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AHRQ Releases Hospital Survey on Patient Safety Culture Results

By Jessica Grogan, MDNews.com | May 02, 2011

The Agency for Healthcare Research and Quality (AHRQ) recently released results from the Hospital Survey on Patient Safety Culture: 2011 User Comparative Database Report.

AHRQ released its first Hospital Survey on Patient Safety Culture in 2004 as a way for hospitals to evaluate how well they had established a culture of safety in their institutions. Since that time, hundreds of hospitals worldwide have participated in the survey.

The survey includes 42 items measuring 12 patient safety culture areas, including communication openness, frequency of events reported and unit teamwork.

The AHRQ developed a database in 2006 for hospitals interested in comparing their survey results to other hospitals in order to establish, improve and maintain a culture of patient safety in their institutions. Comparative database reports were produced in 2007, 2008, 2009 and 2010, and will be produced yearly through at least 2012.

The 2011 report is based on data collected from 1,032 hospitals. On average, the hospital response rate was 52%, with roughly 450 completed surveys per hospital.

The three areas of strength for most hospitals were:

- **Teamwork within units** - The extent to which staff support each other, treat each other with respect and work as a team. (Average: 80% positive response)
- **Supervisor/manager expectations & actions promoting patient safety** - The extent to which supervisors/managers consider staff suggestions for improving patient safety, praise staff for following patient safety procedures and do not overlook patient safety problems. (Average: 75% positive response)
- **Patient safety grade** - 75% of respondents gave their work area or unit a grade of either "A-Excellent" (29%) or "B-Very Good" (46%) on patient safety.

The following three areas showed the most potential for improvement:

- **Nonpunitive response to error** - The extent to which staff feel that their mistakes and event reports are not held against them and that mistakes are not kept in their personnel file. (Average: 44% positive response)
- Handoffs and transitions - The extent to which important patient care information is transferred across hospital units and during shift changes. (Average: 45% positive response)
- **Number of events reported** - 54% of respondents reported no events in their hospital over the past 12 months. It is likely that events were underreported.

For more information and to view the entire report, visit the AHRQ website.
http://www.ahrq.gov/qual/hospsurvey11/