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Notes

Note 1. The number of hospitals and respondents in each breakout category is shown in each table (e.g., the number of hospitals and respondents by bed size, teaching status, region, etc.). However, the precise number of hospitals and respondents corresponding to each data cell in a table will vary because hospitals may have omitted a specific survey item and because of individual nonresponse/missing data.

Note 2. The item's survey location is shown to the left. An "R" indicates a negatively worded item, where the percent positive response is based on those who responded "Strongly disagree" or "Disagree," or "Never" or "Rarely" (depending on the response category used for the item).

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Notes

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

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

Note 3. In tables broken out by item, the item’s survey location is shown to the left. An “R” indicates a negatively worded item, where the percent positive response is based on those who responded “Strongly disagree” or “Disagree,” or “Never” or “Rarely” (depending on the response category used for the item).

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

Patient Safety Culture Composites	Bed Size						
	6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-399 beds	400 or more beds
No. of Hospitals	*41*	*97*	*79*	*61*	*45*	*29*	*30*
No. of Respondents	*2,657*	*8,764*	*10,825*	*14,786*	*21,298*	*17,476*	*32,815*
1. Teamwork Within Units	81%	81%	79%	75%	73%	76%	75%
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	74%	77%	74%	74%	72%	72%	70%
3. Management Support for Patient Safety	73%	74%	70%	66%	65%	68%	62%
4. Org Learning--Continuous Improvement	68%	72%	70%	66%	66%	68%	66%
5. Overall Perceptions of Patient Safety	67%	67%	65%	60%	58%	59%	57%
6. Feedback & Communication About Error	63%	64%	62%	60%	60%	61%	60%
7. Communication Openness	64%	62%	62%	60%	59%	60%	61%
8. Frequency of Events Reported	62%	61%	59%	58%	56%	59%	54%
9. Teamwork Across Units	63%	62%	59%	52%	49%	52%	47%
10. Staffing	62%	60%	56%	50%	49%	50%	49%
11. Handoffs & Transitions	56%	49%	47%	40%	37%	39%	36%
12. Nonpunitive Response to Error	46%	46%	44%	42%	39%	39%	37%
Average Across Composites	65%	65%	62%	59%	57%	59%	56%

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

Item	Survey Items By Composite	Bed Size						
		6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-399 beds	400 or more beds
	No. of Hospitals	*41*	*97*	*79*	*61*	*45*	*29*	*30*
	No. of Respondents	*2,657*	*8,764*	*10,825*	*14,786*	*21,298*	*17,476*	*32,815*
1.	**Teamwork Within Units**							
A1	1. People support one another in this unit.	85%	85%	84%	80%	79%	81%	81%
A3	2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	89%	88%	86%	81%	80%	83%	81%
A4	3. In this unit, people treat each other with respect.	79%	79%	78%	73%	72%	75%	72%
A11	4. When one area in this unit gets really busy, others help out.	71%	70%	68%	65%	63%	64%	64%
2.	**Supervisor/Manager Expectations & Actions Promoting Patient Safety**							
B1	1. My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures.	68%	72%	70%	69%	67%	68%	68%
B2	2. My supv/mgr seriously considers staff suggestions for improving patient safety.	74%	79%	76%	72%	72%	71%	72%
B3 R	3. Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts.	77%	78%	75%	72%	69%	70%	68%
B4 R	4. My supv/mgr overlooks patient safety problems that happen over and over.	76%	80%	77%	75%	72%	73%	72%
3.	**Management Support for Patient Safety**							
F1	1. Hospital mgmt provides a work climate that promotes patient safety.	83%	84%	80%	75%	74%	78%	72%
F8	2. The actions of hospital mgmt show that patient safety is a top priority.	73%	74%	71%	67%	66%	70%	65%
F9 R	3. Hospital mgmt seems interested in patient safety only after an adverse event happens.	62%	64%	60%	56%	53%	56%	50%

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

		Bed Size						
Item	**Survey Items By Composite**	**6-24 beds**	**25-49 beds**	**50-99 beds**	**100-199 beds**	**200-299 beds**	**300-399 beds**	**400 or more beds**
	No. of Hospitals	*41*	*97*	*79*	*61*	*45*	*29*	*30*
	No. of Respondents	*2,657*	*8,764*	*10,825*	*14,786*	*21,298*	*17,476*	*32,815*
4.	**Organizational Learning— Continuous Improvement**							
A6	1. We are actively doing things to improve patient safety.	79%	83%	82%	76%	77%	79%	77%
A9	2. Mistakes have led to positive changes here.	62%	65%	61%	59%	58%	60%	59%
A13	3. After we make changes to improve patient safety, we evaluate their effectiveness.	65%	69%	67%	63%	64%	64%	63%
5.	**Overall Perceptions of Patient Safety**							
A10 R	1. It is just by chance that more serious mistakes don't happen around here.	63%	63%	61%	57%	55%	57%	54%
A15	2. Patient safety is never sacrificed to get more work done.	71%	68%	65%	60%	57%	56%	55%
A17 R	3. We have patient safety problems in this unit.	68%	67%	64%	59%	56%	56%	53%
A18	4. Our procedures and systems are good at preventing errors from happening.	67%	71%	70%	65%	65%	67%	65%
6.	**Feedback and Communication About Error**							
C1	1. We are given feedback about changes put into place based on event reports.	49%	52%	51%	50%	52%	54%	53%
C3	2. We are informed about errors that happen in this unit.	66%	67%	65%	62%	61%	62%	60%
C5	3. In this unit, we discuss ways to prevent errors from happening again.	73%	71%	70%	67%	66%	66%	65%

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

Item	Survey Items By Composite	Bed Size: 6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-399 beds	400 or more beds
	No. of Hospitals	*41*	*97*	*79*	*61*	*45*	*29*	*30*
	No. of Respondents	*2,657*	*8,764*	*10,825*	*14,786*	*21,298*	*17,476*	*32,815*
7.	**Communication Openness**							
C2	1. Staff will freely speak up if they see something that may negatively affect patient care.	77%	76%	76%	73%	72%	74%	73%
C4	2. Staff feel free to question the decisions or actions of those with more authority.	49%	47%	46%	45%	46%	46%	47%
C6 R	3. Staff are afraid to ask questions when something does not seem right.	65%	63%	62%	60%	59%	61%	62%
8.	**Frequency of Events Reported**							
D1	1. When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?	52%	51%	50%	49%	49%	52%	46%
D2	2. When a mistake is made, but has no potential to harm the patient, how often is this reported?	57%	56%	55%	53%	51%	53%	49%
D3	3. When a mistake is made that could harm the patient, but does not, how often is this reported?	76%	75%	73%	71%	69%	71%	66%
9.	**Teamwork Across Units**							
F2 R	1. Hospital units do not coordinate well with each other.	52%	50%	47%	41%	37%	40%	34%
F4	2. There is good cooperation among hospital units that need to work together.	66%	64%	61%	53%	50%	52%	47%
F6 R	3. It is often unpleasant to work with staff from other hospital units.	62%	63%	59%	53%	51%	54%	51%
F10	4. Hospital units work well together to provide the best care for patients.	75%	72%	70%	62%	58%	63%	56%

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

Item	Survey Items By Composite	Bed Size 6-24 beds	25-49 beds	50-99 beds	100-199 beds	200-299 beds	300-399 beds	400 or more beds
	No. of Hospitals	*41*	*97*	*79*	*61*	*45*	*29*	*30*
	No. of Respondents	*2,657*	*8,764*	*10,825*	*14,786*	*21,298*	*17,476*	*32,815*
10.	**Staffing**							
A2	1. We have enough staff to handle the workload.	63%	61%	55%	49%	47%	48%	45%
A5 R	2. Staff in this unit work longer hours than is best for patient care.	58%	57%	53%	47%	48%	49%	50%
A7 R	3. We use more agency/temporary staff than is best for patient care.	71%	67%	66%	60%	60%	61%	62%
A14 R	4. We work in “crisis mode” trying to do too much, too quickly.	57%	54%	51%	43%	41%	42%	40%
11.	**Handoffs & Transitions**							
F3 R	1. Things “fall between the cracks” when transferring patients from one unit to another.	54%	48%	45%	37%	32%	33%	30%
F5 R	2. Important patient care information is often lost during shift changes.	58%	52%	51%	45%	43%	46%	45%
F7 R	3. Problems often occur in the exchange of information across hospital units.	52%	46%	45%	37%	34%	36%	33%
F11 R	4. Shift changes are problematic for patients in this hospital.	59%	51%	48%	41%	37%	41%	38%
12.	**Nonpunitive Response to Error**							
A8 R	1. Staff feel like their mistakes are held against them.	54%	53%	52%	49%	46%	46%	44%
A12 R	2. When an event is reported, it feels like the person is being written up, not the problem.	45%	46%	44%	43%	42%	41%	40%
A16 R	3. Staff worry that mistakes they make are kept in their personnel file.	39%	37%	37%	34%	31%	30%	28%

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

	Bed Size						
Work Area/Unit Patient Safety Grade	**6-24 beds**	**25-49 beds**	**50-99 beds**	**100-199 beds**	**200-299 beds**	**300-399 beds**	**400 or more beds**
No. of Hospitals	*41*	*97*	*79*	*61*	*45*	*29*	*30*
No. of Respondents	*2,657*	*8,764*	*10,825*	*14,786*	*21,298*	*17,476*	*32,815*
A Excellent	23%	22%	22%	22%	21%	23%	19%
B Very Good	49%	51%	47%	47%	46%	47%	45%
C Acceptable	23%	22%	25%	25%	26%	25%	28%
D Poor	5%	4%	6%	4%	5%	5%	6%
E Failing	1%	1%	1%	1%	1%	1%	1%

Table A-4. Percent of Respondents Reporting Events in the Past 12 Months by Hospital Bed Size

	Bed Size						
Number of Events Reported by Respondents	**6-24 beds**	**25-49 beds**	**50-99 beds**	**100-199 beds**	**200-299 beds**	**300-399 beds**	**400 or more beds**
No. of Hospitals	*41*	*97*	*79*	*61*	*45*	*29*	*30*
No. of Respondents	*2,657*	*8,764*	*10,825*	*14,786*	*21,298*	*17,476*	*32,815*
No events	54%	53%	53%	54%	52%	53%	53%
1 to 2 events	27%	28%	27%	26%	27%	28%	28%
3 to 5 events	14%	12%	12%	12%	13%	12%	13%
6 to 10 events	4%	4%	5%	5%	5%	4%	4%
11 to 20 events	1%	2%	2%	2%	2%	2%	1%
21 event reports or more	1%	1%	1%	1%	1%	1%	1%

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

	Teaching Status		Ownership and Control	
Patient Safety Culture Composites	**Teaching**	**Non-teaching**	**Govt**	**Non-govt**
No. of Hospitals	*92*	*290*	*106*	*276*
No. of Respondents	*44,067*	*64,554*	*12,926*	*95,695*
1. Teamwork Within Units	76%	78%	79%	77%
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	72%	75%	75%	74%
3. Management Support for Patient Safety	66%	70%	72%	68%
4. Org Learning—Continuous Improvement	68%	69%	70%	68%
5. Overall Perceptions of Patient Safety	60%	64%	66%	62%
6. Feedback & Communication About Error	60%	62%	62%	61%
7. Communication Openness	60%	61%	61%	61%
8. Frequency of Events Reported	57%	59%	59%	59%
9. Teamwork Across Units	53%	58%	60%	55%
10. Staffing	53%	56%	59%	53%
11. Handoffs & Transitions	42%	46%	49%	43%
12. Nonpunitive Response to Error	41%	43%	44%	42%
Average Across Composites	59%	62%	63%	60%

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

		Teaching Status		Ownership and Control	
Item	**Survey Items by Composite**	**Teaching**	**Non-teaching**	**Govt**	**Non-govt**
	No. of Hospitals	*92*	*290*	*106*	*276*
	No. of Respondents	*44,067*	*64,554*	*12,926*	*95,695*
1.	**Teamwork Within Units**				
A1	1. People support one another in this unit.	82%	83%	84%	82%
A3	2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	83%	85%	87%	84%
A4	3. In this unit, people treat each other with respect.	74%	77%	77%	76%
A11	4. When one area in this unit gets really busy, others help out.	65%	68%	68%	67%
2.	**Supervisor/Manager Expectations & Actions Promoting Patient Safety**				
B1	1. My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures.	68%	70%	69%	70%
B2	2. My supv/mgr seriously considers staff suggestions for improving patient safety.	74%	75%	75%	75%
B3 R	3. Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts.	71%	75%	76%	73%
B4 R	4. My supv/mgr overlooks patient safety problems that happen over and over.	75%	76%	77%	75%
3.	**Management Support for Patient Safety**				
F1	1. Hospital mgmt provides a work climate that promotes patient safety.	77%	80%	83%	78%
F8	2. The actions of hospital mgmt show that patient safety is a top priority.	68%	71%	73%	69%
F9 R	3. Hospital mgmt seems interested in patient safety only after an adverse event happens.	55%	60%	61%	58%

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

Item	Survey Items by Composite	Teaching Status: Teaching	Teaching Status: Non-teaching	Ownership and Control: Govt	Ownership and Control: Non-govt
	No. of Hospitals	*92*	*290*	*106*	*276*
	No. of Respondents	*44,067*	*64,554*	*12,926*	*95,695*
4.	**Organizational Learning— Continuous Improvement**				
A6	1. We are actively doing things to improve patient safety.	81%	79%	81%	79%
A9	2. Mistakes have led to positive changes here.	60%	62%	63%	60%
A13	3. After we make changes to improve patient safety, we evaluate their effectiveness.	65%	66%	67%	65%
5.	**Overall Perceptions of Patient Safety**				
A10 R	1. It is just by chance that more serious mistakes don't happen around here.	58%	60%	61%	59%
A15	2. Patient safety is never sacrificed to get more work done.	59%	65%	68%	62%
A17 R	3. We have patient safety problems in this unit.	58%	63%	65%	60%
A18	4. Our procedures and systems are good at preventing errors from happening.	67%	68%	69%	67%
6.	**Feedback and Communication About Error**				
C1	1. We are given feedback about changes put into place based on event reports.	52%	51%	50%	52%
C3	2. We are informed about errors that happen in this unit.	62%	65%	66%	64%
C5	3. In this unit, we discuss ways to prevent errors from happening again.	67%	70%	71%	68%

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

Item	Survey Items by Composite	Teaching Status		Ownership and Control	
		Teaching	Non-teaching	Govt	Non-govt
	No. of Hospitals	*92*	*290*	*106*	*276*
	No. of Respondents	*44,067*	*64,554*	*12,926*	*95,695*
7.	**Communication Openness**				
C2	1. Staff will freely speak up if they see something that may negatively affect patient care.	74%	75%	75%	75%
C4	2. Staff feel free to question the decisions or actions of those with more authority.	46%	47%	45%	47%
C6 R	3. Staff are afraid to ask questions when something does not seem right.	60%	63%	63%	62%
8.	**Frequency of Events Reported**				
D1	1. When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?	49%	50%	50%	50%
D2	2. When a mistake is made, but has no potential to harm the patient, how often is this reported?	53%	55%	54%	54%
D3	3. When a mistake is made that could harm the patient, but does not, how often is this reported?	70%	73%	73%	72%
9.	**Teamwork Across Units**				
F2 R	1. Hospital units do not coordinate well with each other.	40%	46%	48%	43%
F4	2. There is good cooperation among hospital units that need to work together.	52%	59%	62%	56%
F6 R	3. It is often unpleasant to work with staff from other hospital units.	56%	58%	60%	56%
F10	4. Hospital units work well together to provide the best care for patients.	62%	68%	71%	65%

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

		Teaching Status		Ownership and Control	
Item	**Survey Items by Composite**	**Teaching**	**Non-teaching**	**Govt**	**Non-govt**
	No. of Hospitals	*92*	*290*	*106*	*276*
	No. of Respondents	*44,067*	*64,554*	*12,926*	*95,695*
10.	**Staffing**				
A2	1. We have enough staff to handle the workload.	51%	55%	61%	52%
A5 R	2. Staff in this unit work longer hours than is best for patient care.	51%	53%	55%	51%
A7 R	3. We use more agency/temporary staff than is best for patient care.	63%	65%	67%	63%
A14 R	4. We work in "crisis mode" trying to do too much, too quickly.	45%	50%	54%	46%
11.	**Handoffs & Transitions**				
F3 R	1. Things "fall between the cracks" when transferring patients from one unit to another.	37%	43%	48%	39%
F5 R	2. Important patient care information is often lost during shift changes.	49%	50%	53%	48%
F7 R	3. Problems often occur in the exchange of information across hospital units.	38%	43%	46%	40%
F11 R	4. Shift changes are problematic for patients in this hospital.	43%	47%	51%	44%
12.	**Nonpunitive Response to Error**				
A8 R	1. Staff feel like their mistakes are held against them.	48%	51%	52%	50%
A12 R	2. When an event is reported, it feels like the person is being written up, not the problem.	43%	44%	44%	43%
A16 R	3. Staff worry that mistakes they make are kept in their personnel file.	33%	36%	36%	34%

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

	Teaching Status		Ownership and Control	
Work Area/Unit Patient Safety Grade	**Teaching**	**Non-teaching**	**Govt**	**Non-govt**
No. of Hospitals	*92*	*290*	*106*	*276*
No. of Respondents	*44,067*	*64,554*	*12,926*	*95,695*
A Excellent	20%	23%	21%	22%
B Very Good	47%	48%	48%	48%
C Acceptable	27%	23%	25%	24%
D Poor	5%	5%	5%	5%
E Failing	1%	1%	1%	1%

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

	Teaching Status		Ownership and Control	
Number of Events Reported by Respondents	**Teaching**	**Non-teaching**	**Govt**	**Non-govt**
No. of Hospitals	*92*	*290*	*106*	*276*
No. of Respondents	*44,067*	*64,554*	*12,926*	*95,695*
No events	51%	53%	53%	53%
1 to 2 events	29%	27%	26%	28%
3 to 5 events	13%	12%	13%	13%
6 to 10 events	4%	4%	5%	4%
11 to 20 events	2%	2%	2%	2%
21 event reports or more	1%	1%	1%	1%

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

	Region							
Patient Safety Culture Composites	Mid Atlantic/ New England	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific
No. of Hospitals	*20*	*60*	*100*	*26*	*83*	*31*	*35*	*27*
No. of Respondents	*10,796*	*17,870*	*34,715*	*6,982*	*17,418*	*10,223*	*5,809*	*4,808*
1. Teamwork Within Units	75%	78%	75%	79%	80%	81%	77%	78%
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	71%	76%	73%	77%	74%	77%	72%	72%
3. Management Support for Patient Safety	65%	71%	67%	73%	73%	71%	67%	66%
4. Org Learning—Continuous Improvement	68%	72%	65%	73%	71%	73%	67%	66%
5. Overall Perceptions of Patient Safety	58%	62%	60%	65%	68%	66%	63%	59%
6. Feedback & Communication About Error	61%	64%	58%	65%	61%	66%	62%	61%
7. Communication Openness	62%	62%	60%	62%	60%	64%	61%	64%
8. Frequency of Events Reported	60%	58%	56%	63%	61%	62%	59%	58%
9. Teamwork Across Units	51%	56%	54%	61%	62%	57%	55%	54%
10. Staffing	46%	54%	53%	53%	61%	56%	54%	52%
11. Handoffs & Transitions	40%	43%	42%	48%	51%	43%	44%	42%
12. Nonpunitive Response to Error	38%	42%	41%	44%	48%	44%	42%	40%
Average Across Composites	58%	62%	59%	64%	64%	63%	60%	59%

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

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

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

		Region							
Item	**Survey Items By Composite**	**Mid Atlantic/ New England**	**South Atlantic**	**E. North Central**	**E. South Central**	**W. North Central**	**W. South Central**	**Mountain**	**Pacific**
	No. of Hospitals	*20*	*60*	*100*	*26*	*83*	*31*	*35*	*27*
	No. of Respondents	*10,796*	*17,870*	*34,715*	*6,982*	*17,418*	*10,223*	*5,809*	*4,808*
1.	**Teamwork Within Units**								
A1	1. People support one another in this unit.	82%	83%	80%	84%	85%	86%	83%	84%
A3	2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	82%	85%	82%	87%	88%	88%	84%	84%
A4	3. In this unit, people treat each other with respect.	74%	77%	73%	78%	78%	80%	75%	76%
A11	4. When one area in this unit gets really busy, others help out.	64%	67%	65%	68%	69%	71%	67%	67%
2.	**Supervisor/Manager Expectations & Actions Promoting Patient Safety**								
B1	1. My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures.	68%	72%	66%	75%	68%	76%	68%	70%
B2	2. My supv/mgr seriously considers staff suggestions for improving patient safety.	72%	77%	72%	79%	75%	78%	73%	75%
B3 R	3. Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts.	69%	75%	73%	76%	75%	76%	74%	71%
B4 R	4. My supv/mgr overlooks patient safety problems that happen over and over.	72%	79%	73%	79%	78%	79%	73%	74%
3.	**Management Support for Patient Safety**								
F1	1. Hospital mgmt provides a work climate that promotes patient safety.	74%	80%	77%	82%	83%	80%	78%	78%
F8	2. The actions of hospital mgmt show that patient safety is a top priority.	68%	72%	66%	75%	73%	73%	69%	68%
F9 R	3. Hospital mgmt seems interested in patient safety only after an adverse event happens.	54%	60%	56%	62%	63%	60%	56%	53%

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

		Region							
Item	Survey Items By Composite	Mid Atlantic/ New England	South Atlantic	E. North Central	E. South Central	W. North Central	W. South Central	Mountain	Pacific
	No. of Hospitals	*20*	*60*	*100*	*26*	*83*	*31*	*35*	*27*
	No. of Respondents	*10,796*	*17,870*	*34,715*	*6,982*	*17,418*	*10,223*	*5,809*	*4,808*
4.	**Organizational Learning— Continuous Improvement**								
A6	1. We are actively doing things to improve patient safety.	78%	83%	76%	83%	82%	83%	78%	79%
A9	2. Mistakes have led to positive changes here.	58%	63%	58%	63%	63%	64%	60%	61%
A13	3. After we make changes to improve patient safety, we evaluate their effectiveness.	66%	69%	62%	72%	67%	72%	62%	59%
5.	**Overall Perceptions of Patient Safety**								
A10 R	1. It is just by chance that more serious mistakes don't happen around here.	53%	56%	57%	59%	66%	62%	61%	57%
A15	2. Patient safety is never sacrificed to get more work done.	60%	65%	60%	65%	67%	65%	64%	59%
A17 R	3. We have patient safety problems in this unit.	54%	59%	59%	63%	68%	64%	64%	56%
A18	4. Our procedures and systems are good at preventing errors from happening.	66%	68%	65%	72%	71%	73%	64%	65%
6.	**Feedback and Communication About Error**								
C1	1. We are given feedback about changes put into place based on event reports.	51%	54%	50%	54%	50%	55%	50%	50%
C3	2. We are informed about errors that happen in this unit.	65%	68%	61%	71%	63%	69%	65%	60%
C5	3. In this unit, we discuss ways to prevent errors from happening again.	67%	71%	64%	71%	70%	73%	71%	71%

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

		Region							
Item	**Survey Items By Composite**	**Mid Atlantic/ New England**	**South Atlantic**	**E. North Central**	**E. South Central**	**W. North Central**	**W. South Central**	**Mountain**	**Pacific**
	No. of Hospitals	*20*	*60*	*100*	*26*	*83*	*31*	*35*	*27*
	No. of Respondents	*10,796*	*17,870*	*34,715*	*6,982*	*17,418*	*10,223*	*5,809*	*4,808*
7.	**Communication Openness**								
C2	1. Staff will freely speak up if they see something that may negatively affect patient care.	75%	75%	74%	76%	75%	76%	74%	76%
C4	2. Staff feel free to question the decisions or actions of those with more authority.	49%	47%	45%	47%	44%	50%	48%	51%
C6 R	3. Staff are afraid to ask questions when something does not seem right.	63%	64%	60%	63%	61%	65%	62%	64%
8.	**Frequency of Events Reported**								
D1	1. When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?	53%	49%	47%	54%	50%	55%	53%	50%
D2	2. When a mistake is made, but has no potential to harm the patient, how often is this reported?	56%	54%	51%	58%	57%	57%	54%	52%
D3	3. When a mistake is made that could harm the patient, but does not, how often is this reported?	72%	72%	70%	77%	76%	74%	70%	72%
9.	**Teamwork Across Units**								
F2 R	1. Hospital units do not coordinate well with each other.	38%	45%	43%	50%	49%	44%	41%	39%
F4	2. There is good cooperation among hospital units that need to work together.	51%	57%	54%	63%	63%	60%	55%	54%
F6 R	3. It is often unpleasant to work with staff from other hospital units.	54%	58%	55%	59%	62%	56%	57%	57%
F10	4. Hospital units work well together to provide the best care for patients.	61%	65%	63%	72%	73%	67%	66%	64%

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

Item	Survey Items By Composite	Region							
		Mid Atlantic/ New England	South Atlantic	E. North Central	E. South Central	W. North Central	W. South Central	Mountain	Pacific
	No. of Hospitals	*20*	*60*	*100*	*26*	*83*	*31*	*35*	*27*
	No. of Respondents	*10,796*	*17,870*	*34,715*	*6,982*	*17,418*	*10,223*	*5,809*	*4,808*
10.	**Staffing**								
A2	1. We have enough staff to handle the workload.	43%	54%	52%	50%	62%	54%	55%	53%
A5 R	2. Staff in this unit work longer hours than is best for patient care.	44%	52%	52%	52%	56%	53%	50%	51%
A7 R	3. We use more agency/temporary staff than is best for patient care.	58%	62%	63%	63%	71%	66%	61%	61%
A14 R	4. We work in “crisis mode” trying to do too much, too quickly.	39%	49%	45%	47%	55%	51%	50%	45%
11.	**Handoffs & Transitions**								
F3 R	1. Things “fall between the cracks” when transferring patients from one unit to another.	34%	42%	39%	47%	49%	41%	40%	37%
F5 R	2. Important patient care information is often lost during shift changes.	48%	49%	47%	52%	54%	47%	49%	46%
F7 R	3. Problems often occur in the exchange of information across hospital units.	36%	40%	39%	47%	47%	40%	41%	39%
F11 R	4. Shift changes are problematic for patients in this hospital.	39%	44%	44%	47%	54%	43%	45%	44%
12.	**Nonpunitive Response to Error**								
A8 R	1. Staff feel like their mistakes are held against them.	45%	49%	48%	52%	56%	53%	50%	47%
A12 R	2. When an event is reported, it feels like the person is being written up, not the problem.	40%	43%	42%	44%	47%	44%	42%	40%
A16 R	3. Staff worry that mistakes they make are kept in their personnel file.	28%	34%	32%	36%	40%	36%	35%	32%

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

	Region							
Work Area/Unit Patient Safety Grade	**Mid Atlantic/ New England**	**South Atlantic**	**E. North Central**	**E. South Central**	**W. North Central**	**W. South Central**	**Mountain**	**Pacific**
No. of Hospitals	*20*	*60*	*100*	*26*	*83*	*31*	*35*	*27*
No. of Respondents	*10,796*	*17,870*	*34,715*	*6,982*	*17,418*	*10,223*	*5,809*	*4,808*
A Excellent	21%	21%	21%	24%	23%	28%	21%	20%
B Very Good	46%	48%	49%	49%	52%	47%	39%	48%
C Acceptable	27%	27%	25%	23%	23%	21%	25%	24%
D Poor	5%	4%	5%	4%	3%	3%	12%	7%
E Failing	1%	0%	1%	0%	0%	1%	3%	1%

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

	Region							
Number of Events Reported by Respondents	**Mid Atlantic/ New England**	**South Atlantic**	**E. North Central**	**E. South Central**	**W. North Central**	**W. South Central**	**Mountain**	**Pacific**
No. of Hospitals	*20*	*60*	*100*	*26*	*83*	*31*	*35*	*27*
No. of Respondents	*10,796*	*17,870*	*34,715*	*6,982*	*17,418*	*10,223*	*5,809*	*4,808*
No events	57%	53%	51%	58%	53%	58%	53%	46%
1 to 2 events	26%	28%	29%	24%	26%	25%	28%	31%
3 to 5 events	10%	12%	13%	11%	14%	11%	13%	15%
6 to 10 events	4%	4%	5%	4%	5%	4%	4%	5%
11 to 20 events	1%	2%	2%	2%	2%	1%	1%	2%
21 event reports or more	1%	1%	1%	1%	1%	1%	1%	1%

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

	Work Area/Unit											
Patient Safety Culture Composites	**Anesthe siology**	**Emer-gency**	**ICU (any type)**	**Lab**	**Medicine**	**Obstetrics**	**Pediatr.**	**Pharm.**	**Psych/ Mentl Hlth**	**Radi-ology**	**Rehab-ilitation**	**Surgery**
No. of Hospitals	*88*	*301*	*215*	*319*	*319*	*195*	*116*	*271*	*115*	*330*	*286*	*299*
No. of Respondents	*720*	*5,168*	*5,992*	*5,118*	*8,279*	*3,880*	*1,763*	*2,744*	*2,301*	*5,600*	*4,153*	*9,351*
1. Teamwork Within Units	82%	78%	80%	77%	73%	78%	74%	79%	74%	79%	85%	76%
2. Supv/Mgr Expectations & Actions Promoting Patient Safety	72%	73%	72%	75%	71%	74%	68%	79%	78%	76%	81%	74%
3. Mgmt Support for Patient Safety	67%	61%	59%	71%	64%	65%	60%	70%	67%	71%	75%	68%
4. Org Learning--Continuous Improvement	72%	64%	68%	69%	67%	68%	64%	76%	71%	67%	74%	72%
5. Overall Perceptions of Patient Safety	67%	55%	55%	71%	53%	59%	59%	67%	60%	70%	76%	67%
6. Feedback & Communication About Error	61%	56%	55%	63%	55%	62%	56%	68%	62%	63%	71%	64%

Table B-1. Composite-level Average Percent Positive Response by Respondent Work Area/Unit (Page 2 0f 2)

	Work Area/Unit											
Patient Safety Culture Composites	Anesthe siology	Emer-gency	ICU (any type)	Lab	Medicine	Obstetrics	Pediatr.	Pharm.	Psych/ Mentl Hlth	Radi-ology	Rehab-ilitation	Surgery
7. Communication Openness	71%	60%	61%	63%	55%	64%	58%	71%	61%	64%	71%	65%
8. Frequency of Events Reported	55%	57%	56%	62%	59%	60%	58%	62%	62%	51%	62%	63%
9. Teamwork Across Units	51%	51%	51%	55%	55%	53%	48%	57%	49%	55%	60%	52%
10. Staffing	56%	51%	53%	56%	52%	56%	56%	56%	53%	61%	63%	56%
11. Handoffs & Transitions	36%	50%	46%	38%	47%	50%	41%	34%	40%	43%	42%	41%
12. Nonpunitive Response to Error	44%	36%	38%	42%	39%	40%	40%	57%	43%	45%	59%	45%
Average Across Composites	61%	58%	58%	62%	58%	61%	57%	65%	60%	62%	68%	62%

ICU=Intensive Care Unit; Pediat=Pediatrics; Pharm.=Pharmacy

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

		Work Area/Unit											
Item	Survey Items by Composite	Anesthe-siology	Emer-gency	ICU	Lab	Medicine	Obstet-rics	Pedi-atrics	Pharmacy	Psych/ Ment Hlth	Radi-ology	Rehab-ilitation	Surgery
	No. of Hospitals	*88*	*301*	*215*	*319*	*319*	*195*	*116*	*271*	*115*	*330*	*286*	*299*
	No. of Respondents	*720*	*5,168*	*5,992*	*5,118*	*8,279*	*3,880*	*1,763*	*2,744*	*2,301*	*5,600*	*4,153*	*9,351*
1.	**Teamwork Within Units**												
A1	1. People support one another in this unit.	86%	83%	86%	80%	81%	83%	78%	85%	79%	84%	91%	81%
A3	2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	88%	86%	87%	85%	80%	86%	82%	84%	81%	87%	89%	86%
A4	3. In this unit, people treat each other with respect.	84%	74%	79%	75%	71%	76%	73%	78%	73%	77%	86%	73%
A11	4. When one area in this unit gets really busy, others help out.	70%	70%	69%	70%	60%	66%	63%	68%	64%	67%	76%	64%
2.	**Supv/Mgr Expectations & Actions Promoting Patient Safety**												
B1	1. My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures.	67%	69%	67%	67%	67%	69%	63%	73%	72%	69%	75%	69%
B2	2. My supv/mgr seriously considers staff suggestions for improving patient safety.	70%	73%	72%	74%	70%	75%	71%	79%	77%	75%	84%	75%
B3 R	3. Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts.	74%	73%	70%	80%	72%	73%	68%	79%	75%	78%	80%	72%
B4 R	4. My supv/mgr overlooks patient safety problems that happen over and over.	74%	75%	74%	76%	75%	75%	68%	79%	78%	78%	83%	76%
3.	**Mgmt Support for Patient Safety**												
F1	1. Hospital mgmt provides a work climate that promotes patient safety.	77%	72%	69%	80%	74%	77%	71%	77%	75%	82%	85%	77%
F8	2. The actions of hospital mgmt show that patient safety is a top priority.	67%	60%	59%	71%	65%	66%	61%	72%	68%	72%	76%	68%
F9 R	3. Hospital mgmt seems interested in patient safety only after an adverse event happens.	56%	51%	47%	60%	54%	52%	48%	62%	59%	59%	63%	59%

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

Item	Survey Items by Composite	Work Area/Unit											
		Anesthe-siology	Emer-gency	ICU	Lab	Medicine	Obstet-rics	Pedi-atrics	Pharmacy	Psych/ Ment Hlth	Radi-ology	Rehab-ilitation	Surgery
	No. of Hospitals	*88*	*301*	*215*	*319*	*319*	*195*	*116*	*271*	*115*	*330*	*286*	*299*
	No. of Respondents	*720*	*5,168*	*5,992*	*5,118*	*8,279*	*3,880*	*1,763*	*2,744*	*2,301*	*5,600*	*4,153*	*9,351*
4.	**Organizational Learning— Continuous Improvement**												
A6	1. We are actively doing things to improve patient safety.	81%	75%	81%	78%	78%	77%	79%	87%	83%	78%	87%	85%
A9	2. Mistakes have led to positive changes here.	63%	56%	55%	66%	58%	61%	52%	73%	60%	60%	63%	62%
A13	3. After we make changes to improve patient safety, we evaluate their effectiveness.	71%	62%	67%	64%	65%	67%	62%	69%	69%	62%	73%	69%
5.	**Overall Perceptions of Patient Safety**												
A10 R	1. It is just by chance that more serious mistakes don't happen around here.	66%	53%	54%	64%	53%	59%	56%	64%	58%	65%	74%	63%
A15	2. Patient safety is never sacrificed to get more work done.	60%	55%	49%	70%	53%	54%	61%	66%	64%	74%	76%	64%
A17 R	3. We have patient safety problems in this unit.	67%	52%	53%	71%	49%	58%	58%	64%	49%	71%	75%	67%
A18	4. Our procedures and systems are good at preventing errors from happening.	75%	60%	63%	78%	58%	66%	62%	73%	67%	72%	80%	74%
6.	**Feedback and Communication About Error**												
C1	1. We are given feedback about changes put into place based on event reports.	47%	48%	47%	50%	49%	54%	45%	55%	56%	51%	62%	50%
C3	2. We are informed about errors that happen in this unit.	61%	58%	54%	69%	55%	62%	59%	73%	61%	70%	72%	68%
C5	3. In this unit, we discuss ways to prevent errors from happening again.	74%	63%	64%	72%	62%	70%	62%	76%	69%	69%	80%	73%

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

Item	Survey Items by Composite	Work Area/Unit											
		Anesthe-siology	Emer-gency	ICU	Lab	Medicine	Obstet-rics	Pedi-atrics	Pharmacy	Psych/ Ment Hlth	Radi-ology	Rehab-ilitation	Surgery
	No. of Hospitals	*88*	*301*	*215*	*319*	*319*	*195*	*116*	*271*	*115*	*330*	*286*	*299*
	No. of Respondents	*720*	*5,168*	*5,992*	*5,118*	*8,279*	*3,880*	*1,763*	*2,744*	*2,301*	*5,600*	*4,153*	*9,351*
7.	**Communication Openness**												
C2	1. Staff will freely speak up if they see something that may negatively affect patient care.	82%	73%	74%	74%	71%	78%	72%	80%	73%	78%	83%	80%
C4	2. Staff feel free to question the decisions or actions of those with more authority.	57%	46%	45%	47%	38%	51%	44%	58%	48%	47%	58%	51%
C6 R	3. Staff are afraid to ask questions when something does not seem right.	75%	62%	63%	67%	56%	64%	59%	74%	62%	66%	72%	65%
8.	**Frequency of Events Reported**												
D1	1. When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?	49%	43%	43%	51%	47%	47%	48%	49%	55%	41%	55%	55%
D2	2. When a mistake is made, but has no potential to harm the patient, how often is this reported?	49%	55%	52%	55%	57%	56%	55%	60%	58%	44%	56%	58%
D3	3. When a mistake is made that could harm the patient, but does not, how often is this reported?	66%	72%	72%	79%	73%	75%	70%	78%	72%	68%	75%	75%
9.	**Teamwork Across Units**												
F2 R	1. Hospital units do not coordinate well with each other.	35%	41%	39%	43%	44%	39%	39%	45%	36%	43%	47%	39%
F4	2. There is good cooperation among hospital units that need to work together.	49%	50%	51%	58%	55%	54%	49%	58%	48%	58%	61%	53%
F6 R	3. It is often unpleasant to work with staff from other hospital units.	62%	51%	55%	55%	59%	56%	49%	59%	55%	56%	63%	55%
F10	4. Hospital units work well together to provide the best care for patients.	60%	60%	57%	64%	63%	63%	57%	66%	56%	65%	69%	62%

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

Item	Survey Items by Composite	Work Area/Unit											
		Anesthe-siology	Emer-gency	ICU	Lab	Medicine	Obstetrics	Pediatrics	Pharmacy	Psych/ Ment Hlth	Radi-ology	Reh ab-ilitation	Surgery
	No. of Hospitals	*88*	*301*	*215*	*319*	*319*	*195*	*116*	*271*	*115*	*330*	*286*	*299*
	No. of Respondents	*720*	*5,168*	*5,992*	*5,118*	*8,279*	*3,880*	*1,763*	*2,744*	*2,301*	*5,600*	*4,153*	*9,351*
10.	**Staffing**												
A2	1. We have enough staff to handle the workload.	57%	45%	48%	54%	45%	50%	52%	54%	50%	59%	57%	56%
A5R	2. Staff in this unit work longer hours than is best for patient care.	46%	53%	54%	55%	51%	52%	53%	57%	50%	57%	62%	51%
A7R	3. We use more agency/temporary staff than is best for patient care.	63%	65%	64%	67%	66%	74%	69%	65%	65%	72%	69%	70%
A14R	4. We work in “crisis mode” trying to do too much, too quickly.	56%	43%	45%	48%	44%	47%	51%	49%	48%	55%	63%	49%
11.	**Handoffs & Transitions**												
F3R	1. Things “fall between the cracks” when transferring patients from one unit to another.	32%	50%	37%	29%	44%	43%	38%	29%	29%	42%	40%	41%
F5R	2. Important patient care information is often lost during shift changes.	43%	56%	57%	45%	52%	58%	48%	36%	48%	48%	46%	45%
F7R	3. Problems often occur in the exchange of information across hospital units.	38%	48%	40%	36%	43%	42%	39%	34%	37%	39%	44%	39%
F11R	4. Shift changes are problematic for patients in this hospital.	34%	48%	52%	43%	51%	56%	40%	35%	47%	44%	40%	37%
12.	**Nonpunitive Response to Error**												
A8R	1. Staff feel like their mistakes are held against them.	52%	43%	44%	51%	45%	50%	48%	64%	50%	53%	67%	51%
A12R	2. When an event is reported, it feels like the person is being written up, not the problem.	44%	36%	40%	42%	40%	40%	42%	58%	47%	43%	57%	45%
A16R	3. Staff worry that mistakes they make are kept in their personnel file.	36%	28%	30%	35%	30%	30%	30%	50%	33%	38%	53%	37%

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

		Work Area/Unit											
Work Area/Unit Patient Safety Grade		**Anesthe-siology**	**Emer-gency**	**ICU (any type)**	**Lab**	**Medicine**	**Obstetrics**	**Pediatrics**	**Pharmacy**	**Psych/ Mental Health**	**Radiology**	**Rehab-ilitation**	**Surgery**
	No. of Hospitals	*88*	*301*	*215*	*319*	*319*	*195*	*116*	*271*	*115*	*330*	*286*	*299*
	No. of Respondents	*720*	*5,168*	*5,992*	*5,118*	*8,279*	*3,880*	*1,763*	*2,744*	*2,301*	*5,600*	*4,153*	*9,351*
A	**Excellent**	36%	15%	15%	24%	12%	20%	20%	22%	21%	23%	34%	31%
B	**Very Good**	43%	46%	48%	51%	46%	49%	44%	51%	43%	53%	47%	46%
C	**Acceptable**	15%	31%	29%	20%	33%	25%	28%	20%	27%	20%	15%	18%
D	**Poor**	3%	7%	7%	4%	7%	5%	7%	5%	8%	4%	3%	4%
E	**Failing**	3%	1%	2%	0%	1%	1%	1%	1%	1%	0%	1%	1%

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

	Work Area/Unit											
Number of Events Reported by Respondents	**Anesthe-siology**	**Emer-gency**	**ICU (any type)**	**Lab**	**Medicine**	**Obstetrics**	**Pediatrics**	**Pharmacy**	**Psych/ Mental Health**	**Radiology**	**Rehab-ilitation**	**Surgery**
No. of Hospitals	*88*	*301*	*215*	*319*	*319*	*195*	*116*	*271*	*115*	*330*	*286*	*299*
No. of Respondents	*720*	*5,168*	*5,992*	*5,118*	*8,279*	*3,880*	*1,763*	*2,744*	*2,301*	*5,600*	*4,153*	*9,351*
No events	59%	44%	31%	51%	38%	40%	50%	41%	48%	56%	58%	46%
1 to 2 events	31%	32%	35%	28%	31%	40%	31%	16%	29%	31%	32%	33%
3 to 5 events	5%	15%	24%	11%	22%	14%	14%	15%	14%	10%	7%	14%
6 to 10 events	3%	5%	7%	5%	6%	5%	4%	12%	6%	3%	2%	5%
11 to 20 events	1%	2%	2%	2%	3%	1%	0%	8%	2%	1%	0%	2%
21 event reports or more	2%	1%	0%	2%	1%	0%	0%	8%	1%	0%	0%	1%

Table B-5. Composite-level Average Percent Positive Response by Respondent Staff Position

	Staff Position								
Patient Safety Culture Composites	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharmacist	RN/LVN/LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
No. of Hospitals	*361*	*251*	*204*	*311*	*261*	*374*	*334*	*319*	*354*
No. of Respondents	*6,938*	*4,414*	*725*	*5,904*	*1,561*	*36,991*	*10,947*	*4,791*	*6,848*
1. Teamwork Within Units	85%	81%	76%	72%	80%	78%	76%	83%	76%
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	83%	69%	74%	73%	76%	73%	74%	77%	77%
3. Management Support for Patient Safety	82%	68%	73%	70%	68%	64%	69%	70%	73%
4. Org Learning--Continuous Improvement	79%	70%	68%	70%	74%	69%	67%	70%	68%
5. Overall Perceptions of Patient Safety	71%	62%	65%	58%	62%	58%	69%	70%	66%
6. Feedback & Communication About Error	72%	61%	67%	62%	64%	58%	62%	65%	65%
7. Communication Openness	73%	64%	62%	57%	72%	61%	62%	68%	59%
8. Frequency of Events Reported	64%	56%	53%	63%	52%	60%	58%	56%	63%
9. Teamwork Across Units	62%	59%	59%	59%	56%	54%	55%	62%	57%
10. Staffing	61%	55%	56%	49%	55%	57%	56%	59%	53%
11. Handoffs & Transitions	46%	42%	39%	49%	31%	47%	40%	43%	45%
12. Nonpunitive Response to Error	60%	43%	44%	33%	59%	43%	42%	49%	39%
Average Across Composites	70%	61%	61%	60%	62%	60%	61%	64%	62%

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

Item	Patient Safety Culture Composites	Staff Position								
		Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma-cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respir, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	No. of Hospitals	*361*	*251*	*204*	*311*	*261*	*374*	*334*	*319*	*354*
	No. of Respondents	*6,938*	*4,414*	*725*	*5,904*	*1,561*	*36,991*	*10,947*	*4,791*	*6,848*
1.	**Teamwork Within Units**									
A1	1. People support one another in this unit.	90%	86%	81%	77%	86%	84%	80%	87%	81%
A3	2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	91%	85%	82%	80%	85%	86%	84%	87%	82%
A4	3. In this unit, people treat each other with respect.	84%	84%	74%	68%	79%	76%	74%	84%	75%
A11	4. When one area in this unit gets really busy, others help out.	75%	69%	69%	62%	69%	66%	67%	75%	67%
2.	**Supv/Mgr Expectations & Actions Promoting Patient Safety**									
B1	1. My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures.	78%	66%	75%	70%	70%	68%	67%	71%	73%
B2	2. My supv/mgr seriously considers staff suggestions for improving patient safety.	85%	73%	76%	73%	78%	74%	74%	80%	77%
B3 R	3. Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts.	82%	65%	70%	73%	78%	73%	77%	76%	78%
B4 R	4. My supv/mgr overlooks patient safety problems that happen over and over.	83%	70%	73%	75%	77%	75%	76%	78%	78%
3.	**Mgmt Support for Patient Safety**									
F1	1. Hospital mgmt provides a work climate that promotes patient safety.	89%	78%	83%	80%	72%	73%	80%	81%	83%
F8	2. The actions of hospital mgmt show that patient safety is a top priority.	82%	69%	76%	74%	69%	63%	71%	71%	74%
F9 R	3. Hospital mgmt seems interested in patient safety only after an adverse event happens.	74%	58%	59%	57%	61%	54%	58%	59%	61%

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

Item	Patient Safety Culture Composites	Staff Position								
		Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma-cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respir, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	No. of Hospitals	*361*	*251*	*204*	*311*	*261*	*374*	*334*	*319*	*354*
	No. of Respondents	*6,938*	*4,414*	*725*	*5,904*	*1,561*	*36,991*	*10,947*	*4,791*	*6,848*
4.	**Organizational Learning— Continuous Improvement**									
A6	1. We are actively doing things to improve patient safety.	85%	78%	79%	82%	86%	81%	77%	82%	78%
A9	2. Mistakes have led to positive changes here.	79%	65%	62%	57%	72%	59%	61%	59%	59%
A13	3. After we make changes to improve patient safety, we evaluate their effectiveness.	74%	68%	64%	71%	62%	66%	63%	69%	67%
5.	**Overall Perceptions of Patient Safety**									
A10 R	1. It is just by chance that more serious mistakes don't happen around here.	71%	64%	60%	50%	63%	58%	62%	67%	58%
A15	2. Patient safety is never sacrificed to get more work done.	70%	61%	67%	63%	58%	55%	70%	69%	70%
A17 R	3. We have patient safety problems in this unit.	69%	59%	62%	55%	58%	56%	70%	70%	67%
A18	4. Our procedures and systems are good at preventing errors from happening.	75%	65%	69%	65%	70%	64%	73%	75%	69%
6.	**Feedback and Communication About Error**									
C1	1. We are given feedback about changes put into place based on event reports.	62%	52%	61%	53%	51%	50%	49%	55%	55%
C3	2. We are informed about errors that happen in this unit.	75%	62%	66%	65%	69%	58%	68%	66%	70%
C5	3. In this unit, we discuss ways to prevent errors from happening again.	80%	67%	72%	68%	73%	66%	69%	74%	71%

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

Item	Patient Safety Culture Composites	Staff Position								
		Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma-cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respir, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	No. of Hospitals	*361*	*251*	*204*	*311*	*261*	*374*	*334*	*319*	*354*
	No. of Respondents	*6,938*	*4,414*	*725*	*5,904*	*1,561*	*36,991*	*10,947*	*4,791*	*6,848*
7.	**Communication Openness**									
C2	1. Staff will freely speak up if they see something that may negatively affect patient care.	82%	74%	74%	75%	79%	75%	76%	80%	74%
C4	2. Staff feel free to question the decisions or actions of those with more authority.	65%	57%	53%	39%	62%	45%	45%	54%	41%
C6 R	3. Staff are afraid to ask questions when something does not seem right.	71%	62%	60%	56%	74%	62%	65%	70%	60%
8.	**Frequency of Events Reported**									
D1	1. When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?	56%	48%	47%	60%	34%	46%	48%	49%	57%
D2	2. When a mistake is made, but has no potential to harm the patient, how often is this reported?	59%	51%	46%	57%	50%	58%	51%	50%	57%
D3	3. When a mistake is made that could harm the patient, but does not, how often is this reported?	76%	69%	66%	71%	72%	76%	73%	70%	74%
9.	**Teamwork Across Units**									
F2 R	1. Hospital units do not coordinate well with each other.	51%	46%	49%	48%	44%	41%	43%	49%	45%
F4	2. There is good cooperation among hospital units that need to work together.	64%	61%	58%	59%	57%	54%	57%	63%	58%
F6 R	3. It is often unpleasant to work with staff from other hospital units.	61%	60%	62%	59%	61%	58%	55%	65%	55%
F10	4. Hospital units work well together to provide the best care for patients.	73%	67%	70%	71%	62%	63%	65%	70%	68%

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

		Staff Position								
Item	Patient Safety Culture Composites	Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharma- cist	RN/ LVN/ LPN	Technician (EKG, Lab, Radiology)	Therapist (Respir, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
	No. of Hospitals	*361*	*251*	*204*	*311*	*261*	*374*	*334*	*319*	*354*
	No. of Respondents	*6,938*	*4,414*	*725*	*5,904*	*1,561*	*36,991*	*10,947*	*4,791*	*6,848*
10.	**Staffing**									
A2	1. We have enough staff to handle the workload.	67%	58%	58%	43%	50%	53%	54%	54%	50%
A5 R	2. Staff in this unit work longer hours than is best for patient care.	57%	51%	53%	46%	59%	55%	54%	58%	51%
A7 R	3. We use more agency/temporary staff than is best for patient care.	68%	62%	59%	62%	66%	70%	67%	69%	60%
A14 R	4. We work in "crisis mode" trying to do too much, too quickly.	54%	51%	52%	44%	47%	47%	48%	54%	51%
11.	**Handoffs & Transitions**									
F3 R	1. Things "fall between the cracks" when transferring patients from one unit to another.	43%	41%	35%	46%	28%	43%	36%	40%	44%
F5 R	2. Important patient care information is often lost during shift changes.	48%	46%	41%	58%	34%	53%	46%	47%	50%
F7 R	3. Problems often occur in the exchange of information across hospital units.	45%	43%	41%	42%	32%	44%	37%	44%	42%
F11 R	4. Shift changes are problematic for patients in this hospital.	48%	39%	39%	51%	32%	49%	42%	42%	45%
12.	**Nonpunitive Response to Error**									
A8 R	1. Staff feel like their mistakes are held against them.	67%	49%	51%	39%	63%	50%	49%	58%	48%
A12 R	2. When an event is reported, it feels like the person is being written up, not the problem.	65%	44%	45%	34%	60%	44%	41%	49%	39%
A16 R	3. Staff worry that mistakes they make are kept in their personnel file.	49%	35%	38%	26%	53%	34%	35%	42%	31%

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

Work Area/Unit Patient Safety Grade	Staff Position: Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharmacist	RN/LVN/LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
No. of Hospitals	*361*	*251*	*204*	*311*	*261*	*374*	*334*	*319*	*354*
No. of Respondents	*6,938*	*4,414*	*725*	*5,904*	*1,561*	*36,991*	*10,947*	*4,791*	*6,848*
A Excellent	26%	23%	25%	20%	17%	17%	24%	30%	23%
B Very Good	53%	48%	43%	48%	52%	47%	50%	45%	51%
C Acceptable	18%	22%	26%	27%	23%	28%	21%	20%	23%
D Poor	2%	5%	5%	5%	6%	7%	4%	4%	3%
E Failing	1%	2%	1%	1%	1%	1%	1%	1%	1%

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

Number of Events Reported by Respondents	Staff Position: Admin/ Mgmt	Attending/ Physician/ Resident/ PA or NP	Dietician	Pat Care Asst/Aide/ Care Partner	Pharmacist	RN/LVN/LPN	Technician (EKG, Lab, Radiology)	Therapist (Respiratory, Phys, Occup, Speech)	Unit Asst/ Clerk/ Secretary
No. of Hospitals	*361*	*251*	*204*	*311*	*261*	*374*	*334*	*319*	*354*
No. of Respondents	*6,938*	*4,414*	*725*	*5,904*	*1,561*	*36,991*	*10,947*	*4,791*	*6,848*
No events	47%	61%	69%	72%	24%	28%	55%	59%	79%
1 to 2 events	23%	24%	18%	22%	20%	38%	29%	31%	16%
3 to 5 events	16%	8%	7%	5%	19%	22%	9%	7%	4%
6 to 10 events	7%	3%	3%	1%	15%	8%	4%	2%	1%
11 to 20 events	4%	3%	1%	0%	11%	3%	2%	0%	0%
21 event reports or more	2%	1%	1%	0%	10%	1%	1%	0%	0%

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

Patient Safety Culture Composites	Respondent Interaction with Patients: **WITH** direct interaction	Respondent Interaction with Patients: **WITHOUT** direct interaction
No. of Hospitals	*376*	*367*
No. of Respondents	*78,129*	*24,603*
1. Teamwork Within Units	78%	79%
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	74%	76%
3. Management Support for Patient Safety	68%	75%
4. Org Learning--Continuous Improvement	69%	70%
5. Overall Perceptions of Patient Safety	63%	65%
6. Feedback & Communication About Error	61%	65%
7. Communication Openness	61%	63%
8. Frequency of Events Reported	59%	60%
9. Teamwork Across Units	56%	57%
10. Staffing	56%	52%
11. Handoffs & Transitions	46%	38%
12. Nonpunitive Response to Error	43%	46%
Average Across Composites	61%	62%

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

Item	Survey Items By Composite	Respondent Interaction with Patients: WITH direct interaction	Respondent Interaction with Patients: WITHOUT direct interaction
	No. of Hospitals	*376*	*367*
	No. of Respondents	*78,129*	*24,603*
1.	**Teamwork Within Units**		
A1	1. People support one another in this unit.	83%	83%
A3	2. When a lot of work needs to be done quickly, we work together as a team to get the work done.	85%	86%
A4	3. In this unit, people treat each other with respect.	76%	78%
A11	4. When one area in this unit gets really busy, others help out.	67%	67%
2.	**Supervisor/Manager Expectations & Actions Promoting Patient Safety**		
B1	1. My supv/mgr says a good word when he/she sees a job done according to established patient safety procedures.	69%	73%
B2	2. My supv/mgr seriously considers staff suggestions for improving patient safety.	75%	76%
B3 R	3. Whenever pressure builds up, my supv/mgr wants us to work faster, even if it means taking shortcuts.	74%	75%
B4 R	4. My supv/mgr overlooks patient safety problems that happen over and over.	76%	76%
3.	**Management Support for Patient Safety**		
F1	1. Hospital mgmt provides a work climate that promotes patient safety.	78%	85%
F8	2. The actions of hospital mgmt show that patient safety is a top priority.	69%	77%
F9 R	3. Hospital mgmt seems interested in patient safety only after an adverse event happens.	57%	65%

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

Item	Survey Items By Composite	Respondent Interaction with Patients: WITH direct interaction	WITHOUT direct interaction
	No. of Hospitals	*376*	*367*
	No. of Respondents	*78,129*	*24,603*
4.	**Organizational Learning— Continuous Improvement**		
A6	1. We are actively doing things to improve patient safety.	81%	78%
A9	2. Mistakes have led to positive changes here.	60%	67%
A13	3. After we make changes to improve patient safety, we evaluate their effectiveness.	67%	66%
5.	**Overall Perceptions of Patient Safety**		
A10 R	1. It is just by chance that more serious mistakes don't happen around here.	60%	60%
A15	2. Patient safety is never sacrificed to get more work done.	63%	65%
A17 R	3. We have patient safety problems in this unit.	62%	64%
A18	4. Our procedures and systems are good at preventing errors from happening.	68%	70%
6.	**Feedback and Communication About Error**		
C1	1. We are given feedback about changes put into place based on event reports.	51%	54%
C3	2. We are informed about errors that happen in this unit.	64%	68%
C5	3. In this unit, we discuss ways to prevent errors from happening again.	69%	73%

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

Item	Survey Items By Composite	Respondent Interaction with Patients: WITH direct interaction	WITHOUT direct interaction
	No. of Hospitals	*376*	*367*
	No. of Respondents	*78,129*	*24,603*
7.	**Communication Openness**		
C2	1. Staff will freely speak up if they see something that may negatively affect patient care.	75%	75%
C4	2. Staff feel free to question the decisions or actions of those with more authority.	46%	50%
C6 R	3. Staff are afraid to ask questions when something does not seem right.	62%	64%
8.	**Frequency of Events Reported**		
D1	1. When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?	50%	53%
D2	2. When a mistake is made, but has no potential to harm the patient, how often is this reported?	55%	55%
D3	3. When a mistake is made that could harm the patient, but does not, how often is this reported?	73%	71%
9.	**Teamwork Across Units**		
F2 R	1. Hospital units do not coordinate well with each other.	44%	45%
F4	2. There is good cooperation among hospital units that need to work together.	57%	59%
F6 R	3. It is often unpleasant to work with staff from other hospital units.	58%	56%
F10	4. Hospital units work well together to provide the best care for patients.	66%	69%

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

Item	Survey Items By Composite	Respondent Interaction with Patients: WITH direct interaction	Respondent Interaction with Patients: WITHOUT direct interaction
	No. of Hospitals	*376*	*367*
	No. of Respondents	*78,129*	*24,603*
10.	**Staffing**		
A2	1. We have enough staff to handle the workload.	53%	57%
A5 R	2. Staff in this unit work longer hours than is best for patient care.	54%	48%
A7 R	3. We use more agency/temporary staff than is best for patient care.	67%	56%
A14 R	4. We work in “crisis mode” trying to do too much, too quickly.	49%	46%
11.	**Handoffs & Transitions**		
F3 R	1. Things “fall between the cracks” when transferring patients from one unit to another.	43%	36%
F5 R	2. Important patient care information is often lost during shift changes.	51%	41%
F7 R	3. Problems often occur in the exchange of information across hospital units.	43%	36%
F11 R	4. Shift changes are problematic for patients in this hospital.	47%	40%
12.	**Nonpunitive Response to Error**		
A8 R	1. Staff feel like their mistakes are held against them.	50%	52%
A12 R	2. When an event is reported, it feels like the person is being written up, not the problem.	43%	47%
A16 R	3. Staff worry that mistakes they make are kept in their personnel file.	35%	38%

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

	Respondent Interaction with Patients	
Work Area/Unit Patient Safety Grade	**WITH direct interaction**	**WITHOUT direct interaction**
No. of Hospitals	*376*	*367*
No. of Respondents	*78,129*	*24,603*
A Excellent	22%	24%
B Very Good	48%	50%
C Acceptable	24%	22%
D Poor	5%	3%
E Failing	1%	1%

Table B-12. Percent of Respondents Reporting Events in the Past 12 Months by Respondent Interaction With Patients

	Respondent Interaction with Patients	
Number of Events Reported by Respondents	**WITH direct interaction**	**WITHOUT direct interaction**
No. of Hospitals	*376*	*367*
No. of Respondents	*78,129*	*24,603*
No events	48%	69%
1 to 2 events	30%	17%
3 to 5 events	14%	7%
6 to 10 events	5%	4%
11 to 20 events	2%	2%
21 event reports or more	1%	2%