Patient Safety

Initial assessment by: _____ Date: _____

In consultation with: _____

_____

_____

Date of previous assessment: _____

Since the 1999 release of the Institute of Medicine report *To Err Is Human: Building a Safer Health System*, patient safety has been a major focus of government agencies, consumer groups, and professional associations. For example, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) includes patient safety standards for accredited hospitals; the Centers for Medicare & Medicaid Services uses increased reimbursement as an incentive for quality data reporting hospitals to receive; and a number of states have implemented medical-error reporting systems.

Many safety experts note that initiatives to improve patient safety in healthcare organizations should be preceded by changes in the culture of safety in order to be successful. Most general descriptions define safety culture as the collective product of individual and group values and attitudes, competencies, and patterns of behaviors in safety performance. It is, in either a positive or negative sense, "the way we do things around here." A culture of safety, in which everyone accepts responsibility for patient safety, is necessary before other patient safety practices are introduced. Otherwise, individuals expected to implement the safety initiatives are unable to effectively communicate or work together. After all, good teamwork and communication are the hallmarks of a "patient safe" environment.

A starting point for achieving an improved culture of safety is to conduct an assessment of the current culture (or climate) of the healthcare organization to determine whether and how that culture affects the provision of safe patient care. Once opportunities for improvement are identified, strategies for change can be developed and implemented. Measures should be used to determine the effectiveness of improvement efforts, and ongoing feedback should be provided to staff on the progress made toward established patient safety goals, as well as on new opportunities for improvement.

Patient safety processes include reporting, investigating, analyzing, and reducing identified issues and improving patient care processes. A clear organizational commitment to patient safety as evidenced by a dedicated infrastructure is necessary for success. Components of a patient safety infrastructure include a patient safety leader, a dedicated patient safety committee, a patient safety/event reporting system, an improvement implementation scheme, and formal patient safety education and training programs.

This Self-Assessment Questionnaire (SAQ)* is designed to help healthcare facilities assess their organizations' patient safety programs, practices, and culture. It is broader in scope than specific hospital patient safety culture survey tools, like the one made available by the Agency for Healthcare Research and Quality,

* Some of the material in this SAQ has been excerpted from the November 2005 Risk Analysis "Culture of Safety" under the *Risk and Quality Management Strategies* tab in your *Healthcare Risk Control System* binder.

(continued)

which measures specific organizational conditions that affect patient safety and safety attitudes of staff members. Because great variability can exist between patient care units within an individual facility as well as among hospitals in general, the *Healthcare Risk Control System* recommends that facilities use this SAQ to conduct both unit-based and hospitalwide assessments annually. The following resources were considered in the development of this SAQ:

- Agency for Healthcare Research and Quality
  - —Hospital Survey on Patient Safety Culture (http://www.ahrq.gov/qual/hospculture)
- American Hospital Association Health Research and Educational Trust
  - —Patient Safety Leadership WalkRounds™ (http://www.hret.org/hret/programs/walkrounds.html)
  - —Safety Attitudes Questionnaire (http://www.hret.org/hret/programs/saq.html)
- American Society for Healthcare Risk Management
  - —Monograph: Disclosure, Parts I, II, III (http://www.ashrm.org/ashrm/resources/monograph.html)
  - —White Paper: Strategies and Tips for Maximizing Failure Mode & Effect Analysis in Your Organization (http://www.ashrm.org/ashrm/resources/files/FMEAwhitepaper.pdf)
  - —Youngberg BJ. Assessing your organization's potential to become a high reliability organization. *J Healthc Risk Manag* 2004;24(3):13-9.
- Delaware Valley Healthcare Council/Regional Medication Safety Program for Hospitals
  - —Measuring the Success of the Regional Medication Safety Program for Hospitals (http://www.ecri.org/products_and_services/products/medication_safety/rmsph.pdf)
- Institute for Healthcare Improvement
  - —Safety Climate Survey (http://www.ihi.org/ihi/topics/patientsafety/safetygeneral/tools/safety+climate+survey+%28ihi+tool%29.htm)
- Johns Hopkins Center for Innovation in Quality Patient Care (http://www.hopkinsquality.com)
  - —The Patient Safety Group (with the Josie King Foundation and Johns Hopkins Medicine) (http://www.patientsafetygroup.org/about/about.cfm)
- Joint Commission on Accreditation of Healthcare Organizations
  - —2005 accreditation standards. In: *Comprehensive accreditation manual for hospitals.* Oakbrook Terrace (IL): Joint Commission Resources.
  - —National Patient Safety Goals
  - —Patient Safety Event Taxonomy (PSET)
- Premier, Inc.
  - —A Framework for Safety Culture and Reporting: Summary—Part II (http://www.premierinc.com/all/safety/resources/patient_safety/index_2.jsp)
- University of Texas Center for Excellence in Patient Safety Research and Practice
  - —Safety Attitudes Questionnaires, Safety Climate Survey, User's Guide and Tools (http://www.uth.tmc.edu/schools/med/imed/patient_safety/survey&tools.htm)

	YES	NO	N/I*	N/A	COMMENTS
Safety Culture					
1. Has a safety culture survey been conducted?	☐	☐	☐	☐	
a. If no, are there plans to conduct a safety culture survey?	☐	☐	☐	☐	
b. If yes, was the reliability of the selected safety culture survey tool validated to be high (e.g., Cronbach's alpha** equal to or greater than 0.60) prior to use? (See the sample safety climate survey tool reprinted in the Appendix to the Risk Analysis "Culture of Safety" found elsewhere in the *HRC System*.)	☐	☐	☐	☐	
c. Have the results of the safety culture survey been reviewed by senior leaders?	☐	☐	☐	☐	
d. Are there plans to periodically resurvey the safety culture?	☐	☐	☐	☐	
2. Is the survey tool designed to measure the following dimensions of safety culture:					
a. overall perceptions of patient safety?	☐	☐	☐	☐	
b. organizational learning and improvement?	☐	☐	☐	☐	
c. teamwork and communication?	☐	☐	☐	☐	
d. nonpunitive reporting?	☐	☐	☐	☐	
e. management support for patient safety?	☐	☐	☐	☐	
3. Does the survey tool include Likert scale equivalent (e.g., strongly disagree, disagree, neutral, agree, strongly agree) in its question-answer format?	☐	☐	☐	☐	

* Needs improvement

** Cronbach's alpha assesses the reliability of a rating summarizing a group of test or survey answers which measure some underlying factor (e.g., some attribute of the test-taker). A score is computed from each test item and the overall rating, called a "scale," is defined by the sum of these scores over all the test items. Reliability is defined to be the square of the correlation between the measured scale and the underlying factor the scale was supposed to measure. (About.com. Definition of Cronbach's alpha [online]. [cited 2005 Aug 11]. Available from Internet: http://economics.about.com/cs/economicsglossary/g/cronbachalpha.htm.)

(continued)

	YES	NO	N/I*	N/A	COMMENTS
4. Does the survey tool probe staff perceptions of patient safety by including questions such as the following:					
a. management's promotion of a work climate that is supportive of patient safety?	☐	☐	☐	☐	_____
b. the organization's/unit's valuing of patient safety over production or efficiency?	☐	☐	☐	☐	_____
c. staff members' comfort with speaking up, even to a superior, when they have concerns about patient safety?	☐	☐	☐	☐	_____
d. staff members' understanding that adverse events are due to defective systems and not just to one person's actions?	☐	☐	☐	☐	_____
e. frontline staff members' belief that physician and nurse leaders listen to and act on patient safety concerns?	☐	☐	☐	☐	_____
f. staff members' fear of reporting mistakes and errors due to fear of retribution?	☐	☐	☐	☐	_____
g. staff members' belief that their peers encourage reporting of patient safety concerns and errors?	☐	☐	☐	☐	_____
h. staff members' belief that medical errors are handled the right way in the hospital?	☐	☐	☐	☐	_____
i. staff members' perception that patients and families are appropriately informed of adverse outcomes and errors when they occur?	☐	☐	☐	☐	_____
j. staff members' belief that hospital leaders have communicated a clear vision of patient safety to them?	☐	☐	☐	☐	_____
k. staff members' belief that their suggestions to improve patient safety will be considered?	☐	☐	☐	☐	_____

	YES	NO	N/I*	N/A	COMMENTS
l. staff members' belief that they are informed of errors that occur in their work areas?	☐	☐	☐	☐	
m. staff members' discussion of how to prevent errors from happening again?	☐	☐	☐	☐	
n. staff members' perception that the hospital environment allows learning from mistakes?	☐	☐	☐	☐	
o. staff members' perception that communication among and between physicians and staff members is of high quality?	☐	☐	☐	☐	
p. staff members' belief that they know how to work as teams?	☐	☐	☐	☐	
q. staff members' perception that everyone takes responsibility for patient safety?	☐	☐	☐	☐	
r. staff members' acknowledgment that management frequently reinforces patient safety as a priority?	☐	☐	☐	☐	
s. staff members' perception that feedback is given about plans to improve or changes made as a result of patient safety/event reporting?	☐	☐	☐	☐	
t. staff members' perception that work rules, policies, or procedures are often disregarded?	☐	☐	☐	☐	

Leadership

5. Is the organization's commitment to patient safety reflected in the mission statement or other board-approved statement?	☐	☐	☐	☐	
6. Are specific strategies (e.g., patient safety rounds, hospital newsletter articles, provision of patient safety resource materials) used to communicate and reinforce leadership's commitment to and ongoing support of patient safety?	☐	☐	☐	☐	

(continued)

		YES	NO	N/I*	N/A	COMMENTS
7.	Have the board and the organization's senior leaders received specific patient safety education?	☐	☐	☐	☐	
8.	Has the medical staff been given specific patient safety education?	☐	☐	☐	☐	
9.	Are practicing physicians involved in patient safety activities (e.g., risk and safety programs, standard development, clinical guideline development)?	☐	☐	☐	☐	
10.	Is there a facilitywide patient safety program and plan that has been reviewed and approved by senior management, the medical staff executive committee, and the board?	☐	☐	☐	☐	
11.	Does the plan delineate administrative and clinical responsibilities for ensuring that patient safety goals and objectives are achieved?	☐	☐	☐	☐	
12.	Does the plan address the establishment of performance measures by which progress toward patient safety goals and objectives are gauged?	☐	☐	☐	☐	
13.	Is there ongoing follow-up of performance measures to ensure that improvement is sustained?	☐	☐	☐	☐	
14.	Is there consensus across the organization on what *should not* go wrong?	☐	☐	☐	☐	
15.	Is there consensus across the organization on what *could* go wrong?	☐	☐	☐	☐	
16.	Is there a designated patient safety leader (e.g., a patient safety officer)?	☐	☐	☐	☐	
17.	Is there a patient safety committee?	☐	☐	☐	☐	
18.	Has the organization considered or adopted any of the following to improve patient safety:					
	a. care bundles?*	☐	☐	☐	☐	
	b. patient safety rounds?	☐	☐	☐	☐	

* Care bundles are defined as groupings of evidence-based clinical interventions to improve patient safety. For example, the central line bundle has been effective in significantly reducing (and in some cases eliminating) the incidence of infections associated with intravascular catheters. For more information on the central line bundle, see the Risk Analysis "Invasive Lines" in the *Critical Care* section of your *HRC System*.

	YES	NO	N/I*	N/A	COMMENTS
c. care teams (e.g., teams including a pharmacist/respiratory therapist on patient care rounds)?	☐	☐	☐	☐	
d. checklists?	☐	☐	☐	☐	
e. specific communication techniques (e.g., preprocedural briefings; situational debriefings; Situation, Background, Assessment, Recommendation [SBAR**])?	☐	☐	☐	☐	
f. time-outs before invasive procedures?	☐	☐	☐	☐	
g. simplification of medication processes (e.g., reduce/eliminate look-alike, sound-alike drugs)	☐	☐	☐	☐	
h. standardized abbreviations	☐	☐	☐	☐	
i. standardized emergency protocols/response procedures (when feasible)	☐	☐	☐	☐	
j. standardized equipment setups, displays, supply carts, etc.	☐	☐	☐	☐	
19. Does strategic planning include a patient safety focus?	☐	☐	☐	☐	
20. Are resources (human and monetary) specifically allocated for patient safety initiatives such as patient safety education, data collection and analysis, and technology and equipment?	☐	☐	☐	☐	
21. Are patient safety reports (e.g., reports of sentinel events and near misses, recommendations for improvement, progress reports and updates) reviewed by the governing board on a regular basis?	☐	☐	☐	☐	
a. Is the board kept informed of unresolved facility regulatory or accreditation issues?	☐	☐	☐	☐	

** SBAR is a succinct patient safety communication method in which caregivers define the problem, give a brief overview, summarize their opinion, and state their recommendation(s) for intervention. For more information on SBAR, see "Teamwork Takes Hold to Improve Patient Safety" in the February 2005 issue of the *Risk Management Reporter*.

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	YES	NO	N/I*	N/A	COMMENTS
b. Is the board kept informed of longstanding patient safety issues?	☐	☐	☐	☐	
c. Are internal benchmarks (e.g., medication error rates, ventilator-associated pneumonia rates) and, if available, external benchmarks (e.g., mortality rates, nosocomial infection rates) used to gauge progress made in patient safety improvements?	☐	☐	☐	☐	
22. Do all performance appraisals of staff (including administrators at all levels, professional staff, and other employees as appropriate) have a component on patient safety?	☐	☐	☐	☐	
a. Is there a reward and recognition program for innovation in patient safety?	☐	☐	☐	☐	
b. Are personnel work schedules and provider assignments made in consideration of the effect of workload, staffing levels, and work hours on patient safety?	☐	☐	☐	☐	
23. Is there a means of making patients and families aware of their responsibilities in ensuring their own safety while in the facility?	☐	☐	☐	☐	
24. Is there a policy on communicating outcomes of care to patients that includes disclosure of errors?	☐	☐	☐	☐	
a. Are staff members, physicians, and managers instructed on this policy?	☐	☐	☐	☐	
b. Are unanticipated outcomes communicated to patients/families and errors disclosed according to organizational policies?	☐	☐	☐	☐	
c. Is disclosure with apology and a compensation offer considered when an injury-causing error occurs?*	☐	☐	☐	☐	

* The ability to express sympathy for the occurrence of a medical error without such an expression being admissible as evidence of an admission of liability in a civil action varies from one jurisdiction to another.

	YES	NO	N/I*	N/A	COMMENTS

Patient Safety Identification and Event Reporting

25. Is there a nonpunitive (but accountable) approach to the reporting of patient safety issues, near misses, adverse events, and medical errors? ☐ ☐ ☐ ☐ _____

    a. Is there a rewards and/or recognition program for timely reporting of patient safety issues, near misses, adverse events, and medical errors? ☐ ☐ ☐ ☐ _____

    b. Is there an employee/provider assistance program that assists individuals in coping with the emotional aspects of being involved in an adverse event or medical error? ☐ ☐ ☐ ☐ _____

26. Does the patient safety/event reporting system allow for ease of reporting throughout the organization? ☐ ☐ ☐ ☐ _____

27. Does the report form (paper or electronic) include classifications or categories of situations/events (e.g., type of event [communication, patient management], location, personnel involved, patient demographics, degree of injury) to allow distinctions among key variables affecting patient safety and to promote comparisons of data from external systems?** ☐ ☐ ☐ ☐ _____

28. Does the report form allow for a descriptive narrative of the event? ☐ ☐ ☐ ☐ _____

29. Are aggregate reports analyzed for trends? ☐ ☐ ☐ ☐ _____

30. Are aggregate patient safety/event report data and trending information used to evaluate systems and processes at the department and unit levels? ☐ ☐ ☐ ☐ _____

31. Are the results of this evaluation incorporated into department- and unit-based patient safety plans? ☐ ☐ ☐ ☐ _____

** In 2005, the National Quality Forum endorsed the Patient Safety Event Taxonomy developed by JCAHO to enable interoperability of reporting systems and comparability of error and event information across systems and over time. The taxonomy is available at http://www.qualityforum.org/news/prtaxonomy08-03-05.pdf.

(continued)

		YES	NO	N/I*	N/A	COMMENTS
32.	Are voluntary reports of events made to external organizations (e.g., ECRI, the Institute for Safe Medication Practices, the U.S. Pharmacopeia, a voluntary state reporting system, a specialty reporting system such as the Intensive Care Unit Safety Reporting System)?	☐	☐	☐	☐	
33.	When a potential patient safety issue is identified, is there a process in place to further evaluate the issue, such as a proactive risk assessment?	☐	☐	☐	☐	
34.	Is there an established patient safety improvement and implementation scheme to address identified patient safety issues (e.g., by planning, implementing, and measuring change)?	☐	☐	☐	☐	
	a. Is there periodic feedback to staff on strategies to address reported patient safety concerns?	☐	☐	☐	☐	
	b. Does the organization assess at least one high-risk process annually?	☐	☐	☐	☐	
	c. If yes, and if the assessment reveals failures in a critical process, is the process redesigned and evaluated for effectiveness?	☐	☐	☐	☐	
35.	Does the event reporting policy provide for learning from system failures and identifying contributing causes of adverse events, near misses, and errors?	☐	☐	☐	☐	

Education

36.	Is patient safety education provided to all staff members, physicians, and managers?	☐	☐	☐	☐	
37.	Is a patient safety component included in all new employee/new medical staff member orientation programs?	☐	☐	☐	☐	
	a. Do all staff members, physicians, and managers receive specific education in teamwork and communication techniques?	☐	☐	☐	☐	

	YES	NO	N/I*	N/A	COMMENTS
b. Do all staff members, physicians, and managers receive specific training in procedures to identify and report patient safety concerns, adverse events, near misses, and errors?	☐	☐	☐	☐	
38. Are patient safety concerns/system defects and their resolutions shared among departments and units to promote learning in the organization?	☐	☐	☐	☐	
a. Do all departments and patient care units incorporate what was learned from adverse events, near misses, and errors in department- and unit-level training programs?	☐	☐	☐	☐	
39. When functions cross department lines, do staff in those departments participate in interdisciplinary training programs?	☐	☐	☐	☐	
40. Do staff participate in professional or clinical training programs that use simulation (e.g., simulation of handling high-risk/low-frequency situations, simulation of using new equipment)?	☐	☐	☐	☐	

Environment and Technology

41. When the organization plans to remodel or replace an existing facility or build a new facility, are the following included in patient safety considerations:					
a. whether staff levels are adequate (qualitatively and quantitatively) to meet new patient capacities?	☐	☐	☐	☐	
b. whether the physical environment is conducive to patient safety—especially if designed for high-risk patients or high-risk procedures (e.g., in surgical, emergency, or critical care facilities)?	☐	☐	☐	☐	
42. To the extent possible, are equipment and technology standardized throughout the organization?	☐	☐	☐	☐	

(continued)

		YES	NO	N/I*	N/A	COMMENTS
43.	Are new medical devices and equipment assessed from a patient safety perspective prior to acquisition? (For example, if new clinical skills are needed, does the organization state how training/credentialing will be accomplished, whether hazard/problem/recall and device-related event databases were searched for information on the new device, and whether there are any special cleaning/disinfecting/sterilizing requirements?)	☐	☐	☐	☐	_____
44.	Are new systems and technology (e.g., information systems, electronic records, computerized provider order-entry programs) assessed from a patient safety perspective prior to acquisition/implementation?	☐	☐	☐	☐	_____
45.	Are the following in place to address the introduction of new technology or equipment:					
	a. systems to anticipate new types of errors and to take steps to prevent those new errors from occurring?	☐	☐	☐	☐	_____
	b. professional teams to double-check and pilot-test vulnerable components of the system that incorporate the new technology or equipment?	☐	☐	☐	☐	_____
	c. appropriate orientation and training for all staff?	☐	☐	☐	☐	_____
	d. systems to ensure that staff remain proficient in the use of the technology or equipment?	☐	☐	☐	☐	_____
46.	Has the organization considered and/or implemented the following technologies to improve patient safety (indicate technologies not currently used but planned for acquisition/implementation in the next year):					
	a. computerized provider order entry (CPOE)?	☐	☐	☐	☐	_____
	b. electronic medical records?	☐	☐	☐	☐	_____

	YES	NO	N/I*	N/A	COMMENTS
c. electronic interface between the hospital, CPOE, pharmacy, laboratory, radiology, and other information systems?	☐	☐	☐	☐	
d. intravenous infusion pumps with built-in free-flow protection?	☐	☐	☐	☐	
e. intravenous infusion pumps with computerized dose-error-reduction systems ("smart" pumps)?	☐	☐	☐	☐	
f. bar coding at point of care/bar-coded medication administration systems?	☐	☐	☐	☐	
g. patient identification technologies and security systems?	☐	☐	☐	☐	
h. radio-frequency identification technology?	☐	☐	☐	☐	

Corrective Action Form

Patient Safety

Assessment Completed By:_____ Date: _____

QUESTION NO.	ACTION REQUIRED	RESPONSIBILITY	TARGET DATE	ACTION COMPLETED	
				DATE	INITIALS

QUESTION NO.	ACTION REQUIRED	RESPONSIBILITY	TARGET DATE	ACTION COMPLETED	
				DATE	INITIALS

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