 – Learning culture

On this unit, when an incident occurs, we think about it carefully

On this unit, when an incident occurs, we analyze it thoroughly

On this unit, after an incident has happened, we think long and hard about how to correct it

On this unit, after an incident has happened, we think about how it came about and how to prevent the same mistake in the future

On this unit, when people make mistakes, they ask others about how they could have prevented it

On this unit, it is difficult to discuss errors (modified from SAQ)

F5^{rev} — Note that this dimension has been revised from data presented in the 2007 report (that was based on data collected using the MSI-v2006)

8. Results

8.1. Comparing Mean Scores by Organization, Staff Group and Sector.

Table 3 shows scores on each of the five safety culture dimensions by organization. Table 3 shows that organizations tend to score between 3.4 and 3.7 on both leadership dimensions (organization and unit) and the learning behaviours, learning culture and reporting dimension, while scoring highest (4.2) on the shame and repercussions of reporting dimension and lowest (2.8) on the state of safety dimension. This shows that responses to questions in these dimensions tended to range between just under 3 and just over 4 on a five-point scale where 1 is *strongly disagree*, 3 is *neutral* and 5 is *strongly agree* (with the statements in the dimension). Any negatively phrased items in the dimension were recoded so that a higher mean score is always a more desirable score (with the possible exception of F3)⁵.

Table 3 - Safety Culture Dimension Scores by Organization

	N	Mean	Std. Deviation	Lower Bound (95% CI)	Upper Bound (95% CI)
F1 - Organizational leadership for safety					
Organization 1		3.70	0.65	3.61	3.79
Organization 2		3.27	0.77	3.20	3.35
Organization 3		3.42	0.68	3.35	3.48
Organization 4		3.38	0.76	3.25	3.51
All organizations	1120	3.42	0.73	3.37	3.46
F2 - Unit leadership for safety					
Organization 1		3.71	0.55	3.63	3.78
Organization 2		3.42	0.66	3.35	3.49
Organization 3		3.51	0.66	3.45	3.58
Organization 4		3.52	0.72	3.40	3.65
All organizations	1085	3.52	0.66	3.48	3.56
F3 - Perceived state of safety					
Organization 1		2.92	0.51	2.85	2.99
Organization 2		2.69	0.56	2.63	2.75
Organization 3		2.80	0.53	2.74	2.85
Organization 4		2.72	0.54	2.62	2.81
All organizations	1113	2.77	0.54	2.74	2.81
F4 - Shame and repercussions of reporting					
Organization 1		4.26	0.57	4.18	4.34
Organization 2		4.12	0.63	4.06	4.18
Organization 3		4.16	0.64	4.10	4.22
Organization 4		4.07	0.70	3.95	4.19
All organizations	1122	4.15	0.63	4.12	4.19
F5 ^{rev} - Learning behaviours					
Organization 1		3.62	0.68	3.52	3.72
Organization 2		3.38	0.70	3.30	3.45
Organization 3		3.43	0.63	3.36	3.49
Organization 4		3.33	0.76	3.19	3.47
All organizations	966	3.43	0.69	3.39	3.48
F6 - Reporting culture					

⁵ Higher scores on F3 reflect higher perceptions of the state of safety which may stem from either (a) a truly safer environment or, (b) low levels of knowledge about risks to safety.

	N	Mean	Std. Deviation	Lower Bound (95% CI)	Upper Bound (95% CI)
Organization 1		3.55	0.62	3.47	3.64
Organization 2		3.20	0.71	3.12	3.27
Organization 3		3.28	0.67	3.22	3.35
Organization 4		3.35	0.74	3.22	3.47
All organizations	1125	3.31	0.70	3.27	3.35
F7 - Learning culture					
Organization 1		3.58	0.69	3.48	3.67
Organization 2		3.37	0.76	3.29	3.45
Organization 3		3.45	0.73	3.38	3.52
Organization 4		3.45	0.83	3.30	3.59
All organizations	1066	3.45	0.75	3.40	3.49

F5^{rev} — Note that this dimension has been revised from data presented in the 2007 report (2006 MSI data)

Several of the differences between the organizations shown in Table 3 are statistically significant which means that when data are rolled up to the organization level, we are seeing some organizations performing better than others on certain dimensions of patient safety culture. Organization 1 scores significantly higher than most or all of the organizations on both leadership dimensions (F1, F2), perceived state of safety (F3), learning behaviours (F5), and reporting culture (F6). It is important to note that statistical significance is a function of sample size so that with larger samples, smaller differences become statistically significant.

Effect sizes⁶ tell us about the clinical significance of these differences. Differences between groups of 0.2 or 0.3 on this 5-point scale would be considered small to medium effects. Differences between groups that approach 0.5 would be considered large effects.

Table 4 - Safety Culture Dimension Scores by Staff Group

	N	Mean	Std. Deviation	Lower Bound (95% CI)	Upper Bound (95% CI)
F1 - Organizational leadership for safety					
Nursing	401	3.28	0.75	3.21	3.36
Care aides	199	3.66	0.68	3.57	3.76
Allied & technicians	223	3.37	0.68	3.28	3.45
Clinical care managers	68	3.65	0.52	3.53	3.78
Support staff	159	3.40	0.76	3.29	3.52
Physicians	34	3.04	0.74	2.78	3.30
Other	36	3.80	0.66	3.57	4.02
Total	1120	3.42	0.73	3.37	3.46
F2 - Unit leadership for safety					
Nursing	398	3.48	0.64	3.42	3.55
Care aides	199	3.59	0.64	3.50	3.68
Allied & technicians	220	3.52	0.62	3.43	3.60
Clinical care managers	65	3.74	0.51	3.62	3.87
Support staff	148	3.40	0.81	3.27	3.53
Physicians	28	3.27	0.62	3.03	3.52
Other	27	3.91	0.40	3.75	4.07
Total	1085	3.52	0.66	3.48	3.56

⁶ Effect sizes are differences expressed as a proportion of the standard deviation. Differences of 0.2 of a standard deviation are considered a small effect, 0.5 a medium effect and 0.8 a large effect (Cohen & Cohen, 1983)

	N	Mean	Std. Deviation	Lower Bound (95% CI)	Upper Bound (95% CI)
F3 - Perceived state of safety					
Nursing	401	2.71	0.55	2.66	2.77
Care aides	198	2.96	0.56	2.89	3.04
Allied & technicians	225	2.80	0.53	2.73	2.87
Clinical care managers	68	2.65	0.48	2.54	2.77
Support staff	152	2.78	0.53	2.69	2.86
Physicians	34	2.51	0.45	2.35	2.67
Other	35	2.73	0.49	2.56	2.90
Total	1113	2.77	0.54	2.74	2.81
F4 - Shame and repercussions of reporting					
Nursing	398	4.23	0.56	4.17	4.28
Care aides	197	4.07	0.69	3.98	4.17
Allied & technicians	228	4.12	0.64	4.04	4.20
Clinical care managers	68	4.46	0.46	4.34	4.57
Support staff	162	4.00	0.73	3.89	4.11
Physicians	34	3.86	0.62	3.64	4.08
Other	35	4.44	0.48	4.27	4.60
Total	1122	4.15	0.63	4.12	4.19
F5^{new} - Learning behaviours					
Nursing	366	3.34	0.66	3.27	3.41
Care aides	182	3.66	0.65	3.57	3.76
Allied & technicians	173	3.29	0.67	3.19	3.40
Clinical care managers	64	3.58	0.55	3.44	3.72
Support staff	120	3.47	0.82	3.33	3.62
Physicians	31	3.31	0.65	3.08	3.55
Other	30	3.59	0.68	3.34	3.84
Total	966	3.43	0.69	3.39	3.48
F6 - Reporting culture					
Nursing	401	3.18	0.71	3.11	3.25
Care aides	198	3.54	0.67	3.44	3.63
Allied & technicians	227	3.29	0.65	3.20	3.37
Clinical care managers	68	3.54	0.68	3.37	3.70
Support staff	160	3.28	0.67	3.18	3.39
Physicians	34	2.97	0.61	2.76	3.18
Other	37	3.68	0.62	3.47	3.89
Total	1125	3.31	0.70	3.27	3.35
F7 - Learning culture					
Nursing	394	3.35	0.74	3.28	3.43
Care aides	197	3.59	0.73	3.49	3.70
Allied & technicians	213	3.45	0.74	3.35	3.55
Clinical care managers	62	3.52	0.66	3.35	3.69
Support staff	141	3.40	0.82	3.27	3.54
Physicians	33	3.42	0.77	3.14	3.69
Other	26	3.77	0.57	3.54	4.00
Total	1066	3.45	0.75	3.40	3.49

Table 4 shows scores on each of the seven safety culture dimensions by staff group. There are several interesting differences between staff groups on these dimensions. For instance, care aides provide higher ratings of organizational leadership (F1) and reporting culture (F6) than all other

groups except clinical care managers and they provide higher ratings of perceived state of safety (F3) than all other groups. Care aides higher perceptions of the state of safety may also reflect that this group has less knowledge of the kinds of threats to safety asked about in this dimension. These findings are consistent with other research showing this group tends to overestimate staff perceptions of safety culture (Huang, Clermont, Sexton et al., 2007). Also consistent with literature, clinical care managers tend to provide higher ratings than nurses and physicians on the organizational leadership dimension (F1), and the reporting dimension (F6) and they provide higher ratings than physicians, allied health professionals, care aides, and support staff on the shame and repercussions dimension (F4). Similarly, the staff category “other” which is comprised largely of mid-level managers and directors as well as quality personnel tends to score higher than many groups on several of these dimensions. These results confirm that it is important to talk to various staff groups to obtain their perceptions of the culture of safety.

Table 5 shows the scores on each of the seven safety culture dimensions by sector. Staff in long term care settings score significantly higher than staff in acute care settings on every dimension except for F7 (learning culture). Scores from long term care are also higher than score from out-patient clinics on F1 and scores from community settings on F4 (shame and repercussions). Out-patient settings score higher than acute settings on the learning culture dimension (F7). It is important to note that we tend not to see statistically significant differences that involve the mental health, community and out-patient settings because these groups had very small respondent groups. However, in terms of effects sizes (clinically meaningful differences that can be highlighted even with smaller sample sizes), the mental health settings also score notably lower than LTC on F1, F5, F6 and F7 and out-patient settings score notably lower than LTC on F1, F5, and F6.

Finally, it is important to consider that some of these sector differences we see may be explained by staff group or other differences within these sectors. For instance higher scores in long term care settings may be partially or largely explained by the fact that this setting has a higher proportion of care aide respondents (we know from table 4 that care aides tend to score higher on most dimensions than professional staff groups that are more heavily represented in acute care settings).

Table 5 - Safety Culture Scale Scores by Sector*

	N	Mean	Std. Deviation	Lower Bound (95% CI)	Upper Bound (95% CI)
F1 - Organizational leadership for safety					
Acute inpatients	776	3.33	0.73	3.28	3.38
LTC	209	3.71	0.70	3.61	3.81
Mental health	34	3.39	0.75	3.13	3.65
Out-patient clinics	60	3.33	0.66	3.16	3.50
Community - general	29	3.52	0.57	3.30	3.73
Total	1120	3.42	0.73	3.37	3.46
F2 - Unit leadership for safety					
Acute inpatients	751	3.45	0.67	3.40	3.50
LTC	205	3.68	0.61	3.59	3.76
Mental health	34	3.66	0.65	3.43	3.89
Out-patient clinics	57	3.64	0.54	3.50	3.79
Community - general	29	3.64	0.51	3.45	3.84
Total	1085	3.52	0.66	3.48	3.56
F3 - Perceived state of safety					
Acute inpatients	771	2.72	0.55	2.68	2.76

	N	Mean	Std. Deviation	Lower Bound (95% CI)	Upper Bound (95% CI)
LTC	210	2.88	0.53	2.81	2.95
Mental health	34	2.94	0.51	2.77	3.12
Out-patient clinics	58	2.89	0.46	2.77	3.01
Community - general	29	2.96	0.45	2.79	3.14
Total	1113	2.77	0.54	2.74	2.81
F4 - Shame and repercussions of reporting					
Acute inpatients	776	4.12	0.64	4.08	4.17
LTC	211	4.27	0.59	4.19	4.35
Mental health	34	4.14	0.62	3.92	4.36
Out-patient clinics	59	4.23	0.51	4.10	4.36
Community - general	29	3.82	0.75	3.53	4.10
Total	1122	4.15	0.63	4.12	4.19
F5 ^{new} - Learning behaviours					
Acute inpatients	669	3.38	0.67	3.33	3.43
LTC	179	3.64	0.73	3.53	3.74
Mental health	33	3.26	0.69	3.02	3.51
Out-patient clinics	49	3.38	0.67	3.19	3.58
Community - general	26	3.57	0.50	3.37	3.77
Total	966	3.43	0.69	3.39	3.48
F6 - Reporting culture					
Acute inpatients	781	3.22	0.69	3.18	3.27
LTC	210	3.58	0.66	3.49	3.67
Mental health	34	3.31	0.75	3.04	3.57
Out-patient clinics	59	3.32	0.63	3.16	3.49
Community - general	29	3.55	0.61	3.32	3.78
Total	1125	3.31	0.70	3.27	3.35
F7 - Learning culture					
Acute inpatients	742	3.38	0.73	3.33	3.44
LTC	196	3.56	0.73	3.45	3.66
Mental health	34	3.37	0.93	3.05	3.69
Out-patient clinics	57	3.76	0.73	3.57	3.96
Community - general	28	3.66	0.75	3.37	3.95
Total	1066	3.45	0.75	3.40	3.49

* sector category “other” which includes staff who report working in multiple settings or in pre-hospital care is not reported here as there were fewer than 20 responders in this group. These respondents are included in the “total” line.

8.2. Data for individual survey questions, by Facility, Reporting Group and by Unit

The remainder of the data presented focus on the proportion of positive responses to individual survey questions⁷ in the seven dimensions of patient safety culture that were measured. As noted, it is often these more detailed data that can best help identify and drive specific change and safety improvement efforts. Table 6 shows the percentage of positive responses for the 6 facilities (sites) in the dataset that had > 30 respondents, 17 reporting groups that had > 20 responders and 13 units

⁷ Please note that question numbers used throughout this report ARE NOT consistent with the question numbers that appeared on the 2006 survey or that report. Question numbering is consistent with the 2007 MSI.

that had > 20 respondents. To reiterate, the percentage of positive responses includes the percentage of respondents who *agreed* or *strongly agreed* with positively worded questions, and the percentage who *disagreed* or *strongly disagree* with negatively worded items. Accordingly, a higher score is always better. Negatively worded items are marked with an asterisk in the list of questions that appears under each section of the table.

For data shown in these tables, it is important to note that only differences of about 25% are significantly different from one another for sites or units with 30-35 respondents. Differences of about 18% are significant for sites or units with 60 respondents and, for sites with closer to 100 cases, differences of approximately 10% between sites are statistically significant. Only differences of 30% between units with 20 responders are statistically significant. In addition, caution is required in making straight comparisons as some sites or units may be long term care settings or may have more care aides—two groups that tend to score higher on several dimensions. For this reason, these data are more useful if used to compare how a single facility, reporting group or unit performs on different questions (rather than trying to make comparisons between these groups).

While table 6 suggests differences between some sites, reporting groups, and units on the proportion of positive responses for individual survey questions, it is also clear that the same groups of questions seem to receive higher and lower proportions of positive responses across most facilities and units. The bottom row in table 6 shows the percentage of positive responses to each question across the entire respondent dataset. Box 2 suggests opportunities for celebration and for improvement based on a summary of table 6. Box 2 highlights 3 questions where >80% positive responses were achieved and 9 areas where fewer than 45% positive responses were achieved. These items are coloured green and red, respectively, in table 6.

Box 2 – Questions with the Highest and Lowest Percentage of Positive Responses

Opportunities for celebration on four questions where >80% positive responses were achieved (these items are coloured green in tables 6 & 7):

q8. Asking for help is a sign of incompetence	88.2 % disagree
q9. If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	92.1 % disagree
q11. I am less effective at work when I am fatigued	83.6% agree

In terms of identifying opportunities for improvement, it may be useful to consider the 9 areas where the fewer than 45% positive responses were achieved (these items are coloured red in table 6):

q24. I believe health care errors often go unreported	16.2% disagree
q16. I am rewarded for taking quick action to identify a serious mistake	22.8% agree
q17. Loss of experienced personnel has negatively affected my ability to provide high quality patient care	31.8% disagree
q21. I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	36% agree
q27. Staff are given feedback about changes put into place based on incident reports	37% agree
q44 The patient and family are invited to be directly involved in the entire process of understanding: what happened following a major event and generating solutions for reducing	37.3% agree
q4. Senior management has a clear picture of the risk associated with patient care	43.4% agree
q20. In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time	44.9% disagree
q38. On this unit, after an incident has occurred, we think long and hard about how to correct it	44.9% agree

Table 6 - Percentage of Positive Responses on each Question, by Facility, Reporting Group and Unit

Facility	n	Organizational leadership for safety (F1)							Unit Leadership for Safety (F2)						
		q1	q2	q4	q7	q12	q25	q26	q5	q6	q16	q29	q30	q31	q32
1	205	77.6	71.3	56.2	74.0	64.5	55.8	86.7	85.9	86.8	24.1	55.3	69.8	79.2	67.9
3	419	60.6	55.0	38.6	55.4	45.2	45.0	73.5	70.6	74.6	24.2	45.5	64.3	67.8	64.5
5	30	62.1	59.3	64.3	59.3	53.8	50.0	55.2	73.1	74.1	39.3	65.4	69.2	60.0	64.0
6	54	48.1	40.4	39.2	41.2	40.0	30.8	67.3	60.8	64.7	25.0	46.9	58.0	62.3	63.3
7	327	53.0	42.8	35.3	48.4	39.9	37.5	60.3	60.7	65.0	16.8	43.0	60.9	63.3	64.2
8	53	78.8	66.7	58.5	79.2	68.8	59.2	86.5	78.4	94.1	12.8	43.1	54.9	78.4	64.0
Reporting Group															
9	24	82.6	56.5	45.8	78.3	62.5	39.1	79.2	84.2	78.9	30.4	52.4	68.2	75.0	61.9
10	96	80.0	76.8	62.1	77.2	65.6	58.1	90.6	89.6	89.4	24.2	50.5	73.4	84.0	69.9
11	44	81.0	79.1	58.1	72.5	71.4	55.8	86.0	86.0	85.7	30.8	66.7	66.7	81.0	69.0
12	28	64.3	50.0	42.3	66.7	46.4	55.6	77.8	75.0	76.2	16.0	53.6	64.3	60.7	62.5
13	104	50.5	42.0	38.1	55.8	37.8	37.0	57.8	55.3	64.6	16.5	37.9	66.7	71.4	61.1
14	61	61.7	45.0	33.9	49.2	45.9	33.3	70.5	77.0	70.5	18.3	44.1	58.3	65.5	61.7
15	43	79.1	66.7	55.8	74.4	63.4	61.0	88.4	74.4	93.0	12.8	40.5	51.2	79.1	58.1
16	94	50.0	40.9	26.4	39.6	33.3	39.8	56.5	62.4	68.5	14.6	43.3	52.2	53.3	62.2
17	115	57.4	61.4	40.4	60.5	56.0	54.4	80.9	79.6	86.7	23.4	48.6	65.1	67.6	64.8
18	22	36.4	40.9	22.7	28.6	27.3	13.6	45.5	31.8	36.4	9.1	36.4	50.0	71.4	54.5
19	76	60.8	49.3	35.5	55.4	44.6	41.9	76.0	75.7	70.3	30.6	53.4	67.1	67.6	62.5
20	30	60.0	56.7	36.7	58.6	44.8	46.7	76.7	76.7	76.7	17.2	66.7	83.3	82.8	79.3
21	100	61.7	48.0	36.5	52.6	37.6	44.7	73.7	68.2	78.0	21.7	25.6	65.6	70.1	67.4
22	48	69.8	63.6	53.5	62.5	47.5	51.2	68.2	61.8	70.3	33.3	63.2	61.0	56.1	54.3
23	36	50.0	47.2	36.1	38.9	50.0	33.3	65.7	68.6	68.6	28.6	48.6	69.4	69.4	74.3
24	32	55.2	37.9	46.4	53.6	30.8	27.6	63.3	62.1	62.1	29.0	40.7	40.7	48.3	52.0
25	54	54.7	53.8	56.6	54.9	49.0	43.1	57.7	64.0	70.6	35.3	56.9	68.6	62.0	66.7
Unit															
26	22	86.4	68.2	57.1	81.0	54.5	63.6	81.8	84.2	80.0	21.1	61.9	77.3	85.0	81.0
27	97	79.2	76.0	61.5	76.3	64.8	57.4	90.7	89.7	89.5	23.9	50.0	73.7	84.2	70.2
28	57	78.2	78.6	57.1	69.8	72.7	58.9	87.5	83.9	89.1	25.0	65.5	67.3	81.8	69.1
29	26	60.0	50.0	36.0	44.0	48.0	50.0	57.7	57.7	69.2	26.9	57.7	50.0	57.7	68.0
30	31	61.3	41.9	22.6	45.2	29.0	41.9	58.1	80.6	80.6	6.9	20.0	64.5	51.7	61.3
31	34	40.6	35.3	34.4	45.5	31.3	26.5	61.8	57.6	57.6	9.7	22.6	63.3	66.7	50.0
32	20	64.7	47.1	43.8	81.3	50.0	31.3	55.6	50.0	75.0	15.0	31.3	66.7	82.4	87.5
33	29	65.5	65.5	37.9	55.2	42.9	48.3	86.2	78.6	85.7	18.5	30.8	51.9	41.4	50.0
34	25	52.0	60.0	41.7	70.8	54.2	64.0	92.0	80.0	92.0	8.3	40.0	80.0	92.0	83.3
35	25	69.6	66.7	40.0	56.5	32.0	41.7	60.0	70.8	79.2	21.7	24.0	60.0	62.5	65.2
36	25	40.0	36.0	24.0	25.0	28.0	16.0	48.0	32.0	36.0	8.0	36.0	56.0	70.8	60.0
37	20	60.0	50.0	40.0	55.0	50.0	36.8	84.2	65.0	60.0	44.4	66.7	73.7	63.2	52.6
38	22	54.5	50.0	27.3	40.9	54.5	42.9	77.3	81.8	86.4	38.1	50.0	63.6	68.2	45.5
total	1144	62.1	54.3	43.4	57.6	48.6	45.0	71.7	70.5	74.2	22.8	47.6	64.1	68.7	65.5

Organizational leadership for safety (F1)

- Q1 Patient safety decisions are made at the proper level by the most qualified people
- Q2 Good communication flow exists up the chain of command regarding patient safety issues
- Q4 Senior management has a clear picture of the risk associated with patient care
- Q7 Senior management provides a climate that promotes patient safety
- Q12 Senior management considers patient safety when program changes are discussed
- Q25 My organization effectively balances the need for patient safety and the need for productivity
- Q26 I work in an environment where patient safety is a high priority

Unit Leadership for Safety (F2)

- Q5 My unit takes the time to identify and assess risks to patients
- Q6 My unit does a good job managing risks to ensure patient safety
- Q16 I am rewarded for taking quick action to identify a serious mistake
- Q29 My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures
- Q30 My supervisor/manager seriously considers staff suggestions for improving patient safety
- Q31 Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts *
- Q32 My supervisor/manager overlooks patient safety problems that happen over and over *

... Table 6 Continued

Facility	n	State of Safety (F3)									Shame and Repercussions (F4)			
		q11	q13	q17	q18	q20	q21	q22	q23	q24	q3	q8	q9	q14
1	205	78.8	53.7	42.7	58.2	41.8	51.6	80.3	76.0	20.3	77.9	92.1	93.0	86.1
3	419	83.6	58.8	30.0	45.3	50.3	30.9	72.2	76.3	19.2	76.6	87.2	92.6	80.0
5	30	93.3	72.4	29.2	52.0	52.2	55.6	66.7	72.4	10.3	75.0	89.7	82.8	57.1
6	54	83.3	54.7	30.4	45.8	42.6	38.0	75.5	78.8	5.8	69.2	86.8	98.0	64.2
7	327	87.3	58.4	26.8	39.2	37.7	27.5	76.6	78.3	12.5	70.6	87.4	91.1	77.7
8	53	81.1	51.9	38.3	52.0	58.7	46.8	78.3	76.5	19.2	86.8	84.6	98.1	81.1
Reporting Group														
9	24	91.7	54.2	27.3	60.0	52.4	43.5	87.5	100	8.3	75.0	95.8	100	91.7
10	96	80.2	53.7	50.6	58.7	43.3	56.8	82.4	68.8	19.6	84.4	94.8	91.6	87.5
11	44	69.0	53.7	37.5	52.5	42.1	51.3	80.6	76.7	32.6	76.7	85.7	97.6	90.7
12	28	82.1	60.7	28.6	61.1	31.8	39.1	62.5	74.1	8.0	60.7	88.9	92.3	65.4
13	104	84.6	44.7	32.2	56.7	36.3	35.2	81.2	75.0	10.8	69.9	89.4	94.2	74.0
14	61	90.0	61.0	24.6	38.3	44.4	22.0	76.8	78.3	20.3	73.3	89.5	86.4	88.1
15	43	79.1	52.4	34.1	55.8	52.6	41.5	78.4	73.2	21.4	83.7	81.0	97.7	76.7
16	94	89.2	66.3	25.3	28.6	40.7	26.7	70.3	82.6	11.8	71.4	85.7	98.9	75.0
17	115	83.9	62.8	36.4	45.7	52.5	35.2	68.5	74.1	25.9	77.2	87.0	92.9	82.0
18	22	95.5	72.7	13.6	9.5	40.9	9.5	77.3	77.3	13.6	77.3	90.9	95.5	77.3
19	76	77.0	58.3	35.2	37.5	49.3	29.0	66.2	68.1	16.0	78.7	88.0	96.0	81.1
20	30	80.0	44.8	43.3	56.7	69.0	40.0	72.4	65.5	40.0	76.7	83.3	96.7	73.3
21	100	84.7	56.7	18.5	61.6	49.4	29.7	77.1	84.0	12.5	75.5	87.8	86.6	81.4
22	48	86.7	59.1	31.0	48.1	40.6	41.9	67.5	90.0	9.1	68.9	82.6	90.9	70.5
23	36	83.3	57.1	33.3	48.6	44.1	38.9	82.4	75.0	8.3	77.1	94.3	100	69.4
24	32	84.4	56.3	20.8	45.8	34.8	36.0	70.4	85.7	3.7	50.0	81.3	88.9	61.3
25	54	77.8	61.5	34.0	58.0	57.1	48.0	75.0	81.1	7.4	71.7	86.5	78.8	65.4
Unit														
26	22	86.4	59.1	31.6	52.9	45.0	45.0	80.0	90.9	4.8	72.7	90.9	95.2	81.0
27	97	80.4	53.1	51.1	59.1	44.0	56.2	82.6	68.1	19.4	84.5	94.8	91.7	86.6
28	57	69.1	50.0	41.5	55.8	39.2	52.0	81.6	78.6	32.1	76.8	87.3	92.7	91.1
29	26	88.5	57.7	33.3	20.8	48.0	32.0	73.1	84.6	19.2	80.0	92.0	100	96.0
30	31	90.3	45.2	27.6	45.2	38.7	30.0	76.7	80.0	12.9	56.7	87.1	93.5	64.5
31	34	88.2	35.3	48.3	60.6	22.6	35.5	94.1	67.6	17.6	73.5	88.2	94.1	76.5
32	20	90.0	65.0	28.6	64.3	50.0	53.8	84.2	70.0	15.8	78.9	100	100	75.0
33	29	77.8	60.7	30.8	39.1	39.1	32.0	64.3	80.8	21.4	64.3	82.8	89.3	70.4
34	25	87.5	56.0	31.8	37.5	59.1	40.9	83.3	64.0	24.0	92.0	88.0	95.8	96.0
35	25	80.0	54.2	30.4	27.3	47.6	13.6	62.5	81.8	8.0	87.5	91.7	88.0	83.3
36	25	96.0	60.0	8.0	16.7	37.5	12.5	80.0	84.0	8.0	80.0	88.0	96.0	80.0
37	20	77.8	50.0	16.7	26.3	55.6	41.2	72.2	61.1	22.2	80.0	75.0	94.7	73.7
38	22	68.2	52.4	28.6	45.5	47.6	27.3	54.5	72.7	27.3	81.8	81.8	90.9	76.2
total	1144	83.6	57.6	31.8	47.1	44.9	36.0	75.7	77.3	16.2	75.0	88.2	92.1	79.2

Perceived State of Safety (F3)

- Q11 I am less effective at work when I am fatigued
- Q13 Personal problems can adversely affect my performance
- Q17 Loss of experienced personnel has negatively affected my ability to provide high quality patient care *
- Q18 I have enough time to complete patient care tasks safely
- Q20 In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time *
- Q21 I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care
- Q22 I have made significant errors in my work that I attribute to my own fatigue *
- Q23 I believe that health care error constitutes a real and significant risk to the patients that we treat
- Q24 I believe health care errors often go unreported *

Shame and repercussions of reporting (F4)

- Q3 Reporting a patient safety problem will result in negative repercussions for the person reporting it *
- Q8 Asking for help is a sign of incompetence *
- Q9 If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it *
- Q14 I will suffer negative consequences if I report a patient safety problem*

... Table 6 Continued

Facility	n	Safety Learning Behaviours (F5 ^{rev})					Reporting Culture (F6)					Learning Culture (F7)					
		q41	q42	q44	q45	q46	q10	q15	q19	q27	q28	q33	q34	q35	q36	q37	q38
1	205	63.8	68.3	50.3	62.9	74.6	63.2	66.8	65.5	43.6	68.7	71.6	51.9	76.3	58.7	66.3	51.3
3	419	56.9	44.2	31.6	60.3	65.7	57.1	57.7	49.0	39.9	45.0	63.0	52.2	72.5	46.6	56.5	44.4
5	30	52.2	43.5	26.1	33.3	70.8	53.3	59.3	69.0	37.0	63.0	68.0	56.0	61.5	57.7	65.4	53.8
6	54	43.9	31.6	29.7	45.2	52.3	54.7	49.1	37.7	25.0	54.9	60.0	44.0	62.0	47.1	42.0	39.2
7	327	57.1	44.8	32.4	49.1	57.2	52.5	45.1	45.6	26.2	42.1	58.6	46.2	67.1	42.2	54.6	39.8
8	53	70.8	63.6	59.1	68.0	71.4	59.6	70.0	49.1	55.8	70.0	76.5	52.9	73.6	52.8	51.0	50.0
Reporting Group																	
9	24	65.0	41.2	21.4	31.3	50.0	79.2	45.8	62.5	35.0	65.2	85.7	50.0	77.8	66.7	72.2	61.1
10	96	57.1	69.1	48.8	67.4	78.2	66.7	72.6	69.6	45.2	69.8	71.9	52.6	73.7	53.7	68.4	52.6
11	44	76.9	77.5	65.0	70.7	77.5	62.8	74.4	62.5	54.8	78.0	71.4	50.0	81.0	70.7	69.0	52.4
12	28	66.7	68.8	37.5	36.8	76.2	35.7	60.0	60.0	18.5	44.0	54.5	57.1	72.7	45.5	54.5	47.8
13	104	60.0	40.0	15.2	39.5	51.2	55.3	45.1	55.4	28.1	35.7	56.7	49.0	65.6	44.8	57.6	44.8
14	61	55.0	48.3	48.3	54.2	66.1	59.0	51.7	45.0	34.4	50.8	58.3	49.2	70.5	47.5	56.7	32.8
15	43	65.0	59.0	56.4	65.9	67.5	61.9	65.9	41.9	58.1	69.8	76.2	48.8	69.8	51.2	45.2	43.9
16	94	55.4	36.7	27.0	48.8	52.4	48.4	39.8	40.9	21.7	44.6	63.0	51.1	71.4	37.8	50.5	40.2
17	115	58.7	43.4	29.3	67.3	72.1	60.7	57.0	50.9	44.7	54.0	67.0	52.2	74.6	45.1	56.8	44.2
18	22	35.0	35.0	15.0	50.0	45.0	36.4	36.4	33.3	27.3	50.0	27.3	22.7	50.0	13.6	22.7	13.6
19	76	63.6	47.7	40.9	64.7	65.2	55.4	63.0	51.4	39.7	50.7	67.6	57.5	75.7	53.4	61.6	47.9
20	30	66.7	44.8	27.6	58.6	60.0	60.0	53.3	43.3	46.7	46.7	63.3	55.2	66.7	46.7	70.0	50.0
21	100	49.4	39.4	29.2	47.5	63.4	50.5	55.8	51.6	34.4	36.2	56.7	53.3	71.7	49.5	60.9	40.9
22	48	64.5	53.3	42.3	71.9	69.4	71.1	76.1	47.6	50.0	40.5	76.5	57.1	80.6	52.8	47.4	59.5
23	36	43.3	31.0	32.1	46.7	50.0	50.0	47.2	41.7	27.8	61.1	57.1	40.0	58.8	40.0	40.0	37.1
24	32	47.6	33.3	22.2	45.5	56.5	58.1	56.7	36.7	25.9	48.1	69.2	56.0	70.4	48.1	37.0	39.3
25	54	59.6	54.2	41.7	42.9	67.3	48.1	63.5	64.8	47.1	57.7	68.0	56.0	72.0	58.0	61.2	62.0
Unit																	
26	22	73.3	72.7	20.0	14.3	72.2	59.1	63.2	71.4	26.3	73.7	100	68.4	89.5	84.2	68.4	68.4
27	97	57.6	68.3	49.4	67.8	78.4	66.0	71.9	68.8	45.7	70.1	72.2	52.1	74.0	53.1	68.8	52.1
28	57	73.1	75.5	64.2	74.1	77.4	64.3	69.2	62.3	56.4	79.6	72.7	49.1	81.8	70.4	65.5	47.3
29	26	47.8	47.6	30.0	73.9	65.2	61.5	50.0	46.2	23.1	42.3	57.7	26.9	53.8	11.5	38.5	19.2
30	31	59.3	15.4	12.0	40.7	48.1	32.3	35.5	45.2	10.0	40.0	70.0	70.0	80.0	53.3	60.0	46.7
31	34	53.6	42.3	25.0	32.1	44.4	61.8	50.0	64.7	24.1	41.9	46.9	43.3	65.5	34.5	50.0	43.3
32	20	60.0	33.3	16.7	50.0	83.3	55.0	40.0	50.0	21.1	36.8	64.7	55.6	66.7	44.4	66.7	35.3
33	29	64.0	40.9	8.7	64.0	68.0	48.1	57.1	40.7	34.5	59.3	65.5	39.3	65.5	37.9	33.3	35.7
34	25	42.9	42.9	38.1	50.0	68.2	83.3	52.0	48.0	29.2	48.0	69.6	44.0	72.0	36.0	72.0	36.0
35	25	70.0	45.0	33.3	63.6	55.0	60.0	48.0	66.7	33.3	52.0	66.7	58.3	79.2	45.8	66.7	33.3
36	25	30.4	30.4	13.6	47.8	43.5	40.0	36.0	37.5	24.0	40.0	24.0	20.0	48.0	16.0	24.0	16.0
37	20	50.0	53.3	46.7	62.5	68.8	47.4	66.7	57.9	47.4	68.4	68.4	68.4	78.9	66.7	50.0	44.4
38	22	47.4	42.1	42.1	55.6	66.7	63.6	50.0	54.5	50.0	40.9	50.0	63.6	77.3	23.8	47.6	27.3
total	1144	58.5	49.6	37.3	56.2	65.1	56.8	56.3	51.6	37.0	51.3	64.3	50.6	71.2	48.2	56.9	44.9

F5^{rev} — Note that this dimension has been revised from data presented in the 2007 report (2006 MSI data)

See question bank on next page

Safety Learning Behaviours (F5^{new})

- Q41 Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions
- Q42 A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers
- Q44 The patient and family are invited to be *directly* involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events
- Q45 Things that are learned from major events are communicated to staff on our unit using *more than* one method (e.g. communication book, in-services, unit rounds, emails) and / or at *several* times so all staff hear about it
- Q46 Changes are made to reduce re-occurrence of major events

Reporting culture (F6)

- Q10 I am sure that if I report an incident to our reporting system, it will not be used against me
- Q15 If I report a patient safety incident, I know that management will act on it
- Q19 I am not sure about the value of completing incident reports *
- Q27 Staff are given feedback about changes put into place based on incident reports (modified from AHRQ C1).
- Q28 Individuals involved in patient safety incidents have a quick and easy way to report what happened

Learning culture (F7)

- Q33 On this unit, when an incident occurs, we think about it carefully
- Q34 On this unit, when people make mistakes, they ask others about how they could have prevented it
- Q35 On this unit, after an incident has happened, we think about how it came about and how to prevent the same mistake in the future
- Q36 On this unit, when an incident occurs, we analyze it thoroughly
- Q37 On this unit, it is difficult to discuss errors (modified from SAQ) *
- Q38 On this unit, after an incident has happened, we think long and hard about how to correct it

8.3. Identifying the Most Important Survey Questions

Another approach to prioritizing areas for change and improvement is to try to identify which questions are the most important for patient safety. One way to do this is to look at those questions on the survey that contribute most to overall ratings of patient safety for the organization. To accomplish this, each of the survey questions was correlated with an index of overall safety (this index was computed as the mean of two survey questions asking respondents to rate overall safety at the unit and the organization levels). Questions with the highest correlation to this index of overall safety can be considered to be among the most important contributors to respondents overall safety rating. Box 3 shows 13 questions that were among the most highly correlated⁸ with overall safety ratings for all four organizations combined. These items appear above the faint dotted line in Figure 1 (described below).

Box 3 – High Importance Items	
q6	My unit does a good job managing risks to ensure patient safety
q7	Senior management provides a climate that promotes patient safety
q26	I work in an environment where patient safety is a high priority
q46	Changes are made to reduce re-occurrence of major events
q5	My unit takes the time to identify and assess risks to patients
q2	Good communication flow exists up the chain of command regarding patient safety issues
q35	On this unit, after an incident has occurred, we think about how it came about and how to prevent the same mistake in the future
q36	On this unit, when an incident occurs, we analyze it thoroughly
q45	Things that are learned from major events are communicated to staff on our unit using more than one method (e.g. communication book, in-services, unit rounds, emails) and / or
q15	If I report a patient safety incident, I know that management will act on it
q25	My organization effectively balances the need for patient safety and the need for productivity
q33	On this unit, when an incident occurs, we think about it carefully
q4	Senior management has a clear picture of the risk associated with patient care

8.4. Considering Both Performance and Importance of each Survey Question

Figure 1 combines data on each items performance and importance. The grid plots (1) an items performance (percentage of agree/strongly agree responses –or disagree/strongly disagree for negatively worded questions) as the percentage of positive responses on the X-axis, and (2) the item's importance (an item's correlation with the overall safety rating described above) on the Y-axis. This plot is useful for identifying items with strong performance and high importance to celebrate (top right **yellow** quadrant), items with strong performance but less importance (bottom right quadrant). Items with weaker performance and high importance (the top left **red** quadrant) may be

⁸ $r > 0.47$ for all 13 of these questions (r -squared > 0.22)

The first approach focuses on using patient safety questionnaire data to help identify a few discrete potential problem areas that could be targeted for improvement. This is done by comparing performance across questions (rather than across any groups) as we have done and presented in Box 2 and in Figure 1.

The second approach involves considering patient safety survey results using the kind of qualitative framework suggested by Westrum (1993; 2004) and others in healthcare (Parker, Kirk, Claridge, & et al., 2002). The framework suggests a basic typology of cultures ranging from pathological to generative. The former is one extreme where messengers are shot, safety responsibilities shirked, safety problems concealed, and new ideas for safety are discouraged. The other extreme, generative environments, are characterized by high levels of cooperation and shared ownership of risk and where there is an inherent emphasis on open problem identification and resolution. These frameworks can be used to diagnose and assess the progress of an organization (or area of an organization) in developing a patient safety culture (Westrum, 2004). Your organization's survey results can be used together with this framework by individuals and teams to locate their unit or organization on the typology. Use of the framework in this way has been suggested to facilitate a number of important outcomes including promoting open discussion and raising awareness about patient safety, highlighting differences in perception between staff, stimulating discussion regarding strengths and weaknesses of patient safety culture, identifying areas for improvement, and evaluating safety interventions over time (Ashcroft et al., 2005).

10. Benchmarking Options

Provided that caution is used, the organizations may be interested to see how other hospitals have scored on some of these survey items. There are three options currently available to do this:

- (1) A preliminary pan-Canadian database has been established from data from six Canadian organizations that participated in recent CPSI funded study. These data provide the percentage of positive responses on survey questions in dimensions F1 – F5 by staff group and various care settings. See: <http://www.atkinson.yorku.ca/~safetyculture//reports.htm>
- (2) Singer, Gaba, and colleagues (2003) reported on data from 15 U.S hospitals where a similar questionnaire was completed. Raw data on a question-by-question basis are presented in their paper. When making any comparisons, it is important to recognize that personnel surveyed in the Singer et al. study may not be identical. Also note that Singer et al. report on the percentage of “problematic responses” (those who disagree and strongly disagree with positively worded items and agree to negatively worded items).
- (3) Questions 29 – 32 in this report's unit leadership for safety dimension can be looked at alongside data from AHRQ's “Hospital Survey on Patient Safety Culture: 2007 Comparative Database Report”. Several tables in Appendices A and B of the report (at <http://www.ahrq.gov/qual/hospsurveydb/>) show percentage of positive responses on these four questions (see composite scale 2 (Supv/Mgr Expectations & Actions Promoting Patient Safety) by hospital characteristics and respondent characteristics, respectively).

Frequency tables found in your organization's private appendix are the data that should be used if you are seeking staff group comparisons to any of these datasets. Frequencies for your organization, found in Appendix 2, can be used if you are comparing to entire organizations.

References

Agency for Healthcare Research and Quality. *Hospital survey on patient safety culture: 2007 comparative database report. AHRQ publication no. 07-0025*, April 2007. Rockville, MD. Retrieved 5/31/2007, 2007, from <http://www.ahrq.gov/qual/hospsurveydb/>

Ashcroft, D. M., Morecroft, C., Parker, D., & Noyce, P. R. (2005). Safety culture assessment in community pharmacy: Development, face validity, and feasibility of the Manchester patient safety assessment framework. *Quality and Safety in Health Care* 14(6): 417-421.

Ginsburg, L., Norton, P. G., Casebeer, A., & Lewis, S. (2005). An educational intervention to enhance nurse leaders' perceptions of patient safety culture. *Health Services Research*, 40(4), 997-1020.

Hofmann, D. A., & Mark, B. (2006). An investigation of the relationship between safety climate and medication errors as well as other nurse and patient outcomes. *Personnel Psychology*, 59(4), 847.

Huang, D. T., Clermont, G., Sexton, J. B., Karlo, C. A., Miller, R. G., Weissfeld, L. A., et al. (2007). Perceptions of safety culture vary across the intensive care units of a single institution. *Critical Care Medicine*, 35(1), 165-176.

Parker, D., Kirk, S., Claridge, T., & et al. (2002). *The manchester patient safety assessment tool*. National Primary Care Research and Development Centre, University of Manchester.

Sexton, J. B., Helmreich, R. L., Neilands, T. B., Rowan, K., Vella, K., Boyden, J., et al. (2006). The safety attitudes questionnaire: Psychometric properties, benchmarking data, and emerging research. *BMC Health Services Research*, 6, 44.

Singer, S. J., Gaba, D. M., Geppert, J. J., Sinaiko, A. D., Howard, S. K., & Park, K. C. (2003). The culture of safety: Results of an organization-wide survey in 15 California hospitals. *Quality & Safety in Health Care*, 12(2), 112-118.

Westrum, R. (1993). Cultures with requisite imagination. In J. Wise, V. Hopkin & P. Stager (Eds.), *Verification and validation of complex systems: Human Factor Issues* (pp. 401-416). New York: Springer-Verlag.

Westrum. (2004). A typology of organisational cultures. *Quality and Safety in Health Care*, 13 (suppl_2), ii22.



Patient Safety Culture in Healthcare Organizations Survey

ABOUT THE SURVEY

Improving quality and safety is central to the goal of achieving better health for those we serve. As part of our commitment to patients to provide optimal care without harm, we are asking for your perceptions, advice and evaluation of the Patient Safety Culture at your organization.

To manage the survey process and to ensure confidentiality of survey responses, we have engaged the services of Agili-T Health Solutions Inc. a leading an independent, national healthcare research firm.

Instructions:

1. There are no right or wrong answers, it is your opinion that matters. If you are unsure about a question, give the best answer you can.
2. Mark only **ONE** answer unless a question allows for multiple responses.
3. Think of unit as the area where you do most of your work—whether that is a patient care unit / ward, clinic, dept., the community, EMS, etc... Think of the patient as the client, resident, etc., depending where your work.
4. The survey is seeking your perceptions and opinions of these safety issues. Indicate the extent to which you agree or disagree with each of the following statements. If you are unsure whether you agree or disagree, mark "neutral". If the question does not apply to your role or your work setting, mark "not applicable".

There are two methods for completing this survey: 1) By Mail or 2) On-line via internet

1) Completing and returning the survey by mail

To answer a question, please darken the appropriate circle with a dark pen or pencil. For example:

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Once you have completed the questionnaire, return it using the **PRE-PAID** envelope provided, please note that postage is not required.

2) Completing the survey on-line

To complete the survey on-line visit the following Web address:

<http://survey.agili-t.com>
Your Survey Access Code is: **OGIBCEQ**

If you have any questions regarding this survey, please contact us at 1- 877-904-2542 or e-mail us at surveyhelp@agili-t.com.

OGIBCEQ

OGIBCEQ



Adapted with permission from:



Patient Safety Culture in Healthcare Organizations Survey

A. Patient Safety (Activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care).

	Strongly Agree ▼	Agree ▼	Neutral ▼	Disagree ▼	Strongly Disagree ▼	Not Applicable ▼
1. Patient safety decisions are made at the proper level by the most qualified people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Good communication flow exists up the chain of command regarding patient safety issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Reporting a patient safety problem will result in negative repercussions for the person reporting it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Senior management has a clear picture of the risk associated with patient care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. My unit takes the time to identify and assess risks to patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. My unit does a good job managing risks to ensure patient safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Senior management provides a climate that promotes patient safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Asking for help is a sign of incompetence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. I am sure that if I report an incident to our reporting system, it will not be used against me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. I am less effective at work when I am fatigued	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Senior management considers patient safety when program changes are discussed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Personal problems can adversely affect my performance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. I will suffer negative consequences if I report a patient safety problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. If I report a patient safety incident, I know that management will act on it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. I am rewarded for taking quick action to identify a serious mistake	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Loss of experienced personnel has negatively affected my ability to provide high quality patient care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. I have enough time to complete patient care tasks safely	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. I am not sure about the value of completing incident reports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. I have made significant errors in my work that I attribute to my own fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. I believe that health care error constitutes a real and significant risk to the patients that we treat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. I believe health care errors often go unreported	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. My organization effectively balances the need for patient safety and the need for productivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. I work in an environment where patient safety is a high priority	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. Staff are given feedback about changes put into place based on incident reports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. Individuals involved in patient safety incidents have a quick and easy way to report what happened	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. My supervisor/manager seriously considers staff suggestions for improving patient safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31. Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32. My supervisor/manager overlooks patient safety problems that happen over and over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. On this unit, when an incident occurs, we think about it carefully	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Continued on next page...

OGIBCEQ

*** 2 ***

OGIBCEQ

2007 Agili-T Health Solutions Inc.

Patient Safety Culture in Healthcare Organizations Survey

A. Patient Safety *continued*...

	Strongly Agree ▼	Agree ▼	Neutral ▼	Disagree ▼	Strongly Disagree ▼	Not Applicable ▼
34. On this unit, when people make mistakes, they ask others about how they could have prevented it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35. On this unit, after an incident has occurred, we think about how it came about and how to prevent the same mistake in the future	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36. On this unit, when an incident occurs, we analyze it thoroughly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
37. On this unit, it is difficult to discuss errors	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
38. On this unit, after an incident has occurred, we think long and hard about how to correct it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

B. These questions are about your perceptions of overall patient safety

	A – Excellent ▼	B – Very Good ▼	C – Average ▼	D – Poor ▼	F – Falling ▼
39. Please give your unit an overall grade on patient safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
40. Please give the organization an overall grade on patient safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

C. These questions are about what happens after a Major Event (Incidents causing fairly serious harm to patients that result from the delivery of health care)

	Strongly Agree ▼	Agree ▼	Neutral ▼	Disagree ▼	Strongly Disagree ▼	Not Applicable ▼
41. Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
42. A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
43. Discussion around major events focuses mainly on system-related issues, rather than focusing on the individual(s) most responsible for the event	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
44. The patient and family are invited to be <i>directly</i> involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
45. Things that are learned from major events are communicated to staff on our unit using <i>more than</i> one method (e.g. communication book, in-services, unit rounds, emails) and / or at <i>several</i> times so all staff hear about it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
46. Changes are made to reduce re-occurrence of major events	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

D. Finally, please help us by providing the following information:

47. Setting where <u>most</u> of your work time is spent:	48. Sector where <u>most</u> of your work time is spent:	49. Age:	50. Time in organization:	51. Gender:
<input type="radio"/> Acute in-patient	<input type="radio"/> General adult	<input type="radio"/> <30	<input type="radio"/> < 1 yr	<input type="radio"/> Female
<input type="radio"/> Long term / continuing care	<input type="radio"/> Paediatric	<input type="radio"/> 30-39	<input type="radio"/> 1-2 yrs	<input type="radio"/> Male
<input type="radio"/> Community	<input type="radio"/> Mental health	<input type="radio"/> 40-49	<input type="radio"/> 3-5 yrs	
<input type="radio"/> Different settings/ no specific setting	<input type="radio"/> Chronic care	<input type="radio"/> 50-60	<input type="radio"/> 6-10 yrs	
	<input type="radio"/> Other: ⇨	<input type="radio"/> 60+	<input type="radio"/> > 10 yrs	

52. Your role:

<input type="radio"/> RN / R/LPN	<input type="radio"/> Allied health	<input type="radio"/> Clinical care manager	<input type="radio"/> Support services (food services, housekeeping, maintenance)
<input type="radio"/> MD	<input type="radio"/> Healthcare Aide	<input type="radio"/> Technician (lab, radiology, etc.)	<input type="radio"/> Other: ⇩
<input type="radio"/> EMS	<input type="radio"/> Clinical educator	<input type="radio"/> Unit clerk / clinic reception	

Thank you for taking the time to complete this survey.

OGIBCEQ

*** 3 ***

OGIBCEQ

Page 3
2007 Agili-T Health Solutions Inc.

Appendix 2 – Question Responses by Organization

OLq1 Patient safety decisions are made at the proper level by the most qualified people

		orgID organization				Total
		1	2	3	4	
OLq1 Patient safety decisions are made at the proper level by the most qualified people	1 Strongly Disagree	1.0%	5.2%	2.2%	3.7%	3.2%
	2 Disagree	8.5%	15.1%	13.8%	13.3%	13.2%
	3 Neutral	12.9%	23.0%	23.4%	25.2%	21.6%
	4 Agree	61.7%	49.3%	53.7%	48.1%	53.0%
	5 Strongly agree	15.9%	7.4%	6.9%	9.6%	9.0%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

OLq2 Good communication flow exists up the chain of command regarding patient safety issues

		orgID organization				Total
		1	2	3	4	
OLq2 Good communication flow exists up the chain of command regarding patient safety issues	1 Strongly Disagree	2.5%	5.7%	3.2%	3.0%	3.8%
	2 Disagree	9.9%	22.5%	15.3%	18.5%	17.1%
	3 Neutral	16.3%	25.7%	26.5%	28.9%	24.7%
	4 Agree	55.0%	40.7%	45.5%	43.7%	45.4%
	5 Strongly agree	16.3%	5.4%	9.5%	5.9%	9.0%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

FRq3 Reporting a patient safety problem will result in negative repercussions for the person reporting it

		orgID organization				Total
		1	2	3	4	
FRq3 Reporting a patient safety problem will result in negative repercussions for the person reporting it	1 Strongly Disagree	33.3%	19.3%	25.6%	21.3%	24.4%
	2 Disagree	44.6%	53.6%	51.0%	50.0%	50.6%
	3 Neutral	15.2%	18.8%	15.1%	15.4%	16.4%
	4 Agree	5.4%	6.4%	7.6%	11.8%	7.3%
	5 Strongly agree	1.5%	1.9%	0.7%	1.5%	1.3%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

OLq4 Senior management has a clear picture of the risk associated with patient care

		orgID organization				Total
		1	2	3	4	
OLq4 Senior management has a clear picture of the risk associated with patient care	1 Strongly Disagree	4.5%	9.7%	6.6%	7.4%	7.3%
	2 Disagree	18.4%	25.4%	21.5%	20.7%	22.1%
	3 Neutral	20.9%	26.2%	33.3%	20.7%	27.2%
	4 Agree	46.8%	34.5%	33.7%	43.7%	37.6%
	5 Strongly agree	9.5%	4.1%	4.9%	7.4%	5.8%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

SLq5 My unit takes the time to identify and assess risks to patients

		orgID organization				Total
		1	2	3	4	
SLq5 My unit takes the time to identify and assess risks to patients	1 Strongly Disagree	1.6%	2.9%	2.3%	2.3%	2.4%
	2 Disagree	3.1%	14.2%	11.1%	8.4%	10.3%
	3 Neutral	9.4%	19.7%	16.0%	22.9%	16.9%
	4 Agree	60.7%	51.4%	58.5%	51.9%	55.8%

	5 Strongly agree	25.1%	11.8%	12.1%	14.5%	14.7%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

SLq6 My unit does a good job managing risks to ensure patient safety

		orgID organization				Total
		1	2	3	4	
SLq6 My unit does a good job managing risks to ensure patient safety	1 Strongly Disagree	1.1%	3.2%	1.3%	1.5%	1.9%
	2 Disagree	2.6%	10.1%	8.6%	9.8%	8.2%
	3 Neutral	9.5%	17.5%	15.5%	20.3%	15.7%
	4 Agree	57.1%	57.2%	59.6%	57.1%	58.1%
	5 Strongly agree	29.6%	12.1%	15.0%	11.3%	16.2%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

OLq7 Senior management provides a climate that promotes patient safety

		orgID organization				Total
		1	2	3	4	
OLq7 Senior management provides a climate that promotes patient safety	1 Strongly Disagree	1.0%	4.8%	3.8%	6.0%	3.9%
	2 Disagree	7.8%	19.7%	13.3%	14.3%	14.5%
	3 Neutral	17.2%	23.0%	27.6%	25.6%	24.0%
	4 Agree	57.3%	45.8%	47.6%	46.6%	48.6%
	5 Strongly agree	16.7%	6.7%	7.8%	7.5%	9.0%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

FRq8 Asking for help is a sign of incompetence

		orgID organization				Total
		1	2	3	4	
FRq8 Asking for help is a sign of incompetence	1 Strongly Disagree	55.9%	48.2%	47.3%	48.2%	49.3%
	2 Disagree	36.1%	38.8%	39.9%	40.9%	38.9%
	3 Neutral	5.0%	7.3%	7.5%	3.6%	6.5%
	4 Agree	2.5%	4.3%	3.6%	5.1%	3.8%
	5 Strongly agree	0.5%	1.4%	1.7%	2.2%	1.4%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

FRq9 If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it

		orgID organization				Total
		1	2	3	4	
FRq9 If I make a mistake that has significant consequences and nobody notices, I do not tell anyone about it	1 Strongly Disagree	53.5%	53.4%	56.9%	58.6%	55.3%
	2 Disagree	39.5%	38.7%	35.8%	30.1%	36.7%
	3 Neutral	4.5%	4.4%	3.9%	7.5%	4.6%
	4 Agree	1.5%	2.7%	2.0%	2.3%	2.2%
	5 Strongly agree	1.0%	0.8%	1.5%	1.5%	1.2%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

REPq10 I am sure that if I report an incident to our reporting system, it will not be used against me

		orgID organization				Total
		1	2	3	4	
REPq10 I am sure that if I report an incident to our reporting system, it will not be used against me	1 Strongly Disagree	2.5%	3.8%	3.7%	5.8%	3.7%
	2 Disagree	10.3%	12.9%	11.5%	10.1%	11.6%
	3 Neutral	24.0%	29.8%	27.8%	28.8%	27.9%
	4 Agree	47.5%	41.9%	48.3%	39.6%	45.0%

	5 Strongly agree	15.7%	11.6%	8.8%	15.8%	11.8%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

TSq11 I am less effective at work when I am fatigued

		orgID organization				Total
		1	2	3	4	
TSq11 I am less effective at work when I am fatigued	1 Strongly Disagree	3.0%	1.3%	2.2%	2.1%	2.0%
	2 Disagree	8.4%	4.8%	4.4%	4.3%	5.2%
	3 Neutral	9.9%	7.5%	9.8%	10.7%	9.1%
	4 Agree	55.7%	54.1%	56.5%	54.3%	55.3%
	5 Strongly agree	23.2%	32.3%	27.1%	28.6%	28.3%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

OLq12 Senior management considers patient safety when program changes are discussed

		orgID organization				Total
		1	2	3	4	
OLq12 Senior management considers patient safety when program changes are discussed	1 Strongly Disagree	3.0%	5.8%	1.5%	3.8%	3.5%
	2 Disagree	9.6%	13.9%	10.7%	7.6%	11.2%
	3 Neutral	22.8%	36.4%	42.6%	41.2%	36.8%
	4 Agree	54.8%	38.2%	39.3%	39.7%	41.8%
	5 Strongly agree	9.6%	5.8%	5.9%	7.6%	6.8%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

TSq13 Personal problems can adversely affect my performance

		orgID organization				Total
		1	2	3	4	
TSq13 Personal problems can adversely affect my performance	1 Strongly Disagree	3.5%	5.6%	5.2%	2.2%	4.7%
	2 Disagree	26.4%	16.1%	19.3%	21.9%	19.8%
	3 Neutral	16.4%	20.7%	16.8%	16.1%	17.9%
	4 Agree	43.3%	45.2%	49.1%	42.3%	45.9%
	5 Strongly agree	10.4%	12.4%	9.6%	17.5%	11.7%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

FRq14 I will suffer negative consequences if I report a patient safety problem

		orgID organization				Total
		1	2	3	4	
FRq14 I will suffer negative consequences if I report a patient safety problem	1 Strongly Disagree	34.7%	25.1%	25.2%	24.8%	26.8%
	2 Disagree	51.5%	53.1%	54.8%	44.5%	52.4%
	3 Neutral	10.4%	15.0%	15.1%	21.2%	14.9%
	4 Agree	2.0%	5.2%	4.0%	8.0%	4.5%
	5 Strongly agree	1.5%	1.6%	1.0%	1.5%	1.4%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

REPq15 If I report a patient safety incident, I know that management will act on it

		orgID organization				Total
		1	2	3	4	
REPq15 If I report a patient safety incident, I know that management will act on it	1 Strongly Disagree	1.5%	3.5%	2.2%	2.9%	2.6%
	2 Disagree	6.6%	15.5%	10.1%	11.0%	11.4%
	3 Neutral	25.0%	32.4%	30.0%	27.9%	29.7%
	4 Agree	54.6%	38.1%	48.9%	48.5%	46.3%

	5 Strongly agree	12.2%	10.4%	8.8%	9.6%	10.0%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

SLq16 I am rewarded for taking quick action to identify a serious mistake

		orgID organization				Total
		1	2	3	4	
SLq16 I am rewarded for taking quick action to identify a serious mistake	1 Strongly Disagree	7.9%	9.8%	6.0%	7.5%	7.8%
	2 Disagree	27.2%	31.5%	25.4%	17.9%	26.8%
	3 Neutral	40.8%	42.4%	44.3%	40.3%	42.6%
	4 Agree	22.5%	14.0%	21.9%	28.4%	20.2%
	5 Strongly agree	1.6%	2.2%	2.3%	6.0%	2.6%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

TSq17 Loss of experienced personnel has negatively affected my ability to provide high quality patient care

		orgID organization				Total
		1	2	3	4	
TSq17 Loss of experienced personnel has negatively affected my ability to provide high quality patient care	1 Strongly Disagree	11.4%	6.1%	6.3%	3.4%	6.8%
	2 Disagree	31.4%	22.3%	23.7%	26.1%	24.9%
	3 Neutral	23.2%	25.1%	27.0%	25.2%	25.5%
	4 Agree	28.1%	28.4%	32.7%	26.1%	29.7%
	5 Strongly agree	5.9%	18.0%	10.4%	19.3%	13.1%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

TSq18 I have enough time to complete patient care tasks safely

		orgID organization				Total
		1	2	3	4	
TSq18 I have enough time to complete patient care tasks safely	1 Strongly Disagree	3.3%	8.9%	6.5%	8.1%	6.9%
	2 Disagree	17.0%	24.6%	22.2%	20.2%	21.8%
	3 Neutral	21.4%	25.4%	26.0%	19.4%	24.2%
	4 Agree	52.2%	35.5%	41.7%	49.2%	42.4%
	5 Strongly agree	6.0%	5.6%	3.5%	3.2%	4.6%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

REPq19 I am not sure about the value of completing incident reports

		orgID organization				Total
		1	2	3	4	
REPq19 I am not sure about the value of completing incident reports	1 Strongly Disagree	17.5%	10.2%	13.2%	17.4%	13.5%
	2 Disagree	47.9%	35.8%	35.8%	37.0%	38.1%
	3 Neutral	17.5%	22.4%	22.1%	18.1%	20.9%
	4 Agree	14.9%	24.8%	23.9%	19.6%	22.1%
	5 Strongly agree	2.1%	6.7%	5.0%	8.0%	5.4%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

TSq20 In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time

		orgID organization				Total
		1	2	3	4	
TSq20 In the last year, I have witnessed a co-worker do something that appeared to me to be unsafe for the patient in order to save time	1 Strongly Disagree	8.7%	9.1%	14.6%	12.2%	11.4%
	2 Disagree	33.2%	31.5%	35.7%	33.0%	33.5%
	3 Neutral	16.3%	17.0%	17.0%	17.4%	16.9%

	4 Agree	35.9%	30.6%	26.4%	28.7%	29.8%
	5 Strongly agree	6.0%	11.8%	6.3%	8.7%	8.4%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

TSq21 I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care

		orgID organization				Total
		1	2	3	4	
TSq21 I am provided with adequate resources (personnel, budget, and equipment) to provide safe patient care	1 Strongly Disagree	6.5%	14.7%	10.7%	10.2%	11.2%
	2 Disagree	16.8%	32.3%	29.6%	22.0%	27.3%
	3 Neutral	25.0%	22.8%	28.8%	24.4%	25.6%
	4 Agree	46.2%	26.0%	27.7%	39.4%	32.0%
	5 Strongly agree	5.4%	4.2%	3.2%	3.9%	4.0%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

TSq22 I have made significant errors in my work that I attribute to my own fatigue

		orgID organization				Total
		1	2	3	4	
TSq22 I have made significant errors in my work that I attribute to my own fatigue	1 Strongly Disagree	29.3%	26.6%	30.4%	26.0%	28.4%
	2 Disagree	51.1%	50.3%	41.8%	50.4%	47.3%
	3 Neutral	10.6%	14.1%	16.5%	14.2%	14.4%
	4 Agree	7.4%	8.2%	10.1%	7.1%	8.6%
	5 Strongly agree	1.6%	0.8%	1.3%	2.4%	1.3%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

TSq23 I believe that health care error constitutes a real and significant risk to the patients that we treat

		orgID organization				Total
		1	2	3	4	
TSq23 I believe that health care error constitutes a real and significant risk to the patients that we treat	1 Strongly Disagree	2.5%	1.9%	1.3%	3.0%	1.9%
	2 Disagree	9.5%	7.0%	6.8%	2.2%	6.8%
	3 Neutral	12.0%	13.1%	15.6%	14.8%	14.0%
	4 Agree	57.0%	53.6%	56.9%	51.1%	55.1%
	5 Strongly agree	19.0%	24.4%	19.4%	28.9%	22.2%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

TSq24 I believe health care errors often go unreported

		orgID organization				Total
		1	2	3	4	
TSq24 I believe health care errors often go unreported	1 Strongly Disagree	5.1%	2.2%	2.0%		2.3%
	2 Disagree	15.2%	11.3%	17.2%	8.9%	13.9%
	3 Neutral	25.4%	21.2%	25.6%	23.0%	23.8%
	4 Agree	41.6%	49.2%	45.7%	46.7%	46.3%
	5 Strongly agree	12.7%	16.1%	9.6%	21.5%	13.8%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

OLq25 My organization effectively balances the need for patient safety and the need for productivity

		orgID organization				Total
		1	2	3	4	
OLq25 My organization effectively balances the need for patient safety and the need for productivity	1 Strongly Disagree	2.5%	5.3%	2.5%	6.7%	3.9%
	2 Disagree	9.0%	21.6%	15.6%	14.2%	16.2%
	3 Neutral	32.7%	32.7%	36.9%	38.1%	34.9%

	4 Agree	52.3%	35.7%	40.8%	34.3%	40.4%
	5 Strongly agree	3.5%	4.7%	4.2%	6.7%	4.6%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

OLq26 I work in an environment where patient safety is a high priority

		orgID organization				Total
		1	2	3	4	
OLq26 I work in an environment where patient safety is a high priority	1 Strongly Disagree	1.0%	2.5%	2.0%	3.0%	2.1%
	2 Disagree	1.5%	9.8%	6.9%	9.6%	7.2%
	3 Neutral	10.8%	23.7%	17.6%	23.0%	19.0%
	4 Agree	62.1%	46.6%	55.4%	47.4%	52.7%
	5 Strongly agree	24.6%	17.4%	18.1%	17.0%	19.0%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

REPq27 Staff are given feedback about changes put into place based on incident reports

		orgID organization				Total
		1	2	3	4	
REPq27 Staff are given feedback about changes put into place based on incident reports	1 Strongly Disagree	7.7%	14.7%	9.4%	12.2%	11.2%
	2 Disagree	22.1%	28.0%	28.0%	29.8%	27.1%
	3 Neutral	26.7%	26.9%	22.8%	21.4%	24.7%
	4 Agree	37.9%	25.5%	35.4%	30.5%	32.0%
	5 Strongly agree	5.6%	5.0%	4.5%	6.1%	5.0%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

REPq28 Individuals involved in patient safety incidents have a quick and easy way to report what happened

		orgID organization				Total
		1	2	3	4	
REPq28 Individuals involved in patient safety incidents have a quick and easy way to report what happened	1 Strongly Disagree	2.0%	5.3%	5.0%	5.3%	4.6%
	2 Disagree	9.1%	23.3%	25.1%	9.1%	19.7%
	3 Neutral	20.2%	25.5%	24.9%	26.5%	24.4%
	4 Agree	62.6%	40.7%	41.3%	50.8%	46.1%
	5 Strongly agree	6.1%	5.3%	3.7%	8.3%	5.2%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

SLq29 My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures

		orgID organization				Total
		1	2	3	4	
SLq29 My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	1 Strongly Disagree	4.5%	8.0%	7.8%	8.6%	7.3%
	2 Disagree	16.1%	21.7%	18.6%	16.4%	18.9%
	3 Neutral	24.1%	27.4%	28.2%	20.3%	26.2%
	4 Agree	46.2%	32.2%	36.2%	45.3%	37.8%
	5 Strongly agree	9.0%	10.8%	9.3%	9.4%	9.8%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

SLq30 My supervisor/manager seriously considers staff suggestions for improving patient safety

		orgID organization				Total
		1	2	3	4	
SLq30 My supervisor/manager seriously considers staff suggestions for improving patient	1 Strongly Disagree	2.5%	4.2%	4.1%	3.8%	3.8%
	2 Disagree	6.5%	10.4%	9.4%	11.5%	9.4%

safety	3 Neutral	21.1%	25.4%	22.3%	19.1%	22.7%
	4 Agree	56.8%	50.7%	50.9%	51.1%	51.9%
	5 Strongly agree	13.1%	9.3%	13.4%	14.5%	12.1%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

SLq31 Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts

		orgID organization				Total
		1	2	3	4	
SLq31 Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	1 Strongly Disagree	29.9%	22.5%	20.9%	20.0%	23.0%
	2 Disagree	49.2%	43.0%	46.9%	44.6%	45.7%
	3 Neutral	16.8%	19.7%	20.9%	23.8%	20.1%
	4 Agree	3.6%	11.5%	8.6%	6.9%	8.4%
	5 Strongly agree	0.5%	3.4%	2.8%	4.6%	2.8%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

SLq32 My supervisor/manager overlooks patient safety problems that happen over and over

		orgID organization				Total
		1	2	3	4	
SLq32 My supervisor/manager overlooks patient safety problems that happen over and over	1 Strongly Disagree	31.6%	22.1%	25.7%	23.0%	25.3%
	2 Disagree	36.3%	42.1%	38.8%	45.2%	40.2%
	3 Neutral	19.7%	19.8%	20.3%	17.5%	19.7%
	4 Agree	9.8%	12.3%	11.1%	11.1%	11.3%
	5 Strongly agree	2.6%	3.7%	4.1%	3.2%	3.6%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

LCq33 On this unit, when an incident occurs, we think about it carefully

		orgID organization				Total
		1	2	3	4	
LCq33 On this unit, when an incident occurs, we think about it carefully	1 Strongly Disagree	1.5%	1.7%	1.5%	3.1%	1.8%
	2 Disagree	5.2%	12.5%	10.5%	10.2%	10.2%
	3 Neutral	21.6%	24.6%	24.9%	21.3%	23.8%
	4 Agree	55.7%	52.1%	51.2%	51.2%	52.3%
	5 Strongly agree	16.0%	9.1%	11.8%	14.2%	11.9%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

LCq34 On this unit, when people make mistakes, they ask others about how they could have prevented it

		orgID organization				Total
		1	2	3	4	
LCq34 On this unit, when people make mistakes, they ask others about how they could have prevented it	1 Strongly Disagree	3.2%	3.4%	3.8%	4.8%	3.7%
	2 Disagree	17.5%	24.4%	15.6%	15.9%	18.9%
	3 Neutral	27.5%	25.0%	28.4%	26.2%	26.8%
	4 Agree	48.1%	41.8%	46.5%	46.0%	45.2%
	5 Strongly agree	3.7%	5.4%	5.6%	7.1%	5.4%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

LCq35 On this unit, after an incident has occurred, we think about how it came about and how to prevent the same mistake in the future

		orgID organization				Total
		1	2	3	4	
LCq35 On this unit, after an incident has	1 Strongly Disagree	1.1%	1.7%	2.3%	3.1%	2.0%

occurred, we think about how it came about and how to prevent the same mistake in the future	2 Disagree	10.5%	12.4%	8.6%	12.6%	10.7%
	3 Neutral	12.1%	17.8%	16.7%	15.7%	16.1%
	4 Agree	66.3%	58.8%	62.9%	56.7%	61.4%
	5 Strongly agree	10.0%	9.3%	9.6%	11.8%	9.8%
	Total	100.0%	100.0%	100.0%	100.0%	100.0%

LCq36 On this unit, when an incident occurs, we analyze it thoroughly

		orgID organization				Total
		1	2	3	4	
LCq36 On this unit, when an incident occurs, we analyze it thoroughly	1 Strongly Disagree	1.6%	3.1%	3.8%	3.9%	3.2%
	2 Disagree	15.9%	23.7%	19.6%	16.4%	19.9%
	3 Neutral	23.8%	29.4%	30.0%	29.7%	28.7%
	4 Agree	51.3%	35.0%	39.2%	39.8%	40.0%
	5 Strongly agree	7.4%	8.8%	7.4%	10.2%	8.2%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

LCq37 On this unit, it is difficult to discuss errors

		orgID organization				Total
		1	2	3	4	
LCq37 On this unit, it is difficult to discuss errors	1 Strongly Disagree	18.4%	11.8%	14.8%	17.3%	14.7%
	2 Disagree	47.9%	42.3%	41.7%	34.6%	42.2%
	3 Neutral	22.6%	27.3%	26.5%	26.0%	26.0%
	4 Agree	9.5%	15.8%	13.5%	16.5%	13.9%
	5 Strongly agree	1.6%	2.8%	3.6%	5.5%	3.2%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

LCq38 On this unit, after an incident has occurred, we think long and hard about how to correct it

		orgID organization				Total
		1	2	3	4	
LCq38 On this unit, after an incident has occurred, we think long and hard about how to correct it	1 Strongly Disagree	2.1%	3.7%	3.3%	2.3%	3.1%
	2 Disagree	13.6%	22.3%	15.5%	18.6%	17.8%
	3 Neutral	33.0%	32.8%	36.8%	31.8%	34.2%
	4 Agree	46.1%	35.0%	39.3%	37.2%	38.9%
	5 Strongly agree	5.2%	6.2%	5.1%	10.1%	6.1%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

LBq41 Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions

		orgID organization				Total
		1	2	3	4	
LBq41 Individuals involved in major events contribute to the understanding and analysis of the event and the generation of possible solutions	1 Strongly Disagree	1.7%	3.4%	0.6%	3.5%	2.1%
	2 Disagree	9.2%	5.9%	10.7%	11.4%	8.9%
	3 Neutral	25.3%	31.6%	31.8%	31.6%	30.5%
	4 Agree	52.9%	52.9%	49.6%	44.7%	50.7%
	5 Strongly agree	10.9%	6.2%	7.3%	8.8%	7.8%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

LBq42 A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers

		orgID organization				Total
		1	2	3	4	

LBq42 A formal process for disclosure of major events to patients/families is followed and this process includes support mechanisms for patients, family, and care/service providers	1 Strongly Disagree	1.8%	3.9%	1.5%	2.7%	2.5%
	2 Disagree	5.4%	12.8%	9.8%	14.4%	10.5%
	3 Neutral	24.6%	35.7%	44.5%	39.6%	37.4%
	4 Agree	56.3%	44.3%	39.8%	36.9%	43.9%
	5 Strongly agree	12.0%	3.3%	4.5%	6.3%	5.7%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

LBq44 The patient and family are invited to be directly involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events

		orgID organization				Total
		1	2	3	4	
LBq44 The patient and family are invited to be directly involved in the entire process of understanding: what happened following a major event and generating solutions for reducing re-occurrence of similar events	1 Strongly Disagree	3.0%	4.8%	2.7%	4.5%	3.7%
	2 Disagree	12.1%	13.3%	16.4%	20.9%	15.2%
	3 Neutral	34.5%	45.6%	49.3%	37.3%	43.9%
	4 Agree	40.0%	33.3%	29.0%	33.6%	33.0%
	5 Strongly agree	10.3%	3.1%	2.7%	3.6%	4.3%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

LBq45 Things that are learned from major events are communicated to staff on our unit using more than one method (e.g. communication book, in-services, unit rounds, emails) and / or at several times so all staff hear about it

		orgID organization				Total
		1	2	3	4	
LBq45 Things that are learned from major events are communicated to staff on our unit using more than one method (e.g. communication book, in-services, unit rounds, emails) and / or at several times so all staff hear about it	1 Strongly Disagree	3.4%	6.4%	2.2%	6.0%	4.3%
	2 Disagree	11.2%	16.8%	15.6%	18.8%	15.6%
	3 Neutral	22.5%	24.8%	21.8%	29.9%	23.9%
	4 Agree	52.2%	45.3%	53.9%	37.6%	48.8%
	5 Strongly agree	10.7%	6.7%	6.4%	7.7%	7.4%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

LBq46 Changes are made to reduce re-occurrence of major events

		orgID organization				Total
		1	2	3	4	
LBq46 Changes are made to reduce re-occurrence of major events	1 Strongly Disagree	2.2%	1.8%	1.1%	3.4%	1.8%
	2 Disagree	3.3%	9.0%	7.5%	8.5%	7.4%
	3 Neutral	19.9%	29.8%	25.7%	23.7%	25.8%
	4 Agree	64.6%	51.2%	56.6%	55.1%	56.1%
	5 Strongly agree	9.9%	8.1%	9.1%	9.3%	9.0%
Total		100.0%	100.0%	100.0%	100.0%	100.0%