

Example - Culture of Safety Survey

Regulators and accreditors (CMS, CARF, JC, etc.) increasingly examine the behaviors and systems that reflect safety culture, not just written policies. Conducting a periodic safety culture survey and, more importantly, acting visibly on the results reinforces both your Culture of Safety Plan and your leadership credibility.

Explanation

- An "event" is defined as any type of error, mistake, incident, accident, or deviation, regardless of whether or not it results in patient harm.
- "Patient safety" is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery.
- If you do not wish to answer a question, or if a question does not apply to you, you may leave your answer blank.

What is your primary department/unit? _____ In this survey, your department/unit is the place where you spend most of your work time or provide most of your clinical services.

Please indicate your level of agreement or disagreement with the following statements about your department/unit. Mark your answer by filling in the circle.

Think about your department/unit...	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
1. People support one another in my department/unit.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. We have enough staff to handle the workload.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. When a lot of work needs to be done quickly, we work together as a team to get the work done.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. In my department/unit, people treat each other with respect.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Staff in my department/unit work longer hours than is best for patient care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. We are actively doing things to improve patient safety.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Staff feel like their mistakes are held against them.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. Mistakes have led to positive changes here.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. It is just by chance that more serious mistakes don't happen around here.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. When one area in my department/unit gets really busy, others help out.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. When an event is reported, it feels like the person is being written up, not the problem.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>