



Methodology development and impact assessment in patient safety education for improving effectiveness

Survey on patient safety in the hospital

Dear Sir/Madam,

we would like to ask your kind help to fill out the following questionnaire about patients- and workers safety in the hospital. The research is expanded to all employees of each institution participating in the project "Methodology Development and Impact Assessment for Increasing the Impact of Patient Safety Education". The questionnaire survey consists of two parts, and takes approximately 15 minutes to complete it fully. The anonymity of respondents is preserved and responses are handled confidentially: completed questionnaires are sent directly to the research team and they feedback only the aggregated results of the survey to the concerned institution.

name of your department or research group name of your institution More information: your name, e-mail, postal address

Handover knowledge questionnaire

Instructions

This section of the survey evaluates the current knowledge about the handover process in your institution. Please mark the question option you choose with an X mark. If you can not answer the question with certainty, select "I do not know the answer". The results will give us feedback about the effectiveness of the handover training held in the framework of the project later.

fra	mework of the project later.	
1.	Mark the correct definition of handover! Pl	lease, <u>choose only one answer.</u>
	care for a patient or group of patients	wards, institutions or progressivity levels esponsibility and accountability for the aspects of mentation related to the current state of patient(s
2.	Which cases are considered as handover? □ a) shift change □ b) transfer between units □ c) transfer between institutions with different progressivity □ d) discharge of the patient	P Please, choose only one answer. □ e) a-c answers are correct □ f) all of the answers are correct □ g) none of the answers are correct □ h) I do not know the answer
3.	What does flexible standardization mean? □ a) everybody makes/follows their own rule □ b) there are rules known and followed by □ c) single, designated person is accounta □ d) the process is adapted to the needs of □ e) I do not know the answer	les veveryone ble for the process

4.	Who can take part in the handover process? More	correct answers are possible.
	□ a) specialists	☐ f) security staff
	☐ b) residents	☐ g) patient relatives
	☐ c) nurses	☐ h) cleaning staff
	☐ d) other healthcare workers	\square i) I do not know the answer
	□ e) patients	
5.	Which existing handover tools/techniques do you More correct answers are possible.	know that improve handover safety?
	□ a) ISOBAR	
	□ b) BAROFF	
	□ c) Check-back	
	□ d) SBAR	
	☐ e) patient identification	
	☐ f) I do not know the answer	
6.	What are the results of the unsafe handover practi possible.	ce? More correct answers are
	☐ a) readmissions	
	☐ b) medication errors	
	☐ c) risk reduction	
	☐ d) diagnostic, monitoring errors	
	☐ e) reduction of patient satisfaction	
	☐ f) reduction of length of stay in hospital	
	☐ g) I do not know the answer	
7.	Which of the followings are the elements of the SE are possible.	BAR technique? More correct answers
	☐ a) recommendation	
	☐ b) medical history	
	□ c) background	
	☐ d) situation	
	□ e) assessment	
	☐ f) prescriptions	
	\square g) I do not know the answer	

Survey on Patient Safety Climate

Instructions

This survey asks for your opinions about patient safety issues, such as team work, communication, adverse events including medication errors, event reporting in your hospital.

Please mark the question option you choose with an X mark. There is only one answer option for all questions.

If you do not wish to answer a question, or if a question does not apply to you, you may leave your answer blank.

- An <u>"adverse event"</u> is defined as any type of error, mistake, incident, accident, or deviation, regardless of whether or not it results in patient harm.
- <u>"Error"</u> occurs when the activity is different from the intended one, or a bad plan is used to achieve the goal regardless of the output.
- <u>"Patient safety"</u> is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery.

SECTION A: Your Work Area/Unit

In this survey, think of your "unit" as the work area, department, or clinical area of the hospital where you spend <u>most of your work time or provide most of your clinical services</u>.

What is your primary work area or unit in this hospital? Select ONE answer.

Inpatient care unit:	
☐ a) surgery	☐ g) internal medicine (any type)
☐ b) obstetrics and gynecology	☐ h) neurology and/or stroke
☐ c) otolaryngology	□ i) pediatrics
☐ d) ophtalmology	☐ j) emergency department
☐ e) urology	☐ k) rehabilitation (any type)
☐ f) orthopedics and/or traumatology	□ ৷) psychiatry
$\hfill\square$ m) an esthesiology and/or intensive care unit	
Outpatient care unit:	
□ n) outpatient care unit, specialized in:	
Other departments/units:	
□ o) laboratory	☐ r) hospital hygiene
☐ p) pathology	□ s) pharmacy
□ q) radiology	\square v) economic or engineering field
☐ t) belongs to more units or undefined unit	
□ u) other:	

SECTION A: Your Work Area/Unit (continued)

Please indicate your agreement or disagreement with the following statements about your work area/unit.

Think about your hospital work area/unit	Strongly Disagree ▼	Disagree ▼	Neither¹ ▼	Agree ▼	Strongly Agree ▼
People support one another in this unit.	□1	□2	Пз	□4	□5
2. We have enough staff to handle the workload.	□1	□ 2	Пз	□4	□5
When a lot of work needs to be done quickly, we work together as a team to get the work done.	□1	□2	Пз	□4	□5
4. In this unit, people treat each other with respect.	□1	□2	□3	□4	□5
Staff in this unit work longer hours than is best for patient care.	□1	□2	□3	□4	□5
We are actively doing things to improve patient safety.	□1	□2	□3	□4	□5
7. We use more agency/temporary staff than is best for patient care.	□1	□2	□3	□4	□5
Staff feel like their mistakes are held against them.	□1	□2	Пз	□4	□5
9. Mistakes have led to positive changes here.	□1	□ 2	□3	□4	□5
10. It is just by chance that more serious mistakes don't happen around here.	□1	□2	□3	□4	□5
11. When one area in this unit gets really busy, others help out.	□1	□2	□3	□4	□5
12. When an event is reported, it feels like the person is being written up, not the problem.	□1	□2	□3	□4	□5
 After we make changes to improve patient safety, we evaluate their effectiveness. 	□1	□2	□3	□4	□5
14. We work in "crisis mode" trying to do too much, too quickly.	□1	□2	□3	□4	□5
15. Patient safety is never sacrificed to get more work done.	□1	□2	Пз	□4	□5
16. Staff worry that mistakes they make are kept in their personnel file.	□1	□2	Пз	□4	□5
17. We have patient safety problems in this unit.	□1	□2	Пз	□4	□5
18. Our procedures and systems are good at preventing errors from happening.	□1	□2	□3	□4	□5

¹ You can not decide if you agree with it or not.

SECTION B: Your Supervisor/Manager

Please indicate your agreement or disagreement with the following statements about your immediate supervisor/manager or person to whom you directly report.

		Strongly Disagree ▼	Disagree ▼	Neither ▼	Agree ▼	Strongly Agree
1.	My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.	□1	□ 2	□3	□4	□5
2.	My supervisor/manager seriously considers staff suggestions for improving patient safety.	□1	□ 2	□3	□4	□5
3.	Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts.	□1	□ 2	Пз	□4	□5
4.	My supervisor/manager overlooks patient safety problems that happen over and over.	□1	□ 2	Пз	□4	□5

SECTION C: Communications

How often do the following things happen in your work area/unit?

Th	ink about your hospital work area/unit…	Never ▼	Rarely ▼	Some- times ▼	Most of the time ▼	Always ▼
1.	We are given feedback about changes put into place based on event reports.	□1	□ 2	Пз	□4	□5
2.	Staff will freely speak up if they see something that may negatively affect patient care.	□1	□ 2	□3	□4	□ 5
3.	We are informed about errors that happen in this unit.	□1	□ 2	Пз	□4	□5
4.	Staff feel free to question the decisions or actions of those with more authority.	□1	□ 2	Пз	□4	□5
5.	In this unit, we discuss ways to prevent errors from happening again.	□1	□ 2	Пз	□4	□5
6.	Staff are afraid to ask questions when something does not seem right.	□1	□ 2	Пз	□4	□5

SECTION D: Patient Safety Grade

7. Problems often occur in the exchange of

8. The actions of hospital management show

9. Hospital management seems interested in patient safety only after an adverse event

10. Hospital units work well together to provide

11. Shift changes are problematic for patients in

information across hospital unit.

that patient safety is a top priority.

the best care for patients.

happens.

this hospital.

		☐ 1 Failing	2 Poor	3 Accept	table √	4 /ery good	Exc	5 ellent	
F		E: Your Hospital licate your agree	•	eement	with the fo	ollowing s	statemen	ts about	your
	Think a	bout your hos լ	oital		Strongly Disagree ▼	Disagree ▼	Neither ▼	Agree ▼	Strongly Agree ▼
		oital management ate that promotes			□1	□ 2	Пз	□4	□5
		oital units do not c other.	oordinate well wi	th	□1	□ 2	Пз	□4	□5
	_	is "fall between th ferring patients fr ner.			□1	□ 2	Пз	□4	□5
		e is good coopera that need to work		oital	□1	□2	Пз	□4	□5
		rtant patient care during shift chang		en	□1	□ 2	Пз	□4	□5
		ften unpleasant to hospital units.	work with staff	from	□1	□ 2	Пз	□4	□5
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Please give your work area/unit in this hospital an overall grade on patient safety.

SECTION F: Number of Events Reported

<u>ın</u>	<u>the past 12 months</u> , now many event r	eport	s have you filled out and submitted?
	☐ a) No event reports	□ d)	6 to 10 event reports
	☐ b) 1 to 2 event reports	□ e)	11 to 20 event reports
	☐ c) 3 to 5 event reports	□ f)	21 event reports or more
<u>SE</u>	CTION G: Background Information		
Th	is information will help in the analysis	of the	e survey results.
1.	How long have you worked in this <u>ho</u>	<u>spital</u>	?
	☐ a) less than a year	□ e)	11-15 years
	☐ b) 1-3 years	□ f)	16-20 years
	☐ c) 4-6 years	□ g)	21 years or more
	☐ d) 7-10 years		
2.	How long have you worked in your cu	urrent	hospital work area/unit?
	☐ a) less than a year	□ e)	11-15 years
	☐ b) 1-3 years	□ f)	16-20 years
	☐ c) 4-6 years	□ g)	21 years or more
	☐ d) 7-10 years		
3.	Typically, how many <u>hours per week</u>	do yo	u work in this hospital?
	☐ a) Less than 20 hours per week	□ d)	60 to 79 hours per week
	☐ b) 20 to 39 hours per week	□ e)	80 to 99 hours per week
	☐ c) 40 to 59 hours per week	□ f)	100 hours per week or more
4.	What is your staff position in this hos staff position.	spital?	? Select ONE answer that best describes you
	\square a) specialist/ specialist candidate		
	\square b) resident / starting physician		
	\square c) registred nurse (graduated)		
	☐ d) physician Assistant/Nurse Practiti	oner	
	\square e) other medical staff personnel of the	ie war	d (eg. dietitian, physiotherapist, midwife etc.)
	\square f) other nonmedical staff personnel	of the	ward (eg. medical or class administrator,
	technician, patient transporter, etc.)		
	\square g) hospital management or administ	tration	
	☐ h) other, please specify: (eg. cleaning or technician personnel)		

or contact with patients? s. patients. ssion?
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THANK YOU FOR COMPLETING THIS SURVEY!

Project ID:
Erasmus +

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