

Patient Safety Survey

Emergency Medicine Patient Safety Survey

This survey asks questions about patient safety event reporting.

It should take you about 5 minutes to complete.

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

1. What is your primary role?

- Attending EM Physician
- R1 in Emergency Medicine
- R2 in Emergency Medicine
- R3 in Emergency Medicine
- Other (please specify)

2. If you are an attending physician, how many years have you been in practice after residency?

- Less than 5 years
- 5-9 years
- 10-14 years
- 15-19 years
- 20 years or more

3. Gender

- Female
- Male

4. Please indicate if you agree or disagree with the following statements.

	Agree	Disagree	Not sure
A patient safety event always involves patient harm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A patient safety event always involves an error	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Healthcare workers should report NEAR MISSES to their hospital or healthcare organization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Healthcare workers should report MINOR errors to their hospital or healthcare organization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Healthcare workers should report SERIOUS errors to their hospital or healthcare organization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Healthcare workers should report expected bad outcomes to their hospital or healthcare organization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
As a healthcare provider, I will undoubtedly be responsible for a medical error at some time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patient safety events are very rare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am confident I know what patient safety events to report	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I know how to report a patient safety event at the institutions I work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel confident I know where to find Sensor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel confident I know how to enter a patient safety event into Sensor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. In the past 12 months, how many event reports have you filled out and submitted at St. John's Hospital?

- None
- 1 to 2 events
- 3 to 5 events
- 6 to 10 events
- greater than 10 events

6. What method(s) did you use in reporting events at St. John's Hospital?

- Paper form
- Computerized reporting
- Other (please specify)

7. In the past 12 months, how many event reports have you filled out and submitted at Memorial Medical Center?

- None
- 1 to 2 events
- 3 to 5 events
- 6 to 10 events
- greater than 10 events

8. What method(s) did you use in reporting events at Memorial Medical Center?

- Paper form
- Computerized reporting
- Other (please specify)

9. Do you know how to enter an event into Sensor?

- Yes
- No
- Not sure

10. Have you ever entered an event into Sensor?

- Yes
- No
- Not sure

11. If you have used Sensor to report an event, estimate the time it took you to enter the event (if you entered more than one event in Sensor, please estimate the average time per event):

- Less than 1 minute
- 1-3 minutes
- 3-5 minutes
- Greater than 5 minutes
- I have never used Sensor

12. How easy was Sensor to navigate?

- Very easy
- Moderately easy
- Neither easy or difficult
- Moderately difficult
- Very difficult
- I have never used Sensor

13. If you have been involved or witnessed a patient safety event or events but did not report the event, what was the reason? (list all that apply)

- I did not feel the event warranted reporting
- I was worried about disciplinary action for making a mistake if I reported the event
- I was worried that someone else (nurse, physician or other employee) would be disciplined
- I was concerned about legal action
- I did not think the problem would be addressed so reporting would be futile
- I was afraid of humiliation
- I thought someone else would do it
- Reporting an event takes too much time
- I did not know how to report an event
- Other (please specify)

14. Has a nurse ever asked you to change an order retroactively to make it look as if no error was made?

- Yes
- No

15. Have you ever changed an order to cover a mistake by a nurse?

- Yes
- No

16. Has a physician ever asked you to change an order retroactively to make it look as if no mistake was made?

- Yes
- No

17. Have you ever changed an order to cover a mistake by a physician?

- Yes
- No