



New York State  
Partnership  
for Patients



## ***Hospital Survey on Patient Safety Culture 2019 NYSPFP Report Overview***

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*A partnership of the Healthcare Association of New York State and the Greater New York Hospital Association.*

# Finding Your Report

Go to NYSPFP.org and log into the portal using your email address and NYSPFP password

Navigate to the “Data” section

Select the “Culture” initiative from the menu

Links to your report and related documentation will populate the page

The screenshot shows the NYSPFP website interface. At the top, there is a navigation bar with tabs for myNYSPFP, ABOUT, INITIATIVES, CALENDAR, DATA, and eLEARNING. A red arrow points to the DATA tab. Below the navigation bar, the page title is "NYSPFP Data Collection". Underneath, there are links for Tutorials, Measurement Strategy and File Submission, and Success Stories. The main content area displays "NYSPFP Hospital Performance Report" with links for Q1 2019 and Q4 2018 PDF Reports. A "Menu" section is visible, listing various initiatives: All, ADE, Falls, PI, VTE, CAUTI, CLABSI, ASP, Sepsis, SSI, VAE/Delirium, Culture, and SPH Readmissions. A red arrow points to the "Culture" initiative in the menu. Below the menu, the "Building Culture and Leadership" section is expanded, showing sub-sections for "Data Collection" and "Reports". Under "Data Collection", there are links for "Submit Patient and Family Engagement Assessment" and "Submit Leadership Assessment". Under "Reports", there are links for "Patient and Family Engagement" (including "Patient and Family Engagement Assessment Report"), "Leadership" (including "Leadership Assessment Report"), "Race, Ethnicity and Language (REAL) Data Report" (with links for 2018, 2017, and 2016), and "Health Care Disparities Survey Report" (with links for PDF and Excel). A red box highlights the "2019 Culture of Safety Survey" link, which includes a sub-link for "Hospital Specific Results".



# General Survey Structure

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- Patient safety culture domains
    - 3 to 4 questions for respondents to rate (scale=5)
      - Strongly agree to strongly disagree
      - Never to always
    - 1 composite
      - Average of scores for the individual questions
  - Question to grade the hospital's patient safety
  - Question to quantify the number of event reports the respondent has submitted
  - Demographic questions for respondents
  - Supplemental Questions – Value and Efficiency (optional)
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# Survey Content

Patient Safety Culture Composite	Definition: <i>The extent to which...</i>
1. Communication openness	Staff freely speak up if they see something that may negatively affect a patient and feel free to question those with more authority.
2. Feedback and communication about error	Staff are informed about errors that happen, are given feedback about changes implemented, and discuss ways to prevent errors.
3. Frequency of events reported	Mistakes of the following types are reported: (1) mistakes caught and corrected before affecting the patient, (2) mistakes with no potential to harm the patient, and (3) mistakes that could harm the patient but do not.
4. Handoffs and transitions	Important patient care information is transferred across hospital units and during shift changes.
5. Management support for patient safety	Hospital management provides a work climate that promotes patient safety and shows that patient safety is a top priority.
6. Nonpunitive response to error	Staff feel that their mistakes and event reports are not held against them and that mistakes are not kept in their personnel file.
7. Organizational learning—Continuous improvement	Mistakes have led to positive changes and changes are evaluated for effectiveness.
8. Overall perceptions of patient safety	Procedures and systems are good at preventing errors and there is a lack of patient safety problems.
9. Staffing	There are enough staff to handle the workload and work hours are appropriate to provide the best care for patients.
10. Supervisor/manager expectations and actions promoting patient safety	Supervisors/managers consider staff suggestions for improving patient safety, praise staff for following patient safety procedures, and do not overlook patient safety problems.
11. Teamwork across units	Hospital units cooperate and coordinate with one another to provide the best care for patients.
12. Teamwork within units	Staff support each other, treat each other with respect, and work together as a team.

**\*NEW\***

# 2019 AHRQ Data Redaction Guidelines

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“Breakouts of results by staff position, work area/unit, or other background characteristics. Do not report results for any background characteristic category (e.g., nurses) if there are fewer than five respondents in that category and if there are fewer than three respondents to an item in that category.”

- *AHRQ Hospital Survey on Patient Safety Culture User's Guide*

**\*NEW\***

# 2019 AHRQ Data Redaction Guidelines

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**NYSPFP Approach: Staff position and primary work area response counts have been suppressed when there are fewer than 5 responses for a work area / unit and fewer than 3 responses to a secondary survey question in order to preserve employee confidentiality.**

**Example: Work Area / Unit & Overall Safety Grade (E01) – Survey results are blinded when there are fewer than 5 respondents in a work area such as Pediatrics **and** fewer than 3 respondents to the Overall Safety Grade survey question.**



## Supplemental Survey Questions

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- Supplemental survey questions were an optional add-on to the core survey for 2018 and 2019
- Questions assess organizational priority on:
  - Efficiency
  - Waste Reduction
  - Patient Centeredness
  - Supervisor Support for Improving Efficiency and Reducing Waste, and
  - Experience with Activities to Improve Efficiency
- 2014 Pilot Study comparative statistics are available in the reports



## Calculation and Interpretation

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- Domain questions may be positively or negatively worded in the survey
    - Example of a positively worded question:
      - “Patient safety is never sacrificed to get more work done”
    - Example of a negatively worded question:
      - “We have patient safety problems in this unit”
  - In all cases, a **percent positive score** is calculated for each domain question
    - Numerator: count of all positive responses
    - Denominator: count of all responses
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## Calculation and Interpretation

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- If the question is positively worded, we count all instances of:
    - **strongly agree / agree** responses
    - **always / most of the time** responses
  - If the question is negatively worded, we count all instances of:
    - **strongly disagree / disagree** responses
    - **never / rarely** responses
  - The end result is that the interpretation for all questions and domains will always be towards **positive** achievement
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# Sections of the Excel Report

Navigate throughout the workbook via the **Table of Contents** – all report charts and tables are hyperlinked.

## Comparative Reports

- Utilizes data from previous iterations of the AHRQ Hospital COS Survey conducted as part of NYSPFP
- High-level summary comparisons only

## Annual Reports

- Utilizes data for the current year's survey
- High-level summary and detailed information available

Table of Contents

Comparison of Overall Patient Safety Statistics, 2016-2019		
Report	Description	Care/Supplemental
<a href="#">Compare Hospital Measures</a>	Compare Statistics of Overall Hospital Safety Measurements	Care
<a href="#">Compare Work Area Measures</a>	Compare Statistics of Safety Measurements for Work Area/Unit	Care
<a href="#">Compare Value and Efficiency</a>	Compare Statistics of Value and Efficiency Measurements	Supplemental
<a href="#">Compare Overall Safety Grade</a>	Overall Patient Safety Grade - All Respondents by Selected Work Area	Care

2019 AHRQ Culture of Safety Survey Report		
Report	Description	Care/Supplemental
<a href="#">Summary Hospital Measures</a>	Compare Statistics of Overall Hospital Safety Measurements	Care
<a href="#">Summary Work Area Measures</a>	Compare Statistics of Safety Measurements for Work Area/Unit	Care
<a href="#">Summary Value and Efficiency Measures</a>	Compare Statistics of Value and Efficiency	Supplemental
<a href="#">Overall Safety Grade</a>	Overall Patient Safety Grade - All Respondents by Work Area/Unit	Care
<a href="#">Number of Events Table</a>	Number of Events Reported by Work Area/Unit	Care
<a href="#">Perception of Safety</a>	Domain: Overall Perception of Safety	Care
<a href="#">Teamwork Within Unit</a>	Domain: Teamwork Within Unit	Care
<a href="#">Learning and Improvement</a>	Domain: Organizational Learning - Continuous Improvement	Care
<a href="#">Staffing</a>	Domain: Staffing	Care
<a href="#">Response to Error</a>	Domain: Non-punitive Response to Error	Care
<a href="#">Supervisors</a>	Domain: Supervisor Expectations and Actions Promoting Safety	Care
<a href="#">Communication</a>	Domain: Communication Openness	Care
<a href="#">Error Feedback</a>	Domain: Feedback and Communication About Error	Care
<a href="#">Event Reporting</a>	Domain: Frequency of Events Reported	Care
<a href="#">Hospital Management</a>	Domain: Hospital Management Support for Patient Safety	Care
<a href="#">Teamwork Across Unit</a>	Domain: Teamwork Across Hospital Unit	Care
<a href="#">Handoff and Transitions</a>	Domain: Hospital Handoffs and Transitions	Care
<a href="#">Empowerment</a>	Domain: Empowerment To Improve Efficiency	Supplemental
<a href="#">Waste Reduction</a>	Domain: Efficiency and Waste Reduction	Supplemental
<a href="#">Patient Centeredness</a>	Domain: Patient Centeredness and Efficiency	Supplemental
<a href="#">Leader Support Reducing Waste</a>	Domain: Supervisor, Manager, or Clinical Leader Support for Improving Efficiency and Reducing Waste	Supplemental
<a href="#">Experience Improving Efficiency</a>	Domain: Experience With Activities To Improve Efficiency	Supplemental
<a href="#">Efficiency Overall Rating</a>	Domain: Overall Rating	Supplemental
<a href="#">Demographic Table</a>	Respondent Demographics	Care/Supplemental
<a href="#">Data Table</a>	Patient Safety Culture Scores Compared to NYSPFP and National Benchmarks	Care/Supplemental
<a href="#">Unit-Level Table</a>	Patient Safety Culture Scores by Specific Unit	Care/Supplemental



# Historical Comparative Reports

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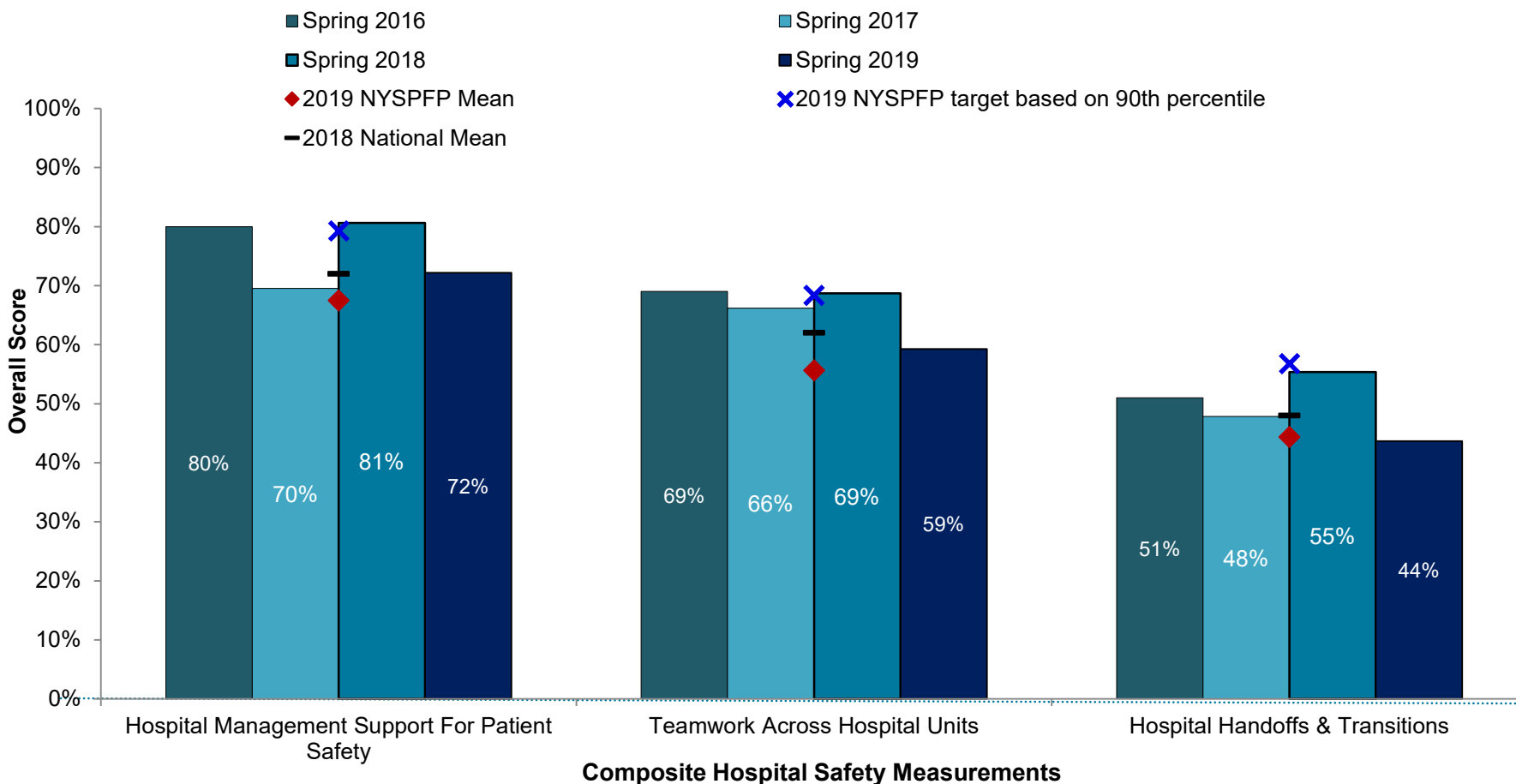
- Three main charts with historic comparative statistics from prior survey iterations:
    - **Compare Hospital Measures**
      - Domains that focus on the hospital overall
    - **Compare Work Area Measures**
      - Domains that focus on your primary work area/unit
    - **Compare Overall Safety Grade**
      - Respondent rated patient safety grade for select units
  - If your hospital participated in the survey with NYSPFP in prior years, those results were brought in
  - Other comparative statistics included for measures:
    - NYSPFP 90<sup>th</sup> Percentile, NYSPFP Mean, National Mean
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# Historical Comparative Reports

## Compare Hospital Measures

Composite Statistics of Overall Hospital Safety Measurements - Trended by Year

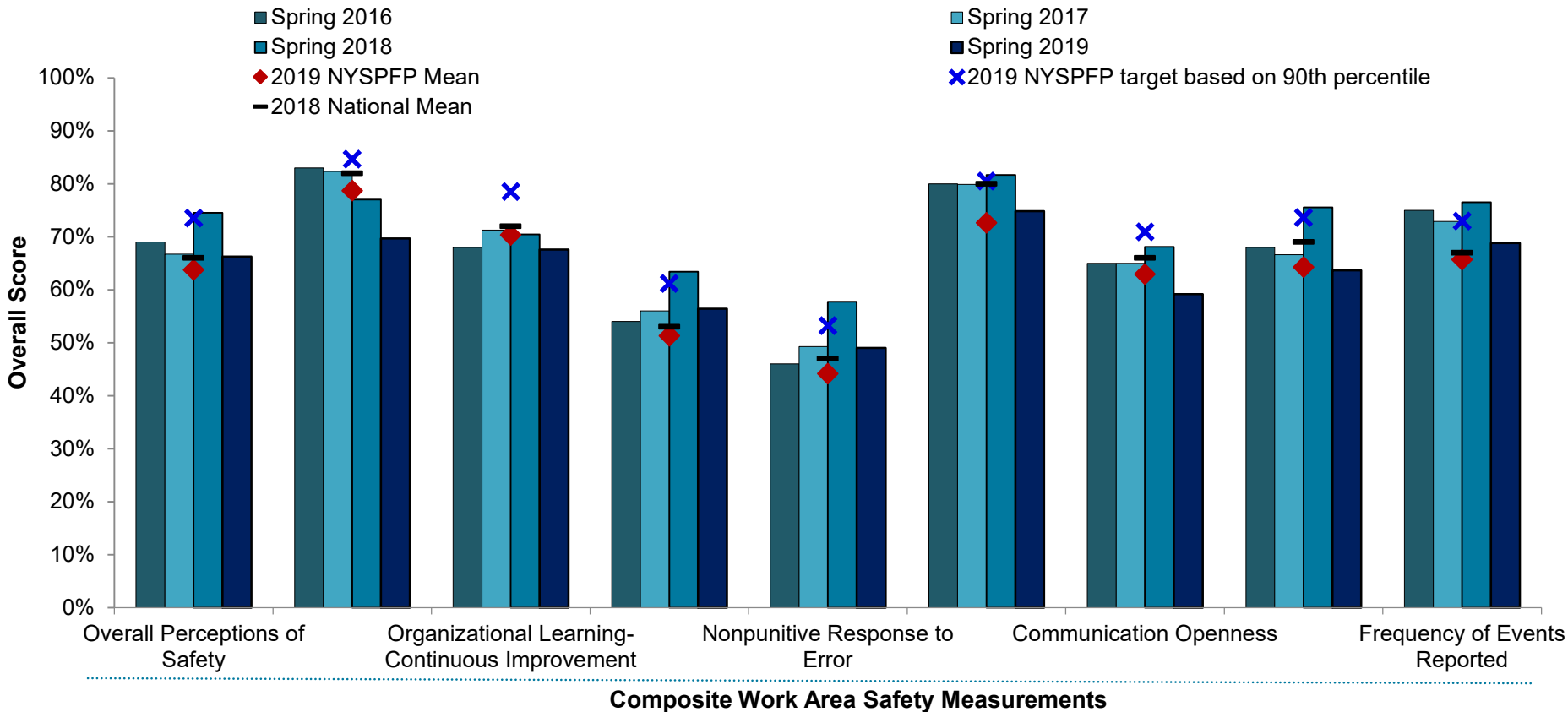




# Historical Comparative Reports

## Compare Work Area Measures

Composite Statistics of Safety Measurements for Work Areas/Units - Trended by Year

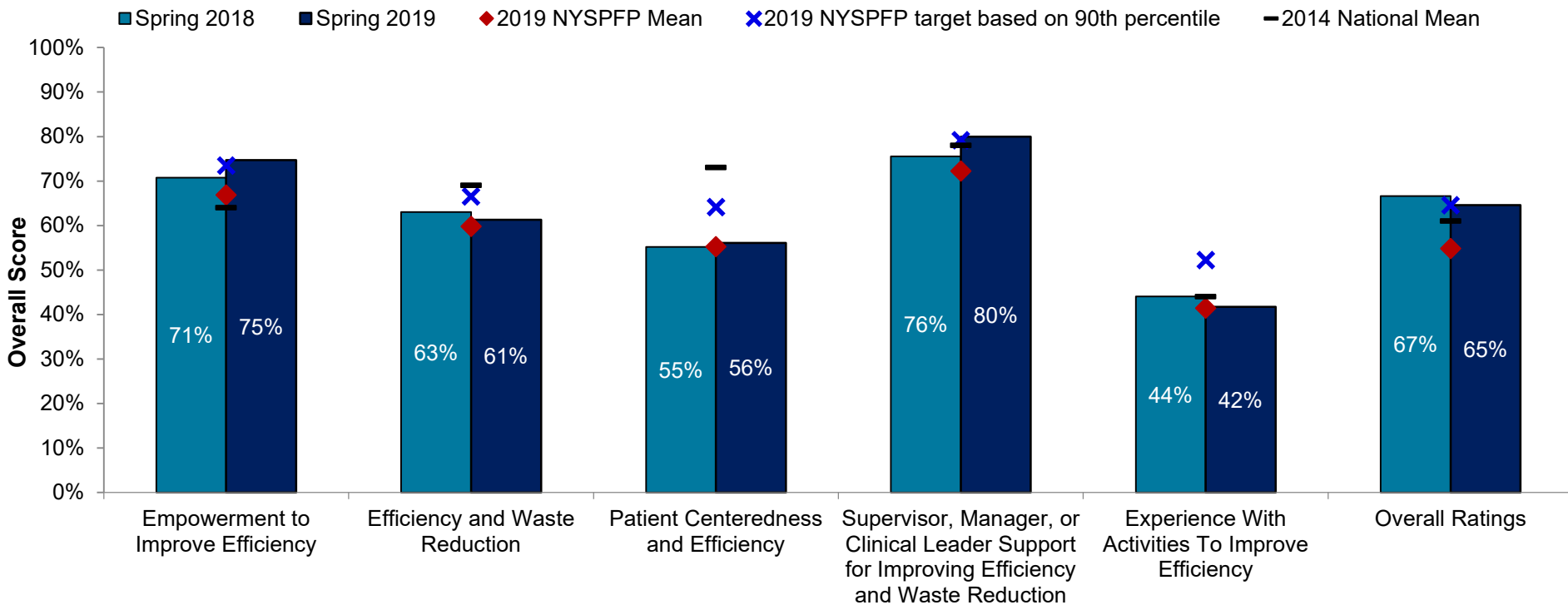




# Historical Comparative Reports

## Compare Value and Efficiency – NEW!

Composite Statistics of Value and Efficiency Measurements - Trended by Year



Composite Value and Efficiency Measurements



# Summary Reports

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- Four main charts with comparative statistics for the current year's survey only:
    - **Summary Hospital Measures**
      - Domains that focus on the hospital overall
    - **Summary Work Area Measures**
      - Domains that focus on your primary work area/unit
    - **Summary Value and Efficiency (Supplemental Survey)**
      - Domains that focus on the value and efficiency supplemental survey questions
    - **Overall Safety Grade**
      - Respondent rated patient safety grade for select units
  - Other comparative statistics included for measures:
    - NYSPFP 90th Percentile
    - NYSPFP Mean
    - National Mean
-



# Number of Events Table

- Focus on the survey item asking:
  - *In the last 12 months, how many event reports have you filled out and submitted?*
- Table displays the distribution of responses stratified by primary work area/unit

In the past 12 months, how many event reports have you filled out and submitted?	Medicine	Surgery	Obstetrics	Pediatrics	Emergency Department	Intensive Care	Psychiatry/ Mental Health	Rehabilitation	Pharmacy	Laboratory	Radiology	Anesthesiology / Operating Room	All Respondents
Number of Respondents	199	60	81	68	75	94	274	21	17	11	26	29	1510
No event reports	67%	60%	69%	53%	76%	59%	58%	67%	47%	91%	54%	62%	62%
1 to 2 event reports	27%	25%	20%	32%	20%	26%	27%	24%	29%	9%	15%	24%	20%
3 to 5 event reports	5%	12%	11%	12%	3%	9%	9%	5%	6%	0%	12%	10%	6%
6 to 10 event reports	1%	3%	0%	0%	1%	5%	4%	5%	0%	0%	12%	3%	2%
11 to 20 event reports	1%	0%	0%	3%	0%	2%	1%	0%	0%	0%	0%	0%	1%
21 event reports or more	1%	0%	0%	0%	0%	0%	0%	0%	18%	0%	8%	0%	1%





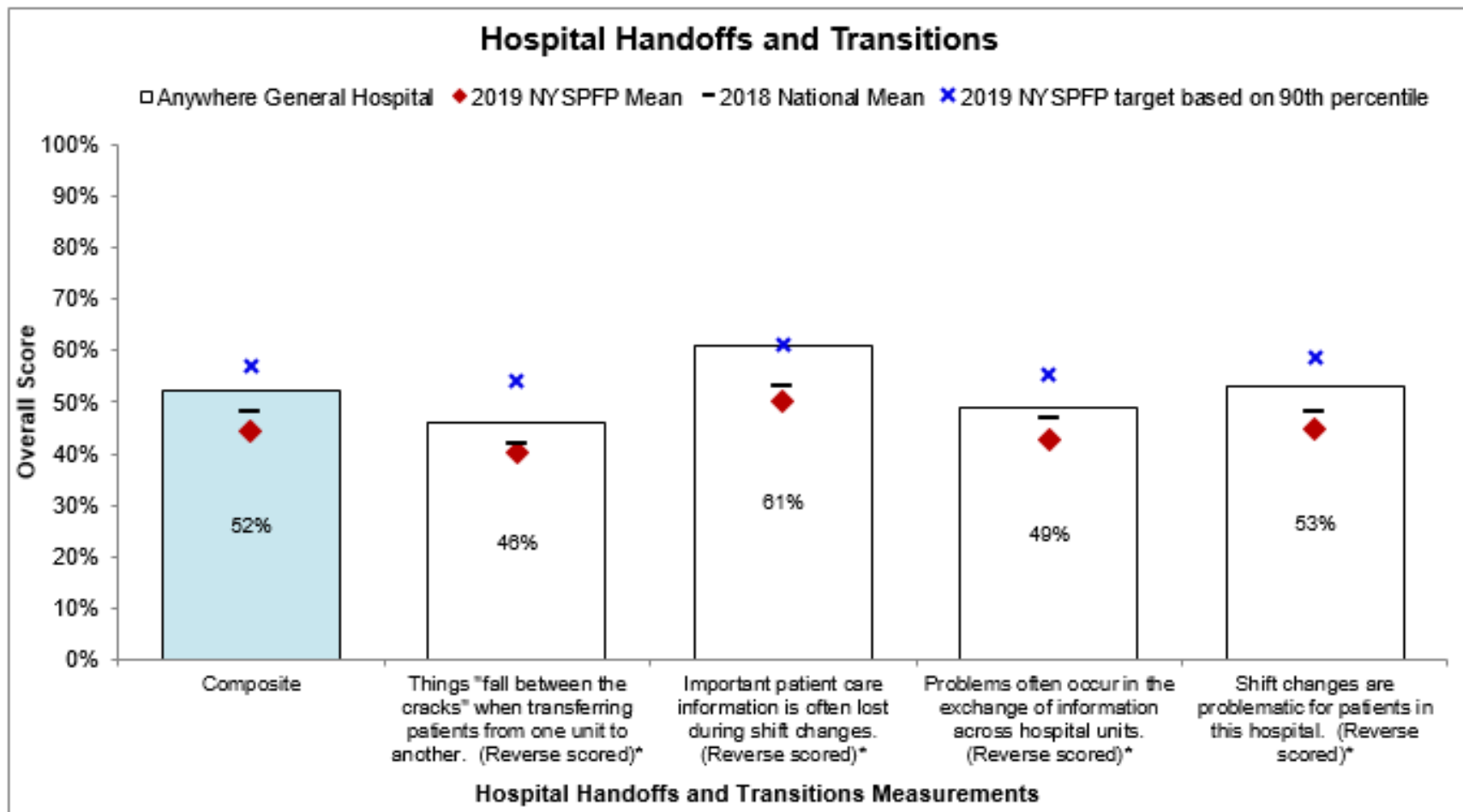
## Domain Specific Charts

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- Vertical bar charts which display the scores for a specific domain
    - Composite score
    - Individual survey item scores
    - Comparative statistics:
      - NYSPFP 90<sup>th</sup> Percentile
      - NYSPFP Mean
      - National Mean
  - Each survey domain will have it's own chart listed on a separate worksheet
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# Domain Specific Charts





## Demographics Table

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- Summarizes the demographic characteristics of participating staff.
  - Statistics provided include:
    - Frequency of response
    - Percent of total responses (your hospital distribution)
    - Percent of total responses (NYSPFP distribution)
  - Statistics from prior iterations of the survey are presented beside the current period
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# Demographics Table

Year of Survey	Spring 2016			Spring 2017			Spring 2018			Spring 2019		
	Anywhere General Hospital	NYSFPF Hospitals		Anywhere General Hospital	NYSFPF Hospitals		Anywhere General Hospital	NYSFPF Hospitals		Anywhere General Hospital	NYSFPF Hospitals	
<b>Number of Respondents</b>	<b>75</b>		<b>70,605</b>	<b>318</b>		<b>32,819</b>	<b>461</b>		<b>46,643</b>	<b>435</b>		<b>46,513</b>
	<b>Number of responses</b>	<b>% of total responses</b>	<b>% of total responses</b>	<b>Number of responses</b>	<b>% of total responses</b>	<b>% of total responses</b>	<b>Number of responses</b>	<b>% of total responses</b>	<b>% of total responses</b>	<b>Number of responses</b>	<b>% of total responses</b>	<b>% of total responses</b>
<b>Number of years worked in this hospital?</b>												
Less than 1 year	29	39%	10%	33	10%	10%	55	12%	9%	40	9%	10%
1 to 5 years	44	58%	25%	88	28%	28%	138	30%	28%	140	32%	28%
6 to 10 years	0	0%	18%	61	19%	18%	68	15%	16%	86	20%	14%
11 to 15 years	1	1%	12%	43	14%	13%	55	12%	13%	52	12%	12%
16 to 20 years	0	0%	8%	22	7%	9%	34	7%	10%	41	9%	9%
21 years or more	0	0%	15%	46	14%	18%	79	17%	15%	43	10%	13%
<b>Number of years worked in this current hospital work area/unit?</b>												
Less than 1 year	30	40%	14%	41	13%	14%	81	18%	13%	43	10%	13%
1 to 5 years	44	58%	34%	104	33%	35%	153	33%	36%	171	39%	34%
6 to 10 years	0	0%	18%	56	18%	18%	61	13%	16%	78	18%	14%
11 to 15 years	0	0%	11%	41	13%	12%	46	10%	11%	43	10%	10%
16 to 20 years	0	0%	6%	22	7%	8%	36	8%	8%	39	9%	7%
21 years or more	0	0%	9%	28	9%	9%	51	11%	9%	26	6%	8%



Demographic questions asked of survey participants



Statistics provided for each iteration of the survey



## Data Table

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- Individual survey items are organized by patient safety culture domains
  - Previous scores from prior iterations of the survey are presented beside the current period
    - Listed as Spring 2016, Spring 2017, and Spring 2018
  - Comparative information included:
    - NYSPFP Distribution
    - NYSPFP Mean
    - National Mean
-



# Data Table

5A. Overall Perception of Safety	Anywhere General Hospital				2019	2019	2019	2019	2019	2018
	Spring 2016	Spring 2017	Spring 2018	Spring 2019	NYSPPF 25th Percentile	NYSPPF 50th Percentile	NYSPPF 75th Percentile	NYSPPF 90th Percentile	NYSPPF Mean	National Mean
<i>Composite</i>	63%	65%	72%	71%	58%	65%	70%	74%	64%	66%
Patient safety is never sacrificed to get more work done.	64%	68%	75%	74%	60%	67%	72%	74%	65%	64%
Our procedures and systems are good at preventing errors from happening.	72%	70%	77%	77%	65%	71%	77%	82%	71%	74%
It is just by chance that more serious mistakes don't happen around here. (Reverse scored)*	55%	57%	65%	63%	48%	58%	64%	69%	57%	62%
We have patient safety problems in this unit. (Reverse scored)*	60%	63%	71%	70%	54%	62%	69%	76%	62%	65%

5B. Teamwork Within Units	Anywhere General Hospital				2019	2019	2019	2019	2019	2018
	Spring 2016	Spring 2017	Spring 2018	Spring 2019	NYSPPF 25th Percentile	NYSPPF 50th Percentile	NYSPPF 75th Percentile	NYSPPF 90th Percentile	NYSPPF Mean	National Mean
<i>Composite</i>	81%	81%	86%	81%	76%	80%	82%	85%	79%	82%
People support one another in this unit.	88%	89%	92%	86%	83%	86%	89%	91%	85%	88%
When a lot of work needs to be done quickly, we work together as a team to get the work done.	81%	87%	93%	86%	83%	86%	89%	90%	85%	87%
In this unit, people treat each other with respect.	87%	81%	87%	80%	74%	78%	81%	85%	77%	82%
When one area in this unit gets really busy, others help out.	68%	65%	71%	72%	63%	68%	72%	75%	68%	72%

5C. Organizational Learning - Continuous Improvement	Anywhere General Hospital				2019	2019	2019	2019	2019	2018
	Spring 2016	Spring 2017	Spring 2018	Spring 2019	NYSPPF 25th Percentile	NYSPPF 50th Percentile	NYSPPF 75th Percentile	NYSPPF 90th Percentile	NYSPPF Mean	National Mean
<i>Composite</i>	71%	72%	78%	77%	66%	71%	76%	79%	70%	72%
We are actively doing things to improve patient safety.	84%	83%	90%	86%	77%	81%	86%	88%	81%	84%
Mistakes have led to positive changes here.	71%	62%	71%	65%	56%	62%	65%	69%	60%	63%
After we make changes to improve patient safety, we evaluate their effectiveness.	59%	72%	73%	80%	66%	71%	77%	80%	71%	70%



Survey items organized by patient safety culture domain



Scores for the current survey and prior iterations



Comparative information: NYSPPF distribution, NYSPPF mean, Natation mean



## Unit-Level Table

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- Hospitals that participated with NYSPFP had the option to provide a specific unit list for participants to choose from
    - This report corresponds to these hospitals only!
  - The units displayed were defined by each facility and are independent from the AHRQ-defined units used in all other areas of the report
  - The table contains percent positive scores for each question and domain by this unit type
  - Survey data is displayed only for specific units with 10 or greater responses
  - Units with 10 or less responses are listed at the top of the table for your reference
-



# Unit-Level Table

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6A. Specific Unit	Unit 1	Unit 2	Unit 3	Unit 4
Number of Respondents	60	35	30	30
Unit Denominator (provided by hospital prior to survey)	-	40	44	51
Unit Response Rate	N/A	88%	68%	59%

6B. Overall Perception of Safety	Unit 1	Unit 2	Unit 3	Unit 4
<i>Composite</i>	63%	82%	61%	48%
Patient safety is never sacrificed to get more work done.	69%	90%	57%	45%
Our procedures and systems are good at preventing errors from happening.	67%	86%	73%	57%
It is just by chance that more serious mistakes don't happen around here. (Reverse scored)*	60%	69%	57%	46%
We have patient safety problems in this unit. (Reverse scored)*	57%	84%	57%	43%



Survey items  
organized by patient  
safety culture  
domain



Scores for the  
current survey by  
specific unit

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## Raw Data

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- Use for your own internal analysis
  - Fields marked with a hyphen “-” represent blank survey responses
  - Fields marked with an asterisk “\*” represent responses that have been blinded to protect the identity of the participant
    - Applies to questions where the participant is asked to identify their primary work area/unit and their staff position
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# Raw Data



New York State Partnership for Patients

**Table 6 - AHRQ Culture of Safety Survey Raw Data**

Asterisk (\*) if fewer than 5 respondents reported the same value

Hyphen (-) if no response was provided for the survey item

PFI	Primary Work Area*	Primary Work Area Other*	Name of unit as instructed by hospital*	People support one another	We have enough staff to handle the workload	When a lot of work needs to be done quickly, we work together	People treat each other with respect	Staff work longer hours than is best	We are actively doing things to improve patient safety	We use more agency staff than is best	Staff feel like their mistakes are held against them	Mistakes have led to positive changes	Is it just by chance that more serious mistakes don't happen	When one area gets really busy, others help out	When an event is reported, it feels like the person is being written up, not the problem	After we make changes to improve patient safety, we evaluate	We work in crisis mode	Patient safety never sac get more w
	Ai	Ai_o	Ai_unit	A01	A02	A03	A04	A05	A06	A07	A08	A09	A10	A11	A12	A13	A14	A1
XXXX	f	-	-	4	2	4	4	4	4	2	2	4	3	2	2	4	4	3
XXXX	b	-	-	3	1	4	4	2	4	2	2	5	3	3	2	3	4	3
XXXX	d	-	-	4	1	4	4	4	5	2	4	3	4	4	4	2	4	2
XXXX	n	-	-	4	1	4	5	3	4	3	3	1	3	4	4	3	3	2
XXXX	n	*	-	3	4	5	5	3	4	2	5	3	2	4	2	4	2	4
XXXX	j	-	-	4	4	4	2	5	5	1	2	2	1	5	2	3	2	4
XXXX	c	-	-	3	1	4	3	3	4	2	2	3	2	2	3	4	1	4
XXXX	d	-	-	5	2	5	5	3	5	3	2	4	1	5	1	4	2	4
XXXX	k	-	-	5	4	4	4	3	4	2	2	4	2	3	2	3	2	2
XXXX	n	*	-	4	2	3	3	4	1	3	3	1	5	1	3	-	-	-
XXXX	d	-	-	3	3	4	4	2	4	2	1	3	2	4	3	3	3	4
XXXX	j	-	-	5	2	4	3	3	4	3	3	4	4	2	3	4	4	3
XXXX	o	-	-	3	4	4	4	2	2	2	2	3	2	4	2	4	3	4

Navigation bar with tabs: Teamwork Across Units, Handoffs and Transitions, Demographics Table, Data Table, Raw Data (highlighted), and a search input field.

**Note: This sample uses randomized example data.**