

Hospital Survey on Patient Safety Culture

A6: In this unit, staff feel like their mistakes are held against them
A7: When an event is reported in this unit, it feels like the person is being written up, not the problem
A10: When staff make errors, this unit focuses on learning rather than blaming individuals
A13: In this unit, there is a lack of support for staff involved in patient safety errors
B1: My supervisor, manager, or clinical leader seriously considers staff suggestions for improving patient safety
C4: In this unit, staff speak up if they see something that may negatively affect patient care
C5: When staff in this unit see someone with more authority doing something unsafe for patients, they speak up
C6: When staff in this unit speak up, those with more authority are open to their patient safety concerns
C7: In this unit, staff are afraid to ask questions when something does not seem right
D1: When a mistake is <u>caught and corrected before reaching the patient</u> , how often is this reported?
D2: <u>have harmed the patient, but did not</u> , how often is this reported?

Nursing Home Survey on Resident Safety Culture

A10: Staff are blamed when a resident is harmed
A12: Staff are afraid to report their mistakes
A15: Staff are treated fairly when they make mistakes
A18: Staff feel safe reporting their mistakes
B6: Staff tell someone if they see something that might harm a resident
B11: It is easy for staff to speak up about problems in this nursing home
C3: My supervisor pays attention to resident safety problems in this nursing home