Agency for Healthcare Research and Quality (AHRQ)
Surveys on Patient Safety Culture™ (SOPS®)
Hospital Survey Version 2.0

Background and Information for Translators

August 2023

Purpose and Use of This Document

This document provides information about AHRQ's *Hospital Survey on Patient Safety Culture Version 2.0* to assist in developing a translation that conveys the same meaning as the original U.S. English version. Many of the items are phrased in the vernacular with idiomatic use that might not be clear to those translating the SOPS Hospital Survey 2.0.

First, we present background information about the survey, including its purpose and intended target population. Next, we group the survey items according to the patient safety culture composite measures they assess and provide more information about the intended meaning of the items.

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Background on the Survey

Recognizing the need for a tool to assess the culture of patient safety in healthcare organizations, the Agency for Healthcare Research and Quality (AHRQ) developed the *Surveys on Patient Safety Culture™ (SOPS®) Hospital Survey*. In 2019, AHRQ released an updated survey, *SOPS Hospital Survey Version 2.0*.

What is "patient safety culture"? Patient safety culture is the extent to which an organization's culture supports and promotes patient safety. Patient safety culture refers to the beliefs, values, and norms shared by healthcare practitioners and other staff throughout the organization that influence their actions and behaviors. Patient safety culture can be measured by determining what is rewarded, supported, expected, and accepted in an organization as it relates to patient safety.

What title should I use on the survey? In the United States, we recommend using the title "Hospital Survey on Patient Safety" and not including the word "Culture." The reason is that in the United States, some respondents do not know what patient safety culture means; they tend to confuse the word "culture" with ethnicity and race. If you think respondents in your country understand the term "patient safety culture," you may leave the word "culture" in the title.

How can the survey be used? The hospital survey can be used to:

- Raise staff awareness about patient safety issues,
- Assess patient safety culture in a hospital,
- Identify patient safety culture strengths and areas for improvement,
- Evaluate the impact of patient safety improvement initiatives, and
- Examine trends in patient safety culture over time.

Who should complete the survey? The SOPS Hospital Survey 2.0 examines patient safety culture from provider and staff perspectives. The survey can be completed by all types of hospital staff, including nonclinical staff such as housekeeping and security, as well as clinical staff, including nurses and physicians. Hospital-based physicians or physicians in outpatient settings with hospital privileges can also be asked to respond to the survey. Overall, when considering who should complete the survey, ask yourself:

- Does this person know about day-to-day activities in this hospital?
- Does this person interact regularly with staff working in this hospital?

Can the unit/work area or staff position categories be modified? Survey users can modify or customize the units/work areas and staff position titles as needed to correspond to the site-specific terms used to refer to departments and job titles. Customized categories will provide more meaningful analysis and feedback results for each hospital or across hospitals in a health system.

Does the hospital survey focus on hospital units or on the hospital overall? The survey focuses mostly on patient safety culture at the unit level because staff are most familiar with patient safety culture at this level. The survey also has a section that asks about the hospital as a whole. A small hospital that does not have differentiated units may want to consider modifying some of the instructions or items in the survey from a focus on the "unit" to a focus on the hospital. Also, the term "unit" may be replaced by an equivalent term, such as "department," if it suits the hospital (just be sure to make this replacement everywhere it applies in the survey, including instructions and section titles).

How was the survey tested? First, we cognitively tested draft survey items with hospital providers and staff to ensure that items were easy to understand and relevant to patient safety in a hospital setting. We revised items as appropriate and pilot tested the draft survey with more than 4,300 hospital providers and staff from 25 hospitals across the United States. We analyzed the pilot data to examine the survey's psychometric properties (reliability, factor structure, etc.), with the goal of shortening the survey by including only the best performing items.

The final survey contains 40 items measuring 10 composite measures. The survey also includes questions asking for an overall rating on patient safety, questions on the number of events reported in the past 12 months, background questions, and an open-ended comments section.

Do I need permission to translate and use the survey? The SOPS Hospital Survey Version 2.0 is publicly available for download on the AHRQ SOPS website; however, international users must contact SafetyCultureSurveys@westat.com for permission to translate and use the survey outside the United States.

Are there recommended steps for translating the survey? Translation Guidelines for the AHRQ Surveys on Patient Safety Culture provide guidance for those interested in translating one of the SOPS Surveys.

Are any translations already available for the survey? The only official AHRQ translations of the SOPS surveys and supplemental item sets are the Spanish translations released by AHRQ. These translations are indicated by use of the trademark symbols "SOPS®" and "Surveys on Patient Safety Culture™".

Spanish translations for all five core SOPS surveys (Hospital, Medical Office, Nursing Home, Community Pharmacy, and Ambulatory Surgery Center) and the supplemental item sets have been developed by AHRQ. The Spanish translations on the AHRQ SOPS website were designed for Spanish-speaking respondents working in U.S. healthcare settings regardless of country of origin.

Many translations into other languages have been developed by international users. They are not official AHRQ translations. While AHRQ does not review the accuracy of these translations, we can connect you with other users who have translated the survey; e-mail SafetyCultureSurveys@westat.com (subject line: International Translations) and indicate the language you are interested in.

More Information About the Items

Below are the SOPS Hospital Survey 2.0 items, grouped according to the patient safety culture composite measures they measure. The item's survey location is shown to the left of each item. We have provided additional information (appears in italic font) to clarify the meaning of the item for translation. In addition, we have provided the response options for each composite measure in parentheses just below the composite measure label. Translators should note that some items are negatively worded, as indicated below.

1. Teamwork

(Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree, Does Not Apply or Don't Know)

A1. In this unit, we work together as an effective team.

A8. During busy times, staff in this unit help each other.

- *More about this item: Staff help one another as needed in this unit.*

A9. There is a problem with disrespectful behavior by those working in this unit. (negatively worded)

- *More about this item: There are staff who do **not** treat other staff with respect in this unit.*

2. Staffing and Work Pace

(Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree, Does Not Apply or Don't Know)

A2. In this unit, we have enough staff to handle the workload.

- *More about this item: "To handle the workload" means "to do the work that is needed."*

A3. Staff in this unit work longer hours than is best for patient care. (negatively worded)

- *More about this item: Staff work too many hours [per shift or per week], which is not good for patient care.*

A5. This unit relies too much on temporary, float, or PRN staff. (negatively worded)

- *More about this item: This unit relies on temporary, float, or PRN staff (contract staff, staff from other units or floors, or nonpermanent staff) more than is good for patient safety.*

A11. The work pace in this unit is so rushed that it negatively affects patient safety. (negatively worded)

- *More about this item: When staff have to rush because there is so much work to do, it is not good for patient safety.*

3. Organizational Learning—Continuous Improvement

(Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree, Does Not Apply or Don't Know)

A4. This unit regularly reviews work processes to determine if changes are needed to improve patient safety.

- *More about this item: In this unit, we regularly examine our work processes to see if we need to change anything to improve patient safety.*

A12. In this unit, changes to improve patient safety are evaluated to see how well they worked.

- *More about this item: Hospital managers/administrators compare patient safety before and after changes are made to see if the changes lead to improvements in patient safety.*

A14. This unit lets the same patient safety problems keep happening. (negatively worded)

- *More about this item: When patient safety problems happen, this unit does not do anything to ensure the problem does not happen again.*

4. Response to Error

- *More about these items: When a mistake happens, those in authority look at all factors that contributed to the mistake, including the organization's systems, practices, and procedures. They do not first conclude the staff member is at fault.*

(Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree, Does Not Apply or Don't Know)

A6. In this unit, staff feel like their mistakes are held against them. (negatively worded)

- *More about this item: Staff feel like they are unfairly blamed when mistakes happen.*

A7. When an event is reported in this unit, it feels like the person is being written up, not the problem. (negatively worded)

- *More about this item: When an event is reported, it feels like the person is the focus of blame instead of focusing on the root causes of the problem.*

A10. When staff make errors, this unit focuses on learning rather than blaming individuals.

- *More about this item: When staff make any errors or mistakes, supervisors/managers don't immediately blame staff, but rather focus on investigating problems with procedures or systems that may have led to the error or mistake.*

A13. In this unit, there is a lack of support for staff involved in patient safety errors. (negatively worded)

- *More about this item: When staff are involved with patient safety errors, there are not enough support services (e.g., peer support or counseling) available for staff to help them work through the potentially traumatizing incident.*

5. Supervisor, Manager, or Clinical Leader Support for Patient Safety

(Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree, Does Not Apply or Don't Know)

B1. My supervisor, manager, or clinical leader seriously considers staff suggestions for improving patient safety.

B2. My supervisor, manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts. (negatively worded)

- *More about this item: "Taking shortcuts" means not following all the standard procedures so they can complete their work faster. "Shortcuts" also implies that this is not good or not safe for patients.*

B3. My supervisor, manager, or clinical leader takes action to address patient safety concerns that are brought to their attention.

6. Communication About Error

(Never, Rarely, Sometimes, Most of the time, Always, Does Not Apply or Don't Know)

C1. We are informed about errors that happen in this unit.

C2. When errors happen in this unit, we discuss ways to prevent them from happening again.

C3. In this unit, we are informed about changes that are made based on event reports.

- *More about this item: When changes are made in response to patient safety event reports, staff are informed about those changes.*

7. Communication Openness

- *More about these items: "Speak up" means to notify someone in authority about the problem. "With more authority" includes physicians, nurse managers, supervisors, managers, clinical leaders, or anyone who provides staff direction.*

(Never, Rarely, Sometimes, Most of the time, Always, Does Not Apply or Don't Know)

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.

- *More about this item: "Open" means willing to listen and consider patient safety concerns identified by staff.*

C7. In this unit, staff are afraid to ask questions when something does not seem right. (negatively worded)

- *More about this item: Staff fear reprisals/retaliation/negative consequences or think they will get in trouble if they ask questions about something they think might be a problem.*

8. Reporting Patient Safety Events

- *More about these items: Refers to reports made to someone in authority or reports submitted through the hospital's event reporting system; the items are NOT about disclosure or reporting of errors to patients.*

(Never, Rarely, Sometimes, Most of the time, Always, Does Not Apply or Don't Know)

D1. When a mistake is **caught and corrected** before reaching the patient, how often is this reported?

D2. When a mistake reaches the patient and could have harmed the patient, but did not, how often is this reported?

- *More about this item: The difference between this item and D1 is that the mistake occurs in D2 – it is not corrected in D2. Although the mistake actually occurs, there is no harm to the patient, but there could have been harm to the patient.*

9. Hospital Management Support for Patient Safety

(Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree, Does Not Apply or Don't Know)

F1. The actions of hospital management show that patient safety is a top priority.

F2. Hospital management provides adequate resources to improve patient safety.

- *More about this item: Resources include, but are not limited to, training, equipment, materials, and staff.*

F3. Hospital management seems interested in patient safety only after an adverse event happens. (negatively worded)

- *More about this item: Hospital managers are only interested in doing something about patient safety when there is an adverse event or a patient is harmed.*

10. Handoffs and Information Exchange

- *More information on these items: "Information is often left out" means patient information is not communicated or gets lost.*

(Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree, Does Not Apply or Don't Know)

F4. When transferring patients from one unit to another, important information is often left out. (negatively worded)

F5. During shift changes, important patient care information is often left out. (negatively worded)

F6. During shift changes, there is adequate time to exchange all key patient care information.

Number of Events Reported

(None, 1 to 2, 3 to 5, 6 to 10, 11 or more)

D3. **In the past 12 months**, how many patient safety events have **you** reported?

Patient Safety Rating

(Poor, Fair, Good, Very Good, Excellent)

E1. How would you rate your unit/work area on patient safety?

Note: Negatively worded questions should be reverse coded when calculating percent "positive" response, means, and composite measure scores.